Primacy of Primary Healthcare: Cuban Experience and Lessons for India

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Abstract

There is an ongoing debate in progress as to the relative merits of a primary/preventive focussed healthcare system versus a healthcare system where the major emphasis is on developing tertiary healthcare needs, with primary and preventive healthcare relegated into background. Each system has its fervent advocates. While we can accept that one model of healthcare may not be suited for all the countries with their differing needs and vastly different sociocultural contexts, it would be instructive to learn a few lessons from one country which has made excellent strides in its healthcare statistics, but with almost an exclusive emphasis on primary and preventive healthcare.

Keywords: Primary healthcare, preventive healthcare, Cuba, consultario.

"Everyone has the right to health protection and care. The state guarantees this right by providing free medical and hospital care by means of the installations of the rural medical service network, polyclinics, hospitals, preventative and specialized treatment centers; by providing free dental care; by promoting the health publicity campaigns, health education, regular medical examinations, general vaccinations and other measures to prevent the outbreak of disease. All the population co-operates in these activities and plans through the social and mass organizations."

- Article 50 of the Cuban Constitution. [1]

Universal healthcare guaranteed by the state is generally dismissed as a Utopian dream by most in the United States of America (US) where there is an inherent resistant to a state guaranteed healthcare model not the least from the medical fraternity itself for reasons that are not difficult to fathom. The US population by and large is averse to any system that would entail institution of waiting lists.

Having had work experience in 12 different countries, both developing and developed, I have had the opportunity to observe and study many health care delivery systems and their contrasting merits within the milieu they are meant to address. Many of them have changed beyond recognition in the more than four decades that I have been in the profession - sadly, not all for the better. The National Health Service (NHS) of the United Kingdom (UK) is a case in point. When I was first exposed to it in the 1970's, it was unquestionably one of the best health delivery systems in the world which I believe was perhaps in total consonance with the above-mentioned article where every individual, irrespective of the financial status could be assured of the best healthcare available without having to bother about expenses. I had myself known of an indigent patient being treated by a heart surgeon for whom a donated heart needed for transplant was flown in a chartered plane from the Netherlands. It is interesting to note the resistance to the concept of NHS when it was first proposed by the liberal peer Lord Beveridge, [2] but Attlee's government instituted it and with the passage of time, it became one of UK's main USP's which even the right wing conservatives, temperamentally opposed to the concept, dared to question. All that

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changed when Margaret Thatcher's A-team took over and in their 11 year reign whittled away at the system to the extent that it has become barely recognizable now.

Tempting though it is to get into a philosophical debate between state-run and laissez-faire ideologies, I tend to dismiss it as irrelevant. Any system which ensures that there are no medical and health bankruptcies is to be welcomed irrespective of whether it eats into the medical practitioner's bank balances, provided we bear in mind that healthcare delivery does not just entail on the spot treatment of a known disease, but a continuous process of overall enlightenment which deals with the mindsets that promote the predisposition and onset of a disease.

It was through this prism I judged the health system of different countries. In my experience, the best healthcare delivery systems I have observed were the ones in Sweden, Denmark, Norway and Switzerland. All four of them are prosperous countries with small populations but they clearly score head and shoulders above the rest of the countries with comparable economic prosperity and demographics. And this is attributable to their deep rooted belief that a government that does not factor health in its scheme of things is not to be entertained - even if it means digging into their pockets. All these countries in particular Sweden have indicated that they would prefer higher taxes to maintain this equitability.

Apart from these prosperous countries, there is another nation which seems to have achieved remarkable strides in its health related parameters - a developing country which is best with numerous social and political problems. Yes the country is Cuba.

I must state at the outset that I have never worked in Cuba although I have had the opportunity to visit the country on several occasions. I must also confess to some major prejudices I had harboured about the country, its political system and its leader. Many of my concerns still remain but the country's strides in healthcare need to be commended and I believe we need to learn many lessons from its experience.

Cuba at present has a life-expectancy figure of close to 80, higher than that of the US. The mortality rate for children under-five is 5 and for infants is 4 - much better than that of the United States of America which spends 25 times more on its healthcare delivery. According to the World Health Statistics 2009, nearly 70 percent of people die in developing countries of communicable diseases - not so in Cuba where the figure is 9 percent.

These figures assume even greater significance when one takes into account that Cuba's per capita income places it firmly within the developing country bracket and for decades it has had to deal with economic blockades. The collapse of the Soviet Union which used to subsidize the country heavily also had a major impact. We should also do well to remember that when Castro took over, nearly all the trained medical personnel had emigrated to the US for greener pastures, and just about a dozen teachers were left in the Havana Medical School. The health statistics at the time were completely in consonance with the other developing nations.

With such scarce resources, the country has been able to eradicate polio in 1962, malaria in 1967, tetanus neonatorum in 1972, diphtheria in 1979, congenital rubella syndrome and post mumps meningitis in 1989, measles in 1993, rubella in 1994, and tubercular meningitis in 1997. Small wonder that the country was showered with panegyrations from many who had otherwise very little time for its political ideology. Kofi Annnan had declared, "Cuba should be the envy of many other nations." The World Bank ex-President James Wolfensohn was effusive in his praise for the Cuban achievements in education and healthcare as was the House of Commons Select Committee in the UK - normally quite hostile to the government. Even the BBC, an archetypical British institution, was constrained to declare Cuba's healthcare system as 'world's best public services'. [3]

Don Fitz, a journalist and a green campaigner in the US has studied the Cuban health system in detail and has adumbrated its distinctive features. I am relying heavily on his observations.

Cubans call their system medicina general integral (MGI, comprehensive general medicine) whose main focus on preventing people from getting diseases and treating them as rapidly as possible. Their main focus is on prevention and primary health care. The general consensus is that these should be available to all. Even today, the number of specialists and super-specialists in Cuba is exceedingly small. Many developing countries have attempted to borrow from Cuba's extensive experience in developing medical science and sharing its approach with poor countries throughout the world. The concepts form the basis of the New Global Medicine and summarize what many authors have observed in dozens of articles and books.

In the Cuban system, doctors live in the neighborhood they serve. Doctor-nurse teams are part of the community and know their patients well because they

live at (or near) the consultorio (doctor's office) where they work. Consultorios are backed up by policlínicos which provide services during off-hours and offer a wide variety of specialists. Policlínicos coordinate community health delivery and link nationally-designed health initiatives with their local implementations. [4]

The MGI integration of neighborhood doctors' offices with area clinics and a national hospital system also means the country responds well to emergencies. It has the ability to evacuate entire cities during a hurricane largely because consultorio staff know everyone in their neighborhood and know who to call for help getting disabled residents out of harm's way.

It is not necessary to focus on expensive technology as the initial approach to medical care. Cuban doctors use machines that are available, but they have an amazing ability to treat disaster victims with field surgery. They are very aware that most lives are saved through preventive medicine such as nutrition and hygiene and that traditional cultures have their own healing wisdom. This is in direct contrast to Western medicine, especially as it is dominant in the US, which uses costly diagnostic and treatment techniques as the first approach and is contemptuous of natural and alternative approaches. [5]

Second, doctors must be part of the communities where they are working. This could mean living in the same neighborhood as a Peruvian consultorio. It could mean living in a Venezuelan community that is much more violent than a Cuban one. Or it could mean living in emergency tents adjacent to where victims are housed as Cuban medical brigades did after the 2010 earthquake in Haiti. Or staying in a village guesthouse in Ghana. Cuban-trained doctors know their patients by knowing their patients' communities. In this they differ sharply from US doctors, who receive zero training on how to assess homes of their patients.

Third, the MGI model outlines relationships between people that go beyond a set of facts. Instead of memorizing mountains of information unlikely to be used in community health, which US students must do to pass medical board exams, Cuban students learn what is necessary to relate to people in consultorios, polyclínicos, field hospitals, and remote villages. Far from being nuisance courses, studies in how people are bio-psycho-social beings are critical for the everyday practice of Cuban medicine.

Fourth, the MGI model is not static but is evolving and unique for each community. Western medicine searches for the correct pill for a given disease. In its rigid approach, a major reason for research is to discover a new pill after 'side effects' of the first pill surface. Since traditional medicine is based on the culture where it has existed for centuries, the MGI model avoids the futility of seeking to impose a Western mindset on other societies.

Fifth, it is necessary to adapt medical aid to the political climate of the host country. This means using whatever resources the host government is able and willing to offer and living with restrictions. Those hosting a Cuban medical brigade may be friendly as in Venezuela and Ghana, be hostile as is the Brazilian Medical Association, become increasingly hostile as occurred after the 2009 coup in Honduras, or change from hostile to friendly as occurred in Peru with the 2011 election of Ollanta Humala. This is quite different from US medical aid which, like its food aid, is part of an overall effort to dominate the receiving country and push it into adopting a Western model.

Sixth, the MGI model creates the basis for dramatic health effects. Preventive community health training, a desire to understand traditional healers, the ability to respond quickly to emergencies, and an appreciation of political limitations give Cuban medical teams astounding success. During the first 18 months of Cuba's work in Honduras following Hurricane Mitch, infant mortality dropped from 80.3 to 30.9 per 1,000 live births. When Cuban health professionals intervened in Gambia, malaria decreased from 600,000 cases in 2002 to 200,000 two years later. And Cuban-Venezuelan collaboration resulted in 1.5 million vision corrections by 2009. Kirk and Erisman conclude that "almost 2 million people throughout the world . . . owe their very lives to the availability of Cuban medical services."

Seventh, the New Global Medicine can become reality only if medical staff put healing above personal wealth. In Cuba, being a doctor, nurse, or support staff and going on a mission to another country is one of the most fulfilling activities a person can do. The program continues to find an increasing number of volunteers despite the low salaries that Cuban health professionals earn. There is definitely a minority of US doctors who focus their practice in low-income communities which have the greatest need. But there is no US political leadership which makes a concerted effort to get physicians to do anything other than follow the money.

Eighth, dedication to the New Global Medicine is now being transferred to the next generation. When students at Cuban schools learn to be doctors, den-

tists, or nurses their instructors tell them of their own participation in health brigades in Angola, Peru, Haiti, Honduras, and dozens of other countries. Venezuela has already developed its own approach of medicina integral comunitaria (MIC, comprehensive community medicine) which builds upon, but is distinct from, Cuban MGI. 11 Many ELAM students who work in Ghana as the Yaa Asantewaa Brigade are from the US. They learn approaches of traditional healers so they can compliment Ghanaian techniques with Cuban medical knowledge.

Ninth, the Cuban model is remaking medicine across the globe. Though best-known for its successes in Latin America, Africa, and the Caribbean, Cuba has also provided assistance in Asia and the Pacific Islands. Cuba provided relief to the Ukraine after the 1986 Chernobyl meltdown, Sri Lanka following the 2004 tsunami, and Pakistan after its 2005 earthquake. Many of the countries hosting Cuban medical brigades are eager for them to help redesign their own health care systems. Rather than attempting to make expensive Western techniques available to everyone, the Cuban MGI model helps re-conceptualize how healing systems can meet the needs of a country's poor.

Cuba has sent over 124,000 health care professionals to provide care to 154 countries and its doctor patient ratio is second only to Italy. [5]

Like other healthcare systems, this system is also not without its problems. There is an acute shortage of trained specialists in Cuba as the system places heavy premium on training family physicians. Their belief is that with an effective primary healthcare delivery, the need for the number of specialists would be concomitantly reduced - exactly the philosophy that guided the framers of the NHS model in the UK. Besides, recent reports have suggested that there is a significant black economy in operation whereby doctors accept illegal gratifications. Additionally, the low salary structure has encouraged significant emigration. But thus far this has not had a significant impact on the healthcare statistics.

I would be the last to suggest that this model can be replicated in its entirety to the Indian context. There are clearly problems. But it could serve as a model for debate. There is a debate in progress in India as to how to transform the entire technology based healthcare system with little emphasis on primary and preventive health into one based on one that is edificed on primary and preventive healthcare. Deficiencies in this model have been cruelly exposed in the massive battle with the COVID-19 pandemic that we are involved in. I believe adoption of the philosophy of this healthcare system and translating it into one that is in sync with the local needs would go a long way in this laudable attempt at course correction.

The most striking part is that the abyssal health care system in India was not credibly discussed in elections until recently. And unless we bring healthcare to the central focus, we are not going to be able to improve upon the shameful health parameters we contend with every day.

- This is a guest editorial. Views expressed are of the author's own.

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