DISSERTATION FOR THE UNIVERSITY OF LIVERPOOL

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

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ABSTRACT

The main objective of this research is to analyse the effectiveness, efficiency and equity of integral health prevention and promotion at the primary health level in Costa Rica, i.e. following the Basic Equipment of Integral Health (BEIH). The methodological framework proposed by Scha et.al. (2013) was used to analyse the structure, processes and results in order to best comprehend the degree of promotional and prevention initiatives at this primary level. This research was limited to a general study of the South Central Regional Direction which is integrated by 45 health areas and 367 BEIHs. The data was obtained by qualitative instruments: in-depth interviews, surveys and an expert panel session.

The main findings of this research regarding management deficiencies in health promotion and disease prevention at the primary health care level are the following. Firstly, the operationalization of the diverse international and national laws concerning an integral health perspective 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 prevention and promotion, 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 CSSF 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 grossly 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. There are no financial or human resources and the 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 to the management level do not possess the necessary skills to allocate resources and manage them appropriately.

1. INTRODUCTION

Like many health systems around the world, the Costa Rican Health System is facing management challenges in order 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 will focus on the primary health care level (specifically the Basic Equipment of Integral Health Care) which belongs to the Costa Rican Security Fund (CSSF), an autonomous state institution, part of the Costa Rican Health System. The study will explore the extent to which the primary level is focused on health promotion and disease prevention (Kawachi, Subramanian & Almeida, 2002).

1.1 Background

Preventive and promotional health have evolved. The strategies gathered 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. Additionally, health systems in many countries have encountered serious problems in terms of effectiveness, efficiency and equity of services (Whitehead, 2007; Kawachi et.al., 2002).

Going back in history, the National Health System in Costa Rica had already gone through care models reforms (Herrero & Collado, 2001), but just after the 80's better definitions of tasks for the Health Ministry (HM) and the Costa Rican Social Security Fund (CSSF) were established due to high levels of demand and need, however the model was not working properly. The Health Ministry was in charge of the control and monitoring of the health sector and the CSSF impacted the provision of health services provided to the population. Since then, the Costa Rican Social Security Fund has been working as an autonomous institution focusing on promotion, prevention, healing and rehabilitation, nonetheless, 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 problems, a national 2010-2020 health policy was established (Avila et.al., 2010), which essentially 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 CSSF's local level which encompasses three health care levels. The study considers the primary health care level, responsible for health prevention and promotion, low-complexity healing and rehabilitation in order to elucidate the reasons behind management deficiencies regarding promotion and prevention issues at the Basic Equipment of Integral Health (BEIH). 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 approach and adopt social determinants of health (employment, housing and environment, among others).

1.2 Research objectives and questions

In order to analyse the effectiveness, efficiency and equity of integral health prevention and promotion at the primary health level in Costa Rica, i.e. following the Basic Equipment of Integral Health (BEIH) 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 in order to promote an integral health and prevent disease?
- Does the Basic Equipment of Integral Health Care (BEIH) have a proper internal management and organizational culture?
- To what extent are the tasks of the BEIH in terms of prevention disease and promotional health well defined?

1.3 Research methodology

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 in order 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 Regional Direction integral by 45 health areas and 367 Basic Equipment of Integral Health (BEIH). Furthermore, qualitative instruments were used, mainly “in-depth interview”

with 15 experts and officials from the Ministry of Health and the Costa Rican Social Security (CSSF). 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, 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 the researcher to assess the performance evaluation system of the organization using assessment criteria.

1.4 Results

Results and analysis discuss the main findings regarding management deficiencies in health promotion and disease prevention at the primary health care level. Data collection 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.

This chapter is divided into three areas: structure, process and outcome. According to experts, there are international and national laws as well as public policies that determine the course of promotion and prevention issues 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 in order to truly comply with promotion.

1.5 Synopsis of the chapters

Chapter one introduces the background of the Costa Rican Health System in order to explain and aid in the understanding of the management organizational practices and its insufficient work on promotional and preventive issues a locally, specifically following the Basic Equipments of Integral Health (BEIH) which represents the primary health care level.

Chapter two presents a literature review in which various explanations and interpretations of management, health promotion and disease prevention from different sources are contrasted. The chapter also provides insights into the main concepts that guide the study. Moreover, this chapter provides an international and national context on topics that have been previously researched and that are analysed in the light of new studies. There have been many debates regarding concepts like health and integral health, health promotion and disease prevention. Furthermore, health systems are facing management struggles and population's demands especially because they have been centralized following a biologist and preventive approach.

Chapter three provides the main research methodology taking into account of the combination of management, health promotion and disease prevention. The selected methods and tools will aid in focusing on the research questions and to organize the fieldwork with an accurate model in order to collect data and solve the research problem. The research arose some central questions that will be answered throughout the research process and which have implications for future studies.

Chapter four displays the information and data obtained through fieldwork. It is organized considering the major issues discussed by experts and users. Following the four research questions adopted for this research, information is analysed and interpreted in order to explain the findings and how to solve the main challenges.

Chapter five presents a summary of the main conclusions found in the previous section. It summarizes the main issues which arose from the results and the analysis presented with recommendations on how to improve the deficiencies in management at the primary health care level regarding promotion and prevention issues. The purpose is to analyse the data collected so as to better explain the management deficiencies at its primary care level in Costa Rica. Essentially, the implementation of the Health Promotion Committee will play an important role at a national level in the improvement and organization of health promotion initiatives, as well as, the monitoring of the work of social actors.

1.6 Conclusion

There have been significant changes at the primary health care level, but it is now time to rethink and redesign a more inclusive model, one truly based on the social determinants of health that looks to highlight health promotion in a broader approach. Moreover, both students and the population as a whole should be educated in the difference between promotion and prevention, resulting in them adopting a healthier lifestyle, at a physical, mental, social and spiritual level.

Furthermore, it is also relevant to consider the cultural organization through which the internal processes at the primary health care level could be improved, changing old promotion paradigms. Also, planning and management need to be linked to budgets and this involves professionals with management or administration skills in organizational management, budgets, human management,

community treatment, community health and resistance to change. It is required that the communication, management and participation of different actors within the primary care level, i.e. The Basic Equipment of Integral Health (BEIH) work on promotion and prevention issues. The next chapter provides an overview of the literature review that aids in the understanding of what researchers discuss when it comes to health promotion, disease prevention and the management of health systems.

2. LITERATURE REVIEW

This chapter firstly introduces a few conceptual clarifications regarding health and integral health and health promotion and prevention. Subsequently a selection of essential findings discovered at the primary health care management is presented, followed by an overview of the Costa Rican case. The purpose of this chapter is to introduce the main issues regarding health promotion and disease prevention. Some views and strategies about these concepts in different historical contexts will be discussed. Health systems around the world are facing challenges in their management and population demand of services. This situation arose due to the great complexity involved with the term health and the different programs implemented in order to improve health, which have tended to centralize the biologist and preventive approach.

The research is focused on Costa Rica's health system, which adopted what the World Health Organization (WHO) has defined as health: "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). This conceptualization surpassed 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 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 different reforms in its care model (Mosh, 1983; Herrero & Collado, 2001), in which tasks for the Health Ministry (HM) and the Costa Rican Social Security Fund (CSSF) were not clear; the roles were later defined, assigning to the HM the

responsibility of controlling and monitoring the health sector and assigning to the Costa Rican Social Security Fund the responsibility of providing health services to the population.

Knowing that the Costa Rican Social Security Fund (CSSF) is the organization responsible for health services, the study will be based at a local level which is integral by three health care levels. At the primary care level, the Basic Equipment of Integral Health Care (BEIH) is responsible for health prevention and 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 will allows the researcher 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.

2.1 Definitions of health and integral health

There have been numerous attempts to define health from anthropological, medical, historical, philosophical and sociological perspectives. Indeed, health is the subject of a seemingly endless semantic debate. The difficulty in defining health can be explained due to the fact that the notion of health is used in multiple contexts. Semantic complexity is additionally increased since the notion of health awakens idealistic hopes for a "stable life". If searching for the one true meaning of 'health' is difficult, it is even more so when it comes to the term 'integral health' since there are abstract terms, such as "peace," "justice," or "happiness" (Callahan, 2012). There are convoluted views expressing

that integral health cannot be defined because it involves the word "integrity", i.e. if any human need has not been satisfied, it is impossible to talk about a welfare state (Medicus Mundi, 2011; Callahan, 2012). Defining a unique concept would be complex, especially because the welfare state can be seen from a subjective (personal point of view) or objective perspective (absence of disease), in which it is viewed more as a process and not as a state (Ponte, no date; Callahan, 2012).

The debate on health and welfare state is essential, especially if it is analysed in light of the social justice principle that requires social inclusion and opportunities. Welfare States were established as a general model of social organization with a central role: the provision of services and social guarantees to its citizens, including health (Baldock, Manning & Vickerstaff, 2012, p.23). The welfare state in Costa Rica was improved with a new social security system that served to promote a better health helping people to take responsibility for their lifestyles (Dixon, 2002). Rudolph Virchow (1821-1902 cited in Rojas, 2004) explains that "medicine is a social science and politics is about health".

Since the 1950s, the World Health Organization (WHO) adopted the term 'health' (Sequeira, 2010, p.26) assuming 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 saying 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.

Health has been considered as "a level of the functional or metabolic efficiency of a human being" (Nordenfelt, 2007). The body and mind undergo several stages, where illness is understood from a

change in the internal state of a person (physical or mental), which could cause distress and impair some functional skills "below typical efficiency", but health is not considered as the complete absence of a disease, because there is an illness, a physical and / or mental discomfort and not a complete well-being. The two concepts are intersected through a functional ability. Others (Berridge & Gorsky, 2011; Minniss, Wardrope & Johnston, 2013; Resnik, 2009) suggest adding other elements in order to formulate a more comprehensive concept, e.g., one in harmony with the environment, or as Corrales, Urrutia & Porras (2007, p.6) argue, "like a constructive social process" in which complete well-being can be achieved only through individual and collective strengthening (Corrales, Urrutia & Porras, 2007, p.6).

According to Medicus Mundi (2011) "health is usually designed with a single criterion, without considering that this concept varies in different societies, as well as their practices" (Medicus Mundi, 2011, p.3). Health is definitely a multiple, relative, dynamic and open concept (Mosh, 1983; Sequeira, 2010). There are also other opinions arguing that integral health does not exist, it is a utopian term, impossible to measure, and an inadequate once because of the "inaccuracies of physical, mental and social concepts, the utopia to achieve the full welfare state, the failure of not relativize the concept, the static nature, and lack of clarity, if it is an individual or collective level" (Medicus Mundi, 2011, p.3). The conceptualization debate will continue and for some the most important issue is focusing on health level's improvement, known as health promotion by preventing diseases (Mendez & Costa, 2011). Redondo (2004, p.15) explains that promotional activities start with healthy people looking to promote better and healthier individual or community lifestyles.

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".

This definition is similar to 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 determine their 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).

For all practical purposes, 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 will be the term responsible to guide all this research. 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 so as to cover its multidimensionality, which complies with the social determinants of health (Medicus Mundi, 2011, p.4) (Medicus Mundi, 2011, p 0.8). 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 an integral health.

Figure 1. Medical Model vs. Inclusive Health

Concept from the medical model	Inclusive concept of health
Biologist Individual Historical	Multidimensional Individual, Family, Community, Environment Procedural

Source: 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. p.100, "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". 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, p.12 claims:

> *"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".*

The researcher neither intends to solve this debate nor have the final word on the subject. Since the latter concept seems to be most realistic, it will be used next to the WHO's concept in order 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 explores to what extent management at the primary health care level undertakes promotion and prevention tasks following the concept of integral health.

2.2 Health promotion and prevention

Due to the concept of health, 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). Due to how difficult it is 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 about Health Promotion was celebrated in Ottawa (Canada) where the Ottawa chart was elaborated (WHO, 1998, p.7) and currently it is the basis to elaborate on other issues related to health policies.

This chart essentially incorporates the concept and application of Health Promotion (Lalonde, 1981) once the need arose to look into new strategies to assist 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 organizations and people world-wide to adopt other ways to work on health issues. In 1997, the WHO established and approved its Jakarta Declaration about 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 centralized one including prevention and promotion, resulting in a holistic approach to health systems world-wide and gaining commitment 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 takes into account a political and social world-wide 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 progressive disease (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 evidently 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 that seeks to implement initiatives and improve people's health by orienting them with information, education, influence and assistance to achieve a better responsibility in their lives and well-being (Donev, Pavlekovic & Zaletel, 2007).

Prevention can be seen at 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 Días, 2011) allows to make risk factors of contracting a disease innocuous by using control tools to anticipate possible effects. Figure 2 shows the main differences between promotional health and prevention of disease according to Redondo (2004) and Hernández (2010).

Figure 2. 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
Requires good social structures	Specific measures for the control of certain diseases
Great potential to improve health indicators	Identifying modifiable causes of disease
More effective if started early	More effective if it is stopped 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, in order 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)

Sources: Redondo, 2004, p.16; Hernández, 2010

According to the WHO, adopting a promotional broad approach could be more relevant for countries that have just one axis, i.e., those countries that emphasize more 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 actions 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 of public health promotion / prevention has been seen as a consistent and harmonic responsibility between 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). Health promotion is considered a means or resource to help people in their economic, social and individual lives, and it should not to be presented as an abstract condition. In other words, health promotion can be considered as an equivalent of "new public health". New public health considers the social determinants in order to improve health promotion from an integral perspective.

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, this goal is often limited because of practical obstacles. This study does not seek to

stress or debate about the meaning of promotion and prevention but to analyse the extent to which there are deficient management practices at the primary level (Callahan, 2012).

2.3 Management Model: Primary Health Care

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 addresses at 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 responsible one for health promotion, advocacy, and influence in the formulation of policies and programs (WHO, 1998, p.13). Later chapters will assess the extent to which these priorities have been kept by the Basic Equipment of Integral Health (BEIH) in Costa Rica's Health System. As mentioned above, primary health care is the main gateway to health care or prevention/ promotion and it is where most concerns should be solved (Beaulieu, et.al., 2013, p.1). For the purpose of this research, the model of the Costa Rican health system is studied, specifically restricted to the first level of care. This way, the analytical characterization of the primary care level of the public health system will be analysed in its health/disease conception, promotion and prevention knowledge and practices, as well as organizational 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 defines 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 may 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 is presented. 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?

2.4 The role of the primary care level

Researchers (Pinto et.al., 2012; Arar et.al., 2011; Akhtar-Danesh et.al., 2013) consider possible promotional and preventive issues through the primary care level of health (PC). **"**It serves as the entry point where core medical and preventive care are delivered" (Crooks & Andrews, 2008, p.6; Mosquera, et.al., 2013). In order to achieve complete welfare, in the former definition, it is necessary to implement initiatives at the PC, which is the main contact with society. Starfield (quoted in Akhtar-Danesh, et.al., 2013, p.2) argues "that it provides person-focused (not disease-focused) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others".

The importance of health care changed its focus to promotional and preventive health initiatives (Comino, et.al., 2012, p.1), defined as a process which helps people to care for their health using participatory approaches "(selection, decision-making authority over planning, budgeting, execution, managing, evaluating and monitoring of activities, follow-up) with individuals, organizations, communities, etc. should be transferred from the national level to the local level" (Cleary, Molyneux & Gilso, 2013). It consists of environmental changes which serve to protect health.

It has been a challenge for many countries, including Costa Rica. Practice has been limited in terms of real initiatives to use an integral perspective that overcomes deficient management at the primary care level of health (PC) for the whole population as real public health (Whitehead, 2007; Bambra, Fox & Scott-Samuel, 2007). Integral health at the primary care level considers activities for society in order to

promote, improve and protect initiatives, and generally speaking, to restore their health. Regardless of its importance, the only way to truly achieve integral health is through the PC being supported by public policies as the main tool to plan strategies and assist population (Pinto et.al., 2012). Its integration encourages inter-sectorial collaboration, allowing different actors to participate: communities, citizens, companies, government institutions, faith communities, NGOs, social and cultural organizations, physicians, health workers and governments, among others. Pinto, et.al. (2012) suggest trans-disciplinary collaboration - inter-sectorial integration - characterized by work with diverse knowledge and solutions in order to promote health. Pinto et.al. (2012) and Akhtar-Danesh et.al. (2013) conceptualize a collaboration encompassing networking, cooperation and coordination.

Despite the tendency to establish partnerships between actors, little is known about the "values, beliefs, and attitudes of that collaboration in public health" (Akhtar-Danesh, et.al., 2013, p.3) i.e. the degree of promotion and prevention which could improve integral care processes. The diagnosis is well known and different actors agree "stronger integration" is needed (Akhtar-Danesh, et.al., 2013, p.14). However, the consideration of how to implement this integration is underdeveloped and "approaches and perspectives differ" (Akhtar-Danesh, et.al., 2013, p.14).

2.5 Costa Rican Primary Health Care Level (PHC)

Both disease prevention and promotional health have evolved. The strategies collected in documents such as the Alma-Ata 1978 (WHO, 1978), the Ottawa Conference 1986 and, more recently, the Health Program for All 2000 driven by the OMS 1981 can be highlighted (Corrales, Urrutia & Porras, 2007, p.10). Moreover, health systems in many countries have encountered severe difficulties in terms of

effectiveness, efficiency and equity of services (Grabovschi, Loignon & Fortin, 2013, Mosh, 1983). This situation caused the reformulation of existing and developing new management methods.

These facts led to focus more on the social determinants of health, specifically, environment and lifestyle in order to redirect the health services towards a more preventive and promotional initiatives (Ávila, et.al, 2011, p.12; Mosh, 1983). Additionally, the concept of health has also evolved to a "public" terminology that extends its perspective to groups of individuals / populations (Avila, et.al., 2010; Comino, et.al., 2012, p.1).

The International Epidemiology Association (quoted in the National Commission on Specialization in Spain, 1996, p.353) has defined and grouped preventive medicine and public health as "a specialized field of medical practice composed of different disciplines that use techniques designed to promote and maintain health and welfare, to prevent disease, disability and premature death. Also as an initiative organized by society to protect, promote and restore health population". The National Health System in Costa Rica has also experimented different reforms in its care model (Mosh, 1983; Herrero & Collado, 2001). During the 80's, Costa Rica suffered a health care crisis. There was high demand and need, but the model was not working properly. Promotional and preventive tasks of the Costa Rican Social Security Fund and the Health Ministry were the same, both institutions had their functions duplicated (Ávila, et.al., 2010).

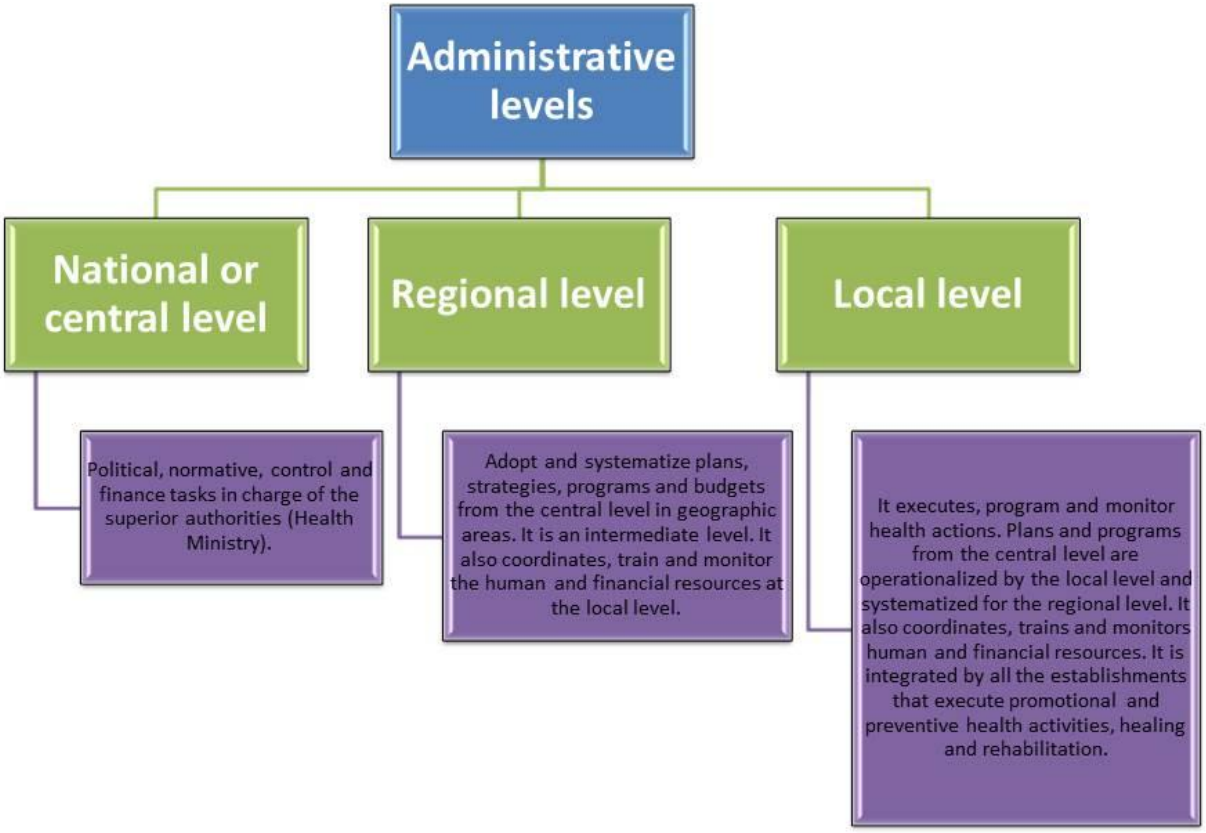
Furthermore, functions were restructured. The Health Ministry was given the responsibility of controlling and monitoring all the units and the Costa Rican Social Security Fund was made responsible for providing health services to the population. The system adopted a biologist care approach, merely based on healing which also lacked follow-up care (García, 2004; Avila, et.al., 2010). Due to inadequate distribution of resources, increased costs and inequity, limited social participation, among other factors, the restriction of the health system did not lead to higher efficiency or quality (Mosh, 1983; Herrero & Collado, 2001). Today, the National Health System in Costa Rica is integrated

by different public and private institutions and organizations directly or indirectly responsible for health and population welfare:

- Health Ministry
- Costa Rican Social Security Fund (CSSF)
- Municipalities
- Communities
- Costa Rican Institute of Aqueducts and Sewers
- National Insurance Institute
- Public and private universities and institutions, in charge of health professional training
- Private health services, cooperatives and self-management companies that provide health promotion and preventive services.

On November 09, in 1989 the Health System was formally established by an Executive Decree. According to García (2004, p.10) "it included all the elements or components of the social system related, directly or indirectly, to the population health". Their integration would be made by state institutions of the health sector working directly with the topic, as well, as other institutions that do not necessarily work directly with health (at least in medical terms). The decree assigned responsibilities to the Health Ministry, to direct and coordinate and to ensure the health sector functions and its services actually achieve health and welfare for the whole population (García, 2004). Despite these tasks, the Costa Rican Social Security Fund works as an autonomous institution in charge of health services provided for the entire population under the principles of solidarity, universality, unity, binding, equality and equity (Mosh, 1983; García, 2004). It also provides financial and social protection to the insured population and those with limited resources. This institution is organized in three administrative levels to fulfil national responsibilities (Figure 3):

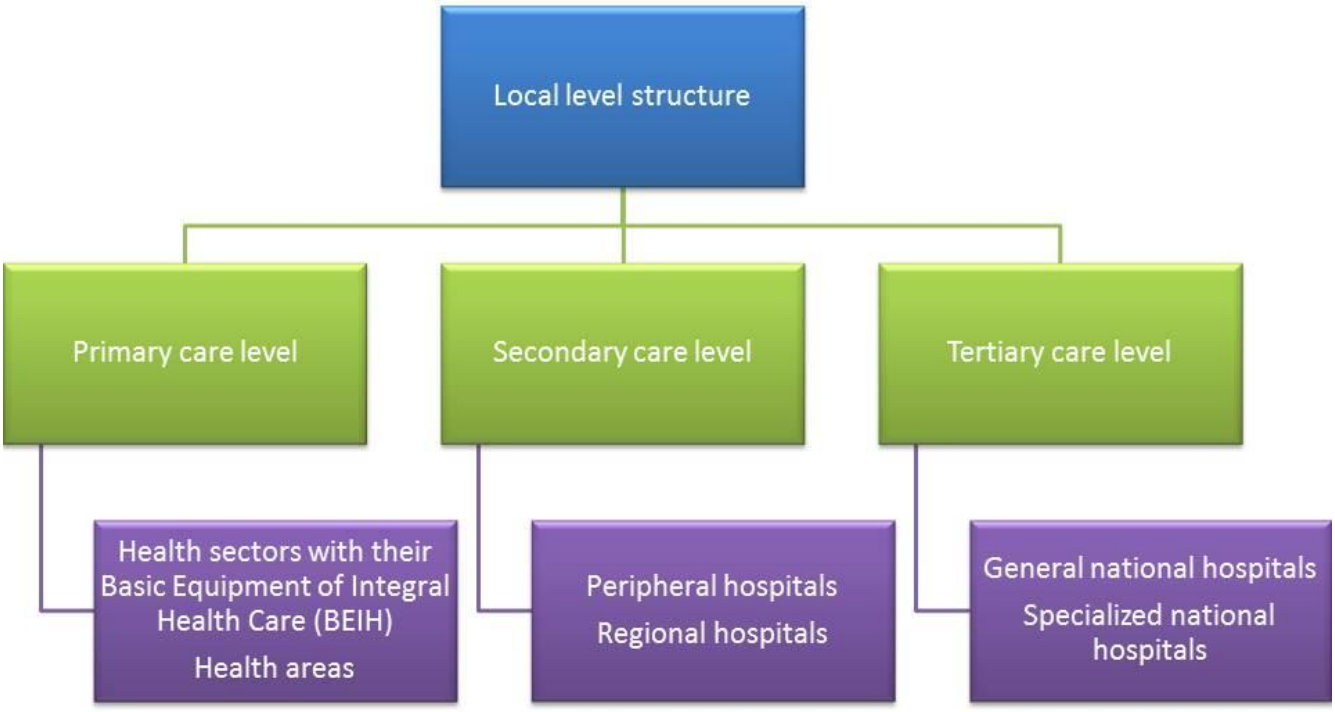
Figure 3. Administrative levels of the Costa Rican Social Security Fund (CSSF)



Source: Own elaboration, 2014

This local level is in charge of the programming, implementation and monitoring of health activities. It is integrated by different physical spaces (See Figure 4) that work on promotion, prevention and rehabilitation activities responsible for health services. Because each one works with different health needs and issues of different complexities (low and specialized care), they are organized in different care levels. Figure 4 presents the local level structure of the Costa Rican Social Security Fund, as explained previously, it is integrated by this physical spaces grouped into health care levels.

Figure 4: Local level structure of the Costa Rican Social Security Fund



Source: Own elaboration, 2014

At the primary care level, the Basic Equipment of Integral Health Care is responsible for prevention and promotion, low-complexity healing and rehabilitation. They fulfil external requirements, general medicine of health clinics and centres, communal visits, schools, work centres and houses (García, 2004). 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 involving complex specialties and subspecialties. The whole model has experienced numerous

modifications. In fact, these three care levels were also improved, but the primary care level has been the most readjusted and the object of this research.

As explained previously the primary care level is responsible for providing basic health services completed by promotion, prevention and rehabilitation healing tasks with little complexity. This role is played by the Basic Equipment of Integral Health Care (BEIH). This level is the first point of contact with the population and performs tasks of "external consultation, general medical clinics, health centres, communal offices, homes, schools and workplaces" (Garcia, 2004, p.26). Its goal is to provide the entire population the right to basic care from health services and to basic conditions in which they can develop and manage their health. In the following section the BEIH and its functions will be explained within its context.

2.6 Primary care level: Basic Equipment of Integral Health Care (BEIH)

Since the 80's the readjustment of the health system involved principles of universality, solidarity and equity (García, 2004) reflected in a primary care strategy implementation supported with an integral and integrated care from a bio-psycho-social (health-illness) approach (Mosh, 1983; Sequeira, 2010). This improvement mixed preventive and promotional actions, healing and rehabilitation care directed to individuals, families, communities, according to their opportunities and risks pertinent to different age groups (children, adolescents, and adults). Initiatives to preserve and improve the environment where they live, work, study, and enjoy were also incorporated (Comino, et.al., 2012, p.1).

According to the national health policy, these actions consider different groups and sectors so as to coordinate actions. Based on this line of argument, the model's focus was not exclusive to health services or to the Costa Rican Social Security Fund (CSSF), but required an active participation of

other groups, individuals or institutions of society to fulfil the integrated and integral model, with care follow-up and social involvement from the community. The reform involved an organizational change, mainly in the activities at the primary health administered by the Ministry of Health (Sequeira, 2010). Activities (promotion and prevention regarding prenatal control, growth and development in children aged 0-6 years old and family planning and vaccination) were transferred from the Health Ministry to the CSSF, as previously pointed out. The CSSF is thus an autonomous institution that is part of the health sector.

In the 90's, the Basic Equipment of Integral Health Care (BEIH) was developed by the CSSF. The BEIHs are the first frontline of the provision of health services. Each BEIH is responsible for the health care needs of its community; a Health Area is an administrative unit in charge of several BEIH which handles management, budget, logistics, and resource distribution tasks. Its purpose is to support preventive and promotional health care processes at the primary health care level.

The health services network is "responsible for integrating and coordinating the operation of the network at the first, second and third levels of care" (CSSF, 2014). It is divided in departments that have different areas of work for the development of strategic management processes, plans, guidelines, etc. There is a total of 7 regional health services departments. This study studies the South Central Regional Direction of Health Services, formed by a total of 45 health areas (CSSF, 2014). Health areas are in charge of a total of 367 BEIH distributed in each area (Vargas, 2006).

BEIH Composition:

- 1 general doctor
- 1 auxiliary nurse
- 1 primary health care assistant. Professional support of social work, pharmacy, dentistry, nursing, psychology, nutrition, family and community medicine.

It was not possible to clearly distinguish outpatient care, health prevention and promotion because of insufficient data from the CSSF which does not distinguish these tasks (Herrero & Collado, 2001). This situation implies it is difficult to assess these tasks at the primary health care level (BEIH) because preventive and healing activities are combined (Herrero & Collado, 2001). According to Flores (2003, p.174), in Costa Rica, the care model is divided in seven health regions subdivided in administrative health areas. The rural area has between 15.000 and 40.000 inhabitants and the urban area between 30.000 and 60.000 inhabitants. These health areas are subdivided in one or more health sectors (BEIH) distributed geographically and responsible for 4.000 to 4.500 people.

Currently, "the new public health" paradigm (Pinto, et.al., 2012) addresses a model for assistance carried out by a professional team of health workers serving people in each BEIH, however, in order to ration human, financial and technological resource health services are offered to public or private organizations, which is called mixed sector, public /private modality through which the CSSF delivers infrastructure and management to a third party (e.g., cooperatives, company medical systems or mixed medicine, elective medicine or third parties services); these are independent but they are also monitored by the CSSF.

The goal of all improvements is to work with a less monolithic and administrative model, one with more of a business approach focusing on people, with more management functions, better defined objectives and links between resources and activities (Comino, et.al., 2012, p.1; Ferrinho & Dal Poz, 2003). Separated functions regarding financing/purchase (CSSF) and provision (local level as lender) of health services were established, i.e., each BEIH is directly accountable to the CSSF for preventive and promotional initiatives.

2.7 Challenges of Costa Rican primary health care level

Due to many issues, one of them being the evident emphasis on prevention and healing processes, a national health policy 2010-2020 was established (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. Costa Rica Social Security Fund would continue with its functions, but divider them into three administrative levels, delegating its tasks for execution, programming and monitoring of health actions and health promotion / disease prevention activities at a local level. Its structure was also divided in different care levels the Basic Equipment of Integral Health Care (BEIH) 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 (BEIH), but its aims now emphasize 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 in order to take care of 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 difficulties in most centres, the area being study hereby (the South Central Region) is facing major deficiencies. The main problem being that population care is insufficient due to bad management; health promotion suffers due to limited resources at all levels of healthcare (Ferrinho & Dal Poz, 2003)

in these BEIH centres (García, 2004). BEIHs are still focusing on a health care that cures disease, rather than health promotional initiatives. They act as small hospitals, causing service saturation (Comino, et.al., 2012, p.1); they prioritize 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 contact. From this perspective, national health systems should develop a public health policy that finds a balance among 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 practice 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 (BEIH) in the South Central Region of Costa Rica is essential in order to analyse how health initiatives are implemented and in order 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 and bureaucratic practices (Picado, 2000), with 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 operational tasks to the CSSF delegated by the Ministry of Health, was intended to be corrected. Since the focus is to cure diseases the staff is insufficiently prepared to be involved in health promotion.

2.8 Summary

This chapter discussed how many of the promotion initiatives were provided to primary health level workers in order to manage programs that would benefit the population. The BEIHs provide work at an individual, family and community level. Other priorities, especially regarding disease treatment, have been defined most in the strategies and planning/ management. It seem from a management point of view the concept of health and promotion activities is not clear.

It was argued that Costa Rica has made some valuable improvements in its management model in some of its primary care centres (BEIH). In spite of its evolution and reform changes, when analysing health promotion and disease prevention, there is still a lack of concrete initiatives, meanings' lead to confusion and bad management practices. Both management and promotion / prevention tasks are inefficient. A real improvement to date has not worked in many centres of the primary health care level.

This chapter pointed out that the BEIHs are still focusing on the type of health care that cures diseases rather than on health promotional initiatives. From this perspective, national health systems should develop a public health policy that would help find a balance among welfare, promotion and prevention (Leon, Walt & Gilson, 2000; Kawachi, Subramanian & Almeida, 2002), and would also improve its

management model. The latter is needed to comprehensively address the health rights of the population.

This research seeks to provide an explanation of the management organization of primary health care level tasks regarding health promotion and disease prevention, specifically in order to understand to what extent there is a deficient focus and how does this affects the effectiveness, efficiency and equity within the Basic Equipment of Integral Health Care (BEIH) in Costa Rica. In the next chapter, tools that served to analyse the main factors involved which hinder the management of promotional and preventive programs will be presented, as well as an explanation of the conceptual framework that supports this research. This research seeks to discover what the deficiencies in management as a diagnosis that will provide relevant data to later improve processes.

3. RESEARCH METHODOLOGY

This chapter will present a conceptual framework and some methodological tools regarding health promotion and prevention disease at a primary health level. The present research uses critical realism as an epistemological model. Critical realism is a philosophical theory of reality analysed from different perspectives and perceptions based on human knowledge and learning. The model allows for balance and credibility (Easterby-Smith, et.al, 2012), guiding the quest for answers and contributing to knowledge creation such as socialization, externalization, combination and internalization (Haslina & Sarinah, 2009). According to Easton (2010), "critical realism is a relatively new approach to ontological, epistemological and axiological issues." This epistemological framework will be used for this study of management practices in the Costa Rican health system because of its emphasis on conceptual aspects from which management issues at the primary health care level are derived (Scott, 2007).

The primary health care level is facing management challenges in terms of planning, coordination, training, and evaluation activities of promotion and prevention programs. This research started with four research questions, which have implications for the data collection methods chosen:

- 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 in order to promote an integral health and prevent disease?
- Does the Basic Equipment of Integral Health Care (BEIH) have a proper internal management and organizational culture?

- To what extent are the tasks of the BEIH in terms of prevention disease and promotional health well defined?

3.1 Methodological framework

The methodology will be based on a framework proposed by Scha et.al. (2013) in which ten variables are selected in order to measure promotion and prevention initiatives at primary health care **(See Appendix I. Structure, process, outcome)**.

- **Structure** contemplates organization, normative, resources, tools, skills, attitudes and hopes of the team.
- **Processes** are related to the activities, strategies and processes.
- **Results** refer to the system outputs transformed into products and the impact on health indicators results as well as beneficiary / user satisfaction.

The methodology will be based mainly on qualitative instruments (as proposed by Wisdom, et.al., 2012) with a little quantitative data. This approach offers mostly an interpretative process which allows for the exploration of experiences in promotional and preventive initiatives (Easterby-Smith, Thorpe, Jackson, 2012) considering how health systems involve dimensions such as social, financial and organizational issues (Morris, Devlin & Parkin, 2012). Quantitative data will be used in order to provide evidence and support qualitative data, so as to achieve a more objective research (Easterby-Smith, Thorpe, Jackson, 2012, p.222).

Considering that Health Management integrates a wide variety of areas, the qualitative data will provide and contribute to developing and refining new management procedures. This will be supported

by a combination of descriptive studies (Saborío, 2012) in order to study activities, processes and people (Robert, 2004) of the BEIH integrated within the South Central Regional Department. These findings will be expanded on by an explanatory study that serves to identify the problem and understand cause-effect relations through analytical observation.

The case study will serve as a means to describe the degree of efficiency, efficacy and quality of promotional health activities and prevention of disease through management evaluation (law, programs, role coordination and cultural organization) (Morris, Devlin & Parkin, 2012). The qualitative data will show ‘opinions, perceptions and visions with its “in-depth interview” (Easterby-Smith, Thorpe, Jackson, 2012, p.126). It will also contribute to the collection of meanings, i.e. to interpret the phenomenon in the eyes of the interviewee (Vargas, 2012). The research will be focused on the health system, specifically the primary health level in where care services are delivered. The objective is to describe and explain activities, processes and people in order to understand the management of promotional health and disease prevention.

Surveys and interviews comparing past research results and conclusions will be used. To expand on the interviews, a survey will be conducted among a small sample of 100 health users residing in the area being studied. Health statistics that report interesting facts in statistical issues already exist (Munck, 2007). Also, a qualitative questionnaire, which involves the application of specific techniques in order to collect, process and analyse characteristics of members of a certain group will help enhance the study. This will be applied to an expert panel, formed by authorities of the health sector. A questionnaire will guide the interviews so as to avoid losing focus (Easterby-Smith, Thorpe & Jackson, 2012, p.133). In addition, past studies will support data and analysis, identifying, from the literature, the influence of past experiences, future projections, social relations and opportunities of context (Durston & Miranda, 2002, p.10).

This research was limited to a general study of the South Central Regional Direction which is integrated by 45 health areas and 367 Basic Equipment of Integral Health (BEIH). The information collected was provided by in-depth interviews with experts and officials from the Ministry of Health and the Costa Rican Social Security (CSSF). Additionally, a web-based survey was made to service users with the support of literature on health care.

3.2 Data sources

The specific data collection and the main sources used are as follows:

- Primary sources:
    - Interviews with officials from the CSSF;
    - Interviews with health researchers;
    - Interviews with officials from the Ministry of Health;
    - Panel group discussion with Ministry of Health and CSSF authorities;
    - Interviews with other health social actors.
- Secondary sources:
    - Document Review for 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 from literature review. 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;
- Bibliography from Health experts.

3.3 Data collection instruments

This section considered the research problem, objectives and research questions (Easterby-Smith, Thorpe & Jackson, 2012). Each research question had its own instrument (interviews, expert panels, surveys, questionnaires, and literature).

Based on the previous ten dimensions to measure primary health care (PHC), questionnaires were used in an expert panel setting involving authorities from the Health Ministry and Costa Rican Social Security Fund. The interviews had open questions that required analysis and were; these were made to political scientists, health authorities, doctors. The interviewees were categorized into four groups:

Group # 1: Authorities

This first group was interviewed using observation, face-to-face and open questions using journalistic style and techniques in order to obtain detailed information based on experiences, perspectives and field work (Easterby-Smith, Thorpe & Jackson, 2012). 10-15 experts belonging to the Costa Rican Social Security Fund (CSSF) and the Ministry of Health (MH) were interviewed. Below the four main and most important questions applied to this group are printed **(See Appendix II. Questions. Group # 1: Authorities)**.

Group # 2: Expert panel (Authorities from the HM and CSSF)

An expert panel discussion was organized in order to make data collection easier and faster, and allow different experts to discuss the topic together (William, et.al., 2012). A questionnaire was applied to each expert. The questionnaire design was adapted from a 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), the "Health promotion at work: questionnaire for assessing quality" questionnaire **(See Appendix III. HM and CSSF Questionnaire)**.

This instrument uses an innovative method based on the European Business Excellence Model (EFQM model) (Solé, 2003). It is a non-regulatory model, its basic premise is self-assessment based on a detailed performance evaluation system of the organization by using guidance criteria model analysis. This model allows to develop improvement plans based on objective facts and the achievement of a common vision using a set of criteria for business excellence (covering all areas of operation of the organization) - structure, process and outcomes (EFQM, 2012). After the questionnaire, all the experts, together, discussed the different issues regarding the questionnaire (**See Appendix IV. Questions. Group # 2: Expert Panel (Authorities from the HM and CSSF**).

Group # 3: BEIH Users

A web-based survey was created for this group and it was sent to BEIH users **(See Appendix V. Users Survey)**. This allowed obtaining critical feedback on the needs and requirements of the user and the level of satisfaction with current services. Additionally, it had a low cost, neither interviewers nor paper was required. Further results were obtained in real time by avoiding data entry errors which in turn resulted in a vast amount of data.

This instrument used was closed questions since it made it possible to collect clear, accurate information and specific data. Although limited to short answers, it also allowed for greater control and more amount of questions. The survey consisted of different closed questions that guided the interviewees' answers. **(See Appendix VI. Questions. Group # 3: BEIH Users)**.

Group # 4: Experts

This group was fundamental, not just because of their expertise, but also because they were external to public health organizations and had other views on promotional health and prevention disease. Open questions were used in order to obtain as much information as possible. Open questions were set in order to gather more information. The fact that the tool was a conversation made it rich in data. The objective was to access the perspective of the subject studied and understand their interpretations, perceptions and feelings, as well as the reasons for their actions **(See Appendix VII. Questions. Group # 4: Experts)**.

3.4 Data analysis

The analysis and interpretation of the data was done following the same guide: structure, process and outcome. The total number of interviewees was 15. A total number of questionnaires were applied to 100 health care service users. The results were based on the interviews, presented with a narrative perspective, i.e. it was developed through accounts and description of situations, often using the explanations of respondents in order to avoid tampering with the collected material and in order to convey to the reader the immediacy of the studied situations. The conclusions of the data analysis were used in order to develop recommendations to improve management of health promotion and disease prevention.

As a backup, qualitative data was the main research method and quantitative expanded on it as a means of providing a different perspective. Qualitative research is widely used in social sciences; its main purpose is to collect, process and analyse characteristics that take place for people of a certain group. Although the research was mainly qualitative, it should be noted that the survey and questionnaire were hosted by a data system that transformed information into quantitative data. This facilitated the process of reorganization. Both methods had a qualitative component in data analysis, but on the one hand, the user survey facilitated the percentages for each question and, on the other hand, the questionnaire also provided an overview 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 enabled the assessment of performance evaluation systems of the organization using assessment criteria.

In short, this was mostly a qualitative research. An intentional focus on the research questions were the best defence against information overload. The information was grouped by categories of ideas, concepts or similar topics using taxonomies and mental maps. They were then related to the theoretical

foundations of the research for further analysis. Still there were some problems in terms of access to confidential information, especially due to bureaucratic processes, however, it was finally possible to obtain information with interviews with experts who had the authority to analyse, comment or explain. All data was analysed in light of the parallel forms reliability, it is a measure that groups and manages different versions of similar groups of respondents. Since it is mostly a qualitative study, the research tried to "generate understanding" (Stenbacka, 2001, p. 551 quoted in Golafshani, 2003, p.600) by showing how the results can be compared to assess the consistency of the results to the various versions. The reliability of the research is reflected in repetitive or similar responses from the interviewees. Basically four criteria on the reliability and validity of this qualitative study were meet: credibility, transferability, dependability, confirmability.

3.5 Political and ethical challenges

The researcher has been cautious with confidential information. The names of interviewees have been changed in order to avoid showing their true identity. The main challenge was related to the access of information since the BEIHs are part of the public system. Officials were sometimes reluctant to give interviews, statistics and financial information. The survey and questionnaire design needed to be approved by the Bioethics Department, which resulted in an extensive and slow process therefore other means of obtaining data, for example, interviews with authorities and experts, were adopted. Moreover, another challenge was interviewees putting off appointments.

All data used in the study came from interviews, literature, surveys and questionnaires. All information is accessible and does not violate confidentiality as it was not possible to work with confidential documents due to the Bioethics Department's requirements. Costa Rican administrative culture

involves many bureaucratic processes within public institutions; however the researcher succeeded in finding strategies to overcome this difficulty.

3.6 Summary

The methodology section described all the tools and processes used for primary data collection, as well as the secondary sources that enhanced the study. The research was conducted primarily with qualitative data because of its information's wealth obtained through interviews, questionnaires and surveys.

Quantitative data was used to a small degree since it was intended to expand on the research. The methodology was chosen in order to apply the critical realism approach which will be discussed in the following chapter along with the results and analysis. The methods and tools selected focused on the research question deciding on an accurate model in order to collect data. Everything was analysed in light of three areas: structure, processes and results to better understand promotional and prevention initiatives at primary health care level. This research was limited to a general study of the South Central Regional Direction which is formed by 45 health areas and 367 Basic Equipment of Integral Health (BEIH).

4. RESULTS AND ANALYSIS

In accordance with the objectives of this research, data was collected in order to assess management challenges at the primary level regarding promotional and preventive issues. It was a challenge to obtain the necessary interviews. While it was intended to interview the BEIH staff, bureaucratic obstacles limited the process. Even so, it was possible to obtain information from authorities of the two main institutions of the health sector: the Deputy Minister of Health and the Executive President of the Costa Rican Social Security Fund, as well as officials with a leading role in health promotion.

4.1 Results of data

This chapter presents the main findings obtained from diverse sources. Since it is mainly a qualitative research, the data is rich in content and provides an explanation to better understand the degree of deficiency in management, health promotion and disease prevention issues at the primary health care level.

The primary collected data was based on the following sources: a) expert panel session with members of both the Ministry of Health and the Costa Rican Social Security Fund, b) open and closed interviews with management specialists in the public health system and c) a survey about health promotional to users of primary health care. This information was supported by secondary sources: bibliographic documents on specialized issues.

As an introduction to this section, first the results of the conducted expert panel session will be presented. The expert panel session consisted of two parts. The first part allowed a group of experts to

evaluate the organizational performance of the Basic Equipment of Integral Health (BEIH) in three areas: structure, process and outcome; and to determine the degree of management efficiency in health promotion at the primary level. It was based on the European Business Excellence Model (EFQM model) and consisted of a total of 43 questions. **(See Appendix III. HM and CSSF Questionnaire)**. The second part was a discussion among experts on these management issues of promotional health at the primary level. Figure 5 shows the results of this evaluation of the work at the primary level based on experts' perception and since it only provides a general picture this will be discussed later in depth.

Figure 5. Results of expert panel session with health experts (Ministry of Health and Costa Rican Social Security Fund, 2014)

	STRUCTURE		**PROCESS**	**OUTCOME**
	1. Strategy and Management Commitment	**2. Human Resources and Organization of Work**	**3. Health Promotional Planning**	**4. Impact of Health Promotion Initiatives**
Success Rate	61,15%	36,70%	47,39%	44,74%

Source: Own data, 2014

The most successful area, in the opinion of those involved in the expert panel session, was the structure, which provides instructions and guidelines on health promotion. This integrates international / national legislation, written assignments and designated actions, which seem clear and were supported by documentation.

The percentage decreases when it comes to the organization of work and human resources. This category integrates budget allocations and task execution. Thus, the guidelines provided in the structure fail to be put into practice because its operationalization is complex. The same occurs with the last two

categories, process and outcome. Planning with a focus on promotion and impact of initiatives is still low, with a success rate below 50%.

Based on this quantitative contribution from authorities, the following information shows some findings that explain these success rates, based on qualitative data obtained through the interviews with experts.

Following the results obtained from the questionnaire completed at the expert panel, the information was discussed by experts who explain the deficiencies in management regarding promotional initiatives at the primary level, as well as an understanding of the causes, starting with 1) the meaning of promotion and prevention, 2) management deficiency in promotional and preventive issues at the primary level (BEIH) and 3) operationalization of the social determinants of health.

As explained in the previous chapter, a framework proposed by Scha et.al. (2013) was used and the analysis was divided into structure, process and results. Each one considers their corresponding variable that contributes to promotion and prevention measures at the primary health care level (**See Appendix I. Structure, process, outcome)**.

- **Structure** contemplates organization, normative, resources, tools, skills, attitudes and hopes of the team.
- **Processes** are related to the activities, strategies and processes.
- **Results** refer to the system outputs transformed into products and the impact on health indicators results as well as beneficiary / user satisfaction.

4.1.1 Structure

4.1.1.1 Understanding of "promotion" and "prevention"

All the interviewees agreed there are fundamental differences between these concepts, they are often mistaken for synonyms; however, it depends on the approach adopted by the health specialist. For instance, if the approach is health-based, there will be health promotion measures; if a disease approach is followed, measures will be preventive and focused on care and rehabilitation. Health promotion is more than just actions that seek to improve conditions and prevent a disease. For Dr. Pedro Abarca, director for the Health Promotional office at the Health Ministry and coordinator of the National Commission for Health Promotion (created in 2014), "preventive efforts can be aimed at health promotion; however, promotion is very specific because it involves a joint political, educational, social participatory effort." This view is shared by Dr. Gustavo Martínez, former Deputy Minister of Health, Dr. Vanessa Salas, current Executive President of the Costa Rican Social Security Fund (CSSF) and Blanca Castro, social worker and marketing coordinator for health promotion and disease prevention at the Ministry of Health, South Central Region.

This view point, i.e. that prevention includes promotion, is a little different from Lidia Picado's conceptualization. She is in charge of the Regional Direction of West Central Health at the Health Ministry and collaborated with the *Strategic Plan for Health Promotion for Central America and Dominican Republic 2014-2018*. According to Picado, "promotional initiatives should not introduce elements within prevention programs because prevention works with risk factors and mere disease. People tend to formulate preventive projects from the perspective of promotion. The CSSF has no parameters to measure promotion".

Luis Hernández, in charge of the marketing department in the Ministry of Health believes health promotion provides various tools to the community and knowledge to address health issues. Sergio Barboza, coordinator of the Pharmaceutical Care and Clinical Pharmacy Department of the University of Costa Rica also thinks of promotion as healthy habits and quality of life, while prevention corresponds to measures taken once a patient is ill.

Health is not just the absence of sickness. The World Health Organization explains that health is the integral well-being of the person: the physical, mental, social, spiritual well-being of the individual, however, Marcela Rivera, social worker and formerly in charge of the Health Promotion and Disease Prevention Commission of the Costa Rican Social Security Fund, East sector of the country, argues that this definition is deficient. She believes people expect too much from definitions: no one can have a complete and perfect well-being.

Alvaro Elizondo, Regional Director of the South Central Region services of the Costa Rican Social Security Fund (CSSF), explains that the CSSF's mission is to promote health and disease prevention. A healthy person is encouraged to stay as healthy as possible, but not in absolute terms. Diseases are prevented for healthy and sick people. Dr. Vanessa Salas, current Executive President of the CSSF also supports this, emphasizing that promotion does not target perfect health because this is impossible. Instead, it aims at the enhancement of the capabilities of citizens to exploit and take advantage of opportunities. According to Marco Segura, a Costa Rican doctor:

> *"Health is three things: body, soul and mind. Chinese medicine seeks to address it in a holistic way. The WHO definition of health seems to cover a lot of social and physical issues, but not spiritual. This is because the approach is based on results and particularly financial management".*

Since the ‘70s numerous studies on health promotion have been carried out and international Charters specifying the foundations of health promotion with modern approaches have been adopted. The most recent sets its roots in the Ottawa Charter, in which 5 lines of action were defined for health promotion:

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

These five actions laid the basis for public policies, but have not received enough support. Precisely, the *Strategic Plan for Health Promotion for Central America and Dominican Republic 2014-2018* seeks a commitment to position health promotion within the policy agenda of the area and to comply with the guidelines provided at the Ottawa Charter and other international documents. The author of such report, Lidia Picado, emphasizes the need for a positive, proactive, and innovative approach.

When the BEIH was created, it was meant to focus 80% of its resources on promotion/ prevention, and only 20% on healing, however, healing takes up most of the BEIH’s resources. Costa Rica still has a system where healing is prioritized over promotion. The Centre for Strategic Development and Information in Health and Social Security highlights that “life as a social process and as a single experience cannot be fragmented. The reality is presented with subjective experiences affecting the body and social relations. The social production of health considers the conceptualization of health as a state of permanent transformation and the health sector is not isolated or autonomous. It is also the result of facts and economic, political, ideological and cultural processes”. (CENDEISSS, ND: 43 quoted in Avendaño, Cruz, et al., 2010, p.104).

Promotion continues to be a complex concept to implement. On the one hand, it is a responsibility of the Ministry of Health, as the governing body. On the other hand, the Costa Rican Social Security Fund (CSSF) has its own promotional department. The CSSF has been working for about 5 years on health promotion but it still has a deficient practice. This section revealed there are many opinions regarding the definition of health promotion and disease prevention. Some experts have a similar conceptualization of both concepts; others clearly distinguish them. Generally, the definition adopted by these experts depends on their knowledge and perspective on the relevance of the terms. The following definitions were raised by the specialists interviewed:

- Promotion has a health-based approach; prevention has a disease approach, involving preventive measures.

- Promotion involves a social, educational, political effort (social determinants of health) that can work in a public policy level in order to improve human well-being. Prevention integrates more clinical contexts and seems to be curative.

- Promotion initiatives should not insert elements in the preventive programs. The latter deals with risk factors and tries to prevent progress, though, some experts believe prevention is part of promotion only considering risk groups.

- Promotion is for healthy people that are educated in order to prevent potential diseases and prevention is the control and monitoring of any disease.

- Promotion implies self-care, an interpersonal community, and global relationships involving different aspects of the human being. It integrates collective actions. Prevention involves more individual and applicable actions.

- Promotion is formed by social participation. It is constructed through community capacity building, empowerment, political negotiation, advocacy, communication, education and participative research. Prevention involves the primary level (sanitary education, community development, communication and information, inter-sectorial action), the secondary level (detection, early analysis), and the tertiary level (treatment, clinical management, rehabilitation).

4.1.1.2 Health System and its reform

In the "National Health Dialogue" which was held in order to strengthen the Costa Rican Social Security, voices of institutional and community representatives regarding strengths and weaknesses of the CSSF services were exposed, highlighting the huge gaps of BEIH effectiveness at the primary care level (Picado & Hernández, 2014). According to Castro (2014), there is also a divergence and weakness among institutions when it comes to complying with several projects in the promotion and prevention areas. Neither the Ministry of Health nor the CSSF have the capacity or resources to comprehensively implement their responsibilities regarding health promotion. Management deficiencies have its origins in recent history. Between 1994 and 1998, the division of the "care component" and the "chief component" was established. It was agreed that primary care programs would be assigned to the Costa Rican Social Security Fund (CSSF), and that the Ministry of Health would continue to fulfil its duty.

This brought on a major issue because of the focus of the CSSF had always been disease care, not prevention or health promotion. When the CSSF assumed the program, all care units collapsed. The CSSF had to allocate time to preventive care programs and little attention to the diseased.

Unfortunately, the system had almost collapsed in this regard. The preventive program was completely saturated. Currently, it is still a huge challenge for the CSSF to comply with the preventive programs duties at a 100%.

4.1.1.3 New health care model reform, human resources and personnel

The interviewed experts agree that the health care model is excellent, but that the challenge lies in human resources. The BEIHs would represent decent models if they actually worked and promoted integral health.

> *"The BEIH model and structure are good, whether it works or not, whether it has an impact or not should be asked as well as how to determine appropriate indicators. High commitment management has deficiencies, those who manage create doubt". Sergio Barboza.*

> *"Is an excellent model, but its primary level is declining. People in management positions have no experience in budgets, human management, community treatment, community health, etc." Luis Hernández.*

The quality of BEIHs at the primary level is declining, especially in some areas. There are many complaints about the CSSF's responsibilities and management organization. The primary care model is where people are educated about health, how to take care, how to be empowered and learn the necessary skills to care individual and community health and how to reduce through the process of

health development (self-care, healthy lifestyles, training, advocacy, social participation, technical and professional preparation). All these problems are now reflected in a saturation of waiting lists for treatment at the primary level (BEIH). The system is unable to face everything and it is failing because planning does not consider needs and budgets. Health is a development factor of any country. If a country sells disease, disease demand increases. That many demands cannot be catered for.

4.1.2 Processes

4.1.2.1 Management and cultural organization

The national level of the CSSF coordinates all health promotion commissions locally. Not much time is spent on promotional activities. The model uses four components: promotion, prevention, cure and rehabilitation, but the CSSF has only worked on the healing / rehabilitation component, the merely biologist approach (Rodríguez, 2014).

CSSF officials and BEIH workers explain that management commitment has been affected because this is measured by percentages of fulfilment established in order to justify budgets. Most agree up to a point and despite the priorities, there are insufficient resources to meet the needs presented. A considerable budget is not defined to develop these programs in communities and the current mismanaged budget.

Alonso Rodríguez, in charge of the Promotional Department at the central level of the CSSF, explains that doctors are in leadership positions. While there is awareness about promotional issues, it is not given the importance it deserves by these doctors. Local committees are integrated by doctors, dentists

and social workers. There is a deficiency of nutritionists and physical education teachers. Committees work without prior knowledge and their promotional focus is limited to physical activity or nutrition. No one guides these processes; there is deficiency regarding human resources and time. For doctors, approaches from the social sciences are hindrances to promotional and preventive processes.

Regarding operational challenges, there are differences as to the approach, techniques, knowledge, etc. For Castro monetary capital is all that matters for many doctors. There is plenty of resistance to change because the social change processes have no credibility, especially because it is too complex to measure its impact efficiency, contrary to accounting consultations. Employees are not encouraged nor engaged to take promotion or prevention measures, on the contrary, they are manipulated and discouraged with words or actions, according to Salas.

Rivera explains that the CSSF is a doctor-centrist organization. Moreover, there is a lot of bureaucracy between normative and field work. Recommendations from the field are usually not fed back into the organization. This problem starts from the mission, vision and values defined by the Ministry of Health, which are recorded on paper. There is no real commitment and organizational environment from workers, especially doctors who see promotion and prevention as a threat. Rivera also thinks universities are a part of the problem, despite being within the health sector because they fail to focus on the importance of health promotion.

Interviewees agree that as for the CSSF's policies and priorities, there is a major contradiction between management commitments and international and national laws. There is no integral and integrated vision of health. The Ministry of Health, the governing body for health in the country, rarely communicates with people within the health sector in order to design the health system they want. The fact that there is high demand at the primary level and saturation of the secondary and tertiary levels also shows a weakness in strategies and outcomes of promotion and prevention issues.

4.1.2.2 Measurement of health promotion results

Picado emphasizes that at this moment evaluation is done at a management level, but these evaluations only look at what has been accomplished. There is a lack of cultural planning at all stages, which is influenced by the type of training health professionals have received. If the training is merely biologist and health is viewed from the disease perspective, health promotion will not be a priority. Moreover, quantitative evaluation tools are more valued. Basically, the more people are helped by medicine, the better. There is little room for qualitative assessments of the work done by agencies of the health system.

Rodríguez explains that the central level conducts workshops and trainings in different districts and with local health areas. Local health promotional commissions, responsible for identifying the needs of the population, create proposals that are reviewed at a central level. The problem is that many of the promotional projects are combined with issues pertaining to prevention, due to the confusion on concepts and initiatives discussed above. Supervision and monitoring is key. Elizondo explains that in the South Central Region, he had to develop a strategic plan because there was none.

In other areas, health officials write a lot, but not much is put into practice. Most reports do not go further than the diagnosis level. Local commissions have a board in which there is a follow up of promotional programs, goal fulfilment and tracking of activities with results' reports according to Gómez. There are areas that work best. Gómez agrees that the South Central Region is one of the areas that report most problems.

4.1.2.3 Communication and awareness

Health care model was one of the main issues discussed in the National Dialogue to Strengthen Costa Rican Health Insurance in the Context of Public Health (2014, p.14). Hernández explains that when the Ministry of Health, in the past, approximately 30 years ago, was in charge of promotion and health care, health centres offered a more humane treatment. Castro also considers that primary health care has declined in quality. At the beginning, with the former Ministry of Health, workers were responsible for visiting people in their homes, but with the creation of the BEIH this has changed.

Every two years seven members are selected to sit on the health board (the CSSF's body) in each area at the primary level. A major challenge is people's commitment because there is not a culture of participation. There are many types of personalities and interests. Moreover, health board participation is conditioned. Abarca explains that the central government should establish rules and regulations. The local government should adapt them to local conditions by municipal council agreements and internal regulations and enforcement via the municipal government in order to develop specific programs in which the municipality, community organizations and citizens work.

4.1.2.4 Operationalization of Social Determinants of Health

Health promotion is the responsibility of the whole health sector. Beyond public health institutions, it involves universities, NGOs and the private sector. The explanation given by the interviewees as to why many doctors do not support promotional initiatives at the primary level is because universities train students in medicine, neglecting the approaches from the social sciences. Because of this, in Costa Rica students are prepared to work in hospitals and at the third level. This being said, Barboza, in

charge of the Pharmaceutical Care and Clinical Pharmacy Department of the Pharmacy Faculty in the University of Costa Rica differs, claims that working with multidisciplinary teams has always been the objective. Health students in public health or pharmacy are taught about the social determinants of health since their University years. Barboza does agree that in practice the biologist care model continues to dominate.

Furthermore, there are many scattered initiatives and the work of the National Commission for the Promotion of Health, created in 2014, is to unite these initiatives and create networks. It depends not only on the state apparatus, but on all NGOs, communities, associations and private companies. Pablo Solano, in charge of the Management and Cultural promotion Department of the Municipality of La Unión in Cartago, explains that:

> *"The municipal code states that all aspects that affect or impact the community's quality of life on which the municipality works are part of the work field of the municipality. Obviously, health issues are under supervision of the Ministry of Health, but local governments should prioritize promotion and health care more". Pablo Solano.*

From the point of view of institutional responsibilities, the municipality does not have direct faculties or resources. However, guided by this broad mandate, during the past three years, it has slowly developed initiatives pertaining to these areas. Several initiatives have been implemented such as support for university projects in health promotion[1], although no strategies were created. Technically, there is no municipal public policy oriented to health promotion. Rarely do municipalities in the country work on raising awareness on the importance of health promotion. According to Picado (2011,

[1] The municipality has promoted healthy lifestyles through an agreement made with the School of Nutrition at the University of Costa Rica who designed a community action program in the field of education and prevention, however, this program is a project of promotion from the field of prevention. This shows again the confusion of terms.

p.11-12), “municipalities as local authorities have different powers that represent opportunities for inter-institutional health actions”.

4.1.3 Results

Results of the BEIH were assessed through a survey about health promotion conducted among users. The survey looked mainly into health promotion issues in order to understand what the real needs of people are vs. what is provided.

4.1.3.1 Information about health care

Figure 6 shows a personal survey conducted among Costa Rican citizens, mainly in the provinces of San José and Cartago that reflect what people think of promotion. First they think about medicine and doctors. When asked from whom they would like to receive information on health care, 39% said they would like to receive if from their doctor or health care provider.

Figure 6. From whom would you like to receive information about health care?

Answer	**#**	**%**
Doctor / health provider	101	39%
Social worker	16	6%
Family	20	8%
People	3	1%
Co-workers	5	2%
Churches / religious groups	8	3%
Neighbours	2	1%
Social media	33	13%
Internet	28	11%
Television	21	8%
Support groups	11	4%
Study centres	9	3%
Others	4	2%
The Company I work for (2)		
None (1)		
Psychologists (1)		

Source: Own survey (2014)

4.1.3.2 Satisfaction with health information

Comparing the previous data with other survey questions, Figure 7 shows a very similar percentage. Whether users are satisfied with the information provided by their doctor or health provider, 37% is satisfied, 35% is not and 28% do not know. This can be explained by the lack of human contact the

doctor should have at the BEIH, which is limited by time, management commitments and preventive focus.

Figure 7. Are you satisfied with the information received from your doctor or health provider?

Answer	**#**	**%**
Yes	45	37%
No	43	35%
Don’t know	34	28%

Source: Own survey (2014)

4.1.3.3 Information users want to receive

In Figure 8 a significant finding is shown, regarding the question: what information would you like to receive from your doctor? Most interviewees stated they need to receive information, techniques and support in health promotional issues. People do have an awareness of the importance of health, although they seem to limit promotion to healthy food and exercise.

Figure 8. Please explain: What information would you like to receive from your doctor?

• General information on promotion and prevention
• Healthy eating
• Information on how to remain healthy and lead a quality life
• Tips, information
• Everything related to diseases. How to fight them, natural care products, exercises to strengthen and avoid injuries
• Reminders of important check-ups
• Current aspects of health problems management
• Information about scientifically proven alternative therapies and new treatments; new discoveries
• Nutritional advice
• Knowing your body and its functioning
• Stress reduction and physiological activity for anxiety
• Follow-up of medical attention
• Promote good lifestyles
• Informative newsletters, prevention and advice

Source: Own survey (2014)

4.1.3.4 Channel to receive information

With the following question: "how would you like to receive information about your health care?," it is evident that modern times demand new ways of helping people improve their health by providing accurate user-friendly information, and using various tools. Figure 9, presents ways in which people would like to receive information from the health sector. It can be seen how email exceeds the other

options with 27%, followed by social media with 20%. These two options are the most requested because people are usually online. Technology dominates and has been changing lifestyles.

Figure 9. How would you like to receive information about your health care?

Answer	#	%
Email	6	27,00%
Social Media	48	20,00%
Written Materials	43	18
Internet	38	16
Videos	29	12
Art	12	5
CDs	7	3
Other: request	2	1

Source: Own survey (2014)

4.1.3.5 Health promotion activities

Figure 10 shows the main activities people consider are part of health promotion. Most of them, with the highest percentage are related to nutrition with 20% and leisure activities with 19%. However, all options have a biological component that seeks to improve people's health at some level, but there were no responses in other social determinants of health such as environment, employment, housing, etc.

Figure 10. Which health promotion activities would you be interested in?

Answer	#	%
Cooking lessons or nutrition	61	20
Leisure Activities / Reduce Stress	58	19
Health Education classes	46	15
Recreational activities	44	14
Fitness Classes	31	10
Art and fantastic literature	23	7
Social groups	20	6
Religious / spiritual activities	20	6
Other: sports, aerobics and dance, health fairs with exams or medical reviews, yoga	6	2

Source: Own survey (2014)

4.1.3.6 Kind of support in health promotion

Figure 11 shows how responses to the question "what kind of support in health promotion would you be interested in?" are also guided mostly to the same two topics; reminders to do exercise has the highest percentage, 23% and reminders for medical tests, 21%. People still think of health promotion as body-health/sickness.

Figure 11. What kind of support in health promotion would you be interested in?

Answer	#	%
Reminders to do exercise	54	23
Reminders for medical tests	50	21
Job training	33	14
Help at home	29	12
Psychological assistance	28	12
Help managing money	20	9
Assistance to find a job	13	6
Help to plan transport	4	2
Other: healthy lifestyles, nutrition plan	3	1

Source: Own survey (2014)

4.1.3.7 Kind of health promotion information

As it happened with the previous findings, people understanding of health promotion is limited. Figure 12 reveals that 33% of users want to receive information about healthy lifestyles and 27% information on healthy eating followed by information on physical activities outdoors with 22%.

Figure 12. What kind of information are you interested in receiving for health promotion?

Answer	#	%
Information about healthy lifestyles	99	33
Information on healthy eating	74	27
Information about physical activities outdoor	61	22
Information about alternative treatments	44	16
Other: management on family budget, information about offers or promotions in medical exams	5	2

Source: Own survey (2014)

Considering the information provided by experts and users, the next section is an analysis based on the four research questions raised at the beginning of this study. The results will be interpreted in order to understand how promotion and prevention work at the primary level.

4.2 Analysis of results

Taking into account the previous data provided by experts and professionals of the health sector, this section will interpret the main findings. Specifically, this section will show the collected evidence for the main objectives of this research, which is to discuss the deficiencies at the primary health care management level in promotional integral health and disease prevention. The analysis will be divided by the four research questions raised of these research objectives. A comparison of the literature reviewed with these findings will help support or refute the hypothesis.

4.2.1 Research Question # 1: To what extent is there a deficient focus on preventive and promotional integral health at Costa Rica's primary health care level (Basic Equipment of Integral Health Care)?

The first research question can effectively be confirmed, as it is confirmed by both the interviewed experts (health specialists) and by the BEIH users' survey. Indeed, all the interviewed experts such as Picado, Elizondo, Abarca, Castro and Hernández, agree that health promotion and prevention receive little (insufficient) attention at all health care levels, including the primary health care level. A particularly striking example in this regard is the confusion these health specialists have regarding their definitions of prevention and promotion.

More often than not, the interviewees point to obstacles in managerial culture which to a large extent explain this deficiency related to health promotion and prevention. As was mentioned earlier, the Costa Rican health system tends to focus mainly on health as medicine, and the whole CSSF system is organized around this concept. The former is in turn explained by the predominance of "classically" trained medical staff within this institution which tends to only consider medicine as their role and not prevention/ promotion.

The survey done to health system users confirms the same hypothesis. Respondents generally have no idea of what health promotion or prevention entail. Moreover, the fact that the great majority indicates it's the medical doctor from whom they would like to receive information about healthy lifestyles once again confirms the predominance of the medicine-driven model. Apart from a few experts there is no intention of involving stakeholders beyond medical specialists in promotional and prevention activities. In summary, the data collected in this research confirms the initial insights obtained from literature, particularly Picado (2011), Corrales, Urrutia & Porras (2007), WHO (2002), Redondo (2004) and Villalobos & Piedra (1998).

The extent to which the focus on preventive and promotional health is deficient is up to debate. This research revealed, specifically, the existence of a discrepancy between the existing legal instruments (both at the national and international level) and the actual policies being implemented at the local level in Costa Rica. Indeed, the legal framework seems very comprehensive as far as integral health goes (although Picado and others like Hernández, Abarca and Rodríguez, may consider it still does not go far enough). At least, it does highlight the importance of health promotion and prevention.

Some of the interviewees like Hernández and Picado point to structural obstacles in the country's health care model, basically confirming the analysis by Villalobos & Piedra (1998). Interviewees agree that policy reforms have improved the situation and integral health is more well-known within the Ministry of Health. Yet, the concepts of preventive and promotional health are not included in public policies, and even when they are, they are not a part of the agenda of the BEIH that that were studied in this research. The creation of a specific committee for health promotion also puts the issue on the political agenda, but it remains to be seen how much will change as a result of this committee's work.

4.2.2 Research Question # 2: Does the primary health care level allocate its financial and human resources efficiently in order to promote preventive and integral health?

As explained in the previous section, the first research question questioned the degree of focus on preventive and promotional health at the primary health care level. This research question was answered positively based on the shared opinion of survey respondents, interviewed experts and the review of the literature. It was argued that although national and international legislation does clearly stress the importance of health promotion and prevention – integral health – it is not part of the day-to-

day operations of the BEIH. It was also argued that although specific policy documents have been written they have not been implemented at the local level.

The second research question is related to the first one, as it looks into the efficiency of financial and human resources allocation for preventive and integral health. The survey of BEIH users makes it clear that most users do not know they can expect support from the BEIH for health promotion. As Elizondo, one of the interviewees confirms, they think of the BEIH (and the CSSF) as an institution that heals them when they are sick, not an institution that can help them improve their lifestyles or to prevent them from getting sick.

Considering the fact that although integral health is on the CSSF's legal and policy agenda but is not implemented by the BEIH as the local health provider (research question # 1) it seems there must be an issue with resource allocation (research question # 2). One essential issue raised by some of the interviewees like Picado, Abarca and Rivera is that budgets meant for health promotion are used for health prevention, precisely because of the confusion about what they mean, as discussed previously.

Also, the existing budgets for integral health are often distributed across numerous tasks, which dilutes any effective health promotion project even more. In the framework of this research, it has not been possible to access any of the budgets to confirm this, the issue was put forward by Costa Rican health systems analysts (see Picado & Quesada, 2011 and Avendaño, Cruz, et al., 2010). Moreover, the survey clearly shows that BEIH users are in fact very interested in receiving information and training on health promotion, but at the same time do not expect the BEIH to provide these services.

This confirms there is, indeed, an inefficient allocation of resources for health promotion. The majority of the interviewees such as Elizondo, Picado, Rivera, Rodríguez, Segura and Castro also point to the fact that the immense workload of the BEIH is oriented towards administrative requirements on the one hand and to prevention and care on the other. Because of this, very little resources are provided to

health promotion. In addition, the interviewees indicate no staff at the BEIH is really knowledgeable on health promotion, nor is much effort put into involving other government institutions and community stakeholders in the promotion of integral health.

It was difficult to fully assess the efficiency of resource allocation at the local level because of the impossibility to speak with BEIH officials due to bureaucratic obstacles; however, the data collected via interviews with experts provide enough ground to respond affirmatively to the second research question.

4.2.3 Research Question # 3: Does the basic equipment of integral health care have an appropriate internal management and organizational culture?

This question is not answered easily as it involves many variables. This research only focused on the general BEIH structure, with a geographical focus on the BEIH in the San José and Cartago provinces of Costa Rica (South Central Area). Also, the question was raised in relation to integral health promotion. Therefore, the scope of this analysis is necessarily limited to the BEIH in the mentioned provinces and to its management culture with regards to health promotion.

Looking at the organization chart of the BEIH, which is a general template for all BEIHs, one immediately becomes aware of the fact no member of staff is accountable for leading health promotion projects. Health promotion is not a transversal policy theme for any of the BEIH, as could be concluded from the assessment of research question # 2.

Interviewees stress there has been some improvement in recent years regarding the focus on health promotion, as Policy Guidelines and other documents have been created (see also research question # 1). It remains that the BEIHs undertake very little health promotion activities. It was argued in the

previous section this may be the result of an inefficient allocation of human and financial resources (research question # 2). But why is this allocation so inefficient? Why are not the BEIHs interested in integral health? Research question # 3 suggests an answer to these questions by looking into organizational culture.

It is known from management literature that organizational culture can be an important obstacle for the implementation of reforms. Child (2005) rightfully conceives corporate culture as a challenge: "Human resistance is yet another justification of the persistence of conventional organizations. (…) The conclusion is that if organizations are still using conventional organizational forms and they are evolving positively they do not have to move towards radical change. "Routine activities continue to have a significant impact in society." Conventional forms do not need to be changed by new ones necessarily". (Quesada, 2012).

The interviewed specialists Hernández, Barboza and Picado, frequently refer to the professional training received by medical personnel (and even to the "medicine-driven culture" of the BEIH) as an important aspect of the BEIH's organizational culture. This training focuses on healing, but neglects prevention and especially promotion. Hence health promotion is simply not on the radar of most BEIH workers. Moreover, the BEIH (and CSSF) leaders are exclusively people with a medical background, with no background in management. This is perhaps the most important explanatory factor of the deficient interest towards integral health in most BEIHs (see also Carpio & Villalobos, 2001). Based on this research question # 3 can be partially answered affirmatively, although more research on the topic is needed.

4.2.4 Research Question # 4: To what extent are the tasks of the BEIH in terms of preventive and promotional health well defined?

Research question # 4 goes back to the issue raised by research questions # 1 and # 2 which looked at the way health promotion is included in legislation, policy documents and in daily operations of the BEIH. There is however one important issue that has not been covered, related to the international organization of the BEIH, and the way its health prevention and promotion tasks are defined.

The core difficulty regarding the definition of the tasks (responsibilities) of the BEIH is the extensive degree of political, administrative and financial autonomy of the CSSF of which the BEIHs are part. This situation makes any health system reform a complex task, as the CSSF will not automatically implement new policies devised by the Ministry of Health, even though the latter is the governing institution in Costa Rica (see the interviews with representatives of the Ministry of Health) health-wise. This being said, the CSSF does acknowledge – in formal documents – that the local level is the first responsible health service provider for health prevention and promotion.

Some interviewees Rodríguez, Elizondo and Rivera (particularly belonging to the CSSF) complain about CSSF policies designed at the central (national) level being out of sync with the requirements and challenges of local BEIHs. Indeed, the experts interviewed believe that recommendations from the BEIHs that are presented to the CSSF are rarely considered, and that the BEIHs are expected by the CSSF to implement policies which are not feasible or necessary. This is also the case for health promotion initiatives, which do not appear on the agenda of the CSSF's implementing departments (unlike the strategic departments of the CSSF) as they should.

Internally, the BEIHs portray a difference between the medical staff and the staff with other professional backgrounds. The former group is not inclined towards health promotion activities,

sometimes blocking the initiatives of the latter due to divergent perspectives on the role of the CSSF. As a result, the disease care focus remains predominant in the BEIH. Interviewees indicate this causes a major confusion for BEIH workers who read about health promotion in policy documents. Consequently, it can indeed be said there is no clarity on promotional tasks. Research question # 4 must be answered affirmatively, with the observation that the lack of clarity is not limited to promotional tasks, but to the work of the BEIH in general. Indeed, some of the interviewees have also pointed at the general lack of strategic planning of the BEIH, particularly in the South Central region studied in this research.

4.2.5 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 have clear international guidelines and they both have action plans as autonomous institutions. The former is the governing body and the latter has a great responsibility as an institution in charge of 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 in order to reorganize this model at the primary level. Prevention is still prevalent in the BEIH 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 operationalizing and measured, in fact, indicators are mainly preventive. This explains why people see the BEIHs as small hospitals, rather than looking for protection and 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 discussed the numerous restructuring processes to better define tasks after a duplication of functions regarding promotion and preventive roles between the Health Ministry and Costa Rican Social Security Fund. On the one hand, the Health Ministry has opted for the coordination and monitoring responsibilities, and on the other hand, the Costa Rican Social Security Fund has adopted health promotion, disease prevention and rehabilitation tasks. The last one has been responsible for providing health services. Its main role at the primary care level has been based on health promotion, being this first level the first point of contact with the population.

There are different international and national laws regarding health and health promotion. In addition, the Costa Rican health sector is integrated by several heterogeneous actors which have a role in the health process like: 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, Costa Rican Social Security Fund (CSSF) has its own internal policies as an autonomous institution, as well as strategic plans. However, despite the existence of specific laws, the primary health care level (BEIH) is not currently complying with its health promotion mission.

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 issues. Costa Rican citizens do not understand what promotion means, they think of medicine and doctors. In addition, there is no awareness on 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 to a large extent be answered positively. It became very clear from the conducted field work 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 actually happens at the level of the BEIH. Moreover, the conceptual confusion about prevention and promotion is shared not only by the medical personnel but also by the users of the BEIH, which naturally has repercussions on the type of care that is delivered at a local level. It also

strongly impacts the way tasks of the BEIH 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 BEIHs, 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 organizational culture of the BEIH (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.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The previous chapter summarized the results of this study based on raised assumptions. In addition, it was intended to show an analysis of some key findings to understand what the main management deficiencies are at its primary care level in Costa Rica regarding promotion and prevention issues, as well as why this happens. In the next and final chapter some main conclusions and recommendations are proposed essentially to improve the processes within the primary care level, i.e. the Basic Equipment of Integral Health (BEIH) in its communication, management and participation of different actors for the implementation of the social determinants of health.

This research offers an analysis and understanding of the effectiveness, efficiency and equity degree of preventive and promotional integral health at the primary health level of Costa Rica in health management. Despite the difficulty in defining concepts like health, it was attempted to show a wide panorama of terms based on different authors' perspectives, even so, the definition proposed by the World Health Organization was mainly used because of its promotion and prevention approach, i.e., "a complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2003, p.1; Callahan, 2012). This definition was also accompanied by two others definitions. "Health promotion is the art and science of helping people discover the synergies between their core passions and optimal health, supporting them in changing their lifestyle to move toward a state of optimal health" (O'Donnell, 2009) and health defined from Costa Rica's Social Security Fund, "as a political and social process, in which people have a better control over factors that determine their

health (social, political, economic, and environmental conditions)" (Corrales, Urrutia & Porras, 2007, p.11).

5.2 Research Findings

Two important findings ought to be highlighted: a) the author has attended meetings of the Health Promotion Committee which has enriched the research with data provided by the director and all organizations that are part of it. This implementation of this committee will impact the public policy level in order to improve processes of health promotion, as well as, to organize the responsibilities of each social actor and b) it has not been possible to conduct interviews among the BEIH staff due to bureaucratic obstacles. These two issues are important findings since along with the creation of the Committee health promotion processes and coordination among actors could be improved in spite of bureaucracy. The main authorities from the Health Ministry and Costa Rican Social Security Fund were willing to collaborate in this research and provide explanatory factors of management deficiencies in promotion and prevention at a primary level, especially promotion.

The Health System reform constituted a very challenging change for the Costa Rican Social Security Fund by caring for the whole of society's health, incorporating prevention and promotional activities, and evaluating the system regarding management commitments; however, currently this institution cannot do so. Promotion continues to be a complex concept to be implemented. The BEIHs still focus on prevention initiatives with few promotional ones and there are no measurement tools for promotion initiatives. There is no specific budget for promotion (Picado & Quesada, 2011, p.22-24). There is a great deficiency when applying programs, management and promotion / prevention are not given enough attention in the South Central Region (area being studied) regarding planning and management since there is relation with needs and budgets. Promotion and prevention are seen as curative biologist

medicine, delegating tasks only to medical professionals and ignoring other social, political, or economic problems. Management is failing planning strategies and allocating resources.

Costa Rica has always been a model country in health and care, but now its primary health care quality is declining, especially in some areas and mainly relating to human resources. The model uses four components: promotion, prevention, cure and rehabilitation, but the healing/rehabilitation component prevails. This situation is explained by management and organizational deficiencies. People who are selected for management/administration have no experience in organizational management, budgets, human management, community treatment, community health, resistance to change because there is no credibility on social processes. There are difficulties in learning and managing change (Carpio & Villalobos, 2001). Specialists and researchers agreed that real care means a "person-focused and not disease-focused care" (Starfield cited in Akhtar-Danesh, et.al., 2013, p.2) using participatory approaches with individuals, organizations, communities, etc. should be transferred from the national level to the local level" (Cleary, Molyneux & Gilso, 2013).

Changing from a medical model (medicine) to a broader concept based on health care was a small change (McManus, 2013, p.15) defined simply as sanitary assistance. Many international and national primary health care strategies have been defined in order to promote new initiatives based on health promotion and the social determinants of health, emphasizing that not all health problems are caused by medical factors, employment, housing, environment, among other factors, impact health as well. Despite the significant and valuable role, over the past years, this primary care level has collapsed because of the demand, mismanagement and few promotion and prevention focus and also due to the fact that in spite of international guidelines, they are not really complying with health promotion, advocacy, and influence in the formulation of policies and programs (WHO, 1998, p.13).

Regardless of these challenges, the creation of the Health Promotion Committee at the Health Ministry, can and should play an important role impacting the public policy level to improve the processes and

help other members (public and private institutions and organizations) directly or indirectly responsible for health and population welfare by defining clear responsibilities to collaborate in health promotion and disease prevention processes and coordination among actors.

These changes and attempts to work on promotional and preventive practices have achieved significant improvements; however, the health dynamics in this modern world demands a new approach, at least a restructuring at the primary health care level. It is important to acknowledge it should not be exclusive to health services or to the Costa Rican Social Security Fund (CSSF), but that it should involve different groups, individuals or institutions of society so they can act in collaboration and truly work towards health promotion with an holistic approach, evolving from the biologist vision to a social vision.

5.3 Main research weaknesses

This research attempted to identify the main causes regarding management issues in order to understand the deficiencies of promotion and prevention practices at the primary health care level in the Basic Equipment of Integral Health (BEIH), however, it had also some difficulties or challenges so as to achieve a more complete study.

Firstly, the problem is more complex than what the author had imagined mainly because health and integral health involve a social, political, economic and philosophical debate and it was not possible to decide on one concept. Just due to the definition, a debatable situation takes place and despite there being lots of literature, the practice shows another perspective with different contexts and ways of working in different countries.

Secondly, the main challenge was the interviews. The main goal was to talk with the BEIH professionals, who are responsible for the field and can have more authority to talk about the work they

do. It was impossible due to bureaucratic obstacles. The process through which one can request permission for a research takes months. This situation was anticipated and despite the difficulty it presented, interviews with the main authorities from the Health Ministry and the Costa Rican Social Security Fund, responsible for delegating and creating the guidelines for the BEIH workers, were carried out.

Thirdly, health promotion and disease prevention involves many factors. It does not work only with the medical/curative process of the body, but with other areas called social determinants of health (social, environment, employment, housing, etc.). For this research it was only possible to talk with Health Ministry and Costa Rican Social Security Fund who are the sole responsible parties for health services and sanitary assistance. This was not possible due to the limited time to interview other institutions taking part of the health system as Education Ministry, Communities, Transport Ministry, Agriculture Ministry, Housing Ministry, and others that are also responsible for participating in health promotion and disease prevention to comply with these determinants.

Fourthly, regarding methodology, the survey instrument applied to the BEIH users was valuable, but it only allowed to indirectly address the research questions. Other instruments could have been used, but lack of time and human resources were an obstacle, still, it was possible to obtain an overview of health in Costa Rica using qualitative data and interviews that enriched the results and their analysis. Moreover, there was an attempt to summarize the main information in response to the research objectives, in spite of the impossibility to get more information that could have better answered each research question. Measuring the degree of management deficiency with qualitative data is not simple, but it did portray a clear situation and it allowed confirming similar studies previously carried out. Based on these weaknesses, in the next section some main areas for future research will be proposed to enrich the study and continue looking for improvements in management, health promotion and disease prevention.

5.4 Recommendations for future research

This section will be based on the previous weaknesses and the research questions defined at the beginning of the research in order to improve processes.

Research question # 1, regarding the extent to which there is a deficient focus on preventive and promotional integral health at Costa Rica's primary health care level in their Basic Equipment of Integral Health Care (BEIH) shows promotion issues are on the agenda but they are not put into practice. The National Committee for Promotion was created but it remains to be seen whether there will be change in health promotion; this can be done by monitoring their different tasks.

From research question # 2, regarding whether the primary health care level allocates its financial and human resources efficiently in order to promote preventive and integral health, interviews and literature were resorted to, but more research is needed. The researcher's recommendation is field work with case studies and pilot plans within the BEIH in order to analyse people, processes and budgets. Due to the obstacles mentioned in the previous section, this will prove to be quite difficult, but it has potential for future studies.

Research question # 3, regarding whether the equipment of integral health care has an appropriate internal management and organizational culture, field work was also difficult. This research question could be answered although not as strongly as compared to research questions 1, 2 and 4 since it requires an in-depth research. It was impossible to obtain more information from interviews.

Finally, research question # 4, whether the tasks of the BEIH in terms of preventive and promotional health were well defined, there is a lack of clarity regarding promotion tasks within the BEIH, but it is

not just limited to promotion. It is a challenge for all the South Central Region. There is a general lack of planning and strategy. The problem is broader and deserves further investigation.

A bigger effort is required in order to think how to change the system based on health trends of the modern world. Several difficulties encountered will be discussed here. The system has a weakness in the organizational culture (a system can be reformed, but will people's behaviours change?). Linked to this issue, universities do not teach about promotion and prevention. Furthermore, it is difficult to deal with the political and administrative autonomy of the Costa Rican Social Security Fund (CSSF). Generally, the biggest challenge is that health promotion is mentioned in all national, international and public policy documents, but it is also grossly neglected. Finally, beyond changing the model, it is about the implementation and work with human resources and organizational culture.

This investigation identified deficiencies in the health system, particularly at the primary health care level regarding promotion and prevention issues. There seems to be a consensus on the importance of the subject, but research also revealed institutional and cultural obstacles to its implementation. Costa Rica has always been a herald on health issues since its system is relatively modern and efficient compared to other countries in the area, but it is time to go the extra mile, modernize it with a view towards health promotion and finally achieve holistic health: proactive, positive and innovative, operationalizing the social determinants of health.

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Appendix I. Structure, process, outcome

From a holistic approach, three important aspects will be assessed and are divided into: a) management (structure), b) programs (process) and c) users (outcomes). Questions for each section are described in the following tables.

Ten dimensions to measure primary health care (PHC) promotional and prevention initiatives

Structure	**Initiatives / Process**	**Outcomes**
Does the basic equipment of integral health care have an appropriate internal management and organizational culture? To what extent are the tasks of the BEIH in terms of preventive and promotional health well defined? Does the primary health care level allocate its financial and human resources efficiently in order to promote preventive and integral health?	What is the process or follow-up of these initiatives to implement policies that improve internal tasks in PHC?	To what extent is there a deficient focus on preventive and promotional integral health at Costa Rica's primary health care level (Basic Equipment of Integral Health Care)?
• Governance of the PHC system • Economic conditions of the PHC system • PHC workforce development	• Access to promotional and preventive services. • Continuity of promotional and preventive activities. • Coordination of PHC in health public policies.	• Quality of initiatives (experiences of users) • Efficiency of activities (progress in population's health) • Equity in integral health

	• Comprehensiveness of PHC services.	(access)

Source: Based on Scha et.al. (2013, p. 69)

STRUCTURE
When did the BEIH start to focus on promotional and preventive PHC initiatives?
How are you organized? Who is responsible for the promotional and preventive program? How are the roles distributed?
Describe the internal organization and decision-making process.
What are the strategies for personnel selection?
What are the identified problems in human resources?
What are some of the guidelines to plan initiatives?
What kind of initiatives does the BEIH plan?
How are health promotional and preventive programs structured?
How is staff organized to implement initiatives? Which official / informal structures were established for decision-making? What was the strategy of leadership and who was involved in it and how you train and incorporate new leaders?
What is the aim of managing? Why? Why do the BEIH exist?
What elements are considered for managing a health promotional program?
Management is always a challenge of continuous improvement. At this point, what are you doing? How do you evaluate the work?
What are the feasible areas to identify for improvement?
What do you consider are the main causes of the problem?
What can be improved? What management measures can be taken to improve the work? If you are not fulfilling the mission of promoting health and preventing disease, what do you need to do?
To what extent does the management process affect health promotion and disease prevention? Are

STRUCTURE
bureaucratic processes an obstacle to the success of promotion initiatives? To what extent? How could they be overcome?
Who should be involved in solving these problems?
How would you describe the organizational climate of the company?
How are the communication channels developing?
What can you learn about efficient management of other BEIH in the country?
Are the workers familiar with promotional health and are they willing to fully participate?
Have there been barriers to employee collaboration? Were these barriers overcome? How?
What is the budget for promotion and prevention of health? How it is this budget structured?
What are the sources of funding?
What are the non-financial resources? From where? (E.g. human resources with technical skills, assets and materials from community, infrastructure, transport volunteers, contributions in kind, media support, etc.).
Were the financial budget management and financial resources adequate to achieve the goals? If the answer is no, explain the challenges and shortcomings.
New alliances are forged? What are these new alliances?
What changes have been important to the internal organization and why?
What are some strengths and weaknesses of the organizational culture?
To what extent are the staff's roles well defined? How can this be improved?

PROCESS
What do you understand by health care, integral health, and promotion and preventive health?
The WHO defines promoting health as "the process to enable people to increase control over their health". How is this definition materialized?

PROCESS
In the WHO conference on Ottawa in 1986, the Ottawa Charter was adopted, a document that recognizes that health is not simply the product of medical conditions, but a comprehensive problem formed by the social determinants of health (housing, education, food, employment, etc..) How do you address this issue to promote equity knowing that there are more factors than just the medical one? Have you created social protection mechanisms? Which ones?
Promotional and preventive activities take into account participatory approaches (individuals, organizations, communities, businesses, government agencies, faith communities, etc.). It is an inter-sectorial task. If the promotion involves participatory collaboration of all stakeholders in the selection, planning, implementation, evaluation and maintenance of interventions and policies. How do they collaborate with changes that promote health in their programs, policies and practices? To what extent the collaboration is just limited to BEIH workers? What do you do regarding this issue?
Which initiatives have you taken for the promotion and prevention? What is the purpose and main focus? What are the expected results? Could you provide some examples of promotional and preventive activities?
How were working relationships established between different stakeholders to implement specific initiatives?
What are the strategies that have been used / are being used to promote health and prevent disease?
To what extent have technological and managerial innovations promoted changes in promotional and preventive projects?
What are the main challenges of the population in which the BEIH work? What are the challenges to work on promotion and prevention projects? Are there local conditions representing barriers to health promotion (lack of sanitation, extreme poverty, local customs that encourage harmful practices to health)?
What is the guide to document promotional and preventive health initiatives?
How are the strategies and methods to provide information, increase awareness, obtain information of the target populations and keep them informed?
Do you think there is a deficient focus on preventive and promotional integral health programs?
Are the elected authorities seeking to support from politics for preventive health? What is the government support for health promotion?
What are the policy priorities of local government? Is health a political priority?
Does the political environment affect your activities or decisions about how to do it? If so, how?
How are strategies aimed to change official policies (laws, regulations, rules and procedures) and

PROCESS
unofficial policies (edicts, etc..) that affect the way things are done and, consequently, influence the development of individuals with regard to specific problem addressed by promotional and preventive initiatives?
How are strategies used to 'sell' the ideas of the initiative, to convince the authorities, employees and citizens to provide support? What did you do to change policies or advocate for policy changes and laws? How was it made?

OUTCOMES
What is the evidence of integral health effectiveness?
To what extent, are promotional policy, plans, programs and projects progress aimed towards the achievement of: • Healthy Development of public policies • Creating supportive environments • Strengthening social and community action • Development of personal skills • Reorienting health services • Formation of strategic alliance • Incorporation of private subsector
Which performance indicators in health promotion apply to measure the effectiveness and efficiency of a promotion program in a population?
Promotion encourages environmental changes helping to promote and protect health. How do you measure these changes? What instruments do you use to measure them?
How did initiatives improve access to resources and services? For example, which policies were modified to enable community members to have greater access to resources and services? What has the initiative done to provide people access to community programs? What was done to make services more affordable?
What have been the main achievements and results of promotional and preventive initiatives? How are initiatives assessed, under what criteria? How do you measure success?
Which recommendations can be made to improve this and other similar initiatives in the future?
How could you modify the initiatives to make them more efficient and effective? What could you do differently next time?

OUTCOMES
How can more participants be incorporated at all stages of the process?
Which practices could be considered best practice or could help others to try to achieve better results for the promotional and preventive initiative?

Appendix II. Questions. Group # 1: Authorities

1. How are you organized? Who is responsible for the promotional and preventive program? How are the roles distributed? How are health promotional and preventive programs structured?

2. Management is always a challenge of continuous improvement. At this point, what are you doing? How do you evaluate the work? What elements are considered for managing a health promotional program?

3. To what extent does the management process affect health promotion and disease prevention? Are bureaucratic processes an obstacle to the success of promotion initiatives? To what extent? How could they be overcome?

4. Promotional and preventive activities take into account participatory approaches (individuals, organizations, communities, businesses, government agencies, faith communities, etc.). It is an inter-sectorial task. If the promotion involves participatory collaboration of all stakeholders in the selection, planning, implementation, evaluation and maintenance of interventions and policies. How do they collaborate with changes that promote health in their programs, policies and practices? To what extent the collaboration is just limited to BEIH workers? What do you do regarding this issue?

5. What can you learn about efficient management of other BEIH in the country?

6. What do you consider are the main causes/problems of promotional and preventive initiatives?

7. What are the main challenges of the population in which the BEIH work? What are the challenges to work on promotion and prevention projects? Are there local conditions

representing barriers to health promotion (lack of sanitation, extreme poverty, local customs that encourage harmful practices to health)?

8. How are the strategies and methods to provide information, increase awareness, obtain information of the target populations and keep them informed?

9. Are workers familiar with promotional health and are they willing to fully participate?

10. How is staff organized to implement initiatives? Which official / informal structures were established for decision-making? What was the strategy of leadership and who was involved in it and how you train and incorporate new leaders?

11. How would you describe the organizational climate of the company? How are the communication channels developing? What are some strengths and weaknesses of the organizational culture?

12. To what extent are the staff's roles well defined? How can this be improved?

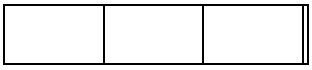
Appendix III. HM and CSSF Questionnaire

STRUCTURE

1. STRATEGY AND MANAGEMENT COMMITMENT

a) A law, rule/regulation or provision exists determining the creation of policy of health promotion (PHP) initiatives.

A B C D

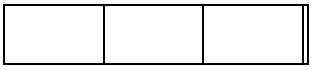


b) There is a manual of functions and procedures that is used.

A B C D

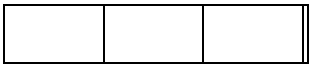
c) The PHP Initiatives are linked to government organizations and non-governmental organizations.

A B C D



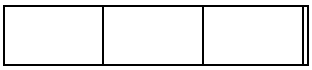
d) The PHP Initiatives are linked to people who practice traditional medicine.

A B C D



e) Principles on which the PHP is based for the population are formulated, with a visible and active commitment of management and other hierarchical structures through their habitual behaviour and management practice.

A B C D



f) The PHP is integral in the structure and processes of the organization.

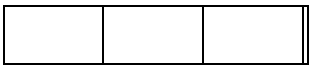
A B C D

g) The necessary resources are allocated (budget, personnel, training, time commitment...) for the development of the PHP interventions.

A B C D

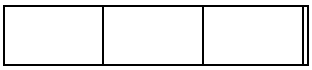
h) The budget for the activities planned for the PHP is sufficient.

A B C D



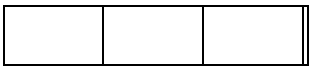
i) There are accounting records of expenses for PHP Initiatives.

A B C D



j) The management periodically reviews the development and results of PHP interventions.

A B C D



k) The PHP is taken into account within the training programs with special managers of the organization.

A B C D

2. HUMAN RESOURCES AND ORGANIZATION OF WORK

a) Tasks related to PHP are well defined.

A B C D

b) There is an assigned and appropriate physical infrastructure to develop PHP initiatives.

A B C D

c) Personal development programs in the field of PHP for workers are promoted.

A B C D

d) Workers are actively involved in decision-making and developing of PHP actions.

A B C D

e) The management and other hierarchical structures take into account and supports workers, promoting a good working environment.

A B C D

f) There is a good balance between personal life and professional life

A B C D

g) There are sufficient financial resources for PHP initiatives.

A B C D

h) There are sufficient human resources for PHP initiatives.

A B C D

i) There is a training system for the responsible staff for PHP initiatives.

A B C D

j) Interdisciplinary teams at the primary level are involved in PHP initiatives.

A B C D

k) PHP is a transversal theme in all operations at the primary level.

A B C D

l) The impact / effects of PHP initiatives on people's satisfaction are systematically measured and evaluated.

A B C D

m) The PHP measures on impact / effects on the economic indicators (staff retention, productivity, cost / benefit studies, etc.) are systematically measured and evaluated.

A B C D

PROCESS

3. HEALTH PROMOTIONAL PLANNING

a) There is an organizational chart for the PHP initiatives. The organizational chart is modified according to the reality of the initiatives.

A B C D

b) PHP activities are developed according to strategies, times and planned resources.

A B C D

c) There are data records of actions taken to achieve the objectives of PHP initiatives.

A B C D

d) Protocols / procedures related to PHP provided by the authorities are implemented.

A B C D

e) There is opportunity for innovative processes at the primary level regarding PHP initiatives without relying on national or regional hierarchy.

A B C D

f) The progress of PHP objectives is evaluated.

A B C D

g) Responsible people for PHP initiatives write reports about the achieved objectives.

A B C D

h) The PHP objectives are measured through qualitative / quantitative indicators.

A B C D

i) There is taskforce for planning, monitoring and evaluating PHP interventions.

A B C D

j) Recipients and measurable objectives for all PHP interventions are defined.

A B C D

k) PHP actions are planned and communicated throughout the organization.

A B C D

OUTCOME

4. IMPACT OF HEALTH PROMOTION INITIATIVES

A B C D

a) The BEIH works with reports about the socio-demographic characteristics of beneficiaries / users of PHP initiatives.

A B C D

b) In PHP interventions, individual, family and community actions are considered and interrelated.

A B C D

c) Demands of beneficiaries / users regarding PHP are met.

A B C D

d) At the primary level interdisciplinary teams work with beneficiaries / users to achieve PHP Initiatives.

A B C D

e) A plan of systematic evaluation and continuous improvement of PHP activities is established.

A B C D

f) PHP actions are based on a periodic review and update of available information on health data: health indicators, stress, risk factors, etc.

A B C D

g) Users satisfaction with the PHP measures is systematically evaluated.

A B C D

h) Population needs / ideas to improve care-related to PHP at the primary level (BEIH) are taken into account.

Source: Based on Solé, 2003, p. 2 & Zanini, 2009, pp.6-12

Procedure and assessment criteria

The questionnaire consists of a total of 43 questions that need to be answered for the final score. The evaluation criteria to answer the questions are shown in Chart 2.

Score Categories

CATEGORIES	EXPLANATION
A = Fully Achieved	The activity has reached its goal. The activity is a good example.
B = Significant progress	There is clear evidence of the development of activities. There are some deficiencies because the projects have not reached the entire organization or have not considered all aspects.
C = Some progress	There is some development evidence. Improvements are carried out occasionally. Successful development or positive results in some sectors.
D = Not started	No evidence of any activity. Some good ideas but intentions prevail.

Source: Solé, 2003, p. 4

For each area, the total number of questions for the categories A, B, C and D is counted. Then, that number is multiplied by the corresponding correction factor (A = 100, B = 67, C = 33, D = 0). The total value of the study area is equal to the sum of the results for each category and the percentage (%) of success is obtained by dividing the total value by the number of criteria that make up the area. This is

how the success rate is calculated for each area. Table 3 provides guidance for evaluating and Table 4 indicates the “profile” of the organization according to the results.

	A	**B**	**C**	**D**	Sum of questions
Number of answers (a)					x
Correction factor (b)	100	67	33	0	
Value (a * b)	+	+	+	=	Total
Total (x)	% Success				

Appendix IV. Questions. Group # 2: expert panel (Authorities from the HM and CSSF)

Questions

1. Does a law, rule/regulation or provision exist that determines the creation of policy of health promotion (PHP) initiatives?
2. Does the PHP is integral in the structure and processes of the organization? Do tasks related to PHP are well defined?
3. Is there an assigned and appropriate physical infrastructure to develop PHP initiatives? Is there an organizational chart for the PHP initiatives? Has the organizational chart been modified according to the reality of the initiatives?
4. Do PHP actions are planned and communicated throughout the organization?
5. Do teams have an interdisciplinary work with beneficiaries / users to achieve PHP Initiatives at the primary level?
6. Does a plan of systematic evaluation and continuous improvement of PHP activities was established?

Appendix V. Users Survey

1. Where would you like to receive information about your health care?

Doctor / health care provider

Caseworker / social worker

Family

People

Co-workers

Church / Religious Groups

Neighbours

Nooks

Internet

TV

Support Groups

Social Services

School

Other: _____

2. How would you like to receive information about your health care?

Written materials

CDs

Videos / DVDs

Large Print

Blind letters (Braille)

Mail / Internet

Social media

Art

Other: _____

3. Are you satisfied with the information you receive from your physician or provider health?

Yes

No

Do not know

4. Please explain: What information would you like to receive from your doctor or health care provider? _____

5. What health promotion activities would you be interested in participating in?

Leisure activities / reducing stress

Health education classes

Fitness Classes

Cooking classes or nutrition

Social Groups

Religious / spiritual activities

Recreational activities

Art & fantasy literature

Other: _____

6. What kind of support from health promotion would you be interested?

Help to prepare your home

Job training or assistance manage your money

Help to plan transportation

Reminders for medical tests

Reminders to exercise

Assistant to look for a job

Other: _____

7. What information health promotion would you be interested?

Information on accessibility services

Information accessibility of roads or other outdoor fitness activities

Information about alternative treatments

List of resources

Other:
_____
_____

8. People sometimes have difficulty doing what's needed to stay healthy. Please indicate how often each of these problems prevent you from doing what is necessary to stay healthy (put a cycle).

Lack of adequate facilities

Never / Sometimes / Often / Always

Too Tired

Never / Sometimes / Often / Always

Lack of transportation

Never / Sometimes / Often / Always

Feeling that what you do is not useful

Never / Sometimes / Often / Always

Lack of money

Never / Sometimes / Often / Always

Difficulties

Never / Sometimes / Often / Always

No one to help me

Never / Sometimes / Often / Always

I am not interested

Never / Sometimes / Often / Always

Lack of information on what to do

Never / Sometimes / Often / Always

Embarrassed about my appearance

Never / Sometimes / Often / Always

Worried about security

Never / Sometimes / Often / Always

Lack of support from family / friends

Never / Sometimes / Often / Always

Interference with other responsibilities

Never / Sometimes / Often / Always

Lack of time

Never / Sometimes / Often / Always

I feel like I cannot do things correctly

Never / Sometimes / Often / Always

Difficulty with communication

Never / Sometimes / Often / Always

Bad weather

Never / Sometimes / Often / Always

Lack of help from health professionals

Never / Sometimes / Often / Always

Lack of access / accommodations of the disease

Never / Sometimes / Often / Always

Other:
_____
_____

Source: National Association of County & City Health Officials (NACCHO), 2014, pp.1-6

Appendix VI. Questions. Group # 3: BEIH Users

Questions

1. Where would you like to receive information about your health care?
2. How would you like to receive information about your health care?
3. Do you have access to resources and services?
4. What kind of support from health promotion would you be interested?
5. Which recommendations can be made to improve promotional and preventive initiatives?
6. People sometimes have difficulty doing what's needed to stay healthy. Please indicate how often each of these problems prevent you from doing what is necessary to stay healthy (example of Likert Scale).

Appendix VII. Questions. Group # 4: Experts

Questions

1. What do you understand by health care, integral health, and promotion and preventive health? The WHO defines promoting health as "the process to enable people to increase control over their health". How is this definition materialized?

2. How are strategies aimed to change official policies (laws, regulations, rules and procedures) and unofficial policies (edicts, etc.) that affect the way things are done and, consequently, influence the development of individuals with regard to specific problem addressed by promotional and preventive initiatives?

3. How do you address this issue to promote equity knowing that there are more factors than just the medical one? Have do you collaborate with social protection mechanisms? Which ones? In the WHO conference on Ottawa in 1986, the Ottawa Charter was adopted, a document that recognizes that health is not simply the product of medical conditions, but a comprehensive problem formed by the social determinants of health (housing, education, food, employment, etc.)

4. How do you evaluate the budget for promotion and prevention of health? How it is this budget structured? Are the financial budget management and financial resources adequate to achieve the goals? If the answer is no, explain the challenges and shortcomings.

5. Which initiatives have you taken for the promotion and prevention? What is the purpose and main focus? What are the expected results? Could you provide some examples of promotional and preventive activities?

6. What are the strategies that have been used / are being used to promote health and prevent disease?

7. Are the elected authorities seeking to support from politics for preventive health? What is the government support for health promotion?

8. Does the political environment affect your activities or decisions about how to do it? If so, how? Are the elected authorities seeking to support from politics for preventive health? What is the government support for health promotion?

9. What are the policy priorities of local government? Is health a political priority?

10. How are strategies used to ‘sell’ the ideas of the initiative, to convince the authorities, employees and citizens to provide support? What did you do to change policies or advocate for policy changes and laws? How was it made?

11. Do you think there is a deficient focus on preventive and promotional integral health programs?

Appendix VIII. Legal framework and public policies

The legal framework (at the international, national and regional levels) provides the basis on which the Costa Rican health institutions construct their political participation, and where different social actors has commitments to build the overall health, especially on health promotional issues. The legal framework for health promotion consists of large number of documents, which can be divided into 5 core topics:

International commitments and charters

Various international conferences have identified the basis for the development of health promotion. Each one presents concepts, objectives, priorities, and actions that governments should adopt. Internationally, the importance of incorporating health promotion in the national life of every country has been recognized, however, in practice very little has materialized in the policies of Costa Rica (Picado 2014).

The next table summarizes the relevance of each conference.

Summary of International Conferences

Conference: Ottawa, Canada 1986	**Conference: Adelaide, Australia 1988**	**Conference: Sundsvall, Sweden 1991**	**Conference: Jakarta, Indonesia 1997**	**Conference: Federal District, Mexico 2000**	**Conference: Bangkok, Thailand 2005**	**Health Promotion Strategic Plan for Central America and Dominican Republic, 2014-2018**
Main goal: "Health for all in the 2000". New vision of Public Health. Promotion involves other sectors. Main principles: peace, food, education, income, housing, stable ecosystem, resource conservation, social justice and equity. 5 lines of action:	Public policies are relevant to influence the determinants of health. The document "Adelaida Recommendations about Favourable Public Policy to Health" was elaborated.	Importance of sustainable development. Call for social action at the community level.	Agreement on five priorities: To increase the community capacity. Empower individuals. Expand and strengthen partnerships for health. Increase investments for health development. Secure an infrastructure for health promotion.	Development of the five priorities of the previous conference. To demonstrate that promotion improved health and quality of life.	Greater policy coherence and better cooperation between governments, international organizations, civil society and private sector. To identify the determinants of health and influence on them.	Generate political, social and technical decisions to empower stakeholders with promotion of health commitment with a proactive, proposing, positive and innovative vision into multi-sectorial work with the determinants of health.

Conference: Ottawa, Canada 1986	Conference: Adelaide, Australia 1988	Conference: Sundsvall, Sweden 1991	Conference: Jakarta, Indonesia 1997	Conference: Federal District, Mexico 2000	Conference: Bangkok, Thailand 2005	Health Promotion Strategic Plan for Central America and Dominican Republic, 2014-2018
Healthy Public Policy Healthy environment creation Strengthening community action Development of personal skills Health services reorientation						

Source: Picado, 2014, pp.2-3

National legislation

Legal precepts regarding health promotion are found in the Political Constitution, the General Health Law, the General Law on Young People, the New Municipal Code and decrees on thematic areas which are (directly or indirectly) related to health promotion. The scope of the existing legislation at the national level can be summarized as follows:

Summary of the political/legal framework

Political Constitution	
Article 50	Everyone has the right to a healthy and ecologically balanced environment The State shall guarantee, defend and preserve that right.
Article 169	The municipal jurisdiction is guided by local interests and services. It should be of interest and public services, which generally concern the canton.
General Health Law	
Article 1	The population's health is a good of public interest protected by the State.
Article 2	It is an essential function of the State to ensure the health of people and the Executive Power, through the Ministry of Health has to define the national health policy, training, planning and coordination of all public and private activities on health.
Article 3	Everyone shall have the right to health benefits and the responsible to provide for the preservation of health and the maintenance of his family and community health. Everyone has the right to obtain appropriate information and instructions in matters of promotion and preservation of health.
N°7739 law Code of childhood and adolescence & General Law of Young Person 8261	Explains everything concerning the rights and responsible people for Childhood and Adolescence. Many issues related to health promotion are highlighted. The cantonal committees of the young person coordinate all the national policies for integral development.
Law No. 7800. Costa Rican Institute of Sport and Recreation. Legal Status of Physical Education, Sport and Recreation Article 1, 3, 8,11, 16, 20 and 76	Promotion, support and encouragement of individual and collective practice of sport and recreation, commitment with the integral health of the population.
Municipal Code	Article 1, 4, 6: It is constituted by the set of neighbours living in the same canton. The municipality should manage and provide public services. Linked with the Article 75 of the childhood and adolescence code, municipalities will establish necessary policies to facilitate recreation fields and ensure the physical and mental health of the population.

Decrees Nº 38218-S Gaceta, No. 50 of March 12, 2014. "National Commission of Health Promotion"	Recently it was created. It is an important issue because will ensure the achievement of equality, rights, and social participation, through the coordinated development of actions of health promotion, functions of development, implementation and monitoring of the National Policy with the involvement of all sectors and stakeholders (individual, community or organizations). Ensure that each public institution takes the necessary measures to promote health. Health sector: Ministry of Health, Institute of Alcoholism and Drug Dependency, Costa Rican Institute for Research and Education on Nutrition and Health, National Centres for Education and Child Nutrition and Nutrition Centres and Integral Care, Costa Rican Social Security Fund, Costa Rican Institute of Aqueducts and Sewers, etc.

Source: Picado, 2014, pp.5-15

Technical framework

This section presents the general guidelines that guide social actors in Costa Rica that are involved in health promotion.

Technical/Political National framework

Plans, programs and projects	**Content**
PND-2010-2014 "Solidarity, Safe and Healthy Communities"	Agenda for sustainable local development with productive and entrepreneurial capacity of the population, executing initiatives for the benefit of education, health, safety, employment, etc.
National Health Policy 2011-2021 and National Health Plan 2010-2021	Human rights, social cohesion, diversity, equality and equity, and guiding principles. To position health as a social value and lead social actors (individual, community or organizations) to make an impact on the determinants of health (biological, environmental, socioeconomic and cultural related to health services).
National Health Strategic Plan of adolescents 2010-	Strengthen and consolidate the efforts of the National Health System (Ministry of Health, Ministry of Education, Ministry of Justice and

Plans, programs and projects	Content
2018	Peace, CCSS, IAFA, DINADECO and Municipalities, public and private entities).
National Strategy Action Plan for Healthy Eating, Physical Activity and Health 2006-2021	Promoting physical activity and recreation.
Strategic Plan RECAFIS Executive Decree No. 32886, 2006	Establish inter-sectorial coordination in the formulation and implementation of national policies on physical activity, sport, recreation. Health alliances with new sectors: transport, security, environment, tourism.

Source: Picado, 2014, pp.15-21

Institutional policies linked to the Rectory of Health Promotion

The fulfilment of the institutional mission of the Costa Rican Ministry of Health is dependent upon its leadership, driving and joint resources. The following section summarizes the conceptual and strategic framework principles and institutional policies.

Institutional policies, Rectory of Health Promotion, Ministry of Health

Institutional policies	Content
Focus on human rights and equity	The right to people's health, not just services.
Technical Leadership	The Ministry of Health is the governing body. It has the responsible for direct and lead social actors.

Institutional policies	Content
Social participation and right to non-exclusion	The rectory should be done in a participatory way, and involve representatives of public and private institutions.
Impact orientation	To clearly identify the determinants of health-disease process.
Search for synergy	To use the available resources to avoid duplication and inconsistencies, and ensure coordination and synergy.
Health promotional approach	Ensures protection and improvement of the health status of the population.
Specific policies	The Minister and Deputy Minister of Health, the General Director, Directors of the governing Health Regions and all Directors of the Governing Health Areas have rectory activities.
Political Direction of Health	Run concrete actions helping social actors to adopt a strategy of health promotion.
Strategic Health Planning	The Ministry should help the social actors of the Social Production of Health, to develop public health policies, objectives and action plans

Source: Picado, 2014, pp.26-29

Institutional policies linked to the Costa Rican Social Security Fund

In previous chapters it was mentioned that the CSSF is an autonomous institution and it has its own policies, however, all the previous laws involve this institution. In the next table, some relevant issues are summarized:

Institutional Policies of the Costa Rican Social Security Fund

The constitutive law of the Costa Rican Social Security Fund	Article 1.The Costa Rican Social Security Fund was created to implement the compulsory social insurance. It is an autonomous institution, which has responsibilities of government and administration of social insurance. The Fund is not subject to orders, instructions, circulars and guidelines issued by the Executive Power in government and administration of insurance, funds or reserves. Section 2. Mandatory social insurance includes sickness, maternity, invalidity, old age, and involuntary unemployment; in addition, participation in loads of motherhood, family, widows and orphans and provision of a fee for burial.
Health Insurance Regulations	Article 17. Talks about and integral health care that includes: promotional, preventive, curative and rehabilitative actions Article 75. Insured rights. Be addressed in a timely way, , within the possibilities of the institution with the greatest of respect, without discrimination, in a relationship that highlights their status as human beings. To be inform about their health (accurate and clear information) and different treatment alternatives.
Institutional Policies 2007-2012, in its document "Renewed CCSS 2025". It has the strategic	5. To strengthen and establish the health promotion and disease prevention, as axes of the integral health care process.

planning with special attention in points 5, 6, 8 and 23.	6. To strengthen citizens' right to information and increase gradually the power of users to make choices and decisions in the care process. 8. To promote the organization and teamwork within and between sectors working together to improve the impact of health programs. Actively promote the development of an organizational culture focused on user's services, transparency and accountability. 23. To develop a new management model of the health services and units under the network approach.

Source: own data based on CSSF documents, 2014

Appendix IX. Public policy recommendations

Based on the findings, regarding management deficiencies at the primary health care level in promotion and prevention initiatives, there are some main recommendations that could help to organize and define the internal organization of the Basic Equipment of Integral Health in Costa Rican to achieve and adopt a better and inclusive integral health. The following recommendations are presented based on the main research questions raised at the beginning of the investigation.

Research question #1. To what extent is there a deficient focus on preventive and promotional integral health at Costa Rica's primary health care level (Basic Equipment of Integral Health Care)?

Review of international and national law

The international and national law is clear in emphasizing the relevance of the promotion relevance, but its implementation process is a slow process and its operationalization inefficient or had not received an efficient operationalization. There is an inconsistency between the conceptualization of the concept proposal and its and the implementation process. The Costa Rican national policy should therefore be further revised in light of the laws and trends of the current environment.

A new guideline should be prepared to elaborate a health policy and healthy policy with a better coordination and materialization of the social determinants of health. The first one, is related to health services and programs;, the second one, to an influence or advocacy focus. Additionally, if health promotion is part of the health sector, a political agenda in all sectors and at all levels of government

should be developed and worked. Indeed, health investment is a strategy to maximize the impact of public policies on health promotion (WHO, 1998, p.26).

Health care model: a new reform

Based on the National Dialogue on Health, in summary, four key issues regarding health reform can be identified: financial sustainability of social security, management of human resources for health, model of organization and management of health insurance, model of health care people and the determinants of health (Ministry of Health, 2014, p.14).

There is a need to reform the health care model, that model, which goes beyond the disease model of care. The model requires adjustments and requires innovation, freshness. It is a very serious issue, but at the political level, it does not receive enough support, as was also highlighted . It was retook the urgency to speak of the renewed primary care and that is within the Regional Plan for Central America and Dominican Republic.

Health systems worldwide are facing the same problem: the "rising costs and uneven quality" (Porter & Lee, 2013, p.1). According to Ruiz (2014), Porter focuses on an integral wellness and explains that the approach should focus on the creation of value. The main thing is to define the goal, there has not been clear goals or people have tried to meet the wrong goal. Everything has been focused on generating profit to improve services but no good results.

The creation of value for the patient is "health outcomes achieved that matter to patients relative to the cost of achieving those outcomes (Porter & Lee, 2013, p.4). Michael Porter proposes the "specialized care units". There are interdisciplinary units where internists, surgeons, social workers, etc. . This shows a complete scheme of services. Currently, the health system does not have integration. This new proposal will help to work as a team. It is a more personalized care.

The primary level of care has been consisted in a management that addresses many heterogeneous needs of heterogeneous groups and value creation has not been possible nor results. This model would work very well at the primary care level because it is holistic. The model would proceed with a change in the centralization supply (what the doctor does) to a patient centralization (what he really needs). Is It is about moving from volume and profitability, i.e. the merely biologist model, to the achieving results for the user, a more comprehensive model. Porter & Lee (2013) call it "the value agenda", where there is a system restructuring in its "organization, measurement and reimbursed" (Porter & Lee, 2013, p.1).

Some organizations have made pilots like in one Costa Rica's hospital. In the USA they are already doing this and England is going to implement it. It is an option that should be evaluated by the authorities. It is an option that should be adapted to the environment and tropicalized. Others have already incorporated this new model in most of the system as Cleveland Clinic and Germany's Schon Klinik. This has provided them with better results and efficiency. According to Porter and Lee (2013, p.4) the agenda of creating value for the patient would have 6 interdependent components:

- **Organize into integral practice units (IPUs):** organization around the user and need. Efforts should be based on the patient's medical history and give a follow up to the patient throughout the process. This would include (depending on the state of the person) a process of promotion, prevention, education, communication, personalization. The proposal will rethink creating value for the patient. There is a more direct contact . This would ensure better promotion based on performance measurement and cost per patient to determine if the promotion is running or not .
- **Measure outcomes and costs for every patient:** It would monitor progress, performance would be compared with their peers inside and outside the organization. It should be measured by medical condition and not for medical intervention, i.e., not clinical indicators. This would be taking into account indicators for health promotion.

- **Move to bundled payments for care cycles:** The better payment approach "is a bundled payment that covers the full care cycle for acute medical conditions" (Porter & Lee, 2013, p.12).
- **Integrate care delivery across separate facilities:** "Many multisite organizations are not true delivery systems" (Porter & Lee, 2013, p.14-16). Systems required to be integral, to remove fragmentation, duplication and optimize care in each location. This integration will be possible with a) defining the scope of service, b) volume concentration in few places, c) choosing the right location and d) integration of the right locations for patient care.
- **Expand excellent services across geography:** The proposal is based in a geographic expansion to improve the value, not to increase volume. It also takes into account the hub-and-spoke model where the staff rotates in different localities. It would be a satellite facility.
- **Build enabling information technology platform:** Health care IT systems have been isolated departments, by type of service, data, etc. They are complex and not integral. A new proposal to improve the value according to Porter should consist of: a) centralization of the user, b) use of common terms of data, c) uses all kinds of user data, d) records are accessible who those that serve, e) includes templates and expert system, e) extract information is easy

Research question #2. Does the primary health care level allocate its financial and human resources efficiently in order to promote preventive and integral health?

Resource allocation has taken relevance within management areas. It is linked with budgets and the way in which planning is developed to allocate it. Analyzing the allocation planning elaborated by the CSSF, it is noted that the entire whole budget is destined to prevention activities. Knowing that this

explains one of the main deficiencies for health promotion, it must be redefined to provide a specific budget. Green, et.al. (2000) propose 4 main components:

- defined roles and responsibilities for human resources
- health needs of a specified population
- the relative costs of different health promotion initiatives
- the relative costs associated with different health promotion areas within the BEIH

All this needs an organization regarding clearly definition of tasks and good decentralization. Health promotion involves a personnel planning, production, and management in a well coordination with each other and with a multidisciplinary team that contributes with their knowledge. The Ministry of Health works with general aspects of national health, policy directions, as lead agency management, the Ministry of Health cannot intervene in the CSSF processes because of its autonomy. Decisions affect the operation of primary care producing imbalances and inequities.

Financial and human resource allocation are two of the main challenges for the primary level, especially regarding promotional health. Time and evaluations have shown that primary health care, is the most important level to include promotion and prevention initiatives, but it lacks of technical and human capacity to implement creativity and efficiency as important work.

Therefore, the inter-sectorial collaboration (public and private sector, civil society, municipality, etc.), comes as a viable option between “different sectors of society who can take action to comply with and be accountable for health outcomes” in a more effective, efficient and sustainable way (WHO, 1998, p.25) without having to allocate all tasks to the CSSF.

There are implications for practice innovation that does not have to be complicated, instead, something simple like “setting up online appointments that are linked with standard procedures such as

handwritten ledgers or computer scheduling. This option can significantly improve accessibility, or simple mobile phone SMS messages as appointment or reminders; networking sites providing advice and supporting people living in regional or rural settings; and teleconference facilities supporting healthy lifestyles through electronic consultations " (McManus, 2013, p.16-17). Primary health care demands a system transformation (staffing, information management systems, tools that support coordination of care and the improvement of quality) (Hutchison 2008; Hutchison, Abelson, and Lavis 2001 quoted in Hutchison, 2011).

As stated previously, the CSSF and Health Ministry has their own autonomy, but being the CSSF one of the actors involved in the National Committee for Health Promotion, it could be coordinate a better intervention and management of resources. The coordination process would enable the CSSF to has its own strategic and together with the other members from the Committee, work on strengths, skills and resources, avoiding that all the promotion and prevention initiatives relapse on the CSSF.

Research question #3. Does the basic equipment of integral health care have an appropriate internal management and organizational culture?

Internal management

One of the main deficiencies corresponds to management processes. Despite the valuable attempts within the health system and specially the CSSF, there is still a lack of vision, leadership, and guidelines. Doctors are not prepare in management issues. They do not know the techniques and tools to manage an organization. There is a weak call. Promotion is a transverse axis, however, people are not renewing. There are not enough human resources. BEIH need to have input and create incentives because people are burning.

It should be create awareness and inform that the impact measures are not seem easily. What people have seen has been a policy and legislation, but health is not an end, it is a tool for improvement. People should learn and wait for results. To improve a better quality in care performance and better human resource tasks, there are at least three areas that could be integrate in the BEIH internal organization, with three groups of management actors: formulators, implementers and evaluators to work in a simultaneous creation (Schofield, 2001):

External and internal knowledge

Authorities has the responsibility to coordinate, design strategies, guide, improve, organize and many other tasks. Before all of this, it is necessary to perceive external domains like: community needs and population characteristics and internal domains like: known their team and their abilities, before designing all the health promotion strategies.

Planning and Organization

Managers or authorities should be available to encourage people for better encouraged and skilled practices. A good step could be the promotion of mentoring/training programs that provide the theoretical-methodological and operational tools needed for all actors, in which they can drive from their management the Health Promotion approach and in that sense consolidate an empowerment. The strategic and operational plans can integrate policies, programs and projects to promote work on the determinants and protective factors of the promotion (Lidia 2011, p.31).

Directing, controlling, and decision making

Katz (1984 quoted in Jones & Bartlett, p.21) mention at least 3 main competencies:

- Conceptual skills: Capacity of critical thinking and analysis.
- Technical skills: Are based on the abilities and talents to fulfil a task.
- Interpersonal skills: Ability to communicate with other, negotiate and coordinate.

Knowing that the primary health level had tend to focus more on prevention health programs, it is important to create health promotion indicators using the previous competencies and: a) develop initiatives in which integral health could be the main purpose and b) to work with an evaluation and results to show success examples on health promotion. Managers should learn how to guide but specially to delegate according to the expertise.

Organizational culture

Findings show how communication and solidarity are one of the challenges between professionals at the primary health level. Even so, it should be explore and make a research to determine culture organizational factors to understand the link between internal culture and the impact on the quality of health care (Glickman, et.al., 2007).

Due the resistance for change in the process between doctors and professionals in the social sciences to respond to promotional initiatives, the implementation of some tools and leadership coaching from the private sector are required to moves towards a learning organization culture (Child, 2004) like the recommended by Carpio & Villalobos (2001), "induction, training, participation, communication and staff training". This could improve the human resources.

Because a deficient coordination between different professions, it should work on sensitization workshops to overcome disrespect attitudes among professionals at different levels. It is to focus on a service line management, which provides benefits like, lower costs, quality, user's satisfaction and team-based model. It is a cultural change to achieve a better meeting planning and teamwork. The effectiveness of an initiative depends not only in education, but to use strategies for motivation and commitment (O'Donnell 2013, p.1)

External culture

People who promotes health must have two basic elements: empathy and social relations, there is a fertile land within communities. Professionals need to investigate people's needs and know reality. It is required to have empathy about people's feelings, a social participation and representativeness. One of the main weaknesses exposed at the National Dialogue was the issue of people's care, beginning to the appointments made to be attend at the BEIH by standing in line since 4:00 am and waiting for the next day in case they had not been attended. Professionals should start from an organizational culture as a form of BEEN, DO, BELIEVE, FEEL, and ACT.

They need to strengthen the culture of the organization to attach high priority to the treatment, to relationships, to allow a patient/professional communication. At the moment there is no communication, only information and commands/order. Health involves many perspectives from the Health Sector as a whole but especially from the Health Ministry and CSSF specialists. They all have their own opinion, but at the end the camp workers have more property to explain their experiences at the local level, with people and communities. Guerrero, et.al (2013) proposed what is called "user embracement/simply embracement". It is a concept that implies a humanized and civil relationship, with qualified listening as an essential technology for the reorganization of services.

Research question #4. To what extent are the tasks of the BEIH in terms of preventive and promotional health well defined?

The issue of health promotion has gained importance in international and national conferences, also in documents that establish a series of actions. Still efforts have been minimal, at least at the primary level where it has privileged the work on disease prevention. The next sections propose some actions to overcome these deficiencies.

Health promotion for people

The concepts of promotion and prevention tend to get confused, therefore many of the initiatives combine both terms in the practice. To overcome this challenge, communication channels should be improved and work on the people's mental maps. Strategies also need to be improved within the operational plans at the local level.

Health sector needs to start from zero, explaining people what means by health, promotion and prevention. Otherwise, people will continue thinking in the BEIH as mini-clinics or emergency services to get pills and heal a disease. People need to know and avoid this saturation. Many patients visit the BEIH and accumulate a lot of drugs that they do not use, which is costly for the health system. Management should have had the responsible to educate with a preventive consciousness, however, they cannot have all the fault because people was also responsibility to know what is the main purpose of a BEIH and need to be educated on promotional issues.

Promotion of health works should work and be seen from four main elements, according to the *Strategic Plan for Health Promotion for Central America and Dominican Republic 2014-2018:*

Positive: working on the health protective factors, i.e., what is good, what is identified, and what should be visible in the planning priorities. In Costa Rica, according to Picado (2014), it has never been worked from these scenarios. Health diagnosis is mostly made from an epistemological profile (morbidity, mortality, and in some cases risk factors) . In this way, how do people can establish a priority for planning health promotion if they have only worked with a preventive approach and care of the disease?

To plan a promotional diagnosis, there should be prepared a review of institutional cultures and the culture of planning, i.e., a situation analysis where all the protective factors that characterize groups of populations, a diverse community since its determinants or dimensions will be identified.

Health Ministry based on different international guidelines, talks about the social determinants of health. Talking about promotion (in the environmental or ecological determinant) should involve all the actors wishing to participate, being committed and plan promotion. What is good requires also action, what is good should continue positive.

Proactive: because there is anticipating decisions and maintaining basic health conditions. Picado (2014) explains that promotion of health has several approaches: lifestyles, human development, health policy. Lifestyles is the most used, but not even in the strict sense of the word, only as physical exercise and nutrition. If actors want to work with lifestyles, it is relevant to create conditions for its development, i.e.., empower people, to develop their potential, internal resources, build self-esteem, the ability to manage emotions, decision-making ability. Lifestyles start with the person.

Inventive: because it involves a constant proposals development that should be consistent with the characteristics for each action to be performed. It always involves changes, along with innovation, creativity, initiatives. It seeks to position the new paradigm of health and its promotion.

Innovative: Promotion of health involves social innovations with new ideas in products, services and models. This focus answers to the social needs and creates new social relations and well-being generation. This approach is based on the participation and incorporation of new techniques (Ministers of Health Council of Central America and Dominican Republic, 2014, p.19). For example, the Regional Central America and Dominican Republic plan is official, but its implementation is not easy, it involves changes in mental maps. There is a new element incorporated, the neuro-linguistic programming. It is believed that people can move faster in that empowerment and make the differentiation between the channels of perception of people. It also has been much confused with health promotion, health education, and social communication.

Health promotion requires a combination of communication techniques to reach its target audience. It is important to set these mental maps, people have been raised with one mind map, which is set just a biologist approach. Therefore, it is difficult to understand promotional of health. Health is thought from the disease. All interests are oriented to build a hospital or clinic.

Promotion works with processes. Costs have been enormous and almost without impact. Every day there is more demand and the panorama must be reinvested working to have more positive people, having a different attitude, talking differently, thinking differently, joining forces, planning. All these should be done by people.

University's training

The National Centre for Medicine of the University of Costa Rica has laid established connections with health fairs and a population of patients in primary care. The Centre has a program of care for patients

and practitioners or students should learn and fulfil with the follow up. Students trace and materialize intervention with promotion tips . At fairs, they give newsletters that talk about the disease. They give active information that has emerged from passive information (Hernández, 2014).

Despite this effort, clearly established leadership in the health sector, starting with schools of public health and academic programs in health sciences should be strengthen. The academic sector should disseminate concrete examples of health promotion that have succeeded in improving the health conditions of urban and rural populations.

A previous diagnosis of the health status of the population is required. Universities can collaborate with demographic and epidemiological study with social determinants of health approach to influence public policy. Also more studies are needed on the cost-benefit and cost-effectiveness for a better decision making.

This diagnosis would formulate more objective promotional strategies and plan all inter-sectorial actions that directly affect negatively on the population. The National Committee for Health Promotion can function as a unit with capacity to coordinate, plan and analyse the scope and consequences of public policy on the health of the population. As well as monitoring and evaluation of policies that affect their social determinants and make proposals to positively help improving health.

Management with vision

Health has become an industry, services are viewed as consumer goods, which is the reason that explains why health expenditure has increased worldwide. This process cannot be a game of supply and

demand, serious measures should use to control the resource optimization, efficient management, quality development, rigorous planning and equitable distribution (WHO, 2003).

It is necessary the management impulse to maximize savings. It must look for a management capacity, a visionary, who always read the international, national and local environment and can do all integrations, links and interpretation of what happens to make future projections and institutional settings.

The social context of a country is required, to organize and developed daily activities in which people interact with environmental, personal, community, economic and political factors, those aspects who affect their health and well-being. In addition, scenarios help people to organize, mold and use the context to create an active project related to their health promotion (Hernández, 2010).

The scenarios' creation requires a change: people and organizational modifications (the management structure). Therefore, the role of the National Health Promotion Committee could be essential by the collection and organization of all the existing scenarios like: schools, workplaces, hospitals, population, cities, etc.; and all the new ones. This is an example of how, from the definition of the WHO, it can acquire life because of changes made in the organizational structure (WHO, 1998, p.30).

Local governments

Local governments (municipalities) in this case are the most important levels and close to towns to promote health from the primary level and specifically from BEIH. With their resources they can achieve significant improvements in health without the other levels. Local governments have the greatest ability to engage politicians, administrators, other sectors and the community itself. It is the

place where it can be implement health policies and influence the life conditions, economy, employment, culture, recreation, education, safety, environment, etc.

According to Villalobos & Piedra (1998), "the municipality must be the geographical setting of political management and resolution of the problems of the people, a space -of inter-institutional coordination". The Costa Rican Social Security Fund, has created strategies for the BEIH, who works in a specific space , with a specific population and a municipal territory. This requires concerted actions in which the basic equipment and municipal authorities could promote actions that address a comprehensive health care.

"Leadership for public health intervention requires practitioners to work more closely with other sectors, like communities, and advocate effectively the public's health" (Nutbeam and Wise 2002: 1883 quoted in Hunter, 2007) Even so, is not only a BEIH responsibility. Health promoters should be put in all health institutions. Strategies and mechanisms should be planned between the Ministry of Health and different actors. Its National Commission for the Promotion of Health should create a cross-platform at all levels, where not only the same health institutions are integral, but also all initiatives that are loose. Thus it could plan and coordinate the tasks for each actor to work and meet the social determinants of health.