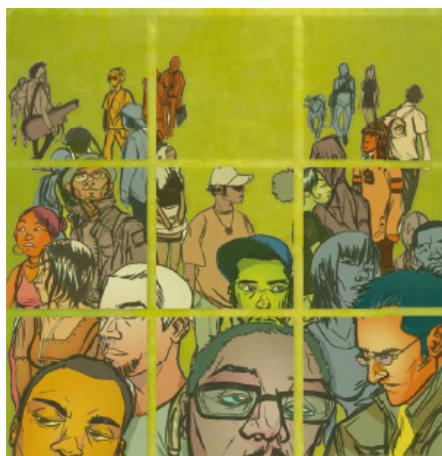




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UNIVERSAL COVERAGE IN A MIDDLE INCOME COUNTRY: COSTA RICA¹

World Health Report (2010) Background Paper, No 11

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Abstract

The Costa Rican State is about to celebrate its 70th year of healthcare management. It all started as social security for public sector workers, but eventually, the structure of the system was consolidated until turning it into one of the most effectively universalized healthcare systems in Latin America, both financially and geographically, and making it reach infant mortality and life expectancy indicators comparable to those of European developed countries. This document offers several elements for analyzing the sustainability of the model, starting with 1) a description of the Costa Rican healthcare system, pointing at antecedents, the 90s reform, and the right to health in the Costa Rican State; 2) the universal coverage data; 3) the service packages, including a description of the regimes and the attention levels; followed by 4) the financing of the healthcare system; 5) the rationing models of the healthcare system; 6) the challenges faced by the universal coverage of the Costa Rican healthcare system, and finally 7) conclusions.

1. INTRODUCTION TO THE COSTA RICAN HEALTHCARE SYSTEM

a. Antecedents

The provision of healthcare services and the management of the various regimes of social security within the Costa Rican healthcare system are sustained in the creation of the *Caja Costarricense de Seguro Social* or CCSS (Costa Rican Social Security Administration) in 1941, which was declared an autonomous institution two years later and enabled in 1949, by the Costa Rican Political Constitution, *to universalize social security services in favor of the workers who reside in the national territory and responsibly pay for social security* (CPCR, Art. 73, 74, and 177).

It is important to add that the constitutional norm makes reference to a social security structure that is based on labor and its territoriality, which in the end was pertinent to the characteristics of the labor market halfway through the twentieth century, thus allowing the CCSS to become the main provider of healthcare in the country. However, this also poses important challenges for the current and future sustainability of the system, according to the informality and extraterritoriality of the market labor, as analyzed below.

During the 1990s, the reformation of the health sector gave priority to nationwide primary healthcare and the deconcentration of the administrative responsibility. The Costa Rican Ministry of Health delegated unto the CCSS the activities of prevention, recovery, and rehabilitation of health, while the Ministry itself undertook the governing functions of defining the national policy on healthcare, planning, promotion, and coordination of all the public and private activities of healthcare. This reform facilitated the expansion of the geographical coverage of the primary level of assistance.

b. The right to health in Costa Rica

In Costa Rica, there is no explicit constitutional reference to the right to health or health protection, as there is to social security. This constitutional void has been partially remedied by repeated resolutions passed by the Constitutional Court (lit. Constitutional Chamber), which, based on Article 21 on the right to life, has guaranteed the right to the protection of health within the human rights doctrine. This has been a vastly transcendental contribution that could become the object of a subsequent comparative study in the context of Latin American legislation.

In this regard, the Constitutional Chamber, in repeated sentences, has developed the extent of the right protected in Article 21 of our constitution, thus recognizing *life as the most important good that can and should be guaranteed by the Legal System, even giving it the status of principal value within the scale of personal rights. This is justified in the fact that without its enjoyment, all the other rights prove to be useless. Therefore, the Political Constitution, in its 21st article, recognizes that human life is inviolable, and from there, the Court has derived the*

right to health as a fundamental one which, from all standpoints, must be guaranteed by this Jurisdiction. As a result, there is no questioning whatsoever about the constitutional protection of this fundamental right, inasmuch as it is inherent to the dignity of the human being, regarding this matter (SC, Sentence N. 2002-06166).

At the normative level, this situation is better defined by the 1973 General Law of Health, which establishes that *all residents have the right to healthcare provisions (...) and the obligation to contribute with the preservation of health and to maintain the health of his/her family and community (LGS 5395, Art 3).*

This regulation expands and universalizes the specific concept of “beneficiary of healthcare provisions” to include every resident, not only those who contribute or are sheltered by a social security regime. At the same time, the obligation imposed on the collectivity of the residents is of a general nature with regard to an integral concept of health, as opposed to a specific or mandatory duty regarding the obligation of financially contributing to social security.

Additionally, the abovementioned law establishes that *the health of the population is a public interest good guaranteed by the State (LGS 5395, Art. 1).*

Likewise, there is also the Law of Rights and Obligations of the users of public and private healthcare services (Law 8239²), whose goal is to *guarantee the rights and obligations of the users of all healthcare services, both public and private, established on national territory (Art. 1).* Let it be noted that these dispositions also apply to private health centers.

In general terms, this law establishes that the users must receive detailed and timely information about their rights and obligations and about the professional degrees and positions of the health professionals from whom they receive attention, and they must be properly informed in order to make a decision about whether or not they should grant their authorization to be administered a given medical treatment or procedure.

Furthermore, it is a right of the users to be treated with consideration and respect, with no distinctions, as well to be assisted without delay under emergency situations, to have access to a clinical file and receive a copy of it, to submit claims about healthcare services to the corresponding authorities, to demand that the confidential nature of his/her clinical file be respected, and finally, a non-insured patient must receive an account of the details and explanations of all the expenses that he/she has incurred during his/her treatment, among other rights (Art. 2).³

As regards obligations, the users must provide the most accurate information about their medical history, as well as other conditions concerning their health. Likewise, they must follow

² Approved March 13, 2002 by the Legislative Assembly

³ Other rights in private healthcare centers are: a) to receive an account of the details and explanation of all the expenses that the user has incurred during his/her treatment; b) to indicate the names of the people who will be give priority to visit them, provided that their state allows them to receive any visitors.

any instructions that they have received and be responsible for their own actions and omissions. Also, they must contribute timely, when their resources allow them to, to the financing of the country's public healthcare services (Art. 4).

2. UNIVERSAL COVERAGE DATA

The Costa Rican healthcare system is one of the few in Latin America that actually offers almost complete, universal coverage, both financial and geographical, an achievement that is sustained in a financing strategy based upon the contributions of workers, employers, and the State, typical of social securities.

With regard to the financing method, the coverage percentage of health insurance for the whole population in the year 2008 was 87.6%⁴ (CCSS, 2009. p.1), of which the economically active population (EAP) represents 70.07%, and as for the non-wage-earning EAP, the coverage reached 62.07% (XV PEN, 209).

A recent study found that the incidence of catastrophic health expenditure in Costa Rican households went from 1.56 to 0.31% in 2004, which is notably low. Out-of-pocket expenditure represented little more than 200% of the total healthcare expenditure. Household expenses for hospitalization are scarce and generally not catastrophic (Zúñiga et al. 2010. Calculation based on WHOSIS).

The CCSS, as an autonomous entity, establishes a series of regulations for its functioning and work, and with regard to insurance methods, it has described the following types of beneficiaries: 1) direct (maintains a conventional employer-employee relationship), 2) self-insured (voluntary insured who works on his/her own account in some activity), 3) pensioner, 4) family insured (indirectly-insured relatives of direct beneficiaries: wage-earners, pensioners, or self-insured beneficiaries, and 5) insured by the State, in whose case the financing is the sole responsibility of the State. These methods of insurance are referred to the social security regimes administered by the CCSS.

The percentage of insurance financing, according to each type of beneficiary and to data made available by the CCSS in 2008, is established at 30,73% for active, direct insured beneficiaries, 6% for direct pensioners, and 10,57% for State-insured beneficiaries (CCSS, 2008); that is to say that approximately 40% corresponds to indirect beneficiaries on account of their condition as economically dependent.

On the other hand, the regulations of the CCSS recognize a "non-insured" category, which has been erroneously justified on account of the existence of sectors that, because of their

⁴ This datum refers to the economically active population that contributes to the system plus those who are economically dependent (children, senior citizens, disabled people) but are covered by one of the insurance regime.

conditions of poverty, cannot contribute to social security. However, this is untrue since for people and families in such condition the CCSS has created the category of “State-insured beneficiaries.” Therefore, the existence of a “non-insured” category offers an opportunity for country residents with contributive capacity, who have chosen not to contribute to Social Security, to have access to the provision of services by way of emergency room (ER) services and primary attention programs.

In the case of geographical coverage, the CCSS offers a whole service network of first, second, and third level of attention (See Chart 1). The country is divided into regions and 105 Health Areas of approximately 30.000 to 60.000 residents. In turn, each area is subdivided into population sectors of approximately 3.500 to 4.000 residents, who are seen at primary attention units called *Equipos Básicos de Atención Integral de Salud* or *EBAIS* (Basic Provision Units of Integrated Healthcare). Their number reaches 947 in the whole country (CCSS 2009, pp. 41-43), and along with some peripheral and deconcentrated clinics, conform the first level of attention.

The secondary level is constituted by a network of 11 major clinics, 13 peripheral hospitals, and 7 regional hospitals, which provide ER services, diagnosis support, specialized outpatient consultation and simple surgical treatments. The third level of attention, on the other hand, provides admission and medical-surgical services of high technological complexity, which are offered at specialized and national concentration hospitals (OPS 2002, pp. 1-2). In sum, the third level is constituted by 4 specialized and 3 national concentration hospitals. (OPS 2002, pp. 1-2 y CCSS 2009, pp. 41-43).

Chart 1. Service network of first, second, and third level of attention, CCSS, Costa Rica

Levels	First	Second	Third
Type of Health Center	EBAIS Peripheral clinics Deconcentrated clinics	Major clinics Peripheral hospitals Regional hospitals	National hospitals Specialized hospitals
Services	Integral attention programs 1. Integral attention of children 2. Integral attention of teenagers 3. Integral attention of women 4. Integral attention of adults 5. Integral attention of senior citizens	1. Emergencies 2. Diagnosis support 3. Specialized outpatient consultation 4. Minor surgeries	1. Patient admissions 2. Surgeries 3. High-technology treatments

Source: Original elaboration. 2010

3. SERVICE PACKAGES OFFERED BY THE HEALTH SYSTEM

Health insurance in Costa Rica is integrated; that is, there is no separation of service packages depending upon different types of insurance. Every insured pays for integrated healthcare as an indivisible right guarded by the constitution and the laws of the State.

Three social security regimes administered by the CCSS may be distinguished: 1) the *Seguro de Enfermedad y Maternidad* regime or *SEM* (Illness and Maternity Insurance), 2) the *Invalidez, Vejez y Muerte* regime or *IVM* (Disability, Old Age, and Death), and 3) the Non-contributive regime⁵.

The *SEM* covers the following integrated healthcare attention services:

- a) Actions of promotion, prevention, treatment, and rehabilitation
- b) Specialized and surgical medical assistance
- c) Outpatient and hospital assistance
- d) Pharmacy service for the provision of medicines
- e) Clinical laboratory service and medical examinations
- f) Oral health assistance

This regime covers the direct insured beneficiary and those of his/her relatives that depend on his/her wages (spouses, parents, children, or other relatives that are financially dependent on and live with him/her).

The *IVM* includes the following services:

- a) old age pension
- b) disability pension
- c) orphanhood and widowhood pension

The Non-contributive regime provides:

- a) healthcare insurance for persons and their dependent relatives that do not contribute to the system on account of their condition of poverty or disability, thus offering all ordinary services that belong to the integrated assistance package of the *SEM*
- b) financial benefit for those families in which there are cases of acute cerebral palsy

⁵ Such cases as labor risk and traffic accidents fall under the responsibility to the *Instituto Nacional de Seguros* (National Insurance Institute), in accordance with Traffic Law number 7331.

In the specific case of primary attention, five integrated attention programs are implemented depending on the age condition of the life process, as well as gender conditions. These services include:

Chart 2. Services of the Integrated Attention Program at the first level of attention, CCSS, Costa Rica

1. Integrated Attention of Children	2. Integrated Attention of Teenagers	3. Integrated Attention of Women	4. Integrated Attention of Adults	5. Integrated Attention of Senior Citizens
1.1 Growth and development Consultation	2.1 Growth and development Consultation	3.1 Prenatal and postnatal attention	4.1 Vaccination	5.1 Early detection and monitoring of risk groups
1.2 Expanded immunity program	2.2 Expanded immunity program	3.2 Psychophysical preparation for labor	4.2 Odontological attention	5.2 Odontological attention
1.3 Integrated oral health	2.3 Contraception	3.3 Detection and basic assessment of infertile couples	4.3 Detection and monitoring of mental disorders	5.3 Detection and treatment of chronic diseases (mainly arterial hypertension and mellitus diabetes)
1.4 Identification and monitoring of risk groups	2.4 Integrated oral health (until age 14)	3.4 Detection and reference of violence against women	4.4 Prevention and detection of risks and chronic diseases (mainly arterial hypertension and mellitus diabetes)	5.4 Treatment of diseases
1.5 Treatment of diseases	2.5 Identification and monitoring of risk groups	3.5 Vaccination during reproductive age	4.5 Treatment of diseases	5.5 Basic rehabilitation
1.6 Basic rehabilitation	2.6 Treatment of diseases	3.6 Early detection of cervix and breast cancer	4.6 Basic rehabilitation	
		3.7 Birth control		
		3.8 Odontological attention		
		3.9 Women-related morbidity		

Source: Original elaboration. 2010

4. FINANCING OF THE HEALTHCARE SYSTEM

The CCSS finances the provision of healthcare services to the population by way of a regime that is nourished by tripartite contributions (from employers, workers, and the State). In this sense, the financing is based mainly on the contributions of the insured beneficiaries and the employer/employee contributions, which correspond to 90% of the finances of the Social Security System. At the same time, the contribution of the Costa Rican State—which participates both as employer of the public sector and as third party within the social security scheme—is getting smaller and smaller; while in 1993 the state financing corresponded to 18.3%, in 1999 it was 9.2%, and in 2001, just 7.3% (Vargas 2007, p. 83).

Currently, the individual amount of the contribution is 22.91% of each insured's salary, out of which the employer provides 14.16% (divided into 9.25% for the *SEM* and 4.91% for the *IVM*), the worker provides a total of 8.25% (5.50% for the *SEM* and 2.75% for the *IVM*), and the State contributes with 0.50% (divided into 0.25% for the *SEM* and 0.25% for the *IVM*). In the case of voluntary insured contributors and independent workers, the amounts that they provide are determined in accordance with the reference income of each applicant, and the State contributes with 0.25%. Thus, if the applicant's income is lower than US\$885, his/her contribution will be 10.5%, but if his/her income is higher than such amount, he/she will provide 13.50% (CCSS, 2010).

The Non-contributive regime is financed by the State by way of the *FODESAF* or *Fondo de Desarrollo Social y Asignaciones Familiares* (Fund for Social Development and Family Welfare), as well as specific charges on electronic lottery activities and tobacco and liquor sales.

Table 1. Scheme of contributive insuring, CCSS, Costa Rica

Scheme of contributive scheme*		SEM	IVM	Non-contributive	Accumulation
Wage-earning worker	Employers	9,25%	4,91%		14,16%
	Workers	5,50%	2,75%		8,25%
	State	0,25%	0,25%		0,50%
Independent worker	Worker with an income lower than US\$885	10,50%			10,50%
	Worker with an income higher than US\$885	13,50%			13,50%
	State	0,25%	0,25%		0,50%
State-insured beneficiary	<i>Junta de Protección Social</i> (Social Protection Board) JPS Law 7395 ¹			95% of the net utilities of the electronic lottery ²	
	Law 7972 of tax charges on liquor, beer and cigarettes			Annual amount of ₡1000 million (US\$1,7 million)	
	Direction of Social Development and Family Welfare			20% of the FODESAF ³ (Aprox. 0,3% of the GDP)	

* The insured relatives are covered indirectly by the contribution of a direct insured (wage-earning, independent, or pensioner), who bears the contributive responsibility. In the case of the pensioner, his/her contribution stops when he/she stops working, but the coverage of rights continues for himself/herself and his/her relatives.

¹ The *Junta de Protección Social* (Social Protection Board) is Costa Rica's oldest public institution, and its mission is to contribute to the strengthening of the country's social security and social welfare by generating resources for state and non-state social institutions and organizations. This is achieved through the efficient administration of national lotteries, under an exclusivity regime for such economic activity.

² The Law of Protection for the Worker No. 7983 of the year 2000, in its Art. 77, established that, when the amount of annual utilities is lower than ₡3,000 million (aprox. US\$5,3 million), the Executive Power shall have to include in the National Budget the transference to the Non-contributive Regime of the CCSS, in order to cover for the difference between what was drawn by the *Junta de Protección Social* (Social Protection Board) of San José and the amount herein established.

³ This was established in Art. 4 of the Law 5662 of 1974, which created the *Fondo de Desarrollo Social y Asignaciones Familiares* (FODESAF). It is financed by contributions from the Law of Sale Taxes No. 3914, as well as a 5% surcharge on the total salaries and wages that public and private employers must pay monthly to their workers, except for the Executive Power, the Legislative Power and the Tribunal.

Source: Original elaboration. 2010

The CCSS recognizes that the main source of income is this tripartite contribution. According to information provided by the *Contraloría General de la República* or *CGR* (General Comptroller's Office)⁶, the CCSS saw, between 2007 and 2008, a slight improvement in its finances, thus reaching a surplus for the last year. 69% of this surplus corresponds to Pension Insurance, 24% to Healthcare Insurance, and 7% to the RNCP (Non-contributive Pension Regime).

Table 2. Summary of budget liquidation, CCSS, 2007-2008
In millions of dollars

Program	Healthcare Insurance		Pension Insurance		Non-contributive Regime		TOTAL	
	2007	2008	2007	2008	2007	2008	2007	2008
Income received	1.433.460,4	1.649.788,4	1.029.547,6	965.412,1	118.402,4	149.631,9	2.581.410,4	2.764.832,5
Minus:								
Expenses incurred	1.313.858,6	1.580.553,4	822.988,2	763.158,2	103.617,3	128.556,3	2.240.464,1	2.472.267,9
Minus:								
Difference of the period		69.235,1		202.253,9		21.075,6		292.564,6

Source: Original elaboration, based on CGR. Annual Report 2007 and 2008

5. RATIONING MODELS

Although the Costa Rican medical health package covers from prenatal assistance to old age, based on primary attention, there are several rationing models, such as the *compromisos de gestión* (management compromises), a mechanism employed to allocate resources based on the analysis and projection of the demographical and epidemiological needs of the population around every healthcare center. This instrument establishes a commitment between the immediate provider (*EBAIS*, clinic, hospital) and the group of its buyers (users) to set their objectives, goals, and financing by means of an allocation of resources that is negotiated with the CCSS (CCSS, 2010).

Another of these rationing instruments is the *lista oficial de medicamentos* or *LOM* (official list of medicaments), a document that explains in detail the available medicines that the CCSS can offer, with which 95% of the population is to be assisted and treated (CCSS, 2009). A minority requires particular assistance; therefore, a special regulation known as "exceptional

⁶ Entity attached to the Legislative Assembly, with competence to supervise the use of public funds by all the entities that integrate and administer the Public Treasury.

medicament” has been created. This modality applies to a special clinical condition that a patient may have developed, a torpid evolution of a given pathological picture, or else because the condition does not respond adequately to the therapeutic alternatives available in the LOM, among others, in a way such that the exceptionality is recognized because the clinical condition *escapes the rules of generality* (Tinoco, 2007, p.3). It is also noticeable that, out of the total amount of out-of-pocket expenses, 80% is related to the purchase of medicines and medical consultations, while 7% corresponds to lab examinations and other procedures (Muiser, 2010).

This satisfaction with which the State must provide the population includes: a) provision of public healthcare service, b) organization of the healthcare system, and c) the obligations that the State has to make the protection of the legal right effective (Vargas 2007, pp. 34-35). With this, the right to health covers the following essential elements:

1. Availability: Sufficient number of public healthcare facilities, goods, and services and healthcare centers and programs
2. Accessibility: Healthcare facilities, goods, and services accessible to all.
 - a. No discrimination: Vulnerable and marginalized sectors of the population having access to healthcare facilities, goods, and services under no discrimination
 - b. Physical accessibility: Within the geographical reach of all the sectors of the population, as well as accessibility to the disabled
 - c. Economic accessibility: Payment of healthcare and healthcare-related services made in accordance with the equity principle
 - d. Access to information: Right to request, receive, and disclose information and ideas regarding health, without detriment to anyone’s confidentiality
3. Acceptability: Respectful of medical ethics and culture
4. Quality: Healthcare facilities, goods, and services appropriate from a good-quality scientific and medical standpoint (Vargas 2007).

In Costa Rica, some economic sectors have advocated—based on rationality and efficiency criteria—the delimitation of the service package as an instrument of rationality that delimits the offer of public services, thus clarifying the market limits between public and private sectors.

To date, the Constitutional Court has appealed to the individual right to health on matters regarding economicist theses that appear evident in the institutional refusals of the CCSS to the timely assist the insured. This is why the Court has even ordered the expansion of healthcare services with regard to therapies that are non-existent at a specific moment within the national healthcare system. The Constitutional Court does not ignore the fact that the resources are always limited, but it is clear in that this cannot be confused with insufficiency and, therefore, does not justify the delimitation of the right to health as derived from the right to life.

It is true that the basic public healthcare services may become an instrument to rationality for those public services that have low coverage and wish to expand it by demanding the right to health in favor of sectors that have been excluded from attention. However, in the case of

highly universalized systems like Costa Rica's, this same instrument opposes the human rights approach and the principle of indivisibility of the right to health, thus promoting spaces of exclusivity between public and private healthcare providers that would turn out to be excluding and not equitable enough.

In this sense, it can be claimed that when in Costa Rica the system has faced financial problems for some specific coverage or for the sustainability of the healthcare system, "the Costa Rica way"—at least the predominant one for the last 60 years—has not been resigning to a cutback in or a delimitation of services by way of packages—although those who prefer it that way have lifted up the banner of economic arguments and have had them "validated" by multiple sectors—, but rather identifying new sources of income and directing them towards strengthening the system.

5. CHALLENGES OF UNIVERSAL COVERAGE FOR THE HEALTHCARE SYSTEM

Notwithstanding the fact that the Costa Rican healthcare system shows important indicators of successful performance, among which are noticeable an average male and female life expectancy of 79,12 years and a rate of infant mortality of 8,95 for every thousand live births (INEC, 2009), the system is also facing significant challenges regarding its sustainability, growth, and level of equity. These challenges arise from:

a. Limitations between health governance with regard to social security.

On the one hand, the Ministry of Health, in its governing role, does not administer or have any competency upon the Social Security Regimes, which makes it possible for inconsistencies and coordination difficulties to emerge from the healthcare policy and the institutional autonomy of the CCSS. On the other hand, the participation of the population in healthcare programs has been mainly oriented towards the collection of specific funds or to the attention of situational needs (purchase and repair of infrastructure and medical equipment), deep-rooted explanations of the scarce or non-existent regulation of the healthcare market.

b. A strong epidemiological transition

According to the five large groups of death causes in the years 2007 and 2008, Costa Rica is characterized, firstly, by illnesses of the circulatory system, with a rate of incidence that surrounds 1,1 for every 1000 residents.

The first causes of death in the country are cardiovascular illnesses, cancer, and accidents. Additionally, for the year 2009, it has been estimated that a total of 10.764 new cases of cancer were diagnosed, which is equivalent to 2.2% of the population. For

the year 2025, a total of 20.161 incidental cases have been projected. With regards to the mortality rate for 2009, a total of 4008 deaths were expected, and for 2025, a rate of 7.507 annual deceases is projected⁷. Breast cancer allows us to illustrate the magnitude of the healthcare response that the population is in need of. It requires the development of intersectorial programs of promotion of health, early detection, treatment, and timely rehabilitation. In the past, Costa Rica has been successful in the attention of infectious and parasitic diseases; the new challenge, however, demands the development of innovation as a means to improve the quality of the attention and the sustainability of the system.

For a system based on primary assistance, but facing high demands of specialized treatment, there is the challenge of balancing the levels of investment in a way such as to cause these indicators to reveal a better performance in all the geographical regions of the country, not only in the central areas.

c. The universalization of a system that was created for the working population and their families.

Reformed in 2006, the Costa Rican Regulations of Social Security, in their 7th article, state: *Affiliation to Social Security is mandatory for all wage-earning workers, independent workers, and pensioners of the national pension regimes in the national territory.* Nevertheless, these regulations did not eliminate the category of “uninsured.” Therefore, although the employers and workers are subject to crossed controls in order to guarantee their contribution, with regard to the individual, the existence of this category calls attention to a necessary discussion about direct contributive mandatoriness for all the population, especially when new sources of financing are needed to face lower EAP scenarios.

According to 2006 data, healthcare insurance statistics report 510.663 people (that is 12,2% of the population) who are not insured, and a high percentage of such group is under the condition of poverty⁸ and labor informality. There are even those who, in spite of being insured by the State, do not have a social security ID, and such deficiency makes it difficult for them to access the services (Rodríguez, 2006, p.5).

Furthermore, the coverage of primary healthcare services distributed among the *EBAIS* of the country demonstrates geographical gaps, since they respond to a population of 3.8 million and not of 4.5 million, as is our current reality. Such drawback affects the effective attention of 5000 people, who are waiting for a closer and more accessible service, and in addition, it undermines the quality of the services received by the users

⁷ For incidence and mortality data, the projections were based on the pattern that cancer has shown in the country during the last twenty-five years (1980-2005).

⁸ In Costa Rica, 14,3% of homes are under the condition of general poverty, and 4,2% under extreme poverty, for a total of 18,5%, according to the measuring methodology of poverty line (INEC, 2009).

of those EBAIS that undertake the assistance of more patients than are recommended for their capacity and burden.

Along with the above, the advancement report of the *Plan Nacional de Desarrollo* (National Plan of Development) 2006-2010 shows a substantial delay in the construction of new EBAIS. According to the report by MIDEPLAN, the level of performance is 7,5% since only 6 of the 80 EBAIS projected were actually built⁹. This demonstrates a late reaction to the needs of the general population.

d. The demographic dynamics of population growth, together with a receiving, demanding economy of a constant migration flow

10% of the population that lacks a formal coverage of the healthcare system corresponds largely to growing flows of migration. According to the data offered by the most recent population census, carried out in 2000, foreign occupation reached 242.910 people, of which the majority came from Central American countries, the Nicaraguans accounting for 45% of such population (INEC, 2000).

The migration rate for every 1000 residents is 2.9 in 2005-2010 (CCP, 2009). In 2008, 19.1% of all births in the country were from foreign mothers, and 16.3% of them were Nicaraguan.

According to Costa Rican legislation, those foreigners who are not legal residents in the country are not allowed to join the CCSS, although they have the right to access the system by way of the ER services, facing thus the problem that this prevents them from being opened a medical file of their own and makes it impossible to monitor their state afterwards.

Nevertheless, the temporary or long-term stay of these new groups is the result of labor demand, from which emerges a social responsibility that must be analyzed, not only from the perspective of the workers' obligation to contribute with the healthcare system, but also with regard to the obligations of the employers, the governments of the countries issuing these migration flows, and the actors of international cooperation.

One of the most representative cases is the coffee harvest in the area known as *Los Santos*. More than 11.000 workers and their families arrive here annually to collect coffee. They are mainly Ngöbe indigenous immigrants from Panama (50%), as well as Nicaraguans (23%) and Costa Ricans from different areas (27%) (SALTRA, 2009). 80% of this migrant working population is transitory, and the main problem for them is the lack of services, social security, and infrastructure.

SALTRA, that is, the *Programa Salud, Trabajo y Ambiente* (Health, Work, and Environment Program in Central America) has proved that half of the shelters that these

⁹ It is worth noting that the report of MIDEPLAN contemplates this goal as unaccomplished since the official administrative account of the CCSS was not submitted in time for the elaboration of the report by the PND (National Development Plan)

immigrants occupy are improvised, damaged structures; many of them do not have a toilet; ventilation and light are deficient; and the quality of the water is poor for 38% of them, while 28% obtain it from rivers or the rain.

Out of a total of 142 women who were pregnant at the moment of this research, 94% had not had access to prenatal control assistance; 77% of the children (81% of which were Nicaraguan) reported not having received basic shots. Despite the data, 35% responded that they had not attended any healthcare facilities when they were sick, and only 4% of this population is covered by the *INS* (National Insurance Institute) for labor risks.

The conditions of the *Zona de los Santos* repeat themselves in other parts of the country and at varying levels of labor situations, hence their importance as representatives about the conditions of the immigrant population of the country.

e. An increase in the offer of private and international healthcare and insurance services and the appearance of alert indicators about the loyalty of the insured population towards the system.

In spite of the fact that there is a favorable response from the population towards the State and its coverage and extension of the services offered by the *Caja Costarricense de Seguro Social*, there is also a marked tendency towards a rise in the use of private healthcare services, caused by long waiting periods before obtaining access to examinations, specialized medical evaluations, diagnoses, and surgery, which are quality problems that undermine the fidelity towards the system.

The economic integration of the Costa Rican population poses challenges for the strict territoriality of the healthcare insurance since the possibility of a movement of high-income contributors to the system towards a substitute insuring model would entail a strong impact on the sustainability of the system. According to some estimations reached in 2004, *if 18% of the highest-income contributors withdrew from the healthcare insurance system, the resources of the institution would be reduced in 48%* (PEN, 2005, p.81).

The recent aperture of the insurance market that was generated by the negotiation of the Free Trade Agreement with the United States, Central America, and the Dominican Republic (CAFTA) did not include the opening of health insurance. However, the truth is that the sectors that, during the negotiation, were in favor of this change do not advocate anymore, as the first step, a reform in the legislation for the integral opening of healthcare insurance; they have rather started to create products, like that which has recently been announced by the *Instituto Nacional de Seguros* (National Insurance Institute) and is now known as “emergency saving/insurance in case of cancer.” This product emerged after the annulment of the law that was created by the *Instituto Nacional Contra el Cáncer* (National Institute Against Cancer) as a system of prevention and attention, together with the creation of a specialized hospital as a response to 10000 new cases of cancer diagnosed annually in the country.

Although this could be seen only as a product that responds to an actual demand, created as a result of the dissatisfaction of a specific need by the public system, the truth is that this type of initiatives, based on the perception of the risk of potential catastrophic expenditure, could lead, in a near future, to the group of new clients—who will be located on medium and high-income strata on account of their capacity to obtain “complementary” insurance—putting pressure on the system to extend the coverage of this kind of insurance. Therefore, the interested sectors will have more support in their movement towards a change in legislation, and this will allow them to offer a “substitute” product for the healthcare insurance of social security, whose consequences have already been analyzed.

Another symptom of dissatisfaction with the solutions offered by the system is reflected in the fact that, during 2009, every week at least 60 cases of habeas corpus and unconstitutionality appeals¹⁰ against the CCSS were filed before the *Sala IV* (lit. IV Chamber; Constitutional Court), whenever doctors prescribed *LOM* medicines or when the insured required a treatment that was not timely offered by the system. In such cases, the *Sala IV* ordered the CCSS to provide the treatment or to obtain it for the patient from external sources.

The *Defensoría de los Habitantes* (equivalent to the Ombudsman’s Office) registers as main healthcare-related denunciations those pertaining medicine supplies, refusals or delays in the provision of healthcare services, and violation of the patients’ rights (DH 2009, p. 213)

La Defensoría de los Habitantes (figura equivalente al ombudsman) registra como principales denuncias atendidos en el tema de salud, las relacionadas con el suministro de medicamentos; la negación o tardanza en la prestación de los servicios de salud y la violación a los derechos de las y los pacientes (DH 2009, p. 213).

Another one of the changes in the Costa Rica scenario, in terms of demographics, is the decreasing Economically Active Population (EAP) that contributes to the healthcare system, a factor that influences the financial sustainability of the system but also affects the senior population, which needs the contributions of this social group for its economical and health subsistence.

Costa Rica has managed to advance in the universalization of a healthcare system that is one of the most significant headings of the National Budget, with a 7.4% relation of the GDP.

In spite of the existence of population groups that are vulnerable to catastrophic expenses in healthcare, which could increase inequity if it is not analyzed as a public politics priority—Gini coefficient went from 0,3758 in 1990 to 0,4390 in 2009 (MIDEPLAN, 2010)—, the system has

¹⁰ Mechanisms for the control of constitutionality, in this case pertaining the right of life and health and the consequent responsibility of the State

maintained a high level of protection in the face financial risks. Nevertheless, more research and its translation are necessary to observe the tendencies of financial protection depending on variables like aging of the population, migration, epidemiological changes in the weight of diseases, major deregulation of labor relationships.

Costa Rica has consolidated a healthcare infrastructure (EBAIS, clinics, hospitals, etc.) that offers a high percentage of universalization; however, the current preoccupation must be the improvement of the quality of the service and the attention offered by the existing resources. This improvement must take place for the benefit of the citizen who is currently selecting private services that offer him/her fast, specialized options, as well as for the contribution to the lower-quality social security.

Significantly enough, the fact that the financing of healthcare insurance relies on tripartite contributions requires a great deal of attention and analysis since negative conditions that affect the macroeconomic variables, like production and employment, generate a significant impact that may cause a reduction in the collection of these contributions and, therefore, also a lack of financing in the Costa Rican healthcare system.

In order to bridge any pending gaps that still separate it from universalization, the healthcare system will have to meet its historic challenges with regard to contributive and geographical coverage. Meanwhile, the system must respond to new challenges in terms of quality and financial sustainability of healthcare services, considering as part of its new socio-economical reality the rise of the informal economic sector, the increasing senior population, a growing unemployment rate, and a preference for the private healthcare sector. These are factors that, in the long run, will affect the model of solidarity and legitimacy of Costa Rican social security.

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