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Public Health Lessons from Cuba

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Public Health Lessons from Cuba

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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

	Cuba	United States
Life expectancy	79	79
Infant Mortality (per 1,000)	4	6
Under-5 mortality (per 1,000)	6	7
Maternal Mortality (per 1,000)	80	28
# physician (per 10,000)	67.2	24.5
HIV/AIDS deaths (per 100,000)	2.6	2.5

How does Cuba spend so little, but get such outstanding results?

Primary Health Care



Assumptions about Health during the Cuban Revolution

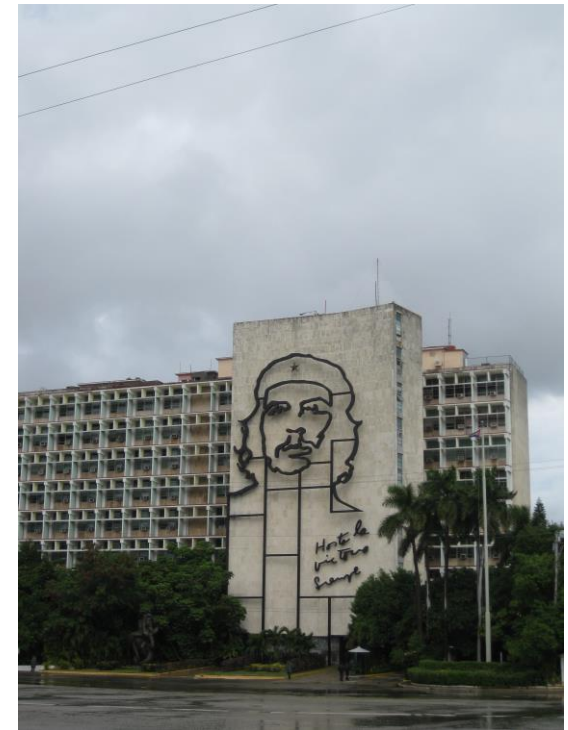
- ▶ 1.) Health is a ***responsibility of the state***
- ▶ 2.) Health is both a ***biological*** AND a ***social*** issue
- ▶ 3.) Health is a ***national priority***

Goals of the Cuban Health System

- ▶ 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?

A handwritten list on a pink sticky note with yellow tabs, showing the following data:

Medical Condition	Count
Población Total	1150
Diabéticos	55
Hipertensos	196
Cardiopatías	50
Asmáticos	89
RPC	38
Patología Cuello	4
Insuficiencia R.C	1
Curas Especiales	1

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.