Reviewer’s report

Title: Cuban health assistance program and human resources for health challenges in the Pacific: analysis of policy implications

Version: 1 Date: 3 March 2011

Reviewer: Robert G. Evans

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Reviewer’s Comments

February, 2011

“Don’t look a gift horse in the mouth, or a gift physician in …” well, wherever? The PICs (Pacific island countries) as a group have low incomes, poor health status, and a minute supply of physicians. Taking Australia as a representative high-income country located in the region, the PICs have roughly one tenth the per capita income, and between 12 and 20 years shorter life expectancies. Physician’ per ten thousand people range from 8 and 9 in Nauru and Tuvalu, to 1 in Papua-New Guinea (PNG), Vanuatu, and the Solomon Islands. And since PNG accounts for 80% of the population in the countries described in this paper (excluding Australia) the population-weighted supply is not much over 1 per 10,000. The prospect of a dramatic increase in physician supply, Cuban at first and then Cuban-trained locals, on far more favourable economic terms than would or could be offered by the non-Cuban world, appears as an unquestionable GOOD THING – indeed a very good thing.

And no doubt it is, from the point of view of the health of the PIC populations. Citizens of PIC countries will in all probability live longer and healthier lives, thanks to the Cuban engagement. But there are also some grubby economic considerations that, although no one likes to talk about them, compete with and sometimes trump the objective of better population health. This paper is a fascinating preliminary consideration of the potential consequences of a rapid and (relatively) inexpensive increase in the supply of physicians in a region with a pretty obvious need for the additional services, but very limited economic resources.

To begin with the grubbiest of the competing economic considerations. PNG, with 80% of the population reported, and 1 physician per 10,000 people, does not participate in the program. The PNG Doctors’ Association has concerns about the quality of the Cuban and Cuban-trained doctors. The paper adduces no evidence for these concerns, and I’ll bet the PNG doctors have no evidence either – at least in terms of health outcomes. In effect they are saying that it is better to have no doctors at all, than to be cared for by Cuban or Cuban-trained
ones. Cuban doctors are a hazard to the health of the people of PNG? Are these people serious?

No, of course not. And it is hard to believe that the PNG doctors are unaware that the health status of the Cuban population, served by all those poor quality doctors, is about on a par with that of the United States. What is really going on in PNG is that there are enough doctors to be a political force, even though their numbers are minute relative to the population. (Language barriers, of course, are a real issue but one that could be straight-forwardly addressed. The paper does not suggest that the PNG doctors have taken up this issue.) They are apparently quite willing to sacrifice the health of that population in order to protect their own economic and professional position against “low-cost foreign competition.” They are certainly willing and able to prevent the vast majority of people in PNG – and particularly those in rural and remote areas where local doctors, according to Section 5.6, refuse to locate -- from having access to “desperately need[ed]” physicians’ services that they themselves cannot or choose not to provide, now or probably ever. The PNG doctors appear to be remaining steadfastly true to the medical tradition of the hypocritical oaf.

Moreover the paper notes that two private medical schools have recently been established. Private medical schools are expensive – even in the PICs the fees must be very high. This suggests that the medical profession must be paying very well indeed, to justify such a large investment. But these are low income countries, which in turn suggests that local physicians are servicing a tiny high-income elite – to which they themselves presumably belong. No wonder the PNG physicians do not want to go out to rural and remote areas, and are concerned about competition from the Cuban model – on quality grounds of course.

This is a pattern we have seen before, in South America. The Cuban system was set up precisely to replace the previous elite system. Many of the ancien regime physicians headed for Florida where the style of local medical practice has made Miami the most expensive region in the American Medicare program.

To me this is the most intriguing part of the paper – but perhaps its expansion would be another paper. This paper primarily maps the terrain.

The authors do refer to problems of “integration” of Cuban-trained physicians into existing systems, and I suspect that this problem is much deeper than simply economic competition. The Cuban model of organization of, and payment for, physicians’ services (insofar as I understand it) is quite different from that which has evolved in the “Western” world, and appears far better suited to the conditions in lower-income countries. It is not clear that the two approaches can co-exist, or whether one must drive out the other.

This political dimension, and what it says about the priorities and professional norms of the PNG doctors, might perhaps justify a bit more attention in this paper. Note too that Fiji, with the second-largest absolute number of physicians, has accepted no Cuban doctors and has sent only (a token?) six Fijians for
Cuban training (and only last year). It appears to be quite literally true that, whatever their impact on their patients, a concentration of local physicians are, through their political activities in this environment, a major threat to the health of the population.

In addition to the economic dimension of suppression of competition, there is the question of the fiscal capacity of the PICs. There just is not much money to go around. The data in Table 1 for Nauru, however, were a bit puzzling. If Nauru spends 15.1% of its GDP on health care, and the GDP per capita is $3433, then total health spending is $518, of which the government spends $575? (How is donor aid accounted for in Table 1?)

Is there any information on how much public money is being paid to physicians, and what the impact might be of doubling or tripling the supply? Cuban (-trained) doctors may be a bargain, but they are not free. And BTW where does the private money go? Is it mostly spent on drugs, or is this part of the (hypothesized by me, admittedly) payment from local elites to local physicians?

And doctors come with a train – sometimes a very large train – of other expenses (such as nurses, who are also in short supply). The authors are clearly well aware of this, and perhaps there simply are no hard data on the relative budgetary impact of expanding capacity.

“...[the Cuban engagement] allows PICs to increase their health workforce numbers at relatively low cost and extends delivery of health services to remote areas. A key challenge is that with the potential increase in the number of medical doctors once the local students return from Cuba, some PICs may face substantial rises in salary expenditure which could significantly strain already stretched government budgets.”

Can the PICs ever support something closer to a modern health care system, or must they be permanent charity cases (until the sea level rises …)? Perhaps it would not be too helpful to dig too deeply into this. But the paper hints at some potential problems of how, and from whom, to raise more donor money to support an expanded medical system. The reference to Australia in particular:

“In 2010, the Australian Foreign Minister expressed Australia’s readiness to collaborate with Cuba citing Cuba’s renowned medical assistance work.”

does leave one wondering what the Australian attitude might be with a different party in power. How close are ties between PNG doctors and the AMA, and thus to the Australian Liberal party? But if the donor field is becoming more crowded, will other countries step up at need?

On a grammatical point, the first sentence of the concluding section which now reads:

“The Cuban health assistance program in the Pacific represents a new and important model of development in the region that has the potential to impact significantly on HRH shortages and ultimately health outcomes.”
should be re-written as:

“The Cuban health assistance program in the Pacific represents a new and important model of development in the region and has the potential to have a significant impact on HRH shortages and ultimately on health outcomes.”

Teeth and traffic (and bureaucracies) can be impacted, but in general the use of “impact” as a verb is grammatically incorrect. It is a noun, not a verb.

I leave my suggestions to the author's discretion, except for some clarification of the contents of Table 1.

**Level of interest:** An article of importance in its field

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

None declared when sent by email.