

CASE-STUDY
COSTA RICA

Felicia Knaul

Gustavo Nigenda

Paola Zuñiga

Costa Rica

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CASE-STUDY: COSTA RICA

*Felicia Knaul, Gustavo Nigenda,
Paola Zuñiga*

1 General background data

1.1 Preamble

Although considered to be a lower–middle income country and ranked 69th in the world according to GDP per capita, Costa Rica was included in 1999 among the 35 countries with the highest Human Development Index. This situation could be explained by the existence of a Welfare State and the implementation of social programmes during the second half of the twentieth century.

The social reform initiated in 1942 created a public and centralized security system managed by the Caja Costarricense del Seguro Social (CCSS). The CCSS was responsible for the provision and financing of health care services. Even though the CCSS was created in the early 1940s, the universal and compulsory character of social insurance coverage was not established by law until the 1970s.

In this decade of the 1970s, and for the first time, a National Health Plan was implemented to redefine the functions of the CCSS and the Ministry of Health. The former was more oriented towards care, and the second to public health promotion and disease prevention. All hospitals were transferred to the control of CCSS.

The Costa Rican social security system has played a principal role in the country's human development. Comparing the health performance of Costa Rica with that of other Latin American countries, this country has the highest life expectancy for males (73.8) and the second highest for females (78.6).

The rate of malnutrition for children under five years is the lowest in the region for boys, and the second lowest for girls. Infant mortality is the second lowest, after Cuba, and health access is only superior in the Bahamas and Barbados while maternal mortality is lower only in Barbados (WHO, 1999).

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If these indicators are compared with industrialized countries, Costa Rica is performing well in life expectancy, ranking 26th in male life expectancy – higher than the United States, Germany, and Finland, among others. If, however, other indicators – such as child and maternal mortality – are taken into account, Costa Rica is far below countries like Japan, Switzerland, and Canada, ranking 37th and 44th respectively for these indicators (WHO, 1999).

There are still many improvements to be made. However, the relative success of the health system was in part due to a higher social public expenditure. It was also a result of centralization of health services in the Ministry of Health, the CCSS, and many other public institutions and Ministries dealing with social care and programmes particularly designed to alleviate poverty.

The provision of long-term care for the disabled has become one of the principal challenges of modern society (Brodsky, Habib and Mizrahi, 2000). In Costa Rica, provision of LTC has been affected by the wide availability of family support, especially from women (and in particular daughters and daughters-in-law) who take on most of the caregiving responsibilities towards elderly relatives.

However, with an increasing percentage of women entering the labour force and a general change in the composition of the family structure, the capacity of the informal care system to maintain such a high caregiving burden is in doubt. This trend indicates a need for more formal care structures. Currently, however, caregiving is still generally considered a family responsibility.

In Costa Rica – as in many other countries – formal care of the disabled was presented until the mid-1990's as part of a comprehensive health care system. This was especially reflected in the creation of specialized hospitals (such as the Geriatric and Gerontology National Hospital, two psychiatric hospitals, and the Rehabilitation Hospital) and through particular programmes for target groups, even though the main objectives of the health system were to extend coverage and improve health.

The experiences of industrialized countries and the relatively rapid growth of the elderly population as a result of improvements in their quality of life, are compelling policy-makers to consider a potential increase in the demand for long-term care over the next 25 years. Some efforts to provide increased LTC at the institutional level have been implemented, in particular through the reform of the health system and the law concerning integral care of the elderly.

This case-study will explore the needs for long-term care in Costa Rica. Further, It will provide a description of the systems currently providing health and social services in the country.

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From an economic point of view, Costa Rica is considered a low–middle income country (according to the World Bank) with a GDP per capita of US\$6700. Its productive structure is dominated by the tertiary sector: in the year 2000, services represented 57%. The proportion of agriculture has slightly decreased. Due to the small size of the market and an open economy, imports and exports represent 94.2% of the GDP (World Bank).

Presented on the following four pages are background data concerning Costa Rica, derived from international data bases.¹ These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

1.2 Background data from international data bases

Demography (year 2000)

<i>Population</i> (thousands)	4 024
<i>Land area</i> (sq km)	50 660
<i>Population density</i> (per sq km)	79
<i>Population growth rate</i> (% 2000–2005)	2
<i>Urban population</i> (%)	59
<i>Ethnic groups</i> (%)	
White (including mistizo)	94
Black	3
Amerindian	1
Chinese	1
Other	1

¹ For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); UNDP, Human Development Report 2001; US Government. The World Factbook 2002; WHO, World Health Report 2002; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.

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Religions (%)

Roman Catholic	76.3
Evangelical	13.7
Other Protestant	0.7
Jehovah's Witnesses	1.3
Other	4.8
None	3.2

<i>Total adult literacy rate</i> (% in 1997)	96
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Age structure (%):

0–14	32.4
15–24	19.2
60+	7.5
65+	5.1
80+	0.8

Projections 65+ (%)

2025	10.0
2050	16.7

Sex ratio (males per female)

Total population	1.02
15–64	1.02
65+	0.87

Dependency ratio:

Elderly dependency ratio in 2000 ²	9.7
Elderly dependency ratio in 2025	17.3
Parent support ratio in 2000 ³	8.7
Parent support ratio in 2025	11.7

Vital statistics and epidemiology

<i>Crude birth rate</i> (per 1000 population) (2000)	21.9
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<i>Crude death rate</i> (per 1000 population) (2000)	4.0
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² Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

³ Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.

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<i>Mortality under age 5</i> (per 1000 births) (2001)	
Males	13
Females	10
<i>Probability of dying between 15–59</i> (per 1000) (2001)	
Males	134
Females	78
<i>Maternal mortality rate</i> (per 100 000 live births) (1995)	35
<i>Total fertility rate</i> (children born/woman) (2001)	2.7
<i>Estimated number of adults living with HIV/AIDS</i> (2001)	11 000
<i>HIV/AIDS adult prevalence rate</i>	0.6
<i>Estimated number of children living with HIV/AIDS</i> (2001)	320
<i>Estimated number of deaths due to AIDS</i> (2001)	890
<i>Life expectancy at birth</i> (years) (2001)	
Total population	76.1
Male	73.8
Female	78.6
<i>Life expectancy at age 60</i> (2000)	
Total population	21.0
Male	20.0
Female	22.0
<i>Healthy life expectancy (HALE) at birth</i> (years) (2001)	
Total population	65.3
Male	64.2
Female	66.4
<i>Healthy life expectancy (HALE) at age 60</i> (2001)	
Total population	14.1
Male	12.9
Female	15.3

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Economic data (year 2000)

GDP – composition by sector (%)

Agriculture	13
Industry	31
Services	57

Gross national income (GNI) (\$PPP)⁴ 30 billion

GNI – per capita (\$PPP) 7980

GNI – per capita (US\$) 3810

GDP growth (annual %) (1999–2000) 1.7

Labour force participation (%):

Male	54.5
Female	25.2

Health expenditure (year 2000)

% of GDP 6.4

Health expenditure per capita (\$PPP) 411

Health expenditure per capita (US\$) 273

⁴ PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries

2 General health and social system

2.1 Basic income maintenance programmes

The contributory retirement system is financed by employers (47.5%), by employees (25.0%) and by the State (0.25%). Until the mid-nineties, this system constituted the biggest pension regime in the country. Currently, it is the only one in existence, but it is complemented with compulsory savings. The non-contributive retirement system is financed by the State and 20% by the *Fondo de Desarrollo Social y Asignaciones Familiares* (FODESAF). The FODESAF is financed through a 5% tax on income and a 3% sales tax.

Even though coverage by the pension system is one of the highest in Latin America, only 36% of those aged over 60 years have a pension from the contributive regime, and about 35% of the population receive a pension from the non-contributive one. This means that about 30% of the population over 60 are not covered.

Only 55% of the economically-active population are covered by any of the pension schemes, and the possibility of savings is currently highly reduced. This fact could affect the sustainability of the system; however, a reform has been introduced in order to address these problems.

The retirement system includes a pension that is equivalent to 60% of the salary when the person has contributed the equivalent of 30 years of work (before the reform, the pension represented 100% of the salary). A pension for the disabled is provided if the individual has contributed at least 36 quotas (around three years) and she/he has lost two-thirds of working capacity.

A subsidy from the State is provided for poor people. Even if they have not contributed to the Social Security Fund, they are entitled to receive a minimum income. The goal is for every poor elderly person to have a minimum level of support. Approximately 80% of the population receive the benefit. This reform was under a law for the protection of workers.

2.2 Organizational structure of decision-making

The Costa Rican Central Government is composed of the Executive, Legislative, and Judicial branches. The Executive branch deals with social programmes, and includes the Ministry of Health, the Ministry of Labour and Social Security, the Ministry of Education, the Ministry of Agriculture, and the Office of National Planning.

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These programmes have a steering role in their respective fields, and they coordinate programmes between them. For example, as part of its programme the Ministry of Education provides meals in primary and secondary schools and transportation subsidies for poor people. The Ministry of Labour operates micro-enterprise programmes, temporary employment programmes, and programmes for those facing retirement.

In addition to the Central Government, the public sector is composed of public institutions such as the State Banks, The National Insurance Institute (INS) and The National Institute of Urbanism and Housing. The National Institute of Urban Affairs and Housing provides credit and conditions for housing.

There are other public institutions under various Ministries, which participate in social programmes and focus on target groups. These include INCIENSA, which has a mandate to alleviate severe malnutrition, especially among children under six years of age. The Childhood National Society (PANI) is a programme for homeless children. The Social Assistance Institute (IMAS) has a programme for family micro-enterprises, a popular housing programme, a programme for supporting small producers, and also provides subsidies for poor people.

The Bank 'Hipotecario' of Housing (BANHVI) provides family housing bonuses for homeless people. The Institute of Agrarian Development (IDA) awards credits for agriculture, and training for small producers. The Institute of National Learning (INA) organizes workshops, particularly for training unskilled workers. All these institutions participate in the promotion of social programmes.

The Ministry of Health, the Ministry of National Planning and Economic Policy, the Costa Rican Institute of Water and Sewage Systems, the National Insurance Institute (which provides life insurance, risk employment insurance **and accident insurance, among other schemes**), and the CCSS comprise what is commonly referred to as 'the health sector' (PAHO, 1998). The Ministry of Health supervises and evaluates health services, and is in charge of epidemiological surveillance. The CCSS is responsible for financing, insurance, and care provision through hospitals and medical centres.

2.2.1 Ministry of Health

According to the Pan American Health Organization (PAHO):

the Costa Rican Ministry of Health is a part of the Executive Branch and has a steering role. It is in charge of supervising and evaluating health service delivery. (PAHO, 1999)

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However, as mentioned previously, information on financing, insurance, and the delivery of services is handled by the CCSS. This agency has an information system that is exclusively devoted to epidemiological surveillance.

Before the reform of the system in 1994–98, all health centres, health posts, mobile medical and dental units, dental school clinics, comprehensive health care centres, school lunch rooms, and comprehensive child health and nutrition centres were provided by the Ministry of Health (MOH).

Since 1995, these services have been progressively integrated into the CCSS. Other services that were transferred to the CCSS involve reproductive health and preventive oral health services provided to schoolchildren and pregnant women.

The Ministry of Health has two Institutes. The Institute for Alcoholism and Pharmacotherapy (IAFA) deals with research, treatment, and rehabilitation in those areas; and The Costa Rican National Institute of Research in Nutrition and Health (INCIENSA) coordinates programmes to alleviate severe malnutrition.

The Ministry of Health is in charge of planning and coordination policies with respect to human resources, and is responsible for accreditation. The Board of Rectors (CONARE) approves the curricula of professional programmes and establishes minimum requirements.

A public fund has been created within the CCS, and is managed by the National Centre for Strategic Development and Research in Health Services and Social Security (CENDEISS). The Fund develops programmes for training technical assistants in primary care, and also provides technical assistants for the CCSS Basic Comprehensive Health Care Teams (EBAIS) and postgraduate programmes, in coordination with the University of Costa Rica (UCR).

2.2.2 Public sector institutions

The CCSS, the National Institute of Life Insurance (INS), and the Cost Rican Aqueducts and Sewage Institute (Icaa) are autonomous entities. The Government must approve the budget of each institution.

However, their revenue comes from normal operations. For example, an important share of the revenue of the CCSS comes from contributions to the insurance scheme (health and pensions).

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2.2.3.1 The Social Security Fund

The CCSS is responsible for the provision and promotion of public health services. Since 1998, it has purchased health care services through the Management Commitment, a contract signed between hospitals and the CCSS about the quantity and quality of services that hospitals will supply every year, and where 10% of the budget is subject to satisfactory performance.

2.2.4 Privatization and modernization

The highly-concentrated provision and financing of health care and the monopoly of insurance by the State constitutes a barrier to private providers, and strongly discourages their participation. As a result, the system has grown and become relatively inefficient.

During the 1980s crisis, some programmes were reorganized to incorporate the private sector into the provision of health care, especially at the ambulatory level. One innovation was 'mixed medicine', where the patient paid for medical consultation (out-of-pocket) and CCSS covered drugs and support services. Another was called 'enterprise medicine', where the strategy was for the enterprise to hire a doctor to provide health care to workers.

These measures were intended to reduce pressure on the demand for medical consultations in public institutions. Various models of care were implemented. These included the Integral Centre of Coronado, a programme of family medicine which is based on a model of community assistance and includes home assistance, home visits, and the integration of functions within the CCSS Basic Comprehensive Health Care Teams (EBAIS). The latter specializes in primary care.

Major changes began in 1992, when the Legislative Assembly passed laws 7374 and 7441. These became effective only in June 1994. The reform had various components, but among the most important was that concerning the provision and financing of services. As PAHO remarks:

Throughout the current decade the prevailing model of health services has been a medical model to meet demand, where hospital care is predominating having few opportunities for community-based work. The emerging model seeks a more integrated approach that anticipates demand, with more community-based work. (PAHO, 1998)

2.3 Financing of services

The provision and financing of the health system in Costa Rica is primarily public. About 25% of the total health expenditure is private and paid out-of-pocket. Private insurance has not been successfully implemented. Public health expenditures are mainly financed by the CCSS, which spends 65% of the total health expenditure and 89% of public health expenditures.

Taxes in Costa Rica are levied at the national level, although only about 10% of total health care expenditure is financed through such means. A 2% sales tax, dedicated to financing the non-contributive regime of the CCSS for poor people, and a 5% income tax are also levied.

The CCSS has two insurance schemes: one contributory, the other non-contributory. The first includes insurance for the independent and self-employed through sickness and maternity insurance, pension insurance (retirement, disability and life insurance), and a voluntary insurance programme for those who are not employees. The non-contributory scheme was specially designed for poor populations. However, most people are covered by maternity and sickness insurance.

Most of the health system is publicly financed through a payroll tax. The health insurance scheme for dependent employees is financed through contributions by the State (0.25% of the total wages of workers); by the employer (9.25% of workers' wages); and by the employee (5.5% of his or her wages). The self-employed contribute 12.75%.

Health and voluntary insurance gives 'free access' to the health care services provided by the CCSS. The insurance covers all economically dependent members of the family. The insured has the right to use health services, and many receive some monetary benefits and subsidies when economic conditions are bad.

The social insurance card gives no access to private health care. To use those services, a fee for service must be paid and there is no mechanism for reimbursement. However, there are systems of mixed medicine where medical care is received privately but the physician works for the CCSS. In this case, the patient pays the fee but is referred to CCSS hospitals for laboratory tests and drugs.

Health care benefits include 'integral care', i.e. prevention and health promotion, specialized hospital care, medical exams, and social assistance. (Access to drugs, dental services and medical supplies depends upon availability within the system.) Monetary benefits include subsidies to buy eyeglasses, and maternity leave equivalent to 50% of salary during four months. Social assistance covers transportation/lodging costs for those who cannot afford them.

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Table 1. Costa Rica health expenditures

	1990	1995	1998	1999
<i>Total expenditure on health/GDP</i>	8.4%	10.5%	8.9%	8.9%
<i>Public expenditure on health/GDP</i>	6.8%	8.5%	6.9%	7.0%
<i>Private expenditure on health/GDP</i>	1.6%	2.0%	2.0%	1.9%
<i>Private insurance on health/GDP</i>	0.0%	0.1%	0.1%	0.1%
<i>External resources on health/THE</i>	0.0%	0.1%	0.5%	0.5%
<i>Social security funded HE/THE</i>	66.7%	71.3%	66.2%	67.5%
<i>Private expenditure on health/THE</i>	19.1%	19.1%	22.6%	21.1%
<i>Out-of-pocket on health/THE</i>	19.1%	18.5%	21.9%	20.4%
<i>Private insurance on health/THE</i>	0.0%	0.6%	0.7%	0.6%
<i>Total personnel compensation/THE</i>	0.0%	0.0%	0.0%	0.0%
<i>Public personnel compensation/PHE</i>	0.0%	0.0%	0.0%	0.0%
<i>External resources on health/PHE</i>	0.0%	0.1%	0.6%	0.6%
<i>THE per capita at X-rate (US\$)</i>	157	266	245	255
<i>PHE per capita at X-rate (US\$)</i>	127	215	189	201
<i>Private HE per capita at X-rate (US\$)</i>	30	51	55	54
<i>OOPS per capita at X-rate (US\$)</i>	30	49	54	52
<i>Private ins. per capita/X-rate (US\$)</i>	0	2	2	2
<i>THE per capita at PPP-rate (US\$)</i>	374	571	499	555
<i>PHE per capita at PPP-rate (US\$)</i>	302	462	386	438
<i>Private HE per capita at PPP-rate (US\$)</i>	71	109	113	117
<i>OOPS per capita at PPP-rate (US\$)</i>	71	106	109	113
<i>Private ins. per capita / PPP (US\$)</i>	0	3	3	4
Source: NHA-WHO.				

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The budgets of hospitals and clinics are set by the CCSS. Before 1998, budgets were set on a global basis based on historical expenditures. Since 1998, part of the budget is linked to the performance of the unit. The only exemption is the Barva Clinic, which has a capitation system.

Long-term care services supplied by hospitals are included in their budget and are mainly financed by the social insurance system. However, some long-term care programmes are financed from external funds raised by foundations. Home care for poor elderly people is financed through general taxation (the tax on alcoholic beverages and cigarettes) and donors.

The last survey of income and expenditures was conducted in 1987. According to that survey, approximately 28.7% of out-pocket-private expenditures were devoted to medical and pharmaceutical products, 11.6% for medical equipment, 50.9% for medical services and diagnosis, and 8.7% for hospitalization.

According to the last Household Survey that included a health utilization module (1998), approximately 20% of the population who use health services have private medical consultations, but only about 2% are hospitalized in private institutions. According to PAHO, about 50% of drugs were supplied by the CCSS. Units (hospitals) are authorized to make cash purchases.

2.3.1 Governmental and/or NGOs health and social programmes

■ Social programmes

Housing, social assistance, education, and nutrition were among the programmes offered by the State. They were focused on population groups: children, the poor, and the elderly. Historically, about 20% of the GDP was devoted to public social programmes. In 1970, 47% of the social Government expenditure was allocated to health and 12.4% to social assistance. This composition changed radically in 1995, when 39.5% was provided to health and 27.8% to social assistance (World Bank, 1995).

In 1994, the Costa Rican public sector managed 31 different programmes to assist priority groups, representing 12% of social expenditure. Programmes were financed by the Fondo de Desarrollo Social y Asignaciones Familiares (FODESAF), or by other designated institutions. Those programmes were coordinated by 11 public institutions.

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The main institutions which are involved in social programmes and responsible for welfare policy are the Caja Costarricense del Seguro Social (CCSS), the Instituto Mixto de Ayuda Social (IMAS), IFAM (Institute for Municipal Advisory Development), the National Institute of Life Insurance (INS), the Board of Social Protection (JPS), the Costa Rican Institute of Electricity and Telecommunications (ICE), the National Institute of Housing and Urbanism (INVU), the Costa Rican Institute of Water and Sewage Systems, and the public financial institutions.

■ *Social programmes and health*

FODESAF finances some preventive programmes, such as the community and rural health programme. This programme divides the country into areas, with 3000 centres extending coverage to almost the entire population. Programmes are focused on various target populations, and have implemented epidemiological controls, health education, family planning, and vaccination programmes, and focalized attention, especially through CEN-CINAI centres that provide meals and milk to children and care to pregnant women. In order to reduce malnutrition, the Ministry of Education provides food through schools to children between 6 and 12 years of age. About 54–68% of the population under the age of ten is provided food by the State (Mesalago, 1992).

2.4 *Services delivery system*

Health services are divided into three levels of care (PAHO, 1998). Primary care is provided by 103 small clinics⁵ and the EBAIS. They provide neither hospitalization nor specialist medicine. This primary care service covers 69% of the total population and more than 90% of the rural population. The secondary level is provided by seven regional hospitals, 13 peripheral hospitals and 38 clinics (type 3 and 4).⁶ Tertiary level care is provided by national and regional hospitals.

There are also three national general hospitals (San Juan de Dios, Dr Calderon Guardia, Mexico) and six specialist hospitals (Raul Blanco Cervantes: National Geriatric Hospital; two Psychiatric Hospitals: Chapuit and Chacon Paut; the Women's National Hospital; the Children's National Hospital; and the National Hospital for Rehabilitation).

⁵ Clinics type 1 and 2 offer ambulatory care, and the latter has pharmacy and laboratory services.

⁶ Clinics type 3 and 4 offer general and specialized medicine, and type 4 the four basic specializations and sub-specializations.

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As a first point of contact, people must attend the assigned clinic according to place of residence. There is a referral system from EBAIS, and from clinics to regional and national hospitals. At the end of the 1990s, the third level was spending half of health expenditures, leaving around 20% for the first level and 30% for the second level (PAHO, 1998).

Those aged 60 years and older are the main users of the health system. On average, 15% of ambulatory care is provided to this group, and in the three national hospitals this ratio is over 20%. The average length of stay is higher among people 65+ for all hospitals, and the main providers of long-term hospitalization are the two psychiatric hospitals, the Geriatric Hospital, the Rehabilitation Hospital, and the National Hospital San Juan de Dios. However, the average length of stay is higher in national general hospitals than in regional hospitals.

On the supply side, 14% of medical consultations are conducted in the national hospitals which cover the metropolitan area. The Geriatric Hospital handles only 0.28 % of medical consultations and the psychiatric hospitals 0.27%. In relation to the share of beds, 58.82% are in the national hospitals – only 2.37% are in the geriatric hospital and 4.88% are for psychiatric patients. The three national general hospitals have an occupancy rate of about 90%. These data offer an idea of the importance of specialist and national hospitals in the supply of general and long-term care.

Psychiatric care is provided in all national and regional hospitals and Type 4 clinics, and in some peripheral hospitals. However, the main institution is the National Psychiatric Hospital with 800 beds – 600 for chronically ill patients – and the Chacón Paut Hospital especially for those who are non-chronically ill.

2.4.1 Auspices of health service providers

The CCSS is a monopolist supplier of health services. Services are supplied through a wide network of health care centres and hospitals, particularly at the tertiary level. The private sector has gained importance as a primary care provider. About 20% of the population receives private medical consultation.

From the point of view of demand of health professionals, the CCSS is also very important. In 1995, about 75% of physicians were hired by the CCSS. As a means of promoting private participation, the CCSS allows its employees to work part-time to facilitate the possibility of setting up their own medical clinic. Employees are paid a salary and are hired according to civil service regulations.

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2.5 Human resources and training

■ *Role of the universities in medicine*

From its inception, the CCSS has promoted the training of physicians abroad, especially through scholarships. When the Faculty of Medicine of the University of Costa Rica was established in the 1960s, the CCSS promoted the practice of those students in hospitals. In the last few years, four private universities have begun to teach medicine, and have also signed agreements with the CCSS allowing them to practise medicine within its system.

Since the Faculty of Medicine at the University was created, there has been cooperation between the University and the Social Security System. In 1974, they signed an agreement extending the use of its clinics for teaching and research postgraduate programmes to 34 clinical specialties.

The National Centre of Strategic Development and Information on Social Health and Social Security (CENDEISS) was created to provide coordination. In 1988, CENDEISS became the Centre for Development Strategy and Information on Health and Social Security. It administers all training programmes of the CCSS and the training of human resources. Among other programmes, it offers training for technical assistants in primary care (EBAIS).

All programmes of medicine include the first two years in basic sciences, plus three more years of courses and rotation internships. The number of years varies according to the university. Once the internship has been completed, the graduate must complete one year of social service in a hospital or a clinic before receiving a diploma. For the training of specialists in the field, there is a school of psychology and a graduate programme in psychiatry. A graduate programme in gerontology and geriatrics and a masters' programme in gerontology at the State University is also offered.

The ratio of physicians to population has increased in the last nine years from 97.1 to 163 per 100 000. This ratio is lower than in countries such as France (303) Sweden (311), or Switzerland (323), but similar to the United Kingdom (164). It is also important to note that previously almost all physicians were hired by the CCSS – but that the percentage has declined from 85% in 1990 to 51% in 1999.

■ *Regulation*

To work as a physician, it is mandatory to be affiliated with the Physicians and Surgeons College. A further requirement is the completion of a diploma at one of the universities recognized by CONARE (Board of Rectors, which approves the curricula of professional career programmes in coordination with the Ministry of Health).

■ *Hiring*

In the public sector, the Budget Authority is in charge of establishing new posts, although the CCSS has its own recruitment policy. All public sector contracts are under the authority of the Civil Service, where payment is according to years of experience in the institution, on a salary basis.

However, according to the law of medical incentives, an increase in salary must be based upon the judgement of the Budget Authority as to what is fair compared with general public sector salaries. On average, the salaries of the CCSS personnel are approximately 20–40% higher than those in the public sector.

■ *Nursing*

Nursing is taught at the University of Costa Rica and, more recently, at three private universities. The duration of the nursing programme is approximately four years, plus eight more quarters for a bachelor's degree and 11 more for a licenciante (considered equivalent to a Master's degree). Studies include practise in hospitals and in the community.

The ratio of nurses to population was 109 per 100 000 in 1997. This share is very low as compared with countries such as the United States (972) or even the United Kingdom (164), but similar to Mexico (86.5). This situation reflects a severe nursing shortage. The primary employer of nurses is the CCSS (employing nearly half of Costa Rica's nurses). In 2001, there were 5251 nurses affiliated to the Nursing Association.

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■ *National Centre of Strategic Development and Information on Social Health and Social Security (CENDEISS)*

The Centre was opened in 1972. Its objective is the training of personnel, based upon new methodologies and evaluation. Another primary aim of the Centre is to promote social and biomedical research.

The University of Costa Rica and CENDEISS offer more than fifty postgraduate programmes or specialities with very high requirements.

***Table 2. Health professionals
per 100 000 population***

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
<i>Physicians</i>	97.1	98.4	99.0	99.0	103.8	107.5	141.2	147.2	156.1	163.3
<i>Dentists</i>	36.6	37.0	68.0	37.7	37.2	37.3	37.1	37.5	36.9	39.2
<i>Pharmacists</i>	32.1	32.0	33.8	32.8	33.0	33.4	33.8	33.6	34.5	36.9
<i>Microbiologists</i>	26.0	26.0	25.8	25.8	25.8	26.1	26.4	26.7	27.1	28.3
<i>Nurses</i>	45.0	46.9	49.9	48.7	49.1	49.2	50.0	48.5	30.2	30.6

Source: Authors' calculations based on social indicators from Mideplan (Ministry of National Planning and Political Economy) (www.mideplan.go.cr)

3 LTC Provision

3.1 Provision and services related to LTC

3.1.1 Private institutions: nursing homes for the elderly poor, homes for the elderly, and day care centres

In Costa Rica, the care of the elderly is still considered a family responsibility, contrary to the situation in the United States and other industrialized countries. Until recently, nursing home services have not been considered an important alternative for the care of older people. Rather, housing and care institutions are available for poor older people, although financing of the services provided is not included in the benefits of the social security insurance as in the USA. These houses are privately managed, and some of them receive State support as long as they meet certain minimum requirements.

There are three kinds of private care institutions (Lizano, 2000): nursing homes for the elderly, shelters for the elderly, and day care centres. The difference between the first two is the degree of independence. To be accepted in these insitutions (Laake & Morales, 1996), a person must:

- be 65 or older;
- be indigent;
- be without familial resources or family to take care of them;
- live in the community;
- not be disabled; and
- not have any communicable disease.

The nursing homes for the elderly poor offer the following services: shelter, medical and paramedical services, nursing, laundry service, nutrition, spiritual support, social workers' services, rehabilitation services, cultural and entertainment activities, a proper infrastructure, and trained personnel. In sheltered housing, only meals and social activities are provided.

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The day care centres complement the needs of daily life for people with economic problems or at social risk (loneliness, abuse, or nutritional problems). These centres do not provide health care.

3.1.2 Caregivers

According to Laake and Morales (1996), the majority of the managers of these centres are women between 31 and 60 years of age. However, these women are also required to fill other roles besides that of manager (e.g. teacher, secretary). Most of them have training in health or social care. There is an average of four staff for each patient.

The institutions are mainly located in the metropolitan area. They serve 4513 persons, less than 2% of the elderly population.

Another important participant in care for the elderly is the National Gerontology Association. The Association organizes activities and informational materials for elderly people. In addition, the Association Pro Geriatric and Gerontology National Hospital (APRONAGE) obtains resources – particularly through the donation of medical equipment. The National Crusade for the Protection of the Elderly (FECRUNAPA) is particularly helpful in providing training for the elderly at home.

3.1.3 Institutional participation in care for the elderly

An important characteristic of the welfare state is responsibility for the delivery of social services. Social support is important to the welfare of disabled persons. An earlier study (Ramirez, 1991) showed that social security institutions offered some assistance in the metropolitan area.

Coverage of social support services provided by the CCSS in 1991 included:

- services for people of 60+ years (personal services, such as home assistance and training of relatives;
- 'Third Age' clinics;
- retirement orientation courses; and
- guidance to social and community services.

3.1.4 Specialist hospitals: The Geriatric and Gerontology National Hospital

The hospital was transformed into a health centre specializing in gerontology in 1978. It offers assistance services such as medical consultation, day care centre, community care, and hospitalization.

Medical consultation includes the support of laboratory and pharmacy services. The hospital provides the following services: geriatric, internal medicine, cardiology, dentistry, special attention (pain, diabetes, high blood pressure, etc.).

The day care centre provides geriatric and nursing services, physical therapy, and psychological support. The patient is in the hospital during the day (8–16h) and returns to his/her home or to the hospitalization programme at night. In 1988, the programme had 30 patients. In 2001, the programme served 70–80 patients.

The programme of community care services provides integral care to elderly people who cannot travel to the hospital. The team is composed of a geriatrician and nurses and, as necessary, staff from the department of social work, as well as the pharmacy, and laboratory services.

3.1.4.1 Day hospital

One innovative programme is the day hospital which was started in 1973. Initially, it provided care to tuberculosis patients. It later became a service for patients at high risk – those over 60 years of age who suffer from aggression, depression, and functional disorders, and who need social support.

An interdisciplinary team is composed of a nurse, a nurse's assistant, a part-time social worker, a psychologist, a physical therapist, an occupational therapist, a geriatrician, and a person in charge of therapeutic work who runs the occupational workshops. Four volunteers and a bus for transportation of the patients are also included in the team.

To participate in the day care hospital, candidates should be aged 60 or older, and be considered by a specialist (geriatrist) as a patient at risk. The patient is referred to the Hospital Blanco Cervantes. His or her situation is analysed by a hospital geriatrist, and finally by the geriatrist in charge of the day hospital.

Each day the programme cares for 20–25 patients. Ten to fifteen patients are hospitalized with an average length of stay of two to three months. Usually patients attend twice a week and most of them (80%) are referred by doctors from the same hospital. The most common illnesses among patients are high blood pressure and diabetes. Approximately 85% of the patients present with depression.

LONG-TERM CARE

The programme includes a medical check-up service from 8 to 8.30 in the morning. If the patient presents any problems, he/she is referred to a geriatrist. From 9.30 to 11.30, personal care therapy and physiotherapy are provided. When assisted by volunteers, patients do handicraft and cognitive exercises. A lunch break follows. From 12.30 to 13.30, there is group therapy, such as physical exercises and educational programmes, including topics such as the prevention of falls, diet, ageing, self-confidence, and depression. The programme ends with coffee. Every two months, an excursion is organized.

The board of the day care hospital meets every eight days in order to analyse the situation of patients and caregivers and consider possible discharges from the hospital. Relatives receive training for the provision of care. If there is any problem with a patient, the family is called in to seek a solution. When the family is not present, or the patient is not at the hospital, the social worker visits them at home.

The amount of hospital day care available does not meet the demand. Services are provided in a small hall, although there is a plan for the construction of a new one. The bus is not appropriate for transporting disabled people. There is a shortage of resources to improve the service and to provide individualized care. An additional problem lies in the fact that dementia is not treated because of scarce resources.

The hospital is financed through the budget of the CCSS. It also receives donations through a fund-raising programme (a telethon) promoted by the Office of the First Lady. In 2001, this fund-raising activity was carried out for the second time.

3.1.4.2 Home assistance

Services are provided to support rehabilitation and are composed of a mobile unit with a doctor, a nurse and a social worker, who give training to the family. This service is organized primarily by social workers. Some specific programmes for home care will be discussed below.

3.1.5 Community care services: home medical visits and hospitalization at home

This programme, which began in 1996, is provided for those aged 60 or older. The objective of the programme is to provide care at home for those patients who cannot attend the medical centre. Initially, patients included those with problems of readmission, or who were receiving poor care.

CASE-STUDY: COSTA RICA

Currently, care is provided to all patients referred from the Hospitalization and Ambulatory Care Unit of the hospital and other medical centres in the metropolitan area (the capital and neighbouring cities). To receive this type of care, the person must have a disability that precludes his/her attendance at the medical centre. The caregiver must follow the course of basic care for the elderly (once a week for four weeks).

The basic team is composed of a doctor, a geriatrician, and a nurse. In addition, the team has the support of social workers; the pharmacy, laboratory, respiratory therapy, and dental services of the hospital; and two well-equipped vehicles for conducting approximately ten visits per day.

The programme covers approximately 550 patients in the metropolitan area. Of these, about 70% are women. Of that population, one group is visited once a month because patients need a feeding tube or are oxygen dependent; the other group is visited once every two months. Depending on the patient's situation, he/she is followed through a telephone diary system.

During the first medical visit, a medical evaluation of the patient is conducted, and instructions given to the caregiver and family. In addition to medical services, the programme includes a service of telephone advice to the patient or relatives, as well as programmes for borrowing medical equipment, delivering drugs, and taking samples for tests. However, it does not include emergency services.

3.1.6 Calderon Guardia Hospital: hospitalization at home

The Calderon Guardia Hospital covers a population of 650 000 directly, and another 700 000 indirectly. Together, this includes approximately one third of the total population.

The programme began in 1987 and was intended for patients 60 years or older, with disabilities, familial problems, or health problems that result in long periods of hospitalization.

The basic team is comprised of a doctor, a social worker, a nurse and a volunteer, and is coordinated by a geriatrician. Services include medical consultation, delivery of drugs, laboratory examinations, nursing care, and home visits by the social worker.

The objective of the programme is to facilitate the acceptance in their home and community of a patient with psychic limitations or terminal illness.

LONG-TERM CARE

The role of the social worker was very important in the development of the programme, especially concerning support and guidance to the patient and family, types of training, and special topics connected to the care of the elderly.

3.1.7 National Centre for Rehabilitation

The National Rehabilitation Hospital (CENARE) provides care targeted to patients with medullar lesions (traumatic or congenital), tumours, infections, cranial traumas, cerebral paralysis, degenerative illness such as progressive muscular dystrophy, neuropathies, polio effects and post-polio syndrome. All of these patients require continuous medical attention.

The programme also includes patients who need therapy, especially those with problems of the skeletal muscular system. Medical attention is provided each year to approximately 50 000 patients with medullar lesions.

In addition, programmes are conducted such as 'The Back School' for patients, caregivers, and relatives. This three-day course is for groups of fifteen persons. During the course, participants receive theoretical training concerning the anatomy of the back, its care, and related exercises. A workshop for GPs on handling lumbar pain was begun five years ago. It convenes three times per year for 18 hours during two days.

The hospital operates a number of specialist neurological, neurosurgical and orthopaedic clinics. All of these clinics have socio-educative groups and provide services to the community.

Training for patients, relatives, and caregivers is also provided. Its purpose is to assure that patients, particularly those with brain paralysis, can follow the exercises and therapy at home, .

3.1.8 Reform of mental health care

Historically, mental health problems were treated at the third level of care, and therefore no emphasis was placed upon prevention. Provision of mental health care presents some weaknesses – such as lack of resources and deficient coordination at the intersectoral, community, and interinstitutional levels. Lack of information about the demand for these services, programmes for hospitalization at home (visits at home) and psychotherapy, also presents problems.

For these reasons, a project is currently being implemented with the purpose of reforming the model of mental health care. The goal is to improve the quality of life of the patient and to integrate him/her into the community.

CASE-STUDY: COSTA RICA

At the end of 2001, specific goals included:

- the provision of at least 25 units of mental health and psychiatric care;
- an inventory of personnel working in the field;
- an understanding of the epidemiological impact of problems encountered; and
- the initial stages of reform of the Psychiatric Hospital.

The Department of Mental Health of the CCSS is in charge of institutional policy and implementation of the project. The project should be completed in three years.

The concept involves each hospital and each clinic having a multidisciplinary team; decentralization of care to other residential options (with only 40% of cases treated by CCSS hospitals); and an increase in the number of beds and the number of emergencies treated in the other hospitals. A budget is to be set for human resources training, and the participation of EBAIS in the promotion of mental health is to be increased.

3.1.9 National Centre for Pain Control and Palliative Care

The National Centre for Pain Control and Palliative Care was created in July 1999 by an Executive Law. It assigned the Centre a steering role over the various entities providing palliative care in the country.

In 1990, the Committee of Palliative Care was created in the Max Peralta Hospital, which was transformed in 1993 into the Walk Together Association (Caminemos Juntos). This was the first formal group to provide care to terminal patients with cancer and AIDS.

In 1990, the first Unit of Palliative Care for children in Latin America was created in the National Children's Hospital. One year later, a pain clinic was established at the Calderón Guardia Hospital (National Hospital), to provide support in pain management to terminal patients and to those who suffered from chronic benign pain. During the past decade, other clinics have been created in different hospitals throughout the country.

LONG-TERM CARE

The Centre's first duty was to elaborate plans for the provision of services and drugs. Next, it was responsible for developing the organization of the clinics, and a training plan. The National Centre for Pain Control and Palliative Care team is comprised of nine specialists (physicians), three psychologists, a nutritionist, a physical therapist, four nurses, and two assistants.

Coverage is national, especially through the services of home visits. Its services comprise three specialties:

- oncology palliative care;
- non-oncology palliative care; and
- chronic benign pain care.

The first two specialties offer external consultation, home visits, and hospitalization; the last is provided only through external consultation.

The home services team is comprised of a psychiatrist, a physician (internist), a physician specializing in pain, and two psychologists. The first two specialties have a base group formed by a specialist, a nurse, and a support team of nutritionists, a respiratory specialist, a physical therapist, and a psychologist.

Home visits for oncology purposes cover the Metropolitan Area. Non-oncology visits are extended to rural areas. The total number of patients who were provided with home services between October 2000 and October 2001 was 1301. The main reasons for providing these services involved prostate gland cancer (784 cases); breast cancer (131); and stomach cancer (116). Patients were visited from one to three times per month by a nurse and a specialist. These staff also provided medical consultations to 7912 patients, and psychological consultation to 2353 patients.

In December 2001, 14 pain clinics existed in the country. There are two located in the capital, six located in the provinces and the rest are distributed in the cantons which have the highest population concentrations. Personnel who work in different areas of the country receive training (a month of internship with classes) at the Centre.

3.1.10 Golden Citizen Programme

The Golden Citizen Programme was implemented by the CCSS in July 1997. The programme covers all persons of aged 65 years or older. Golden Citizen was created with the objective of improving the physical, mental, and social conditions of the elderly through special treatment in all administrative and medical units of the CCSS and public institutions. One of its goals is to promote discounts in stores, public shows, workshops, seminars, and participation in activities. Special treatment in health care includes ambulatory care, pharmaceutical, laboratory and administrative services, and hospitalization. Currently 75 medical centres are committed to the programme.

By means of Executive Policy 26991, all public institutions are responsible for giving special treatment to the elderly. The CCSS has agreements with 34 institutions, including banks, postal services, electricity providers, ministries, and municipalities. The CCSS participates in the organization of physical training courses, taught by a professional twice per week. In 1999, 52 groups involving 1700 persons were organized. In addition, 16 cultural workshops were conducted, involving especially handicrafts. The CCSS also arranges discounts in museums, national parks, hotels, travel agencies, and the like. In 2000, approximately 84% of elderly people had a Golden Citizen Card, which permitted them to enjoy all of these benefits.

3.1.11 Other programmes for care for the elderly and disabled

■ *Training for relatives*

At least half of the health centres that answered a survey reported that they provided training on care to the relatives of the elderly. These programmes are especially prevalent in the West Pacific Region and the Metropolitan Area.

■ *'Third-age' clinics*

These are ambulatory care services, focusing on elderly people, which provide appointments and drugs.

■ *Community services*

These are mainly offered through the provision of medical assistance and training to the home centres.

LONG-TERM CARE

3.2 *NGO's involved in the organization of LTC services*

3.2.1 *NGO's involved in the financing and provision of care for the disabled elderly*

3.2.1.1 *Office of the First Lady and APRONAGE*

The Office of the First Lady is active in raising funds through special events. One special activity consisted of a sixteen-hour live concert by national and international artists. The objective was for businesses and individuals to make donations. The goal was to raise around US\$2.2 million.

3.2.2.2 *Costa Rican Gerontology Association*

The Costa Rican Gerontology Association was created in 1980. The objective of the Association is to promote programmes that improve the quality of life of people aged 60 years and older. Its work focuses on education and the prevention of illness among older people, their families, and the community. Although the latter pay for some of the Association's activities, the amount is not significant.

The Association's main office is in San Jose, and its staff is composed of a technical team of four social workers, a public relations representative, an anthropologist, an executive director, and administrative staff. The Association maintains inter-institutional relations with the National Chain of Associations, the Permanent Forum of Abuse against the Elderly, Help Age International, the Inter-American Association of Gerontology, and the Latin-American Gerontology Commission. It is financed partly from private donors, and partly from airport exit taxes which are charged when leaving the country – these funds are then transferred to the Gerontology Association. The Association has implemented numerous programmes during the past 20 years, including:

■ ***Community clubs***

Groups of no more than 25 persons are located throughout the territory, and receive technical support from the nearest health centre, the Preventive Medicine Department at the CCSS and AGECO.

■ ***Specialized clubs***

Largely in the metropolitan area, these clubs organize various activities such as walking, music, handicrafts, theatre, cooking, singing, chess, and others.

■ *Physical activity clubs*

These clubs meet twice a week, and offer yoga, gymnastics, and other courses. Each participant pays US\$5–7 for each course.

■ *Volunteers*

People 50 years or older serve as volunteers in libraries, homes for poor elderly, in the Centre for National Rehabilitation, and in the Hospital Blanco Cervantes. Volunteers are provided with training and must work at least four hours per week, but may choose the location of service. The volunteer programme was begun in 1991, and 85% of the volunteers are female, and approximately 75% serve in the San José area.

■ *Recreational activities*

Trips, camping, walks, and meetings are organized, and expenses are covered by the participants.

■ *Institutional training*

This is provided especially for caregivers in homes for the elderly.

■ *Loan of medical equipment to the disabled elderly*

Equipment includes wheelchairs, beds and walking aids. The only requirement is a medical statement that the person requires the equipment. They have use of the equipment for a monthly payment of approximately US\$3.

■ *Ongoing training*

The AGECO offers courses of three to six months' duration, on subjects such as managing stress, self-confidence, training for relatives on caregiving, pensioners' concerns, nutrition, health, physical activities, internet, and Tai Chi.

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■ *Providing information to the media*

Each Monday, a space in one of the main newspapers, entitled “Golden Age” promotes these activities. Every two months, a bulletin is published.

■ *Orientation for new pensioners*

This orientation has been provided since 1986 for the public and for institutions. Groups of 20–25 persons meet for 4–12 sessions, addressing topics such as nutrition, pensioners’ benefits, physical health care, etc.

3.2.2 *NGOs’ involved in work for disabled young adults and children*

The Office of the First Lady, in coordination with the foundation “A World of Opportunities”, and the National Hospital of Rehabilitation, have promoted activities, such as the provision of wheelchairs, in order to allow disabled people to lead productive lives.

The Museum of Senses with interactive displays where art works can be exhibited art works was another addition. A temporary hall for this purpose was opened in 1999.

“The Journey without Barriers” was organized in order to promote the law Equity of Disabled Persons, particularly in rural areas. Also planned is the creation of a centre to provide training and information to relatives of disabled people.

The construction of a new building in the National Centre of Special Education for children with visual and hearing impairments is part of a bigger project. Its departments for visual, audio and language deficiencies and mental problems, are funded through a donation from Proctor and Gamble.

The Foundation Pro-Unit of Palliative Care in Costa Rica was created in 1992 with the objective of supporting the Unit of Palliative Care in the Childrens’ Hospital, created in 1990. The clinic provides care for children with life-threatening illness (estimated at life expectancy of six months or less), and has already cared for eight hundred children.

CASE-STUDY: COSTA RICA

The team is composed of a doctor, a psychologist, and two nurses. Services include medical visits in the home, drugs that are not included in the basic list of the CCSS, and the loan of medical equipment.

The Foundation also trains parents in caring for the child and provides some education about cancer, pain, and dying. Psychological support is provided to parents and relatives, and a group of volunteers has been established for this purpose. The Foundation seeks to implement the first Latin-American shelter for paediatric palliative care, and has created an Education Centre for Palliative Care. The main resources are volunteers, donations by private enterprises, and proceeds from activities. Other specific projects include:

■ *Pro-National Childrens' Hospital Foundation*

The objective of this organization is to improve the functioning and financing of the National Hospital for Children through the participation of public institutions and enterprises. Funds come from donors and a special television programme.

■ *The National Centre for Prevention of Disability*

The Foundation is currently providing support for the construction of a five-story building with laboratories for the diagnosis of genetic illness. Construction began at the end of 2001. The cost of the project will be approximately US\$4.5 million. Tax-deductable resources are sought. The CCSS has committed to the operational costs, including human resources, once the centre is built.

■ *National Centre of Medical Specialities of the National Hospital for Children*

Five years ago, the authorities realized that the infrastructure of the National Hospital for Children was not sufficient, and organized a telethon to raise funds for its improvement. Now the National Centre of Medical Specialities has been constructed with the following services: psychiatry, psychology, adolescent clinics, paediatrics, endocrinology services and laboratory, haematology, oncology, immunology, neurology, cardiology and a unit for teaching and conferences. The cost of the project is US\$4.5 million, and the funds are managed by the Foundation.

LONG-TERM CARE

3.3 Caregiving

One of the main problems of long-term care services involves the rapid growth of the elderly population. This places enormous pressures upon the demand for care services, while women's participation in the labour force reduces the supply of informal caregivers. Usually, most informal caregivers are women.

According to a UN assessment, women's participation in the labour force in Costa Rica has not significantly increased. The household survey data for Costa Rica shows that there has been only a slight increase: in 1983 the labour force was composed of 75% males and 25% females; in 1998 these shares were around 68% and 32%, respectively. In 1983, the share of employed men was 72%, and that of employed women was 27%. In 1998 the share of employed women increased to 33%, and the rate of employment was 32.7%. However, the share of employed men remained at about 72%.

This increase in women's participation in the labour force seems to be the result of improvements in the public sector employment policy. While in 1994 only 39% of employees were women, in 1998 the share was 48%. The participation of women in the private sector and the share of women that were owners of small enterprises remained almost unchanged. There has been a slight increase in self-employment. The State is the third source of employment after the private sector and self-employment. At the household level, 25% of the heads of household were women.

In 1998, 94.8% of households included a female. This percentage was the same in 1994. The share of households with women between 12 and 60 years of age was 85% in 1998 and 87.7% in 1994. From that sample, it is possible to conclude that 62.4% (68.4% in 1994) of households were composed of at least one woman who is voluntarily or involuntarily unemployed.

Only 8% (7% in 1994) of households are composed of an older person and a woman who does not work outside the home. This means that 32% of the households with elders include a woman who works outside the household, and this ratio increases when the age range is reduced.

In 1998, 62.27% of the households had children aged between 6 and 17 years and 40.49% had children under six years old. In that year, 76.68% of households with children between 6 and 17 years included a woman not working outside the household. It seems that caregiving is associated more with the care of children. It is important to note that elderly people play an important role in the care of children in the family.

3.3.1 Training for informal caregivers

The National Geriatric and Gerontology Hospital offers courses for caregivers. The programme has been operational for more than ten years, and has been developed by social workers with the participation of nurses and psychologists. Courses are offered in particular to relatives and other caregivers of hospital patients. The course is taught each semester, twice per week in the afternoon, and enrolment is free.

In 2001, groups were comprised of approximately twenty persons, of whom an average of fifteen were women, especially housewives. The course has a social perspective, and covers topics such as family relations, ageing, family crises, the psychosocial processes of ageing, and the responsibilities of caregivers.

3.3.2 Formal caregiving

The specialized Geriatric Hospital gives training to midwives, assistant nurses, and nurses. Each year, the training is evaluated by means of a survey of the hospital personnel. As a result of the survey, conferences, seminars and workshops are organized. Personnel receive training in pathologies of elderly people, concepts of gerontology, nutrition, equipment utilization, and leadership.

3.4 Laws and legal information related to care for the disabled and elderly

3.4.1 Changes in legislation

In recent years, long-term care programmes have been developed more under the auspices of welfare institutions than that of the health services. These institutions have focused on programmes to care for the elderly, with special support from the First Lady's Office, which strongly promoted the Integral Law for the Elderly, approved in November 1999.

The laws approved and the programmes implemented have been oriented towards the enhancement of family participation in the care of the elderly, the introduction of changes in the social perception of the elderly, and the creation of mechanisms that permit the coordination, support, and surveillance of the institutions that provide care to the elderly. Financing of the programmes is through special funds and taxes, and is separate from the health and social insurance budget.

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The 'Integral Law for Elderly People' defines the principal rights and benefits of the elderly, as related to labour conditions, housing, and well-being. It also defines the duties of the State and the Ministry of Health, and creates the National Council of the Elderly (Consejo Nacional de la Persona Adulta Mayor).

3.4.2 Integral Law for the Elderly

All the beneficiaries of the law are elderly (sixty five years or older), with a CCSS card, identity card or passport.

3.4.2.1 Programmes for incorporating the elderly into the community

The Law promotes the improvement of the quality of life of the elderly through the implementation of educational programmes and cultural activities. The programme guarantees access to a shelter or a substitute house when the person is considered at risk, or has problems in access to credit. It also promotes prompt attention in hospitals and preferential treatment in administrative offices, and facilitates pensions that help to satisfy basic needs, even when the person has not contributed. It also includes social assistance in case of disability or loss of means of subsistence.

3.4.2.2 Responsibilities of care institutions

The Law also regulates private home care in relation to the rights of the elderly. For example, older persons must not be isolated, except for therapeutic reasons recommended by a professional. They are permitted to manage their own finances, and are informed about health status, treatments, and the services of the facility. They have right to privacy during visits of their spouse, and the right of free circulation within the facility.

3.4.2.3 Responsibilities of the State

The principal institutional reform is the creation of geriatric services in all national and regional hospitals, and clinics Type 3 and 4, with the technical support of the National Geriatric and Gerontology Hospital.

The State is also responsible for integral health care, and for promoting integration in the family through training programmes for family caregivers. Institutions offering public services are responsible for giving preferential treatment to elderly people, having the infrastructure to give these issues proper attention.

CASE-STUDY: COSTA RICA

The CCSS is responsible for obtaining discounts for public transportation, public and private cultural and entertainment activities, hotels and tourism centres, and for private medical services.

3.4.2.4 *National Council of the Elderly*

The Council's main objective is to encourage the family and the community to:

- participate in the development of the elderly;
- protect the rights of the elderly; and
- be responsible for their economic well-being.

The main functions of the Council are the formulation of policies to coordinate and assess the performance of the programmes, and the distribution of resources for their financing.

The Council is directed by a Board composed of the President or his representative, the Health, Public Education, Labour and Social Security Ministers, the Presidents of the Board of Social Protection (another public institution that finances social programmes), JPS, the President of the Social Assistance Institute (IMAS), Social Security Insurance, a representatives of the National University, the Costa Rican Gerontology Association, the association of pensioners and the National Crusade for the Protection of the Elderly. In 2000, the President of the Board was the First Lady, acting as the President's representative.

3.4.3 *Law No.7972: Tax on alcoholic beverages and tobacco*

Another important source of finance for programmes to improve the quality of life of the elderly was the implementation of Law No. 7972. This Law includes a tax of five cents per cigarette, and 10% sales tax on cigarettes and tobacco. Under the law, considerable amounts of funding from the proceeds are devoted to the Council of the Elderly and nursing homes for the poor, and to financing the non-contributive pension system.

LONG-TERM CARE

3.4.4 *Law No. 5662: Social Development and Family Allocation*

This legislation finances three programmes:

- attention to the elderly poor;
- “Ageing with Quality”, encourages an active life and offers educational programmes; and
- the “institutional attention” programme that provides financial support to home care for the elderly.

Just recently begun, these programmes are not universal. For example, one part of the programme “Age with Quality” is the “Intergenerational Bridge”. This programme consists of inviting elderly people to schools to talk and share their experiences with students, in order to change their perspective of the elderly in society.

It also includes visits by groups of students, particularly from the metropolitan area, to nursing homes for the elderly poor, to share opinions with them in order to sensitize children to their needs and living conditions.

3.4.5 *Law No. 7938: Protection to the Worker*

The non-contributive pension scheme was created in 1974. According to the CCSS, 35% of the elderly have a non-contributive pension. By law, FODESAF finances 20% of the non-contributive scheme and another part is to be financed through the Law that imposes taxes on cigarettes.

As part of the Government plan, the President proposes to increase the monthly pension from Colones 8500 to 10 000, and to universalize pension coverage. According to the CCSS, 42 000 persons – of a total of 54 000 elderly people living below the poverty line – are assigned pensions. Coverage is nearly 80%.

4 General questions pertinent to LTC development

4.1 Present and future needs for long-term care and gaps between needs and provision of services

Although Costa Rica has the highest life expectancy in Latin America for males, and is one of the top thirty best performing countries in terms of life expectancy for females, this position changes when the concept of HALE – healthy life expectancy – is introduced. In this case, life expectancy is reduced to 65.3, and Costa Rica's ranking in Latin America drops considerably.

Costa Rica has a relatively young population structure, as compared with industrialized countries, with approximately 7.3% of the population over 60 years of age. The high level of life expectancy and the decrease in the fertility rate, have caused the population structure to experience considerable changes.

In only ten years (1990–2000) the proportion of the population over 60 years of age increased from 6.4% to 7.3% (World Health Report, 2000). It is expected that for the year 2025 this group will represent 15% of the population (Claire, 2000). This situation will result in an increase in health costs, even though the health care reforms were to reinforce community services.

Other factors, also related to age, that may explain the potential increase in demand for long-term care services are changing morbidity and mortality patterns. The mortality rate was reduced in the last 25 years by almost half, as a result of improvements in health, health coverage, and living conditions.

In 1987, the leading causes of medical consultation were respiratory (17.8%), skin (9.3%), musculoskeletal (8.3%) and cardiovascular diseases (8.1%). However, for the population over age 60, the morbidity pattern is different. For this group, the main causes of medical consultation in 1997 were cardiovascular diseases (21.5%), endocrine disorders (14.7%), and musculoskeletal diseases (10.9%).

Endocrine disorders have increased in importance and cardiovascular diseases have decreased in the last ten years. The main causes of hospitalization are maternal conditions (32.6%) and digestive diseases (9.0%) for the population as a whole, and cardiovascular diseases (20.9%) for the elderly.

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The mortality pattern has changed significantly, and the rate of mortality from infectious diseases has been reduced in the last 25 years. In the 1970s there was a slight difference between the pattern of mortality of the total population and that of the elderly. Infectious diseases (97.8)⁴ and perinatal conditions (77.5) were important causes of mortality for the entire population, but for the elderly the main causes were malignant neoplasm (864.2) and cardiovascular problems (1796).

At the end of the 1990s, there was a convergence in mortality patterns. Cardiovascular and malignant neoplasm became the main leading causes for the entire population, and the mortality rate was reduced.

According to the CCSS, in the year 2000 the main causes of sickness among the elderly were, among other causes, hypertension, diabetes mellitus, and acute lower respiratory infections. The latter is one of the main causes of ischaemic cardiopathy. All these problems are related to nutrition, alcohol, and stress.

Another group requiring long-term care services comprises the mentally ill. Mental diseases represented 3% of the causes of hospitalization in 1987. By 1997, however, the percentage was reduced to 2%. In 1997, just 1% of emergencies and 4% of ambulatory care were related to mental illness. These problems are slightly greater for older people.

According to the household survey conducted in 1994, which included a sample of 2000 people aged 60 and older, only 4.39% of those who responded reported the need for help to carry out daily activities, 22.7% reported falling, but a very small proportion reported broken bones.

Of the principal diseases, approximately 13% of this age group reported suffering from diabetes, 33% from high blood pressure, and 20% from depression, with 100% of them taking drugs against those diseases. In this group, 65.2% used eyeglasses, 1.62% used hearing aids, and only 1.15% used wheelchairs. However, women tended to report suffering more than men from diseases, especially diabetes (8% of males and 16% of females) and high blood pressure (27% of males and 41% of females).

⁴ All mortality rates are by 100 000 population.

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Table 5. Percentage of elders needing help and medical equipment for daily activities, 1994

	<i>Total</i>	<i>Male</i>	<i>Female</i>
% of elderly needing help for daily activities	–	3.6	4.7
Medical appliances			
<i>Eyeglasses</i>	65.3	62.2	68.5
<i>Hearing aids</i>	1.6	0.9	2.3
<i>Walking cane (baston)</i>	6.1	6.6	5.8
<i>Walking aid (andadera)</i>	0.5	0.4	0.6
<i>Special shoes</i>	0.4	0.7	0.2
<i>Wheelchair</i>	1.2	1.1	1.2
Falls	22.3	19.0	24.8
Fractures	–	0.7	0.8
Medicines			
<i>Diabetes</i>	12.8	8.6	16.9
<i>High blood pressure</i>	33.4	26.6	40.7
Broken bones	36.5	34.1	39.5
Depression	20.0	14.4	22.0
Source: Authors' calculations from the Costa Rican household survey of 1994.			

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It seems that the demand for long-term care in Costa Rica is mainly determined by the care needs of the elderly. Although mental diseases are an important source of need for long-term care, the pattern has not changed over time. Diseases such as Parkinson, Alzheimer, and other dementias are considered age-related problems.

On the supply side, two main factors have reduced the provision of care for the elderly. First, the composition of families has changed – formerly parents stayed with their children, currently older people tend to live alone. Second, women have slightly increased their participation in the labour market, leaving less time to care for the elderly people in their families.

4.2 Developments that will impact on LTC

The reform of the health system is oriented towards community services and integrated care to patients. The main idea is the separation of financing and service delivery functions of the three levels of care.

Historically, the health system has been financed by a general budget, but the 1997 reform implemented Management Commitments – initially in some hospitals and health centres, and universally in 2000. These are agreements with anticipated objectives signed by the financing–purchasing entity and the health services provider.

Under this programme, a fixed percentage of the budget is established according to the performance of the unit. Accordingly, each medical unit and the CCSS are committed to achieve certain targets. The CCSS will then purchase various services from the hospital, according to the contract signed with them.

At the hospital level, under the Management Commitments 2000, the concept of the ‘day hospital’ was introduced. This concept has three components:

- daily care;
- home assistance; and
- ‘substitute transitory houses’.

Daily care is offered to ambulatory patients with mental problems, and to elderly persons and their families. Services include assistance, preventive, educational, and therapy services. The ‘substitute houses’ are temporary shelters for rehabilitation of patients with mental problems.

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At the first level, the reform was implemented through EBAIS. It provided a programme of basic comprehensive care, which includes at least comprehensive care for children (0–9 years), adolescents (10–19 years), women, adults (20–59 years), and the elderly.

These ‘packages’ are universally applied. Their purpose is the prevention of diseases and the provision of health education for the entire primary care level. At the first level of care, the health team is responsible for:

- individual case finding and case management;
- detection and oversight of risk groups;
- health care; and
- rehabilitation.

4.3 Concluding thoughts

Costa Rica is a country with extensive health service coverage, mainly through public provision and financing. Progressively, a greater amount of coverage and financing has been transferred to the CCSS, contrary to the recent worldwide trend of privatizing health services.

Health policy is established at the national level by the Ministry of Health and the CCSS, giving the appearance of a very centralized system. However, one expression of the decentralization policy is the creation of regional offices of the Ministry and regional hospitals that belong to the CCSS.

In the latter case, each hospital receives a budget set by the CCSS but has autonomy in its allocation. Sometimes, this can create an incentive for the inefficient allocation of resources. Management Commitment agreements try to avoid these problems by setting standards through a contract drawn up between the provider of services and the CCSS as the purchaser.

Public health care in Costa Rica is mainly provided and financed by the CCSS. Most health expenditures are financed through social insurance collected at the national level as a tax on revenue. Indirect taxes used for financing health care programmes represent a small share of the health budget and are collected at the national level.

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This situation is made possible because Costa Rica is a small country with a relatively small population. Most of that population is concentrated in the metropolitan area.

Licensing of professionals and service providers is also established at the national level. In the case of professionals, university curricula are set by the CONARE (Board of Rectors).

The main providers of health care are the CCSS hospitals. Private providers are regulated by the Ministry of Health. Social insurance contributions are established by the Government each year according to the needs of the CCSS; and the drug list available under the Social Security Card is set by the CCSS. The CCSS is the main body responsible for the provision of health services.

However, there are some public institutions that have developed social programmes. Duplication and overlap are widespread, since inter-institutional coordination is weak and there exists no mechanism for resolving cross-jurisdictional issues.

Moreover, the wide dispersion of social programmes complicates allocations, as well as the effectiveness of alternative programmes. Health system reforms, and the according of more power to the CCSS, were attempts to solve these problems.

The provision of long-term health care services is still viewed as an improvement in the quality of health. There is no comprehensive understanding of long-term care services, except the belief that it is necessary to improve the quality of health for vulnerable groups.

At the institutional level, the CCSS, with its departments for mental health, the disabled, and the elderly, has tried to improve the quality of those services. However, it seems that there is no general long-term care plan (especially with regard to financing). Funding for programmes are raised in two ways:

- privately – especially for initial investment purposes through charitable activities managed through foundations; and
- publicly – once the programme is operational, expenses are covered by the normal budget of the institutions and the CCSS.

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There is no special insurance policy created for the purpose of supporting these new programmes, except for the Law concerning taxes on alcoholic beverages and cigarettes.

From the point of view of provision, NGOs participate in the organization of activities for improving the quality of life.

Finally, there is not much information about informal caregivers, and few incentives for them. However, it can be stated that caregiving is still considered a responsibility of the family.

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Interview with Dr Isaías Salas Herrera, Director of the National Centre for Pain Control and Palliative Care

Interview with Marielos Arce, psychologist at the Shelter Saint Gabriel