

**PROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.:PID0033477

Program Name	Strengthening Universal Health Insurance in Costa Rica
Region	Latin America and Caribbean Region
Country	Costa Rica
Sector	Health Nutrition and Population
Lending Instrument	Program for Results
Program ID	P148435
Borrower(s)	Ministry of Finance of Costa Rica
Implementing Agency	Caja Costarricense de Seguro Social
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I. Country Context

1. **Costa Rica stands out for being among the most politically stable, progressive and prosperous countries of the Latin America and the Caribbean region (LAC).** This model has resulted in important economic, social, and poverty dividends, with sustained growth, upward mobility for a large share of the population, important gains in social indicators, and one of the lowest poverty rates in LAC. Using the poverty and extreme poverty lines of US\$4 per day and US\$2.5 per day respectively, just 12 percent of the Costa Rican population is considered poor (less than half of the LAC average), and 4.7 percent is considered extremely poor (about one-third of the LAC average). Moreover, only 1.4 percent of the population lives under the US\$1.25 poverty line. The country's success is also reflected in indicators beyond headcount poverty, such as upward mobility, which has contributed to the rise of the middle class¹ from one-third of the population in the early 2000s to nearly half of the population today, or in its strong human development indicators, which continue to rank higher than those of other countries in LAC.

2. **The country's social compact has to be credited for many of the social outcomes as it resulted in sustained investments in human capital over many decades, with solid results in health outcomes in particular.** Costa Rica's trademark universal health public insurance model (*Seguro de Enfermedad y Maternidad, SEM*) managed by the Costa Rican Social Security Administration (*Caja Costarricense de Seguro Social, CCSS*) has provided access to health care to its entire population, including the poor and bottom 40 percent. The country's universal health care system is considered one of the key reasons behind its strong health outcomes. For example, the infant mortality rate declined from 90 deaths per 1,000 live births in 1960 to just 10.6 deaths per 1,000 today—one of the lowest rates in LAC.

¹ Defined as the share of the population with incomes between US\$10 and US\$50 per day.

3. **Despite these achievements, there are emerging structural issues that threaten the sustainability of Costa Rica's health achievements.** These are related to the need to face: (i) a demographic transition resulting in changing demand for health services; (ii) the deterioration in the quality of care; and (iii) sustainability issues related to increasing health costs.

4. **There is widespread consensus in Costa Rica that the health system is in need of significant reforms to continue providing the expected services.** The CCSS Board of Directors, which oversees CCSS operations and is made up of representatives from the Government, trade unions, and the private sector, has approved the reform plan that the proposed Program-for-Results (PforR) Operation will support. This has the benefit of reducing risks associated with the reform of a sector as sensitive as the health sector. The reform plan was developed with World Bank support and therefore, the proposed Operation builds on knowledge acquired in recent years.

II. Sectoral and Institutional Context

5. **The CCSS manages Costa Rica's SEM and is the largest health care provider in the country.** With the exception of a small set of health services and facilities that cover work injuries, the CCSS is the sole public provider of health services at all levels of care² and is also responsible for public sector health financing. Costa Rica's universal health insurance model has many strengths. An important feature of the model is the network of Primary Health Care (PHC) providers. Building off this extensive physical network, the CCSS uses population-level data gathering tools to collect more than 267 variables of socio-economic, health risks and other key data. Digitization of this information could be used for many health insurance purposes, including better monitoring of intermediate and final outcomes at the regional and national levels and refining risk-adjusted capitations by cause of morbidity. Another key strength is the ability of the CCSS to facilitate changes in the national health insurance system without the need for difficult inter-agency coordination. The CCSS already provides a single risk pool for cross-subsidies, collects its own revenues, and uses its purchasing power for negotiating better prices for several costly pharmaceuticals.

6. **Despite these strengths, the system does require important changes to be able to respond to the needs of an aging population and the increase in NCDs.** The increasing prevalence of chronic conditions such as hypertension, diabetes and different types of cancer, along with the growing demand for specialized care is putting a strain on the health system in many ways. In the past two years, the CCSS carried out an in-depth review of the main institutional capacity challenges to improving quality and efficiency of care. The analysis found three priority areas of weaknesses that needed to be addressed: (i) the delivery of health care has not fully adapted to the changing needs of the population, given the rise of NCDs; (ii) the CCSS requires greater institutional capacity to manage the system; and (iii) financial management within the CCSS will need to be improved and modernized in order to allocate resources more efficiently.

7. **To improve the efficiency and quality of care, the CCSS has put forth a comprehensive program in its *Agenda Estratégica para el Fortalecimiento del Seguro de***

² The Ministry of Health transferred all health care facilities to the CCSS in the 1990s.

Salud (Strategic Agenda to Strengthen Health Insurance, or SASHI). SASHI is a comprehensive and ambitious institutional capacity building program with the dual goals of increasing the efficiency and quality of the CCSS health insurance system. The proposed PforR will support SASHI over six years (2016-2021).

III. Program Scope

8. The Operation focuses on three priority areas: (i) re-organizing the health care model; (ii) enhancing institutional management; and (iii) improving financial management.

9. ***Reorganizing the Health Care Model:*** SASHI aims to boost the scope and capacity of PHC to prevent and control NCDs, and integrate health services across different levels using international best practices. The CCSS will implement a series of activities to modernize and strengthen the PHC network nationwide to improve the quality of services, increase coverage of the population, and ensure that the network has greater capacity for prevention, early diagnosis, and control of NCDs and other conditions that are relevant to the local, regional, and national epidemiological profile. The CCSS will also work to progressively strengthen the integration of PHC services into the network of services at all levels of care. Key activities and inputs include: (i) expansion of infrastructure at the first and second levels of care; (ii) improving human resources for outreach to patients; (iii) upgrading equipment; (iv) updating clinical guidelines and pathways, with an emphasis on chronic conditions affecting a large part of the population; and (v) increasing the use and impact of the large amount of household data collected by the PHC teams. To facilitate these activities, it is critical to harness the power of available health and demographic information by digitalizing data and linking it to existing E-Health tools to generate big data pools for managers to better allocate resources and monitor results. A pilot program will be carried out to test new mechanisms for integrating PHC with second level services (hospitals) using international best practices.³ The pilot aims to improve the navigation of the patient across all levels of care, with the help of strengthened teams at the first level of care and new E-Health tools that would facilitate the exchanges between medical staff at the first level of care and specialists. This would reduce lengthy travel time and distances to reach services, and ensure that complex conditions are treated in a timely fashion and in accordance with quality standards introduced by the new clinical guidelines and pathways.

10. ***Enhancing Institutional Management and Improving Financial Management:*** In the aftermath of an internal financial crisis in 2011, the CCSS convened a panel of independent experts who recommended various interventions to enhance the efficiency, governance, and accountability of CCSS central level management. Subsequently, the Board of Directors has identified a number of key activities to strengthen institutional capacity to better manage the CCSS in general, and the SEM in particular. These include: (i) aligning central level management to reduce the complexity of bureaucratic administrative processes; (ii) reducing management in silos without linking health care decisions with their impact on administrative and financial changes and nation-wide objectives; and (iii) improving the quality of financial data for Senior Management and the Board of Directors to closely monitor trends regarding the actuarial analysis and income/expenditure trends. These activities are expected to enable the

³ The pilot has been under discussion for nearly a year, and has received input from various international organizations, including the Pan American Health Organization (PAHO) and the World Bank.

CCSS to make more informed and strategic decisions and avoid repeated income/expenditure crises. These institutional changes also aim to allow the CCSS to stay abreast of the ever evolving technology and international quality standards.

The Program-for-Results (PforR)

11. **The Operation will support all lines of action of SASHI with exception of large scale civil work contracts for hospital replacements that do not contribute directly to the PDOs.** The Operation will focus on developing the primary care network and increasing the integration of services across all levels of care. The financing of the large civil works for replacement of hospitals has been excluded from the proposed Operation, as it is not directly contributing to the results areas under the proposed Operation; however it will be financed and implemented by the CCSS. The total cost of implementing SASHI from 2016-2021 is estimated to be US\$2.14 billion, which includes large scale civil works for hospitals. The total cost of implementing activities under the Operation is estimated to be US\$1.575 billion.

IV. Program Development Objectives

12. The development objectives of the PforR are to contribute to: (i) improve the timeliness and quality of health services; and (ii) enhance the institutional efficiency of the CCSS.

V. Environmental and Social Effects

13. **The Environmental and Social System Assessment (ESSA) to identify any adverse environmental and social impacts that the Operation could generate was carried out and will be disclosed prior to appraisal.** The ESSA has taken into consideration the requirements of the PforR Policy and Directives, and was informed by a review of available information as well as a stakeholder consultation carried out in August 2015. Based on ESSA systems and risk evaluation, a Program Action Plan (PAP) was developed and discussed with the CCSS.

Environmental Aspects

14. **The existing and planned systems for environmental management are adequate to mitigate any potential negative impact of the Operation.** The ESSA notes that potential environmental impacts may derive from the construction and rehabilitation of medical facilities and operation of medical facilities.⁴ Both the CCSS and the environmental regulatory authority have sufficient institutional capacity to ensure compliance with Costa Rica's existing environmental, health, and safety laws and environmental regulatory standards. Mechanisms to evaluate the potential environmental impact and establish appropriate mitigation measures are already in place (both within CCSS and the environmental regulatory authority), and deemed adequate. However, opportunities to support more efficient and effective environmental, health and safety management remain, including: (i) improving coordination among CCSS departments responsible for environmental management; (ii) ensuring robust oversight and management of environmental requirements at all facilities; (iii) putting in place an integrated

⁴ Potential negative impacts related to operation of facilities include waste water discharge and generation of both solid and medical waste, as well as air emissions.

environment, health, and safety information system to improve compliance with regulatory requirements and strengthen decision-making and resource allocation; and (iv) developing a plan for future investments to ensure full compliance with environmental regulatory standards, in particular related to potable water, waste water, air emissions, and solid and hospital wastes.

Social Aspects

15. **The Program's social system was assessed as adequate and without substantial negative impacts on the society; thus the overall risk profile is assessed as moderate.** Participation and citizen engagement processes are well-established in the CCSS and will likely improve, rather than suffer, from implementation of the proposed Operation. The Operation will support the CCSS in ensuring that programs and outreach activities are relevant and accessible to all vulnerable populations. With the understanding that indigenous populations and other vulnerable groups face access barriers, the Operation will ensure that culturally appropriate information is shared in a timely and sensitive manner. The Operation also features several mechanisms to allow citizens to provide feedback on the quality, timeliness, and effectiveness of the healthcare services provided by the CCSS. The World Bank will work with the CCSS to ensure that citizen engagement mechanisms and dialogue spaces are improved or created, and that they suit the needs of all Costa Ricans, particularly the indigenous and other groups with special needs, such as the Lesbian, Gay, Bisexual, Transsexual and Intersexual (LGBTI) community.

VI. Financing

PforR Operation and SASHI Expenditure Framework Overview

Scope	Expenditure (US\$ million)
<i>SASHI Total</i>	2,140
Less hospital replacement	565
<i>PforR Operation Total</i>	1,575

** This amount includes the financing of replacement of hospitals that are large civil works some of which already have started to be constructed with CCSS funds and some of which will be completed beyond the year 2021 and therefore, will not be financed by the PforR.*

Financing Source	Expenditure (US\$ million)
World Bank	420
CCSS	1,155
<i>Operation Total</i>	1,575

VII. Program Institutional and Implementation Arrangements

16. **The CCSS is the sole implementing agency for SASHI.** As such, and as agreed by the CCSS Board of Directors and Senior Management, the PforR will be implemented using the same institutional arrangements, in line with the guidelines and priorities of SASHI. The Board of Directors will oversee the overall implementation of SASHI, while the Executive President

of the Board will manage the implementation of the PforR with the support of a coordination team, made up of members of Senior Management. To ensure a fluid flow of funds, an implementation agreement will be signed between the Ministry of Finance and the CCSS for the implementation of the PforR's activities under terms and conditions acceptable to the World Bank.

VIII. Contact point

World Bank

Fernando Montenegro Torres
Title: Senior Economist
Email: ferxmont@worldbank.org

Borrower/Client/Recipient

Contact: Jose Pacheco
Title: Vice Minister of Finance

Tel: +506-2284-5154
Email: pachecojj@hacienda.go.cr

Implementing Agencies

Name of Agency: Costa Rican Social Security Administration (Caja Costarricense del Seguro Social)

Contact: Rocio Saenz
Title: Executive President of the CCSS
Tel: +506-2539-1146
Email: mrsaenzm@ccss.sa.cr

IX. For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: <http://www.worldbank.org/infoshop>