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Learning from Costa Rica: Creating Public Health from the Ground Up

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Our colleague Dr. Atul Gawande has done it again. His recent article about the Costa Rica public health model in *The New Yorker* ("Costa Ricans Live Longer Than We Do. What's the Secret?," August 23, 2021) is a shocking reveal of how much impact simple solutions can have on our collective health. The article struck me in so many ways, but primarily in the fact that Costa Rica, a mostly rural, very poor third-world country, has made public health central to the delivery of medical care and now has better outcomes than we do at an exponentially lower cost. I wondered what the U.S. would look like if we were to do something similar?

Our political environment and social aversion to anything that looks a tiny bit like socialism will never allow our public health system to be built up to what is occurring in Costa Rica. We should not wait and hope for that. But I believe the private sector can go further in bridging this gap, and that we need to reconsider our mindset that the responsibility for public health should lie only with the government.

First, let's look at why we should consider such an approach. Here is a small picture of the main building blocks of the Costa Rica model as described in Gawande's article, and the results.

In the 1970s, "Costa Rica identified maternal and child mortality as its biggest source of lost years of life." The public health units put in place many of the same maternal care programs we have in the U.S. and encouraged more mothers to give birth at the hospital, rather than at home. But where our system leaves off, Costa Rica continued with nutrition programs to reduce food shortages and underweight births; sanitation and vaccination campaigns to reduce infectious diseases; a network of primary-care clinics to delivered better treatment for children who do fall sick; and better access to contraception.

Leading up to present day, every community has a primary care team made up of a doctor, nurse, and community health worker. Each person is assigned to a primary care team. It's a mindset that is entirely different from ours: "There are critical services that have to reach everyone in the community at every stage of life… Children have regular pediatric visits, starting from the first days of life. Pregnant women have their prenatal and postnatal checks. All adults have tests and follow-up visits to prevent and treat everything from iron deficiency to H.I.V. It's all free. If people don't show up for their appointments…their team finds out why and figures out what can be done."

Each team is responsible for visiting all the people assigned to it. "The homes are grouped into three categories. Priority 1 homes have an elderly person living alone or an individual with a severe disability, an uncontrolled chronic disease, or a high-risk condition; they average three preventive visits a year. Priority 2 homes have occupants with more moderate risk and get two visits a year. The rest are Priority 3 homes and get one visit a year." Data about household conditions and needs (whether there is a refrigerator, a phone, a computer, reliable electricity, etc.) are integrated with the electronic medical record system.

During a public health crisis such as the coronavirus pandemic, such a system has clear benefits: "because everyone was enrolled in the program, everyone was contacted individually about a COVID vaccination appointment."

In another example, a group program for people who have poorly controlled diabetes meets on Mondays for two hours in "a 12-week course covering topics from cooking proper meals to administering their insulin. They learn far more than they would in sporadic office visits, and they become a group of peers who know and encourage one another." The group's care team has seen substantial reductions in blood-sugar levels and thus have begun to set up other groups addressing issues such as adolescent depression and a nutrition program for bus drivers, who have higher rates of obesity.

Gawande pointed out that much of the care taking place was very simple and typical—nothing "magical"—but that physicians had become "… the point of contact between a national system and a great many individual lives, seeing to every small detail required for the broader demands of community health."

Since putting in place this community-based primary health structure, "deaths from communicable diseases have fallen by 94 percent, and decisive progress has been made against non-communicable diseases as well…. For people between 15 and 60

years of age, the mortality rate in Costa Rica is 8.7 percent, versus 11.2 percent in the U.S.—a 30 percent difference…. The average 60-year-old survives another 24.2 years, compared with 23.6 years in the U.S." And according to Gawande, Costa Rica spends less than not just the U.S. but the world average on healthcare.

> "The concern with the U.S. health system has never been about what it is capable of achieving at its best. It is about the large disparities we tolerate." —*Atul Gawande*

Lessons and Questions to Consider

What is possible to occur in the U.S. in this context, and who needs to be involved in making it happen? While hospitals have an integral role in the healthcare delivery system, all providers must switch their mindset and work at the community level first (e.g., we need to find a way to get faster to the "clinics with a hospital" system rather than the "hospital with clinics" system). I am optimistic that the disparities that have been tolerated to date will no longer be so, but it took a worldwide pandemic that has cost our nation over 700,000 lives as I write this to bring the right sense of urgency to it.

Here are some key action steps that I believe private health systems can employ and/or do more with today:

- Target funding to the most readily preventable kinds of death and disability.
- Work towards installing mobile and/or neighborhood (free or affordable) clinics for rural areas, areas that lack access, and those especially where telehealth is not feasible due to lack of broadband Internet.
- On the flipside, work to expand access to telehealth to those areas that are lacking.
- Consider building capabilities to "assign" everyone a primary care clinic or physician, using the expansion of mobile/neighborhood clinics and telehealth to enable this.
- Add community health and mental health expertise to primary care and pediatric offices. (My children's pediatric office has recently hired a therapist as part of its team to provide mental health services to children and also to train doctors to ask different questions and recognize signs of problems sooner.)

- Gather more/different data about social determinants of health for individual patients (such as their household conditions, whether they live alone, and what their risks are) that could be accessed for decision making via the EHR.
- Medical and nursing schools can expand training to students in primary care programs to include public and community health education.
- Boards must spend time discussing the role of their organization and its mission in this context, and hold management accountable to making progress by putting in place goals and deadlines, integrating them into the strategic plan and monitoring implementation.

I also pose the question of whether primary care teams could also serve as the public health department's "front door"? What would our healthcare system be like if we knew a deeper level of information about our patients, similar to the priority tiers in Costa Rica, and had a way to funnel it into a triage-like capability?

In Costa Rica, the Ministry of Health's public health officials set objectives for the healthcare system as a whole. It is not a perfect system and there are still problems due to constrained resources. But it is a simple and stark reminder of how much more we can be doing here, in the comparatively rich U.S., that we are not doing.

While private health systems might not be able to "merge" with public health the way the Costa Rica model has been done, the message is clear that the more integration with public health (along with a new mindset about the role of private providers in public health), with better access to data about social determinants of health in our communities, the closer we all get to meeting our mutual goals of improving access, equity, and outcomes while lowering costs. The political will and funding from the government side will be slow to trickle in. I charge our private non-profit healthcare systems to consider these lessons carefully and take ownership in leading the effort, opening doors and funding to your local public health agencies, engaging local businesses and large employers in your regions that also have a stake in the effort, and identifying simple, elegant innovations that can be implemented relatively easily and swiftly, at a low cost. The adage, "It's not our job," just isn't good enough anymore.