



Studying Health Care in Costa Rica

by **Fred Gifford, PhD**
Department of Philosophy

This past summer marked the first offering of a new MSU Study Abroad program enabling students to study another country's health care system: "Ethics and History of Development and Health Care in Costa Rica." Seventeen students, mostly from Michigan State, spent six weeks studying questions concerning health and Costa Rica – the health care system, the society of Costa Rica more generally, and the social determinants of health – while also having opportunities to live with a Spanish-speaking Costa Rican family and to visit the rainforest.

Administered by the Department of Philosophy, the Costa Rica program is a descendent of the long-standing program, "Medical Ethics and History of Health Care in London," which is administered by MSU's Interdisciplinary Programs in Health and Humanities (IPHH). Interestingly, there are similarities between these health care systems. Like the United Kingdom, Costa Rica is a country with many fewer resources than the U.S., and yet which manages to provide good quality health care for almost all its citizens and to generate impressive health outcome statistics through a large government program. Indeed, those in Costa Rica's health care system over the years have paid attention to and tried to learn from health care reform in the U.K. (and elsewhere). There are certainly large differences of culture, politics and environment, and this goes even deeper than the smaller number of Indian restaurants and the larger number of palm trees and active volcanoes!

The program welcomes both undergraduate and graduate students, and both students and practitioners in the health care professions. Those going into the health field can gain a lot from this course – they can examine a health care system that is very different from our own, learning the perspectives of practitioners, policy makers and academics in this small and proud country. They can get an international perspective on health and health policy, due, for instance, to the role of the World Health Organization and the Pan-American Health Organization. They can expand their cultural horizons, learn about Costa Rican life, culture, history, economy and politics, and see how those matters of culture play a role in health and health care. At the same time, they can work on their Spanish (invaluable for those intending to work in health care in the U.S.)! The classes are held in English, but to navigate and enjoy the country (including one's home life) requires knowledge of Spanish. Further, this coming summer there will be 60 hours (4 credits) of Spanish language instruction. This is in addition to four credits of philosophy and three of history.

The home base of the program is San Jose, Costa Rica's capital and largest city, located in the temperate Central Valley. Students divide their time between classroom and trips to museums and health care settings and other locations. They visit a variety of national hospitals in San Jose, as well as a regional hospital and some EBAISs (primary care centers), both urban and rural. Presentations are given by a variety of local speakers, health care professionals, as well as professionals concerned with health care policy and professors at the University of Costa Rica.

Students explore such questions as: How did Costa Rica's health care system come to be, and how does it operate within the present political and social milieu? What deficiencies does it have, and what challenges does it face as the government is no longer able to provide the amount of resources for the system that it did in the past? What ethical issues emerge in such a health care system, in the attempt to provide health care effectively, efficiently and fairly, with limited resources? How are these similar to and how are they different from those that arise in a country like the U.S.? How can these challenges be met, and how can these ethical issues be addressed?

Doing this requires placing questions concerning the health care system and the analysis of ethical issues in Costa Rica in the context of the country as a whole, its culture, its history and political and economic system, its natural environment and its status as a developing nation. This is, of course, a multi-faceted, interdisciplinary endeavor. Topics addressed range from public health to rainforest preservation to alternative medicine and medicinal plants to international debt to doctor-patient relationships to the role of government in health care, to poverty, health care access, human rights and the social determinants of health.

Costa Rica is an especially interesting place to examine health care. It is a developing nation that has in many ways been successful in providing health care and other services. Life expectancy and infant mortality statistics are roughly the same as in the developed nations of Europe and the United States. The WHO's *World Health Report* for 2000, ranking members states' health systems in terms of overall performance, gave Costa Rica a ranking of 36th. (The United States ranked 37th.) Substantial governmental effort is put into the health of the people. Indeed, the public system of health care, the Caja Costarricense de Seguro Social (the "Caja") is the largest segment of the government. Begun in 1940, the Caja today provides high quality health care for almost all Costa Rica's citizens. There has been a lot of emphasis on public health, as well as on extending health care to the rural areas. Over 800 small, local community clinics, called EBAIS's, provide primary care, including vaccinations, health education, and yearly home visits. But there is still significant (and indeed increasing) poverty, and Costa Rica struggles to meet the health care needs of its people with quite limited resources – especially since the economic crisis of the early 1980's and the subsequent "structural adjustment" requirements attached to further international loans.

A private system of health care for those who can pay for it has grown up along side the Caja, and many people who can afford to do so go instead (or in addition) to these health care services to avoid what are sometimes long waits. As might be expected, the interaction between the public and private systems of health care generates a number of complicated policy and ethical questions. (Some of these arise from the fact that many physicians are employed by both systems.) The emergence of many new private medical schools raises a number of dilemmas as well, both with respect to regulation of quality and with respect to the crowding of teaching hospitals with medical students.

The private sector draws a certain amount of "health tourism," where the lower cost of high quality cosmetic surgery in Costa Rica induces many to travel from other countries, including the U.S., to Costa Rica for such elective treatment.

The public medical system is equally a modern scientific one, but there are also especially interesting issues to study concerning traditional medicine and the health beliefs of the people. For instance, the rule has been that traditional healing is not to be covered by the government health system, but there have recently been movements in the direction of having such care "within the Caja."

The Caja provides high tech and expensive treatments, such as transplantation and (by law) full coverage of drugs for persons with AIDS, despite its huge cost. Indeed, the latter is taken advantage of by individuals who come from other countries and find a way to qualify to get this

treatment. This results in pressures elsewhere in the system, so the country is facing grave challenges and is being forced to rethink how it is going to provide and pay for health care, and what modifications there may need to be in the system that has worked pretty well for decades.

A central challenge to the system arises from the huge numbers of Nicaraguan immigrants into Costa Rica. The Nicaraguans do make a contribution to the economy, taking many jobs that Costarricenses tend not to want to take, but their numbers also put a tremendous strain on the social resources, especially health resources. These facts pose ethical and policy dilemmas concerning the provision of medical care to illegal immigrants and their families, as well as the question of whether Costa Rica should be compensated with resources from richer countries for this care that they provide.

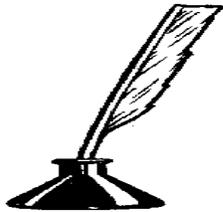
The environment plays a role in this course in a number of ways. First, there is the connection to public health. On the one hand, Costa Rica has emphasized public health. It has had for some decades an impressive public system of water and sewage, providing potable water to the vast majority of people. On the other hand, the pressures of urban expansion and the agricultural use of chemical pesticides pose significant threats to public health.

Second, the natural environment is a crucial resource for a developing tropical nation like Costa Rica. One of the most striking features of Costa Rica – certainly one of the strongest tourist draws – is the country's enormous degree of biodiversity and natural beauty (i.e., rainforests, cloud forests, mountains, beaches, active volcanoes). For instance, Costa Rica covers only 0.03 % of the Earth's surface, roughly the size of West Virginia, yet it contains 5% of all of the Earth's life forms. On the other hand, it lost almost half of its forest cover between 1950 and 1990, during which time it had the highest deforestation rate of Central America. Then again, Costa Rica has put together an extraordinary system of national parks and other protected areas, so that the 25% of the country which remains forested is now pretty well protected, and has been a world leader in its attempts at conservation. Tourism (including eco-tourism) has been in recent years Costa Rica's most important industry; many are hopeful that this will allow the convergence of the goals of economic self-interest and environmental protection.

Another connection between environmental issues and health concerns the rich resource that the rainforest provides in terms of potential medicines. Students in the program visit INBio (Instituto Nacional de Biodiversidad), a research and education institute that has been involved in cataloguing those resources for over a decade, and which has also — quite controversially — worked with corporations such as Merck & Co. to discover and exploit those resources.

Students also explore a number of questions about the environment, such as: What policy and ethical issues emerge concerning the management and preservation of the natural environment? What is important about preserving the environment? How is this to be balanced with the short-term economic well-being of individual human beings? How does the "health" of the ecosystem relate to the health of the people? Whose responsibility is it to do something about it? Is eco-tourism going to succeed as a way to provide for sustainable economic stability?

This coming summer, "Ethics and History of Development and Health Care in Costa Rica" will span eight weeks, from June 3 to July 26, 2002. For more information, please feel free to contact Fred Gifford via email (gifford@msu.edu) or call Michigan State University's Office of Study Abroad at (517) 353-8920. The deadline for receiving applications is March 1, 2002.



InkLinks is a regular column in which readers reflect on issues related to the lead article. This month contributors, in company with Fred Gifford in his lead article, write about what they've learned from studying and working in other countries. *Lessons from Abroad: Reflections from Readers of the Medical Humanities Report.*

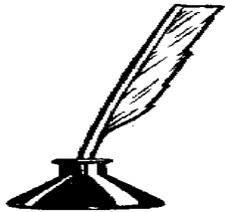
A Physician Ethicist in London: “We became Londoners each morning”

Howard Brody

*Center for Ethics & Humanities in the Life Sciences
and Department of Family Practice*

I have taught the London course in ethics and history of medicine three times since our first offering in 1986. I was privileged to be part of its inauguration, working in tandem with Peter Vinten-Johansen, who deserves credit for making it come about. The course has been one of our most successful undertakings; I am regularly gratified to speak to former “Londoners” and to hear from them uniformly high praise for the learning experience.

Peter made an important strategic decision when the course was first planned. He insisted that we use dormitory space at the University of London and classrooms at St. Bartholomew’s medical school a couple of miles away. In contrast to students in many MSU London summer programs, ours had to become London commuters each morning, using the tube or the bus to get to class. From Day One the students felt part of the life of the city. When they then had their experiences watching the National Health Service at work in physicians’ offices (“surgeries”) or in hospital wards, students had a better sense of the daily lives of the patients whom they observed. Seeing health care in another country is a way of learning things that no classroom lecture could convey. Because Costa Rica is considerably more different from the U.S. than is the U.K. (even if parts of London seem at times like parts of Bangladesh), the new course [described in Fred Gifford’s lead article] adds an important dimension to our Study Abroad efforts.



InkLinks is a regular column in which readers reflect on issues related to the lead article. This month contributors, in company with Fred Gifford in his lead article, write about what they've learned from studying and working in other countries. *Lessons from Abroad: Reflections from Readers of the Medical Humanities Report.*

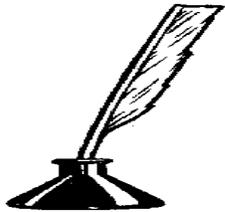
An Anthropologist in Mexico: “No ethical map is conceivable”

Linda Hunt

*Department of Anthropology and
Julian Samora Research Institute*

Conducting research in southern Mexican hospitals, I am regularly challenged in my notions about moral principles in health care, and reminded that medical practice must be assessed within its socio-economic and cultural context. The profound inequalities between rich and poor nations constitute a hard-edged frame within which hospital staff and patients must make terrible choices. I remember the weary sadness of a pediatrician who explained his criteria for deciding which babies would be placed in the hospital's two incubators; the anguish of a surgeon as he futilely negotiated for anesthetics that were being diverted to a bigger hospital, forcing him to choose which desperately ill patients could have surgery. I remember the subsistence farmer who sold his family's land and livestock to buy chemotherapy drugs, only to run out of assets before completing treatment. His death left his family with nothing.

Where is the right and wrong in any of this? How should one even frame the questions? Local circumstances must be central: local power structures affect who has decision-making authority; the appropriate unit of analysis may sometimes be a family or community, rather than an individual. While such reframing may be useful for specific cases, the bigger picture remains disturbing. True resolution to these ethical dilemmas would require a more equitable distribution of medical resources world-wide. Without that no real ethical map even seems conceivable.



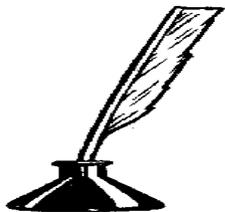
InkLinks is a regular column in which readers reflect on issues related to the lead article. This month contributors, in company with Fred Gifford in his lead article, write about what they've learned from studying and working in other countries. *Lessons from Abroad: Reflections from Readers of the Medical Humanities Report.*

A Student in Nepal: “I saw problems and beauty from the front line.”

David Miller
Psychology Major

We spent approximately three weeks in Nepal studying health care. We visited Red Cross stations and hospitals, interviewed doctors and patients, and talked with ayurvedic doctors who are a large part of the culture and have many ties to religion. The way religion is tied to everything in the country is so unusual. In visiting hospitals I saw bribery, a chaotic lack of organization, unsanitary conditions, and primitive treatment methods. In contrast to this, many Nepalese had never had Western health care, but they showed amazing health even in old age. We visited their form of a hospice—a sacred community where elders go to live in a community together to find peace and not be a burden to their families.

It was the most amazing experience of my life. (It was also affordable, as Nepal is one of the cheapest countries to visit.) Living with a Nepali family, learning from native teachers, and grasping the language allowed me to see the problems and beauty from the front line. There were so many ways to attempt to make a difference—many non-governmental organizations (NGOs) and countries tried to intervene but made things worse, while others really helped. It was a chance to see the masked problems that the world faces.



InkLinks is a regular column in which readers reflect on issues related to the lead article. This month contributors, in company with Fred Gifford in his lead article, write about what they've learned from studying and working in other countries. *Lessons from Abroad: Reflections from Readers of the Medical Humanities Report.*

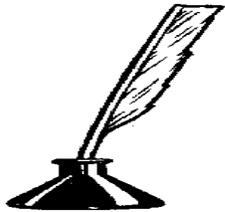
A Nurse Researcher in Zimbabwe: “Is it too late?”

Barbara Sparks

*Dept. of Osteopathic Surgical Specialties
College of Osteopathic Medicine*

In 1980 a newly independent Zimbabwe under a socialist government poured scarce resources into the well organized but impoverished health care system. For the first time it became possible for black Zimbabweans to use all health facilities, even if equipment and physician numbers were still inadequate. Childhood immunization numbers increased while water borne infectious diseases decreased. Life expectancy for men and women rose by 20 years.

In 1985 the World Bank began to loan the government funds for development, in exchange for promises of a capitalist economy. As a result of this and other factors the economy has been decimated, and the health care system has crumbled with it. The AIDS epidemic is devastating the working and middle classes. Now the country is in turmoil. Providers strike for realistic wages, or simply emigrate. Two tertiary hospitals have closed. Formal health care is now primarily available to the elite, black and white. President Mugabe governs despotically. The rule of law has vanished. Would different policies by the World Bank have avoided the economic collapse? Why are the world's leaders willing to ignore catastrophes in Africa? Would enlightened intervention by more stable countries have helped avoid the decline of Zimbabwe? Is it too late?



InkLinks is a regular column in which readers reflect on issues related to the lead article. This month contributors, in company with Fred Gifford in his lead article, write about what they've learned from studying and working in other countries. *Lessons from Abroad: Reflections from Readers of the Medical Humanities Report.*

A Physician in Zambia: “Nothing provides me as much perspective.”

Gretchen Birbeck

*Departments of Neurology & Epidemiology
College of Human Medicine*

Each year during Zambia's rainy season, while malaria rages and the queue of outpatients seems never-ending and hospital wards burst to overflowing (two children to a bed – siblings, if possible), and wails rise from the mortuary just outside the hospital, I arrive for a 3-month visit. I return looking haggard, tired, sleep-deprived, thin. Why this strange annual retreat?

Perhaps it is the vague look of relief on the faces of exhausted medical staff. Or the rush that comes with caring for truly sick patients in an environment with minimal resources. Or even the words of admiration from people at home (“Gee Dr. Birbeck, it's really wonderful, that work you do over in Africa”). No—what I gain is deeper.

So often day-to-day annoyances overwhelm us – incompetent clerks, traffic jams, telemarketers, whining children. Nothing provides me as much perspective on this as my annual three months of reality: malnourished children carried for hours by growth-stunted mothers just to reach the clinic; running out of Tylenol just as another febrile seizure case arrives. Yesterday, here in Michigan, I found myself furious about some misplaced x-rays. Then I remembered that next month, in a TB ward in Zambia, I might not have developing solution for the chest films. My fury evaporated.



Center News & Announcements

Len Fleck is on sabbatical at Northeastern University for the next six months completing the writing of a book for Oxford University Press under the title “Just Caring: The Moral and Practical Challenges of Health Reform and Health Care Rationing.” This book explores a broad range of cases of health care rationing, asking in each case what the role of rational democratic deliberation (as he explicates it) is in addressing these issues.

Tom Tomlinson was a panelist on a forum titled “Biotechnology’s Impact on Society: Food, Agriculture and Human Health”, Wharton Center, MSU (Jan. 23, 2002).

Libby Bogdan-Lovis published a review of Donald Caton’s book *What a Blessing She Had* *Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present*, (Yale University Press, New Haven, CT and London, 1999) in *Victorian Studies* 43(4):686-88.

Judy Andre, speaking at the MacLean Conference, University of Chicago, delivered a paper titled “Moral Distress, Nurse-Patient Ratios, and the Quality of Care” (Nov. 4, 2001).

Clayton Thomason and Gregg VandeKieft, M.D. are serving as co-directors of the Mentor Program, a required element of the professional development curriculum for first year College of Human Medicine students here at Michigan State University.

Judy Andre spoke for St. Luke’s Day at St. Mary of Nazareth Hospital, on “Compassion and Medical Error” (Oct. 16, 2001).

Len Fleck will be presenting at the annual meeting of the American Academy for the Advancement of Science in Boston, Feb. 14-19. His presentation is titled “Genetics, Science Literacy, Social Values, and Democratic Deliberation.” This is part of a session titled “Have Your Say: A Town Meeting on Behavioral Genetics,” which in turn is part of a three-session sequence on behavioral genetics. This presentation is based on his work in the “Communities of Color and Genetics Policy” ELSI project and his work with the Behavioral Genetics Working Group of the Hastings Center and the AAAS.

Tom Tomlinson served as moderator for panel discussion of religious perspectives on end-of-life care, McLaren Hospital, Flint (Nov. 27, 2001).

Clayton Thomason has recently joined the institutional review board (IRB) at the Michigan Public Health Institute, Okemos, MI, a group with the mission of reviewing research proposals for compliance with legal and ethical standards for research involving human subjects (Dec. 2001).

Len Fleck has an essay titled “Last Chance Therapies: Can a Just and Caring Society Do Health Care Rationing When Life Itself is at Stake?” in the *Yale Journal of Health Policy, Law, and Ethics* (Fall, 2001).