HEALTH FINANCING PROFILE - COSTA RICA

Costa Rica is among the top performers in health outcomes in the Latin America region with life expectancy, fertility rates and infant mortality rates comparable to higher income **OECD** nations.[1] Significant historical investment in clean water and sanitation (97% of Costa Rican households have potable water piped in[2] and 95% have what is considered the highest level of sanitation facilities[3]) together with fairly comprehensive primary health care coverage has contributed greatly to these positive health outcomes.

Costa Rica is well on the way to meeting the **Millenium Development Goals (MDGs)** for child and maternal mortality after having seen infant mortality drop from 14 per 1,000 live births in 1995 to 9 in 2011. The maternal mortality ratio is among the lowest in the Latin America and Caribbean (LAC) region at 40 per 100,000 live births (2010) decreasing at 1.7% annually from 2000-2010 while over 95% of births are attended by skilled personnel.[4]

Costa Rica's HIV/AIDS prevalence remains below 1% in the general population and it exhibits one of the lowest prevalence levels of tuberculosis for the region at approximately 15 per 100,000 population in 2011.[5]

These positive advances, however, have been accompanied by challenges familiar to **OECD** nations, namely issues of equity, financial sustainability and the increasing prominence of costly chronic illnesses relative to infectious disease.

Health Finance Snapshot

Total Health Expenditures (THE) have increased steadily as the covered population has expanded and the demographic and epidemiological transitions have advanced.

General Government expenditure on health (GGHE) as a share of **THE** decreased by close to 7 percentage points from 1995 through 2011 (from 76.5% to 70.1% of **THE**) with **Private Expenditure on health (PvtHE)** increasing proportionally (Table 1, Figure 1).

Table 1. Health Finance Indicators: Costa Rica

	1995	2000	2003	2005	2007	2009	2011
Population (thousands)	3,469	3,919	4,133	4,245	4,200	4,591	4,727
Total health expenditure (**THE**, in million current US$)	763	1,129	1,418	1,545	2,202	3,032	4,457
THE as % of **GDP**	7	7	8	8	8	10	11
THE per capita at exchange rate	220	288	343	364	524	660	943
General government expenditure on health (**GGHE**) as % of **THE**	76.5	78.6	75.3	70.6	67.3	68.1	70.1
Out of pocket expenditure as % of **THE**	20.6	18.8	22.2	24.8	28.7	28.8	27.2
Private insurance as % of **THE**	0.6	0.5	0.8	2.7	2.4	1.9	1.5

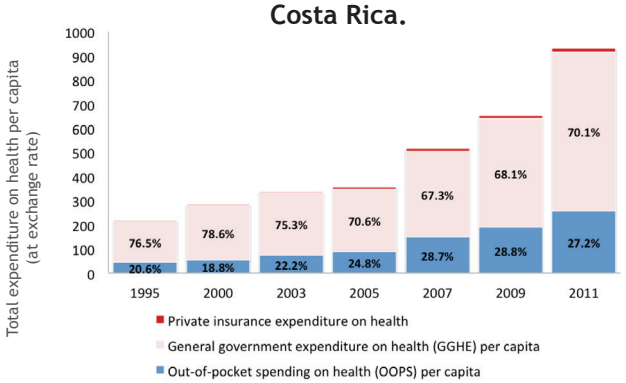
Source: WHO, Global Health Expenditure Database; National Health Accounts, Costa Rica

- **Out of pocket spending (OOPS)** makes up a significant portion of **THE** (Table 1, Figure 1) and is used for[6]:
  - purchase of medications;
  - medical consultations;
  - lab examinations.
  - OOPS does not include insurance premiums or payroll deductions for public health insurance.

- Though usage of private insurance remains low, it is increasing
  - Private insurance does not substitute public coverage.
  - It allows its beneficiaries to avoid queues for basic services by attending private providers.
  - Most privately insured individuals then return to public providers (and insurance) for inpatient and costly services.

- External resources spent on health remain below 1% of **THE**.

Figure 1. THE per capita by type of expenditure, Costa Rica.



Note: Private insurance expenditure on health was below 1% before 2005.
Source: WHO, Global Health Expenditure Database; National Health Accounts, Costa Rica

Health Status and the Demographic Transition

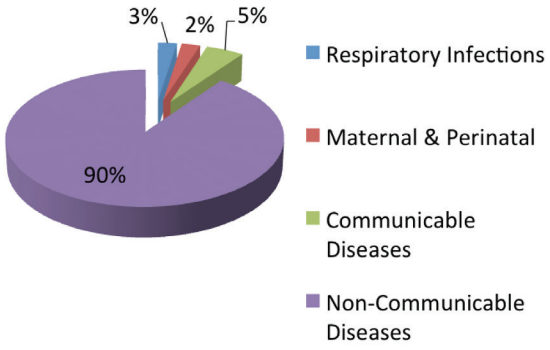
Adults and the elderly typically utilize a greater number of costly health services. An aging population that is accompanied by a decrease in the young, healthy working-age population has long-lasting impacts on health finance and sustainability.

A. **Birth and mortality rates** are declining steadily (figure 2).
B. **Life expectancy** is increasing.
C. **The total fertility rate (TFR)** fell from 3.1 in 1990 to 1.9 in 2012.
D. The 'bulge' in the **population pyramid** is moving markedly upward (figure 3).

This demographic transition goes hand-in-hand with the epidemiological transition

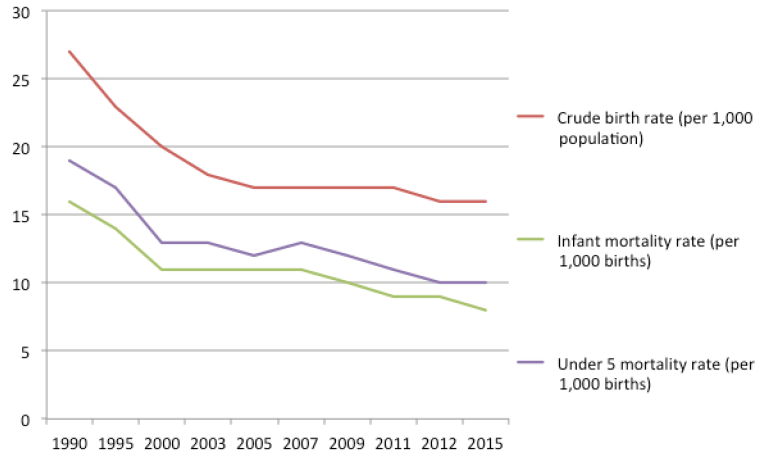
E. Non-communicable (chronic) illnesses have eclipsed infectious diseases as major killers (Figures 4 and 5).

Figure 4. Mortality by Cause, 2008. Costa Rica.



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 2. Demographic Indicators: Costa Rica



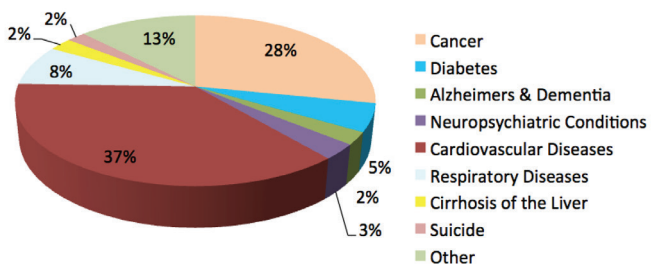
Source: Interagency Estimates (WHO, World Bank and UNICEF) and the Instituto Nacional de Estadistica y Censos, Costa Rica.

Table 2. International Comparisons, health indicators.

	Costa Rica	Upper Middle Income Country Average	% Difference
GNI per capita (year 2000 US$)	3,749.9	1,899.0	97.5%
Prenatal service coverage	89.9	93.8	-4.1%
Contraceptive coverage	80	80.5	-0.7%
Skilled birth coverage	99.3	98.0	1.3%
Sanitation	95	73	30.1%
TB Success	54	86	-37.2%
Infant Mortality Rate	8.7	16.5	-47.3%
<5 Mortality Rate	10.1	19.6	-48.6%
Maternal Mortality Rate	40.0	53.2	-24.9%
Life expectancy	79.2	72.8	23.4%
THE % of GDP	10.9	6.1	79%
GHE as % of THE	53.7	54.3	-1.1%
Physician Density	1.3	1.7	-21.9%
Hospital Bed Density	1.2	3.7	-67.3%

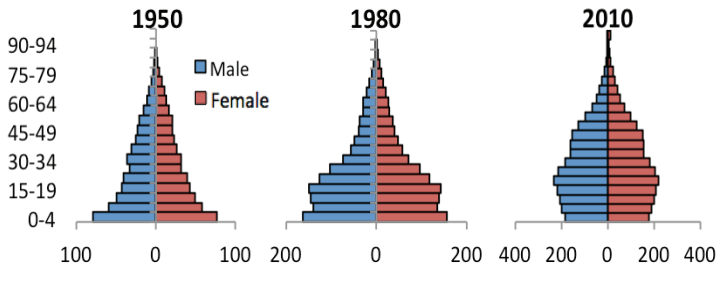
Source: Torres, Fernando Montenegro. "Costa Rica Universal Coverage Challenges and Opportunities Policy Note", World Bank, 2012.

Figure 5. Non-Communicable Disease Mortality, 2008.



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 3. Population Pyramids of Costa Rica

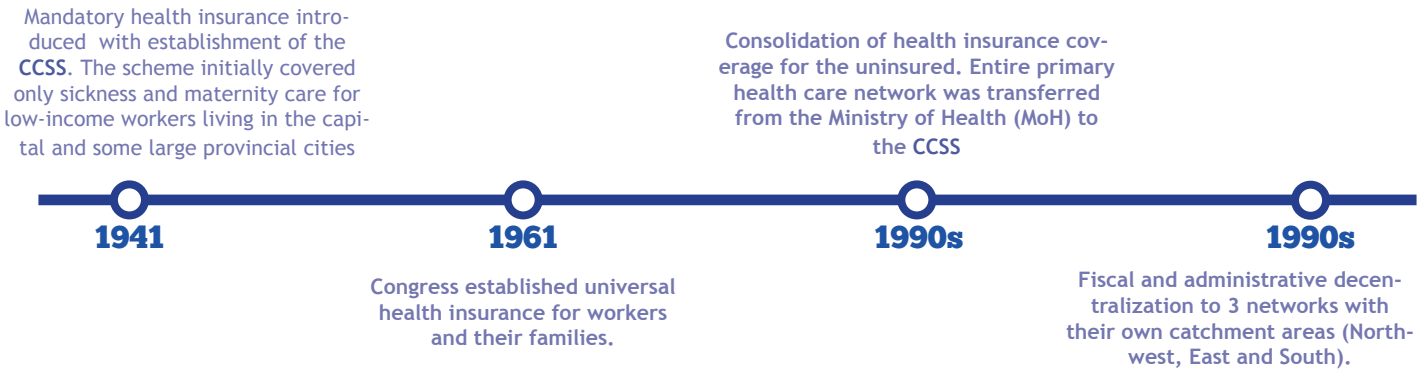


Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision.

Health System Financing and Coverage

Costa Rica's Social Security Fund **(Caja Costarricense de Seguridad Social, CCCS)** was introduced in 1941 and has gradually evolved to cover increasing numbers of Costa Ricans (Figure 6). It includes not only health coverage but also disability, old age and life insurance components. **CCSS** has achieved near-universal health coverage which is credited for Costa Rica's overall population health while also being strained by persistent and emerging challenges to safeguarding equity and sustainability.

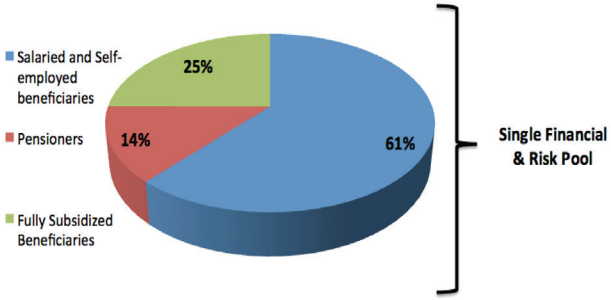
Figure 6. Timeline of Costa Rica's Health Insurance Scheme



The **CCSS** is a single purchaser, vertically-integrated public body. It administers the following social security regimes which include a health insurance component (**SEM**)[6]:

A. Salaried (conventional employer-employee relationship with both contributing premiums through automatic, mandatory payroll deductions) with dependents;
B. Self-employed (independent worker who earns a minimum wage – determined annually - is required to sign up for coverage and contributes a percentage of income in premiums. Enrollment is not automatic[8]) with dependents;
C. Pensioner (retirees formerly in groups A or B and with a minimum pension – determined annually – contribute with an automatic, mandatory deduction from pension income[9]) with dependents;
D. Fully Subsidized Beneficiaries (financing is the sole responsibility of the State and is based upon taxes levied on luxury goods, tobacco, liquor, imports and proceeds from the national lottery.)

Figure 7. Distribution of CCSS Enrolled Beneficiaries, 2011.



Source: CCSS,Annual Statistics (Anuários Estadísticos)

Since 2007, Costa Rica has required explicit enrollment of group D (state-insured) beneficiaries in the **CCSS.**[1] There is a small portion of residents who remain unenrolled and who are classified as "uninsured".[6] These residents may only receive (free) emergency room care from public facilities but cannot access follow-up care, non-emergency prescription medications or any other non-emergency health services.

- Migrant workers, particularly those from neighboring nations who are ineligible for benefits;
- Unenrolled poor households (many with heads working in the informal sector)
  - Burdensome and complex enrollment procedures for potential Fully Subsidized beneficiaries are blamed for the continued exclusion of otherwise eligible households.

However, indigenous populations, pregnant women, children under 18 and individuals over 65 years old or with disabilities are entitled to all of the Group D healthcare benefits regardless of enrollment or immigration status.

Self-employed or independent workers are often referred to as 'Voluntary' contributors as they are not automatically enrolled in the **CCSS** and must earn a minimum income in order to be required to contribute. Once enrolled, however, they are permanently in the **CCSS** system. Their status will then be changed (to 'Salaried', 'Fully Subsidized Beneficiary', etc…) if and as their employment circumstances change.

Public expenditure on health in Costa Rica is progressive[7]

- The poorest 20 percent of the population (earning <5% of national income), receive close to 30% of public health expenditures.
- The wealthiest 20 percent of families (earning 48% of national income) receive approximately 11% of public health expenditures.

Costa Rica does not have a specific list of covered services, rather relying upon general 'right to health' legislative language and a general list of broad services to be provided by the **CCSS** (figure 8).

Figure 8. CCSS Contributions and Services

		% of earnings contributed to SEM§	% of earnings contributed to IVM*	General Health Services Covered
Salaried/Wage-earning workers	Employers	9.25%	4.91%	• Health promotion, prevention, treatment, and rehabilitation • Specialized and surgical medical assistance • Outpatient and hospital assistance • Pharmacy service/prescription medications • Clinical laboratory services • Dental/Oral health assistance
	Workers	5.5%	2.75%	
	State	0.25%	0.25%	
Self-employed/ Independent workers	Worker with income between a minimum and US$885	10.5% (combined SEM & IVM)		
	Worker with income above US$885	13.5% (combined SEM & IVM)		
	State	0.25%	0.25%	
Fully Subsidized Beneficiaries	State	..		

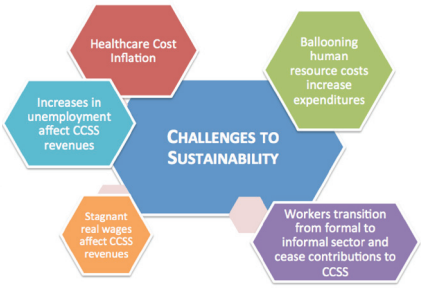
Source: World Health Organization "Universal Coverage in a Middle Income Country: Costa Rica", World Health Report, Background Paper, No 11, 2010
Note: Former workers who contributed to the CCSS and are collecting a minimum pension also make a mandatory 5% contribution to SEM. Indigent pensioners do not.
§ SEM is the health portion of the CCSS
***IVM is the disability and pension portion of the CCSS**

Basic Primary Health Care Teams (Equipos Básicos de Atención Integral en Salud, **EBAIS**) form the backbone of Costa Rica's near-universal primary health care system.

- **EBAIS** are assigned a health area and typically comprise a physician, nurse and technician.
- Responsible for preventive and curative services as well as health promotion for beneficiaries in their area.
- Responsible for identifying and targeting poor households for enrollment with **CCSS**.

Challenges and Financial Sustainability[1]

- Better integration of health care network management units is needed to ensure the continuum of care across all levels with a focus on health promotion, prevention, and provision of patient support.
- Identification and enrollment mechanisms for the poor must be harmonized.
- Public health institutions require clearly delineated standards and improved incentives for quality and timely care.
- Investments in basic technology to allow monitoring of key cost and performance indicators at the national and regional level are needed.



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