Costa Rica and Cuba both have very similar, low infant mortality rates—almost as low as Canada’s though at much lower incomes (figure 1).442 Their routes to this happy circumstance, however, have been quite different. In 1945, infant mortality—measured in deaths of infants under one year per 1,000 live births—was 100 in Costa Rica and 40 in Cuba, respectively. Up to 1960 Costa Rica made progress largely due to economic growth and aggressive public health programs.443 Hookworm was eliminated with a program starting in 1942, and public health campaigns accelerated after the revolution of 1948. As a result, malaria, tuberculosis, and most diseases that were preventable by vaccines at that time were also eliminated by 1960. In stark contrast, Cuba’s admittedly low level of infant mortality stagnated under a particularly corrupt political regime. 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 percent from 1960 to 1970—the same rate, coincidentally, that infant mortality declined. Income growth of 40 percent by 1980 along with the universalization of coverage for health care saw a further decrease of 60 percent 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.

**The Cuban puzzle—good health without growth**

The puzzle is Cuba. How has Cuba managed to maintain an infant mortality rate at least as low as that of any developing country in the Western Hemisphere and quite a few industrial counties as well? The sustained focus of the country’s political leadership on health for more than 40 years surely played a big part. After the revolution, universal and equitable health care was one of the government’s top three goals. The government sees good health as a key performance indicator for itself. Despite low infant mortality before the revolution, rural areas lagged far behind urban areas. The new government, committed to changing this, concentrated on providing health care to rural areas. It required all new medical school graduates to serve for one year in rural areas. It also increased the number of rural health facilities. In 1961 the government nationalized mutual-aid cooperatives and private hospitals, which left the public sector as the sole provider of health services—a feature of the system that remains today. At that time many of the country’s medical professionals left the country (as many as two-thirds by one estimate).

In the mid- to late 1960s there were two major innovations in the health system. First was the establishment of policlinics—the basic unit of health services—each staffed by several specialists and nurses and serving a population of 25,000–30,000. This was combined with campaigns to immunize many more people, control vectors (such as mosquitoes), and promote good health practices.

Second was the creation of a community health program, with specialists tending patients in clinics as well as at home, school, or work. In the mid-1980s this community-based approach was intensified with the Family Doctor Program. The goal: to place a doctor trained in primary health care and a nurse in every neighborhood (serving about 150 families). By 2001 there were more than 30,000 doctors—a ratio of one family doctor for every 365 Cubans.444 Services are free, although nonhospitalized patients are required to co-pay for medicines.

While this approach clearly contributes to better health outcomes, it is also expensive. Indeed, Cuba spends substantially more of its gross domestic product on health than other Latin American countries: 6.6 percent in 2002. (Average public spending on health is 3.3 percent in Latin America and the Caribbean, but some other countries also spend substantial amounts—Costa Rica 4.4 percent and Panama 5.2 percent).445

**Specifying what you want—and keeping track of what’s going on**

The Cuban health model rests on three pillars: giving clear instructions to providers, motivating staff, and monitoring and evaluating the system.446 Clear guidelines are provided through national specialist advisory groups—which draw up standards and technical procedures (and evaluate the performance of physicians and specialists)—and regulations that standardize activities in the national hospital care system.

Health staff in Cuba typically are highly motivated. Medical training emphasizes the altruism of medical service—often culminating in service of one or two years abroad. This is volunteer service, but there are strong social pressures for it. Serving in poor rural areas in Cuba remains a right of passage for many newly trained doctors. Television programs lauding health workers...
engaged in international solidarity missions raise their profile and contribute to a sense of pride in Cuba’s doctors.

Cuba also keeps close track of what’s going on in health facilities. Monitoring is strong, with information flowing in many directions. The main elements are:

- An integrated national health statistics system that collects data routinely from service providers. Indicators of particular concern, such as infant mortality, are collected with high frequency—some even daily.
- Regular inspection of, and supervision visits to, health facilities.
- Annual evaluations of health technicians on the technical and scientific results of their work. In addition, a randomly selected sample undergoes external evaluation.
- Annual reports by the Ministry of Public Health and the provincial and municipal health directorates to the People’s Power Assembly.

Monitoring and evaluation go beyond statistical and expert assessments. Public dissemination of health indicators, at the end of each year, draws citizens into the process. In addition, citizens can complain about providers. Their complaints can go through the health system—such as the policlinic that coordinates the local health facilities, the municipal health council, or hospital administrators. Or they can go through political channels—say, to the local representative of the People’s Power Assembly, which is required to respond. Despite this monitoring, there is limited direct citizen control: participation in administrative and health councils does not entail much more than setting broad targets. Likewise, citizens play only a small role in setting priorities within the health sector, and between health and other sectors.

Can Cuba sustain the system?

The 1990s were difficult for Cuba. The collapse of the socialist system in Europe and in the Soviet Union and the tightening of the economic embargo by the United States led to a severe economic contraction. Cuba lost the trading partners that had provided most of its imports of medicines, food, fuel, and equipment used in agriculture and mining. Between 1988 and 1993 imports of medicines fell by more than 60 percent. By 1994 agricultural production had fallen by almost half. Drug shortages persist today.446 Government spending on social services, particularly health care, was protected, with public spending on health exceeding 10 percent of GDP in 2000. But in real terms, spending had gone down. Health outcome indicators worsened in the early and mid-1990s, recovering only somewhat by the end of the decade.

As health infrastructure suffered, so did transport services. Public transport had all but disappeared by the early 1990s, and fuel shortages limited the use of private cars. Cubans resorted to walking miles to work, and the use of bicycles skyrocketed.449 The economic reversal also appears to be weakening motivation among staff. Physicians are paid relatively well, earning almost 15 percent more than the average national wage.450 But their pay is in local currency, with purchasing power declining steadily over the past decade. The legalization of a separate “dollar economy” has made occupations that pay in dollars highly prized. Stories of doctors shirking their formal duties to join this parallel economy—driving taxicabs, for example—are common.451 Time will tell whether an approach that relies on a publicly paid doctor for every 150 families can be sustained in times of economic hardship—and with competition from an economy that relies more on the dollar.