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Dear Peter,

"JUST"A CLUE ABOUT THE CUBAN PRIMARY HEALTH CARE DELIVERY SYSTEM

When I first learnt about the Cuban health care system and its achievements I asked myself " will I ever have the chance to see it?" I do not ask this question anymore because I am right in it. I am seeing it unfolding right in front of me. The emphasis on primary health care is not just a another story here but a practice pursued with much interest and vigor for the last two decades plus. Pues entonces, vamos a ver!

Polyclinic Lawton:

My first encounter with the health care system began on November 11, 1992. From the outset, it is important to mention that different levels of health care exist: from tertiary care in highly specialized medical centers, secondary care in hospitals to primary care mainly in the polyclinics. The main institutions responilble for the delivery of primary health care are the polyclinics.

I had opportunity to meet with Dr Jose Rodriques Abrines, director of Polyclinic Lawton in the municipality of deiz de octubre in Havana. A graduate of the Havana medical school in the mid-fifties, he is one of the first pioneers of the polyclinics' experiment in Cuba after the 1959 revolution. I asked him what is the focus of primary care in Cuba?

Dr Redriques: a brief historical review of the health situation and the distribution of health services in Cuba before the 1959 revolution is necessary for appreciating the present organization of the health care delivery system. Before the revolution, two-thirds of health services were available to only a small population of Cubans who lived in the main cities and towns of the country. The majority of people in the rest of the country

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had if anything very little access to health care. Medical care was mainly oriented toward curative care which were provided through private health facilities or institutions. Most common were the Casas de Seguros. These were small clinics or hospitals that provided health care through an insurance system. Membership was sold to anyone who could afford to pay the premuims and most beneficiaries were people who worked in the cities or towns and had constant income. The majority of Cubans who lived mostly in the countryside depended for their health care on other health practices and cures provided by curanderos (traditional healers). The main causes of morbidity and mortalilty then were due to infectious and parasitic diseases, diarrhoea, tuberculosis, worms infestations etc. The training of medical doctors at the time took place at the only medical school of the University of Havana. Now there are 21 medical schools and 421 polyclinics spread throughout the country.

A Pan American Health Organization review (1976) of the Cuban health services highlight some aspects of the access to health care. Before the Cuban revolution, health services in Cuba conformed with social class. The very small wealthy class was served by purely private doctors and hospitals. The middle class and skilled workers - about 10% of the population-were served largely by the resources of the mutual societies, also known as casas de seguros. The large class of rural peasants and urban proletariat were served in crowded and understaffed govermental hospitals and clinics, if they received care at all.

Why the focus on primary health care? Well, with the triumph of the revolution, a promise was made to provide full health coverage of the entire population by extending health services to all parts of the country, urban and rural areas that were neglected before and were lacking of essential health services, both preventive and curative. Thus in 1964, most of the casas de seguros were coverted into what are now know as polyclinics (or health centers in other countries). These are comprehensive health care clinics that provide both preventive and curative services. They are the main centres of activities for primary health care in Cuba. Each polyclinic will usually serve a population of about 25,000 to 30,000.

Through a political decision in 1959, the revolutionary goverment passed a new law aimed at improving the health conditions of the poor people living in the rural and urban areas that were wanting of immediate health services. Most were peasants working on agricultural farms. The decision also aimed at increasing jobs for medical doctors many of whom were already redundant in the cities. A regulation was then enacted which made rural service obligatory for one year for all medical doctors after their graduation from the medical school. The period was subject to extension for another two years. Many small rural hospitals were constructed throughout the country as a consequence of the new policy.

In 1970, a nation-wide programme to decrease infant mortality was initiated. The means of achieving this specific objective was through health education, promotion of health and prevention of diseases, prenatal and antenatal care and hospital delivery for all pregnant women. Infant mortality dropped to 20 per 1000 live births in 1980 compared to 40 per 1000 live births in 1970. By 1982, some communicable diseases such as malaria, poliomyelitis and diphtheria were irradicated. In the same period only 180 cases of tetanus were reported. Last year, infant mortality for the whole country was 10.7 per 1000 live births although the national objective remains to improve that figure to 10.4 per 1000 live births.

A vigorous programme of immunization is followed now in Cuba. All children are vaccinated against 10 communicable diseases (tuberculosis, hepatitis B, tetanus, diphtheria, whooping cough, measles, mumps, rubella, meningitis and polio). However, the disease pattern in the general population in Cuba is changing. Now that the average life span is about 74 years, chronic diseases associated with old age are increasingly common. Cancer, heart diseases and stroke are among the leading causes of death in the elderly.

Furthermore, in 1974, health services were re-structured in an effort to take health care closer, available and accessible to the community. Hence the population was divided into geographic areas (provincial,municipal and health areas). Each health area would usually have a population of about 25,000 to 30,000 and would be served by one polyclinic for ambulatory care. The re-structuring of services meant construction of new facilities all over the 14 provinces(there were 6 provinces before the revolution) of the country. Of course the population density is different from one province to another but the population served by a polyclinic is more or less similar throughout the country. However, it could be less in very isolated areas. Finally, the health areas were subdivided into health sectors each with a population of about 4,000 people, for the purpose of work assignments among the area's health personnel. Usally these personnel would be medicos de familia (or family doctors) and nurses. Each family doctor serves a population of about 600-700 people in one or two blocks.

Community participation in primary care: the family doctor is assisted by the community through the peoples' committees or organizations such the Poder Popular (or Peoples'power), Federacion de Mujeres Cubanas (Federation of Cuban Women), Committee for the Defence of the Revolution, Brigada Sanitaria (or Sanitary Brigade) and Circulo de Abuelos (or Elderly clubs) etc. The representatives of these committees are selected by their own communities. The committees support the work of the family doctor by way of providing general information about the health situation in the community.

Comprehensive Integrated Medicine:
Having stablished extensive health services and polyclinics all over the country, concern was express over the quality of medical care which the communities were getting. So a debate about improving the quality of care took place in 1982. This debate resulted in the conception of a new approach or new model of primary health care delivery. The new model became known as the Medicina General Integral(or comprehensive integrated medicine). The objectives of this new programme include the promotion of health and prevention of diseases, curative services for adults, pediatrics, the elderly, pregnant women, and also to deal with the psycho-socio-economic issues in the community. The polyclinic is the centre for all the new primary care activities. And specialized departments were stablished for example, obstetrics and gynaecology, pediatrics, psychiatry, internal medicine, physiotherapy,and investigative departments for diagnostic laboratories and X-ray.

All departments are headed by specialists. They are responsible for the training of the new type of family doctor who will be a specialist in comprehensive integrated medicine.
The work place of this new type of family doctor is in the community. The family doctor works in a consultorio (clinic). This is usually a two-story building. The ground floor serves as the clinic. This is where he/she consults his/her patients. The second floor is the house of the doctor. All family doctors are assisted in their work by nurses. Living in the community, it is expected that the family doctor will become well acquinted with the health problems in the community. Some family doctors whom I interviewed have been working in the same neighbourhoods for more than 5 to 6 years. They seem to relate quite well to the community.
Every patient seen by the doctor has a personal file kept at the clinic together with the files of the other members of their families. Besides their work in the consultorio, the family doctor also looks after the health of the elderly in the Circulo de Abuelos(or Elderly Club). The clubs are not really health institutions per se, but rather social groups for various activities including physical exercise. There is an exercise specialist attached to every Circulo de Abuelos. All aspects of the clubs' business are managed by the elderly themselves.

I asked Dr. Jose Diaz Novas, professor of comprehensive integrated medicine at Polyclinic Lawton about the training programme for family doctors who want to specialize in Medicina General Integral: The person wanting to specialize in Medicina integral would normally be a graduate of the faculty of medicine having pursued medical studies for six years. He/she must want to work in the community. After graduation, he/she will spend one year working in the community. Then does another 3 years in residency at the polyclinic where he/she will receive regular tuition and assessment of their work progress from specialists in the various departments.

Medicina integral is geared toward learning about the health of the society as a whole. Thus the ciriculum consist of studying the determinants of health, for example, education, housing, nutrition, environment, social organization, health education about life styles (effects of smoking, alcohol ingestion) and the role of physical exercise and diet on health. While the general effort is directed at improving the health situation of the population, there is also a stress on the quality of the activities of the family doctor. This is accessed through periodic surveys of patient satisfaction either by interviewing consumers of health care or by their complaints through the peoples' committees.

The family doctor is also periodically assessed for apptitude by the teaching professors at the polyclinic or at the work place in the consultorio. This is accomplished through revision of the clinical records of patients by the professors and also by occassional on-the-job supervision. Family doctors are also required to present cases for discussion in seminar sessions at the polyclinics. Usually most family doctors will be conducting some research projects which they will present as theses at the completion of the three years of training. Specialist status is confered on successfull candidates at the end of the three years residency. It is up to the candidate to continue practicing as a family doctor or switch to other specialities if desired, but in most cases the majority of them choose to remain so.

A visit to the consultorio of a family doctor:
I visited the consultorio of Dr. Leonardo Cuesta Mejias. It is just a short walking distance from polyclinic Lawton. The clinic consist of the doctor's consultation room, waiting room for patients, and the physical examination room. There is a refrigerator for keeping vaccines and an autoclave for sterlization of instruments used in special examinations. Also there are weighing scales for adults and children. The general environment of the clinic is quite tidy. The nurse has a desk inside the doctor's consultation room. And beside helping with keeping records of patients and the general order in the clinic, she is responsible for vaccination and monitoring growth of children and does home visiting for various health care activities.

According to the doctor, many of the patients he sees are elderly, usually presenting with some kind of chronic health conditions, for example, high blood pressure, heart and vascular problems, diabetes mellitus, psychiatric problems of the elderly etc. In younger patients, parasitic infection by giardia, amoeba, oxyuris or thread worm is more common.
I had opportunity to talk to a 64 year old man who had been operated for some type of abdominal cancer 15 years ago. He had a permanent colostomy tube fixed to his abdomen since the operation. I asked him how he was feeling? He said, he was quite well and that he was visiting the doctor today for a different

reason. According to the doctor, this patient had his condition diagnosed early before it had spread to the other parts of the body, hence his long post-operative survival. It is recognised here that secondary care is quite expensive. And so to cut down cost, efforts are directed on early diagnosis of diseases, their treatment to achieve cure and follow up of treated cases. In this way, the work of the family doctor links up with secondary care(in hospitals) and so both levels of health care systems are seen to complement each other. Infact, family doctors can refer some patients directly to hospitals for specialzed care or for special investigation,if such services can not be obtained in the polyclinic.

A healthy 21 year old married woman came for routine check up. She was 22 weeks pregnant. In Cuba nearly all pregnant women must see their doctor after the 14th week of gestation. All are tested for the presence of alfa-fetoprotein at 15-19 weeks of pregnancy. The test is done for early detection of congenital malformations such as anencepahly or spina bifida. Early termination of pregnancy is carried out if test is positive for alfa-fetoprotein. This particular young woman had a negative test and she was scheduled for ultrasonography and other tests (e.g. for sickle cell anaemia) at a hospital in the following week. I asked why sickle cell anaemia is tested for? The answer was that sickle cell anaemia is a medical condition commonly occuring in many Cubans of mixed parentage(black and white) and so the test was mandatory. Also all pregnant women must be tested for human immunodeficeincy virus or HIV.
A normal healthy baby of one year was brought by her mother for routine check up too. She weighed 11kgs and 78cm in length. All healthy babies must be seen by the doctor every 3 months. When sick, a baby can be brought to the clinic anytime without an appointment. All have vaccination cards that must be checked by the doctor to ensure that they received appropriate vaccinations.

I asked Dr. Leonardo whether there are <u>other providers of health care</u> in the community? After the revolution of 1959, medical services were extended throughout the country and access to health care has improved. Also, the use of health care facilities by the population has increased very much. Medical care is provided <u>free of charge</u> to Cubans. In the past, traditional healers (either herbalists or spiritual healers) were the resort of many poor people who had no access to medical care or could not afford the cost of private hospital care. Of course, traditional healing still exist in some communities today, but the demand for their services have declined quite remarkably over the past years since most people now have access to free medical care. It must be made clear that the care provided by traditional healers is not (and had not been) discouraged at all, but it is regulated to some extent by the medical sector. The fact is that, through health education campaigns by the social workers, community awareness about their health and health needs has increased. And as a result of that increased awareness, many

people choose to seek medical attention from the available health facilities i.e. from polyclinics, family doctors or hospitals. Spiritual healing is practiced by spiritual healers (or the Babalawos). They derive their spiritual powers and beliefs from the Yoruba tradition which is quite strong in the Cuban Culture. I am told that the origin of the Yoruba tradition in Cuba is traceable to the west coast of Africa.

Green/Herbal medicine (or medicina verde as it is known here) is not the domain of the traditional healers alone, it is also practiced by medical doctors who regulate its use by the former. I was given a book of Plantas Medicinales (or medicinal plants) by Dr Leonardo as a gift. It contains the list of all the medicinal plants that the medical doctor can use to prescribe to patients for treatment of different kinds of illness. Such prescriptions are obtained from pharmacies just like other ordinary pharmaceutical products.

Acupuncture is also widely used. There is a special "pain clinic" in the area of deiz de octubre for acupuncture. According to the doctors I talked to, it is viewed as necessary to pool together all available health care resources to maintain the present health status of the country's population as a whole during this difficult times of the periodo especial (or special period). This is a reference to the economic blockade on Cuba which is causing enormous difficulties to the country in obtaining essential medicines and medical equipment from international markets abroad. There are problems of availability of recent scientific literature as well. From my inquires, it appears that there has not been any significant reversals in the major indicators of health in the last two years and infant mortality has remainded fairly stable at about 10.7 per 1000 live births for the whole country.

Computers in primary health care:
There is a computer department in Polyclinic Lawton. I talked to the head of the department, Dr Carlos Pelaez: computers were introduced into the polyclinic in 1986. The objective of the programme is to obtain a database of information for all patients and their families in the whole area which is served by the polyclinic. In this way, it will be easier for the family doctors to access information of patients without going through the tedious routine of looking into files and papers. It is time saving. The computer keeps the medical records of all 25,989 people living in the area.

I had direct opportunity of seeing how information is gathered and entered into the computer for storage. Two technicians(women) are responsible for this job.
But first of all, what is the kind of information to be collected and what are the sources?
The main sources of information are the family doctors. About 56 family doctors are associated with polyclinic Lawton. Forty nine

of them are working all time and 7 are reservists(working in polyclinic), just in case replacement of a family doctor is required for whatever reason and this is to insure continuity of work.
Daily records of patients are sent from all forty nine consultorios of family doctors to the polyclinic. Information sorted out for each patient include personal history(e.g. age, sex, marital status, occupation, smoking/non-smoking, socio-economic situation etc) and medical history(previous illnesses and treatments received), results of previous and current laboratory tests, also present and past drug treatments and the diagnosis of the present medical condition. For each patient, there is information about their family and living condition in the house; hygiene and sanitation plus the number of rooms and space available for the members of the family. Addresses of all patients are entered into computer too.

By the way, all family doctors have different identification code numbers on the computer. To access information of a particular patient, the ID code for the family doctor responsible for him/her must be known and the patient's own identification number. Information on computer is keep confidential and only produced to health authorities and doctors concerned when such information is required. It is worth mentioning that the coding of diseases is unified with that of the World Health Organization. The standardization of codes is hoped to facilitate international comparisons of health data.

Thus, according to Dr.Carlos Pelaez, the usefulness of computers in primary health care is obvious. Besides providing easy access to informtion about the general health situation of the population, computers could as well provide information of how health resources are being utilized and help to identify which health areas are consuming the most resources. Also the information obtained will be useful in directing the future planning of health services according to the specific needs of the health area in question.
Moreover, the pooling together of such information from all over the country will be informative about the health status in all the different provinces and regions of the country or in short the state of health of the nation as a whole could be determined. Hence, national health planners at the Ministry of Public Health will benefit from information from computers in directing national health policy.

However, computers have until now been introduced in only 22 polyclinics throughout the country, but it is hoped that expansion will occur to include most polyclinics in the future if opportunity allow. Now some computers come as donations from organizations. Others are bought from international markets at about 2,500 US dollars. The two computers that are in use in polyclinic Lawton have good capacity for data storage and so health data from other polyclinics can be stored in them too.

Support of primary health care services, who pays?
So far, I have been talking about primary care activities in one polyclinic. But the polyclinic system extends across the whole country in both urban and rural areas. And there are already 421 of them operating throughout the country. Besides, there are other higher levels of health care too which consume consideralble resources e.g. secondary and tertiary care in hospitals and specialized institutions. I also mentioned that medical care is free. At this point, I believe you must be wondering where does the resources for supporting all these services come from, in other words, who pays? Is it the individual, the family or the community. Well, the Ministry of Public Health pays. It is responsible for the full support of all health services i.e. adminstration, personnel,salaries, overseeing the operations of all the health facilities and meets the costs of care etc.

According to Dr Redriques, about 10-12% of the gross national product is spend on health care alone. I asked whether such services were not expensive to run, since primary care was supposed to be at affordable cost. He said that the health authorities are aware of the expense, but that this expenditure on health care alone was inevitable because the national health care strategy and goal right after the revolution was a promise to extend and improve health care sefvices to people in all parts of the country. At present, the indicators of health are good and the general health status of the population is reasonable. Peoples' productivity increase if they are healthy. This makes such investment is health care worthwhile. I asked Dr Victor Figueroa about accessibility to health services. He said that access has improved, for example, the consultories of most family doctors now are about one-half of a kilometer from where the community live. And the polyclinics are about 2-4 kilometers.

The objective of the health sector now is the consolidation of the present health structures and their improvement. The national target of the 1960 1970s was to construct 500 600 polyclinics throughout the country, but there are now 421 of them. It is hoped that Cuba will achieve the "health for all" objective by the year 2000. In Cuba, the Ministry of Public Health gives much attention to comprehensive health care delivery through its polyclinic and family doctor programme. This is viewed as the best approach to solving the health problems in the country.

As you have seen from the narration above, the Cuban approach to primary care is not dissimilar from the Alma-Ata declaration on primary health care in 1978 which was adopted by the World Health Organization (WHO). As defined by WHO (1978):

" primary health care (PHC) is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and

at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of individuals, the family and the community. It is the level of first contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work and constitute the first element of a continuing health care process."

I hope that the above definition will refresh our minds as to what primary health care is all about. PHC is given much attention in many developing countries. Some observers think that health care alone can not bring about good health and the promotion of of wider changes in society is also required, thus health must be seen as only part of total care- nutrition, education, water supplies and shelter are also essential minimal requirment to well-being. It is interesting to note for example that the reduction in infant mortality (in the 1960s', 1970s and 1980s) in Cuba is not only attributable to medical intervention per se but according to Dr. Rodriques it is also linked to the re-distribution of resources to the population, for example, free access to education, employment and improvement in housing, water and environmental sanitation etc! In the next letter, I shall talk about <u>community participation</u> in primary health care.

Well, señor Peter. I don't know why things always have to follow some kind of natural order, but it seems true that the first born of anything always comes after a long story. I guess this is what happened to my first newsletter too. For some reason, it had to wait until I got information and experience with primary health care delivery right here in Cuba! But I am glad it is finally out and I hope that you will find the newsletter informative and interesting.
As I mentioned on the first page, this is "just" a clue about primary care delivery in one polyclinic in Havana City. There is more to tell you, but I think I have said enough for now. You will hear from me again shortly before Christmas.

Hasta el proximo carta y muchas gracias.

Cordialmente,

B.O Bwogo

Bacete Othwonh Bwogo, M.D.