Cuba’s health system: an eyewitness report

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I just returned from a week’s visit to Cuba with a group of journal medical editors and public health people. We met with many people in the medical professions including family doctors and nurses and people from highly specialized referral centers in pediatric cardiac and hepatobiliary surgery, nutrition, and diabetes, and with faculty and leaders from the school of public health and some of Cuba’s medical journals, including the Cuban Journal of Public Health. We met with US students from ELAM, the Latin American Medical School that trains (for free) students with social commitment and economic need from not only Latin America (and North America) but the entire world.

Much has been written on the Cuban medical system, and how it is structured. One of the best recent articles is by C. William Keck and Gail Reed in the American Journal of Public Health in 2012, “The Curious Case of Cuba”.[1] Keck and Reed are, respectively, editor-in-chief and executive editor of MEDICC Review, an academic journal that publishes research and commentary from both Cuban and US (and other international) authors about the Cuban health system and health status, and is part of MEDICC (Medical Education in Cooperation with Cuba). They were also leaders of our MEDICC-sponsored trip. I will not try to provide yet another in-depth description of the Cuban health system, with which many readers may be familiar, but will rather highlight some aspects of it that struck me as particularly important, and explain why.

First of all, the medical system in Cuba is a national priority. As a socialist country, its centralized nature exceeds that seen in the more-commonly described wealthy Western European nations, and it provides care for everyone. This is a positive, obviously, but also (of course) limits the access to some elective procedures for those who would be rich enough to afford it in another society. It also, of course, limits the ability of those people to be at the front of the queue, which is a particular irritation to the privileged, high-income people who are often those most critical of any type of equitable health system. The health statistics are excellent; several indicators, including infant mortality rate (4.8/1000 in 2013) are much better than in the US.

It is also very primary-care based. Teams of family doctors and nurses are in every neighborhood (in the densely

populated parts of central Havana where we were, actually every few blocks) and are responsible for the health of a geographically defined population of 800-1800 people (depending on percent of older, high need people). They spend half their day seeing people in the office, and the other half making home visits, most frequently to those who are high-need because of chronic disease or recent mothers (the nurse sees almost daily). They also live in the neighborhood, frequently in or over the clinic, and are expected to be available 24-7 for any of the patients in their community who needs urgent help. Some of the doctors in these settings are residents in the second of their two-year FM residency, and they include those from other countries whose governments permit residency training in Cuba (we met a resident from Ecuador, who would be returning to his own country).

At the next level are polyclinics, also very neighborhood-based and serving a number of family medicine practices. Staffed with a family medicine professor as well as other specialists (pediatrics, IM, OB-Gyn, etc.) they see patients referred to them by the FM practices (and send them back for continuing care) as well as provide some procedural and imaging services. All physicians complete the 2-year FM residency, and then do residencies in other specialties; about 40% of doctors are FM. There are also hospitals, emergency / urgent care settings, and several levels of referral centers. The ones we visited in Havana for pediatric specialty surgery (including transplants of livers, although not yet hearts for children), nutrition, and diabetes were the most high-level referral centers in the country. At every level the centrality of the family medicine community practice for ongoing follow-up was emphasized. Specialty doctors have great respect for this system. In addition, although they make earn more than family doctors, the difference is small, and all earn far less in relation to the income of others in society than in the US. Doctors are not in it for the money. Public health is a much more prominent part of the health system in Cuba than it is in the US, and there are strong centralized efforts to integrate it more with the medical care, and particularly primary care, system. It remains underfunded relative to medical care delivery, but the inequity is significantly less than in the US where public health receives about 3% of the health care dollar compare to 97% for medical care.

In addition to the medical care that they provide to their own people, the Cubans provide care all around the world, and train doctors (as indicated above) from all around the world. Many poor nations have their health facilities staffed by Cuban physicians, and their human resource commitment to fight the Ebola outbreak in West Africa dwarfs any comparable effort by the US or other nations (see the article "Cuba vs. Ebola" on the MEDICC webpage). As noted above, ELAM graduates several thousand physicians from other countries every year, including the US. The students from the US, selected by the organization Pastors for Peace, are typically from lower-income families and ethnic groups under-represented in US medicine. The US students are required to have at least 2 years of college, and spend at least 6 years in the medical school, plus an extra one before if they are not fluent in Spanish. They are provided free tuition, room, and board. Life is not easy, and like most Cubans – even those working in the most advanced centers, including the National Medical Library – have limited and slow Internet access, a result, apparently of the lack of access to satellites resulting in the "low bandwidth" we heard about constantly. But the graduates are expected to enter primary care and work in communities of need that are like those they come from, and despite the inability of Cuba to enforce this, most of them do. Many have completed residencies in the US and others are currently training, predominantly in primary care. They tend to bring excellent history-taking and physical examination skills, although need time to adapt to the electronic medical record and the ability to "just order a CT scan".

The hardest part for me about the US medical students at ELAM is that they are exactly the kind of students that every medical school in the US should be aggressively recruiting: from families and communities that have not typically produced physicians, from underrepresented groups, and with a passion and commitment to provide care for those communities. It embarrasses me that they have to go to Cuba to school, while our medical schools are filled with "more of the same": privileged, generally majority, students with much more interest in high-specialization than primary care, and much more commitment to themselves than to the needs of society.

There are a lot of problems with Cuba, and even with their health system. It is very expensive and very dependent upon physicians and upon paying relatively low salaries to health workers. It is handicapped by limited resources in a relatively poor country, even though the largest portion of that nation's resources are spent upon health care and education. Its poor access to the Internet and lack of money for international travel limit the ability of its health professionals to collaborate and stay on top of what is happening in the rest of the world. But what the Cuban model shows is that it is possible to have a health system based on trying to provide needed health care, relatively equitably, to everyone in the society. It starts with primary care, and everyone gets that before anyone gets more; as time and resources progress, more people get more, but still equitably. The emphasis is that health and healthcare and medical care are for everyone, not for a portion of the population. It is based upon the presumption that everyone should get what they need before anyone gets what they do not.

Advocates of a market-based model for health care in the US may insist that they are not mean or selfish, but that the market is the best model for organizing everything, including health care. Their mantra is that “the market will provide”, presumably not just profit for the providers of services, but health to the people.

How’s that working for us?