Review

Creating a Successful Primary Care Model: Lessons Learned From the Cuban Health System

Hilla Sang, MBA*

Department of Health Policy and Management, College of Public Health, Kent State University, Kent, OH

With the U.S. economic embargo lifted from Cuba, the time has come to learn from the successes of the Cuban health system. This study suggests an alternative model of health care delivery that has been successful both in addressing the population's health needs and in reducing health expenditures. Drawing on interviews conducted with Cuban health professionals, this study illustrates that non-neoliberal policies such as dominant public sector and strong social support enhance health outcomes in the population. Additionally, population-wide education and empowerment increase adherence to preventive care, which translates to lower health care costs. Cuban primary care practices are described and key lessons for the U.S. health system are offered.

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INTRODUCTION

Neoliberal ideology has been adopted by numerous governments in an attempt to control spending and minimize government debt. Rooted in capitalism, neoliberal ideology is based on three pillars: privatization of public programs such as education and health, promotion of market-driven economy, and endorsement of individual freedom of choice and responsibility. In the U.S., neoliberalism-friendly government prefers the health system be run by private insurance and health corporations, which leads to defunding or deprioritizing public health initiatives.[1] Neoliberal practices in health care have left many Americans vulnerable to medical debt regardless of their health insurance status.[2] As many as 62.1% of all U.S. consumer bankruptcies are related of medical bills,[3] and 63% of adults with medical debt report forgoing medical visits and 43% failed to fill a prescription due to cost.[2]

This study presents the success of non-neoliberal policies on health outcomes in Cuba. Unlike the U.S., Cuba contributes the success of its national health system to its "privileged position as a non-member of the International Monetary Fund (IMF)".[4] Against guidelines advocated by the World Bank and the IMF, both heavily-neoliberal bodies, Cuba's government prioritizes publically-funded health and enjoys a dominant public sector with strong social support.[5] Cuban health practices call for education and empowerment of the population on matters of disease prevention and health promotion, which translate to lower reliance on medical supplies to maintain a healthy population.[6] Consequently, Cuba leads the developing world in terms of health indicators - outcomes often compared to some of the most developed nations, such as Denmark or France - while maintaining relatively low expenditure on health. This study presents a viable alternative to the current American political ideology, and elucidates a potential system and budgetary structure upon which the American health system can draw to improve population health in the U.S.

METHODS

In-depth discussions took place over an 8-day period in April, 2015, as part of an educational exchange in Cuba between American and Cuban health professionals. The educational exchange was organized by Medical Education Cooperation with Cuba (MEDICC) in collaboration with the American Public Health Association (APHA). Cuban participants, whose number in each session varied between three and ten, were recruited by MEDICC, and were comprised of Cuban health professionals in various capacities, such as trained volunteers in an HIV/AIDS community outreach program, physicians, medical faculty, and administrative personnel. Recruitment of American participants (n = 19), of which the author was one, was done via e-mails from the APHA to the Association's members.

The discussions were conducted in English and Spanish and were translated by two interpreters trained in medical translation. The educational exchange participants travelled in two Cuban provinces and visited various health organizations. In those visits, Cuban health professionals introduced their respective organizations for approximately one hour, and then a dialogue between the discussants and

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***Corresponding Author:** Department of Health Policy and Management, College of Public Health, Kent State University, P.O. Box 5190, 750 Hilltop Drive, Kent, OH 44242. (Email: hsang@kent.edu)

participants took place for another hour or two. Where available, statements from these discussions were compared with existing literature for validation.

RESULTS

Overview of Primary Care in Cuba

As part of this educational exchange, APHA attendees travelled to San Nicholas, located approximately 30 miles southeast of Havana. Attendees visited San Nicholas's Policlinic, which is a regional medical clinic, and a primary care (PC) clinic. In Cuba, a primary care physician (PCP) is assigned to each neighborhood and is responsible for the health of about 1,000 residents. The PCP is partnered with an assigned nurse and a team of gynecologist, internist, pediatric, psychologist and medical students, who together care for all the medical needs of their neighborhood. The PC team is given housing in close proximity (about three blocks) to the PC clinic so that the PC team is familiar with the specific needs of that population. PC teams usually stay in the neighborhoods for years and decades, which helps facilitate continuous care and a trusted physician-patient relationship.

Daily Routine and Responsibilities of PCPs

The daily PCP routine is divided into two portions: in mornings the PC team sees patients in the PC clinic on a first-come-first-serve basis, and the afternoons are dedicated for home visits. PC clinic visits range from pediatric visits and childhood vaccinations to screening for hypertension, diabetes, and tuberculosis. All women under 65 receive HPV tests regularly, and all men over 45 are screened for prostate cancer and over 50 are screened for testicular cancer. Patients have the right to refuse screening and treatment, but it is rare because the medical team educates the patient and the patient's family about the importance of early detection. PCPs also advise patients on family planning and provide condoms, hormonal contraceptives, and IUDs in the PC clinic. On the day of the group visit, the PCP was already visited by 32 patients in six hours, and considered that day a "slow" one.

Medical Census

The PC team is also responsible for the medical census of the neighborhood. Twice a year the PC team, in collaboration with medical students, visits every house in the neighborhood, interviews the residents, evaluates the household's environment, and creates a household profile based on this data. In addition to the semi-annual census, the PC team analyzes census data on an annual basis to monitor differences in population disease and trends.

Collaboration of PCP & Specialists

Disabled or homebound patients, as well as patients who failed to appear for their follow-up care, receive home visits from the PCP, nurse, medical students, and any necessary specialists on a regular basis. Incapacitated patients will be visited by the PC team in the patient's home once a month; those who are otherwise have difficulties leaving their homes, such as older adults, will be visited three times a year. Older adults are also screened for depression, dementia, cognitive impairment, and alcoholism. In cases in which the patient is cared by a specialist the PC team will be accompanied by the specialist during the home visit. If for some reason the PCP was unable to attend the specialist visit, the PCP will follow up in person with the specialist to make sure the PCP is updated with any medical developments for that patient. The ongoing, open communication between the PCP and specialist enhances the continuum of care for the patient and ensures the patient receives the best care possible. Timely and accurate communication is also important because the Cuban health system is exclusively paper-based, so each patient has only one comprehensive medical file with his or her PCP.

Pay and Benefits

Providers who work at any part of the health system are hired permanently and provided with equal pay and benefits that rival developed countries, such as year-long maternity leave and government pension. The salary is computed based on specialty and number of years worked, and stays consistent regardless of the amount of prescribed exams or services. Salaries are a part of an annual budget that is provided for the province from the Cuban government. The physician discussants repeatedly claimed that they get intrinsic joy from their job, that their incentive to keep a healthy population does not depend on external financial benefit, but rather "the gratefulness of a family, the smile of a child" is their reward for doing their job well (testimony of physician at policlinic).

Health Outcomes and Indicators

Cuba spends about 8.8% of its GDP on healthcare while providing free healthcare services to the entire population. Health indicators of the Cuban population rival those of developed countries: physician density is 6.72 physicians per 1,000 population,[7] infant mortality rate is 4.2 per 1,000 live births,[7] and have not seen cases of vaccine-preventable diseases such as measles, mumps, or pertussis since 2011.[8]

DISCUSSION

Findings demonstrate that the Cuban health system succeeds because of its emphasis on preventive medicine and community-oriented care. Despite claims made by the World Bank and the IMF encouraging neoliberal methodologies of privatization of public goods, the Cuban health system continuously elucidated that social investment in health yields better and longer lasting returns. Rejection of neoliberal ideology, as illustrated by Cuba, results in a well-coordinated health system that prioritizes the population's health over individual gratification.

There are three key take-home points from this study. The first is not all health spending are equal. Investment in preventive and community health yield more favorable, widespread, and long term outcomes than investment in technology and treatment. For example, medical records in Cuba are exclusively paper based, but are comprehensive and include information about every person in the country. In contrast, American health information systems act in silos

and only gather information about patients within the specific hospital system.[9] As a result of comprehensive medical records and the twice-yearly medical census, stakeholders are better informed about emerging issues within the population, and are able to stop a disease before it becomes an epidemic or create effective PSAs to facilitate the public health interventions. Additionally, investment in advanced technology is less crucial when the disease is diagnosed and treated in its early stages. Workers of the Cuban National Institute of Exercise visit areas that suffer from increased prevalence of obesity almost daily, and guide the community in a variety of physical activities in the morning and in the afternoon. Investing in these exercise programs costs a fraction of the costs of bariatric surgeries and obesity-related comorbidities.

The second lesson is coordination and communication is the key to success. The hierarchy present in American medical practitioners between physicians and nurses or specialists and PCPs is not present in Cuba. Specialists, PCPs, and nurses work together and coordinate care both horizontally and vertically within the health system. Specialist care is coordinated through the PC team because the PCP has the most intimate knowledge of the patient and most comprehensive medical record. Additionally, Cuban health professionals coordinate interventions with professionals outside the health system, as was discussed in the community exercise intervention above. All actors in the system act to benefit the population, creating a truly patient-centered system.

Lastly, caring for the entire population is not an option. Unlike the American health system, the Cuban health system is free to every person in Cuba. Protecting the entire population is more than a value perceived by this anti-neoliberal country - it is a necessary practice. Vaccines, health screenings, and environmental treatments (such as drying standing water) are provided free for the entire population, because infectious disease do not discriminate a wealthy patient from a poor one. Universal health care helps keeps herd immunity at maximum and prevents expensive – both in price and in human life - problems down the road. Patients have the right to refuse any treatment, but thanks to effective educational and PSA campaigns the population is knowledgeable about the importance of preventive interventions.

Despite the general positive outcomes of the Cuban health system, it is imperative to note that the system has its flaws. Resource scarcity affects diagnostic practices, such as breast cancer diagnosis that is conducted only by ultrasound because mammography machines are not available in Cuba. Availability of some specialty care may be scarce, as was illustrated by anecdotal personal stories. Future studies should incorporate the experience of medical care recipients to gain a deeper understanding of the health system.

LIMITATIONS

Findings from this study should be evaluated under some limitations. First, Cuban participants were recruited from MEDICC's network of contacts in Cuba, and thus may not necessarily be a representative sample of all health professional in Cuba. Second, the author relied on translators to communicate with Cuban participants, meaning that some linguistic subtleties may have been missed. Future studies should include a nationally representative sample of health professionals, and offer a more comprehensive implementation plan of these findings.

CONCLUSION

This study suggests an alternative model of health care delivery that has been successful in both addressing the population's health needs and reducing health expenditures. The Cuban health system effectively delivers preventive health care services to its entire population at a fraction of the costs that the U.S. faces, and does so with significantly better outcomes. With the U.S. embargo on Cuba coming to an end, it is imperative that the American health system learn from the success of the Cuban health system, which will greatly improve both the health outcomes and the health expenditures of the U.S.

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