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THE PROCUREMENT OPTIONS STUDY

Contraceptive Procurement in Costa Rica

DECEMBER 2005

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

CONTENTS

| | |
|--|-----------|
| Executive Summary | iv |
| Abbreviations | v |
| Overview | 1 |
| Introduction | 1 |
| Methods | 1 |
| Background Country Information | 2 |
| The Health System in Brief | 3 |
| Supply and Distribution of Contraceptive Products in Costa Rica..... | 5 |
| Context | 5 |
| Legal and Regulatory Framework for Family Planning | 6 |
| Supply and Distribution for Contraceptives in the Public and Private Sectors | 7 |
| Procurement in the Public Sector | 9 |
| Withdrawal of USAID Support | 11 |
| Cost Structure and Price Analysis..... | 12 |
| Public Sector Procurement Costs | 12 |
| Retail Prices for Contraceptives | 13 |
| Conclusions and Lessons Learned..... | 14 |
| Legal and Regulatory Environment for Procurement..... | 14 |
| Supply and Distribution Mechanisms..... | 14 |
| Public Sector Procurement | 14 |
| USAID Phaseout..... | 15 |
| Cost Structure and Price Analysis | 15 |

EXECUTIVE SUMMARY

USAID and its cooperating agencies are studying procurement issues and options for countries that no longer receive USAID and/or international donor support for contraceptive commodities, including Brazil, Chile, Colombia, Costa Rica, and Mexico. This report summarizes the key findings from Costa Rica.

In Costa Rica, health sector reform began in the early 1990s. As part of this reform, the Ministry of Health transitioned from being a service delivery institution to a normative body for the overall health system. At this time, the Costa Rican Social Security Fund (CCSS) became the sole provider of government healthcare services. As part of the health sector reform process, an integrated healthcare model was proposed that incorporated prevention and health promotion, increased social participation, and integrated primary care with basic healthcare teams located throughout the country.

Although Costa Rica does not have a strong legal and regulatory environment supporting reproductive health—and family planning in particular—the procurement regulations and norms for health products are well established and have also served to facilitate the procurement of contraceptive commodities. To improve procurement practices, the Costa Rican legislature approved a separate law for medicines and medical supplies. Law 6914 outlines a more streamlined process specifically for the procurement of medicines, which allows the CCSS to function with a list of pre-enrolled suppliers for virtually all of the 541 medicines included in the *cuadro basico* or basic list of medicines.

The CCSS is currently the major provider of family planning services in Costa Rica, serving more than 72 percent of all family planning users. The fund (which is the only public sector organization that procures medicines on behalf of the Costa Rican government) is sourcing contraceptive supplies that are manufactured abroad and imported into Costa Rica (through a local importer/distributor), as well as oral contraceptives that are locally manufactured. The procurement of contraceptives within the CCSS was relatively stable from 2000–2003 but increased significantly in 2004. From 2000–2003, the fund procured an average of US\$395,000 per year in contraceptives, with only minor variations from year to year. However, in 2004, the CCSS increased its procurement levels by almost 100 percent to US\$778,000. The major increase in procurement costs appears to be related to injectable purchases, which have fluctuated dramatically over the years, representing 3 percent of the budget in 2000 and 46 percent in 2004.

This review of Costa Rica's contraceptive procurement practices suggests that the country program has been successful in maintaining a consistent supply of contraceptives from a variety of sectors. The Costa Rican government received its final contraceptive commodity support from international donors more than 12 years ago. In 1992—just before USAID's withdrawal from Costa Rica—contraceptive prevalence was already high at 75 percent. The latest reproductive health survey conducted (1999) showed another increase in prevalence to 80 percent—almost six years after USAID's withdrawal. This report highlights the key factors that were important in procuring sufficient contraceptive commodities to meet the needs of Costa Rican men and women.

ABBREVIATIONS

| | |
|--------|--|
| ADC | Demographic Association of Costa Rica |
| AIDS | acquired immune deficiency syndrome |
| CIF | cost, insurance, and freight (price) |
| CCSS | Costa Rican Social Security Fund |
| CONAPO | National Population Committee |
| EBAIS | basic healthcare teams |
| GDP | gross domestic product |
| HA | health areas |
| HIV | human immunodeficiency virus |
| INS | National Institute of Insurance |
| IUD | intrauterine device |
| MOH | Ministry of Health |
| NGO | nongovernmental organization |
| OC | oral contraceptive |
| PSI | Population Services International |
| TL | tubal ligation |
| USAID | United States Agency for International Development |

OVERVIEW

Introduction

USAID and its cooperating agencies are working to strengthen the planning process for achieving contraceptive security within the Latin America region. It is anticipated that by the end of 2008, USAID will have phased out its support for contraceptive commodities in the majority of the region's countries—although the timeline for graduation is different in each country. During 2004, the POLICY and DELIVER projects conducted assessments in five countries (Bolivia, Honduras, Paraguay, Peru, and Nicaragua) to determine their readiness in achieving contraceptive security.¹ As a result of these assessments, POLICY and DELIVER provided technical, consensus building, and policy and logistical support to help country programs prepare for and achieve contraceptive security.

To continue this regional effort for contraceptive security, the POLICY and DELIVER projects assessed potential procurement options in the eight Latin American countries where USAID is currently operating—Bolivia, Dominican Republic, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, and Peru. The study is designed to identify the legislative, normative, and programmatic issues that affect the procurement of contraceptives in these countries; and the procurement options currently being used in country programs that no longer receive USAID and/or international donor support for contraceptive commodities. There will likely be substantial lessons learned from the countries that have already graduated from USAID assistance; these five countries include Brazil, Chile, Colombia, Costa Rica, and Mexico—and have not received commodity support for several years. This report summarizes the key findings from Costa Rica.

Methods

The methodology for this procurement options study included key informant interviews with the government, particularly the Costa Rican Social Security Fund (CCSS); nongovernmental organizations (NGOs); and commercial sector partners. The analysis included the review of laws and regulations pertinent to reproductive health programs as well as public sector procurement. The study has also included the review of documents related to the structure of the overall health system, procurement norms and procedures, and other background information on the demographic and health situation in each country. The study also collected cost and pricing information for products distributed through public sector programs, social marketing programs, and the commercial contraceptive market through review of public sector procurements and site visits to pharmacies. In some cases, pharmaceutical distributors also provided the cost, insurance, and freight (CIF) and distributor prices for products. Pricing information was collected on the top-selling commercial contraceptive brands (e.g., Microgynon and Depo-Provera) that have a regional presence—as well as the top-selling social marketing brands in each country.

¹ Taylor, Patricia A., Nora Quesada, Wendy Abramson, Varuni Dayaratna, and Leslie Patykewich. 2004. Regional Report: Contraceptive Security in Latin America and the Caribbean. Results and Recommendations. Arlington, VA: John Snow, Inc./DELIVER, and Washington, DC: Futures Group/POLICY Project.

BACKGROUND COUNTRY INFORMATION

Costa Rica, located in the southern region of Central America, is a small country of approximately 4 million people. It borders both the Caribbean Sea and the North Pacific Ocean, between Nicaragua and Panama (see map).² The country is divided into seven major provinces: Alajuela, Cartago, Guanacaste, Heredia, Limon, Puntarenas, and San Jose.

Costa Rica's basically stable economy depends on tourism, agriculture, and electronics exports. The country's major agricultural products include coffee, pineapple, bananas, and sugar—and coffee, bananas, sugar, and pineapples are the country's primary exports. Low prices for coffee and bananas have hurt the agricultural sector. Poverty has been substantially reduced over the past 15 years, and a strong social safety net has been put into place. Costa Rica recently concluded negotiations to participate in the U.S.-Central American Free Trade



Agreement, which if ratified by the Costa Rican Legislature, would result in economic reforms and an improved investment climate. See Tables 1 and 2 for selected sociodemographic indicators for Mexico.

Table 1. Socioeconomic Indicators

| | |
|---|-----------------|
| GDP Per Capita (2002 US dollars) ¹ | 7,966 |
| Population Below the Poverty line (2001) ² | 18% (2004 est.) |
| Total Expenditure on Health (as a % of GDP 2002) ¹ | 9.3 |
| Public/Private Breakdown of Health Expenditure ¹ | 65.4%/34.6% |
| Per Capita Total Expenditure on Health (2002) ¹ | US\$743 |
| Per Capita Government Expenditure on Health (2002) ¹ | US\$250 |

Sources: (1) <http://www.who.int/countries/cri/en/>, (2) CIA facts: <http://www.cia.gov/cia/publications/factbook/geos/cs.html>.

Table 2. Demographic Indicators

| | |
|--|---------------------------------------|
| Total Population Estimate (2004) ¹ | 4,173,000 |
| Annual Population Growth Rate (1993-2003) ¹ | 2.3% |
| Total Fertility Rate (per woman) Estimated (2005) ² | 2.3 |
| Infant Mortality (2004) ² | 11 females, 9 males/1,000 live births |
| Life Expectancy (2004) ² | 67.2 years |
| Contraceptive Prevalence (modern methods) (1999) ³ | 80% |

Sources: (1) <http://www.who.int/countries/cri/en/>, (2) CIA facts <http://www.cia.gov/cia/publications/factbook/geos/cs.html>, (3) Salud Reproductiva y Migración Nicaragüense en Costa Rica 1999–2000. Resultados de una Encuesta Nacional de Salud Reproductiva. PCP. Universidad de Costa Rica.

² <http://www.cia.gov/cia/publications/factbook/geos/cs.html>.

THE HEALTH SYSTEM IN BRIEF

Costa Rica's system of health coverage is different from most other Latin American countries. In Costa Rica, health sector reform began in the early 1990s. Its main objectives have been to maintain universal health insurance coverage, create greater equity in access to health services, guarantee the high quality of care, and improve the efficiency of resource use. As part of this reform, the Ministry of Health (MOH) transitioned from being a service-delivery institution to a normative body for the overall health system. At this time, the Costa Rican Social Security Fund (CCSS) became the sole provider of government healthcare services. As part of the health sector reform process, an integrated healthcare model was proposed that incorporated prevention and health promotion, increased social participation, and integrated primary care with basic healthcare teams (EBAIS) located throughout the country.

The MOH—in its normative role—regulates health services, health supplies, and environmental health. As such, the MOH is responsible for the qualification and accreditation of public and private health services. The MOH has a Bureau of Registration and Control that is responsible for regulating drugs, food, and other products for human use; and maintaining a list of proprietary and generic as well as over-the-counter drugs registered in the country. Since 1995, the MOH has had a national program for Health Promotion and Protection, which encourages social participation complemented by education and mass communication.

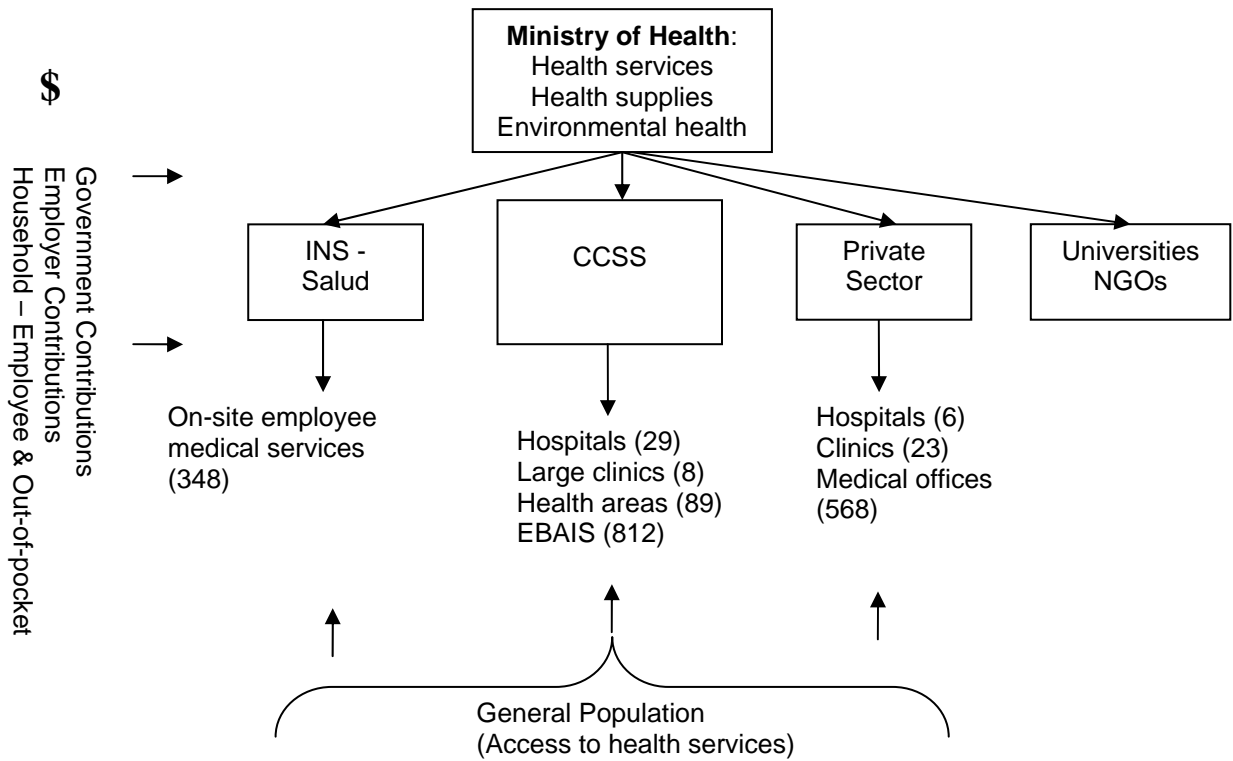
The National Institute of Insurance (INS) is responsible for overall administration of the insurance industry to ensure that the insurance market develops to meet the economic and social needs of the country. INS develops and offers a wide variety of personal, life, health insurance products. It also provides special services to employers to ensure appropriate workplace and occupational safety insurance, preventive health programs, and on-site medical care. The INS operates and manages approximately 348 on-site medical clinics for employers (see Figure 1).

The CCSS provides healthcare services at all levels. In addition, the CCSS also serves as a social safety net for non-beneficiaries—as the healthcare facilities are obligated to provide care to even those persons that are not officially registered. There are high rates of migration from Nicaragua to Costa Rica, accounting for a large portion of the unregistered population—although these individuals are not denied care if they attend a CCSS clinic or hospital.

The fund is currently the major provider of family planning services in Costa Rica. The CCSS directly procures all contraceptive commodities centrally and distributes them directly via their central warehouse to hospitals and other large polyclinics, which in turn distribute to their affiliated EBAIS. Recent investigations³ have reported problems with the fund's capacity to store its own supplies, including everything from office supplies to laboratory equipment and medications. The agency therefore leases warehouse facilities from private firms. In recent months, payment for storage services has been delayed because of complications with inter-agency communication and oversight processes between the CCSS and the National Controller Agency (Contraloría General de la República). Nevertheless, interviews with CCSS staff revealed that the agency's central warehouse has a low stockout rate for medicines, which is estimated at 2 percent according to warehouse personnel. Although no stockout rate was available by category of product (and specifically for contraceptives), none of the healthcare facilities nor the representatives of the CCSS central warehouse interviewed for this study could remember any period of stockout.

³ http://www.nacion.com/ln_ee/2005/noviembre/15/pais8.html.

Figure 1. The Costa Rican Health System⁴



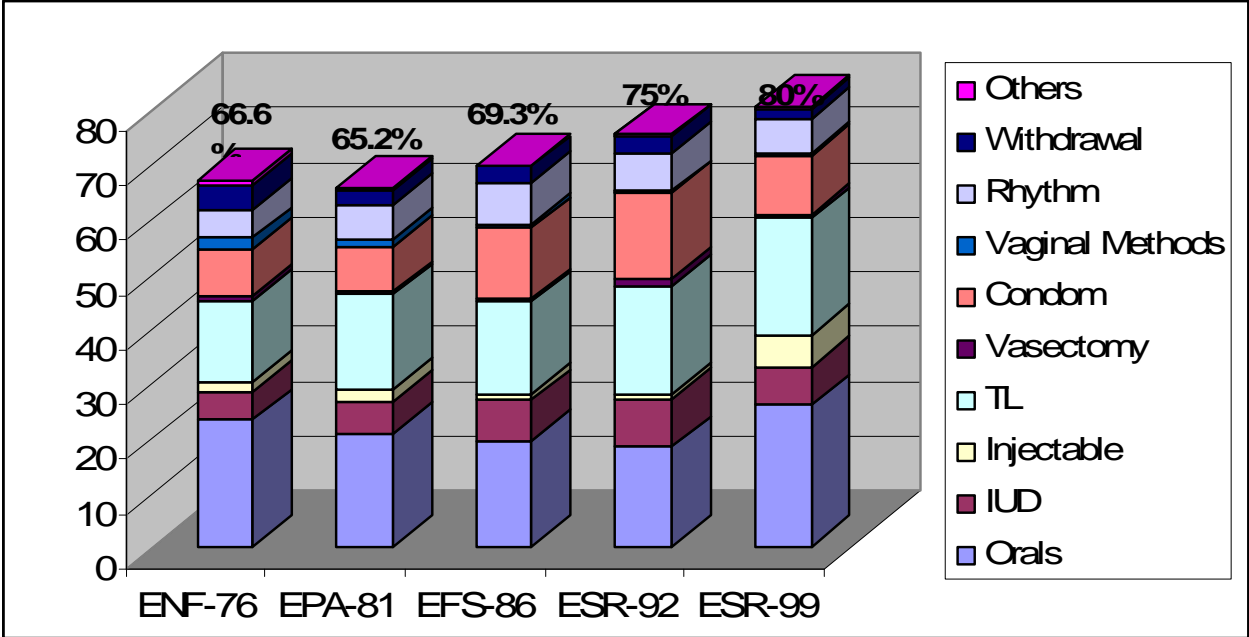
⁴ Dra. Maria del Rocio Saenze Madrigal, Ministra de Salud, Powerpoint presentation, January 2003.

SUPPLY AND DISTRIBUTION OF CONTRACEPTIVE PRODUCTS IN COSTA RICA

Context

Costa Rica has one of the highest contraceptive prevalence rates in the region. The latest demographic and reproductive health survey in Costa Rica was conducted in 1999 by the Central American Center of Population at the University of Costa Rica.⁵ Between 1976 and 1999, contraceptive prevalence increased from 66.6 to 80 percent, increasing most significantly in 1999 among young women (see Figure 2). In 1999, the most widely used method is oral contraceptives (25.6% of the population), followed by female sterilization (21.4%). Injectables and intrauterine devices (IUDs) are used by 5.9 and 6.9 percent of women, respectively—although injectable prevalence has increased since the last survey and IUD prevalence has decreased. Condom use is 10.9 percent, a decrease from 15.7 percent in 1992. Prior to 2000, female sterilization was only allowed with specific written consent from the husband. In comparison with 1992, the reproductive health survey also showed important increases in the number of women seeking preventive healthcare (papsmear, breast exams, and tetanus vaccines).

Figure 2. Contraceptive Prevalence by Method (1976–1999)



Sources: Various demographic and health surveys in Costa Rica (dates as noted).

These results suggest that Costa Rica has maintained a strong emphasis on reproductive health and family planning since the phaseout of donor support and has even been able to strengthen the provision of services to younger women.

⁵ Chen, M., L. Rosero, G. Brenes, M. León, M. González, and C. Venegas. 2001. Salud Reproductiva y Migración Nicaragüense en Costa Rica 1999–2000. Resultados de una Encuesta Nacional de Salud Reproductiva. PCP. Universidad de Costa Rica.

Legal and Regulatory Framework for Family Planning

Despite the strength and success of Costa Rica’s family planning and reproductive health program—the legal and regulatory framework for family planning and reproductive health rights is less well-defined. In 1999, Costa Rica established a presidential decree recognizing the right of all men and women older than 18 years of age to control their own sexual and reproductive health. This decree, therefore, eliminated the need for men and women to seek approval from their spouses for surgical sterilization—increasing access to and availability of female sterilization services. Costa Rica’s General Health Law is currently under review—and the inclusion of emergency contraception is being considered. The General Law on HIV/AIDS was approved in April 1998 and specifically recognizes the importance of the condom in HIV prevention—and therefore, the responsibility of the CCSS and MOH in procuring and ensuring access to condoms for the general population. The law also requires that all motels provide at least two condoms in each room as a basic part of the service.

The Costa Rican government has several national procurement laws that regulate all government purchases—helping to maximize efficiencies and economies of scale for medicines and medical supplies. In general, all procurement transactions made by government organizations must follow the procedures outlined in Law 7494 for Administrative Contracting. This law and the corresponding regulations outline the general requirements for bidders, their rights and obligations, and the procedures for all public tenders. However, because these public procurements are announced in the official government newspaper (“diario oficial”) and are open to all suppliers, they tend to take a significant amount of time.

To improve procurement efficiencies for the CCSS, the Costa Rican legislature approved a separate law for medicines and medical supplies. Law 6914 outlines a more streamlined process specifically for the procurement of medicines, which allows the fund to function with a list of pre-enrolled suppliers for virtually all of the 541 medicines that are part of the “cuadro basico” (basic list) of medicines. The medicines are classified according to their use—and all medicines that are considered necessary for the general population are classified as Category A and purchased centrally by the CCSS. Other medicines considered for specific illnesses, such as for cancer treatment, are classified differently and may be purchased by the health facilities that deal directly with those illnesses. In addition, under Law 6914, health facilities are permitted to purchase medicines directly from the provider in the case of an emergency or impending stockout. Health facilities are also able to trade with other health facilities to prevent shortages.

All entities interested in responding to tenders issued by the fund must be pre-enrolled. Tenders are issued individually according to the type and source of medication being purchased—that is, each medicine has its own individual tender—and suppliers must be registered for that specific medication. There is no direct law that inhibits international suppliers from participating in tender requests from the CCSS. However, there is a law/decreed that favors national suppliers, which states that if proposals are similar in price, the national supplier (manufacturer) should be selected. In this scenario, a 10 percent penalty is added on to the international price as a means of quantifying the added cost to the country of purchasing from abroad. In other words, the decree attempts to quantify the economic value to the country of purchasing from a local producer by placing a 10 percent penalty on international suppliers. If there is a price difference after applying the penalty (with an international supplier providing the better price), then the international manufacturer is selected. However, all internationally manufactured products must be registered and have local representation within the country. All medicines are exempt from sales tax and import duties.

All medications, whether purchased by the CCSS or distributed and sold by a private entity, must be registered at the MOH. The registration process takes 4–6 months. Registration approval is required by origin and, thus, similar products require separate approvals when their origins differ. Medications currently purchased by the fund are tested for quality at CCSS laboratories. However, a recent decree (January 2005) established a national commission for the regulation of medications, and, consequently, responsibility for quality control is being transferred to the MOH. The MOH will test the quality of all medications from all sectors (public, NGO, and private). In addition, the MOH issued a policy (August 2005) that it will require certain generic medications, which it deems to be of high sanitary risk, to be tested beginning in February 2006 for therapeutic equivalence and proper dosage prior to their approval.⁶ Finally, due to public concern about impending changes resulting from the Central American Trade Agreement and increased public vigilance generated by recent government corruption scandals, a healthy public debate has emerged around procurement. Citizens are concerned about the efficiency and integrity of the procurement process for medicines and the quality of health commodities. As a result, new laws, decrees, and policies designed to streamline the procurement process, increase transparency, and improve the quality of products within the CCSS are being widely discussed at all levels of government.

Supply and Distribution for Contraceptives in the Public and Private Sectors

The supply of contraceptive products for both public and private sectors come from international as well as local pharmaceutical manufacturers. There is a well-developed pharmaceutical market in Costa Rica, with more than 48 local and international pharmaceutical laboratories. All the major international contraceptive manufacturers have local representatives and designated commercial representatives that are authorized to import and distribute foreign-manufactured pharmaceuticals. There is also a local, Costa Rican manufacturer of oral contraceptives, which has been the main supplier for the CCSS over the last several years.

As seen in Figure 3, the CCSS (which is the only public sector organization that procures medicines on behalf of the Costa Rican government) is sourcing contraceptive supplies manufactured internationally and imported into Costa Rica, as well as products manufactured locally. In terms of the overall family planning market, the fund is the main provider of family planning services and products in Costa Rica, serving more than 72 percent of all family planning users. As expected, a higher percentage of users of long-acting and permanent methods obtained their method through the CCSS. Ninety-five percent of users had tubal ligation done at the fund or other public health facility. Seventy-six, 65, and 44 percent of users obtained their IUDs, pills, and condoms, respectively, at the CCSS. The fund maintains a central warehouse that is responsible for overall inventory management and distribution of medical supplies to regional hospitals.

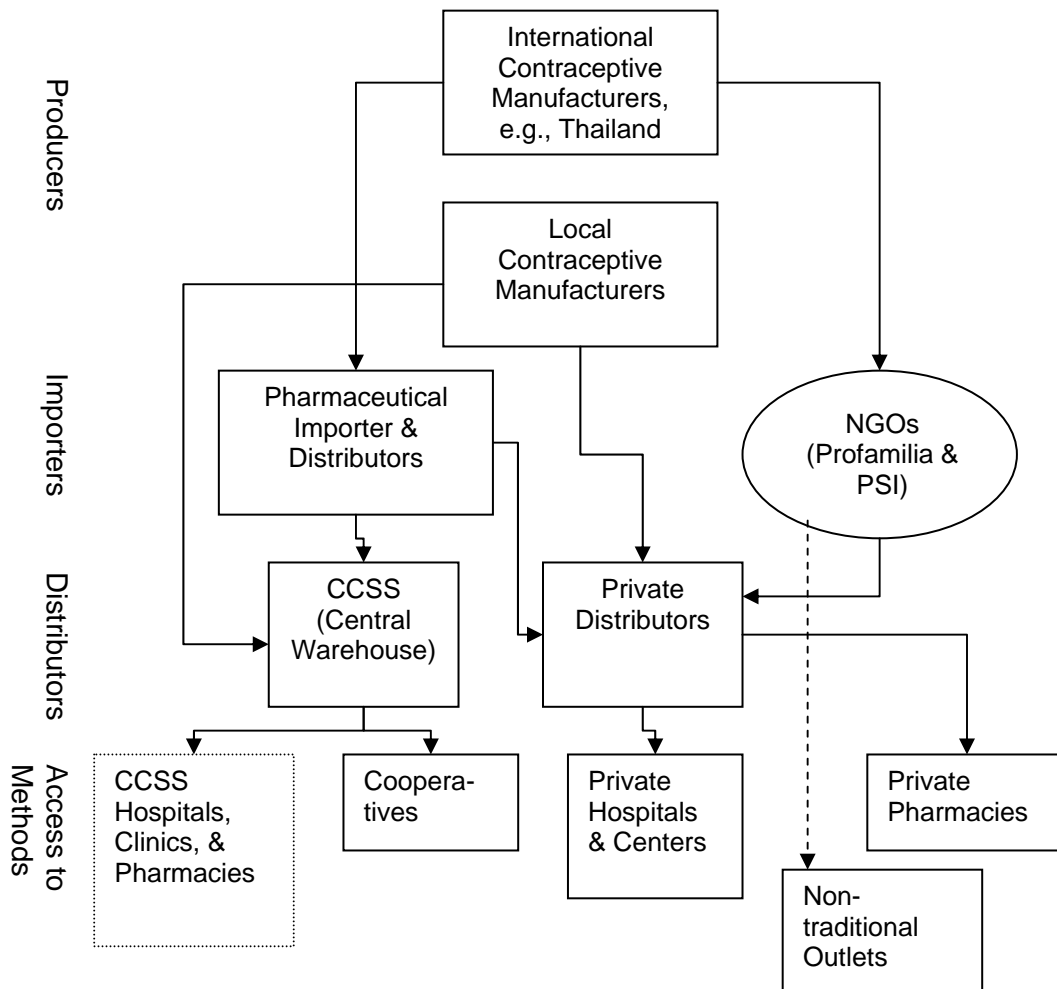
The private market also provides internationally manufactured and imported contraceptive supplies from multinational pharmaceutical laboratories, as well as locally manufactured oral contraceptive products. The internationally manufactured products are imported and distributed through traditional commercial channels. These products are distributed directly to private healthcare facilities, such as hospitals, clinics, and pharmacies. The commercial market serves primarily those users interested in using other, newer formulations and contraceptive products (e.g., lower dose orals, implants, and patches). Approximately 700 private pharmacies exist in the country, as well as several pharmacy chains. There are no regulations on maximum pricing levels or mark-ups for commercial products.

There are two local NGOs, Profamilia and PASMO, that are also procuring contraceptive products on the international market and importing them to Costa Rica. The local NGO, Profamilia, procures and imports

⁶ As of March 2006, the MOH is still developing the list of drugs that will be required to undergo testing for bioequivalence. Source: http://www.nacion.com/ln_ee/2006/marzo/05/pais5.html.

a range of medical supplies and consumer products. It also socially markets the oral contraceptive brand, Perla, which is sourced through the International Planned Parenthood Foundation. In the few pharmacy visits conducted as a part of this study, the Perla brand was not easily found—suggesting that overall distribution may be limited and/or targeted to more peri-urban and rural areas. Profamilia also procures and imports condoms—which are marketed as part of an affordable condom line (Baron). This brand was easily found on visits to pharmacies and grocery stores in both urban and peri-urban areas. Profamilia’s condom was consistently found to have one of the lowest prices on the market. Another local NGO, PASMO, is also socially marketing a line of condoms in conjunction with a regional HIV prevention project. These condoms are also procured internationally through Population Services International (PSI) and imported into Costa Rica. Both NGOs use commercial distributors to ensure accessibility of their products in the retail distribution chain. Figure 3 summarizes the primary supply and distribution mechanisms used in Costa Rica.

Figure 3. Supply and Distribution Chains in Costa Rica



Source: Interviews with key informants.

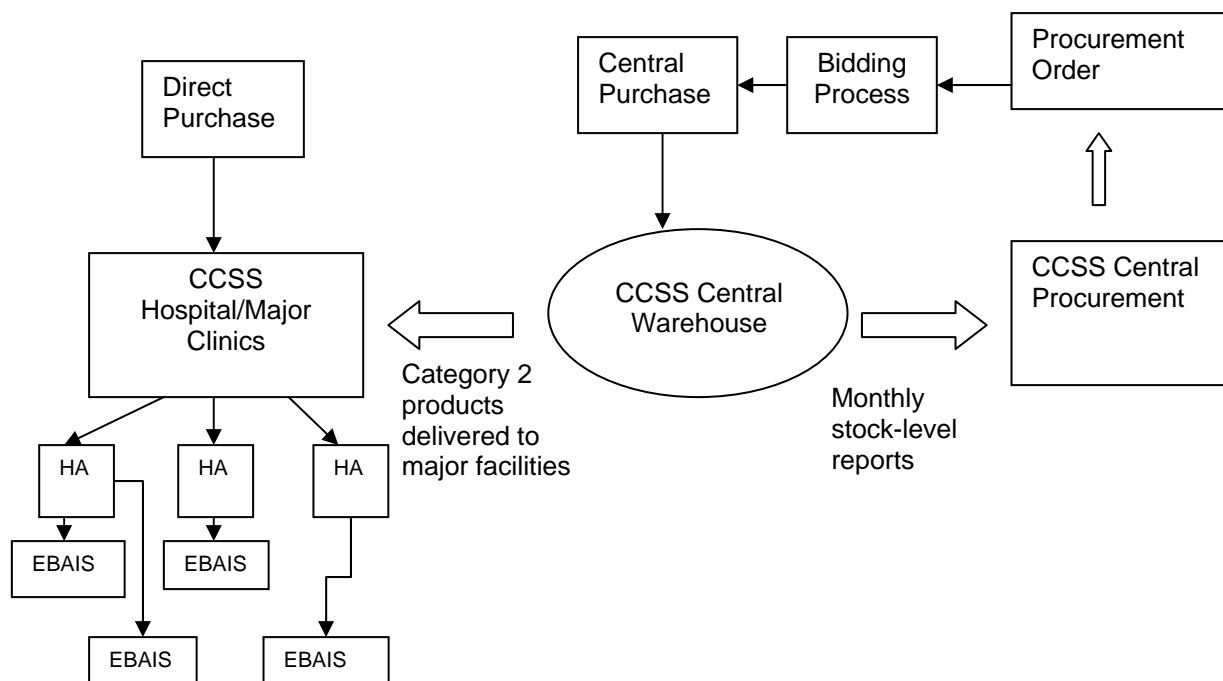
Procurement in the Public Sector

The CCSS has developed an efficient and effective procurement system that ensures the availability of essential medical supplies (see Figure 4). The procurement system is linked closely with the fund's warehousing and distribution system. The CCSS procures all of its contraceptive supplies centrally through its system of pre-enrolled bidders—and the current sources of supply in Costa Rica for contraceptives are all commercial. Contraceptives are considered as part of the “cuadro basico” of medicines in Costa Rica, but there is a relatively limited choice of methods. The cuadro basico includes only two formulations of oral contraceptives, a three-month injectable (Medroxiprogesterona 150 Mg), normal and extra strong condoms, and the Copper-T IUD. The CCSS has procured oral contraceptives through the local manufacturer for the most recent tenders. There are also several distributors that have registered and imported generic injectable products from Thailand to respond to tenders from the CCSS; this importer (Medirep) has been the primary supplier of injectables to the fund over the last several years.

All procurement orders are generated based on monthly reports (from the central warehouse) of the stock levels of the 541 medicines managed by the CCSS. A procurement order is issued when stock levels of any particular medicine fall below nine months of estimated supply. The procurement order requests sufficient quantities of the medicine to ensure stock levels for 24 months of supply. Each product handled by central warehousing has its own technical sheet, which describes the components, administration, presentation, packaging, and required life cycle of the medicine. The technical sheet also includes the necessary quality specifications. Each product is issued as a separate tender—and the pre-qualified suppliers for the CCSS are notified of the tender and invited to bid. Suppliers generally have three days to submit an offer. Once bids are received, they are opened in a public forum, which generates a report of the received offers. All offers are analyzed, and those that meet the requirements of the tender are reviewed by an external commission that evaluates the quality and price of the bid. The commission ultimately recommends which bid should be accepted. In general, the procurement process may take 7–8 months to complete. The CCSS has a low level of stockouts at only 2 percent.

On the ground feedback from informants in all sectors confirms that stockout levels are low at CCSS facilities. As mentioned above, many informants emphasized that they could not recall ever experiencing a contraceptive stockout. However, note that condoms are not included in the basic list of medications. For this reason, Law 6914, which improves procurement efficiencies for the CCSS, does not apply to condoms. Condoms are regulated by the more cumbersome Law 7494 for Administrative Contracting. In various interviews, informants reported considerably more delays in the purchase of condoms than with other contraceptives. Although there have not been stockouts, informants noted that health facilities have had to resort to the emergency option to directly purchase condoms from suppliers in order to avoid shortages. Informants indicated that when engaging in direct purchases, facilities must purchase at much higher prices than those obtained by the CCSS.

Figure 4. Procurement Process in the CCSS



The procurement of contraceptives within the CCSS was relatively stable from 2000–2003 but increased significantly in 2004. From 2000–2003, the fund procured an average of US\$395,000 per year in contraceptives, with only minor variations from year to year. However, in 2004, the CCSS increased its procurement levels by almost 100 percent to US\$778,000 (see Figure 5). The major increase in procurement costs appears to be related to injectable purchases, which have fluctuated dramatically over the years, representing 3 percent of the budget in 2000 and 46 percent in 2004.

Figure 5. Procurement of Contraceptive Supplies by CCSS

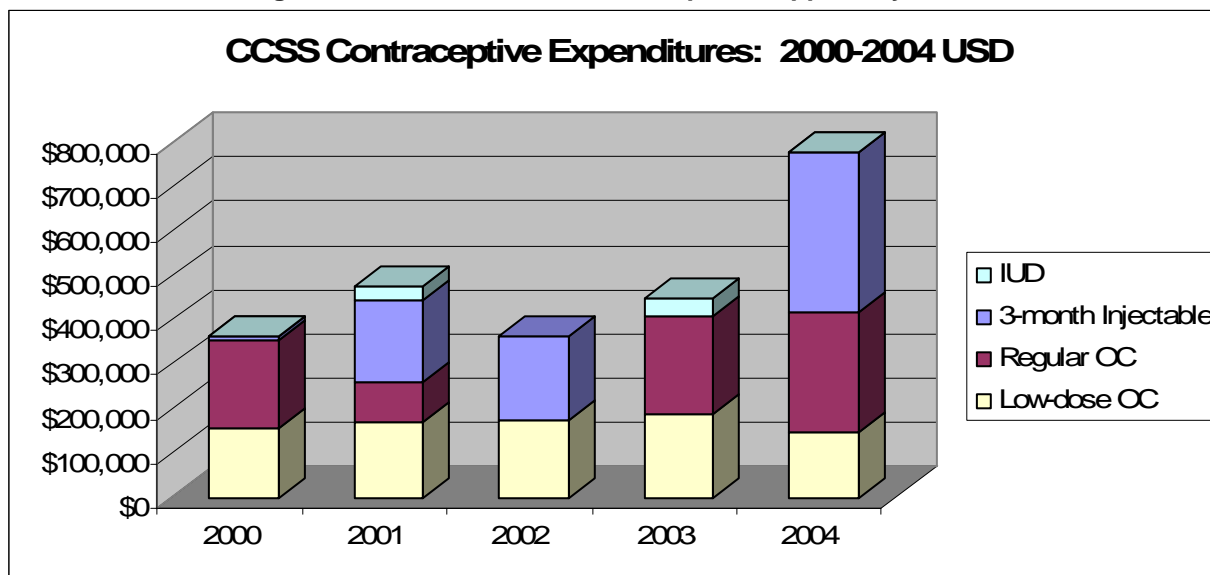


Table 3. Volume and Expenditure on Contraceptive Methods Acquired by the CCSS, 2004

| | Volume | Unit of Measure | Expenditure |
|-------------------------------|---------------|------------------------|--------------------|
| Condoms (extra strong) | 1,560,000 | units | US\$32,760 |
| IUDs | n/a | n/a | n/a |
| Orals (low-dose) | 1,100,000 | units | US\$148,500 |
| Injectables | 344,080 | units | US\$359,577 |

The CCSS is also currently developing and evaluating new strategies to further improve procurement efficiencies and ensure more competitive prices. Table 3 reviews the volume and expenditure on contraceptive methods acquired by the CCSS in 2004. Staff mentioned the limitation of supplying a small market when negotiating prices with suppliers. They have considered the possibility of merging with larger countries (e.g., Brazil) to conduct what they describe as “parallel” purchases—whereby they would purchase some medications directly from these larger countries to gain access to the same economies of scale. This strategy has still not yet been fully evaluated, and CCSS staff are still discussing the details.

The fund has also considered establishing its own capacity as a legal importer of medical supplies, whereby it would compete side-by-side with other commercial suppliers in responding to tenders for medical supplies. There are several regulatory changes that would have to be implemented for this to be feasible, but it is another unique strategy that the CCSS is considering.

The fund is also looking at ways to improve efficiency through technology; and has considered the feasibility of automating tenders, increasing use of the Internet as a procurement vehicle, and even conducting its own procurements online.

Withdrawal of USAID Support

In support of the activities of the Program for Consolidation of Family Planning and Sexual Education in Costa Rica—led by the National Population Committee (CONAPO)—the United Nations Population Fund provided the first international donor support to Costa Rica for family planning from 1974–1978.⁷ From 1983–1988, USAID provided significant support to Costa Rica in reproductive health and family planning through a project agreement with the Demographic Association of Costa Rica (ADC), which served as the executive secretariat for CONAPO. The ADC was responsible for managing the project’s overall resources, as well as for importing and distributing commodity donations. This project was designed to increase the public sector’s participation in the provision of reproductive health and family planning services—as well as to increase the provision of services by the private and NGO sectors.

From 1988–1993, USAID provided its final support to Costa Rica’s family planning program through an agreement with the CCSS to assist it with assuming total responsibility for the family planning program by the end of 1993. By this time, the MOH had already transferred all of its healthcare facilities to the CCSS as part of the health sector reform. According to one official that was involved in the final USAID project, there was already significant political support for family planning within the government and CCSS, as well as the technical and management skills to fully support the program.⁸

⁷ Fuente: Asociación Demográfica Costarricense. Información sobre los programas de población en Costa Rica y las actividades de la ADC. 1990.

⁸ Telephone conversation with Ms. Betsy Murray, former USAID Mission representative in charge of the family planning program.

COST STRUCTURE AND PRICE ANALYSIS

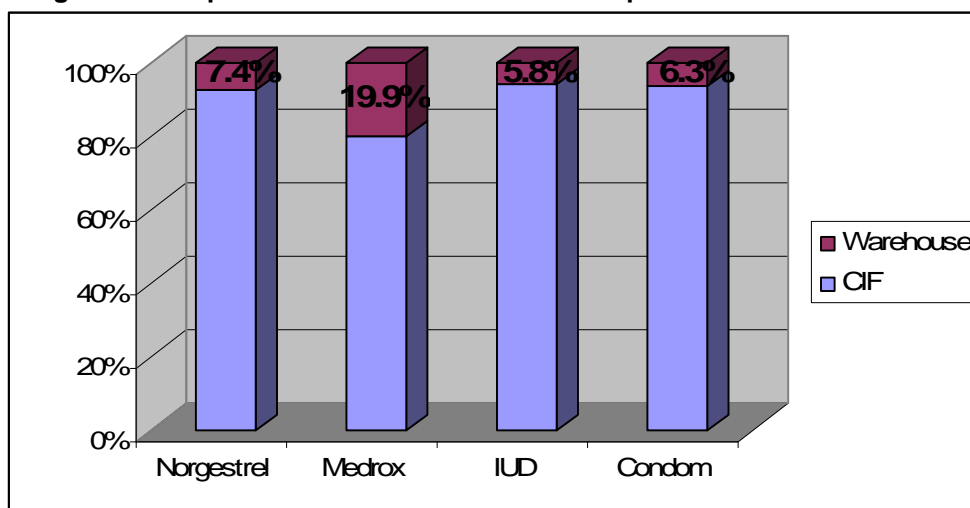
The assessment of supply and distribution channels for contraceptive products also included a review of the cost structure related to contraceptives. In the public sector, contraceptive products are distributed for free; therefore, the analysis included only the cost structure at various levels for contraceptives. The assessment also included a review of contraceptive prices for the private sector. For proprietary reasons, commercial manufacturers and distributors were reticent to share CIF prices, so the estimates provided here are based on estimated margins. In general, NGOs were more willing to share cost and pricing information.

Public Sector Procurement Costs

The CCSS has procured contraceptive products at competitive pricing levels during the last five years. The cost of oral contraceptive products has ranged from US\$.25/cycle to US\$.13/cycle for its low-dose product, with pricing levels gradually declining over time, with the lowest pricing level achieved to date during 2004. The standard dose pill procured by the CCSS has ranged from US\$.24/cycle to US\$.27/cycle, with prices increasing slightly since 2000. The pill products have been procured consistently from Gutis, a Costa Rican manufacturer. The cost of the three-month injectable procured by the CCSS ranged from US\$.78/vial to US\$1.12/vial, with costs gradually increasing over time. This product was procured through a local importer, Medirep, and manufactured in Thailand. Because these products are procured directly from local importers/distributors in Costa Rica, the CIF prices are unknown (confidential). However, the CCSS publishes its procurement costs for all tenders—which includes the CIF as well as a margin for the importer/distributor.

Each healthcare facility, in its annual budget plan, must project costs for all required medications, including contraceptives. The cost of these medicines is deducted from the facility's available budget each time it requests products from the central warehouse. The CCSS central warehouse provided the costs paid by health facilities for each contraceptive product, allowing us to estimate the additional warehousing and distribution costs represented in Figure 6. For pills, IUDs, and condoms, the procurement costs represent approximately 93–95 percent of the total costs—and warehousing and distribution represent between 5–7 percent. For injectable contraceptives, warehousing and distribution costs appear to be higher, representing almost 20 percent of the total commodity cost.

Figure 6. Components of the cost structure for public sector commodities



Retail Prices for Contraceptives

The private sector prices were collected for several contraceptive products available in pharmacy outlets. For each product, several price points were collected from different parts of the capital. The average prices for these products are summarized in Table 4.

Table 4. Retail Prices for Contraceptive Products

| Product Category | Product Brand | Average Retail Price |
|---------------------------|----------------------|-----------------------------|
| Oral Contraceptive | Yasmine | US\$19.48 |
| | Microgynon | US\$5.85 |
| | Nordette | US\$5.66 |
| Injectable | Depo-Provera | US\$9.04 |
| | Mesigyna | US\$7.66 |
| Condom | Durex | US\$.67/single condom unit |
| | Baron | US\$.36/single condom unit |

CONCLUSIONS AND LESSONS LEARNED

This review of Costa Rica’s contraceptive procurement practices suggest that the country program has been successful in maintaining a consistent supply of contraceptives from a variety of sources. The Costa Rican government received its final contraceptive commodity support from international donors more than 12 years ago. In 1992—just before USAID’s withdrawal from Costa Rica—contraceptive prevalence was already high at 75 percent. The latest reproductive health survey conducted (1999) showed another increase in prevalence to 80 percent—almost six years after USAID’s withdrawal. The key factors that have contributed to the program’s continuing success, based on this study, are summarized in the following sections.

Legal and Regulatory Environment for Procurement

Although Costa Rica does not have a strong legal and regulatory environment supporting reproductive health rights—and family planning in particular—the procurement regulations and norms for all health products are well established and have also served to facilitate the procurement of contraceptive commodities. Law 6914, which outlines a more streamlined process for the procurement of medicines, allows for a much more efficient and timely procurement process.

Supply and Distribution Mechanisms

The CCSS has played a major role in providing contraceptives for more than 72 percent of users—at the same time that the overall health system was in a major transformation. The strength of the public sector system remains in its consistency and reliability in ensuring that the products included in the “cuadro basico” are readily available. However, there have been relatively few changes in the cuadro basico to expand the range of methods, such as low-dose pills, implants, and patches. The private sector, however, seems to have filled the niche in the market place. The private pharmaceutical market has continued to introduce a wide range of contraceptives for those consumers with the ability to pay commercial prices for their products. And although the NGO sector accounts for only a small percentage of the overall contraceptive market, it has also sustained its important role in the social marketing of condoms by ensuring that affordable products are available and by developing informational and educational messages to support HIV prevention.

Public Sector Procurement

There are several unique factors related to the Costa Rican experience that have served to facilitate contraceptive procurement. First, the procurement of all medicines and medical supplies is driven by a transparent and autonomous procurement process. Because procurement orders are generated automatically by the central warehouse system (based on supply levels and projected consumption), there is little room in the process for political pressure and/or stalling tactics that could be used to inhibit the procurement of contraceptive commodities.

Second, there is a single agency in Costa Rica—the CCSS—that procures all medical supplies for the public sector, which provides the agency with a strong leveraging position with commercial suppliers—even though Costa Rica represents a relatively small market. As the CCSS procures the majority of its medicines centrally, it has significantly more negotiating power, as well as more control over the quality of products received.

USAID Phaseout

The phaseout of USAID support for contraceptive commodities reflected the achievement of an overall supportive environment for reproductive health and family planning. In general, contraceptive prevalence had reached a mature level, the government's support for family planning and reproductive health had been institutionalized, and the program and the public health sector had the technical and financial capacity to meet the family planning needs of the Costa Rican population. These critical factors set the stage for a smooth transition from USAID support.

Cost Structure and Price Analysis

The cost information provided by the CCSS suggests that the fund has established several cost-effective alternatives for the procurement of contraceptive supplies. The commodity costs incurred by the public sector are quite competitive internationally. The fact that the CCSS can procure a locally manufactured oral contraceptive product gives it an important alternative that is not available to many countries. It is likely that the retail prices for contraceptives are higher than those found in the rest of the Central American region, given the slightly higher per capita income in Costa Rica.

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