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The Health Care System in Cuba

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Content

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1. Country overview (latest data available)

Source: https://ontheworldmap.com/cuba/ (Accessed May 19, 2025)

- Sub-Region: Caribbean
- Capital: Havana
- Official Language: Spanish
- Population size: 11,019,931 in 2023 (World Bank 2025)
- Share of rural population: 2,476,950 in 2023 (World Bank 2025)
- GDP: 107,351,800.00 US dollars in 2023 (World Bank 2025)
- Income group: Upper-middle-income
- Gini Index: No data available
- Colonial period: The period of colonization lasted between 1492-1902. Cuba became an independent republic on May 20, 1902.

2. Selected health indicators

Indicator	Country	Global Average
Male life expectancy in 2023	76	71
Female life expectancy in 2023	81	76
Under-5 mortality rate per 1000 in 2023	8	37
Maternal mortality rate per 100,000 in 2023	35	197
HIV prevalence (15-49 age range) in 2022	0.6	0.7
Tuberculosis prevalence per 100,000 in 2023	8	134

Source: The World Bank (2025)

3. Legal Beginning of the System

Name and type of legal act	Organic Law of the Executive Power (regulatory)
Date the law was passed	January 11, 1909
Date of *de jure* implementation	1909
Brief summary of content	This legislation created the Secretariat of Health and Welfare, the world's first organized health ministry. This entity overhauled the various private and mutual aid health schemes that operated during the colonial period.

Socio-political context of introduction	During the period of colonization (1492-1902), regional Boards of Health oversaw a healthcare system that delivered services along ethnic and class-based lines with colonial elites and Spanish migrants being the primary beneficiaries. In the processes of decolonization, especially after the Spanish-American war ended (1898), Cuban health concerns became bargaining chips in the geo-political struggle for Cuban independence from American annexation. On May, 17 1902, Decree, No 159 codified sanitary codes with the creation of a network of Superior and Local Boards of Health in municipalities across the country (Rodríguez 2020). Even though Cuba became an independent republic on May 20, 1902, from that time until 1909 when a de jure Cuban government was installed, Cuban society was impacted by the Platt Amendment, a US legislation which mandated that substandard health and sanitary conditions in Cuba posed threats to US interest. This placed conditions on Cuba's existence as an independent nation with sovereign autonomy, and territorial integrity and forced attention to these issues (Hitchman 1967).

4. Characteristics of the system at introduction

a. Organisational structure

Percentage of population covered by government schemes	negligible
Percentage of population covered by social insurance schemes	Unknown
Percentage of population covered by private schemes	Unknown
Percentage of population uncovered	majority

5. Characteristics of the Cuban Systems at Introduction

The Cuban Health system that was codified in 1909 retained elements from the colonial era Boards of Health which were designed to provide preventive care to exclusive segments of the population. As such, at inception the National Department of Health functioned as a highly fragmented fee-based system that consisted of a public and private sector, as well as membership based medical cooperatives and other facilities run by religious organizations, charities and mutual aid societies. In terms of access, the system replicated the colonial era racial and social hierarchies providing services to segments of the population, in this case wealthy urban residents as the majority of practitioners, facilities and services were located in Havana (Stusser 2013; Rodriguez 2020).

From 1909 to 1959, there were periodic administrative and substantive changes in the health system reflective of decades of domestic political instability and the influence of external actors. Organizationally, the Health Ministry had two national directorates, one for Health and the other for Welfare, as well as a National Board of Health and Welfare. Together they had regulatory and administrative oversight responsibility for health care, sanitation, maritime and port migration control, disease vector controls and health statistics management. It was during this period that the first school of public health and scientific research was founded in 1927 (Beldarrain-Chapel 2014).

Indicator	Value
Number/density of physicians per 7.5 million in 1958	6000 total 9.2/10000
Number/density of Nurses and Midwives per 1000	Unknown
Number/density of beds in 1958	4.2/1000 28536 beds in Havana 1 hospital with 10 beds in rural Cuba

Source: OAS 1983; Lamrani 2021; Sixto 2002)

» Importance of inpatient and outpatient sectors: Negligible.

Despite the changes, health care eligibility continued to be race-based with coverage targeting European immigrants, American business elites, and dues paying cooperative and mutual aid society members to the exclusion of the Black population (Fitz 2020)

a. Financing

During this period the health sector was a hotbed of graft and corruption, and data from that era tend to be inconclusive, however an Organization of American States report has established that in 1958 public expenditure on health was 22 million pesos, which amounted to about $3.30 cents per capita (OAS 1983).

6. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Establishment of the Ministry of Public Health Law No. 717 of 1960
Date the law was passed	January 22, 1960
Date of *de jure* implementation	1960
Brief summary of content	The creation of a cohesive public health system to provide health care to all Cuban citizens.
Socio-political context of introduction	Constitutional reforms in 1940 brought sweeping changes to the health sector landscape. The health secretariat was renamed the Ministry of Health and Social Assistance and the new structure incorporated allied and affiliated clinics, institutes and research centers under the ministry's mandate. Despite the changes, health care eligibility remained exclusionary. Moreover, due to internal political disturbances there was a general decline in the health sector and this became the source of popular discontent. These developments form the backdrop for the Fidel Castro led movement to begin addressing the economic, social and political injustices and racial inequalities which had plagued Cuba since colonial times. On taking power in 1959 health sector reform took primacy on the revolutionary agenda. 1959 (Fitz 2020: 180; Hirschfeld 2009).

b. Major reform II

Name and type of legal act	Constitution of the Republic of Cuba
Date the law was passed	February 24, 1976
Date of *de jure* implementation	1976
Brief summary of content	It established equal rights for all Cuban citizens and enshrined the provision that health was a right that each Cuban should enjoy (Republic of Cuba 1979).
Socio-political context of introduction	The 1976 constitution built on the Fundamental Laws of 1959 and was influenced by the need to legitimate the processes of change in the post-1959 era. Its enactment as the first socialist constitution of Cuba codified the social, ideological and institutional framework for promoting the socialist agenda of the revolutionary government. It delineated the political party structure, enshrined executive and legislative power, institutionalized Soviet style centrally planned economy, and legitimized the revolution and national governance structure (Dominguez 1979).

c. Major reform III

Name and type of legal act	Public Law 41 of 1983 (regulatory)
Date the law was passed	August 15, 1983
Date of *de jure* implementation	1983

Brief summary of content	Created the framework for the national assembly and the health ministry to regulate public health.
Socio-political context of introduction	In consolidating the delivery of universal health care, it became necessary to empower the actors who would have regulatory oversight over the system.

d. Major reform IV

Name and type of legal act	Constitution of 2019
Date the law was passed	April 10, 2019
Date of *de jure* implementation	2019
Brief summary of content	This constitution reaffirms the rights of citizenship, and to clarify gender related issues and questions of the right to life and euthanasia (Republic of Cuba 2019).
Socio-political context of introduction	In light of ongoing economic crises and contractions in aspect of the health system a referendum was held to give constitutional protection to legacy and emerging health guarantees.

7. Description of current health care system

a. Organisational structure

Cuba's current comprehensive and highly decentralized public health system begun in 1960. The health sector benefited from the social and economic reforms that saw increased government intervention in areas of financing, personnel training, infrastructure and capacity development and operations (Navarro 1972; Fitz, 2020). As a consequence, the Rural Health Services (RHS) was created to facilitate the expansion of medical services and training in the rural areas that were traditionally underserved. Likewise, the Comprehensive Polyclinics network of neighborhood clinics were conceptualized to undertake health services delivery in areas that did not previously have access to such care. Simultaneously there was the establishment of medical and dental schools in the provinces beyond Havana. These early initiatives became the cornerstone of the Cuban National Health System (*Sistema Nacional de Salud*, hereafter SNS) that was formalized in 1960, and which today operates as a 3-tier system: national, provincial and municipal, across the 15 provinces and the Island of Youth Municipality. The Ministry of Public Health (*Ministerio de Salud Publica*, hereafter MINSAP) is the central organ of the state that manages all aspects of public health and medical sciences training. It has regulatory over-sight for the sector and is responsible for health policy formulation and implementation (Lamrani 2021; Lievesley 2004).

Other significant developments in the ensuing decades contributed to the creation of the com-prehensive, highly decentralized, regional and municipality-based character of the present system. In the 1970s, the community-based primary health care model of medicine was developed. This along with the 1976 constitutional enshrinement that "establishes basic principles for regulation of social relations in the field of public health in order to contribute to ensuring health promotion, disease prevention, health recovery, patients' social rehabilitation, and social welfare" (Serrate 2019: 4), further strengthened the public health system. In synergy with the 1978 Alma-Ata Declaration, Cuba introduced the Family Doctor and Nurse medical model in 1984. In the 1990s Cuba entered a 'special period' of economic downturn when external geo-political factors impacted the health system. Since then, Cuba has undertaken continuous reforms and adjustments to cauterize against the erosion of fee-free universal health care as it tackles enduring and emerging challenges from domestic sources and external actions (De Vos 2005).

Regional allocation of responsibilities for healthcare.

The MINSAP as the governing body sits at the apex of the SNS, and works with regionalized and municipal assemblies and local government agencies in the administration of the system and to provide care in order of subordination as follows:

» National: Tertiary level care at ministry-controlled specialist hospitals and research institutes that deal with specific types of diseases and handles about 5% of all cases.
» Provincial: Secondary level care for about 15% of all cases is offered at provincial hospitals treating patients with chronic illnesses most of who are referrals from the polyclinics and family doctors.
» Municipalities: Primary preventative care at first point of contact with family doctor and nurse at facility close to home. Each clinic treats about 600 patients on average and handles about 80% of all cases (Sixto 2002).

Medical Specialization: Tertiary Level

Hospitals	Institutes
Adult Intensive Care and Emergency Medicine	Institute of Endocrinology
Adult Psychiatry	Institute of Hematology
Allergology	Institute of Neurology
Anatomical Pathology	Institute of Nephrology
Anesthesiology and Resuscitation	Institute of Ophthalmology
Angiology and Vascular Surgery	Institute of Orthopedics, Rehabilitation and Trauma
Biostatistics	
Cardiology	
Cardiovascular Surgery	
Child Psychiatry	
Clinical Biochemistry	
Clinical Genetics	
Comprehensive General Medicine	
Dermatology	
Embryology	
Endocrinology	
Gastroenterology	
General Surgery	
Gerontology and Geriatrics	
Gynecology and Obstetrics	
Hematology	
Hygiene and Epidemiology	
Immunology	
Internal Medicine	
Microbiology	
Natural and Traditional Medicine	
Neonatology	
Nephrology	
Neurology	
Neurosurgery	
Normal and Pathological Physiology	
Oncology	
Ophthalmology	
Orthopedics and Traumatology	
Otolaryngology	
Pediatric Intensive Care and Emergency Medici	
Pediatric Surgery	
Physical Medicine and Rehabilitation	
Plastic Surgery and Burn Therapy	
Pulmonology	
Psychiatry	
Rheumatology	
Speech Therapy and Phoniatrics	
Urology	

Source: Anuario (2022) 50th Edition. Anuario Estadístico de Salud.

Health education and training.

All educational and training services fall under the auspices of the MINSAP. These include:

- 13 Medical School with 25 faculties of Medical Sciences.
- 4 Dental Schools
- The National School of Public Health
- The Latin American School of Medicine.

Source: Yaffe 2023; Martinez 2016

Eligibility/entitlement

Since 1976 the constitution of Cuba guarantees the right to health care for all citizens. The Public Health Law 41 of 1983 established the legal and operational framework for the universal public health system. It outlined the role of the health ministry and the scope of practice and delivery of health services.

Article 72 of the 2019 constitution has reaffirmed that "public health is a right of all persons and it is the states the responsibility of the State to guarantee access to free, quality medical care, health protection and rehabilitation" (Constitution of Cuba 2019).

Public Health Law of 2023 again reaffirmed access to universal healthcare, incorporated international treaty agreements into the public health framework and strengthen the modalities of health care delivery and practice (Ballaga 2023).

Coverage

Percentage of population covered by government schemes	100%
Percentage of population covered by social insurance schemes	100%
Percentage of population covered by private schemes	N/A
Percentage of population uncovered	N/A

b. Provision

Indicator	Value
Number/density of physicians per 1000 in 2018	8.4
Number/density of Nurses and Midwives per 1000 in 2018	7.6
Number/density of beds in public institutions per 1000 in 2021	4.2
Number of Hospitals per 1000	4.2
Total Number of Polyclinics	450
Total Number of Pharmacies	2180

Source: World Bank data 2024: Anuario Estadístico de la República de Cuba 2022

Outpatient sector is very important because preventative therapies prevent the development of more complicated illnesses. For 2022, there were a total of 94,773,278 outpatient visits; 13, 813,177 emergency room visits, and 1,177,845 admissions (Anuario Estadístico de la República de Cuba 2022).

c. Financing

The government of Cuba is the primary source of finance for the national health system. Total expenditure for health (as percentage of GDP) 11.79% of GDP (World Bank data 2025).

d. Regulation of dominant system

The MINSAP has full regulatory oversight for the entire SNS. As governing agency, it its jurisdiction includes:

- Regulation of the practice of medicine
- Epidemiological and surveillance of diseases
- Biomedical research
- Sanitation and hygiene standards
- Vital and social statistics
- Medical education, training and licensure.

In addition, there is active civil society participation in quality control and service delivery. Unions, community groups such as the Committee for the Defense of the Revolution (CDR) and the Federation of Cuban women (FMC) all have health officers who perform epidemiological surveillance in activities coordinated by neighborhood Family Doctor clinics and polyclinics (Dominguez-Alonso and Zaceo 2011).

Benefit Package

The SNS offers a full complement of care with access from primary to specialist providers. as inpatient, outpatient or through hospitalization. Benefits also include pharmaceuticals, social services and therapies (Lamrani 2021, Serrate 2019).

8. Co-existing systems

There is no co-existing system.

9. Role of global actors

Since the mid-90s during the special period Cuba has used the remittance of health professionals who participate in medical diplomacy collaborations with global partners, primarily in the Global South to augment the budget of the particularly in area of salaries for people working in the SNS (Gorry 2019).

10. List of additional relevant legal acts

Law 723 of 1960, establishing the Rural Health Services.

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