Explanatory Factors of the Deficient Service of Promotional and Preventive Health at the Primary Care Level in Costa Rica

Factores Explicativos del Deficiente Servicio de Salud Promocional y Preventiva en el Nivel Primario de Atención en Costa Rica

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Abstract

The main objective of this research is to analyse the effectiveness, efficiency and equity of integral health promotion and disease prevention at the primary health level in Costa Rica. The methodological framework proposed by Scha et al. (2013) was used to analyse the structure, processes and results to best comprehend the degree of promotional and prevention initiatives at the primary level. This research was limited to a general study of the South-Central Region which is comprised of 45 health areas and 367 EBAIS (Basic Equipment of Integral Health). The data was obtained using qualitative instruments: in-depth interviews, surveys and an expert panel session. The main findings of this research regarding management deficiencies at the primary health care level are the following. Firstly, the operationalisation of the international and national laws concerning an integral health perspective

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is an ongoing challenge for the Costa Rican health system. The identified deficiency is explained by three main aspects: a) misuse of concepts, establishing the same concept for both health promotion and disease prevention, b) implementation of promotional activities as part of prevention programs, c) limited conceptualization of health promotion. Secondly, a problem regarding the concept of health was identified. Indeed, health culture has tended to be curative. Thirdly, this research reveals that health services from the CCSS (Costa Rican Social Security Fund) should be based on an integral care model, but to date, preventive programs have more support and priority than promotional programs, and the "integral" dimension of the concept has been neglected. Moreover, it was argued that planning processes do not respond to the approach of health promotion and is limited to prevention only. Fourthly, there is a great deficiency in health promotion projects. Her available capital is oriented towards the implementation of preventive programs. The resistance of doctors to promotional programs prevails. In addition, many of the professionals assigned tasked with management do not possess the necessary skills to allocate resources and manage them appropriately.

Keywords: PRIMARY HEALTH, HEALTH PROMOTION, DISEASE PREVENTION, CCSS, EFFICIENCY, INTEGRAL CARE, MANAGEMENT DEFICIENCIES

Resumen

El objetivo principal de esta investigación es analizar la efectividad, eficiencia y equidad de la promoción integral de la salud y la prevención de la enfermedad en el nivel primario de salud en Costa Rica. Se utilizó el marco metodológico propuesto por Scha et al. (2013) para analizar la estructura, los procesos y los resultados con el fin de comprender mejor el grado de las iniciativas de promoción y prevención en el nivel primario. Esta investigación se limitó a un estudio general de la Región Centro Sur, que comprende 45 áreas de salud y 367 EBAIS. Los datos se obtuvieron utilizando instrumentos cualitativos: entrevistas en profundidad, encuestas y una sesión de panel de expertos. Las principales conclusiones de esta investigación en relación con las deficiencias de gestión en el nivel de la atención primaria de salud son las siguientes. En primer lugar, la operacionalización de las leyes internacionales y nacionales relativas a la perspectiva de salud integral es un reto permanente para el sistema de salud costarricense. La deficiencia identificada se explica por tres aspectos principales: a) mal uso de los conceptos, estableciendo el mismo concepto tanto para la promoción de la salud como para la prevención de la enfermedad, b) implementación de actividades de promoción como parte de los programas de prevención, c) limitada conceptualización de la promoción de la salud. En segundo lugar, se identificó un problema relativo al concepto de salud. En efecto, la cultura de la salud ha tendido a ser curativa. En tercer lugar, esta investigación revela que los servicios de salud de la CCSS deberían basarse en un modelo de atención integral, pero hasta la fecha, los programas preventivos tienen más apoyo y prioridad que los de promoción, y se ha descuidado la dimensión "integral" del concepto. Además, se argumentó que los procesos de planeación no responden al enfoque de promoción de la salud y se limita únicamente a la prevención. En cuarto lugar, existe una gran deficiencia en los proyectos de promoción de la salud. El capital disponible se orienta a la implementación de programas preventivos. Prevalece la resistencia de los médicos a los programas de promoción. Además, muchos de los profesionales encargados de la gestión no poseen las competencias necesarias para asignar recursos y gestionarlos adecuadamente.

Palabras clave: SALUD PRIMARIA, PROMOCIÓN DE LA SALUD, PREVENCIÓN DE LA ENFERMEDAD, CCSS; EFICIENCIA, ATENCIÓN INTEGRAL, DEFICIENCIAS EN LA GESTIÓN

Introduction[3]

Like many health systems around the world, the Costa Rican Health System is facing management challenges while attempting to provide good health care for its population. It has encountered serious problems in terms of effectiveness, efficiency and equity of services (Whitehead, 2007; Kawachi, et.al, 2002).

Health is both a right and "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" according to the World Health Organization (WHO, 2003). This statement justifies the importance of the primary health care level since it is the first point of contact with the population.

This research focuses on the primary health care level (specifically the Basic Equipment of Integral Health Care) which offered through the Costa Rican Security Fund (CCSS in Spanish), an autonomous state institution which is a part of the Costa Rican Health System. The study explores the extent to which the primary level is focused on health promotion and disease prevention (Kawachi, Subramanian &Almeida, 2002).

Preventive and promotional health have evolved. The strategies offered in documents like the Lalonde Report 1974 (Lalonde, 1981), the Alma-Ata Report 1978 (WHO, 1978), the Ottawa Conference 1986 (WHO, 2013) and more recently, the Health Program for All 2000 (WHO, 1998) highlight this evolution. Health systems in many countries have encountered serious problems in terms of effectiveness, efficiency and equity of services (Whitehead, 2007; Kawachi et.al., 2002).

Historically, the National Health System in Costa Rica had already gone through care model reforms since its foundation (Herrero & Collado, 2001), but just after the 80's better definitions of tasks for the Health Ministry (MS in Spanish) and the Costa Rican Social Security Fund (CCSS) were established to address high levels of demand and need. However, the model which came about as a result was still insufficient. The Health Ministry oversaw the control and monitoring of the health sector and the CCSS handled the provision of health services provided to the population. Since then, the CCSS has been working as an autonomous institution focusing on promotion, prevention, healing and rehabilitation. Nonetheless, health promotion activities seem to be ignored, preventive and curative programs prevail over health promotion, a biologist care approach is adopted, merely based on medicine (García, 2004; Avila, et.al., 2010). This posed a challenge because of demand and inefficient organization.

Due to several issues, a national health policy for the years 2010-2020 was formulated (Avila et.al., 2010). The policy highlighted three clear objectives in the promotion and prevention field: a) individual and collective care culture, b) individual health care services, c) strengthening of health workforce development and its impact on health promotion and prevention. The research is based on the CCSS's local level which encompasses three health care levels. The study considers the primary health care level: it is responsible for health promotion and disease prevention, low-complexity healing and rehabilitation to elucidate the reasons behind management deficiencies regarding promotion and prevention issues at the Basic Equipment of Integral Health (EBAIS in Spanish). Since the primary health care level is the first point of contact with the health system it should solve most health issues following integral initiatives that transcend the biologist and medical approaches and adopt social

3 This article is based on Christy Quesada Segura's master's thesis, Explanatory Factors of the Deficient Service of Promotional and Preventive Health at the Primary Care Level in Costa Rica, which she successfully defended at the University of Liverpool in 2014.

determinants of health (e.g. employment, housing and environment).

After outlining the methods used for this study, we present our theoretical framework in two parts: definitions of health and integral health, as well as health promotion and prevention. To provide additional context, we describe the management model of primary health care in Costa Rica. We then transition to the empirical findings, discussing the challenges faced by Costa Rica's primary health care system, before concluding with key insights.

Research methods

To analyse the effectiveness, efficiency and equity of integral health promotion and disease prevention at the primary health level in Costa Rica, i.e. the Basic Equipment of Integral Health (EBAIS) the following questions were posed:

» To what extent is the focus on disease prevention and integral health promotion at the primary health care level (Basic Equipment of Integral Health Care) deficient in Costa Rica?
» Does the primary health care level allocate its financial and human resources efficiently to promote integral health and prevent disease?
» Does the Basic Equipment of Integral Health Care (EBAIS) have a proper internal management and organizational culture?
» To what extent are the tasks of the EBAIS in terms of prevention of disease and promotional health well defined?

The methodology which was chosen uses critical realism as an epistemological model where reality is seen from a human perspective. The methodological framework used was the one proposed by Scha et.al. (2013) which analyses the structure, processes and results to understand the promotion and prevention initiatives at the primary health care level. This research was limited to a general study of the South-Central Region of Costa Rica, which is comprised of 45 health areas and 367 Basic Equipment of Integral Health (EBAIS). Qualitative instruments were used for analysis, mainly "in-depth interviews" with 15 experts and officials from the Ministry of Health and the Costa Rican Social Security (CCSS).

In addition, surveys to a small sample of 100 health users residing in the area being studied and interviews comparing past research results and conclusions were used; and a qualitative questionnaire, which was applied to an expert panel of authorities of the health sector was also used, based on the model developed by the Ministry of Labour and Social Affairs of Spain and the National Institute for Safety and Health at Work in Spain (Solé, 2003): European Business Excellence Model (EFQM model). The model allowed us to assess the performance evaluation system of the organization using assessment criteria.

The study focused on the 45 health areas and 367 Basic Equipment of Integral Health (BEIH) units that comprise the South Central Region of Costa Rica. These units were selected as they represent the totality of the region's primary healthcare system, ensuring a comprehensive analysis of health promotion and disease prevention initiatives at this level. The South Central Region was specifically chosen due to its diverse characteristics, encompassing both urban and rural areas with varying

socioeconomic conditions and health challenges. This approach allows the findings to reflect the overall performance and challenges within the region's primary healthcare system. While the results are primarily specific to the South Central Region, the representativeness of the sample provides valuable insights that could be applicable to other regions with similar healthcare structures and socio-demographic profiles. It is important to note, however, that the study's conclusions may not be fully generalizable to all regions of Costa Rica or to other countries with differing healthcare contexts. Future research could expand the scope to include other regions to further validate and compare the findings across diverse healthcare settings.

The data and the main sources used were divided into two categories. The primary sources included interviews with officials from the CCSS; interviews with health researchers; interviews with officials from the Ministry of Health; the realization of panel group discussion with Ministry of Health and CCSS authorities and interviews with other health social actors.

The secondary sources used in this study included documents' review of the Centre for Strategic Development and Information in Health and Social Security (CSDIHSS) and the Institute for Research and Education on Nutrition and Health (NIRENH); journal articles, findings obtained from literature reviews, including a document review of the National Health System and the Primary Care Policy and existing research and data; technical documents/statistical data; government plans; official reports; national and international bibliography and bibliography from Health experts.

Results and analysis discuss the main findings regarding management deficiencies in health promotion and disease prevention at the primary health care level. Data was obtained from three main sources: a) panel sessions with experts from the Ministry of Health and the Costa Rican Social Security Fund, b) interviews with management specialists in the public health system (open and closed interviews) and c) a survey about health promotional topics filled by users of primary health care. This information was supported by secondary sources: bibliographic documents on specialized issues.

According to experts, there are international and national laws as well as public policies that determine the course of promotion and prevention initiatives clearly supported by documentation although its operationalization is complex and messy. Planning with a focus on promotion and impact on initiatives is still low. Additionally, it is difficult to distinguish the terms promotion and prevention, where the latter is more privileged compared to the promotion intervention resulting in management deficiency of promotional and preventive issues and the operationalization of the social determinants of health that seek a broader approach to truly comply with promotion.

The research is focused on Costa Rica's health system, which adopted the World Health Organization's (WHO) definition of health: "health is a complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 2003, p.1; Callahan, 2012). This conceptualization surpasses the physical aspect and integrates what is called "the social determinants of health", defined as the circumstances in which people are born, grow, live, work and age, etc., which in the end may play the same role as health promotion, helping people discover how to best cater for their health needs at different levels: social, political, cultural, etc. The focus of this research is health promotion, characterized as a multidimensional and inter-sectorial field. The health promotion approach transcends the biological approach because it considers the social determinants of health. In Costa Rica, the National Health System has undergone various reforms in its care model (Mosh, 1983; Herrero & Collado, 2001), in which tasks for the Health Ministry (MS) and the Costa Rican Social Security Fund (CCSS) were not clear; the roles were later defined, assigning to the

MS the responsibility of controlling and monitoring the health sector and assigning to the CCSS the responsibility of providing health services to the population.

Knowing that the Costa Rican Social Security Fund (CCSS) is the organization responsible for health services, the study is based at a local level which is comprised of three health care levels. At the primary care level, the Basic Equipment of Integral Health Care (EBAIS) is responsible for prevention and health promotion, low-complexity healing and rehabilitation. The secondary care level provides support to primary care, outpatient and hospital procedures (basic specialties and subspecialties). The tertiary care level provides outpatient and hospitalization services with complex specialties and subspecialties. Due to the purpose of this research the primary health care level is the object under study which allows us to better understand the management deficiencies in terms of health promotion and prevention. According to the WHO, the first primary health care is the "main gateway" (WHO, 1998, p.12) of the whole system where most health issues should be solved, focusing more on integral initiatives.

Definitions of health and integral health

Turning to our conceptual framework, it is important to define the concepts of health and integral health. Since the 1950s, the World Health Organization (WHO) adopted the term 'health' (Sequeira, 2010, p.26) contending that the human being transcends the merely physical aspect of life and is involved with a multi-causal process (Sequeira, 2010, p.26), which integrates the person to the social world (Corrales, Urrutia y Porras, 2007, p.6). This conceptual evolution emerged replacing health as the absence of biological illnesses (Callahan, 2012); doctors and health workers had been trained to treat disease, not to build integral health, understanding 'integral' as "total, complete, global" (Torres, et.al., 2004, p.14).

The WHO was the first organization to agree on a standard and universal definition established in 1946 and ratified in Alma Atta (1978) by asserting that integral health is "a complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2003, p.1; Callahan, 2012). Health and illness are related concepts which should not be seen as segmented variables.

The definition that seems most realistic is given by O'Donnell (2009):

> Health Promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health.

O'Donnell's definition is like the one provided by Costa Rican Social Security Fund, which defines health as a political and social process, in which people have better control over factors that determitheir health. This is achieved through their abilities and capabilities, strengthening and developing actions aimed at modifying social, political, economic, and environmental conditions to help decrease its impact on health. People are responsible, transforming agents; and developers of individual and collective health (Corrales, Urrutia & Porras, 2007, p.11)

Integral health receives little priority within health systems. Based on the previous information, an inclusive theoretical framework is suggested by the author, in which "health promotion" is the term

this research explores and examines. It is characterized as a procedural, multidimensional and inter-sectorial field. The former means that health is not static; on the contrary, it goes through constant movement and change. Multidimensional refers to the fact that it is determined not only by biological elements but also by social, economic, cultural, geographical, psychological and spiritual, among other factors. This requires an inter-sectorial process where the impact must be on the individual and collective level to cover its multidimensionality, which complies with the social determinants of health (Medicus Mundi, 2011, p.4; p.8). Figure 1 shows a comparison between the medical model vs. inclusive health, the first one contemplates a more biological view, and the latter one is closer to the ideal of integral health.

Figure 1.

Medical Model vs. Inclusive Health

Concept from the Medical Model	Concept of Inclusive health
Biologist Individual Historical	Multidimensional Individual, Family, Community, Environment Procedural

Note. Medicus Mundi, 2011, p. 3

These two concepts have been reviewed and discussed. The first one attempts to merely treat physical disease, it has a more preventive focus, or according to the Centre for Strategic Development and Information in Health and Social Security (p.12) quoted in Avendaño, Cruz, et al. (2010) "The biologist conception is a restrictive health term. It reduces the disease phenomenon to cause-effect, which may have different origins; the disease always refers to the biological level and clinical level" (p.100)

The second concept refers to a more integral health that works with promotion and a better wellness model including social, environmental, emotional factors and so forth. The last one is more holistic and attempts to help people improve their lifestyles. Gabriela Salguero (2006) quoted in Avendaño, Cruz, et al. (2010), contends that:

Man has become less dependent on the biological state and increasingly into the social state, i.e., its degree of social integration, social inclusion, the conditions of life and the answers given by the society to different problems and needs with which man is confronted (p.12)

We neither intend to solve this debate nor have the final word on the subject. Since the latter concept seems to be most realistic, it is used in conjunction with the WHO's concept to explore and analyse practices in Costa Rica. Due to the consensus reached among countries when applying the ambiguous concept of integral health, each health system, particularly in Costa Rica and especially in terms of promotion and prevention at the primary health level, has been attempting to achieve the current goal. Drawing on the former, the following sections of this research explore to what extent management at the primary health care level undertakes promotion and prevention tasks while

adhering to the concept of integral health.

Health promotion and prevention

As part of our conceptual framework, a clear understanding of health promotion and prevention is essential for this research. Due to the way health is conceptualised, these terminologies vary depending on explicit idealism (Callahan, 2012), bearing in mind that people will not reach the ideal level, but will go from one extreme (health) to the other (disease). As it is difficult to agree on a particular concept, an ideal and perfect practice, the health concept has evolved (Lopes, Saraiva, Fernandes & Ximenes, 2010). In 1986 the first International Conference on Health Promotion was held in Ottawa (Canada) where the Ottawa charter was presented (WHO, 1998, p.7). Currently it is the basis to elaborate on other issues related to health policies.

This charter essentially incorporates the concept and application of Health Promotion (Lalonde, 1981) once the need arose to investigate new strategies to tackle multiple health problems, though as an integral work, requiring a process through which people would be trained on how to increase control on and improve their health. Some of health conditions and resources are peace, education, housing, economic incomes, stable ecosystems, sustainable resources, social justice and equity. This requires coordinated action by all actors: government, health services, social and economic sectors, NGOs, media, private sector, etc. The commitment suggested was to introduce a healthy public policy that worked with health differences, to acknowledge human beings as the main source of health, to redirect resources to promotional initiatives and finally to acknowledge that health equals investment.

The 20th century changed and challenged both organisations and people worldwide to adopt other ways to work on health issues. In 1997, the WHO established and approved its Jakarta Declaration on Health Promotion through a glossary in order to allow the planning of better action strategies in promotional issues (WHO, 1998, p.6), by promoting coherent policies, investments and partnerships between governments, international organizations, civil societies and the private sector (Lopes, Saraiva, Fernandes & Ximenes, 2010), but, above all, to think about how to integrate the health promotion approach “into existing structures and processes” (Meyer, et.al., 2008) within management systems.

The progress in medicine was noticeable, it changed from a purely medical approach to a more centralised one which includes prevention and promotion, resulting in a holistic approach to health worldwide and that is committed to health promotion. This effort has linked and challenged states in modifying the reform by developing other strategies in public health (Unger, et.al, 2008) and to rearrange the relevance of health services (WHO, 1998, p.7), even going from being a purely private issue to acquiring a public and political dimension.

Health promotion, according to the WHO (WHO, 1998, p.10) is defined as the process that allows people to increase control on their health and to improve it (Ferguson & Spence, 2012, p.523; Lopes, Saraiva, Fernandes & Ximenes, 2010). Moreover, it considers a political and social worldwide process, guiding society towards improving a) its skills and b) its economic, social, personal and environmental conditions. It consists of working on the social determinants of health firstly (Sequeira, 2010), defined as the circumstances in which people are born, grow, live, work and age, including the health system (Wilkinson & Marmot, 2003), since multiple factors impact health. Picado (2011) explains that it involves health protection, education, and prevention.

Furthermore, preventive tasks are targeted actions that serve to prevent diseases from occurring and to decrease progressing diseases (Corrales, Urrutia & Porras, 2007, p.8). Authors Donev, Pavlekovic & Zaletel (2007; WHO, 2002) have also discussed the relationship between promotion and prevention. They claim that, despite their similarities, they are different. The prevention of disease encompasses "measures not only to prevent the onset of disease, but also to stop its progress and reduce its consequences once established" (WHO, 1998, p. 13 based on Health for All series of 1984; Redondo, 2004, p.7) as opposed to promotion which seeks to implement initiatives and improve people's health by providing them with information, education, influence and assistance to achieve a better responsibility in their lives and well-being (Donev, Pavlekovic & Zaletel, 2007).

Disease Prevention can be split into three levels: primary (to avoid the beginning of a disease), secondary and tertiary (to stop or slow the progression of disease). For all practical purposes, prevention is used as a complementary term for promotion, especially because there is no such thing as perfect health, only tool to improve or control it. Prevention (2004, p.15; Mendes and Costa, 2011) allows to make risk factors of contracting a disease innocuous, by using control tools to anticipate possible effects. Table 1 shows the main differences between promotional health and prevention of disease according to Redondo (2004) and Hernández (2010).

Table 1.

Differences between promotion and prevention.

Promotion	Prevention
Process: provides tools to exercise greater control over health	The action comes from the health sector; individuals and populations are exposed to risk factors
Population approach	Risk approach
Efforts to maintain and improve individual, family and community's health	Direct measures to prevent disease Specific measures for the control of certain diseases
Requires good social structures Great potential to improve health indicators	Identifying modifiable causes of disease More effective if it is stopped early
More effective if started early Measures designed to change attitudes and behaviours	Measures designed to prevent the onset of disease and / or stop its progress
Low individual perception of Benefit	High patient and doctor motivation
Social, political and community auditors, for groups and individuals to act, be empowered and make decisions.	Primary prevention (social, political and community auditors). Secondary and tertiary prevention (clinical auditors to prevent complications and death. Scientific and technical faculties)
Information, communication, education, social marketing, strengthening participation, political action to implement public policies	Primary prevention (information, communication, education, social marketing, strengthening participation, political action to implement public policies). Secondary and tertiary prevention (discriminatory tests and early diagnosis of the disease, clinical management)

Note. Redondo, 2004, p.16; Hernández, 2010

According to the WHO, adopting a broader promotional approach could be more relevant for countries that have just one axis, i.e., the countries that put greater emphasis on preventive approaches. Strategies should be based on five action areas according to the Ottawa Charter Principles (McManus, 2013, p.16; (Corrales, Urrutia & Porras, 2007, p.10; Ferguson & Spence, 2012, p.523; Lopes, Saraiva, Fernandes & Ximenes, 2010):

- To establish a healthy public policy
- To create environments that support health
- To strengthen community action towards health

» To develop personal skills
» To redirect sanitary services

Adopting these 5 lines of action aided the WHO to further clarify its objectives, which are considered essential in the integration of the concept of "new public health" as "the science and art of promoting health, preventing disease and prolonging life through organized efforts of society" (WHO, 1998, p.12). Additionally, these features were critical for the establishment of strong inter-sectorial action for mobilization and social transformation (Corrales, Urrutia & Porras, 2007). Since then, the relationship between public health promotion and disease prevention has been seen as a consistent and harmonic convergence of social and political destiny. It should be noted there is a distinction between "public health" and "new public health". The latter refers to the social determinants of health and how lifestyles and life conditions determine the health state (Corrales, Urrutia & Porras, 2007).

The selection of this framework was based on its alignment with the specific objectives of this article, particularly in addressing the complexities of health promotion and disease prevention within the context under discussion. While other frameworks, such as systems theory and public health management theory, offer valuable insights, this framework was chosen for its ability to more effectively capture the dynamic interactions and broader social determinants influencing health outcomes. Its focus allows for a more nuanced understanding of how health interventions can be tailored to diverse populations.

Health promotion is considered a means or resource to help people in their economic, social and personal lives, and it should not be presented as an abstract condition. In other words, health promotion can be considered tantamount to "new public health". New public health considers the social determinants needed to improve health promotion from an integral perspective.

Thus, the following question arises: who is responsible for promotion and prevention issues? The World Health Organization has proposed a series of actions to help countries achieve a decent level of health care. However, achievement of goal is often hindered by practical obstacles. This study does not seek to stress or debate the meaning of promotion and prevention, but to analyse the extent to which there are deficient management practices at the primary level (Callahan, 2012).

Management Model: Primary Health Care

To provide further context for our study, we now analyse Costa Rica's primary health care management model. According to the WHO, primary health care is the "essential health care, accessible, at a cost the country and community can afford, with practical methods, scientifically sound and socially acceptable" (WHO, 1998, p.12). This issue was addressed in the Alma Ata Declaration, held in Geneva, 1978. It stressed that all people should have access to primary health care (WHO, 1998, p.12) through equity, inter-sectorial participation, education, preventive methods, etc. Since this declaration, the strategy of Primary Health Care (PHC) was promoted (Medicus Mundi, 2011, p.7), including new initiatives such as the Ottawa charter for Health Promotion, the Millennium Declaration and the Social Determinants of Health perspective.

Since primary health care is the first point of contact with the population, the WHO considers this level as the one responsible for health promotion, advocacy, and influence in the formulation of policies and programs (WHO, 1998, p.13). As mentioned above, primary health care is the main gateway to

health care or prevention and promotion and it is where most concerns should be solved (Beaulieu, et.al., 2013, p.1). In this research, the model of the Costa Rican health system is studied, specifically focusing on the first level of care. This way, the analytical characterisation of the primary care level of the public health system is analysed: its health/disease conception, promotion and prevention knowledge and practices, as well as organisational resource allocation and processes.

The core components of the Costa Rican primary level are:

» The local concept of health and illness and its approaches.
» The programmatic / normative level.
» The administrative level (management processes, planning, organization, staffing, human and financial resource allocation, assessment / measurement).
» The instrumental/operational level in promotion and prevention activities.

It was previously explained that the understanding of health has evolved from a medical model (medicine) to a broader concept based on health care (McManus, 2013, p.15), but only defined as sanitary assistance accessible to the whole population. The WHO defined it as promotional and preventive initiatives, however there was a need to expand on the concept to consider the social determinants of health, arguing that health systems cannot be responsible for many factors that are the responsibility of other actors. This means that not all health problems are caused by medical factors, they might be caused by employment, housing, environment, among others.

Accordingly, Health Systems were given the responsibility for one essential task: to promote health and healthy lifestyles and prevent disease (Corrales, Urrutia & Porras, 2007, p.8). But how can this be possible if there is no consensus on basic concepts? Health promotion has often been confused with education (knowledge transfer) the idea that just by sharing information health can be improved. Health promotion refers to the dissemination of certain actions that encourage good health providing a broader perspective, from a campaign to the development and implementation of public policies, whereas regarding education, once the actions are known, they can be applied in a timely fashion by teaching people to take control and improve their health. The World Health Organization (WHO) is responsible for defining the basis to guide Health Systems world-wide. Essentially, the terms have been accepted in many health documents and laws but making them a reality has posed a challenge (Baldock, Manning & Vickerstaff, 2012). The question remains: how to put theory into practice?

There are different international and national laws regarding health and health promotion. In addition, the Costa Rican health sector is made up of several heterogeneous actors which all have a role in dictating the course in which the health process unfolds such as: General Health Law, Law for Ministries, the Political Constitution, Executive Orders, International Conferences, etc. Despite these guidelines, there are some deficiencies in compliance regarding the institution that provides health care services, the Costa Rican Social Security Fund (CCSS) has its own internal policies as an autonomous institution, as well as strategic plans.

Challenges of Costa Rican primary health care level

Against the backdrop of the conceptual framework and the broader institutional context of Costa Rica's primary health care level presented above, we now turn to the empirical part of our research and present the main findings of our qualitative work. The findings presented below are based on extensive empirical research conducted in 2014 and 2015, which included in-depth interviews with 15 experts and surveys with 100 health users. Due to space limitations, only the main conclusions are discussed here, and as such, the detailed analysis of the interview and survey results is not fully explored in this article. While some perspectives from the interviewees are presented, a deeper examination of the reasons behind these views and their broader implications for the health system is available in the original research report (master's thesis). For those seeking a more comprehensive understanding of the data, the complete thesis (Quesada, 2014) provides full access to the empirical findings.

Due to many issues, one of them being the evident overemphasis on prevention and healing processes, a national health policy for 2010-2020 was formulated (Avila, et.al., 2010) which stressed three objectives for promotion and prevention: a) individual and collective care culture, b) individual health care services, c) strengthening of the development of a healthy workforce and its impact on health promotion and prevention. The Costa Rica Social Security Fund (CCSS) would continue with its functions but divide them among three administrative levels, delegating its tasks for execution, programming and monitoring of health actions and health promotion / disease prevention activities to a local level representative. Its structure was also divided into different care levels, the Basic Equipment of Integral Health Care (EBAIS) being responsible for prevention and promotion, low-complexity healing and rehabilitation (García, 2004; Flores, 2003).

Costa Rica has improved its management models in some of its primary care centres (EBAIS), its aims now emphasise care. When analysing the issue of health promotion and disease prevention, there is still a lack of concrete initiatives. Additionally, both management and promotion / prevention are not given enough importance in the South-Central Region: a) there is an abuse of the medical profession (promotion and prevention as curative medicine), b) problems related to "social well-being" are delegated only to medical professionals (Callahan, 2012) taking responsibility for social, political and economic problems of the population and c) management fails to adopt good practices that utilise available resources and efficient planning strategies (Ferrinho & Dal Poz, 2003).

A real improvement to date has not worked in many centres of primary health care. Despite the existence of difficulties in most centres, the area being studied (the South-Central Region) is facing major deficiencies. The main problem being that the care provided to the population is insufficient due to bad management; health promotion suffers due to limited resources at all levels of healthcare (Ferrinho & Dal Poz, 2003) and in EBAIS centres particularly (García, 2004). EBAIS are still focusing on a sort of health care that cures disease, rather than on health promotion initiatives. They act as small hospitals, causing service saturation (Comino, et.al., 2012, p.1); they prioritize the disease and thus do not fulfil their duties when it comes to quality, equity, efficiency and care (Picado, 2010; Hernández, 2014).

The inefficiency problem is also accompanied by a lack of communication, information and

community relations. From this perspective, national health systems should develop a public health policy that balances welfare, promotion and prevention (Leon, Walt & Gilson, 2000; Kawachi, Subramanian & Almeida, 2002) and that change the management model. It is a way to influence and fight for the rights of the population. There are many obstacles in management practices.

Primary care depends on factors like "time, financial support, payment reform, health policy support and physician support" (Arar, et.al., 2011, p.290), all of which are interconnected and affect practice. Due to this reason and others, understanding the situation of the Basic Equipment of Integral Health Care (EBAIS) in the South-Central Region of Costa Rica is essential in order to analyse how health initiatives are implemented and to explore the main factors influencing the readiness to introduce new procedures at the primary care level management, applied to three main aspects: (a) a vision put into practice, (b) needs for practice improvement and (c) obstacles that hinder practice improvement as explained by Arar, et.al. (2011, p. 292) at the three levels of care: structure, process and outcome of care (Scha, et.al, 2013). Despite the progress, public health systems face critical situations regarding people's care and illnesses. Health institutions still focus on curative health (curing the disease), rather than on promoting health (Baldock, et.al., 2012). Additionally, the primary health management level still works with traditional bureaucratic practices (Picado, 2000), which translates to serious problems in terms of effectiveness, efficiency and equity of services (Bambra, Fox & Scott-Samuel, 2007). This situation stresses the need to rethink management methods. The gap that had caused the transformation of the health sector, i.e. the delegation of operational tasks to the CCSS by the Ministry of Health, was intended to be corrected. Since their focus is to cure diseases, the staff is insufficiently prepared to be involved in health promotion.

From the conducted interviews, it was found that it is a challenge to establish a unique definition for promotion and prevention, they are often thought of as synonyms. Many promotional projects are combined with prevention initiatives. Costa Rican citizens do not understand what promotion means, they think of medicine and doctors. In addition, there is no awareness of the importance of health and promotional issues are limited to healthy food and exercise. All interviewees agreed there are differences between both concepts. Health is not just the absence of sickness, but an integral well-being of the person: the physical, mental, social, spiritual well-being of the individual. Since the '70s health promotion have been defined from five lines of action with Ottawa Charter roots but has not received sufficient support:

1. Healthy public policy creation.
2. Establishment and improvement of environments.
3. Development of skills and attitudes of the citizen.
4. Ensure social participation.
5. Reorganization of health services.

The questions used for the research at the beginning can be largely answered positively. It became very clear from the conducted fieldwork that there is indeed a deficient focus on preventive and promotional integral health at the primary health care level (research question # 1). This issue had already been mentioned in the literature by several authors (Picado & Quesada, 2011 and Avendaño, Cruz, et al., 2010), and this research clearly laid out the difference between what is stated in policy documents and what happens at the level of the EBAIS. Moreover, the conceptual confusion about prevention and promotion is shared not only by the medical personnel but also by the users of the EBAIS, which naturally has repercussions on the type of care that is delivered at the local level. It also strongly impacts the way tasks of the EBAIS are defined when it comes to prevention and promotion

(research question # 4).

The issue of effective allocation of financial and human resources (research question # 2) was also confirmed by the interviews conducted in this research. Although it has not been possible to review budgets of EBAIS, the qualitative observations of all interviewees refer to this issue, which applies not only to prevention and promotion, but to the health care system in general. As for internal management and organisational culture of the EBAIS (research question # 3) what was highlighted in literature (Carpio & Villalobos, 2001) was confirmed: it is insufficiently in tune with the requirements of a holistic vision of health.

Conclusions

Health is a complex concept. It certainly carries several characteristics and dimensions that require a broad classification, either on welfare terms, or strengthening of people's abilities. International statements have established a set of guidelines that should be reflected in national laws and the operationalization of the health sector. As this research has shown, the Ministry of Health in Costa Rica and the Costa Rican Social Security Fund (CCSS) have clear international guidelines and they both have action plans as autonomous institutions. The former is the governing body, and the latter is an institution in charge of providing health services, including those related to health promotion and disease prevention.

This research revealed that due to poor planning, duplication of tasks, lack of coordination, mismanagement at local level on issues of promotion and prevention, among others, there is still much work to be done to reorganize this model at the primary level. Prevention is still prevalent in the EBAIS and this is reflected in the programs and resource allocation. This research also found that promotion is still ignored and the concept of a complete physical, mental and social well-being state proposed by the World Health Organization is not operationalised and measured, in fact, indicators are mainly preventive. This explains why people see the EBAIS as small hospitals, rather than facilities for the implementation of disease prevention and health promotion initiatives that improve their lifestyles, as the conducted survey indicated.

At the beginning of this research an inclusive theoretical framework was proposed in which health promotion should be seen as a procedural, multidimensional and inter-sectorial field. Health promotion means that health evolves and is determined not only by biological elements but looks to comply with social determinants of health (environment, housing, employment, etc.) which requires an inter-sectorial process.

This research discusses the numerous restructuring processes aimed at better defining tasks following the duplication of functions related to promotion and preventive roles between the Ministry of Health and the Costa Rican Social Security Fund. The Ministry of Health retained control over coordination and monitoring responsibilities, while the Costa Rican Social Security Fund was tasked with health promotion, disease prevention, and rehabilitation. Its main role at the primary care level should, therefore, be health promotion, as it is the first point of contact with the population. However, despite the existence of specific laws, the primary health care level (EBAIS) is not currently fulfilling its health promotion mission.

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