Lessons from Cuba on improving primary care in Canada

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Canada spends a significant proportion of its budget on health care, while achieving average population health outcomes compared with other OECD countries. It is difficult to achieve coordinated and comprehensive care, due in part to the strain of a dependence on acute care services, accounting for nearly 30% of total health care costs. An aging population, inequities for aboriginal people and immigrants, and socioeconomic gradients in health continue to put pressure on the system. Most health care stakeholders would contend that spending more money in acute care will not equal better health for Canadian citizens. Rather, initiatives that improve efficiency will provide a more cost-effective way to improve the health of Canadians. In this regard, Canada can learn from a country that has achieved remarkable health outcomes, while demonstrating that health does not require wealth: Cuba.

Historically, the Cuban health care system performed poorly on population health measures, despite the efforts of well-trained physicians. When Fidel Castro took control of the country in 1959, there were extensive health disparities. Half of Cuba's doctors were concentrated in the capital, Havana; the country had only one rural community hospital; and the rural infant mortality rate stood at 100 per 1,000 births. Recognizing these challenges, the government created a national health system based on universality, comprehensiveness and public accountability. By 1976, all Cubans received universal health coverage, and delivery of health services was intertwined with broader social and economic development. That included efforts to increase access to education, provide essential food, and build safe communities, as the government recognized that these factors, among others, have a bearing on health outcomes. Since these reforms, the country's health indices have thrived: 2010 data shows Cuba has an infant mortality rate and life expectancy on par with that of the United States. The country also boasts the highest rates of treatment and control of hypertension in the world and the lowest AIDS rate in the Americas.

The Cuban model of health care delivery centres around interdisciplinary polyclinics, which are found in every Cuban community. They provide collaborative primary care, social services and housing services, and address both public health and clinical medicine. Health system architects reasoned that care providers should reside in the communities they serve, so they could appreciate the health status of their community and the environmental,

social and economic factors that influence their patients' health. The Cuban teams coordinate medical care and targeted health promotion efforts based on evidence gathered about their geographic catchment area. While this reflects the reality for some health care practitioners in Canada, many may not have this experience. While we are moving towards team-based community practices, historically, we have struggled to provide comprehensive, one-stop care to meet unique community health needs.

The Cuban approach – community oriented primary care – isn't a new concept. It has its roots in rural practitioners providing care to their communities, and we know that when it's coupled with inter-professional practice and community-based agencies, practitioners are better able to identify and address social determinants of health. Despite this knowledge, health care planning and provision in Canada is often siloed into individual and population health domains. Cuba has demonstrated that effective health care provision requires professionals who deliver individual and population health interventions simultaneously. In addition to providing clinical medicine, Cuban physicians visit their patients' homes once a year to get a sense of living conditions, monitor communicable diseases, and link patients to community resources as needed. Health requires more than medical care, which in Cuba has meant simultaneously addressing both medical and non-medical needs.

However, the country's health care still has many challenges. Because of the United States embargo on trade, which limits access to pharmaceuticals and medical equipment, Cuba had to develop an internal pharmaceutical industry to supply the health care system. As a result, many medications not normally available in pharmacies can be purchased illegally in the community or from practitioners who loot hospital resources for personal financial gain. Physicians are paid about $20 per month, and are provided benefits such as housing and food. Patients have been known to bring physicians goods to receive preferential treatment, such as being seen earlier. And resources such as dialysis machines and CT scanners are limited.

Despite these challenges, Cuba has created a culture where health professionals value population health and community-based care. Community oriented primary care relies on health services being married with broader social services in a manner appropriate to that area. For Canada to improve population health outcomes in a sustainable way, we will need to improve health provision and design at the community level. Ultimately Cuba demonstrates that rigorous and continuous evaluation of community health by healthcare practitioners can benefit all citizens, even in a resource limited setting. We believe lessons from Cuba can translate to Canada's healthcare system, thereby improving delivery of healthcare and the health of patients.