

La institucionalización de la política universal de salud en Costa Rica y sus retos actuales

The Institutionalization of Universal Health Policy in Costa Rica and Current Challenges

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ABSTRACT

Objective: To analyze the role of the Ministry of Health in Costa Rican public policy.

Methods: The analysis is a case study comparing two periods (1950 – 1990 and 1990 - 2010) using qualitative data collection instruments, including review of literature and institutional documents as well as in-depth interviews and focus group discussions, all with data triangulation.

Results: The analysis found important differences between two periods: before the 1990s, consecutive governments were strongly committed to the pursuit of universal health coverage (UHC); afterwards, resources moved to the *Caja Costarricense de Seguro Social* (CCSS) and the private sector, causing a chain of effects that complicated the search for financial sustainability.

Discussion: The 1990s health system reforms were a turning point in Costa Rica's UHC process. Searching for increased efficiency and sustainability, primary health care was integrated into the CCSS schemes triggering an implicit boom in private sector activity, also related to changes in the political-economic context. The plan to strengthen the Health Ministry's stewardship role did not really succeed. UHC in Costa Rica enjoys strong popular support, which guarantees a level of political sustainability, but to ensure its financial sustainability, concerted government action is required to improve inter-institutional, sectorial and inter-sectorial coordination.

Key words: Health Policy, Health Insurance, Public Policy (source: MeSH, NLM)

RESUMEN

Objetivo: Analizar el papel del Ministerio de Salud en la política pública costarricense.

Métodos: El análisis es un estudio de caso que compara dos periodos (1950 – 1990 y 1990 - 2010) utilizando instrumentos de recolección de información cualitativos, incluyendo la revisión de literatura y documentos institucionales, además de entrevistas a profundidad y grupos focales, todo con triangulación de datos.

Resultados: El análisis encuentra diferencias importantes entre los dos periodos: antes de los 1990s, gobiernos consecutivos estaban fuertemente comprometidos para lograr la cobertura universal de salud (CUS); después, los recursos de poder se movieron hacia la Caja Costarricense de Seguro Social (CCSS) y el sector privado causando una cadena de efectos que complicó la búsqueda de sostenibilidad financiera.

Discusión: La reforma de salud de los 1990s fue un punto de cambio en el proceso hacia la CUS en Costa Rica. Buscando más eficiencia y sostenibilidad, la red de salud primaria se integró en el esquema de la CCSS lo que desencadenó un auge implícito en la actividad del sector privado, relacionado también con cambios en el contexto político-económico. El plan de fortalecer el papel de rectoría por parte del Ministerio de Salud no se efectuó. La CUS en Costa Rica cuenta con fuerte apoyo popular lo que le da cierto grado de sostenibilidad política, pero para garantizar la sostenibilidad financiera se requiere acción concertada del gobierno para mejorar la coordinación inter-institucional, sectorial e inter-sectorial.

Palabras clave: Política de Salud, Seguro de Salud, Política Social (fuente: DeCS, BIREME)

The guard [...] did not have social guarantees, so he never felt like a Costa Rican. 'El vigilante [...] no tenía garantías sociales, por lo tanto no se sintió nunca un costarricense' (1).

The population of Costa Rica often considers universal health care (UHC), institutionalized in the more than 70 years old *Caja Costarricense de Seguro Social (CCSS)* as a given. Most living generations do not know their country without it and for many the CCSS has become a part of their national identity. Indeed, Costa Rica's UHC scheme has achieved and continues to do so, many successes in population health despite the country's modest resources. Life expectancy at birth is now getting close to 80 years on average for both sexes. Not for nothing, Costa Rica was one of the four case studies presented in the 'Good health at low cost' report published by the Rockefeller Foundation in 1985, a report that was revisited in 2011 (2).

The analysis presented here describes not so much what the country has achieved, as that is documented in previous studies (3-6), nor does it provide a historic actor centered analysis that was the focus of a paper complementary to this one (7). This study explores more in depth the role of the Health Ministry in the achievement and sustenance of UHC since the creation of the CCSS in 1941, in particular in view of the context in which it operated and the way it coordinated its actions with other actors. It follows the proposal by Walt and Gilson (1994) and discusses their assumption that health policy was generally low on the policy agenda before the 1980s given the supposed consensus about how to implement it, and high afterwards when the field became more complex.

Methodologically, the analysis explores the behavior of four groups of factors that determine the health policy process: context, content (formal rules), actors and process (the implementation of formal rules depending on context and unwritten or informal rules). Given its importance for UHC, the analysis focuses on the stewardship function. Guided by indications from key informants, the analysis represents a preliminary exploration of the relationship of the government and Health Ministry with the CCSS and private sector respectively. Data were collected using qualitative research instruments, in particular literature reviews and in-depth interviews with key informants.

Concept definitions and methodology of research

This health policy analysis is part of a larger research project that aims to unravel the policy process of UHC in Costa Rica. This paper presents a first exploration of the stewardship function; how the function was shaped and implemented over time, and how the Health Ministry coordinated its actions with the CCSS and other actors over time.

Following the WHO definition, stewardship is considered 'arguably the most important' health system function that should primarily be exercised by the Health Ministry. The latter 'must oversee and guide the working and development of the nation's health actions on the government's behalf'. On top of that, the government-as-a-whole should assume the tasks that go beyond the Health Ministry's mandate, including affecting the behavior of actors in other sectors of the economy. Stewardship at the level of government means guaranteeing coherence and consistency in the health policy process; at the level of health care purchasers and providers it implies guaranteeing that resources are used efficiently and equitably (8).

The analysis distinguishes the periods before and after the 1990s. In line with Walt and Gilson, for both of these periods, four groups of factors were analyzed: the key actors in the health policy process, the formal or written rules that prescribe their responsibilities and duties (content), the context in which they operate, and the informal rules that explain how they actually implement those rules (process). Actors and institutions are distinguished and assumed to reciprocally influence each other depending on their relative access to power resources, perceptions, interests, past experiences and policies (9) (10) (11). The approach differs principally from traditional institutionalism that only analyzes formal rules and neglects that implementation depends on the actors and their context.

Qualitative instruments used to collect data and information include a review of previous studies on Costa Rica's health system development and reform processes; a review of literature on historic socio-economic and political developments, as well as on public administration; a review of institutional documents, in particular health legislative documents, institutional rules and regulations and institutional annual reports; 17 in-depth interviews and 2 focus group discussions with institutional and non-institutional actors selected through a snow-ball

mechanism prioritizing the representation of the main institutions: the Health Ministry, the CCSS and the private health sector.

Questions focused on: 1) how was universal health coverage achieved and sustained and within what context; 2) who were the key actors and how did they coordinate their actions; 3) what implied the role of stewardship in the process; and 4) what are the main challenges today. Literature review was used mainly to further explore contextual changes over time, to analyze the relevant formal rules on UHC and to collect statistics describing health and social outcomes. Data triangulation distilled out the most broadly supported conclusions. The study limitations are the relatively restricted number of in-depth interviews carried out offering personal perceptions of 17 key informants only. This is particularly important given the significant differences found in the perceptions of those related to the CCSS or Health Ministry respectively, in particular since the 1990s health sector reform.

Findings

The findings of the study are presented in three sub-sections focusing on changes before and after the 1990s in: context, formal rules, and actors, their relative access to power resources and process.

1. A changing context

Costa Rica's population, less than a million until the 1960s, included 2,3 and 4,6 million people respectively by 1980 and 2010 (Centro Centroamericano de Población 2013). A coffee and banana exporter, the country experienced social conflicts during the pre-Second World War period in the middle of which the CCSS was founded. According to key informants, Calderón Guardia, President of the Republic between 1940 and 1944, was asked by US President Roosevelt to implement social programs in support of his New Deal plan. Having negotiated a social pact with San José's Bishop Sanabria and the Communist Party's Secretary Mora, Calderón managed to get his social security bill through Parliament. It turned out helpful that several key actor, including Calderón and Mora, were ex-students from Leuven University as confirmed by key informants.

After the Second World War, in 1949, the abolition of the army and the social security scheme as designed originally, were integrated into a new Constitution passed by José Figueres' short interim government

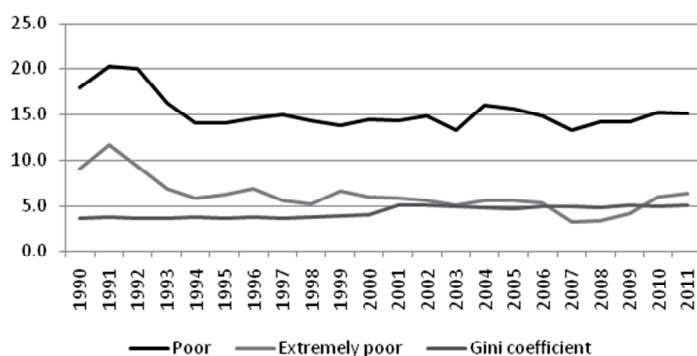
that followed a 48-days-during civil war. After handing back power to the legitimate President, he was elected in 1953 and 1970 respectively to continue his socio-democratic institution building process. While applauded by many, Figueres' intentions have also been described critically and his interim government characterized as a political system dominated by the 'extreme center' ... 'with a low tolerance to the dissidence in the extremes of the ideological spectrum' (12). Indeed, he prohibited the communist party, and health policy, among other policies, was implemented largely top-down.

During the 1950-1980s, consecutive governments in Costa Rica based their policies on the premises of the Welfare State. Different from other Central American countries, the policies had impact, as public resources used to finance civil wars in neighboring countries, were effectively invested in education and health. Based on an import substitution model, economic growth and wealth distribution were promoted simultaneously. Autonomous institutions, providing services like water and sanitation, electricity and telephony, were created to generate public employment and opportunities for social mobility. In line with Immergut's arguments and as key actors also confirm, through universal social policies, solidarity was constructed that in turn facilitated the finance base to further expand those policies (13). Health policy formed an inherent part of the national development strategy with the government taking the lead in the promotion of UHC as one of the social determinants of health (Focus group 1).

The international economic crisis of the 1980s and the following introduction of Structural Adjustment Programs (SAPs) initiated contextual changes. These developments affected Costa Rica, although differently from other countries in the region. Being an 'island of peace' in a conflictive region, the country enjoyed continuous support from multi- and bilateral donors. Within this context, Costa Rica's leadership looked for new economic opportunities on the global market, both in Europe and the United States. By the 1990s, an elite group developed, linked to transnational companies making fluency in English and computer skills the new instruments for social mobility. Social programs and public spending reduced, but not as radically as elsewhere. Costa Rica's public health care scheme was not privatized as for example in Chile. Public employment however was largely replaced by jobs in the private sector and private health spending started to increase.

Costa Rica today is experiencing the consequences of the demographic and epidemiological transition. It is an ageing society with non-communicable diseases representing 62 % of the health burden in 2008 (WHO Global Health Observatory Data Repository). In socio-economic terms, the country moved from a poor to an upper middle economy and from one of the most equal countries in Latin America to one of the few with a widening income gap. Poverty decreased between 1991 and 1994 from 31,9 to 20,0 % of the population, of which 11,7 and 5,8 % represented by extreme poverty respectively, but as shown in Figure 1, these numbers did not improve ever since. At the same time, the income gap widened over those two decades with the Gini-coefficient increasing from 3,7 to 5,2 overall showing a steep increase in particular in the period 2000-2001 (Estado de la Nación 2012). Since the 1990s, increases in total health expenditure take place mostly in the form of out-of-pocket payments.

Figure 1. Trends in poverty, extreme poverty and Gini coefficient (1990 – 2011)



Source: Own Elaboration based on Estado de la Nación 2012

Health outcomes continue to remain favorable in Costa Rica but are argued to be rooted in the past. There is uncertainty about the future impact of chronic disease on these indicators given the high level of risk factors prevalent in the country and the relatively low resolving capacity of the CCSS in this respect (14).

2. Constitutional, general and specific formal rules

The CCSS was founded in 1941 as an institution with full political and administrative autonomy. Following its Constitutive Act, the CCSS is an autonomous institution responsible for the governance and administration of the social insurances and is not submitted to the Executive Branch in matters of governance and the administration of those

insurances, their resources or reserves apart from public employment and salaries (Ley Constitutiva de la Caja Costarricense de Seguro Social).

Constitutional rules

The 1949 Constitution formulates the responsibility of the state and consecutive governments for the well-being of Costa Rica's residents through the production and redistribution of wealth as well as for a healthy and ecologically balanced environment. It also establishes (or better confirms, because it was in the previous Constitution as well) social insurances for manual and 'white collar' workers under responsibility of the CCSS. Importantly, a constitutional amendment in 1968 limits the autonomy of autonomous institutions to administrative independence only establishing that the autonomous institutions of the State enjoy administrative independence but that they are subject to the law in matters of governance. (Art. 188 of the Reformed Constitution of Costa Rica).

The decision to reform the Constitution was made after a heated debate in Parliament and two decades of problems created by autonomous institutions enjoying full political independence: 'The 1968 amendment was a response to the original Article 188 of the Constitution that created an institutional archipelago resulting in the Executive Branch and the President of the Republic having no power to govern' (15). The amendment, meant to improve inter-institutional coordination, had little effect on the health sector. According to key informants, the quality of the coordination between the Health Ministry and CCSS generally depended, despite existing rules, on the quality of the relationship between its leaders.

General rules

Improved inter-institutional coordination continues to be the goal of a series of reforms shaping Public Administration during the period 1950-1980. In 1970, during Figueres' second administration, the President of the Republic is made to assign four out of the seven members of the autonomous institutions' Boards with three members remaining from the previous administration to safeguard continuation. As of 1974, the President nominates among those four, one as Executive President to lead that Board and coordinate the institution's actions with the President of the Republic, the Ministers of Government and Executive Presidents of other relevant autonomous institutions.

Also in 1974, the newly created National Planning System establishes ministerial planning offices, decentralized institutions and local and regional public entities as well as coordination and advisory mechanisms. The 1978 General Act on Public Administration gives Ministers responsibility for sectorial coordination and the 1983 Sectorialization Act nominates them as sector 'stewards'. The 1983 health sector Constitutive Act reconfirms the Health Ministry's authority over private actors acting on health as well (already established in the 1973 General Health Act).

Specific health policy related rules

The 1961 Social Security Universalization Act commits consecutive governments in Costa Rica to expand social security coverage across the population within ten years. The 1973 Hospital Transfer Act facilitates the universalization process transferring most (semi-) public and private hospitals in the country to the CCSS. The General Health Act, also from 1973, reaffirms that population health is of public interest mentored and monitored by the state. It makes explicit that the definition of the national health policy, norms, planning and coordination of all public and private health related actions corresponds to the Executive Branch through the Health Ministry. The Act attributes power at times of national emergencies to the Health Ministry to impose its authority over all public and private actors, but does not limit the Health Ministry's mandate to such events (although it is sometimes interpreted as such).

The Health Ministry's Organizational Act, also from 1973, reaffirms the leading role of the Health Ministry in health policy and confirms that it exercises the jurisdiction and technical control over all public and private institutions that realize actions on health in all of its forms. It adds, however, that the actions of the Health Ministry in terms of service provision cannot damage those actions that are realized by other institutions, and that no other duty attributed to the Health Ministry by law or regulation can be of damage to the attributes the law gives to the autonomous institutions of the health sector. Willingly or not, the Act limits the Health Ministry's attributes to so-called negative coordination, implying government organizations and programs 'merely to get out of each other's way' rather than to produce negative interactions among themselves (16).

The rule is one of several that limit the Health

Ministry's authority over other social actors. The same Act, for example, while establishing the National Health Advisory Board as an advisory organ responsible to collaborate with the Minister in the health policy formulation process, formally requires the CCSS and other institutions to send a representative, but not necessarily its leaders. In 1989, the National Health System is constituted by decree, positioning the autonomous institutions and private health sector once again within the Health Ministry's domain, but without changing any of these legal imperfections.

From different perspective, parliament takes over the CCSS attribution to increase social insurance contributions when considered necessary in 1990. This limits the institution's capacity to unilaterally increase its funding base at times of financial hardship which had been a crucial instrument to safeguarding a degree of financial independency from the government in the past (17). The reform would reinforce the negative impact of the government's structural avoidance since the 1980s, to timely pay its contributions to the CCSS and increase problems related to financial liquidity for the institution.

After 1990, a new set of health policy rules is adopted seeking to consolidate UHC and to make the CCSS scheme more efficient and sustainable. The 1994 health sector reforms, financed by two grants from the World Bank and Inter-American Development Bank respectively, facilitates the integration of primary health care within the CCSS and the institutional strengthening of the Health Ministry as health system steward. The latter was meant to improve the governance of the health system at large; the former to change the focus within the CCSS network from curative care to prevention and health promotion and to enhance the scheme's efficiency, responsiveness and sustainability.

The 1998 De-concentration of CCSS Hospitals and Clinics Act supports the same objectives establishing an internal market within the CCSS network based on contractual arrangements and community Health Boards to enhance social participation. In 2008, a new regulation for the Health Ministry is adopted by decree reformulating its mandate into guiding the activities of all public and private actors towards the Social Production of Health, defined for the first time in 1989 with all previous legislation except for the 1983 health sector constitutional decree, remaining in force. The Health Minister's role is described

as one of sectorial and inter-sectorial coordination (Reglamento Orgánico del Ministerio de Salud 2008).

Notably, coordination as an instrument of public administration is not an unambiguous concept. Peters, referring to Scharpf (1964), distinguishes four degrees of coordination with an increasing investment of political capital. As mentioned above, negative coordination involves government organizations and programs to not disturb each other; positive coordination refers to working together; policy integration to different public organizations developing shared goals to be pursued; and strategy development to having a clear vision for the future of policy and government. UHC could be an example of such a strategy and success towards achieving it may depend in a large part on the degree of coordination achieved within a certain context.

3. Actors, their relative access to power resources and process

As key actors in Costa Rica's health policy process, informants mentioned consecutive governments and the Health Ministry as its delegate, the CCSS and private actors, next to political parties, medical unions and the population. The relative importance of each of these actors has changed over time (7). Most important, before the 1990s, consecutive governments pushed the UHC construction process and the expansion of the CCSS. The Health Ministry played its role as government delegate and as provider of primary health care in marginal rural and urban areas. Conflicting interests between the Health Ministry and the CCSS were resolved through government intervention with the President of the Republic stressing the need, according to key informants, for both institutions to work together: *'I want the Ministry and the CCSS working together, not fighting, as it was the tradition (7).*

Private health care providers, who had opposed the UHC scheme in the beginning, became neutral players by the 1970s. Health policies were reinforced by other social policies shaping a political and socio-economic context favorable to UHC (18). Solidarity became the essence of Costa Rica's UHC model: *... the essence of (Costa Rica's health) system in the first instance is the solidarity of the Costa Rican society, because without this solidarity the other principles cannot work. You may want to be universal, but if the people do not accept (financial) solidarity, you cannot achieve it (Key informant 1).*

After the 1990s, universal social policies slowly faded out, including the Health Ministry's primary health care programs that have been considered central to Costa Rica's successes in population health (Focus group 1). The reestablishment of the programs under the CCSS implied a substantial part of the Health Ministry's staff and resources to be transferred to that institution. The process has been described as a 'traumatic experience' for many (7), and it sparked off disputes between both institutions that continue until today.

The Health Ministry lost most of its resources and leadership as the involvement of the government in health policy declined. As a result, the so-called 'national authority' in health never really took control of the process. The government focused on economic policies that would allow a trend of implicit privatization on the health care market (19). Despite the fact that the Health Ministry was health system steward and resources were invested in strengthening this role, the institution never got properly equipped to direct the actions of the CCSS and other social actors.

The private sector is not involved in the processes that relate to the stewardship of the Health Ministry... and the CCSS does whatever it wants ... it does exactly ... what it feels like taking the luxury to not take into account anything the Health Minister says, because the Health Ministry does not have money (Key informant 2).

Illustrative for the lack of power by the Health Ministry to impose its authority over the social actors, is how the CCSS over time started to neglect the National Health Advisory Board: *Whether the Health Ministry convokes the CCSS? From a single provider and the one that had the health services, the Health Ministry transformed into steward, there was a change in the 1990s, a very big transformation at the level CCSS-Health Ministry. ... It were times ... with a lot of hassle and power games between those who worked in the Health Ministry and those who worked for the CCSS, because, those who have the money, strength, political power, and everything else; why would they have to sit and talk with the Health Ministry, for what reason? At that time, there was an absolute power of the CCSS, they said it is better not to go to the Health Ministry, because if I go, they will ask for money for this and for that ...; so I better don't go. So the second bosses started to go, not the Executive President, and later the third and then it died (Key informant 3).*

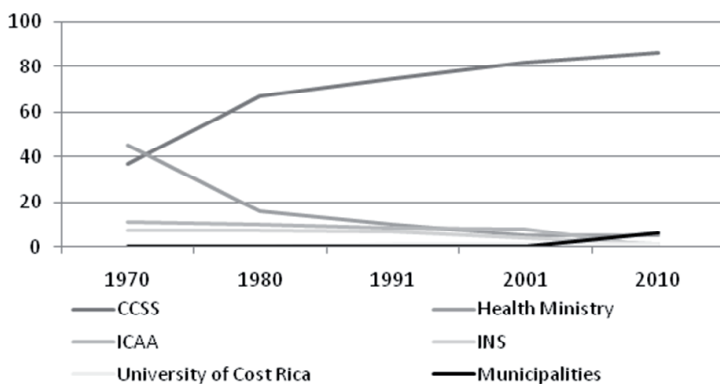
Key informants blame the lack of capacity of the

Health Ministry on the Structural Adjustment Programs ...: *The Health Ministry had its fundamental momentum (during the 1970s) and it fell with the crisis of the 1980s. The oil crisis, that is when everything came down, and the only way to pay the State was reducing it, and on top of that, the concept that the State should not be in everything, and that the private firm should do the work, that were the SAPs of the 1980s ... the aim (of the SAPs) was to reduce the State. In health this was a disaster* (Key informant 4).

... and on the fact that no new law was enacted with the 1990s reforms: *The reform of the 1990s came without a law, and that law is indispensable. The Health Ministry must have a National Health Commission, where each month will meet the CCSS President, the INS President, the AYA, the municipalities ...* (Key informant 5). *You ask me whether there is stewardship. I will explain why the stewardship function does not exist. It is because of the law that was never changed* (Key informant 6).

Figure 2, illustrates how already since the 1980s the Health Ministry saw its financial resources transfer, relatively, to the CCSS with other actors on that market, including the Water and Sewage Institute, the University of Costa Rica, the National Insurance Institute and the Municipalities, playing a minor role.

Figure 2. Distribution of financial resources within the health sector (1970 – 2010)



Sources: Own Elaboration based on Güendel L and Trejos JD. Reformas recientes en el sector salud de Costa Rica. Proyecto Regional de Reformas de Política Pública 18. CEPAL/Gob. Países Bajos. 1994, Memoria Institucional CCSS 2005 y 2011 and (20)

It seems that before the 1990s, with the government leading the health policy process, and the Health Ministry, CCSS, and private health sectors each operating in their own domain, there was a sufficient degree of coordination. The CCSS was

still 'under construction' and the private sector small. It accommodated the interests of the population with capacity to pay to elect their preferred provider and those of the medical doctors, to practice with no exclusive dedication. The public-private mix worked well controlling waiting lines and lists for primary and secondary care, while for specialized hospital care the CCSS was the best option for all.

The 1994 reforms while successful in bringing all personal health care services under one roof had some unintended outcomes. When health areas and primary health care teams were established across the country under CCSS management, private practitioners, working for the CCSS as well, found ways to catch the demand not served by the public institution or maybe to sometimes even push out CCSS demand to their private clinics: *They (the private sector) have benefitted from the reforms more than anyone else; that is why you always see a 'garden' of private practices next to the services of the CCSS. Today you open a hospital in Heredia and they already open their private practices, because the CCSS will never be able to meet all the demand. They really benefitted from the reform, and in big, and they have filled their pockets. It is good, because the people have options* (Key informant 1).

The trend triggered change that was leveraged by a new macro-political context. Not reform as formulated, but the way it was implemented with no one pushing for coordinated action, had by-effects in terms of a shift in the distribution of power on the health care market. Not the goal changed, but the process. With a weak Health Ministry, 'holes' in legislation got subject to interpretation by vested interests and reforms aimed to increase the financial sustainability of the CCSS and strengthen the Health Ministry's stewardship role, were blocked. As a result, the shift from curative to preventive care did not take off; the Decentralization Act was implemented only partially; a project to review the 1973 General Health Act presented by the Health Ministry in the early 21st century never got accepted; and the 2008 Health Ministry's new regulation mentioned above was largely neglected by the CCSS and other social actors.

The increase in private sector activity made private health expenditure grow between 1999 and 2009 from 23,7 % to 32,6 %, and out-of-pocket payments from 20,9 % to 28,6 % of total health expenditure. So far, no or little catastrophic health expenditure has been found in Costa Rica (6), but the increase in

out-of-pocket spending does indicate a relative loss in UHC threatening financial risk protection and equity of access. Costa Rica's health outcomes may seem robust, but for key informants these result largely from the past. They argue that new measures are needed to sustain that level of outcomes: With (the lack of stewardship) we lose the impact we can have on the population. *What happens is that... the health indicators in this country are very solid and they have been produced not in 10 or 15 but*

over 100 years. If we look at the process: in 1922 the Health Secretariat was created, then all the sanitation campaigns that were implemented, that is when begins the whole intensive program, the Social Security, the Water and Sewage Institution, the electrification, all the vaccination campaigns, the campaigns of shoes for the children. The impact of these actions is something we do not lose overnight, but to sustain it, the actual model demands much more substantial efforts (Key informant 2).

Figure 3. Analysis of actors, interests and outcome during the UHC process 1940-1950

Actors	Formulation: Central government, Health Ministry and think tank Implementation: Central government; certain fractions (health) policy elite
Interests	Restore social stability in a period of civil unrest and protests. Health policy was part of the newly established social pact. Fragmented health policy elite: some fractions supported CCSS. others prioritized private interests.
Outcome	Creation of the CCSS and other social and democratic institutions
1960 – 1980	
Actors	Formulation: Central government, increasing fractions health policy elite Implementation: Central government, Health Ministry, CCSS, private sector; increasing fractions health policy elite
Interests	Construction of modern state with health policy part of national development strategy; health policy elite de-fragments as government negotiates deals on salaries and non-exclusive dedication.
1990 – 2012	
Outcome	Democratic institutional building process: universalization of social security and other social policies. Adoption of several rules to enhance health policy process and inter-
1990 - 2010	
Actors	Formulation: Certain fractions of the health policy elite linked to the CCSS and private sector with tacit approval from the central government Implementation: Same
Interests	Central government changed focus to economic participation in globalization process through deregulation holding low profile on sustaining internationally recognized health achievements; health policy elite re-fragmented with some fractions focusing on furthering UHC and others prioritizing private interests.
Outcome	Re-fragmentation of health policy elite and wider society on UHC enhanced by new political economy: ineffective implementation health reform; Health Ministry no capacity to act as steward; booming private sector; CCSS moving towards tacitly provoked financial/managerial crisis.

Source: Own elaboration based on (7)

CONCLUSION AND DISCUSSION

In Costa Rica, different from Walt and Gilson's suggestion, health policy topped the national agenda before the 1980s and became low politics, once UHC was achieved after the 1990s. Through central government imposition emphasizing the need for inter-institutional coordination, the UHC process moved forwards relatively smoothly during the

1960s through 1980s, despite opposition by certain fractions and despite some imperfect or ambiguous rules. When the distribution of power resources on the health care market shifted, the relative absence of government in health policy and the resulting lack of capacity by the Health Ministry to act as health system steward caused new reforms seeking the sustainability of UHC in Costa Rica not or only

partially being implemented. One of the reasons why this could happen despite UHC being a formal policy in Costa Rica seems the sensitivity of those rules within a changing context to manipulation by private interests in the absence of a strong steward. Neither the rules nor the goals may have really changed after the 1990s, but the way policy was implemented—ultimately a story of personal relationships—, i.e. the process, did.

Lessons for other countries from Costa Rica's experiences are that UHC policies need to remain structurally high on the policy agenda, not only during the pursuit of UHC but also once this is achieved. Costa Rica's health system, as any other health system today, and more so than two decades ago, faces increasing challenges posed by the demographic and epidemiological transitions, technological advances, changes in the labor market composition and many other contextual developments. These require reforms adopted formally during the past decades and/or others possibly, to be effectively implemented if UHC is to be sustained. The key question is whether the government (who else?) is willing and capable to re-establish its leadership position in this important process and to push for strategic coordination in view of UHC.

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