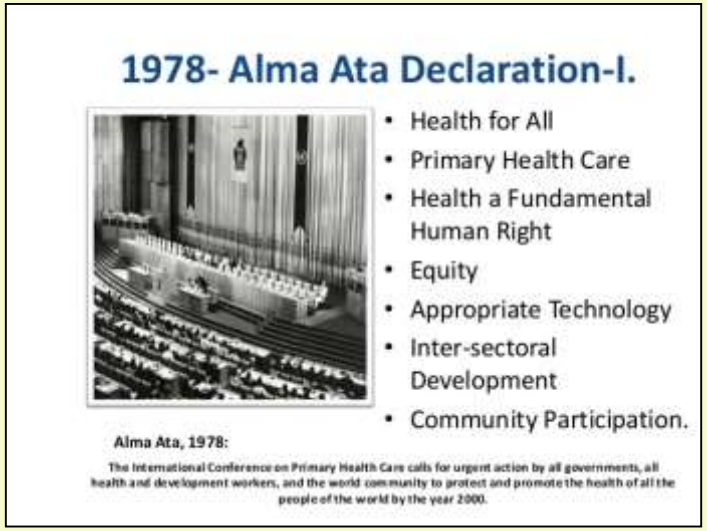
Public health systems (Cuba)

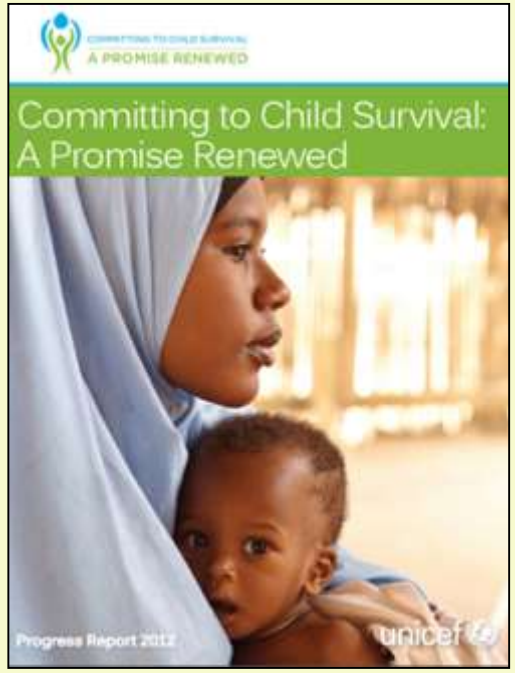
SDPCW-8, Class notes by Dr. Tim Anderson

Overview

1. Social or private medicine?
2. Health in the world
3. Cuban social medicine

There is a strong international consensus on the need for good universal health outcomes. But the **means** to achieve this are hotly disputed. Much of the debate turns on the weight given to public health systems.





Q: What do strong public health system do best? Give two detailed examples

Readings:
Janes, Craig R and Oyuntsetseg Chuluundorj (2004) 'Free Markets and Dead Mothers: The Social Ecology of Maternal Mortality in Post Socialist Mongolia', Medical Anthropology Quarterly Washington;
Kirk, John M. (2009) 'Cuba's Medical Internationalism: Development and Rationale', Bulletin of Latin American Research;
Sachs, Jeffrey D. (2001) Macroeconomics and Health: Investing in Health for Economic Development, WHO.

1. Social or private medicine?

- **Universal health and Self Determination**
- **Social Medicine**
- **Big money and public institutions**

Universal health and Self Determination

- Good health is foundational for the realisation of the human capabilities necessary for individual development and social participation;
- What means are available to enhance universal good health?

Public or private medicine?

- While most societies have some sort of hybrid, some systems emphasis private and others emphasise the public or shared;
- Social structures also affect health: workplace safety, family planning, healthy food, tobacco use, decent housing.
- **Privatised systems** not only affect **access** to good health care, they change its character, e.g. emphasising **treatment** rather than prevention;
- **Public systems** systematically address promotional/educational and preventive health: hygiene, education, clean water, vaccination campaigns.

Consensus on the right to health, but not on the **means**

ICESCR (1966)

- Art 7: 'conditions of work which ensure… safe and healthy working conditions'
- Art 12: 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health .. [including] provision for the reduction of the stillbirth-rate and of **infant mortality** and for the healthy development of **the child**; improvement of all aspects of environmental and industrial **hygiene**; prevention, treatment and control of **epidemic**, endemic, occupational and other diseases; … assure to all **medical service** and medical attention in the event of sickness"

UN (1966) International Covenant on Civil and Political Rights

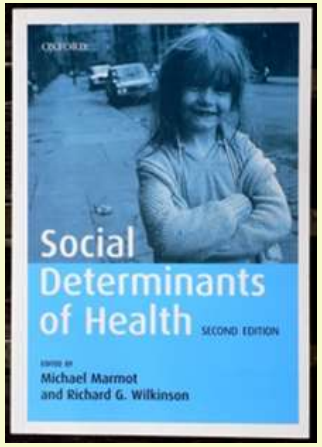
UN General Comment No. 14 (2000)

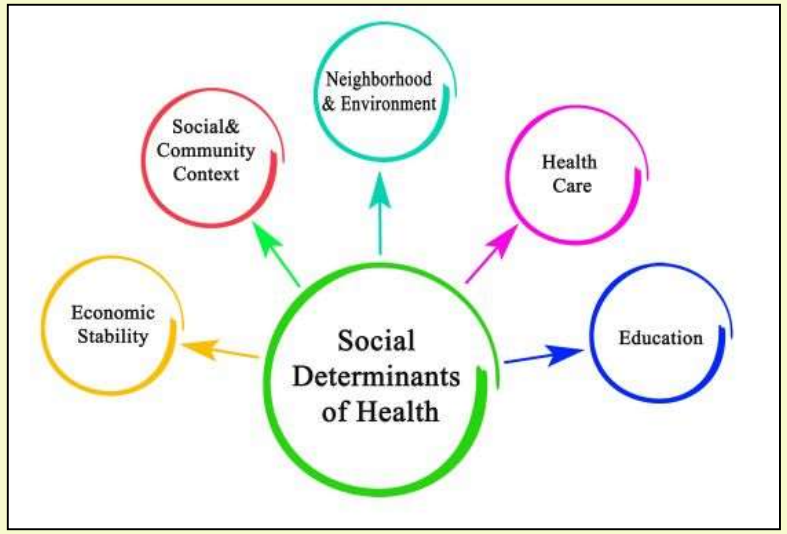
- "the right to health … extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment"
- "A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence … [and consistent with **CROC**] to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children."

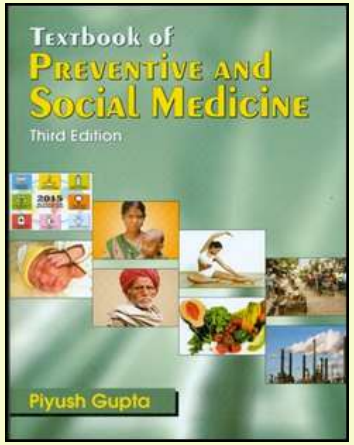
UN (2000) General Comment No. 14: The right to the highest attainable standard of health.

Social Medicine

- Health care as a broader social phenomenon, rather than just a clinical process;
- Latin America's social medicine tradition has "significant differences" with the WHO's 'Social Determinants of Health', influenced by European social epidemiology. Both are wider views of public health, Latin American social medicine stresses social transformation and "emancipation" from dysfunctional capitalist social structures (Guzmán 2009: 114-118);
- **Epidemiological**: mapping and explaining the social distribution of disease;
- **Preventive**: taking measures to preserve health and prevent illness;
- **Promotional / educational**: informing patients about their health;
- **Participatory**: encouraging people to become active participants in their health







Active participation in health promotion implies: the development of public health policy, the creation of favourable environments

Allende's Social Medicine ideas, in Chile

- Most prominent exponent of social medicine in Latin America was former Chilean President Dr Salvador Allende, who "came to know at first hand the misery, lack of housing, lack of medical care and lack of education of the Chilean people" (in Winn 2005: 133);
- His experience was backed by the ideas of German doctors Rudolf Virchow and Max Westerhofer, at the University of Chile in the 1920s;
- The idea of 'social medicine' was also promoted in Chile's labour movement, by Luis Emilio Recabarren, leader of the Salt Workers Union;
- Allende refused to delink medical from social issues; tuberculosis was a "social disease" because it improved as much by socioeconomic advance as by medical intervention; poor housing was linked to infectious disease and addictions were rooted in social misery;
- Allende's book *Chile's Medical-Social Reality*: "[wanted] to reclaim the social wealth and the economic potential of the nation … to reacquire the physiological capacity of a strong people, recover its immunity against epidemics … allow a better performance in national production while also providing a better … spirit to live and appreciate life (Allende 1939).
- In 1952, as a senator, Allende introduced the law that created Chile's National Health Service, the first national program in the Americas that guaranteed universal access (Waitzkin 2001).

Anderson, Tim (2010) Social Medicine in Timor Leste, Social Medicine, Vol 5 No 4
Guzmán, Rafael González (2009) 'Latin American Social Medicine and the Report of the WHO Commission on Social Determinants of Health', Social Medicine, Vol 4, No 2
Waitzkin, Howard (2001) 'Social Medicine Then and Now: lessons from Latin America', American Journal of Public Health, October 2001, Vol 91, No. 10
Allende, Salvador (1939) Chile's Social Medical Reality, translated excerpts online: https://www.socialmedicine.info/index.php/socialmedicine/article/view/4/86

International students at Cuba's ELAM college

Social medicine in Cuba

Commitment to health became central to Cuban revolutionary social transformation, and its internationalism. The **Cuban Revolution** promoted participation within community and popular organizations, and within a firm state framework. This participation helped drive initiatives in literacy, sport and hygiene.

Argentine doctor, **Ernesto 'Che' Guevara**, a friend of Allende's had also seen poverty and the stunting caused by malnutrition. He argued: "The principle upon which the fight against disease should be based is the creation of a robust body ... our task is … [to direct] all medical professionals towards the task of social medicine … not only to visit and become acquainted with the people … but to find out what diseases they have … what have been their chronic miseries for years" (Guevara 1960).

Solidarity: observing the failure of the middle classes to provide health services to the poor, Guevara asked: "What would have occurred if two or three hundred peasants had emerged, let us say by magic, from the university halls? .. [they] would have run … to help their brothers" (Guevara 1960).

Can 'big money' compensate for the lack of public institutions?

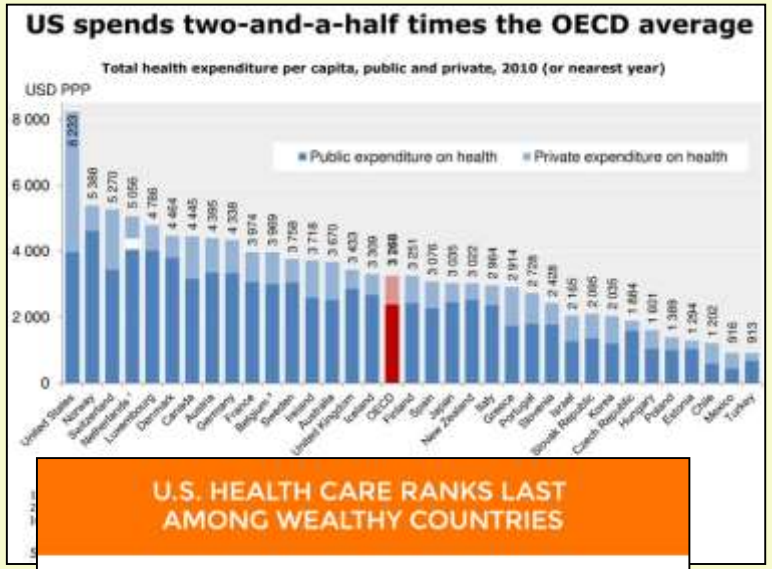
OECD (2003) argues for "scaling up resources and private investment … scaling up financial resources for health should be a priority"

Jeffrey Sachs (2001) previously from the World Bank, wrote 'Macroeconomics and Health' for the WHO:

> "The level of health spending in the low income countries is insufficient to address the health challenges ... poor countries can increase their domestic resources … for the health sector and use those resources more efficiently . . . donor finance will be needed to close the financing gap … [this will mean] approximately $27 billion per year in donor grants by 2007"

'Donor finance' often means a core of public 'seed' money which sets the conditions for entry of private, commercial capital (c.f. S.A.P.s)

The USA spends far more on health than any other OECD country yet has the worst health outcomes, in terms of care quality, access, healthy lives, infant mortality



Problems with 'big money‘ and privatisations/’partnerships’

- Public-private 'partnerships' often lead to fragmented systems and failures in universal access – targeted programs aim to ‘plug gaps’
- undermines/duplicates the coordination in public health systems
- diversion of resources to (i) cities (ii) high salaried professionals and (ii) curative rather than preventive efforts
- Emphasis on **treatment**, which is always more expensive

Keywords: supplementation, resource pool, public-private participation, choice of service provider

Public institutions can offer:

- Bureaucracy! but also universal and equal access regimes
- well coordinated responses to public health crises (e.g. epidemics)
- **preventive** health system development (e.g. vaccination, health education) - in mixed systems the public sector carries most of this

Keywords: public systems, coordination, preventive and promotional health

NB. forces which help shape health worker ideologies
e.g. "should we share information with the patient?'

2. Health in the World

- ❑ 'Developmental diseases' - the use of indicators
- ❑ MM and IM - critical indicators
- ❑ Preventive and promotional public health

Chronic and developmental disease

- ☐ **chronic disease** - universal longer-term problems (heart disease, cancers, diabetes) - more diagnosed in wealthy countries - morbidity (illness), mortality (30m+ deaths pa)
- ☐ **'developmental disease': (a) communicable disease** (15m+ deaths pa) and **(b) maternal-infant conditions** - (3m+ deaths pa) - DCs
- ☐ **global shortage of health workers** - plus the 'brain drain' problem for most developing countries - steady emigration of skilled workers

WHO 2003

'developmental diseases'

Communicable, maternal, child, nutritional disease, 2002

Causes of death	HM Africa to LM America ratio	000's Deaths	Illness
Total CMPN		**18,416**	
Tuberculosis	167	1,605	35,361
HIV/AIDS	1,210	2,821	86,072
Diarrhoea	163	1,767	61,095
Measles	INF	760	27,058
Malaria	INF	1,222	44,716
Respiratory infec.	7	3,845	90,252
Maternal mort.	120	510	33,625
Perinatal mort.	15	2,464	97,423
Nutritional deficiency	10	475	34,070

WHO 2003

Q: 'Developmental' (or 'preventable') diseases occur at many times a greater frequency in 'high mortality' countries than in 'low mortality' countries.

Why?

Qs: What are the implications for developing country health priorities? (treatment? prevention? chronic diseases?)

'Developmental disease' deaths - mostly preventable:

HIV/AIDS - preventive care / HAART treatment

- Tuberculosis - preventive care / BCG vaccination / antibiotic treatment
- Measles - vaccination
- Malaria - preventive care / simple drug treatment
- Diarrhoea - preventive care / mostly oral re-hydration
- Maternal & infant mortality – nutrition, pre-natal care, presence of skilled birth assistant (and ante-natal care)

Oral rehydration

maternal and infant mortality

infant mortality: the death of a child following a live birth, up to the age of one year (ratio: per 1,000 live births)

Global infant deaths:

4.6 million (**2013**) (WHO 2015)

maternal mortality: the death of a woman while pregnant or within 42 days of the termination of a pregnancy (ratio: per 100,000 pregnancies)

Global maternal deaths:

361,361 (**2008**) (WHO 2012)

295,000 (2017) (WHO 2019)

WHO (2019) Trends in Maternal Mortality, online: https://www.who.int/publications/i/item/9789241516488

Deaths of mothers and babies, about 5 million per year
Largest preventable health crisis in the world

	Maternal deaths per 100,000 pregnancies	Infant deaths per 1,000 live births (WHO 2014-2019)
'Natural Rate' (unassisted)	1,500	
OECD countries	4 to 60	2 to 30
Developing countries	30 to 2,000	5 to 165
Worst MM rate in the world:		
Sierra Leone	1,100 (2013)	

Statistical note: (i) note the difference between infant mortality (< 1 y.o.) and Under Five, and (ii) the different denominator for maternal mortality

Sustainable Development Goal 3.1: "By 2030, reduce [global MM] … to less than 70 per 100,000"

'More than half of under-five child deaths are due to diseases that are preventable and treatable through simple, affordable interventions. Strengthening health systems to provide such interventions to all children will save many young lives' (WHO 2015).

major global causes of maternal mortality

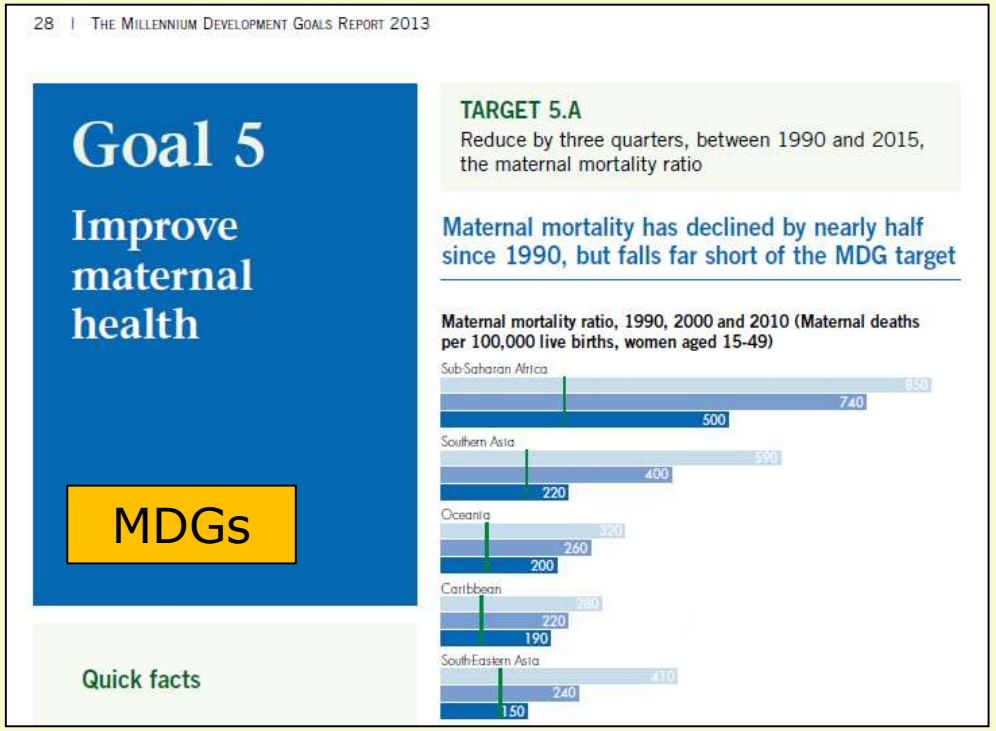
(2008)		on the basis of 361,361 deaths
Haemorrhage	35%	125,359
Sepsis	10%	36,057
Eclampsia (seizures)	10%	37,706
Obstruction	6%	21,117
Unsafe abortion	14%	49,408
Other	25%	91,719

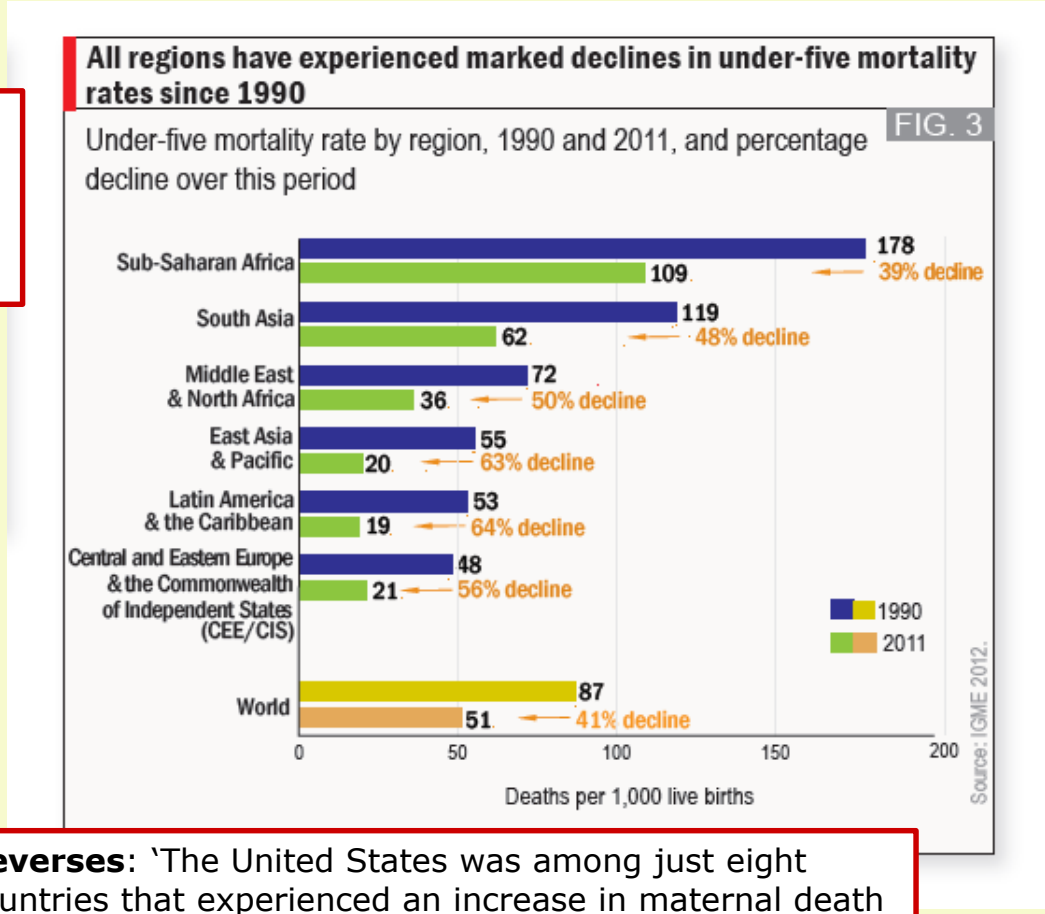
The vast majority of maternal deaths are avoidable

Unsafe abortion is a serious risk to women's lives, that is why the UN HRC urges safe, legal abortion

The 'good news' and the uneven outcomes

2013: 4.6 million infants died, most from preventable illnesses
2013: MM has fallen but five regions won't meet MDG targets
2014: 'Child deaths cut nearly in half since 1990' (Lancet 2014)
2013: Maternal deaths down to 289,000 down 45% from 1990 (WHO 2014, 2015)





Reverses: 'The United States was among just eight countries that experienced an increase in maternal death rates since 2003, joining countries including Afghanistan and El Salvador' - *Lancet study, 2 May 2014*
MM rates*: USA: 28, UK: 8, Australia: 6 (WHO 2013)*
Why poor performance in the USA? – highly privatised health care, exclusion and poor coordination

How was MM progress made in western countries?

	1900	1935	1950	2005
Sweden:	230	300	65	
England and Wales:	450	400	90	
USA:	800	600	100	
OECD range (2005):				2 to 22
developing country range (2005):				40 to 1,600
'natural' rate?				~ 1,500

Sources: UNDP 2007; De Brouwere and Van Lerberghe 2001: 11

Questions: what were the reasons for Sweden's early 'success'? And for slower progress in the USA?

breakthroughs:

- **Sweden** - wide network of midwives by 1900
- **USA** - Emergency Maternity Care Programme (WW2)

sources of mortality reduction, 1960-1990:

	Income	Women's education
Under 5 mortality rate	17%	38%
Female adult mortality rate	20%	41%

Wang J. et al (1999) [study of 115 DCs]

primary means of preventing maternal mortality?

- presence of a **skilled assistant**, to stop bleeding, prevent shock, infection or obstruction

De Brouwere and Van Lerberghe 2001

Except for large scale training, health aid doesn't help much

Large scale systematic studies (over 100 countries)

- IMF commissioned study finds that bilateral aid does not reduce infant mortality (Masud and Yontcheva 2005: 20)
- Another IMF study suggests that "doubling health aid" is associated with a 2% reduction in infant mortality; very small re. MDGs (Mishra and Newhouse 2007)

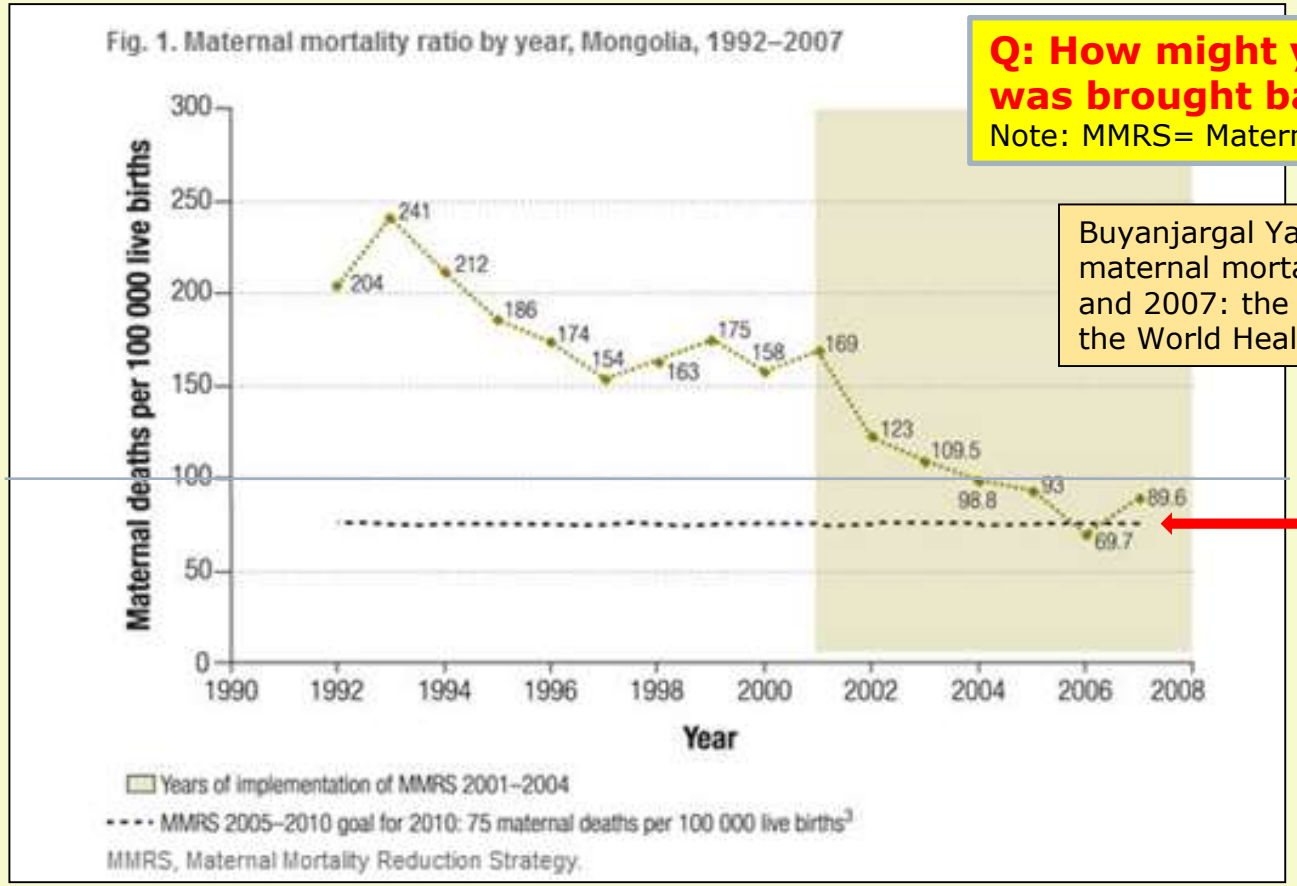
Indication? -

- Capacity building needed – health workers (human capital) and public health systems (with a primary and preventive focus)

Video: Midwife training in Afghanistan (2'23")
Video online: https://www.youtube.com/watch?v=B9wzP-1izPM

Maternal mortality in Mongolia

Q: Why the rapid rise in MM in the 1990s?
MM rose from **119 in 1990** to **240 in 1994**, then declined to 175 in 1999 (Janes and Chuluundorj 2004:277) – NB. difference in 2010 data below



Q: How might you imagine the MM rate was brought back down, in the 2000s?
Note: MMRS= Maternal Mortality Reduction Strategy

Buyanjargal Yadamsuren et al (2010) 'Tracking maternal mortality declines in Mongolia between 1992 and 2007: the importance of collaboration', Bulletin of the World Health Organization 2010;88:192-198

1990 level

Skilled assistants: reduce both maternal and infant mortality

infant mortality and health exp: OECD sample:

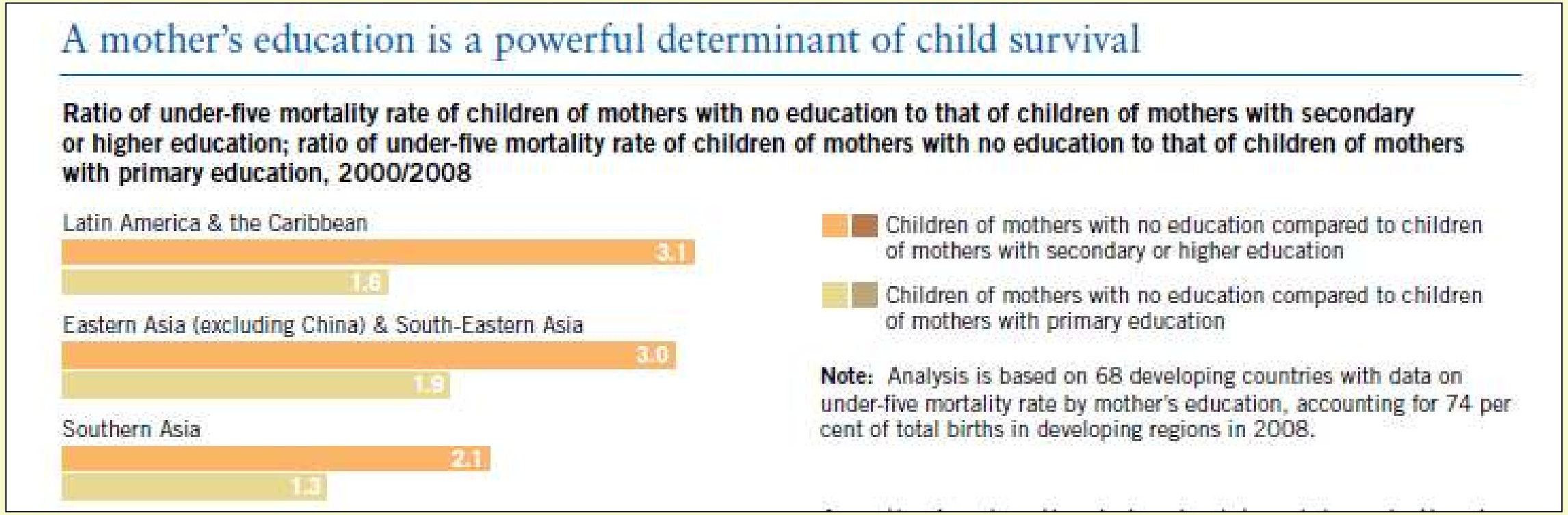
NB: the method used here

	1970	1980	1990	2000
OECD average	26.3	16.7	10.3	6.5
High Public Expenditure Countries (>80% public): Denmark, Iceland, NZ, Sweden, Norway, UK				
average of above six	14.4	9.4	7.1	4.5
re OECD av?	+45	+43	+31	+31
High private insurance countries (>40% private): Greece, Korea, Mexico, Switzerland, Turkey, USA				
average of above six	55.7	37.5	21.9	14.5
% re OECD av?	-112	-124	-112	-123

Sources: OECD 2003; Anderson 2006

Questions: (i) do these categories allow a reasonable search for correlations? (ii) how might you interpret this data?

Mother's education levels: why is this important?



UN MDG Report 2011: children of poorly educated mothers die at much higher rates

3. Cuban social medicine

- ❑ Cuba social medicine
- ❑ Cuban public health
- ❑ Medical internationalism

- ☐ Cuba: best health outcomes in the developing world (infant and maternal mortality, HIV/AIDS, tuberculosis, malaria)
- ☐ yet a 'counter model' to economic liberalism – public system, guaranteed free health services

"Nearly 40 countries across five continents have received Cuban medics during the pandemic, as the island nation—home to just over 11 million inhabitants—has once more punched far above its weight in medical diplomacy" Reuters 15 Sept 2020

Social Medicine in Cuba

Cuba's medical internationalism

This grew as an extension of its revolutionary socialism, and of its social medicine. Health in Revolutionary Cuba went through several extended phases.

- the creation of an integrated national health system, through the 1960s,
- consolidation of this single public system in the 1970s
- the introduction of higher medical technology, research and services in the 1980s (Delgado Garcia 1996).

Cuba sent doctors to **Chile** after a huge earthquake in 1960, despite a lack of doctors in Cuba at that time. The first medical mission to **Algeria** was organised in 1963 when José Ramón Machado Ventura led a group of 50 doctors, dentists nurses and technicians to that newly independent country (Gleijeses 1996: 164-165). The Algerian program marked the beginning of Cuba's health aid 'missions', to assist capacity building in newly independent countries.

From 1999 onwards a **Latin American School of Medicine** (ELAM) was set up in Cuba to train thousands of mainly Latin American and African students.

Delgado García, Gregorio (1996) 'Etapas del desarrollo de la salud pública revolucionaria cubana', Revista Cubana de Salud Pública, V.22, n.1, ene-jun, online at: http://scielo.sld.cu/scielo.php?pid=S0864-34661996000100011&script=sci_abstract&tlng=en

Gleijeses, Piero (1996) 'Cuba's first venture into Africa: Algeria, 1961-1965', Journal of Latin American Studies, Vol.28 No.1, Feb, pp. 159-195

the Cuban health system

- mainly public system (95% public exp)
- guaranteed universal access and free care
- high density of health professionals (6 per 1,000) – medical training free & promoted
- highly coordinated system (‘*intersectoral coordination*’)
- ‘free for life’ education system
- Huge foreign aid health missions
- Large biotech / medicines industry

Some unique medicines and a different type of commercialisation: Cuban combined **meningitis-pneumonia vaccine currently** costs about $5 a dose – they hope to reduce this to $1 or $1.50

Cuban achievements were ignored by the **World Bank** until 2004, when Cuban infant mortality fell below that of the USA. In response to questions, the World Bank discussed **Costa Rica and Cuba**

World Bank: 'how has Cuba done it?'

- "the sustained focus of the political leadership on health for more than 40 years .. universal and equitable health care ..
- "concentrated on health care to rural areas ..
- "public sector as the sole provider of health services ..
- "policlinics … mass immunizations ... monitoring
- "community health programs .. highly motivated staff ..
- "Cuba spends substantially more of its GDP on health .. [8%]
- WB asks: "[can] an approach that relies on a publicly paid doctor for every 150 families can be sustained during economic hardship?"

World Bank (2004) 'Spotlight on Costa Rica and Cuba', *World Development Report 2004*, Washington, 157-158

Q: Why does Kirk say that Cuban health aid programs have 'forced the re-examination of societal values and the structure and functioning of health systems' in many developing countries?

Cuba & Costa Rica: critical health indicators

	Cuba	**Costa Rica**	**World average**
Life expectancy at birth (2011)	79.1	79.3	69.8
Infant mortality (2010) per 1,000	5	9	c. 20-40
Maternal Mortality (2008) per 100,000	53	44	176
Fertility Rate (2011)	1.5	1.8	2.4
Means years schooling (2011)	9.9	8.3	7.4
Under Five Mortality (2009) per 1,000	6	11	58
HIV prevalence youth: 15-24 (2009)	0.1	0.2	na
Adult literacy % (2005-2010)	99.8	96.1	80.9
GDP per capita $US PPP (2011)	5,416 *	10,497	c. 10-12,000

Source: UNDP (2011) Human Development Report; WHO (2012) Global Health Observatory: Child Mortality

Question: The UNDP listed Cuba's GDP pc at US$6,200 PPP in 2012 but revised it up to US19,844 PPP in 2013 – why might such a large adjustment have been made?

Health in Costa Rica

According to the World Bank (2004):

- "Since 1960, progress in Costa Rica has been rapid, but not too difficult to explain.
- "Costa Rica's **real income** per capita increased by 25% from 1960 to 1970 – the same rate coincidentally that infant mortality declined. **Income growth** of 40% by 1980 along with the **universalisation** of health care saw a further decrease of 60% in infant mortality.
- "After recessions in the 1980s **growth** has resumed and progress on health status continues. One way to attain good health from initially low income is surely to **stop having a low income**."

World Bank (2004) 'Spotlight on Costa Rica and Cuba', *World Development Report 2004*, Washington, 157

NB: the CCSS:

Between 1961 and 1974, Costa Rica transformed its semi-private health insurance system into a contributory public body, with **universal coverage**

The *Caja Costarricense de Seguro Social,* (CCSS or the 'Caja', the Costa Rica Social Security Fund) is a central public institution which underwrites health care and pensions for all citizens - the CCSS may be in line for privatisation ..

Notice what a key financial agency (the World Bank) emphasises and what it sidelines!

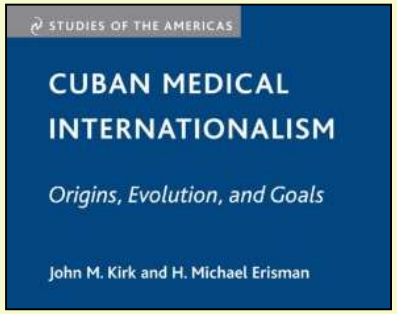
Cuba's medical internationalism

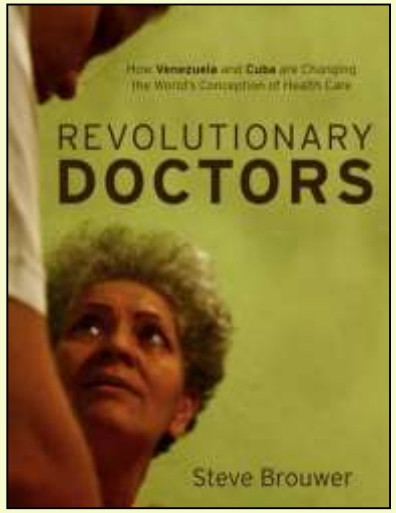
Cuban doctors have provided overseas support since the early 1960s and the current tens of thousands of Cuban medical personnel abroad surpass those of the combined G8 countries (Kirk and Erisman 2009: 3). For every Cuban doctor deployed there is usually an offer of 2 or 3 medical scholarships, to help locals replace the Cubans and so avoid dependency.

Cuba doctors are trained as salaried public health professionals, rather than private vendors of health services. Focussing on rural and marginalised populations (Brouwer 2011) they are trained in large numbers so as to collaborate in maintaining that public service ethos and minimising the 'brain drain' through emigration. As Cuba is a low wage country with a strong 'social wage', Cuban doctors abroad do not contribute to inflationary economies.

There is no single financial model. Cuban programs are generally financed by the Cuban government, or through co-financing - sometimes called 'compensation' - depending on the capacity of the recipient country (MEDICC 2008). In recent years, there has been consolidation and increase in these 'compensation' measures. But there are no private shareholders or private service providers, and charges are raised only for those with a capacity to pay.

A more commercial arrangement for health services has been established with Venezuela, Brazil, Qatar and some others. Cuban doctors are now increasingly paid their salaries by local governments, at local rates.





The ethos and values of Cuban training

The recent version of Cuba's doctor training is more humanist than socialist. Fidel Castro said: "We will not teach political material … [but rather] complete dedication to the most noble and human of its tasks: to save lives and preserve health" (Castro 1999). Cuba thus minimises conflict with the variety of countries with students under training.

Nevertheless, there is often 'ambivalence' about accepting Cuban aid, both because of local professional jealousies and fear of jeopardising relationships with the USA. The main resistance comes from local private health workers, who fear an undermining of their position. Nevertheless, these 'south-south' programs show a way into the "radically new relations … necessary to the decolonization process, of building independent capacity and quality in education and other fields" (Hickling-Hudson 2004:305-9).

Analysts differ over Cuba's motives. Its program is seen as an assertion of 'soft power', or as creating a 'symbolic capital' which can be drawn on for material or political benefit (Feinsilver 2006). Others suggest it is more deep rooted and complex, a humanitarian project which may at times have diplomatic, trade or political benefits, but not formulated simply to that end (Kirk and Erisman 2009:170-83).

Fidel Castro argued that the 'secret' of Cuba's approach: "lies in the fact that human capital is worth far more than financial capital. Human capital involves not only knowledge but also … conscience, ethics, solidarity, truly humane feelings, spirit of sacrifice, heroism, and the ability to make a little go a long way" (Castro 2005).

Former WHO Director General Dr Margaret Chan (with Cuban Health Minister Dr Roberto Morales in 2014)
said Cuba's medical colleges were "a commitment and a contribution to a better training of the health professionals that the world needs today".

Cuba training and the 'brain drain'

Cuba assumes a global shortage of health workers, particularly in rural areas, and recognises the ‘brain drain’ (emigration of professionals) as a serious problem affecting developing countries. Cuban doctors themselves emigrate at about 2% p.a (Jiménez 2007).

In most developing countries the figure is much higher. From the 1980s to 2000 Ghana lost 60% of its doctors and post-independence Zambia lost over 90% of its locally trained doctors (Kirk and Erisman 2009:114).

In the Pacific there are almost as many Fijian born doctors in Australia and New Zealand as in Fiji; while Australia and New Zealand also had more nurses and midwives from Samoa, Tonga, Fiji and Niue than were working in those island states (Negin 2008). In the Solomon Islands, until the Cubans took in 90 students, doctor training only equalled the rate of doctor emigration (Alependava 2012).

Kirk, John and Henry Erisman (2009) Cuban Medical Internationalism: origins, evolution and goals, Palgrave MacMillan

Anderson, Tim (2014) Unlikely partners: challenges for an Australia-Cuba collaboration in public health', Journal of Australian Political Economy, No 73

Video excerpt: 'Not really Europeans' (1'36")
Full video (26'08") is online: https://www.youtube.com/watch?v=u3BqKrrkbVo

Cuba's handling of the COVID19 Pandemic

Cuba's superior outcomes after 14-15 months of the COVID19 pandemic (low absolute deaths and low death rate per infection) can be seen in the table below. Reasons include:

- Strong epidemiological vigilance and rapid mobilisation of quarantine controls;
- Universal free treatment, free of drug company dictates;
- Henry Reeves Brigades in 33 countries to help with the pandemic (see map below).

Cuba's COVID19 'vaccine sovereignty':

- Globally, by March 2021 there were 23 candidate vaccines in phase 3 trials, two of those were Cuban (Soberana 2 & Abdala); no other Latin American candidate in this group.

Yaffe, Helen (2021) Cuba Libre to be COVID-Libre: Five Vaccines and Counting, Counterpunch, 30 March, online: https://www.counterpunch.org/2021/03/30/cuba-libre-to-be-covid-libre-five-vaccines-and-counting/

Anderson, Tim (2020) 'Cuba Faces the Pandemic' in The Pandemic and Independent Countries, CCHS

Cuba and her neighbours: COVID19 control

At 10 May 2021	Total deaths	Cases/ million	Deaths/ million	Tests/ million	Deaths/ cases
Cuba	741	10,344	65	341,097	0.6%
Jamaica	809	15,740	272	116,230	1.7%
Mexico	218,985	18,186	1,683	51,943	9.3%
USA	596,179	100,748	1,792	1,381,034	1.8%

Source: Worldometers 2021; NB1: global IFR is between 0.6-1.0%
NB2: Haiti was not included because its test rate was only 5,215/million

A new focus in developing countries: the BRICS influence:
Unlike the OECD group, which has focussed on commercialisation and PPPs, the BRICS countries (with 50% of world poverty) promote distinct principles (1) universal health coverage, (2) public systems, (3) cooperation, and (4) low-cost medicines and vaccines.

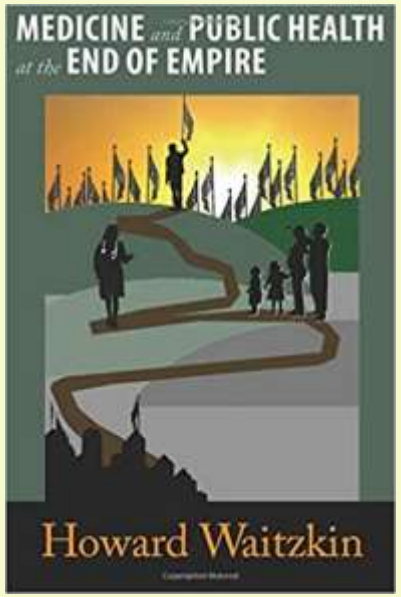
Types of health systems	e.g.	Features
Wealthy and privatised, weak public system	USA	- profitable health industries - 'user pays' in force
Universal service guarantee, privatised profession	Western Europe, Australia	- full 'coverage', access to care - public subsidy of private industry - commodified 'service' delivery
Weak developing systems	Most developing countries	- minimal city-based public sector - private clinic networks - NGO and aid sector
Public sector growth	Venezuela, Bolivia, **Timor Leste**	- commitment to rising public sector - competition with private sector
Public system	Cuba	- 95% pubic sector

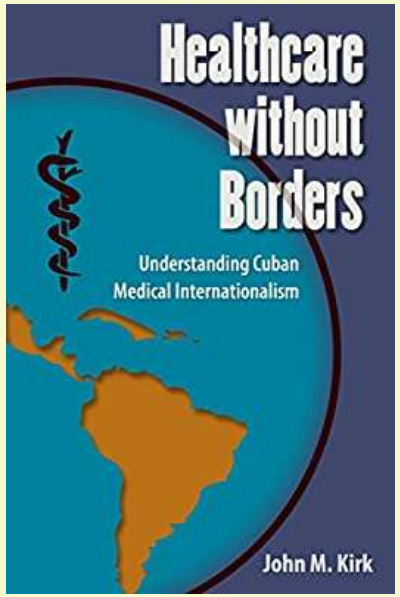
See: *Bulletin of the World Health Organization*, 92, 6, June 2014

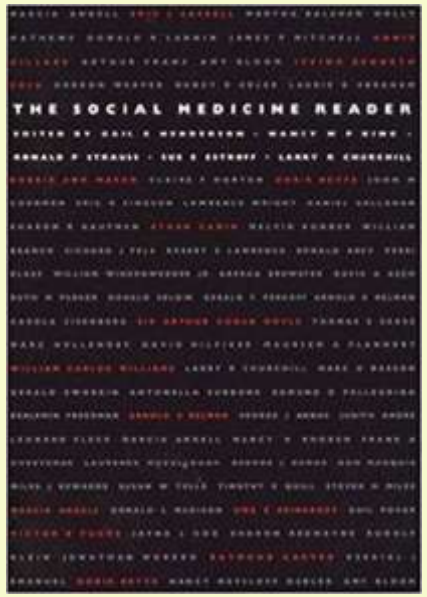
Summary:

- Public v private: a clash not only in access to health services but in the nature of health care: education, participation and prevention are stressed by public systems;
- Almost all countries are improving in maternal and child mortality, but those with well-organised public institutions, well trained health workers ('skilled assistants') and universal access regimes have superior outcomes;
- The big debate over the **means** of achieving the right to health: ‘scale up resources’ and PPPs v. build public health systems;
- Aid programs in health add little, unless they involve substantial human capacity building;
- Cuban health – a 95% public system with a commitment to prevention and health education, this contrasts with the western treatment focussed service industry;
- New priorities in developing countries attempt to restore a focus on public systems, prevention and affordable medicines.

Further Reading







Waitzkin, Howard (2011) Medicine and Public Health at the End of Empire, Routledge
John M. Kirk (2015) Health Care without Borders: understanding Cuban Medical Internationalism
Gail E Henderson (1997) The Social Medicine Reader, Duke University Press
MEDICC (2021) MEDICC Review (Journal), online: https://mediccreview.org