11-4-2014

Public Health Lessons from Cuba

Kristy Maher

Furman University

Recommended Citation
http://scholarexchange.furman.edu/records-ghs/4

This Presentation (Conference, workshop, or webinar) is made available online by University Records and Archives, part of the Furman University Scholar Exchange (FUSE). It has been accepted for inclusion in Greenville Health System by an authorized FUSE administrator. For terms of use, please refer to the FUSE Institutional Repository Guidelines. For more information, please contact scholarexchange@furman.edu.
Public Health Lessons from Cuba

KRISTY MAHER, PHD
SOCIOLOGY DEPARTMENT
FURMAN UNIVERSITY
What can we learn from Cuba about health?

- Cuba **spend less** than most countries on health care and yet has comparable **health statistics** to the USA.
- How do they do it?
- To answer this must look at bit at **history** and a bit at how they **organize** their health care delivery system.
  - PHC – Primary Health Care model
  - Focus on Prevention and Community Based Medicine
Total Expenditure on Health Care

- Cuba spends $558 per capita
  - Total expenditure on health as % GDP 8.6%
- US spends $8,895 per capita
  - Total expenditure on health as % GDP 17.9%

- 2012 statistics at average exchange rate in USD
### Comparative Health Statistics

<table>
<thead>
<tr>
<th></th>
<th>Cuba</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>79</td>
<td>79</td>
</tr>
<tr>
<td>Infant Mortality (per 1,000)</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Under-5 mortality (per 1,000)</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Maternal Mortality (per 1,000)</td>
<td>80</td>
<td>28</td>
</tr>
<tr>
<td># physician (per 10,000)</td>
<td>67.2</td>
<td>24.5</td>
</tr>
<tr>
<td>HIV/AIDS deaths (per 100,000)</td>
<td>2.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>
How does Cuba spend so little, but get such outstanding results?

Primary Health Care
Assumptions about Health during the Cuban Revolution

1.) Health is a **responsibility of the state**
2.) Health is both a **biological** AND a **social** issue
3.) Health is a **national priority**
1.) *Eradicate corruption* in the health sector

2.) Give priority to the development of *social capital*

3.) Craft *health policy* and implement health programs

4.) Develop *epidemiological system* of data collection

5.) Create *multidisciplinary, integrative* health system

6.) *Prioritize equality* as a goal in health care delivery

7.) Work to achieve and maintain *quality*

8.) Establish *community participation* in health system

9.) Achieve a *sustainable* health system
History of Health Care Delivery - Polyclinic Model

- Introduced in 1962 – original core of Primary Health Care (PHC)
- Center for health screenings, vaccinations, and community campaigns
- Increased access
- Weaknesses:
  - Specialty fragmentation
  - Focus on medical intervention or curative medicine
Community Medicine Model

- Introduced in 1974 to place more emphasis on integrative and preventative measures
- Teaching and research re-located into polyclinics
- Extended hours for continuous care
- Risk assessment evaluations

Limitations:
- Criticized for unequal quality of care
Family Doctor Model

- Introduced in 1984, this model placed the primary care physician at the core of its system
- All medical residents must have 3 yrs. of training in family medicine
- Aimed to increase access, communication, and equity
Specifics of Family Doctor Model

- Each doctor-nurse team charged with specific geographic location with ~120-150 families
- Doctors and nurses live in the communities they serve
- Minimum of one unannounced house call per year
- Monitors: lifestyle patterns, behavior risks, and overall hygiene
- 5 health categories: high maintenance – perfectly healthy
3 Tier National Health Structure

Tier One (consultorios)
- Basic Health Team – BHT (~120-150 families)
  - Doctor-Nurse partnership
  - Continuous patient assessment and risk evaluation
- Group Health Team - GHT (2-4 GHTs monitor 20,000-40,000 citizens)
  - Nurse teams and specialists (internal medicine, OBGYNs, social workers, etc.)
  - Monitor identified medical conditions

Tier Two (polyclinics)
- Acute and Long-term care facilities (eg. Nursing homes)

Tier Three (hospitales)
- Highly specialized care with treatments focused on “scientific investigation”
Free, Universal Access

- More people can see a doctor
- Higher frequency of visits
  - There are about thirty-eight required doctor visits for Cuban children between the ages of one and fourteen, compared with twenty-two visits for American children from prenatal to twenty years old
- Reduces poverty and inequality
  - Removes a major expenditure from people’s lives, benefits the poor the most
  - *Reduces inequality* which has positive health effects
    (Wilkinson and Pickett in *The Spirit Level*)
Community Based Medicine

Community diagnosis

- Since each polyclinic is responsible for one community, they can tailor specific health programs for the need of the community.

- If there are a high rate of smokers in a neighborhood, counseling can be scheduled for multiple times a week. If there are many allergies in the area, then the polyclinic can have allergy testing services, etc.

- Medicine can adapt and be responsive based on community needs.
Community Based Medicine

- **Epidemiological Surveillance**
  - Epidemics can be caught before they spread by isolating the area and possible causes

- **Civilian Health Groups**
  - Elected officials from each neighborhood represent their community to the provincial and national health commissions
  - Manage day care centers, immunization clinics, blood drives
Prevention Based Care

- Home visits

  - “I can see if the grandmother is depressed, if the daughter needs someone to talk to about birth control, if the uncle is drinking too much...I can see five or six people and help forestall problems that might deteriorate without some attention” (Whiteford and Branch, 2008: 53)

  - Inspect the sanitation of the house

  - Examine family dynamics: death in family, child neglect, abuse
The Logic Behind the System

- By focusing more on prevention and community based medicine, the costs of providing universal access is mitigated while maintaining a healthy population.

- BHT approach– doctor-nurse teams in neighborhoods - allows for close surveillance and early intervention.

- Focus on primary care over specialty care
Is Cuban PHC as good as advertised?

- The statistics say yes
  - My observations
- Some question the reliability of the statistics
  - Provided by government officials (propaganda?)
- Limited supplies and aging facilities
Drawbacks of the System

“Sociolismo” - informal system of bartering used to compensate for shortcoming in the state-run system

Doctors have low salaries, so they perform favors in order to make ends meet (Usually an exchange of other favors)

Ethical Questions – autonomy? Patient rights?
What can we learn from Cuba?

- Primary Care Health (PCH) model – low cost, good outcomes
- Prevention Focus
- Community Based Approach
- Other important social determinants of health (SDH) may be at play:
  - Social capital (networks and social support)
  - Greater equality
- If part of the focus of this new initiative is to “keep people healthy in the places they live” there may be some lessons to learn from Cuba.