
Integrated People-Centred Health Services Case Study: Comprehensive Primary Health Care Reform in Costa Rica

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A. Summary

In the beginning of the 1990s Costa Rica had a duplicative and fragmented public primary health care system. In 1994, the country initiated a sweeping reform of the health system, including primary health care. These reforms centered around four central actions: bureaucratic reorganization of the Ministry of Health (MOH) and the Social Security Agency (CCSS), which led to the integration of all health care delivery under the CCSS, from primary health care activities to tertiary care. Comprehensive multidisciplinary primary health care teams (EBAIS)—comprising a doctor, nurse assistant, technical assistant, and medical clerk—were created to care for approximately 5,000 patients each. A system of geographic empanelment was implemented to assign every Costa Rican to one of the newly-formed EBAIS teams. Finally, quality assurance mechanisms were initiated, promoting data collection and feedback as a central function of the EBAIS teams.

The first EBAIS teams were established in 1995. Their work helps to ensure that individuals have a direct link with a health care provider, and that equitable, continuous care through the course of a person's life is available. Today, more than 1,000 EBAIS teams provide comprehensive, continuous, coordinated, and first contact access to nearly 95% of Costa Ricans. Over the first decade of the reform, areas with EBAIS teams saw an 8% decrease of infant mortality and a 2% decrease in adult mortality.

However, by 2016 - more than 20 years into the reform - dozens of EBAIS teams still had more than 7,000 patients empaneled to their clinic, well over the target number. Nearly 300 additional EBAIS teams and clinics would need to be established to fully complete the reform. As the burden of disease and population characteristics shift over time, new work needs to be done to determine how best to ensure comprehensive, integrated primary health care can continue to be provided equitably across the country.

B. Description of the Practice

Section 1. Context and problem description

During the 1980s, Costa Rica struggled with decreased funding to the main providers of primary health care including the Ministry of Health (MOH) and the Social Security Agency (*Caja Costarricense de Seguro Social*, or CCSS). Responsibility for primary care service delivery was shared between the MOH and CCSS, with overlapping charters that made responsibilities unclear and efforts duplicative. After the 1982 global financial collapse, resources devoted to primary care dwindled, leading to public perception that primary care services lacked basic resources and were not the best source to receive health care [1]. Because of the perceived lack of primary care services, demand for secondary and tertiary care increased, exacerbating long wait times for specialty care [2,3]. From 1985 to 1990, primary care visits decreased by 17% [1].

As a result, public dissatisfaction with the country's health care system was high and growing. State cuts to personnel in public works departments had led to problems managing sanitation and water supply [4]. In 1991 there was a major measles outbreak. Employers were a main funder of the public health care system, yet were forced to pay for private medical care as well when the public system was unable to meet the demand create by the outbreak [5]. They threatened to stop paying their mandatory CCSS contributions if something wasn't done to fix the system. The need for health system reform had become urgent.

Section 2. Key milestones

Timeline for transformations

In 1990, Costa Rica had a duplicative and fragmented public primary health care system. After planning for reform and securing financing, in 1994, the country initiated a sweeping reform of the health system, including primary health care. Bureaucratic reorganization of the MOH and the CCSS led to the integration of all health care delivery under the CCSS, from public health activities to tertiary care.

Comprehensive multidisciplinary primary health care teams (*Equipos Básicos de Atención Integral de Salud*, or EBAIS)—comprised of a doctor, nurse assistant, technical assistant, and medical clerk—were created to care for approximately 4,000 patients each. A system of geographic empanelment was implemented to assign every Costa Rican to one of the newly-formed EBAIS teams. Quality assurance mechanisms were initiated and promoted data collection and feedback central as a central function of the EBAIS teams.

The first EBAIS team was established in 1995 and by 2002, there were 818 active teams throughout the country. Today, these teams provide comprehensive, continuous, coordinated, and first contact access to nearly 95% of Costa Ricans. Over the first decade of the reform, areas with EBAIS teams saw an 8% decrease of infant mortality and a 2% decrease in adult mortality.

However, by 2016 - more than 20 years into the reform - 81 EBAIS teams had more than 7,000 patients empaneled to their clinic, well over the target number [6]. A study in 2017 found that nearly 300 additional EBAIS teams and clinics would need to be established to fully complete the reform [7].

Table 1: Chronology of the initiative

1990	Duplicative and fragmented public primary health care system; President Calderon establishes Commission for the Reform of the Costa Rican State
1991	Measles outbreak leads to calls for major reform
1993	Financing commitments from WBG, IADB, and others are secured
1994	Sweeping reform of the health care system to extend coverage and provide comprehensive care to all
1995	Implementation of reforms: The first EBAIS teams and primary health care clinics are established, and consolidation of roles in Ministry of Health and the Social Security Administration takes place
1998	Presidential transfer of power; commitment to reforms retained
2002	818 EBAIS clinics have been established, with 88% of population empaneled to an EBAIS team
2017	1,030 EBAIS clinics have been established, with 94% of the population empaneled 295 more clinics are still needed to complete implementation of the reform [7]

Section 3: Health service delivery transformations - the ‘WHAT’ of the practice

I) Selecting services

Costa Rica’s health care reform encompassed two major priorities. The first was to extend coverage across the population. The second was to ensure more comprehensive care [4]. The reform included a new basic care provision model in addition to several important administrative reforms to better align with population health needs. These included moving the health care delivery function entirely under the CCSS - rather than split across the CCSS and the MOH. In addition, the reform supported increased decentralization and independence for administrators, particularly at hospitals [2].

II) Designing care

Integrated primary health care teams (EBAIS teams) were formed at the community level, comprising a doctor, nurse assistant, a technical assistant (*asistente técnico de atención primaria*, similar to a community health worker), *registros y estadísticas de la salud* or medical clerk, and sometimes a pharmacist. By design, members of EBAIS teams work together to serve as the first point of contact with the health care system, capable of providing comprehensive, continuous care. As EBAIS teams were formed, every Costa Rican citizen was geographically empaneled to a specific team. At the national level, data collected by technical assistants and medical clerks were used by the CCSS in order to identify regions with higher health risks and burdens and to prioritize resources to improve health equity in those areas.

III) Organizing providers

Each member of the EBAIS team has a specific set of responsibilities. The physician provides curative and preventive care, diagnosing, treating, and managing acute and chronic conditions [8]. The nurse assistant is in charge of basic clinical tasks and health counseling. The technical assistant conducts health promotion activities outside of the clinic including disease prevention education and basic sanitation activities, collects population health data, identifies disease risk factors, and makes referrals to EBAIS physicians as needed. The medical

clerk does patient registration, manages patient data collection, and does epidemiological population health surveillance. The pharmacist dispenses prescribed medications.

In general, physicians and nurse assistants see patients and families in EBAIS clinics. Technical assistants spend much more time outside the clinic, conducting home visits and group visits in community settings including churches, schools, and town centers. EBAIS teams are able to provide all but the most specialized care to their patients, including health education, medications for illness, and management of chronic diseases. This approach to localizing public health, preventive care, and curative care within an EBAIS team means that patients and community members receive comprehensive primary health care.

IV) Managing services

Costa Rica's health system is divided into Health Areas, which oversee EBAIS clinic operations. Health Area directors are physicians who manage the health area and have significant autonomy to determine how best to run their EBAIS clinics to meet the needs of the local context. Physicians can make home visits to see patients who cannot make it to the clinic [9]; appointments can be made based on a triage system that determines priorities based on the urgency of a condition, or be "first-come, first-served" [10]. Further, the physical clinic is secondary to the EBAIS team itself. In extremely rural, sparsely populated areas, teams will routinely travel outside of the clinic in order to make contact with remote populations [8]. Conversely, in urban areas, it is not uncommon for a single clinic space to serve several EBAIS teams.

EBAIS teams can refer patients to secondary and tertiary care as needed, and secondary and tertiary providers can refer patients back to the primary care level once their condition has been treated and/or stabilized. A new Universal Digital Health Record has made referrals and counter-referrals easier as doctors in each area can see clearly the notes of the other physician. A current area of work for the CCSS has been to clearly define networks of care so that it is explicit exactly which secondary and tertiary care center each primary care clinic should refer to [11].

V) Improving performance

After the reform, all primary care doctors in Costa Rica who wanted to work for the CCSS had to participate in a yearlong training in the new model of comprehensive primary health care [10]. Weekly sessions covered topics including information systems, analyzing the population's health in a Health Area, epidemiological surveillance, and integrated health care [10]. Within a decade the whole population of primary care physicians had received this training, including medical students. Nursing and pharmacy directors could also become trained, in order to pass this information along to their staff [12]. These trainings, and the addition of EBAIS medical clerks whose job was to transmit health and service delivery data back to the CCSS, helped to facilitate the increased emphasis on continuous performance improvement as a critical component of the health system reform.

VI) Engaging and empowering people, families, and communities

Geographic empanelment was a cornerstone of the health system reform. It helps to ensure that individuals have a direct link with a health care provider, and that continuous care through the course of a person's life is available. The EBAIS teams are trained to provide care across a patient's life, from prenatal to geriatric care. And because the teams are stable, they can build long-term, trusting relationships with patients that help to facilitate crucial conversations about health care and disease prevention.

Section 4. Conditions enabling change

I) Information systems and data use

The development of quality assurance mechanisms was a major component of the health system reform, and included an “information cascade” system that both supported quality improvement efforts but also helped to strengthen the institutionalization of the reform. This has been facilitated by more recent innovations including the development of the *Expediente Digital Único en Salud*, the Universal Digital Health Record. These records allow providers and planners to analyze patients by diagnosis, health status, living conditions, or risk score. Developed by the CCSS, the Universal Digital Health Records are tailored to the preventive, community-based health care focus of the country’s health system. For example, the form that technical assistants fill out during home visits is directly incorporated into the Universal Digital Health Record [10].

II) Quality improvement and safety

Quality improvement efforts were a core principle of the health system reform, and involved a bi-directional information cascade approach. At the EB AIS clinic level, the medical clerk collates and sends the information about patient characteristics, diagnoses seen, and procedures to the Health Area administration. The Health Areas aggregate these reports to send further up the line to the CCSS. This movement of local data to the national level is a mechanism for ensuring national policymakers are informed by detailed population health data from the whole country [8]. The cascade also moves in the reverse direction, providing feedback and benchmarking to Health Areas and clinics. The CCSS uses the data collected within each Health Area to track performance against targets that have been set previously and works with Health Areas to create action plans for improving clinics’ performance in the coming year. This is an efficient measurement and feedback loop between local settings and the national policy level. It allows Costa Rica’s primary health care system to ascertain the highest priorities of its population’s health and incorporate population needs into health planning.

III) Workforce

One of the reform’s major changes to Costa Rica’s health system was to transfer all public health and primary care functions to the CCSS, which was already responsible for service delivery for secondary and tertiary care. This meant that a single agency was now responsible for all aspects of health care service delivery, including preventive and curative services [8]. This move required substantial efforts to convince employees of both agencies to support it, but the success of the merger was critical in allowing Costa Rica to build a new primary health care system [8]. Further, public health and preventive health service proponents who moved from the MOH to the historically more curative-services-oriented CCSS helped to ensure commitments to both these aspects of primary health care in the move to the EB AIS team model.

IV) Regulatory frameworks

A team of health care providers was charged with developing the primary health care service delivery model that became the heart of the reform [10]. High-ranking policy officials from the MOH and CCSS were given autonomy to negotiate for the funding commitments from the World Bank, and also played a role in championing the reform’s acceptance in Costa Rica once financing was secured [10]. Once World Bank funding was secured, a national law approved the loan and consequently committed the CCSS to carrying out the reform described

in it, while the Ministry of Health was made overall steward of the health system and given responsibility for accrediting and regulating the private sector [19].

Once the health system reform was adopted, the consolidation of health care service delivery under the CCSS - one of the reform's cornerstones - was also a critical facilitator of the work of the EBAlS teams. The teams provided both public health/prevention services as well as primary care services. If their work had been managed, and funded, by different organizations, this would have impeded their ability to effectively share roles and responsibilities team-wide [8].

Over time, multiple regulatory frameworks have been developed related to the work of CCSS and EBAlS teams, for example around quality improvement initiatives. Regulations have also been established regarding financing of the CCSS, which is shared between employers, employees, and the federal government [19].

V) Funding and payment systems

Once the proposal for the health system reform was fully developed, Costa Rica brought it to the World Bank Group to seek funding. Negotiations with the World Bank were complex, but helped to ensure the reform's primary health care model reflected the country's values, including health as a human right, and the importance of comprehensive health care that also promotes individual well-being [10]. After obtaining funding and technical support from the World Bank and other sources including the Inter-American Development Bank, PAHO, and the Spanish and Swedish governments, Costa Rica raised a total of \$123 million dollars [13].

Section 5. Barriers to change

I) Workforce

As mentioned previously, one of the reform's first transformations to Costa Rica's health system was to transfer all public health and primary care functions from the MOH to the CCSS, which had already been responsible for service delivery for secondary and tertiary care. The MOH was to take on a stewardship role in the health care system. This was a major change - including the transfer of 1,700 employees from the MOH to the CCSS [1] - and a challenging one. The CCSS experienced huge growth in a short period while the role of the MOH suddenly became less clear, as no supporting law had accompanied the change to its new role as steward [19]. Staff in the two agencies had somewhat ideologically opposing views about health system priorities which led to challenges at the national level as they began to learn to work more closely together, though these changes did not necessarily translate to negative impacts on the quality of service delivery or priorities locally [10].

II) Regulatory frameworks

Costa Rica's health reform made primary health care services available to all, yet, to some extent, patients who could afford private health services have chosen to do so for primary and secondary health care needs [19]. As a result, private health care services have been able to bridge some of the remaining gaps in care and long wait times, for those who are able to afford them. Although the Ministry of Health was given the authority to regulate the private sector, for the past 15 years the private market has been largely unregulated and growth has not been controlled. [10,19]

III) Funding and payment systems

The reform established a measurement system for EBAIS teams through management contracts, a modified pay-for-performance system introduced in 1998 [8]. Health Areas would receive financial rewards if health indicators were met, and this money could be used to invest in the primary health care provision framework through staff education or infrastructure development [10]. However, this approach was deeply unpopular with physicians; it did not fit the country's philosophy of health and health care service delivery. In 2008, the financial incentives that had been linked to performance were removed. Today, EBAIS teams receive feedback on the quality of the care they deliver through a national quality assurance evaluation. The result of this yearly evaluation is a ranking of the quality of care provided in each of the country's 106 Health Areas [8].

IV) Changing population health needs

One ongoing planning challenge faced by Costa Rica's health system is the epidemiologic transition to greater chronic disease burden. Diseases including cancers, heart disease, and diabetes have begun to be a substantial contributor to the population's burden of disease. As the population ages, and as infectious diseases are increasingly prevented or treated, chronic diseases will grow increasingly important to Costa Rica's health system. However, EBAIS teams were formed largely to focus on infectious, nutritional, and childhood disease management and control. Chronic disease prevention, identification, and treatment have classically been more often been associated with specialty care services. While the CCSS is slowly beginning to incorporate chronic disease management into the EBAIS clinical service package, the process of developing clinical pathways to improve and standardize care for NCDs is still ongoing. it still [14,15].

V) Linkages with the rest of the health system

While the health system reform guaranteed primary health care access to Costa Ricans and made major efforts to increase service availability at this level, waiting lines have continued to be burdensome to patients in need of more specialized services. In fact, they are the number one complaint of health system users [15,16]. For some treatments or procedures, patients often have to wait as long as one or even two years [15,16]. While quality improvement and timeliness were high priorities of the reform this is a growing problem particularly in a setting where chronic disease is a growing contributor to the population's health burden: some cancer screening, including mammograms, colonoscopies, and other imaging services, is part of the secondary care system. This means that long wait times impede the ability to both effectively prevent or treat the accelerating burden of chronic diseases [17,18].

Section 6. Outputs, outcomes, impact

Processes

Costa Rica's reforms have seen remarkable success. EBAIS teams and clinics were rapidly established. By 2002, over 818 EBAIS clinics had been established and 88% of the Costa Rican population was empaneled to an EBAIS clinic. Today, there are more than 1,030 EBAIS clinics, and 93% of the population has access to primary health care.

Outputs

Access and use of health care services have improved since the reforms began in the mid 1990s. The reform has led to increased access to primary health care; before the reform, only

25% of the population had access to PHC; by 2006, this had reached 93% [20]. Today, EBAIS teams provide care for 80% of Costa Rican's health needs - providing for three-fourths of all medical consultations in the country [21,22].

Outcomes

As measured by the primary health care surveillance system that was established, deaths from communicable diseases dropped from 65 per 100,000 people in 1990 to 4.2 per 100,000 in 2010. A 2004 demographic study looked at the impact of the reform on mortality and showed that implementation of the reforms resulted in an 8% reduction in infant mortality and a 2% reduction in adult mortality in the first decade of the reform [23]. Household expenditure on health care services was dramatically lower than in Latin American countries as a whole within a decade - 25% of health expenditures were private in Costa Rica compared to 58% on average in the region [24].

Impact

EBAIS teams have also increased the equity of the primary health care system. The first EBAIS teams started in areas with lower access to care, and over time the geographic distribution of clinics in the country improved [4]. The CCSS uses data collected by EBAIS clinics to target resources to higher-risk areas in order to improve equity, budgeting nearly one-third of its funds on the poorest 20% of the population [24]. Premature mortality decreased in Costa Rica from 1980 to 2000, but it did so faster for the poorest 20% (a 48% drop) than for the richest 20% (a 39% drop) [24]. In addition, a 2009 analysis of infant mortality showed high regional equity: geographic region was not associated with increased mortality [25].

The long-term impacts of Costa Rica's health system reforms are clear. Maternal mortality, infant mortality, and under-5 mortality have steadily declined since 1995 [24,26]. Costa Rica has demonstrated effective primary health care coverage compared to other low- and middle-income countries on priority health outcomes including appropriate care for diarrhea in children and adult mortality from chronic disease [27]. Importantly, Costa Rica has been able to achieve lasting improvement to the quality of health care and health outcomes while spending less on health care than the world average, measured both by share of gross domestic product (7.6% versus 10.0% in 2016) [28] and by per capita spending (US \$889 versus US\$1,026 in 2016) [29].

Section 7. Leading and managing change - the 'HOW' of the practice

1) Initiating change

The public dissatisfaction, financial strains, and duplicative care experienced in Costa Rica during the 1980s and early 1990s helped to create momentum for reform. In 1990, a Commission for the Reform of the Costa Rican State was established for government-wide reform strategies and, as part of this commission, officials from the MOH and the CCSS began to work together on a health care reform strategy. The resulting national health care strategy put primary health care at the foundation. By 1994, there were two main goals of the reform: to extend coverage to achieve universal health care coverage, and to provide comprehensive care to all Costa Ricans.

The 1994 reforms included four cornerstones that impacted primary health care service delivery:

- 1) Responsibility for primary health care service delivery was moved from the MOH and consolidated within the CCSS;
- 2) Multidisciplinary Integrated Basic Healthcare Teams (EBAIS) were created as the principle provider of primary health care services;
- 3) Every Costa Rican was empaneled, by geographic location, to an EBAIS team;
- 4) Continual quality improvement measures were initiated to support system-wide learning and adaptation as well as the ability to proactively adjust to changing population health needs.

II) Key actors

System or macro-level actors: The EBAIS model was developed by a small group of Costa Rican health care professionals in the early 1990s. The model was based on their experience with previous health care programs in the country. Once the reform proposal was fully developed, policy leaders from Costa Rica's MOH and the CCSS worked with government leaders to seek funding from sources including the World Bank and the Inter-American Development Bank, ultimately raising \$123 million dollars. After funding was secured, the health policy champions worked with political leaders to gather support for the reform. The congressional vote to accept the loan and pass the reform was unanimous [5]. The president of Costa Rica from 1994-1998 supported the reform and appointed a president of the CCSS who would promote the implementation process. The reform survived the presidential transfer of power in 1998.

Organizational or meso-level actors: A key component of the reform was the development of EBAIS teams and clinics. In order to create this new structure, Costa Rica's CCSS established health networks: 106 Health Areas nationwide, belonging to seven different Health Regions [30]. The Health Area is the main organizational unit for primary health care and each has have from five to 15 EBAIS teams, with between 30,000 to 110,000 people per Area [9,15]. Secondary care clinics, which provide specialty care and sometimes general surgery, are referred to by two or three Health Areas; more specialized tertiary care is primarily provided in the capital [15]. Health care referral networks that carefully delineate how patients should move through the health care system are currently being developed and improved.

Clinical or micro-level actors: The development of primary health care teams to provide clinical services to communities was a major component of the health system reform. The importance of the different roles of EBAIS team members in providing comprehensive care cannot be overstated, with each team member serving to ensure the provision of comprehensive care. The new approach to primary health care service provision was a change for providers as well as patients, who all needed time and education to adapt to the change in service that resulted from the reforms.

III) Implementation methodology

Implementation of these reforms began in 1995, with the transfer of all personnel in the MOH who previously participated in direct health care provision to the CCSS. This made the CCSS the sole public health care provider in the country and allowed Costa Rica to integrate preventive care (previously led by the MOH) and curative care (previously provided by both the MOH and the CCSS). The MOH became the overseer and strategist of the health care system. This merger was challenging but critical: it forced champions of preventive health

services and proponents of curative health services to work together and compromise, ensuring the population received truly comprehensive primary health care.

EBAIS teams, including a doctor, nurse assistant, technical assistant, and medical clerk were formed beginning in 1995. By design, members of EBAIS teams work together to serve as the first point of contact with the health care system, capable of providing comprehensive, continuous care. As EBAIS teams were formed, every Costa Rican citizen was geographically empaneled to a specific team. This process required mapping the location of each home in the country before satellite imaging and GIS were developed: planners divided the country into seven Health Regions and 106 Health Areas. Each Health Area was further divided into five to 15 smaller geographic units, each of which was assigned to a particular EBAIS team. All Costa Ricans living within each geographic unit were then empaneled to the corresponding EBAIS team, with the goal of achieving an approximate ratio of 4,000 individuals per EBAIS team.

Finally, as a part of creating a new primary health care delivery model, a process for quality assurance was developed. At first it was based on a pay-for-performance schema, but it has since evolved into an internal system without financial incentives, as described in Section 5. The process relies on a chart-audit process and a public ranking of the quality performance of every Health Area. The data collection and feedback process are fundamental to a central effort for continual quality improvement.

IV) Moving forward

Once reform changes were mostly achieved, momentum began to slow as the CCSS broadened its focus to other important aspects of health care provision, including improving hospital infrastructure and improving long wait times for specialized health care services [10]. By 2016 - more than 20 years into the reform - 81 EBAIS teams still had more than 7,000 patients empaneled to their clinic, well over the target number of 4,000-5,000 [6]. A study in 2017 found that nearly 300 additional EBAIS teams and clinics would need to be established to fully complete the reform [7]. Further, dozens of teams, largely in denser metropolitan areas, do not have the full array of team members: a doctor, nurse assistant, technical assistant, and medical clerk [31]. Comprehensive primary health care service delivery to individuals empaneled to these clinics that lack the full human resources capacity intended by the EBAIS team model is a challenge. Private health providers have the potential to help fill in some of the remaining gaps in full implementation of the primary health care model, but this notion is contentious in a country that has committed so fully to the public system. Private providers do not currently have the same requirements to provide the broad primary health care services as the public EBAIS teams, and are not overseen in the same way as public providers [10]. More work needs to be done to determine how best to ensure comprehensive, integrated primary health care is provided equitably across the country, into the future.

C. Takeaway Messages and Recommendations

Costa Rica's reforms have seen remarkable success over the last 25 years. Today, EBAIS teams provide care for 80% of Costa Rican's health needs. The reform has led to increased access to equitable primary health care with delivery mechanisms that have focused on continuous improvement. The country has shown that it is possible to integrate preventive and curative health services, providing comprehensive, team-based primary health care at a national scale. Other countries have taken on aspects of Costa Rica's reform, such as geographic empanelment. However, Costa Rica is unique in moving beyond simple assignment of patients to providers, to embrace comprehensive population health management interwoven with accountability mechanisms for patient outcomes [8].

Costa Rica's health system reform began with the bureaucratic integration of its two government health overseers. This integration enabled all components of population health to be managed by one agency, the CCSS, with one set of goals and one budget. Critically, this ensured that both preventive and curative services were equally represented in the new EBAIS model [10].

Teams composed of service providers across disciplines ensure the provision of comprehensive, coordinated care for populations. Preventive, promotive, and curative health care services are all prioritized [10]. Technical assistants are similar to community health workers in other countries in their role, but are unusual in the depth of their training, their responsibility for collecting community health data, and the extent to which they are incorporated into the primary health care teams [8]. Few countries have undertaken similar levels of implementation of the multidisciplinary primary health care team structure, and Costa Rica's example of national adoption serves as an important example of the potential of such an approach.

Geographic empanelment of all Costa Ricans has been crucial to creating stable relationships between EBAIS teams and the individuals and communities they serve. Empanelment ensures first contact with all health system users, and the stability of the teams facilitates continuity of care for people at every age [10].

The measurement system and feedback loop built into the reformed health care system has strengthened the country's ability to be proactive in health care planning and provision. It facilitates the identification of high-risk regions and populations, which the CCSS prioritizes for additional resources and support [10].

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