

From The Director:

# The Cuban Health System and the American Public's Health

by Marsha Hurst

This winter I was asked by the Westchester Health Action Coalition to give a talk on the American public health system. Having recently returned from our Health Advocacy educational trip to Cuba (see *The Paradox of Cuba*, p. 10), I couldn't help but think comparatively about the two systems. The differences are, as expected, striking—but so are the similarities.

Ironically, what these two systems have in common are significant health problems and similar health outcomes. Cuba's population, like ours, is aging, which presents new, multidimensional and expensive demands on the health care system. Infectious disease as a cause of mortality has given way to diseases of the heart, cancer and stroke, and these 20<sup>th</sup> century killers are becoming the 21<sup>st</sup> century chronic conditions. Cubans also struggle with the high cost of medications, and have additional problems of drug availability because of the American embargo.

The differences between the two health systems include almost everything else—the structure of care, financing of care and right to care. Cuba is a poor third world country with a first world health care system. While the country has few resources, and the institutions of care are threadbare, there is one doctor for every 172 people<sup>1</sup>, health and medical care are free, medical education is free, and health care is a right—not a privilege.

The structure of care in Cuba is a pyramid, with the foundation resting on family doctor-nurse teams practicing in the community in which they live. They hold office hours in the morning and the afternoons are reserved for home visits, accompanying patients to the hospital, or meeting with specialists and specialist teams at the polyclinic—the community health center at the next level up on the pyramid. The family doctor is the patient's

advocate, and is expected to practice the elements of “boutique” or “concierge” medicine for which our physicians are now charging those who can afford it thousands of dollars extra. These elements include extra time with patients, continuity with hospital care, joint meetings with specialists, patient education, and help navigating the system. For economic reasons Cuba has been doing more “home hospitalization” (although we still found much longer hospital stays and more hospitalization than we have come to expect in the US), which is built on the availability of family doctors for home visits, as well as on the strong family support and intergenerational living situations. With an extremely high literacy rate (96% in 2000), Cuba can and does rely extensively on patient education. To bolster the family role, employers are required to give time off with pay for any family member who stays in the hospital with a sick relative (and no one goes to or stays in the hospital alone).

Physicians in Cuba are not only plentiful, but they are well-educated. There are medical schools in every province, and a Latin America program accepts low income students from countries in the region (now including the US) for free Cuban education. Although specialty care is readily available, the system is built on primary and preventive care. All doctors (with a few exceptions in areas of great need) who want to specialize are required to go through a family medicine residency before doing a specialty residency. While patients can bypass the family doctor and go right to a specialist—and they can also bypass their neighborhood family doctor to go to another family practitioner—most people use the family doctor, feeling that she (and most are women) is more an advocate than a gatekeeper.

Cuban medical care is widely considered to be high quality. Patients come from all over central and south America, as well as from parts of Europe, to receive complicated treatments, diagnostic procedures and surgeries in Cuban hospi-



tals. They pay with dollars (and stay in separate hospital areas) and this “health tourism” helps support the free care and medical training available to Cuban nationals. Cuban doctors, particularly family doctors, are “exported” to third world countries in need. This medical service brings added respect and a “pension” supplement to the normally very low salary of the participating doctors.

In terms of health status of the population, Cuban life expectancy is 76 years as compared to American 77<sup>2</sup>. The infant mortality rate in both Cuba and the US was 72 in 2000 and Cuba reports a 2001 drop to 6.2. Cuban infant vaccination rates are higher than ours.

While we know that health status of a population is not a simple product of either medical interventions or health care spending, it is still interesting to note that the US reports spending twice the proportion of its GDP on health (13%) that Cuba spends (6%).

So what did this mean for us as health advocates visiting Cuba for the first time? Our trip was organized as a “course” about the Cuban health care system. We spend a week meeting with Cuban health professionals, visiting providers and educators, and asking endless questions, particularly of our exceptional host, Dr. Clarivel Presno, President of the Cuban Society of Family Medicine and Professor at the National School of Public Health. As a learning experience, the visit was not easy. First, we had to adjust to a system in which health care *is* public health. A healthy population is a national goal and a public responsibility. Second, we had to get past the contradictions, par-

<sup>1</sup> Cuban health data for this article come from the Pan American Health Organization ([www.paho.org](http://www.paho.org), accessed 4/10/02). This ratio is from 1999 data. US ratio for the same period is one doctor per 358 inhabitants.

<sup>2</sup> PAHO, 2001 data.

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ticularly the high quality of medical care in a threadbare and resource-bare system. Third, we needed to learn to look for advocacy within the structure and practice of medical care and within the context of a family and community-oriented society. Fourth, although health care is free, the health care system, like much of the Cuban economy, now rests on a dual economy—pesos for the Cubans and dollars from the tourists. In our short time we could not determine the impact of the crossover—and the social significance of some Cubans having access to dollars.

We left with many more questions than we arrived with; and our hope is to bring our host, Clarivel—and perhaps others—to the States so that we can continue this learning process. Cubans are proud of their health care system, and there are many opportunities for American health care professionals to visit Cuba legally on educational trips. Go if you possibly can—and then let's continue our learning experience together. ■