

Notes from Cuba: the importance of primary care

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This past winter I conducted fieldwork in Cuba studying the role of family physicians within its urban communities. I wanted to answer the question: how does a country with such little infrastructure and resources maintain a successful national health program? My intuition led me to the community physician.

From my pre-departure research I knew that Cuba maintained a healthy population yet I was astounded at the extent of their success. For example, fewer children under the age of five die every year in Cuba than in the United States. This figure published by the World Health Organization is referred to as the under-five-mortality rate and it is considered a key indicator in the general “healthiness” of a country. Furthermore, they do so spending one-twentieth per patient, at \$350 compared to \$6,700 (dollar to dollar). Yet these figures do little to elucidate the reality of matters on the ground.

After arriving in Havana, I soon discovered that an informal interview style was required to gather veritable field data, due to a common fear of anything recorded or on the record. Thus not surprisingly, the most revealing information came at unexpected moments. For instance, while sitting in on a local *consultorio* (community doctor’s office) with a physician who I will give the pseudonym Dr. Gonzalez, a casually dressed woman of middle age strode through the derelict waiting area and interrupted an ongoing patient interview.

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Although the interruption surprised me, the doctor and patient continued on as if nothing important had happened. Noticing my puzzlement, Dr. Gonzalez pulled me aside and explained. The woman who had entered was a physician herself, a paediatric specialist responsible for a zone that encompassed his *consultorio*. She made bi-monthly visits to each of the offices and together they reviewed and accepted cases of paediatric relevance.

I peered into the waiting room and noticed a deluge of parents and sick children awaiting a visit with the community physician and the scheduled paediatrician. When I returned to the examination room I found the doctors examining an eight-year-old child with a skin infection exuding a fetid odour, while the anxious mother rattled off medical history to the two of them. At the end the nurse administered a topical treatment while the paediatrician scribbled a prescription. All throughout the rest of the morning the two doctors worked in tandem in the office for interviews and in the examination room. They deliberated together on treatment plans – corrected each other when wrong and seamlessly conveyed the

appropriate information to the parents.

The paediatrician is not a special case. Numerous specialties work with family physicians in a similar manner: internists, cardiologists, and gynaecologists, just to name a few. This is only one part of what makes the Cuban system special, fitting in to a much larger picture of remarkable continuity of care.

The family physicians such as Dr. Gonzalez act as a hub to the care of their community members. Certain specialties rotate to visit *consultorios*, but not all, and the *consultorio* redirects patients with more serious conditions to the nearest hospital. However, when patients visit hospitals for emergencies or specialized care, the family physician speaks directly with the attending doctor upon entry and discharge. Although Cuban physicians imprecate the extra workload, I believe that it is the second crucial facet to the success of Cuban community medicine.

The third crucial factor is intrinsic to the structure of the system. Cuban physicians live within the community they serve, often in the office itself. Thus community health statistics mean not only happy superiors, but more importantly, happy neighbours, less late night visits, and thus more sleep and personal time.

According to a review published by the British Medical Journal¹ continuity of care must be viewed from the patient's perspective and maintain three key elements. The first is managerial continuity, the integration of services by a central figure or team, especially important in cases of chronic illness or mental health. The second element is informational continuity, the maintenance of patient information, including medical records, preferences, values and context. Lastly, relational continuity must be maintained, providing coherent and predictable care.

In Cuba, the family physician is the crux to all of this; he or she along with the medical staff, which usually includes a nurse and a medical assistant, effectively provide all three levels of continuity. Furthermore, they go a step further by inhabiting the community of the patients and thus acquiring detailed knowledge of familial and community dynamics & history (a factor critically important in

cases of mental health).

The size of *consultorios* and their community responsibilities vary by community. In more urban areas, patient lists may number up to 1,500, although 700 is the average. But in any neighbourhood throughout Cuba, white coats of physicians and nurses invariably are streaking by. Physicians only spend a portion of their day in the office, while the rest is spent checking up on community members, following up on non-compliant patients and the infirm, too sick to leave the house. By mandate, all patients in the community are seen at least twice a year, and according to a risk assessment the physician then monitors others more frequently.

I must concede that Cuba is not the paradise that some left leaning provocateurs portray. Throughout the country there is a desperate lack of medicine, which leaves physicians often searching through pharmacy lists for creative solutions to seemingly easy diagnoses. Among the number of hospitals I visited all were in some state of decay, or simply dilapidated, in desperate need of even just a good landscaping crew. In the *salas* (wards) of the Hospital Calixto Garcia in Havana, the paint chips off the walls revealing spots of mold behind teal paint, and weeds sprout through cracks in the pavement all throughout the expansive grounds.

Yet when I stopped at the bedside of several patients and inquired about their satisfaction with their care, they unanimously responded with glowing praise. Perhaps the Cubans have nothing with which to compare. But, then again, even as the son of a physician, I have never experienced the continuity of care enjoyed by most Cubans.

In answering my initial question, how does Cuba maintain the outstanding health of its population, one can easily rule out several possibilities. It is not their medicine: they lack many of even the most basic modern prescriptions. It is not the facilities or the technology. Health care is free, but so is it in Costa Rica and Venezuela; Cuba's statistics more closely resemble Canada and France. Thus, the structure and function of the Cuban healthcare system must play some vital role. Hospital based physicians and specialists play a very similar role as in the US or any other modernized country: patients are admitted, treated, then discharged. It is

the Cuban family physicians whose role is unique compared to other countries.

I am not yet a physician, although I hope to be some day soon. But I have been on numerous occasions a patient. As stated by Haggerty in the British Medical Journal¹, continuity must be understood from the perspective of the patient. As an observer to the Cuban system, I was floored. It seems that the battle for health doesn't begin in the research laboratory, where a miracle pill or device may one day be constructed. The Cuban example suggests that the key to creating a healthy population is in primary care. Imagine the potential outcomes if the United States could combine its already outstanding training, facilities, and technology with the understanding of primary care as found in Cuba.

Reference

1. Haggerty, Jeannie. "Continuity of care: a multidisciplinary review." British Medical Journal (2003).

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