

## The idea of the polyclinic

The polyclinic is a concept currently being promoted by the government as a solution to two related issues:

1. The increasing gap between a) health care that requires highly specialised facilities (tertiary referral centres, on a regional or sub regional basis where a sufficient critical mass of expertise can be concentrated and the necessary facilities economically provided, and b) those interventions that can now be carried out in primary care or other small settings, i.e. that do not need a general hospital. The supposed problem is that there is a reducing role for the District General Hospital, previously one of the cornerstones of the National Health Service.
2. The relative isolation of some general practitioners and the need to provide stronger integration, support and back-up for primary care (which, by the way is not just provided by medical GP's). This goes with the need to manage these independent practitioners, extracting better value and greater patient centeredness.

The polyclinic, originally established in France and Germany towards the end of the 19th century, was the cornerstone of the health care systems of the former socialist countries, established first in the Soviet Union in the 1920s and then in the various countries of Eastern Europe. The concept was developed by soviet planner AN Semashko as the location of basic primary care services, guaranteeing a level of cover to the population in what was still a developing country with low levels of cover. In effect the Semashko model was never implemented in pure form: the polyclinic-based system was augmented by effective workplace based health services and other parallel developments. Nevertheless, the polyclinic still exists as a key element of several Eastern European health systems, although the model has been eroded by the introduction of market models and social insurance.

In Cuba polyclinics were established in 1964, soon after the establishment of the national public health service in 1961, converting some health centres and integrating the newly developing rural hospitals. Again the polyclinic was originally the access point for health services. The system has been described as follows:

“Each of the polyclinics administers health services to a specific geographical region comprised of between 25,000 and 30,000 people<sup>1</sup> and serves as the point-of-entry for most patients... In addition to treating patients, the clinics educate patients by holding daily lectures on health care in clinics' waiting rooms. The region served by a

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<sup>1</sup> As of 2001 there were 444 polyclinics covering a population (2000) of 11,217,100: i.e. 1 per 25493 people.

polyclinic is further divided into health sectors. Within these sectors, all people are seen by the same medical teams, which after 1976 were mostly comprised of a physician and nurse trained in the same specialty. So for example, within a health sector, all children have the same pediatrician and all women have the same gynecologist. The polyclinic medical teams operate according to a paradigm known as “medicine in the community” which aims to treat patients as a biopsychosocial being in their respective unique environments. The medicine-in-the-community model is also designed to focus on disease prevention by identifying risks present in the environment before they become health problems.”

<http://www.cooperativeresearch.org/context.jsp?item=CubanPolyclinics#CubanPolyclinics>

By the 1980s however it was clear that the polyclinic model was insufficient in promoting a truly preventative social medicine. Accordingly, and consistent with the continual process of evaluation, invention and development that is the Cuban revolution, the unique Cuban Family Doctor system was established. One Cuban family doctor told me that the British NHS with its GPs was in part the inspiration for their primary care led system. However the model is actually very different:

“Under the new system, Cuba aims to [*and has, MB*] put a physician and nurse team on every city block and in the remotest rural communities. The plan calls for the creation of 25,000 such teams by the year 2000, 5,000 of which would be assigned to factories, schools, ships, and homes for the elderly. The teams are charged with providing comprehensive medical attention to everyone in their districts, both healthy and sick. Each district consists of between 120 and 150 families. Special emphasis is placed on prevention and people are encouraged to exercise, eat well, and avoid unhealthy lifestyle habits such as smoking. Implementing the system also requires corresponding changes in the country’s medical schools. All medical graduates except surgeons, nonclinical specialists, and future medical school professors are now required to complete a residency in family medicine before completing a second residency in a specialty area. After the Family Doctor Program was implemented, medical costs began to drop. The reduced costs are attributed to decreased hospitalization and emergency room use, better health monitoring, improved patient fitness, and more effective prevention.”

<http://www.cooperativeresearch.org/context.jsp?item=FamilyDoctorProgram#FamilyDoctorProgram>

Once the family doctor programme was established the polyclinics took on a largely coordinating role, as well as doing training (basic and continuing) and research (more than 50% are ‘teaching polyclinics’). They also facilitate interdisciplinary consultations, and auxiliary diagnostic services.

This contextualisation is most important: the Cuban polyclinic is different from that in the soviet bloc Semashko systems. It exists in dynamic interaction with the community based family doctor programme. The family doctor will use the polyclinic as a resource. Staff from the polyclinic will accompany the family

doctor on her rounds from time to time, providing specialist advice. It is not uncommon for a family doctor to accompany a patient to the polyclinic, or for a polyclinic doctor to go with the patient to a hospital consultation: integration and patient pathways are embedded in practice, not just in administrative arrangements. The family doctors live alongside their patients in the same neighbourhoods, experiencing the same things, and understanding the determinants of health and well being close up.

Meanwhile the polyclinics are not somewhere into which GPs are unwillingly 'herded' (to quote one of the silly statements made in relation to the Darzi proposals). Instead it is the resource that supports them and which provides the next line of health care – secondary care in our terms. There are nearly three times as many doctors in Cuba per head of population as in the UK and they are paid a wage closer to the population average (differentials are low and most people have to supplement their salary with other earnings or sources – for health workers the opportunity to join one of Cuba's international health missions is one way of augmenting the basic salary). After the revolution a majority of doctors emigrated and the Cubans had to start again – a missed opportunity here in 1948?!

In Cuba there is no Private Finance Initiative, there is no internal or external market, so no split between planning and provision. There is no private sector. Developments are paid for by the state (there is no income tax except for those earning foreign exchange). The efficiency of Cuba's health system in terms of health outcomes per unit of GDP is unparalleled. Its infant mortality is lower than Manchester's and its life expectancy is close to the UK average. The Committees for the Defense of the Revolution and the mass organisations also have an important role in promoting health, for example in the campaigns against the Aedes mosquito which carries dengue, or in the campaigns of the Cuban Women's Federation on behalf of women's and children's health.

The polyclinic is a great success, working as it does as an integral part of a planned and coordinated system of health services themselves an integral part of society.

If the UK is to adopt the polyclinic model it would do well to learn from the integrated prevention model in Cuba where the most local tier of the health service is neighbourhood based but integrated into a tiered system of health and other services all working together without competition or the intrusion of private capital.

Differences:

	UK	Cuba
Doctors per 1,000 of population	2.3	6.3
Nurses Per 1,000	12.12	7.95
Infant mortality	5.1 (Manchester 7.4)	5.3 (Havana 4.9, Santiago 7.9)

Life expectancy	77.6	78.5
Finance of new buildings	Private Finance and State	State
Coordination and management	Quasi market with private elements. Quasi autonomous hospitals. Professional managers	Unified system Senior professional staff in management roles. Trade unions participate in decision making.
Pharmaceuticals	Reliance on multinationals. Some use of NHS purchasing power and economic appraisals of treatments.	Mixture of imported medicines, herbal treatments, nationalised pharmaceutical industry produces both vheap generics and innovative biomedical products based on Cuban research (e.g. meningitis and hepatitis vaccines, cholesterol lowering medicine).

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