

Socialized Medicine in Cuba

In the late 1950's and early 1960's, the Democratic Party of the United States worked to extend Social Security to include health insurance for the elderly, a program that is now known as Medicare. The conservative American Medical Association responded by enlisting then movie star Ronald Reagan to record a vinyl LP called *Ronald Reagan Speaks Out Against Socialized Medicine* (Reagan Speaks Out, 2007). The record was the focal point of a campaign called Operation Coffee Cup, in which the Women's Auxiliary to the American Medical Association urged members to host coffee gatherings in their homes and listen to the LP with friends. The eventual goal was to inspire a massive letter writing campaign, warning congressmen against the evils of *socialized medicine* and those who promote it (operation coffee cup, 2007).

These efforts to preempt Medicare eventually failed, but they were successful in making the term *socialized medicine* a powerful rhetorical tool that remains a pillar of the conservative health care agenda (Meaning of Socialized Medicine, 2007). Although *socialized medicine* is a ubiquitous term in today's health care debate, the politicians and individuals that use it seldom offer a lucid analysis of Cuba, the one nation in the Western Hemisphere that has implemented a socialist medical system for more than four decades. Academic outlets have more frequently surveyed the successes and failures of the Cuban medical system, but their broad analyses have often emphasized population health indicators, infrastructure and medical capability, and the ideological and financial structures that support them. In this paper, I will offer a brief summary of these findings, and draw on interviews and ethnographic fieldwork in an attempt to provide a richer

description of how some Cubans understand and experience the medical system their state has implemented. In particular, I will emphasize the experiences and opinions of doctors, an important group of stakeholders that in the United States have often been outspoken in their opposition to socialized medicine.

Building Cuba's Socialist Health System

After the 1959 Revolution, the equitable distribution of necessary foodstuffs achieved the most immediate and dramatic improvements in public health, all but eliminating malnutrition by the 1970's (Pérez, 2006, pg 275). With regard to health care delivery, the Cuban state had a relatively clean slate from which to build a Socialist system. Although some infrastructure existed in Havana and provincial capitals, medical professionals that did not support the Revolution emigrated en masse, leaving behind only 16 professors, about 3,000 doctors, and a nonexistent rural medical infrastructure. Those who remained built Socialist medicine from the ground up (Farag, 2000).

The Castro regime made improvement in the population's health a priority, describing it as a source of the Revolution's legitimacy. Eventually the Revolutionary government enshrined the right to comprehensive health care in the Cuban constitution (Cuban Constitution Retrieved from WHO, 2007). By 1960, the state was sending physicians into the mountains and the rural reaches of Cuba that had never seen medical care before (Farag, 2000). An increase in coverage and emphasis on prevention resulted in the total elimination of Polio in 1962, and Malaria, Neonatal Tetanus, Diphtheria, Meningitis, Chicken Pox, Measles, and Whooping Cough by 1997 (Bringas, 2006). In part due to success in combating major infectious diseases, important population health

indicators have increased consistently and dramatically since the revolution. As of 2005, Cuba rivaled or surpassed developed nations such as the US in important general health indicators, including a life expectancy of 77 years and infant mortality of 5.8 per 1,000 live births (Bringas, 2006). The major causes of death today are heart failure, cancer, and stroke, the same as most developed nations (Pérez, 2006, pg 278).

Universal access to health care and massive disease prevention campaigns are at the root of many of Cuba's initial population health successes. In addition, such sustained improvements in a resource poor environment reflect a continued evolution of the organization of Cuban health care. The early years of the Revolution were concerned with building regional medical schools and hospitals necessary to meet the mandate of care for all. Decentralization of the health system continued in the early 1970's with the expansion of the capacity of local primary care centers called *policlinicos*.

In the mid 1970's, Cuba began to transition from *policlinico*-centered care to primary care organized around individual communities. Community-oriented medicine attempts to localize the work of doctors and enable them to be more attentive to the specific environmental, psychological, and social factors that influence the health of a small population of patients. In 1984, Cuba launched the Family Doctor Program. Although community medicine existed before the Revolution, this program was indeed "revolutionary," as it was the first concerted effort to make community and family medicine the norm for the population of an entire nation (Feinsilver, 1989). To implement this program, Castro called for massive increases in medical education, with the eventual goal of placing "a doctor on every fishing boat, on every merchant ship, in every school, in every factory, on every block" (Feinsilver, 1989).

Critiques of Cuba's Socialist Health System

Cuba's humanitarian achievements in health care far outstrip those of nations with comparable economic resources (Feinsilver, 1989). Many international observers have applauded such dedication to health promotion, but others highlight a tension between humanitarian and political or economic motivations. Such tension is present in Castro's fervent dedication to developing human resources and Cuba's internationally renowned hospitals, two hallmark initiatives of Cuban health care.

In 2004, the US had a doctor-patient population of 1 to 337 and the UK had 1 doctor for each 610 people. Cuba had 1 doctor for each 165 people, more than six times greater than the minimum suggested by the WHO (Sankore, 2006). Despite this apparent excess, Cuba was training 76,770 medical students in academic year 2004-2005, 10,801 of which were foreign (Bringas, 2006). Such large investments in free medical education might seem unwarranted, perhaps even fiscally irresponsible, in a country with significant shortages in housing, infrastructure and other areas. It turns out that Cuba does not actually need that many physicians; many graduating medical students are destined to work abroad on "solidarity" missions.

The nature of these solidarity missions highlights the control that the state has over the careers of individual doctors, an aspect of Socialist medicine that pundits from the US have commented on since Operation Coffee Cup (Reagan Speaks Out, 2007). Many missions are acts of charity, but the Cuban state charges based on ability to pay. In 2004 the Cuban government received an estimated \$1 billion from Venezuela, their largest medical patron (Kitchens, 2005). Cubans often work in remote areas that local doctors have neglected, but are compensated only enough to pay for room and board. The

Cuban state receives extra profits associated with the work of its doctors (Sánchez, 2007). Doctors do not expect to become rich when they return to Cuba either; an average salary is only 350 Cuban pesos, the equivalent of twelve dollars a month. It is unclear whether the state allows doctors to have any say regarding where, when, and on what terms they work. American physicians have been highly critical of the potential for limiting the individual freedoms of doctors in Socialist medical systems. Later I will explore some Cuban responses to these issues.

Economic and political powerhouses tucked inside medical programs also exist at home in Cuba, in the form of tourist hospitals such as Hermanos Almejeiras and Cira Garcia. Both hospitals serve primarily foreigners and Cuba's political elite. The government invests heavily in providing state of the art care at these sites. Just four months after the Yale Medical School Hospital performed its fifth heart transplant, Almejeiras performed its tenth (Feinsilver, 1989). In addition, Almejeiras hospital has often treated symbolically important patients. It was featured in Michael Moore's recent documentary SICKo for treating several 9-11 rescue workers who had been unable to access care in the US.

Although the care provided by these hospitals is excellent, critics have argued it does not reflect the reality of health care for most Cubans (Boadle, 2007). Cuban health officials answer that their investments in local hospitals have favored disease prevention, but others describe the differences in access to diagnostic equipment and some medicines as characteristic of a two-tier system (Boadle, 2007). In light of these critiques, understanding "second-tier" care in Cuba, and how it has achieved such excellent population health statistics, is at the root of understanding Cuba's Socialist medical

system. In the next section, I will describe “second-tier” care in Cuban *consultorios*, and offer the opinions of several doctors regarding the Cuban health system’s achievements and failures.

Care in a *Consultorio*

I was not sure exactly what I was looking for, but the directions from my contact at the *policlinico* were simple enough. Walk one and a half blocks towards the ocean, turn right, take about fifteen steps and the *consultorio* will be on your right. After circling the correct block twice, I circled a different block once, asked for directions four times, and doubled back twice before finding the *consultorio*. The door was less than twenty feet from where I had last been given directions, but still I was doubtful as I walked up the cement Dr.iveway. Then I noticed a broken payphone and a piece of notebook paper with a schedule on it that had been tacked to the door. I decided to enter, but still the building looked so convincingly like a private residence that I knocked before I entered, Dr.rawing some strange glances from the people in the waiting room. This consultorio occupied one corner of the ground floor of an apartment building whose peeling pastel paint looked just like all the other apartment complexes on the block. Although perhaps conveniently located for the residents of this neighborhood, no one had made any apparent effort to make the office visible to newcomers.

Inside, the building did not look dirty so much as worn, and tired. The front door opened into a small waiting room. To my left, four splintered plywood chairs and their bored looking occupants were waiting to be helped. Above their heads, the faded yellow walls were scattered with printed and home made posters about HIV, pregnancy, and

dengue fever. Below that height, a wavy line of raw concrete marked the passing of a flood that had removed the building's paint and stained its linoleum floors. On the other side of the room, a woman wearing a crisp white nurse's outfit sat behind a desk. When I asked her for Dr. Pérez, she waved me in to the exam rooms.

I spent my first several days of fieldwork with Dr. Garcia. Her old desk sits near the door between exam rooms, so that the doctors can shout questions and jokes to one another every few minutes. One wall had high wooden shelves filled with old books or manuals that did not appear to have been disturbed in a very long time. The shelves opposite the desk were empty. The bottom shelf was hanging off its hinges over a short, collapsed filing cabinet that still had papers in it. While she finished a consultation, Dr. Garcia gestured for me to sit on the other side of her desk in a chair that was surprisingly sturdy given that the back was missing and the legs bowed out. I sat while she finished that consultation and then we had a minute to talk.

Dr. Garcia wears a white lab coat and glasses while at work. She ties back her long, strait black hair and has a very professional demeanor. She likes to smile and speak in English that I find even less intelligible than her Spanish, which is quite a feat. Our interviews are stop-and-go affairs, as she never really takes a break from seeing patients while I am there. Occasionally when she calls a patient in, they look at me and say, "Well, he can go first."

"No, he's just a student I'm telling something," she replies.

The patients that frequent this office are a diverse bunch. I saw old women, middle aged men, young women with babies, teenage women with boyfriends, black skin, white skin, happy, bored, and tired, to describe just a few. The atmosphere is very

informal; none of the patients ever seem to mind my presence, or even find it curious. Each time Dr. Garcia calls another patient into the room, they walk in and have a choice between the chair beside the desk, about a foot from their doctor, and several chairs that would put the desk in between them. In a familiar pattern, not a single patient I saw hesitated before choosing the chair beside the desk.

Not having noticed any secretaries on the way in, I asked how she managed the schedules and appointments of all these patients. Smiling knowingly at me she said, “It’s like the line for bread.” They walk into the waiting room and say “¿*Ultimo?*” (last?), and the person who is last in line raises their hand. I asked why the office was never overfull, if anyone can walk in without an appointment. “Well”, she said, “Dr. Pérez and I only serve two city blocks.” She gave me the exact addresses by street, and told me that the area housed just over one thousand people. “I have only been here a little over a year, so I have not been to all their homes yet,” she said.

You visit all your patients in their homes? I asked. She explained that from about 8:30 AM to 12:30 PM she would work in the office, seeing patients from her two city blocks for all of their needs. Occasionally she would write prescriptions for medications that they could pick up for free at the *policlinico*. Other times she might refer a patient to a specialist. In the afternoons, she would go from house to house checking in on people. She pulled out four tattered, soft cover notebooks containing the names and addresses of each of her patients, and explained that she first would try to see women with new babies. She also frequently visited people that she knew might not want to go to the doctor’s office because they were sick or for any other reason. Sometimes she would visit people with environment related health problems, like smoking or diabetes, and she would check

in to make sure that their diet was good, or that they were not smoking around children. If she did not have any special cases, she would just keep moving through the list until she had seen everyone in their home, and made sure it was a safe and healthy place to live. She called these home visits *terreno*.

The main purpose of *terreno* is disease prevention. In addition to education and prevention, *terreno* enables her to notice many illnesses as early as possible, when they are more easily treatable. This practice has reduced costs by decreasing hospitalization and the need for emergency care, and by improving patient compliance to treatment regimens (Feinsilver, 1989). Building better, more understanding relationships with her patients is also an important goal of *terreno*. In many regards, she acts as a doctor in the morning, and a social worker with an advanced medical background in the afternoon.

After developing a basic understanding of the daily workings of *consultorios*, I began more in depth interviews with Dr. Garcia and Dr. Pérez. In particular, I attempted to understand what these doctors believed to be the strongest and weakest points of the Cuban health care system.

Medicine in a Resource Poor Setting

Perhaps by design as well as by necessity, Dr. Garcia used very few tools or sophisticated equipment in her work. I saw her use a blood pressure cuff and a stethoscope. Her exam room also had a scale and an x-ray light, but I only saw the scale used once by one of the nurses who wanted to weigh herself. The x-ray light had a rusty plug that probably had not touched a socket in years. I am not sure the *consultorio* had

electricity anyhow. Many western doctors would see these as major obstacles to practicing medicine, but the following story expresses a more positive perspective:

For example, consider you are doing terreno and you have a child with a bean stuck up their nose. In developed countries, there is probably a sophisticated piece of equipment to reach into the child's nose. Here, you learn how to get that bean out with a bobby pin (as she said this she snatched a bobby pin out of the hair of a nurse sitting near us in order to demonstrate the twisting motion she would use to get a bean out of a small nose). This little thing will definitely work, and the little girl is familiar with it, so it will not scare her... Within the problem that we have regarding development, there is also an advantage, because you can work in any area, in Africa, wherever you want. Invent! Resolve! Do you understand me?

Dr. Pérez was more critical of the lack of equipment, but expressed similar sentiments. After lamenting the hassle of referring patients to specialists just because the necessary diagnostic equipment was not available at the *consultorio*, she made the following statement.

There are times when perhaps the technology gets a little bit past what medicine is, when really what's important is clinical practice, and looking at the patient like a biological, psychological, and social being. Sometimes this is more important than having great technology. Sure, it is good to have good diagnostic equipment, but if there is not a good relationship between the patient and the doctor, it is not worth anything.

While the *consultorio* was sparsely equipped by international standards, both doctors seemed confident that their patients could access technologically sophisticated care when necessary. They said that their patients were able to go to the *policlinico* or a hospital for whatever needs could not be met at the *consultorio*.

Both doctors talked about adapting to equipment shortages in a positive and even passionate manner, but they found other aspects of Cuba's tight budget less manageable. When I asked what aspects of the Cuban medical system need the most improvement,

both talked about the salaries of doctors. This is no surprise, given that a normal salary for a Cuban doctor is about twelve dollars a month. Dr. Pérez was outspoken about her frustration with the matter, saying “There are people who are not doctors that earn a lot more than us, but our jobs are very important, because it is better to be healthy than to have a sack of money.” Dr. Garcia did not describe salaries as unfair in relative terms, but still made clear that the economic circumstances of many Cuban doctors are desperate. When I asked Dr. Garcia if her salary was at least enough to get by in Cuba, she said “Well, no, it is not enough. It is not enough because one has a little kid, and then you have to buy clothes and shoes, this, and that, and it just is not enough.”

She surprised me when she added that medicine is no longer a very popular profession among young people in Cuba. Although she and all of the other doctors I spoke with say that they enjoy their work very much, Dr. Pérez agreed with Dr. Garcia on the following statement:

Health care in the rest of the world is commercial, and in Cuba, it is not. That is why it is popular in the rest of the world... Here not so many people want to study medicine because what happens? Many sacrifices during your education, many sacrifices during the whole life of the doctor, and there are many specialties that are stressful...not everyone wants that kind of stress. You can do other things where you earn more with less stress, less work, and less dedication.

These frank statements call into question why many thousands of Cubans, knowing the sacrifices that Socialism and poverty demand of doctors, still chose to begin medical school each year. Despite the hardships, the motives of all the doctors I spoke with were very clear. Cuban medicine, in their opinions, is not a business or normal job; it is a humanitarian mission. They boasted that Cuba provides inclusive care, and that race, age, class, and gender do not influence access. Each time I asked about the strengths

of Cuban medicine or asked for comparisons between the US and Cuba, the most prominent and passionate answers were similar to Dr. Garcia's. "It is humane here because you are cared for the same whether you have a good job, a poor job, or no job at all. If someone does not pay, they are still attended to just like everyone else." They never described care as lavish or state of the art, but instead emphasized that no one falls completely through the cracks. Dr. Pérez compared Cuba's safety net with the state of health care in other developing countries "I have never been to Africa, but I know someone who was, and people were dying because they could not get medical care, but here this does not happen. It is a sad reality that does not happen here."

Throughout our interviews, both doctors consistently conveyed how difficult they believed it is for the government to fund their medical system. Good health comes at a cost in Cuba.

Perhaps you see here poverty and dirtiness that does not exist in your country, because it is not a priority here... What would you prefer? That the house be painted every year, and that we let people die? It seems that the humanitarian point of view is that the people should not die. It is a radical difference [between the US and Cuba]. It is a priority here that children drink milk until they are seven, even if they do not get much milk after that.

In the opinion of the doctors I spoke with, this humanitarian approach is the core strength of a socialist medical system. These doctors were making due with few resources, and struggling to survive with very small salaries, but they were adamant that Cuban medicine would not and should not sacrifice equity for profitability.

Conducting Ethnographic Fieldwork in Cuba

When I arrived in Cuba, I faced several significant barriers to conducting field research in the medical system. The most noticeable and superficially most significant barrier was my comprehension of Cuban Spanish. Cuba's fast, slurry Spanish is unique and horrifying for most who only speak marginal Spanish of a different dialect.

Fortunately, my ability to comprehend Cuban Spanish progressed in step with my research project and, after overcoming initial paralysis, I was able to pursue fruitful fieldwork.

A subtler yet more significant barrier relates to the Castro regime and Cuban society in general. Many of my contacts were very reluctant to talk about controversial issues. While they may have feared repercussions from their government to some extent, I would not describe Cuba as a fear state. I do not think any of my contacts have ever feared being disappeared or tortured. To the contrary, I think my contacts strongly preferred the Cuban medical system and the Cuban government to that of the US. They seemed to fear that any critique of Cuba might weaken the island's reputation, resolve, or ability to remain independent of its northern neighbor.

A breakthrough moment occurred during an interview when Dr. Garcia asked me to turn off my audio recording device. Among other things, we talked extensively about drug use in schools in the US, and I gathered that she was considering moving to the US with her young child. She was afraid her child would not be safe from drugs in American schools, and was asking my advice. Although she only asked me to turn off the recorder one other time, there was an understanding after that first experience that she could be

honest with me, and simply ask to go off record when necessary. I include this story on the condition that all names in this report are pseudonyms.

Conclusions

When I asked Dr. Garcia what single change would improve the health of the Cuban people the most, she pulled out her pen and one of the slips of paper she uses for writing prescriptions. She drew a big glob with a peninsula and called the glob US. Just beneath, she drew a tiny sliver called Cuba. Far off to the right she drew another large glob and called it Europe. “How much do you think milk would cost if it came from here?” she asked, pointing to Florida. “How about from here?” pointing to what might have been the Iberian Peninsula. “It does not matter exactly, but when I draw this for my five year old he says, ‘yes, it is logical Mama.’ The blockade costs us so much money; we could do so much more for our people if we just had a little more money.”

The doctors I spoke with conveyed a consensus that their major contentions with the Cuban health care system all relate to a lack of resources. Poor pay, mediocre access to expensive equipment, and the necessity of sending hordes of doctors abroad all tie into this theme. In the face of these challenges, the Revolutionary government has implemented a community based health system that provides at least a basic level of effective care to every Cuban.

I have found some of the common critiques of socialized medicine to be accurate. Cuban doctors are paid almost nothing, they often work in lamentable conditions, and the Cuban state exercises a huge influence over where they work. Cuban doctors do want to be able to buy clothes and shoes for their children; a desire that I think transcends

socialist and capitalist systems. Beyond lacking such necessities, however, most Cuban doctors do not seem to find their conditions as restrictive or burdensome as many in the US have claimed. To the contrary, they tend to be more critical of the failings of capitalist medicine, decrying the willingness of governments, communities, and physicians to let poor individuals be sick and die without health care.

It is particularly interesting that Cuban doctors tend to attribute the achievements of the Cuban health care system to its humanitarian motivations and organization. Its failings, on the other hand, they blame on external forces, repeatedly citing the economic blockade imposed by the US. It is entirely possible that the opinions of these doctors, and the way they chose to express them to me, were influenced by the pressure and propaganda of the Castro regime. Nonetheless, it is clear that Cuban doctors are the champions, not the victims, of a health care system that has proven astonishingly efficient at using the resources it has available to promote the health of its people.

Interviews

In addition to informal interviews and observations at Cira Garcia, Hermanos Almejeiras, and a policlinico and a consultorio in Centro Habana, I conducted multiple formal interviews with the following people.*

Doctora Jillian Garcia Especialista Medicina General Integral, La Habana Cuba.

Doctora Gladys Pérez Especialista Medicina General Integral, La Habana Cuba.

Doctora Maile de León Profesora del Escuela Latino America de Medicina. Especialista
Medicina General Integral y Epidimiologia.

Doctora Damaris Vasquez Especialista Medicina General Integral y Epidimiologia

* I changed the names of all informants. I left all positions unchanged.

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