HEALTH CARE IN CUBA AND IN THE UNITED STATES OF AMERICA: AN ECLECTIC APPROACH

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"No hay dinero que pague una buena atención médica" or *"La medicina es un sacerdocio."* These colloquial phrases used in Cuba many years ago refer to medical services as an almost divine vocation. Things are different now in most highly industrialized societies. Why has reality changed so dramatically? It seems that when monetary compensation is included in the economic provision of health care, significant problems arise.

In reference to economics, healthcare is highly price-inelastic. In other words, when price increases, quantity demanded decreases by a lesser extent. In some instances, however, and as a result of treatment being very specific, it is said that demand is perfectly inelastic: as long as the patient or a third party is capable of paying, the quantity demanded will not decrease no matter the increase in prices. Economists call this service a "necessity" or an "essential." In addition, most economic principles do not fully apply the provision of health care in a market economy. Therefore, it is irrelevant to try to uphold consumer sovereignty in a context where asymmetry, lack of information, irrationality and contradictions between market and religious-philosophical values prevail. In other words, the benefits of the market are not applicable to the health care industry in the U.S. and other market oriented economies.

HEALTH CARE IN CUBA BEFORE THE REVOLUTION

Before 1959, Cuba was able to find partial solutions for most health problems. Cuban physicians and healthcare institutions were internationally recognized and accepted as offering high-standard and reliable services. Physicians, nurses and allied-health science professionals in every field were trained in Europe, the United States, and Cuba. Some of Cuba's most adept and venerable physicians volunteered their expertise and time in teaching hospitals. In addition, doctors with successful practices frequently maintained beds in public hospitals, and paid all expenses with their own resources.

During that time, the health care system in Cuba consisted of the traditional fee-for-service private practice and the free public health system, financed by the State, which oversees hospitals, and research facilities. Not to mention, some of the most advanced medical technology was available, including the use of recently developed antibiotics.

An additional system, widely used by a significant segment of the country's population, was the *"Sistema de Clínicas Mutualistas y Regionales."* This system consisted of independent organizations capable of providing for their associates comprehensive health care packages with particular emphasis on the development of specializations, full hospitalization, outpatient clinics, medications and urgent care. The state initially implemented the system as a way to provide affordable health care for members of regional associations—in this case, for people born in different "regions" of Spain or their descendants. For example, people coming from Galicia and their descendants typically joined the Association of the Galician Center (*Asociación del Centro Gallego, Hijas de Galicia*) for a modest monthly fee of 2 to 3 pesos per fam-

ily. Similarly, those coming from Asturia joined the *Centro Asturiano, Quinta Covadonga*, and those from the Canary Islands joined the *Quinta Canaria.*

Each of these regional associations owned its own hospitals where all medical specialty services were available. All these services were included in the health package, which typically covered the cost of the patient visit to the urgent care facilities or scheduled specialist, completing all indicated lab tests, X-rays, microbiology, etc. Hospitalization, surgery (emergency and elective), urgent care and physiotherapy were also offered. Hospital staff also provided house calls. When the diagnosis was completed, the center's pharmacy provided the prescribed drugs. There were no out-of-pocket expenses for patients. They only had to prove that their membership was in good-standing by presenting the updated payment receipt. The monthly fee for these services was very low, around 2-3% of the household income.

This system proved so effective that it was later copied and implemented in the same manner by other organizations and trade unions (*Clínica de Dependientes*). Additionally, that could be joined with no requirement other than payment of the monthly fee adapted the system. Prior to 1959, Kaiser Permanente sent researchers to Cuba to study this system.

HEALTH CARE UNDER THE REVOLUTION

The Cuban revolution in 1959 marked a significant change in the way Cubans received health care. The Revolutionists promised free access to healthcare for all Cubans. The MINSAP (Cuban Ministry of Public Health) began to own and control every activity related to health care in the country. Furthermore, the authorities banned new graduates from private practice and gradually they confiscated the private clinics and hospitals. By 1968, only a handful of private practices remained.

Today, no professional can enter or leave the health care field without approval from MINSAP. The MINSAP decides where and when things will be implemented in the country's health care system, from the introduction of new instruments and diagnostic machines to the implementation and application of new therapeutical approaches. Everything related to healthcare, except for ambulatory drugs, is free because there is no health insurance system in the country.

This system was purported as universally egalitarian, where everybody would have the same access to existing facilities and resources available in the country. However, the system was corrupted from the very beginning and special hospital and clinics were created for high-level governmental officials and their families. Thus, this healthcare system has evolved into several sub-systems. For the general population, there is a sub-system whose quality and availability of resources and supplies varies according to the country's general economic situation. There is a much better sub-system for high-ranked civil servants, party officials and military personnel. In addition, when the number of foreign visitors started to increase, some extremely well maintained and equipped facilities were established, providing excellent health care services paid in foreign currency. Both pathological and non-pathological conditions were treated, including cosmetic surgery under the general umbrella of health tourism. The sub-system catering to foreign tourists raised many bio-ethical issues, such as aborted fetal brain tissue transplant, obtained without parental consent, which was advertised abroad with false promises, as a cure for neurological disorders.

The healthcare system available to the population has experienced a precipitous decline over the years to the point where patients must provide many supplies for themselves. An extraordinary economic gulf divides Cuba into two classes, people with access to U.S. dollars and people without dollars. This rendered devastating consequences to the healthcare system, because the general population, those who have the US dollars can access better healthcare than those without the "enemy's money." It seems that in Castro's Cuba the circle has been completed and, people with hard currency can get much better health care than without.

BIOETHICS IN CUBA AND IN THE USA

Physicians in Cuba face a perplexing situation. They have to juggle conflicting interests—their obligations to the revolution, their own patient's welfare, and their own conscience. For instance, if a pacemak-

er is required but not available, a physician is forced to obfuscate the situation ("shuffle the deck of cards") so patients' relatives do not complain to the administrators. Interventions, such as abortions of high-risk pregnancies, are practiced upon patients without proper "informed and due" consent. Added factors, such as legal concerns and expected good revolutionary behavior, exacerbate these embarrassing conflicting situations and make mutual tolerance and communication quite difficult.

The U.S. is not free from bioethical dilemmas. Physicians must also juggle patients' values when suggesting appropriate treatment with what is suitable from the patients' perspectives, what is medically appropriate and by the physician's conscience. Patients, however, do have the right to refuse a given course of treatment. They often request that their physicians perform or omit a given procedure, when said actions or omissions will violate the physician's values or medical protocol.

U.S. liberal constitutionalism (which stresses a utilitarian, individualist, expressivist philosophy), posits equality and openness with minimal state interference; on the other hand, Cuba's practice, institutionalizes deceit and concealment. In order to enhance appropriate decision-making both countries need to work with bioethics consultants and committees to provide equal and efficient care.

HEALTH CARE IN THE UNITED STATES OF AMERICA

Thirty-seven years ago, President Johnson presented the first Medicare benefits card to Harry Truman, the former president. Medicare was signed into law with the hope of providing low-cost quality healthcare to senior Americans, but Medicare finances were based on wrong assumptions. Seniors enrolled in Medicare today are responsible to cover a large deductible.

A recent study by the National Coalition on Health Care predicted a 20% increase in premiums for small business. Recession, rising unemployment, increases in premiums, and the aftermath of the terrorist attacks is expected to result in close to 45 million Americans lacking health insurance coverage. The money spent on health care in the United States today, is officially around 14% of the Gross Domestic Product (GDP). The U.S. expenditure in healthcare as a percentage of GDP is greater than that of most European countries (between 7 and 10%), Canada (9.5%), Japan (7.6%), and New Zealand (8.1%). This disparity began in the 1980's and has been broadening since.

Health Maintenance Organizations (HMOs) were created as an alternative to control the increase cost of health services, and work differently from the traditional health insurance plans by actually providing both health insurance and medical treatments to the insured. An HMO is usually a for-profit corporation with responsibilities to its stockholders and controls the amount of health care that the doctor is allowed to provide. In the 1990's a new trend known as Managed Care Organization (MCO) emerged as a combination of HMO and other insurance plans, where patients are kept in the organization despite their changing needs. Capitation is a system where the basis of payment to physicians is the number of people covered, and not the service actually provided. A conflict of interests was created between good health care and financial interests when MCOs offered incentives to physician for reducing costs. This resulted in physicians endangering optimal clinical outcomes under the guise of efficient and optimal care. This was finally solved in 1996 when the American Medical Association (AMA) Council on Ethical and Judicial Affairs declared this practice unethical.

With the current state of affairs, both patients and physicians feel that a healthcare reform is long overdue in the United States. Last year, President Bush acknowledged that Medicare needs to expand its coverage, improves its services and strengthen its finances, giving seniors more control over their health care. He announced a national drug discount for seniors. The idea of the administration was to protect seniors without overtaxing their children.

The question remains whether citizens are able to reconcile values like efficiency and equity with the realities of a budget. Governments and their health care reform consultants have to struggle with a very human experience because of technological advances.

It is evident that health care delivery deals with individuals, family members, (their norms, mores, values), and their moment of confrontation with life and death. It is about the individual, their family and the collectivity. Unfortunately there is a trade-off and sacrifice to improve imperfect systems of health care delivery.

HEALTH CARE IN CUBA AFTER THE REVOLUTION

After a period of propitious political and economic changes in Cuba, many Cubans living overseas may want to return to their motherland. This event will create tremendous developments in the health care system. While in the U.S., the Congress is considering reforming private insurance, encouraging medical savings, providing financial assistance and reforming medical malpractice some Americans want to be able to use the free market to choose the care that suits their needs. Congressional actions in the US may eventually amend the Social Security Act of 1965, allowing the Medicare services to be provided outside its borders (See Díaz-Briquets, 2001). Currently, the pharmaceutical industry in Cuba is a state monopoly where workers make a nickel an hour and quality control is not subject to reliable scrutiny. Our research indicates that a transition toward a mixed economy (returning to a modern version of the *Clínicas Mutualistas*) could provide an acceptable way to deliver health care in a post-revolutionary Cuba. If the situation changes, some Congressional actions in the U.S. may create the conditions for a rapid transformation of the health care sector in Cuba, providing services in Cuba to Cubans living abroad and to U.S. citizens. This change of health care policy in the United States could lower the price of this service in America and would create an incentive for economic development in Cuba, providing unemployed and underemployed healthcare workers in Cuba the opportunity to become highly productive and restore and augment their medical tradition.

A long-term universally accessible, publicly and/or privately funded healthcare system, with adequate resources and sustainable foundations, should be able to secure future access to high quality and continuity of care. The long-term goal for the highest quality healthcare should be patients and provider's satisfaction, adequate supplies of human resources, and efficient delivery systems at a reasonable price.

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