Primary Health Care in Cuba: Fulfilling the promise of Alma-Atá

Dr. Jorge Luis Hadad Hadad
Instituto Superior de Ciencias Médicas de la Habana
Republic of Cuba
July 2009
Learning Objectives

1. Characterize Primary Health Care (PHC) as the base of a Health Care System
2. Identify the components of Primary Health Care and their application models
3. Describe Cuba’s Primary Health Care Model and its main experiences
4. Identify the reasons behind the renewal of the Primary Health Care
Contents

• PHC Concepts
• PHC Components
• Application Models
• Primary Health Care in Cuba
• The Family Physician and Nurse model
PHC Concepts 1

- Essential health care
- Based on methods and practical technologies
- Scientifically substantiated and socially accepted
- Accessible to every individual and family of the community through their full participation
- Affordable for both the community and the country
- In the spirit of self-responsibility and self-determination
PHC Concepts 2

- PHC is an integral component of both the Health Care System and the global, social and economic development of the community.
- It is the central function and core of the Health Care System.
- It is the first-level contact of the individual, family and community with the Health Care System.
- It is provided as close as possible to the home and workplace.
- It is the first component of a permanent, health care process.
PHC Concepts 3

- PHC is a representation and consequence of the economic conditions and the socio-cultural and political characteristics of the country and its communities
- It applies the pertinent results from social, biomedical and health care service research and the accumulated experience in public health
PHC Concepts 4

- PHC targets the main health problems of the community.
- It provides the following services: promotion, prevention, treatment and rehabilitation. They are all necessary to resolve those problems.
PHC Concepts 5

PHC includes the following activities:

- Education about the main health problems, and their preventive and corrective methods
- Promotion of proper nutrition, food provision, drinking water supply and basic sanitation
- Mother-child assistance and family planning
- Immunization against the main, infectious diseases
- Prevention and treatment for local, endemic diseases
- Treatment of common diseases and trauma
- Supply of essential medicines
PHC Concepts 6

Coordinated participation of the health sector and all the sectors and areas of activities:

- Agriculture
- Zootecnics
- Nutrition
- Industry
- Education
- Housing
- Public Works
- Communications
- Other Sectors
PHC Concepts 7

PHC demands and fosters:

• Self-responsibility
• The participation of the individual and the community in:
  – planning, organization, operation and control
• Rational use of local and national resources
• Appropriate education to develop the community’s ability to participate
PHC Concepts 8

- Integrated systems to supply cases
- Health teams that include:
  - Professionals
  - Technicians
  - Auxiliaries
  - Community workers, and
  - Practitioners of natural and traditional medicine
Primary Health Care

Base of the Health System

• Health system organization
• Organizational levels and management
• Hospital model vs. PHC
• Medical practice models
• Human resource development models
Organizational levels and the management of health services

- Individual, family and community (self-care and home)
- Individual provider (physician, nurse, others)
- Health team (first level, second level)
- Department or Service (lab, rehabilitation)
- Health facility (health center, hospital)
- Service network (health facilities, specialties)
- Health system (national, regional or local)
Levels of Care

EQUITY

CONTINUITY - RESOLVABILITY

COVERAGE - ACCESSIBILITY

HOSPITALS

INSTITUTIONS

HOSPITALS

HEALTH CENTERS

DOCTOR’S OFFICE

SELF-CARE

PRIMARY HEALTH CARE
<table>
<thead>
<tr>
<th>CURATIVE</th>
<th>PRIMARY HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORIENTED TO THE PERSON WITH AN INDIVIDUAL APPROACH</td>
<td>ORIENTED TO THE INDIVIDUAL, THE FAMILY AND THE COMMUNITY</td>
</tr>
<tr>
<td>ISOLATED AND PHYSICIAN DRIVEN</td>
<td>IN TEAMS AND INTERDISCIPLINARY</td>
</tr>
<tr>
<td>AID BASED IN SPECIALIZATION</td>
<td>PREVENTIVE BASED IN GENERAL AND INTEGRAL MEDICINE</td>
</tr>
<tr>
<td>ORIENTED TO DISEASES AND AFFECTED ORGANS WITH A BIOLOGICAL APPROACH</td>
<td>ORIENTED TO MAN AND ENVIRONMENT, WITH A BIOLOGICAL, PSYCHOLOGICAL AND SOCIAL APPROACH</td>
</tr>
<tr>
<td>AIMED AT CLINICAL ASPECTS (DIAGNOSTICS AND THERAPEUTIC)</td>
<td>AIMED AT CLINICAL ASPECTS, PLUS EDUCATION, PLANNING AND LEADERSHIP</td>
</tr>
<tr>
<td>EPISODIC AND FRAGMENTED PRACTICE</td>
<td>INTEGRAL AND CONTINUOUS PRACTICE</td>
</tr>
<tr>
<td>PRESCRIPTION BASED RECOVERY AND REHABILITATION</td>
<td>PREVENTIVE AND PARTICIPATIVE FUNCTION</td>
</tr>
</tbody>
</table>
Human Resource Development Models

**Curative**
- Classrooms
- Hospitals
- Clinical
- By Specialties
- Diseases
- Knowledge Receiving
- Passive
- Academic: Knowledge Oriented
- Limited Practical Use
- Away from the System Necessities

**Primary Health Care**
- Community
- Level I of Care
- Clinical + Public Health
- General, Integral
- Health and Its Management
- Knowledge Management
- Proactive
- Practical Education: Know-How
- Practice Oriented Professionals
- Educación Based On and Oriented To Health Necessities

Note P
Primary Health Care - Cuba

• Primary Health Care model
  – Service organization
  – Medical practice
  – HR development

• Model evolution - phases
  – Integral health care
  – Community care
  – Family physician and nurse
Primary Health Care - Cuba

Elements conditioning the primary health care development and implementation:
– Political will
– Social model
– Economic conditions
– Health situation
– Advances in science and technology
Evolution of PHC Model in Cuba

1960 -1970 “INTEGRAL”* HEALTH CARE

• Single and universal
• Coverage and accessibility
• Integral care. Prevention. Environment
• Divisions: health area
• Programs to control the main issues affecting health
• Community participation
• First-level care institutions: Integral Polyclinic and Rural hospitals

*See Note S for a definition of “integral health care,” which has no good translation into English.
Evolution of PHC Model in Cuba

1970 - 1980 COMMUNITY CARE
• Integral Care: Prevention. Environment.
• Divisions: adults, children and women
• Teamwork
• “Dispensarización” (see Note S for a definition)
• Continuity
• Regionalization
• Organized community participation
• Institution: Community’s teaching polyclinic
Evolution of PHC Model in Cuba

1980  FAMILY PHYSICIAN AND NURSE

• Divisions: 120 families (600-800 persons)
• Pharmacy services
• Continuity
• Teamwork
• Regionalization
• Organized community participation
• Institution: University polyclinic
Family Physician and Nurse

Model characterization

Unique: It is unique. No other models.
Universal: For all the rural and urban population
Coverage: All the population in all locations
Access: Access increase. Both home and office of the family physician and nurse are located in the community.
Model characterization

**Integral:**
- Individual-family-community
- Health and its determinants
- People and their environment
- Epidemiological monitoring

**Integrated:**
- Teamwork
- Service network

**In Teams:**
- Horizontal: Physician and nurse
- Vertical: Specialist
- Interdisciplinary
- Inter-consulting
Family Physician and Nurse Model Characterization

REGIONALIZED

National Health System

Provincial Health System

Municipal Health System

Health Area

Polyclinic

B.W.G*

Family Doctor’s Office

HOSPITAL SERVICES

DENTAL SERVICES

EPIDEMIOLOGY AND SANITATION CENTERS

SOCIAL SERVICES INSTITUTIONS

TEACHING & RESEARCH

*Basic Work Group

Note X
Family Physician and Nurse Health Area

Dr. OFFICE NETWORKS

- NURSERY HOMES
- MENTAL HEALTH CENTER
- MATERNITY HOME
- GASTRO INTESTINAL (G.I.) CLINICS
- PHARMACIES
- OPTICS
### Family Physician and Nurse Model Characterization

<table>
<thead>
<tr>
<th>Subdivided</th>
<th>Direct Responsibility upon a specific social-geo-demographic area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family Physician and Nurse 600-800 hab</td>
</tr>
<tr>
<td></td>
<td>Basic Work Group 10,000 hab</td>
</tr>
<tr>
<td></td>
<td>Health Area 30,000 hab</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuous</th>
<th>Time</th>
<th>Lifecycle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Specialized Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home, school and workplace</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr. Offices and Community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focused</th>
<th>Individual and Family</th>
<th>Dispensarization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Demographic</td>
<td>Heath Situation Analysis</td>
</tr>
</tbody>
</table>
Dispensarización: Program to provide active, continuous and controlled primary health care in line with the individual and family health needs.

- It identifies health problems and needs
- In every individual and family
- In terms of risk, disease and disability
- In the biological, psychological and social areas
- Referred to the health components and their determinants
- It designs individual strategies
- It applies the strategies and controls them in time and space
Family Physician and Nurse
Model characterization

Analysis of the health situation: Methodology for the identification and prioritization of health problems, their causal explanation and the design of population-scaled, intervention strategies.

• Participation of the community and relevant sectors
• It identifies community health problems and needs
• Referred to the health components and their determinants
• With focus on the causes and risks
• It designs integral strategies
• It applies the strategies and controls them in time and space
## INTERVENTIONS

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Individual</th>
<th>Family</th>
<th>Diagnostic</th>
<th>Therapeutic</th>
<th>Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiologic aspects</td>
<td>Individual</td>
<td>Family</td>
<td>Community</td>
<td>Risks</td>
<td>Determinants</td>
</tr>
<tr>
<td>Public Health</td>
<td>Program management and Health services</td>
<td>Inter-sectors and community Government participation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEALTH CARE</td>
<td>ACTIONS</td>
<td>ENVIRONMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promotion</td>
<td>Outpatient Visits</td>
<td>Polyclinic Dr.’s Offices</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention</td>
<td>Home Care</td>
<td>Outpatients Bed bound</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recovery</td>
<td>Emergency</td>
<td>Polyclinic Dr.’s Offices SIUM##?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Family Physician and Nurse
Community and inter-sector participation

**National Assembly of the People’s Power**
- Health Committee
- Health Council

**Provincial Assembly of Government**
- Health Committee
- Health Council

**Municipal Assembly of Government**
- Health Committee
- Health Council

**President of the People’s Council**
- Community Organizations
- Sector Representatives

**Circumscription Delegate**
- Neighbors - Women - Students
- Worker - Agricultural Workers
- Administrations

**Public Health Ministry**

**Provincial Health Director**

**Municipal Health Director**

**Polyclinic**

**Family Physician**
### Primary Health Care in Cuba
#### Distribution of expenditures

<table>
<thead>
<tr>
<th>Services</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals / in-patient institutions</td>
<td>42.3</td>
</tr>
<tr>
<td>Polyclinics</td>
<td>31.6</td>
</tr>
<tr>
<td>Dental clinics</td>
<td>2.4</td>
</tr>
<tr>
<td>Maternity homes</td>
<td>1.5</td>
</tr>
<tr>
<td>Service units</td>
<td>2.9</td>
</tr>
<tr>
<td>Other units</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Cuba 2007

Note FF
### Medical consultations per year 1980-2006

<table>
<thead>
<tr>
<th>Year</th>
<th>External</th>
<th>Urgent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>30 000 165</td>
<td>15 165 458</td>
<td>45 165 623</td>
</tr>
<tr>
<td>1990</td>
<td>48 079 149</td>
<td>20 122 071</td>
<td>68 201 220</td>
</tr>
<tr>
<td>1999</td>
<td>60 866 546</td>
<td>20 388 191</td>
<td>81 254 737</td>
</tr>
<tr>
<td>2003</td>
<td>52 658 212</td>
<td>18 846 698</td>
<td>71 474 910</td>
</tr>
<tr>
<td>2006</td>
<td>39 172 468</td>
<td>22 247 804</td>
<td>61 420 272</td>
</tr>
</tbody>
</table>

| Per capita | 3.5 | 2.0 | 5.4 |

### Note GG
### External and Urgent Consultations per Type of Unit (Percent)

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital</th>
<th>Level I</th>
<th>Other</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EXT</td>
<td>URG</td>
<td>EXT</td>
<td>URG</td>
</tr>
<tr>
<td>1970</td>
<td>24.6</td>
<td>80.2</td>
<td>69.6</td>
<td>18.9</td>
</tr>
<tr>
<td>1980</td>
<td>21.7</td>
<td>80.2</td>
<td>73.2</td>
<td>18.9</td>
</tr>
<tr>
<td>2005</td>
<td>14.4</td>
<td>42.2</td>
<td>84.9</td>
<td>57.2</td>
</tr>
<tr>
<td>2006</td>
<td>13.3</td>
<td>39.1</td>
<td>85.7</td>
<td>60.2</td>
</tr>
</tbody>
</table>

**Note HH**
External and Urgent Consultations per Type of Unit (Percent)

* Cuba. Yearly Statistic Journal
### Yearly Hospital Bed Supply 1980-2006

<table>
<thead>
<tr>
<th>Year</th>
<th>Beds</th>
<th>Per 1,000 People</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>44339</td>
<td>4.5</td>
</tr>
<tr>
<td>1990</td>
<td>63205</td>
<td>6.0</td>
</tr>
<tr>
<td>1998</td>
<td>66948</td>
<td>6.1</td>
</tr>
<tr>
<td>2003</td>
<td>55428</td>
<td>4.9</td>
</tr>
<tr>
<td>2006</td>
<td>54771</td>
<td>4.9</td>
</tr>
</tbody>
</table>
Medical Care Actions at the Polyclinic, centered on the family and according to their health condition, life cycle and gender.

- **CURATIVE**
  - Protocols for care, including rehabilitation and prevention.

- **PREVENTIVE**
  - Case history interview,
  - Physical Exams.
  - Diagnostic Tests.
  - Prophylactic Measures.
  - Health Advice.

- **DISABILITY**
  - ILL ACUTE & CHRONIC

- **RISKS**

- **“HEALTHY”**

Note LL
Quiz

I invite you to take the following quiz and assess your knowledge about this module.

The quiz includes 8 general questions related to the essential knowledge presented along this module. Every quiz question has one short answer.

Once you have finished with the quiz, please return to read the module summary.
Summary – part 1/2

This module covered:

• The concept and contents related to Primary Health Care
• How Primary Health Care is applied in health systems, medical care and HR development.
• The approach of the Cuban Health System to Primary Health Care and every one of its components.
• Some examples of how the consistent application of Primary Health Care in a health system impacts services and their results.
Summary – part 2/2

This module will inform you about PHC, its contents, application models and their implementation in the Cuban Health System, its organization and health workforce development. You can apply these concepts to your eventual health-related practice, your education and the organization of health systems from their first-level care to the overall, integrated system.
References

• Starfield B, Shi L. Contribution of primary care to health systems and health. Milbank Q 2005
• La Renovación de la Atención Primaria de Salud en las Américas
• Economía de la Salud. Texto Básico. Instituto Superior de Ciencias Médicas. 2004
• Salud para todos. Si es posible. Sociedad Cubana de Salud Pública. 2005
Credits

Dr. Jorge Luis Hadad Hadad
Public Health Professor
The Global Health Education Consortium gratefully acknowledges the support provided for developing these teaching modules from:

*Margaret Kendrick Blodgett Foundation*

*The Josiah Macy, Jr. Foundation*

This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 United States License](https://creativecommons.org/licenses/by-nc-nd/3.0/).
Supplementary Notes
The strategy **Health For All by the Year 2000 (HFA/2000)** was launched internationally to respond to the worthy call from countries, especially those less developed, to increase their health levels in the midst of their adverse, economic and social conditions at the end of the 70s.

The World Health Organization, a specialized organization of the UN System, assumed the responsibility to conceptualize the demand and define the objectives, goals, and plans to respond to this demand through a feasible, sustainable, technical and social movement.

The community of countries represented at the 32nd World Health Assembly of 1979 presented, debated and accepted the Strategy for Health for All by the Year 2000. This strategy proposed Primary Health Care as the way to reach Health for All by the Year 2000.

This is how the Resolution WHA 32.30, including both the report and Declaration of Alma-Atá, was approved. This resolution was originally defined in a technical meeting in Alma-Atá, the capital of Kazakhstan, in September 6-12, 1978, by 134 countries and 67 organizations. Thus, Primary Health Care, its contents and fundamental approaches, were defined in a way that satisfied the interests and positions of all the countries and organizations represented there.

Primary Health Care is a philosophy, a strategy and an approach that ensures the delivery of health-related services, both medical and public health, in all its essential aspects, with practical technologies and methods, at a sustainable and reasonable cost. It is accessible by all, scientifically substantiated and socially accepted.

Thirty years later, Primary Health Care enters a new, defining moment. International meetings have been held with deep and broad-scope discussions. The most recent meeting was celebrated in Alma-Atá, capital of Kazakhstan, the same place where the original strategy was approved and launched.
Note B: Primary Health Care

Besides being an academic concept, Primary Health Care is the base and core of the organization of the Health Systems. It is also the base for the inter-relation between the Health Systems and the socio-economic organization. From the operational standpoint, Primary Health Care is the way individuals, families and communities connect with the health system. Primary Health Care is also their first contact with the system from home, school or the workplace. From that first contact, individuals, families and communities walk through a system of organized services that are both based on the principles of primary health care and provisioned properly to satisfy all the health needs.
Note C: Primary Health Care

Primary Health Care, conceptually unique, is applied according to the political, economical and social conditions and possibilities of every country, region and community.

The possibilities and ways to face the health situation of a society cannot be disconnected from the social and economic order in which they are inserted. Every country, respecting principles and contents, should find its own path. Without pretending to copy ‘international models,’ it should find its path through the appropriation of the best experiences, both positive and negative, acquired by other countries, regions and communities.

The scientific base referenced by the Primary Health Care concept implies the use of research and its results in the identification and tackling of health problems with the participation of diverse sciences.
Note D: Primary Health Care

As the means to make more efficient and effective both health systems and services, primary health care should be based on a hierarchy and a set of priorities of health problems. It should also start by focusing on those problems that both the health system and the community rank as the main one.

Primary Health Care bases its interventions on its four essential functions: promotion, prevention, recovery and rehabilitation. It does so through integral interventions and by giving priority to those functions necessary for the resolution of the particular problem. Its main emphasis will be on the correct and timely application of the health promotion and preventive functions. These are more effective, durable, scientific, human and economical.
When Primary Health Care was defined 30 years ago, a number of activities were defined as the essential ones. This was a means for getting the acceptance and adherence to the concept and its instrumentation by all the parties involved. Nonetheless, these activities should not be regarded as the only ones. These should be modified and amplified as a function of the moment and place of their application.
Health “Intersectoriality” is an intervention coordinated by institutions representing several social sectors. Its actions are fully or partially dedicated to treat the problems linked to health, well-being and quality of life. This inter-sector focus is indispensable in the current model for both defining conceptually and tackling health.

Primary Health Care bases its focus and application model in the coordinated participation of the diverse sectors related to health. However, the leadership among these participants could vary depending on both the health problem and the socio-economic organization of the place.
Note G: Primary Health Care

Health, as a bio-psycho-social problem of all, the individual, the family, the community and society, can not be approached from the sole perspective of a health service, even when counting on the best human and technological resources.

PHC conceives the components individual, family and community not as receptors of health services but as actors with a true leading role in the health process that unfolds in them. Thus, the self-responsibility and active participation that integrates all the following: the understanding and processing of a reality, the identification and formulation of a problem, the proposal of alternatives for a solution, and the participation in the decision making, execution, control and evaluation, are essential premises for the true implementation of Primary Health Care.

To achieve this level of empowerment and true participation by individuals, family, community and society, Primary Health Care demands and fosters: participatory spaces and procedures and the rational use of resources. It also demands and fosters the education and preparation of people and communities so they can act efficiently.

Community participation is the process in which both individuals and families take responsibility for their personal and collective health and wellbeing, and thus, improve their ability to contribute to their own and their community economic development. Individuals and families should acquire the necessary ability to assess a situation, ponder diverse possibilities and estimate their own contribution.

While the community should be willing to learn, the health system has the responsibility to explain, advice and offer clear information about the favorable and unfavorable consequences and relative costs of the proposed activities.
Primary Health Care (PHC) conceives the care process as unique and continuous. However, the organization of the system disposes technological, material and human resources in a step manner to ensure higher levels of specialization, quality and efficiency in diagnosis, therapy and services. Furthermore, PHC both integrates the services of the system and creates reference and counter-reference procedures to ensure the timely access to the required services.

PHC starts with two fundamental premises. Both the complexity of the human, illness-health process, and the development of complex, diagnostic and therapeutic technologies demand the participation and teamwork of different professionals, technicians and auxiliaries. Occasionally with diverse professions and specializations, they should act with a unity of objectives and procedures.

The spirit of PHC demands the consideration of the traditional, natural, community and local technologies and their practitioners in the process of integral care. The ability to integrate and harmonize these practices and their practitioners under one scientifically-based and socially-accepted leadership will enrich the primary health care and its results.
Note I: PHC Application Models

Implementing the concepts and approaches of Primary Health Care require their instrumentation in three basic areas: the medical practice, the organization of health systems and services, and the programs for human resource development in health.

These components are the application areas of Primary Health Care. They adopt particular models that characterize them and differentiate them from others. They also enable putting into practice both PHC concepts and contents in different times and contexts.

It is difficult to define a central component. They all condition each other. Achieving coherence, harmony and integrality among all three components and defining Where and How to apply the concepts of PHC in this complex system constitutes the main challenge.
Note J: Primary Health Care

Primary Health Care determines the organization of the health system. However, whether Primary Health Care and its qualitative characteristics are implemented or not depends on both the existence of political will and how the health system evolves in the socio-geo-demographic space and time.
Classically, health services are organized and managed in levels. They are structured in various ways. In general, services go from the self-care level, those are: individual, family and community levels, to the highest levels of aggregation in the local, regional and national, health systems.

Primary Health Care is indissolubly linked to the concept, organization and performance of a health system. Thus, Primary Health Care is present in every one of the service organization and management levels.

The current slide shows the classic levels and some examples of the services they include.
In general, health systems are structured in three levels. And these create sublevels according to their individual characteristics. Primary Health Care is mostly applied at the first level. However, it serves as the basis for every level. Every level and its respective services ensure coverage, accessibility, continuity and resolvability. Furthermore, Quality and Equity are essential objectives of both the overall health system and every care level.

Primary Health Care is present at every level of the system. It is the base and the driving force of the health system organization and operation. However, its highest and most important definition is reached at level I, the level characterizing the system. We could say that Health Systems are characterized by their first level of care and the PHC application model adopted. To a large degree, this is due to the adequacy and relationship built at this level between the health services and the population and its social system.

This first level, as we have mentioned before, begins with the individual and family self-care, the doctor offices served by a professional, a health technician or both, and the health centers with more comprehensive health teams, specialists and support services for diagnosis and therapy. It is this level that provides the most possibilities in which to apply Primary Health Care.

The second level is represented by hospitals that are referred locally, municipally and provincially. The third level is represented by national, hi-tech institutes and hospitals.

I would like to emphasize that all the health system should be organized departing from the principles and contents of Primary Health Care. It should offer full coverage and accessibility. It should also ensure continuity and the maximum ability to resolve problems at every level and service. Furthermore, the objectives of Quality and Equity will guide the organization and performance of all the system.
Primary Health Care is the base and the central core of a Health System.

PHC is present in all the components and levels of the system. Health teams are responsible for executing PHC activities through the functions: promotion, prevention, recovery and rehabilitation. At all components of the health care system health teams relate to the public health and other sectors.

The first level of care is considered the most representative and important in the strategy of primary health care. Besides all the relations represented in the slide, including specialized care services, the first level reaches and interacts closely with individuals, families and community.
Note N: Service Organization Models

Web Object Placeholder
Address: 111notas/notaN.htm
Displayed in: Articulate Player
Window size: 720 X 540
Note O: Medical Practice Models

Medical practice has also evolved with the development of the medical, health and other sciences, the evolution of health systems and its technologies, and the profound transformations of society. Primary Health Care has both contributed to and required the transformation of medical practice. From a physician-centered practice that served people individually and delivered its service in isolation, medical practice was transformed into one that both considers the individual qualities of processes and applies them properly to act on the family and the community. It also incorporates health teams and the various required disciplines to approach the disease-health problem holistically.

Before the Primary Health Care approach, medical practice was approached purely as service. It was based on the specialization and oriented to the disease and the particular organ affected. It had an essentially biological focus. And it aimed at the clinical aspects, both diagnosis and treatment. Primary Health Care exceeds the previous practice by: (1) aiming at the person, her health and her environment with a bio-psycho-social approach, (2) being preventive, general and integral, beyond the specialization, and (3) including not only the clinical diagnostic and therapeutic aspects but also the educational, leadership, planning, monitoring and evaluation components of health management.

The hospital-model medical practice is also episodic. It takes care of the patient at the moment of a particular illness and the respective demand for health care. This makes the practice fragmented, oriented to the recovery and rehabilitation of the patient and based on the prescription and the medical act. Different from this, Primary Health Care develops an integral and continuous practice. It takes care of the individual in every moment of his life and in front of every circumstance of his disease-health process. It has a predominantly preventive approach. And it promotes the participation of the individual, the family and the community in the resolution of the problems.
Note P: HR Development Models

The development of human resources should respond to the models in both medical practice and the service organization. Therefore, it should respond to the needs of the health system and society according to the way it conceives and approaches health.

Traditionally, health professionals and technicians have been taught in classrooms and hospitals with an exclusively clinical and specialty-driven base, oriented to the disease and its diagnosis, treatment and rehabilitation in a hospital environment. Primary Health Care imposes the need and creates the technologies and spaces needed to develop a new HR development model that is oriented to satisfy its own needs and the needs of the health system. It widens and moves the educational environments to the community, the healthy human being, the environment and the services of the level I of care.

Besides the clinical education, it includes the education in public health, epidemiology especially. It also extends the scope from the specialties to the integral care of the person and the general process disease-health. Therefore, learning happens not only from the a person’s illness and his recovery, but also from the healthy condition and the way to preserve it and promote it, all with specialized education.

For new professionals and technicians to meet the demand for health services, the new HR development model emphasizes the development of skills to manage knowledge proactively. This knowledge is fundamentally practical, necessary for the professional practice in the first level of care. This emphasis is higher than the one on the passive reception of academic knowledge tailored mostly to “know” and with limited practical utility under the new conditions of the health system.

In this HR development model, the specialist is educated departing from her education as a doctor in integral, general medicine. Therefore, primary health care permeates the thinking and practice of professionals in all the specialties and levels of the system.
Note Q: Primary Health Care

We will approach the Cuban model for Primary Health Care from the perspective of the organization of services, the medical practice and the development of human resources.
Note R: Primary Health Care

Health systems and their central core, i.e., Primary Health Care, evolve and change in one or other direction, quickly or slowly, depending on a number of factors that include: political will, social transformations, economic models and conditions, demographic changes related to health such as morbidity, mortality, disability and others, determinants of these demographic changes, and scientific and technological advances impacting health directly.
Cuba started to implement the concept of Primary Health Care in the early 70s. It started along with the construction of rural hospitals, integral polyclinics and programs to fight the main threats to health. The health system started by being state-run, single and universal. It provided free services with full access and coverage.

These programs and services approached the health problems integrally. They included a strong preventive component, health education and care for the surrounding environment. Cuba also defined the organization called Health Area (Área de Salud), a social-geo-demographic space of 30 to 50 thousand habitants with a health institution responsible for the integral health of this community. In urban areas this institution was called a polyclinic. In rural areas they were rural hospitals. They had the in-patient hospitalization capacity to care for pregnant women up through labor and delivery, and later, children and adults with less complex diseases. Polyclinics were served by general medical doctors and rural hospitals by social service post-graduates. In this phase, Cuba also created Maternity Homes as institutions without the hospital feel and aimed at the in-patient care of pregnant women nearing full term and no easy access to hospitals at the time of labor. All these institutions were inter-related through administrative procedures to achieve comprehensive and continuous care in a regionalized system. The community component emerged through the participation of women and organized neighbors who supported the health programs and services provided by the polyclinics. Many times communities sourced these institutions to fill the shortcomings in trained personnel.

Health programs, called “Against Harms” (“contra daños”), were directed to take care of the main health problems affecting the population: infectious diseases such as the acute diarrheas, tuberculosis, malaria, typhoid fever and others. Poliomyelitis, tetanus, difteria and others were precociously faced through vaccination programs. A decisive community participation ensured a wide coverage, access, acceptance and quick impact over all the infant population.

Translator’s note: The underlying meanings of “Integral Health Care,” an essential concept in Cuba and other parts of Latin American, cannot easily be translated to English. A useful expansion on this term is provided on Wikipedia by the Faculty for Integral Health Care though undoubtedly other definitions exist. It notes that: “Integral Health Care is the synergy that comes out of the synergy of all forms of healing. Together they can PREVENT, PREVENT, CURE offer PALLIATION. This they can do because they can
Note T: Primary Health Care

Web Object Placeholder
Address: 111notas/notaT.htm
Displayed in: Articulate Player
Window size: 720 X 540
Ten years of experience and development of the community model, profound transformations in the socio-economic organization and government system in Cuba, the integral development of the health and education systems, and changes in the health conditions of the Cuban population brought forward a new health care model: **the family physician and nurse.**

From 1960 to 1984, Cuba graduated more than 21,000 physicians. This let Cuba make an important leap in its health model. Furthermore, the principles and successes from the previous model also enriched and perfected this new model throughout all its components.

The family physician and nurse model emphasizes both health promotion and prevention. It also acts through a new organization and technologies over the environment. It reduces the number of habitants per Sector but widens the Sector’s scope. It now defines the family and not the individual as the base of its organization. It strengthens and enables a better application of the Dispensarization component. It achieves a qualitative improvement in the conception and operation of the continuity of care. It widens and strengthens team work and elevates the community participation to become an essential component for the development of Primary Health Care. With this new model, Inter-sector actions (Intersectorialidad) emerge as a means to the solution of important problems determined by the environment and the human behavior.
The model of the **family physician and nurse** expanded quickly. This was sustained by a large program for human resource development that produced graduates in integral and general medicine. A reformed curricula gave the new physician both knowledge and skills in clinical medicine, epidemiology and public health. These were necessary to both undertake the integral care of the population through their life cycle and manage the health improvements of individuals, families and community under the health team’s responsibility. The model is unique because it does not co-exist with any other organization form or model. It is also universal because it is directed to all the population.

It offers coverage to all the population and prioritizes rural, mountain and remote areas with less-favorable, socio-economic conditions. The model includes care in residential areas, children institutions, schools and workplaces.

Health services are free and legally, culturally and socially accessible since 1959. From the geographic standpoint, the access to health services increased with the extensive development of the system and later, through its intensive development as exemplified by this model. Here the doctor’s office is located in the center of the assisted community and neighboring the homes of both the physician and the nurse.
Note W: Family Physician and Nurse

Web Object Placeholder
Address:111notas/notaW.htm
Displayed in: Articulate Player
Window size:720 X 540
Note X: Family physician and nurse. Model Characterization

The scaled disposition of resources and procedures ensures the quality and efficient access to services at different levels of complexity. This assumes the definition of responsibilities, the relationships, and the reference and counter-reference system between levels.

The lower levels of the system are included in the higher level. The municipal, provincial and national systems include the following services: hospital, dental, epidemiological hygienic, social assistance, teaching and research.

The offices of the family physicians are located in factories, schools, children circles or in the community. Every family physician is integrated to all the system. This let them complement their functions with the higher levels, if necessary, so they can reach any resolution as required.

The model of family medicine does not establish a subordinate relationship between the parties or levels. On the contrary, it builds a matrix of tight interrelations and integrations where support, complementation, continuity, opportunity and resolvability define the relationships between the levels, without any hierarchies.

The BWG or Basic Work Group includes specialists in Integral and General Medicine, Internal Medicine, Pediatrics, Obstetrics and Gynecology, Psychology and Nursing. Based on education and assistance, they organize the work of both nurses and physicians of approximately 15 family care offices.
The health area is the basic and central organization of the level I of care and the primary health care. It is a socio-geo-demographic space with approximately 30,000 habitants that counts on the diverse, health services integrated to the respective polyclinic. The polyclinic is the leading health institution in the territory from the managerial, service, teaching and research standpoints. This institution counts on a strong, technical and administrative leadership and the sufficient human, technological, material and financial resources to fulfill its complex task. It also counts on 25 clinical services, both diagnostic and therapeutic, with qualified specialists and means.

Organizationally, the model led to a strong, descentralization process that moved the planning of health work and activities to the family doctor’s office. The latter became the active component around which the institution organizes all the work.

The polyclinic incorporates undegraduate teaching. At this time, it includes the fields of medicine, nursing, psychology and health technology. It fully trains the Integral and General Medicine specialists, the main medical force of this model.

This institution assumes the dimension of University Polyclinic. It is the teaching scenario for a variety and numerous plans for the continuous training and improvement of the human resources in health.
Note Z: Family Physician and Nurse. Model Characterization

The creation of Sectors (Sectorization) is essential in the primary health care model. Living in the respective community, the family physician and nurse assume the responsibility for the approximately 700 habitants, 120 families, of the community. The Basic Work Groups that include the specialists in Internal Medicine, Pediatrics, Obstetrics and Gynecology, Nursing, Psychology and Social Work are available to support between 10 and 15 of these family physicians. Altogether they are a working team for the collective and integral analysis of the population health in their scope of responsibility.

Continuity acquires a new dimension in both time and space. In time, the model takes care of all the phases of the life cycle and every one of the times specialized care services by the vertical and interdisciplinary teams are referred. In space, the continuous and integral care is provided in both the patient places such as home, school or the workplace, and the environments of the health system and the community.

The continuity of care has also two approaches: ‘dispensarization’ for the individual and family, and the health situational analysis that we will describe in a later note.
Dispensarización* is a methodology for proactive work. It identifies the health needs of individuals and families in the area, and then establishes a tailored care program with all the components: promotion, prevention, cure and rehabilitation. It also sets a continuous follow-up program at the doctor office, home, polyclinic and any other service of the system.

When examining every habitant individual and family, it uses research and screening techniques to find risk factors, diseases or disabilities in the physical, biological, psychological and social realm. Dispensarization encompasses individual care programs based in: the health needs and conditions of individuals and families, the monitoring of the programs and its effects, and the assessment of their results.

(Translator’s note: this term has no ready equivalent in English so it is preserved in the original Spanish and its meaning defined by the module author. Additional information is available in Note S.)
At the population level, the methodology used is the Health Situation Analysis. This is valid from the level of the Doctor Office, Basic Work Group and Health Area, to the level of the Municipality and Province. It is done every year with an assessment run every 6 months. Community, related sectors and government representatives participate in it. In the methodology, people accountable for the execution use problem prioritization techniques and elaborate, execute and control action plans with integral strategies.
Note CC: Family Physician and Nurse.
Model characterization

Those interventions derived from the analysis of the health situation are implemented within the scope of the clinic, the epidemiology and public health. They are implemented at the proper scale, either individual, family or community. They are also oriented to the components, the risks and the determinants.

Interventions include areas of health management, programs and services. They also include actions from both the health sectors and the community. Government may also participate depending on the needs.
Note DD: Family Physician and Nurse. Model characterization.

Those interventions derived from the analysis of the health situation are implemented within the scope of the clinic, the epidemiology and public health. They are implemented at the proper scale, either individual, family or community. They are also oriented to the components, the risks and the determinants.

Interventions include areas of health management, programs and services. They also include actions from both the health sectors and the community. Government may also participate depending on the needs.
The community and inter-sector participation is one of the most developed components in the new model. This is a subproduct of a number of factors: the descentralization of the socio-economic organization, the empowerment of the population and the community organizations in the management of social programs, health in particular, the epidemiological and demographic transformations, the stronger participation of the issues associated to environment and behavior, and as a consequence, the new strategies oriented to the promotion and prevention. The integration of the model with the community and its representatives, and the sectors and health problems related to environment and behavior are such that they demand promotional and preventive strategies that far exceed the previous models.

In the scope of the family physician, the intersector and community participation comes from the Circumscription (or geo-political area) Delegate (a representative of the community in the municipal government) and the neighbors of the health sector, including predominantly women, students, workers, and agricultural workers in the rural environment. The administrators of the labor centers, serving as representatives, or public officials at the municipal level also participate if they are called.

At the level of the polyclinic, the relationship is established with the president of the People’s Council on the government side, the representatives of the sectors and the community organizations or groups in that scope. Starting with the municipal level, and through the national one, the territorial director offices and the Ministry for Public Health relate to the sectors fundamentally through the spaces offered by the Assemblies of the People’s Power, through both their health committees and the Council for health created around it. At the national level, the Commission for Life Quality, directed by the secretary office of the Ministry Council, ensures the intersector participation in the problems related to this important component of the social and economic life of the country.
Note FF: Primary Health Care in Cuba.  
Expenditure distribution

Hospital institutions are the services that generate most expenditures. In Cuba, more than 42% of the expenditures are produced by these services. However, both the extensive and intensive development of services at the first level of care, in polyclinics and at maternity homes represent one third of the expenditures in health care services. This increment shows the participation of these services in the execution of the budget. It also reflects the service priorities, volume and complexity.
Starting in 1980 the number of medical consultations grow continuously until 1999 when they reach a maximum with twice the out-patient consultations of 1980 and a 30% growth in the emergency ones. This impact represents a higher level of ambulatory services to the population. These are mostly out-patient consultations that are for the most part scheduled and providing preventive content, as compared with the non-scheduled consultations including the emergency ones. The emergency consultations went from representing half of all medical consultations in 1980 to one-fourth of consultations in 1999.

From 2003, the number of consultations declined. In 2006, they were below the level of 1990 and with a higher presence of emergencies. This increment in emergency consultations was due to the re-organization of the model caused by both a reduction in the respective workforce and the increase and strengthening of the polyclinic services.
If we analyze where these consultations take place, we appreciate the following:
before the model PHC health system was in place, one-fourth of the out-patient consultations and 80% of urgencies happened in the hospital. With implementation of the model this distribution was modified successively until 2006 when the first level of care produced more than 85% of the out-patient consultations and, what is even more significant, 60% of the emergency ones. Beyond the distribution of services, we appreciated a positive impact in the quality of care, the access to the population and the expenses of the system. Out of the total of medical consultations in the first level of care, family physicians produced directly 80% of the consultations and more than one-fifth of them were performed at the beneficiary homes.
Note II: External and Urgent Consultations per Type of Unit

If we analyze where these consultations take place, we appreciate the following: before the model PHC system, one-fourth of the out-patient consultations and 80% of emergency ones happened in the hospital. With implementation of the model this distribution was modified successively until 2006 when the first level of care produced more than 85% of the out-patient consultations and, what is even more significant, 60% of the emergency ones. Beyond the distribution of services, we appreciated a favorable impact in the quality of care, the access to the population and the cost of the system.
The development of Primary Health Care and the family medicine model in particular, as well as the new hospital technologies, have made possible the reduction of hospital beds that originally increased during the 80s and 90s. Since then, medical care has been based on: technologies, sophisticated ones included, available at the first level of care, the use of the ambulatory modalities for many diagnostic and therapeutic processes, and home care in the case of family medicine. The latter brings health care to the family and community environment with better quality, humanism, accessibility and satisfaction.
Consistent with our previous analysis, hospital admissions increased until the 90s and declined immediately later, keeping this declining tendency until 2006. This has allowed for improvements in medical care in both the first level of care and the hospital system. The decongestion of services has let hospitals both reserve their services to those patients who need them the most and thus, improve the care and comfort in these institutions.
Note LL: Medical Care Actions at the Polyclinic, centered in the family and according to their health condition, life cycle and gender

The approach of medical care directly on people is based on the needs generated by the individual health status, age, gender, family and social condition, and the environment. Curative actions are organized and fundamentally oriented to the disabled and ill, both acute and chronic. Care protocols are elaborated for every health problem and later tailored to every individual by the physician. Actions for both promotion and prevention are not only pre-planned for every health problem but also conceived to be adapted to the individual conditions of people, family and community.