LIVING IN A HEALTHY WORLD: A COMPARISON OF THE UNITED STATES, INDIAN, AND CUBAN HEALTH CARE SYSTEMS

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By

Kiran Ann Faryar

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Abstract

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Throughout the world, health care distribution, access, and quality are astonishingly uneven and poor. Both developing and developed countries struggle to meet the health care needs of their populations. In order better understand the global challenge of health care, this thesis seeks to describe and compare the health care systems of three very different countries, Cuba, India, and the United States. What lessons might each country draw from the other two in order to improve their own health care systems, and what lessons, if any, might be applicable to other countries? The three case studies were chosen in large part due to their distinct approaches to health care management. The Cuban government, following the Revolution, took over all aspects of health care. They made health care a national priority. Their system has achieved successes domestically with emphasis on community-based, preventative medicine and personal health, as well as internationally through their medical diplomacy initiative. In India a division exists between the substandard government-funded facilities and the expensive privately-funded facilities. Demands from the emerging middle class for higher quality, lower cost health care services have spurred the development of a middle ground in health care facilities throughout India. The United States is recognized internationally for its complex, interconnected network of health services. Although criticisms often focus on this system’s costliness and inefficiency, it excels in the field of medical education and continued physician training and collaboration. After each country’s system is described, their individual successes will be highlighted as well as their failings. The conclusion subsequently presents the overall findings from the comparison and points to lessons that the three countries can draw from each other. The health care successes of Cuba, India, and the United States are instructive for the international community as it shifts its attention and resources to tackling health care issues.
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By: Kiran Ann Faryar

Approved by:

___________________, Advisor
Dr. Melanie Ziegler

___________________, Reader
Dr. Sheila Croucher

___________________, Reader
Dr. Barnali Gupta

Accepted by:

___________________, Director
University Honors Program
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Introduction:

Health care distribution, access, and quality are astonishingly uneven and poor throughout the world. The past several decades have resulted in the decolonization, political transformation, and economic liberalization of many developing countries. However, as these developing countries set goals for the future, complex issues about how to manage health care delivery and services have emerged. Moreover, even a highly developed country like the United States is increasingly challenged to meet the rising costs of health care for its population. Developing and developed countries alike are constantly reexamining, expanding, and revising their systems in order to meet their growing health care needs.

An analysis of global health care systems reveals that no health care system is perfect. Within each system, there are noteworthy accomplishments and failings. Internal population dynamics, economic development, and political climate represent some of the many contributing factors to the success of a health care system. Comparisons can be drawn across these different dimensions, specifically in regards to whether the basic needs of a population are being met. This thesis therefore seeks to describe and compare the health care systems of three very different countries, Cuba, India, and the United States. What lessons might each country draw from the other two in order to improve their own health care systems, and what lessons, if any, might be applicable to other countries?

The three cases were chosen primarily for their different approaches to health care delivery and management. While Cuba provides government-regulated universal health
care to its population, the health care system of both India and the United States is a combination of public and private services. Although government regulation has been a necessity to the success of Cuba, progress and development in India and United States stems more from privately-funded initiatives. Healthcare is a field in which countries can learn from their counterparts regardless of the level of government involvement because the lessons learned can be adapted to each country’s needs.

Cuba, a small developing island nation with a population of approximately 11 million people, can point to health care accomplishments on both domestic and foreign fronts. By making health care a national priority following its revolution, Cuba has placed considerable emphasis on community-based, preventative medicine, personal health maintenance, and nationwide public health campaigns. Its primary foreign policy initiative – known as medical diplomacy – seeks to improve health care indicators in other developing countries, while simultaneously acquiring international recognition and praise.

India, a sprawling developing country with 1.12 billion people, has experienced a remarkable disconnect between its public and private medical services. The social divide between the “haves” and the “have nots” within India is evident in the access and quality of health care provided for each sector of the population. To alleviate these discrepancies, the booming private health care industry is taking steps to bridge this gap by attempting to provide more affordable health care to more metropolitan areas and second tier cities.

The United States, a highly developed country of 300 million people, is internationally recognized for its rigorous medical education and institutional high
standards of basic science and clinical training. Moreover, the high education standards of physicians are maintained by medical societies and associations at national, state, and local levels. These associations facilitate the exchange of medical knowledge between physicians within the same specialty (i.e. the American Surgical Association). However, the complex and inefficient network of physicians, hospitals, ambulatory care, and health insurance poses massive challenges for the future.

Although no perfect health care system exists today, by identifying and extrapolating the successes of Cuba, India, and the United States, these three countries can offer valuable lessons for each other and can also serve as important models for other countries. In this way all can improve upon their respective shortcomings. Such efforts at comparison are important for the international community as it shifts its attention and resources to tackling health care issues.
Case 1: Cuba

Cuba represents an unlikely source for some of the world’s highest health care indicators, thriving preventative medicine programs, and internationally-recognized medical schools. Nevertheless, on this small island located merely 90 miles away from the Florida coast the health care needs of all Cuban citizens are being met. The transformation of this country’s health care system was undertaken shortly after the Revolution as the new leadership faced economic challenges and political discontent regarding its socialist policies. Forty-seven years ago, when the United States first enacted its trade embargo on Cuba, such positive outcomes would have been nearly impossible to imagine. The U.S. trade embargo not only severely restricted the sale of food to Cuba but also the sale of pharmaceuticals and medical equipment. These problems were further exacerbated by the flight of Cuban doctors from the island.

In spite of these many challenges, the Revolution survived, and Cuba retrained new doctors and researchers in the field of biotechnology. However, when Cuba lost the financial subsidization of the Soviet Union, U.S. trade restrictions caused a 75% drop in Cuban exports between 1989 and 1993, and greatly reduced the availability of resources (Collinson 2002, 1-2). As Cuba’s domestic policy and global image began to suffer, President Fidel Castro embarked on several ambitious projects in order to sustain the Revolution. One major change in response to Cuba’s economic crisis included a reorientation of Cuba’s historically ambitious medical program towards preventative health care. In addition, Cuba ended its military presence abroad and its foreign policy subsequently became refocused on sending its doctors to other parts of Latin America,
Asia, and Africa. This policy became known as medical diplomacy, and it has received praise from international organizations such as the United Nations and the World Health Organization. Today Cuba serves as a beacon for other developing countries in the fields of community-based, preventative medicine and medical diplomacy.

**Healthcare as a Domestic Priority**

Cuba’s domestic medical system has very high standards. Its achievements and results are often compared to the most industrialized, wealthy country in the world, the United States. Cuba’s strong commitment to health care as a national priority has resulted in measures of infant mortality and life expectancy that compare favorably with those of the United States. In fact, Cuba ranks higher in these indicators than does the United States. The government points to these successes as proof of the moral superiority of Cuba’s social development policies. Fidel Castro’s passion for this accomplishment was evident in his last public speech on July 26th, 2006. He cited Cuba’s infant mortality rate as 5.6 per 1000 live births as compared to the United States which lags behind at 7.0 per 1000 live births. In addition, the life expectancy for this developing country (77 years) is equivalent to that of the United States. Lastly, over the past thirty-five years, Cuba has tripled the number of health care professionals in their country from one doctor per 1,393 people in 1970 to one doctor per 159 people in 2005. Cuba’s health indicators stand as a potential role model for other developing countries (Feinsilver 2006, 81-94).

One particular domestic initiative pursued by Cuba was recently highlighted by “Health and Medicine News of Cuba.” In 2005 on World AIDS Day, Cuba organized a full week of educational activities led by a national team for the management and fight
against HIV/AIDS. This team consisted of major ministries, media, and civil groups aimed at educating individuals as to HIV/AIDS prevention techniques. In addition, this team helped to build and strengthen the relationship between individuals and their community in the new Cuban healthcare system. The agenda for this week-long public health program highlights how the domestic healthcare agenda is a national priority. The increased emphasis on personal health care management and disease prevention illustrate how Cubans have been educated to take responsibility for their health. Ideally, this basic health care tenant can be spread to the rest of Latin America and the world through the country’s international medical diplomacy efforts (Fuller 2006, 1).

Cuba’s promotion of individual health and well-being is also evident in its commitment to mentally ill patients. Previously, mental health facilities were regarded as lunatic houses, or perhaps concentration camps, in which individuals were physically immobilized and incarcerated. In these private clinics, a patient’s mental health condition was neither evaluated nor diagnosed. After the Revolution however, Castro aimed to transform the state of these hospitals. Dr. Eduardo B. Ordaz Ducunge was appointed the director of the country’s first psychiatric hospital, the Hospital Psiquiatrico de la Habana, largely because of his very humane approach to mental illness. Under this new leadership, Dr. Ducunge and his team first attempted to classify each patient’s mental condition and later reformed the hospital into a rehabilitation institute. Today, all 14 regions of Cuba have a psychiatric unit attached to a general hospital with usually 20-30 beds. Separate psychiatric hospitals also exist and are fully contained medical facilities with acute and emergency units, as well as forensic and rehabilitation. While admission
into these separate psychiatric hospitals is traditionally non-voluntary, admission into the psychiatric units attached to general hospitals is voluntary. Treatment in these facilities is eclectic meaning that rehabilitation, social therapies, occupational therapy, and medication are all combined within patients’ treatment regimes. Psychiatrists strongly encourage both emotional and social benefits in their care of patients as opposed to the single-minded approaches evident in the United States and Europe. High staff-patient ratios allow for frequent and personable interactions. Lastly, these psychiatric facilities also experience the burst of medical tourism seen in Cuba. Patients from neighboring Latin American countries such as Venezuela and Columbia are known to frequent these centers for problems such as drug and alcohol addictions (Collinson 2002, 2-3).

Cuba’s development of high technology medicine and biotechnology receives government support. Throughout the 1990s, Cuba placed biotechnology research and development was at the forefront of a governmental policy which devoted over one billion dollars to this venture alone. With 38 biotechnology centers all grouped together in a science park in Western Havana, Cuba has led the way in the production of vaccines and cancer therapy drugs as well as fetal monitoring equipment. Cuba exports their biotechnology products to over 20 countries including the United Kingdom and Canada. Cuba is also in the process of testing several biotechnology products in clinical trials such as vaccines for AIDS, cholera, and cancer. By focusing attention on biomedical research and strategy, Cuba has been able to eradicate diseases and control epidemics within its own boundaries representing another positive and noteworthy healthcare indicator (Aitsiselme 2002, 1).
Through a variety of international medical conferences and scientific papers, Cuban scientists and researchers share their expertise with the world. Such conferences, however, have not been embraced by all of the invited countries. The U.S. government refused to allow its physicians to attend international medical conferences held in Cuba (Feinsilver 2006, 81-94). As an example, in 2004, President Bush threatened to fine and to imprison approximately 70 scholars and scientists waiting to attend a conference on coma and death. The conference continued without American representation, but the United States was deprived the scientific and scholarly exchange (Eaton 2004, 1). And finally, more evidence of Cuba’s commitment to medical research and knowledge is Cuba’s publication of fifty-four professional journals nation-wide (Feinsilver 2006, 81-94).

The emphasis on health care as a national priority has been supported through the decades by government spending on domestic health care needs. Beginning in 1982 and continuing throughout the 1990s, Cuba progressively increased its spending on domestic health care relative to total government spending in an effort to protect the less fortunate subset of their population from the disastrous consequences of their economic struggle. As health indicators in Cuba rose to higher levels, Cuba also expanded their foreign policy initiatives with the hope of producing similar results in Latin America and beyond (Feinsilver 2006, 81-94). Let us now redirect our focus from Cuba’s domestic program to Cuba’s use of medical diplomacy as a tool for foreign policy.

Medical Diplomacy
With the fall of the USSR and the end of the bipolar international system present during the Cold War, Cuba needed to foster new allies. One avenue that the Castro regime decided to strongly pursue was medical diplomacy. Medical diplomacy involves collaboration between countries that improve each country’s health care services, delivery, and treatments. The exchange of health care resources also facilitates open and friendly political sentiments between the parties involved. This program became a centerpiece of Cuba’s foreign policy in an effort to deflect attention away from their domestic economic difficulties that culminated in the mass exodus of many Cubans during the rafter crisis of 1994.

As far back as 1960, Cuba began exporting medical teams to other developing countries providing medical aide and disaster relief. Its first recorded diplomacy effort extended to Chile to contribute to their earthquake disaster relief. Later, a long-term, fourteen-month aid project to Algeria was assigned to a group of fifty-six doctors and other health care professionals. As noted by these two historic cases, Cuba has long led the way in providing both long-term medical assistance and short-term disaster relief to numerous developing countries worldwide.

Most recently medical relief was provided to Pakistan after an earthquake leveled large swaths in northern Pakistan according to an article from the “Health and Medicine News of Cuba.” The article names the Henry Reeve International Team of Medical Specialists in Disasters & Epidemic as the first group to aide the 100,000 injured and 3 million homeless Pakistanis. The Henry Reeve Contingent, was officially constituted on September 19th, 2006 in Havana immediately after their preceding disaster relief mission.
in Guatemala following Hurricane Stan. This 2,000 member group consisted of specialists ranging from gynecologists, cardiologists, dermatologists, and physical therapists. In addition to this medical team, other doctors, nurses, and paramedical personnel from Cuba contributed to disaster relief efforts and helped hundreds of thousands of Pakistanis in earthquake-affected areas (Gorry 2006, 1-3).

Cuba’s medical foreign policy initiative has far-reaching political consequences as this island’s leadership attempts to win the hearts and minds of its Latin American neighbors. Relations with the governments which receive medical aide have improved allowing Cuba to pocket a growing number of supporters. These relationships even transcend the regional political arena as countries in Asia and Africa voice their support for Cuba’s program in international organizations such as the United Nations and the World Health Organization. By maintaining a medical presence in sixty-eight countries and improving the lives of millions of people worldwide, Cuba’s efforts have paid with improved bilateral and international relations. Scholar Julie Feinsilver terms this “symbolic capital” defined as goodwill, prestige, influence, credit, and power obtained as a result of investing material capital (money and resources) into various foreign projects. This symbolic capital can be used at the discretion of the country who receives it. Options include accumulating, investing, and spending these rewards as if they were material capital. The conversion of symbolic capital to material capital, as explained by Feinsilver, has resulted in both bilateral and multilateral aid, trade, credit, and investments in favor of Cuba (Feinsilver 2006, 81-94).
Although Cuba and the host countries benefit from this relationship, Cuba faces challenges in maintaining its medical diplomacy. Cuba’s medical assistance has created resource and medical personnel scarcities at home. In order to offset these challenges, medical education programs have been integrated into international health care agreements with other countries so as to train foreign physicians in the medical and social style of healthcare initiated by Cuba. As part of these agreements Cuba offers free education in the form of scholarships to aspiring healthcare workers of developing countries. Cuban specialists are involved in on-site training courses both in Cuba and in medical schools in their own countries. Those who travel to Cuba in order to receive a medical education are required to return to their home country and practice medicine for an extended length of time such as five years (Feinsilver 2006, 81-94). This way, education can transcend the boundaries of Cuba as these educated healthcare professionals return to their countries as dictated in the agreement. Their role in the medical field is crucial, because it extends the same benefits provided by Cuban physicians to their home country while avoiding the necessity of Cuban medical personnel. Such educational endeavors strengthen the political alliances Cuba seeks to develop for the roots of these comprehensive agreements can still be traced back to the hospitality and generosity of the Cuban government.

The educational component of medical diplomacy is currently evident in East Timor. Since 2004, Gorry notes that Cuba and East Timor have maintained a “medical cooperation program”. This bilateral initiative recently expanded to include a more significant presence of Cuban doctors within the country as well as medical scholarships
for students of East Timor. “Providing education and training for human resources for health is a top priority in a country that was left with only 35 physicians after violent clashes in August 1999 displaced 75% of the population” (Gorry 2006, 1-4). The philosophy behind Cuba’s pre-existing medical education and now East Timor’s emerging medical foundation can be summarized by Dr. Medina, the head of Cuba’s Comprehensive Health Program in East Timor, as follows: “We’re the first to get rid of the desk separating doctors from their patients, and many times the first to see them not just as cases, but as human beings” (Gorry 2006, 1-4).

As the primary recipient of Cuban medical assistance, Venezuela under the leadership of Hugo Chavez has responded with trade, credit, aid, and investment in Cuba’s economy in exchange for healthcare workers and low-cost education and training. This is currently the largest Cuban medical collaboration program. Furthermore, both countries have initiated the Latin American Bolivarian Alternative [to the US] as an agreement for integrating Latin American countries “in a social justice-oriented trade and aide block” (Feinsilver 2006, 81-94). Specifically, it is the oil-for-doctors trade agreements between the two countries that has yielded both symbolic and material capital for Cuba. Cuba’s preferential pricing for their export of medical services in tandem with a constant supply of oil from Venezuela has increased investments and provisions of credit in both Cuba and Venezuela (Feinsilver 2006, 81-94).

The extent of medical aid includes 30,000 medical professionals, 600 health clinics, 600 rehabilitation centers, 600 physical therapy centers, 35 diagnostic centers, and 100,000 ophthalmologic surgeries. In addition, in order to continue this ongoing aide,
it is anticipated that 40,000 doctors and 5,000 healthcare workers in Venezuela will be trained in Cuba at their on-site medical schools. Medical scholarships at Cuba’s medical schools will also be granted to 10,000 medical and nursing students in Venezuela. A new addition to this partnership includes an extension of the ophthalmologic surgery program of Latin America and the Caribbean, and 600,000 eye surgeries are to be performed over the next ten years in the program entitled Operation Miracle (Feinsilver 2006, 81-94).

Barrio Adentro program I, the first primary healthcare program in Venezuela, consisted of 31,390 medical personnel as of March 25th, 2006. Of those medical professionals, 75% (23,382) were Cubans and the remaining 25% (8,008) were from Venezuela. The 23,382 Cuban medical professionals have conducted large numbers of consultations, health educational activities, and home visits which were previously almost nonexistent. The Barrio Adentro program II provides secondary care services such as medical diagnostics, physical therapy, and rehabilitation. Within this program, 10,856 histological exams, 84.4 millions clinical labs exams, 808,153 Cat scans, and 47,454 nuclear magnetic resonance exams were conducted, to name a few. Finally, under the jurisdiction of the Barrio Adentro II program are Comprehensive Diagnostic Centers and Rehabilitation Wards (Feinsilver 2006, 81-94).

Overall, it is with a strong political relationship that Cuba and Venezuela continue to enhance one another’s economy and healthcare status as developing countries. While most countries view this relationship as highly beneficial and advantageous, United States finds this relationship disturbing as it grows stronger each consecutive year. This has further soured relations between the United States, Venezuela, and Cuba.
In Bolivia, the second largest medical cooperation program has been initiated. Recent 2006 statistics estimate that more than 1600 Cuban doctors in Bolivia have treated over 1.4 million patients free of charge (ABC News International). Unique to this relationship is the National Ophthalmologic Institute in La Paz where high-technology equipment and trained professionals have treated more than 1,500 patients at no cost. Because of their overwhelming success and demand, two new centers in Cochabamba and Santa Cruz are expected to open in the near future. These centers will extend Bolivia’s ability to conduct ophthalmologic surgeries to, at minimum, 50,000 patients per year.

In addition, the Latin American Medical School in Havana has enrolled over 5,000 Bolivians who have received full scholarships to study at this institution. The Latin American Medical School is one of President Fidel Castro’s long-cherished projects. Castro’s idea was spurred by his desire to not only make medical education more accessible, but also to teach the compassionate side of medicine- an aspect of health care which American medical schools are struggling to integrate. Without neglecting its focus on basic science education, this school also emphasizes the need for “health care for the struggling masses” and encourages students to educate their communities about health maintenance (Lacey 2006, 1). The dean of the school, Dr. Juan Carrizo Estevez, describes the students as “true missionaries, true apostles of health” (Lacey 2006, 1). Also distinct to this school is its effect on students’ political perspectives. Students from various countries such as the United States, Panama, and Mexico indicate that their image of Castro has changed after spending time in this country further highlighting the connection
between medical diplomacy and political relationships. After the Bush administration rejected Cuban offers of medical aid to New Orleans following Hurricane Katrina, students began to question America’s dictatorial perception of the Castro regime (Lacey 2006, 2). The school housed in a former naval academy located on the outskirts of Havana now enrolls 3000 students from 19 different Latin American countries and the United States (Flying doctors 2000, 34). Low-income students are provided a six-year program at no cost in exchange for a pledge to practice in their home country after graduation. By training physicians and sending them back to their home country, Cuba further collects symbolic capital and good will. In addition, these recipient countries do not suffer the burden of “brain drain” because these newly trained physicians pledged to return to their home countries (Feinsilver 2006, 81-94).

While two Latin American countries—Venezuela and Bolivia—have certainly reaped the benefits of Castro’s medical diplomacy program, so too have other countries within the Western Hemisphere. These countries have received assistance which would otherwise be far beyond their reach. The 1970s’ medical teams in Guyana and Nicaragua traveled to Belize, Bolivia, Dominica, Guatemala, Haiti, Honduras, Nicaragua, and Paraguay. Within these countries, Cuba’s comprehensive health programs can range from providing free medical care in hospitals to financial agreements in which doctors are exported for a set period of time as evidenced in Haiti. In 1998, Haiti and Cuba created a medical agreement whereby Cuban President Fidel Castro and Haitian President Rene Preval agreed to commit 4,000 physicians and $1.8 million dollars over a two year period in order to assist Haiti’s poor population with their medical personnel and equipment
needs. The positive health outcomes which emerged from this plan were invaluable. Jamaica, another struggling country within the Western Hemisphere, received free eye surgeries from the team Operation Miracle in their comprehensive health agreement with Cuba. The Health Ministry calculated that the number of complications was less than three per cent of the 1,854 patients treated in 2006 indicating at this initiative produced successful medical outcomes (Feinsilver 2006, 81-94).

**Political Implications of Medical Diplomacy- Power and Prestige**

The domestic and foreign health benefits achieved by Cuba are gaining the participation of other donor countries. Financial support has been offered to further Cuban medical assistance in developing countries in a partnership referred to as “triangular cooperation.” With Cuba at the apex of the triangle, Germany is positioned at one end providing financial assistance and both Niger and Honduras are located in the third corner receiving support and aide which they desperately need. Acting as another donor country, France has provided additional funding to initiate a healthcare program in Haiti. Japan has also offered two million doses of vaccines to 800,000 children in Haiti and $57 million dollars to provide equipment for a hospital in Honduras- home of an existing Cuban medical team (Feinsilver 2006, 81-94).

International organizations such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO) are providing Cuba with financial assistance. Cuba’s comprehensive health programs are supported by a large number of non-governmental organizations receiving millions of dollars in assistance. The continued contributions from countries such as Germany, France, and Japan attest to their
belief in the success and potential of the Cuban healthcare system (Feinsilver 2006, 81-94).

Ties between the civilian aid programs and military support are also evident in both Angola and the Horn of Africa. These countries have received help in both civilian and military programs throughout the past thirty years. Africa’s apartheid brain drain, or white flight, left this continent in desperate need of Cuban physicians. While the scope of the military program was far larger thirty years ago than it is today, the civilian aid programs in Angola and the Horn of Africa remain intact. For instance, beginning in 1996 more doctors traveled to these areas with a 400 member Cuban medical team providing healthcare to people in remote townships and rural areas. As of 2004, an estimated 1,200 Cuban doctors were providing care to thousands of Africans in various countries (Feinsilver 2006, 81-94).

Making Enemies

While Cuba’s medical diplomacy has arguably earned more friends than enemies, there have been protests among some local medical associations and individual doctors. Some medical associations and doctors have argued that Cuba’s presence in their countries creates job competition. In addition, Cuban’s “different” manner of working and treating patients is also questioned. These groups are also critical of the perks Cuban physicians receive such as free room and board. In Bolivia and Venezuela for instance, medical associations have held strikes in order to protest Cuba’s presence. At times, in their outrage, they have resorted to the press in an effort to publicize their sentiments and begin a wave of anti-Cuban sentiment. These efforts have been largely futile, because the
press generally devotes more attention to successful patient care rather than to protests and strikes (Feinsilver 2006, 81-94).

Opponents are also skeptical of the certification, credentials, and quality of care provided by these foreign doctors. These arguments are used at times to discredit the medical diplomacy policy of Cuba. Because a universal certification process does not exist, the verification of health degrees is a responsibility of each country’s health ministry and local medical associations. While a supra-national, independent agency would be ideal in order to set medical degree standards and validate medical licenses, such an organization would be nearly impossible to establish and would likely take years to successfully implement. As a result, local overburdened health agencies are given this responsibility which is usually placed as a low priority. Problems with this system, however, lie in the fact that vested political interests are often associated with the validation process. The extent of these political interests and the underlying consequences that befall an unfavorable decision interfere with the verification process leading to dishonest judgments. For example, in 2003, the Venezuelan Medical Federation which ideologically opposed the Chavez government and the Barrio Adentro medical program filed a lawsuit to prohibit Cuban doctors from practicing medicine through a certification rejection. Early court rulings upheld the Venezuelan Medical Federation’s claim despite persistent government objections (Feinsilver 2006, 81-94).

Similar feelings of discontent in Bolivia resulted in a strike and evolved into a protest. The Colegio Medico de Bolivia and the association of unemployed doctors protested the presence of Cuban physicians. The government under President Evo
Morales publicly insisted that the Cuban physicians were going to stay as long as he remained president. The health benefits gained by their presence in Bolivia were too great to consider a policy change. While no official judgment from a medical association or Bolivia’s Health Ministry has been passed against the Cuban doctors, the polarizations resulting from medical diplomacy is evident as governments are pitted against healthcare divisions. Governments of Venezuela and Bolivia have attempted to assuage discontent and resolve conflicts by asking medical associations for cooperation in an effort to better regulate the diversity and quality of medical personnel. This shift in attitude and policy requires a level of compromise that is unlikely to occur. In a much publicized case in Venezuela, doctors from the host country refused treatment of a patient referred to them by a Cuban doctor (Feinsilver 2006, 81-94). This example of patient negligence brought about a malpractice lawsuit, because the denial directly violated the Hippocratic Oath. On the other hand, it is not surprising that the involvement of Cuba in the domestic healthcare affairs of another country regardless of their international allied relationship upsets a certain number of civilians. While the principles behind this “intrusion” may be well-intentioned, some citizens will inevitably become territorial as “medical diplomats” invade their communities and rural areas.

In addition to protests from local medical associations and individual physicians regarding certification dishonesty and unemployment, the underlying motivations of Castro’s medical diplomacy have been called into question by some Cuban physicians as well. An article written in the Wall Street Journal noted that two Cuban doctors sent to Zimbabwe were imprisoned by Zimbabwean police after attempting to seek political
asylum in Harare. These two physicians identified their work in Harare as part of Castro’s public-relations medical diplomacy program, and they argued that Castro was merely trying to “appear to the world as a good man” when, in actuality, they had been sent to Zimbabwe for purely political goals” (More Cuban Flight 2000). According to these two physicians, they had participated in medical diplomacy only to get a one-way ticket out of Cuba (More Cuban Flight 2000).

The Future of Cuban Medicine

Cuba’s continued emphasis on community-based medicine, public education, and preventative programs will provide for a healthier, more informed population. Challenges face Cuba’s foreign medical diplomacy policy, because this program is quite costly. Inside Cuba there is growing resentment about a physician shortage since sometimes it appears that more Cuban physicians are serving outside the country than inside. Nevertheless, given the fact that Cuba has been focused on medical diplomacy since the early years of the Revolution, this practice is likely to continue. Cuba proudly marches into the twenty-first century as a leader in domestic health care and as a leader in medical diplomacy. Both components further Cuba’s revolutionary goals of social justice and equality.

Case 2: India

Throughout the last four years, as India experienced historic economic growth, political leaders have become focused on their healthcare crisis. In order to rise as a global economic superpower, investments within the country’s social framework, particularly education and healthcare are necessary. In addition to dreams of rising global
economic performance, India’s population will soon rival that of all other countries by 2035 (Gupta 2008, 1-2). Meanwhile, health care indicators and the increasing gap between government-funded and private facilities are stark reminders of the long road ahead.

One initiative established, in part, by Rajat K. Gupta, a guest columnist of *Business Today* and senior partner in the global management consulting firm McKinsey & Company, highlights the vital interplay between business, government, and civil society (Gupta 2008, 1-2). Timing is in India’s favor on several levels. First, India is fortunate to be able to learn from and possibly avoid costly health care errors experienced by fellow advanced economies (Gupta 2008, 1-2). By utilizing this keen position of observation, India can draw lessons from successful healthcare systems and/or adopt specific components. Secondly, India has the ability to establish newer models drawing from resources from every sector of Indian society. These resources include the organizational dexterity of business in mobilizing resources and delivering services, the philanthropic character of the non-profit sector, and the legitimizing role of the government in finding a balance between society’s democratic impulse and the economy’s demand for the efficient delivery of services. Overall, while some countries, such as Cuba, look to health care policy as both a domestic requirement and a tool for foreign policy, India’s attention is focused entirely on domestic development.

**Basic Healthcare Profile**

After India’s independence, health indicators within the country significantly improved. For instance, life expectancy increased from 29 years at the time of
independence to 69 years of age (Economist Intelligence Unit). In addition, infant mortality rates dropped to 34.6, although this number remains unacceptably high (India 2008, 1-3). According to the United Nations, however, India has the largest HIV/AIDS epidemic in the world with an estimated 5.7 million people infected by the end of 2006. Malnutrition also plagues one of the most populated countries in the world. Studies by the National Nutrition Monitoring Bureau indicate that less than 15% of people are adequately nourished, however 96% of people receive adequate calorie intake. Malnutrition accounts for approximately half of infant deaths (Economist Intelligence Unit). Discrepancies in health care access and basic health needs between urban and rural areas are also prevalent. For instance, 80 percent of Indian villages do not have access to clean drinking water and shortages in nutritious food and proper housing are rampant (Privatise 2007, 1). While India has a basic system of hospitals and clinics in place, basic healthcare treatments and medicines must be purchased out-of-pocket, on a fee-for-service basis. Amid this disorganized and deteriorating infrastructure, promising steps are being taken and reforms are beginning to emerge to alleviate human suffering in this booming subcontinent.

**Organization of India’s healthcare system**

India’s administrative system is divided into three tiers. At the apex of this organization is the Ministry of Health and Family Welfare. Acting in accordance with the guidelines dictated by the Indian Constitution, the Ministry serves as a coordinator between the state health departments, the Planning Commission, and the Central Council of Health. Administrative staff within this system includes the Secretary for Health, the
Secretary for Family Welfare, and joint secretaries drawn from the Indian Civil Service. In addition, to healthcare oversight and state coordination, this tier of government is program- or project-based meaning that ad hoc projects such as those for malaria or TB are created as needed.

The second tier of this system rests at the state levels. India’s geographically divided state governments implement more frequent health projects and deliver regular health services within each state region. Each state’s capital holds the head office, or directorate, which manages primary, secondary, and tertiary health care in addition to medical colleges and medical education. Within each state are between 10 and 25 districts, which represent the final tier of the Indian healthcare system. The majority of the state’s revenue and civil administration is governed at the district level. Administrative officers and physicians at this level manage between 10-15 hospitals, 30-60 primary health centers, and 300-400 sub centers (or secondary facilities) (Bodavala, 2-4). With these vertical channels of information, the mirage of agencies, and dual reporting systems, it is no wonder decisions are made sporadically and inefficiently.

Indian healthcare is currently dominated by both the government, as outlined above, and by private, nongovernmental networks of physicians, facilities, and insurance companies. While state governments continue to manage the bulk of public sector spending, the central government, at the Ministry level, initiates national policies with participation from the states. The perception of central governmental influence remains within each state regardless of the differences in health plans and programs across states. A few decades after independence, the government represented the initial provider of
hospital services. However, following the 1950s and 1960s, widespread nongovernmental providers dominated ambulatory care, specifically on a fee-for-service basis. Despite this shift, the central government remains at the forefront of personal preventative services and population-based public health interventions (Berman 1998, 1463-1479).

**Government-funded healthcare**

At one end of the Indian healthcare spectrum there are the government-funded and operated hospital facilities. Because these are typically located in the cities, they face significant overcrowding and receive media attention. Since these urban facilities are legally prohibited from turning away a patient, they usually see two to three times as many patients than capacity permits. As a result, patients are forced to share beds within the children’s or maternity wards (Singh 2002, 1). Despite the inconvenience and discomfort of these hospitals, this form of publicly delivered healthcare is “theoretically available to all and free for the poor” (Roy 2007, 1-2).

The reason governmental hospitals are unable to meet the demands of the population is because the Indian government spends 0.9% of its gross domestic product (GDP) on healthcare as opposed to 40% seen in countries in northern Europe (Quality 2008, 1). Of the total healthcare costs in the country, 16% comes from government spending with the other 84% coming from the private sector (Singh 2002, 1). According to Ravi Duggal, an activist and expert on health in India, the lack of government investment in health care is further crippling this over-burdened system. The government fails to invest in new infrastructures and refuses to maintain those that currently exist. With a healthcare budget equivalent to one third of its defense budget, India lags behind
other developing countries such as Brazil and Nepal in terms of health care investment (Experts 2008, 1).

Further estimates show that India’s health care sector is growing at a rate of 13 percent annually. Currently, government hospitals have only 0.7 beds for 1,000 people as opposed to the global average of 2.6 beds. To meet these health care demands, an additional $550 billion is needed with at least two million beds by 2027. For instance, the Government Hospital in Coimbatore sees approximately 10,000 patients daily. Of those 10,000 patients, only 2,000 are accommodated in the hospital wards that have a capacity for 500 patients (Quality 2008, 1). Although nearly all of the politicians wish to make health care a priority, more emphasis has been placed on economic development over human development. Because economic production and viability retain more weight within the global economy, there exists a lack of political will to improve this health care crisis (Singh 2002, 1). Politicians and health campaigners are raising public awareness about health as a fundamental right for citizens in an attempt to encourage more government allocation of resources.

Uniformity in terms of resources does not exist across states, nor does it exist between the rural and urban populations. Because government hospitals are typically built in major cities such as Delhi, Mumbai, Chennai, Bangalore, Kolkata, and Hyderabad, healthcare is virtually non-existent in rural areas (Singh 2002, 1). Here, basic health necessities such as clean drinking water are not met (Privatise 2007, 1). However, in a series of studies conducted by Rohde and Vishwanathan in the 1990s, a more accurate image of the “rural private practitioner” was determined. By asking rural Indians
to name those individuals referred to as “doctors” and then interviewing these “doctors”
y they were able to collect information on rural practices-an area of Indian health care
overlooked by the government. Over 80% of these providers were not legally qualified
doctors. These less-than-fully-qualified (LTFQ) clinicians practiced eclectic health care
in that they combined methods from a variety of therapeutics systems such as allopathy,
ayurveda, unani, siddha, and homeopathy. These practitioners were primarily male and
relatively young with an average age of less than forty years old. While they were given
the label LTFQ, the “doctors” were modestly educated and about half of them had some
type of formal health care training. The practitioners interviewed in these studies had
about 10 years of experience and saw approximately 11 patients a day. While they
prescribed and dispensed medicines and treated patients on a fee-for-service basis,
medical consultation and advice from all different areas of medicine was free. Although
LTFQ allopathic practice was outlawed in the 1970s, the lack of up-to-date lists of LTFQ
practitioners makes it nearly impossible to monitor and enforce this law. In one particular
state, Uttar Pradesh, Rohde and Vishwanathan predicted that there was one LTFQ
practitioner for every 600 rural inhabitants. This number seems promising compared to
national studies that cite one physician for every 3,500 people in both the urban and rural
areas (Berman 1998, 1463-1479). Overall, because government hospitals in the cities
receive more media attention and criticism, healthcare in the rural populations is often
overlooked, and often written-off, despite the presence of modestly trained practitioners
and healers.
Discrepancies across states are also present within government-based healthcare. For instance, some states such as Orissa, Mizoram, Tamil Nadu, and Gujarat are investing money in healthcare and building up infrastructure (Experts 2008, 1). Typically, southern states in India fare better in terms of healthcare allocation and innovation. The state of Kerala, located on the southern coast of India, is deemed the model of successful health policy. In Kerala, private ambulatory provision and LTFQ practitioners are common. In addition, Kerala has the largest share of private hospital beds of any state in India (Berman 1998, 1463-1479). In contrast, the western state of Maharashtra fares worst in terms of health care spending (Experts 2008, 1). These regional discrepancies are the result of differences in population sizes and central government funding allocations, as well as corruption and state government greed.

After reviewing government-funded health care facilities, it is clear that since economic, rather than human, development remains at the political forefront, many problems still exist. This healthcare industry is plagued with inadequate paramedical manpower, a lack of management skills, and the need to improve the skills of the existing manpower. According to G. Thiruvasagam, the Vice Chancellor of Bharathiar University, “health care management was just an evolving concept in India” (Quality 2008, 1). Upcoming health care managers must learn and perfect the process of how to receive a patient, direct them to the right doctor, make them feel comfortable, and see to it that they are satisfied with the services they receive at the hospital (Quality 2008, 1).

**Private Sector healthcare**
At the other end of the health care spectrum there are privately-funded and operated hospitals and outpatient facilities. Private hospital groups were primarily designed to serve Indians’ growing demand for higher-quality healthcare services. Within the last few years, India’s hospital sector has grown and improved dramatically. Earlier, hospitals were funded by either the state, or by private trusts and charities. However, with the emerging prosperity of many households, and the increasing demand for higher-quality medical care than that received at government-funded hospitals, the healthcare delivery system has evolved into a profitable business industry. Hospital chains that were established by private physician groups are now beginning renovation campaigns in order to modernize and expand the types of medical services they offer. In addition, this profitable industry is attracting the attention of future private groups and foreign businesses looking to invest in this booming healthcare infrastructure (India 2008, 1-3).

Several motivating factors can be attributed to this surge in private health care. As India’s economy prospers, so too does the standard of living in Indian households. As eluded earlier, consistent increases in household incomes prompt a growing demand for better health care treatments and services. The private healthcare market has therefore expanded to meet this consumer-driven demand. In addition, the abysmal state of government-owned hospitals is forcing health care consumers to look elsewhere for service. Constraints within government budgets prevent state-run hospitals from receiving valuable financial resources. With the government increasingly unable to cover medical expenses, private hospitals are attempting to drive down their costs in order to make health care more affordable for a larger number of patients. As households begin to
prosper, the incidence of “lifestyle” diseases such as heart disease, cancer, and diabetes increases as well. These diseases often require long hospitalizations and more expensive treatments than typical infectious diseases. India’s aging population is further accelerating the incidence of “lifestyle” diseases. Finally, the advent and expansion of health insurance in India has allowed patients to afford private health care. Previously, state-owned insurance companies offered minimal health coverage that barely penetrated the health care sector. It was not until 2000 that private companies were legally allowed to offer health insurance to patients. However, by opening health insurance to the private sector and foreign businesses, insurance competition has soared, new health care schemes and plans have been introduced, and marketing efforts have abounded. Consequently, while health insurance may remain low considering India’s enormous population, many more Indians have medical insurance and are therefore able to afford more expensive private health care. In 2001, an estimated 4 million Indians had health insurance. As of 2006, that number had increased nearly three times to 12 million insured Indians (India 2008, 1-3).

In an effort to capitalize on these new business opportunities and remain competitive in this market, private companies are undergoing a multitude of expansion and diversification strategies to take their business to the next level. These campaigns represent a distinct success in the Indian healthcare system. Private hospitals are expanding their networks to major cities such as Delhi, Mumbai, Chennai, Bangalore, Kolkata, and Hyderabad where there is a larger population of middle-class and affluent families. In addition, “tier 2” cities across India also offer a high amount of business
potential. These cities include Surat, Nagpur, Chandigarh, Ludhiana, Bhopal, Agra, Patna, Jaipur, and Visakhapatnam. Private companies are also looking to acquire existing hospitals with the intention of expanding their network of services without having to build and staff costly new infrastructures. Fortis Healthcare, a leader in the private health care market, took over Escorts Heart Institute and Research Centre near Delhi in September 2005. This acquired facility allowed Fortis to develop into a leader in cardiac care and surgery. Two years later, Fortis acquired Malar Hospital in Chennai. While some of these arrangements are simple franchise agreements with a fixed return on profits, other arrangements, termed brownfield projects, are more extensive. In a brownfield project, the company that is looking to acquire a facility agrees to revamp, refurbish, and manage the existing hospital thereby assuming financial responsibility for its profits and losses (India 2008, 1-3). Inequities in health care accessibility can significantly decrease with the expansion of health care facilities into smaller urban environments.

The example of Fortis Healthcare’s takeover demonstrates another strategy utilized by private companies, specialization. While the demand for general, primary care hospitals remains high, more companies are choosing to set up specialized hospitals. Recently, Wockhardt Hospitals began focusing their efforts towards cardiology and cardiac surgery while Healthcare Global Enterprise in Bangalore began specializing in oncology. Although specialized hospitals may not attract the larger patient base of general care hospitals, these facilities eventually develop a reputation and attract patients throughout the country therefore increasing consumer demand (India 2008, 1-3).
Apollo Hospitals, a leading private health care company in India, last year opened a high-end “boutique birthing centre” entitled The Cradle in Bangalore, as an example of their specialized health care services. Women ranging from housewives to wives of bureaucrats, politicians, and business professionals are attracted to the facility’s “bright colours, no visiting hours, a cake shop, private birthing suites, and all-in-one labour, delivery, and recovery room equipped with imported Hill-Rom [multi-functional] beds” (Sharma 2007, 1-3). Although it has been open for only nine months, The Cradle has delivered 382 babies and allows mothers 48 hours of recovery before retuning home (Sharma 2007, 1-3).

Technology investments are increasing as private companies invest in high-technology medical equipment such as 64-slice CT anglo-imaging systems, PET-CT scanners, MRI scanners, and linear accelerators. Because most government hospitals cannot afford this equipment, this distinguishes private hospitals (India 2008, 1-3). One internationally recognized example of India’s technology advancements is the L.V. Prasad Eye Institute in Hyderabad. This eye institute is the only one in the world to have successfully restored eyesight via stem cells for corneal reconstruction. In the last five years, this facility has treated 500 patients which is the highest number of any eye institute worldwide. Almost half of the patients they receive are outside of Andhra- the region of India in which Hyderabad is located. Critical care treatments such as corneal transplant, ophthalmic plastic surgery, care of tumors, and eye cancers are common at L.V. Prasad Eye Institute. In order to provide half of all surgeries free-of-charge, wealthier patients are charged heavily for the institute’s services (Sharma 2007, 1-3).
However, private hospitals who invest in this technology must pay high import costs and risk losing patients if their charges are forced to increase. In order to cover expansion and technology expenses, private companies are looking to private-equity funds and the capital market to raise money. Due to the growing profitability in the healthcare market, foreign and domestic private-equity firms are willing to purchase stakes in these hospital groups. Well-established hospital groups have acquired funds from the capital market through initial public offers. Recently, Fortis Healthcare’s initial public offer was oversubscribed by nearly three times in 2007 and Wockhardt Hospitals anticipates building 14 more hospitals with the funds acquired through their initial public offer early this year (India 2008, 1-3). India’s leading position in the technological market through both invention and acquisition represents an important contributor to the quality of the medical treatment that is delivered to patients.

The growing trend of international patients seeking inexpensive higher-quality health care, known as medical tourism, represents another untapped financial resource. This advantage, which is shared by Cuba, brings in not only revenue, but also international recognition and prestige. The international patients that arrive in India can be Americans who are unable to afford the high cost of hospitalization, Europeans and Canadians who can not afford the long waits for surgeries, and patients from other countries with deteriorating health care facilities. In comparison, private hospitals in India offer low-cost medical treatment and readily-available surgical procedures. The emerging medical tourism business, while still in its infant stages, saw 200,000 patients in 2006, the majority of which were from neighboring Asian countries. In 2007,
Wockhardt Hospitals treated 3,000 international patients primarily from the United States and Europe which is a 35% increase from last year’s figures. The internet represents a vital motivating force in medical tourism because international health care facilities can be easily accessed online. For instance, Vishal Bali, the managing director of Wockhardt Hospitals, maximizes the internet’s potential by placing audio and video files of international patients on YouTube. While patients were initially skeptical of medical tourism due to India’s third-world image and the high costs of hotel stays, such constraints are no longer pertinent. Many private groups are arranging for patients to recover in their hospital facilities rather than returning to expensive five-star hotels in India’s bustling cities. The presence of Indian physicians abroad helps to boost this country’s reputation as a leader in health care treatment and services (India 2008, 1-3).

Private companies are improving their services by initiating alliances with foreign hospitals such as Harvard Medical International and John Hopkins Medicine International. From Harvard Medical International, Wockhardt Hospitals receives design advice and assistance for their medical facilities and clinical programs. Apollo Hospitals, a leading private hospital company in India, has partnered with Johns Hopkins Medicine International to conduct and assist with research on cardiovascular diseases. In addition, these private groups are setting up hospitals abroad in Asian, African, and the Fiji Islands. Finally, private companies are hoping to heighten their credibility and reliability by attaining international certification by the US-based Joint Commission International (JCI). Because the JCI is affiliated with the Joint Commission on Accreditation of Healthcare Organizations which is the largest US accreditor, professional notability can
be achieved through this process. Diversification of services helps to boost the image of comprehensive care that private companies wish to attain. Expansions into tertiary healthcare pursued by Apollo Hospitals include clinics, pharmacies, medical business-process outsourcing, health insurance, telemedicine, education, and project consultancy (India 2008, 1-3).

Despite all of the efforts in expansion and diversification of private health care companies, obstacles such as rising property costs in cities and nursing staff shortages creates barriers for advancement. As India’s economy continues to boom and cities attract more foreign and domestic companies, real-estate prices in these metropolitan areas are enormous. A significant amount of expansion funding is devoted to property costs alone representing an area of vulnerability for any potential buyer. As a result, expansion into “tier 2” cities is being pursued as a favorable alternative. Another obstacle is the growing scarcity of nursing staff in these new facilities. Other countries, such as the United States which is a leader in medical education, offer higher salaries and therefore attract international nurses. Some private companies, such as Apollo Hospitals, are resolving this problem by educating nurses in major cities and requiring two years of work in India before turning elsewhere (India 2008, 1-3).

In private health care, the opportunities are endless. Companies are experiencing tremendous increases in health care spending as household economies grow and consumer demands heighten. India’s leading credit rating agency predicts that between 2006 and 2011, the healthcare-delivery system is expected to double allowing hospitals to continue their investment endeavors. This profitable private health care industry will
likely expand in the years to come in India, and may spread to the rest of the developing world (India 2008, 1-3).

Reforming the system - a step towards privatization?

Proposed efforts to reform the Indian healthcare system are mixed. While some analysts seek to privatize the system and put the government in a monitoring capacity, many experts warn against this type of system using the U.S. system as the caveat. Regardless of the plan initiated and its degree of privatization, it is evident that steps must be taken to bring India closer to universal healthcare in order for the country to realize its dream of global economic superiority.

In his paper “Rethinking Health Care Systems,” Peter Berman uses India as an example to argue that private health care provisions should be maximized in order to attain universality. He states that the government’s role should shift from trying to supply and provide all services itself to assuring that primary care services (or priority services) are accessible at adequate quality without imposing a financial burden on those individuals who cannot pay. He wishes to allow private ambulatory care providers to expand their primary level treatments. At the forefront of his plan, Berman urges the Indian government to dispose of all notions of universal, public ambulatory care. Rather, the government should establish new programs “to develop the methods and experience needed to improve and strengthen the existing private supply and to integrate that capacity in achieving public goals” (Berman 1998, 1463-1471). The mechanisms available for this task include integrating and training private providers, diverting public funds to private provisions, and public education campaigns. In addition, by moving high
rates of spending into health funds that could pool risks and support both public and private providers, health care financing could be significantly altered. However, with the increased freedom of private companies, comes the possibility of corruption and greed, which are the major fears of Berman’s opponents. Increased government regulation and restriction must follow this new wave of private company liberalization. Positive health standards must be maintained and abuses punished. The impact on access, utilization, and quality of this system must be analyzed consistently considering the significance of this policy departure. Lastly, Berman points out that in planning future health care renovations, current information and statistics must be known. Therefore, as the final aspect of his plan, Berman recommends making data gathering and analysis a top priority (Berman 1998, 1463-1471).

Despite this comprehensive health care reform plan, analysts and health care experts from India and the United States warn against this system. According to Arnold Relman, professor at Harvard Medical School, India should avoid the allure of privatization. The costliness and inefficiency of this system is evident in the U.S. health care system, which has been globally-discredited and targeted as a sign of disgrace. With up to 20% of its GDP allocated to health care, the wealthiest country in the world is still unable to insure one out of four workers. However, the perspectives of private company executives such as Ranjit Chaudhury, chairman of the Apollo Hospitals Education and Research Foundation, are slightly different. Research and development could be maximized by fusing these two systems. Here, private research companies would develop drugs and pull patients for their clinical trials from government hospitals (Privatise 2007,
1). The possibility of corruption, insurance cherry picking, and inefficiency soars with a merger of public and private health care systems (Roy 2007, 1-2).

It has been argued that insurance company risk decreases as the base of patients insured widens, because the risk is spread out more evenly. Ideally, all 1.1 billion Indians would be insured under a single policy. Here, the government would assume premiums for the entire population and would levy a health insurance surcharge from income taxes. Reality, however, proves otherwise. Amid the heated debate over the best course of reform action, comes the quiet voice of reason that argues tackling small changes incrementally. While a complete overhaul of India’s health care system is enticing, providing one small village in southern India clean drinking water is more practical. Government advisers, such as B.M. Hegde of Bihar, see more merit in merging medical care (treating diseases) and health care (promotion of health and prevention of diseases) rather than combining private and public health care sectors. India’s advantageous position allows it to adopt and pursue successful health care practices such as technological invention and acquisition, hospital expansion, and foreign investment to better meet its needs.

**Case 3: United States**

Unlike the Cuban healthcare system, which was divided into distinct domestic and foreign policy categories, and the Indian healthcare system which was classified according to government-funded and privately-funded services, the American healthcare system contains multiple, interconnected categories. All of the individual components of the American healthcare system, while distinct in their function, are essential to the
overall structure of the system. While current analyses of the American healthcare system primarily criticize the use of managed care and highlight the system’s ineffectiveness, this analysis will focus on both the areas of medicine in which America thrives as well as the dilemmas this system is currently facing. Within these many categories, prominent achievements and strengths of the system will be recognized, and current and future challenges will be addressed. As the richest, most developed country in the world, the United States is globally ridiculed for its surprisingly poor health outcomes and inefficiency. However, as seen with Cuba and India, each country possesses its own strengths from which other countries can build upon and adapt.

**The Evolution of Medical Education and Practice**

Within the American healthcare system, the nineteenth century saw the transition from “traditional” medicine to “modern” medical practices. After many medical practitioners began to recognize that the higher quality medical education available abroad barely rivaled that of the United States, numerous, incremental changes were made during this century. For instance, inspired by the formation of medical societies and associations at the local and state level, a national medical society called the American Medical Association (AMA) was established in 1847. Its primary goal was to reform medical education in the United States in order to better compete with healthcare education worldwide. Reforming medical education later evolved into a continual process which implements changes to this day. Another initiative undertaken during this transition period was the establishment of medical journals as a way to disseminate new knowledge and continually educate physicians. To further propel this transition, the
Association of American Medical Colleges (AAMC) was formed in 1876 to enact and oversee improvements in the medical education process. Lastly, licensure of physicians and candidate testing for licensure was adopted in the later part of the century. Through the establishment of these associations and reforms, the United States sought to evolve into a modern medical nation, and a global competitor in medical education and practice (Raffel and Raffel 1994, 32-34).

As physicians developed interest and competence in specific medical fields, medical specialties evolved. Medical treatment took a more organ systems-based approach once practices such as bleeding and purging were recognized as inefficient. Physicians with similar specialty interests organized themselves into specialty societies and established admission standards into these associations. For example, the American College of Surgeons set standards for surgical practice and helped to raise hospital standards. Later, in collaboration with the AMA, they sponsored national certifying boards for various specialties. The number of specialty boards to date has reached twenty and, among all of them, training and testing requirements are enforced in order for physicians to be board certified (Raffel and Raffel 1994, 32-34).

With the establishment of specialty certification and licensing examinations, new problems within hospitals arose such as fee splitting, ghost surgeries, and unnecessary surgeries. In fee splitting, the surgeon’s fee was divided with other physicians without either the knowledge or consent from the patient. Ghost surgeries were surgeries performed by a surgeon other than the one engaged by the patient. Despite certification, some surgeons would knowingly operate when there was no medical need for surgery.
Unnecessary surgeries also occurred when the diagnosis was unknown, but the surgeon felt obligated to “treat” the patient in some manner. To rectify these problems, there was a shift from the business of medicine to the honorable and ethical nature of medicine (Raffel and Raffel 1994, 32-34). Unfortunately, this shift was short-lived. Business eventually found its way back into medicine as physicians recognized the need to earn a living from this career. As a result, physicians entered into contracts with organizations that focused on the delivery of care. In addition, physicians formed group practices to attract and ensure a constant flow of patients in an effort to stabilize their incomes. Although the AMA vigorously opposed these agreements, this practice of contracting soon developed into the health maintenance organization (HMO) and preferred provider organization (PPO) system seen today (Raffel and Raffel 1994, 32-34). Currently referred to as managed care, the theory behind it was that a coordinated series of services including a network of organizations such as hospitals, physicians, clinics, and hospices would provide managed care and managed costs for a defined population. However, the legalization of this system quickly brought about competition and new dangers such as under-service and over-service. Overall, all of the incremental changes described above highlight two important points. First, the evolution of a system aimed at competing with other global systems and secondly, an emphasis on a physician-centered healthcare system with limited government involvement (Raffel and Raffel 1994, 32-34). These points, in addition to the interconnected network of healthcare services and facilities, distinguish the American healthcare system from others such as Cuba and India.

Unrivaled Medical Education
One of the most prominent and distinguishable aspects of the American healthcare system is the rigorous medical education for training physicians. This four-step process is one of the most lengthy and time-consuming in the world, and certainly attests to the quality of the physicians in America. The four steps of the process include: premedical education, undergraduate medical education, graduate medical education, and post-graduate (continuing) medical education. During the premedical phase, students at a college or university are expected to master necessary science courses. Their expertise in these science courses is quantified via the Medical College Admissions Test (MCAT), from which entry into the second phase, undergraduate medical education, is determined (Raffel and Raffel 1994, 58-59).

Within the second phase, four years are reserved for both basic medical science and clinical science. While each component traditionally occurs during two consecutive two-year periods, a trend towards the integration of these components throughout all four years is emerging. Although the completion of these four years results in obtaining a medical degree, physicians are required to pass the state-administered licensing examination before they are able to practice. An additional period of supervised clinical experience, also known as graduate medical education, is required before independent practice can begin. This period, commonly referred to as residency, further prepares the physician for practice within their specialty field. This period is, at minimum, three years long. The final phase is continuing medical education in which physicians pursue educational experiences in order to keep them up to date with the latest medical treatments and practices. Specialty boards, societies, and state medical associations are
beginning to set medical education course requirements in order for physicians to retain their membership and license (Raffel and Raffel 1994, 58-59).

**Practical Medicine - A Look into Managed Care**

While the American system leads the way in its medical education process, medical practice, specifically its managed care component, is globally recognized as both inefficient and costly. Once physicians enter into practice, they can chose to be self-employed in solo or group practice, or they can enter hospital-based practice. In both systems, the patients pay a fee for a service. This fee is typically negotiated by their primary employee-sponsored insurance provider (Raffel and Raffel 1994, 83-84).

Within the domain of solo or group physician practices, there exists a growing trend toward group practice. In a group practice, three or more physicians of either the same or different specialties work together. The benefits of group practice include greater consultation with colleagues, coverage on nights and weekends off, sharing of equipment and support personnel, and intellectual stimulation. Group practices frequently contract with a population to provide complete medical services in exchange for regular payments regardless of whether or not the patient uses the services. Physicians within HMO networks are usually salaried. Hospital-based practice is also seeing the entrance of more and more physicians. While patients pay according to the services they receive, physicians can be paid on either a fee-for-service basis, or in some cases they can be salaried directly including a percentage of the income generated (Raffel and Raffel 1994, 83-84).
The intended goal of these HMO organizations was to focus on preventative medicine. However, recent challenges such as rising medical costs are preventing HMOs from focusing on preventative care. While it is known that performing a mammogram is cheaper than treating advanced breast cancer, few physicians encourage low-cost check-ups and physicals, and fewer patients take the initiative to maintain their health. A trend in increased personal awareness of one’s health risks is taking place in the United States. For instance, pharmaceutical companies are focusing more on preventative medicines with advertisements that alert patients to their potential risk. Brand-name food companies such as Kellogg are introducing entire food lines that are low-calorie, low-fat, and low-cholesterol. These efforts, however, represent merely the tip of the iceberg.

From a patient perspective, health insurance through HMO networks is two-faced. The benefits of the system include financial relief from expensive medical costs such as hospital visits. However, the acquisition, coverage, and limitations of health insurance cause problems in health care accessibility and quality for many individuals (Raffel and Raffel 1994, 83-84). Although these problems are also indicative of the healthcare systems of developing countries, their presence in the United States system is surprising due to this country’s sheer size, power, and wealth.

Health insurance, in general, is acquired through each patient’s employer. (Already, challenges arise for the many Americans who are unemployed.) Blue Cross is the designated hospital coverage insurer while Blue Shield covers physician services. Some large commercial insurance companies including Cigna and Prudential cover both hospital and physician services. Government-sponsored programs include Medicare for
the elderly (over the age of 65) and Medicaid for low-income individuals. Specific concerns regarding the challenges of managed care include: limited benefits, the exclusion of coverage for certain conditions, waiting periods before covering preexisting conditions, limited hospital and nursing home stays, and limited funding for physician fees. While there is currently a trend towards more comprehensive medical coverage, employers are finding it difficult to ensure such coverage due to the poor experience rating of small businesses employees and self-employed persons (Raffel and Raffel 1994, 229). The additional burden of low wages and low profit margins also contribute to this access inequity. An individual’s insurance payments are used to cover hospital visits and routine office care to a primary care physician, for instance. Due to the increase in chronic health conditions and the aging population, major medical coverage is emerging as a way to protect against these astronomical costs; however its usage is limited (Raffel and Raffel 1994, 229).

Despite this highly integrated and complex healthcare system, two basic problems contribute to the rise in insurance costs: expensive medical costs and administrative costs. While some medical costs are outside the health sector, others are medicine-specific. For instance, economy-wide occurrences (such as inflation and population increases) are outside the health sector. Technological advances, malpractice insurance, disease-specific pharmaceuticals, government programs, morbidity among the aging population, and longer hospital and nursing home stays are sources of medicine-specific inflation (Raffel and Raffel 1994, 205). The high incidence of malpractice in the United States demands attention because not only does it represent one explanation for rising healthcare costs,
but also it speaks to the culture of American medicine. It is increasingly difficult for physicians to establish and maintain a practice under the current system due to malpractice costs and insurance. Because physicians are worried about malpractice lawsuits and the potential to be sued, patients receive a plethora of tests to ensure the most thorough treatment regardless of whether the tests are necessary. Physicians are over-treating their patients not for the additional costs they will receive, but rather to cover their own backs should a problem arise. However, without possessing malpractice insurance, physicians are essentially unable to find employment in our current healthcare system. In addition, the prevalence of malpractice indicates that American culture pays physicians less reverence than other cultures which view physicians as almost divine healers. Overall, while all of these factors are outside insurance company control, administrative costs are indicative of insurance companies.

Administrative costs also contribute to the growing costs of health insurance plans. Consumer pooling, a practice utilized by private insurance companies, result in expensive insurance premiums. Because insurance companies pool their buyers in terms of numbers and types, their rates represent the averages of low-risk and high-risk coverage. Therefore, while people buy into private insurance in order to protect against risk, low-risk people find themselves paying more than what they require while high-risk individuals are underpaying for their health coverage. In addition, since likely and unlikely events are pooled, a company’s marginal cost of processing these claims is fairly high. As a result of these high marginal costs and processing charges (loading costs), adverse selection is often evident as insurance companies are less likely to ensure high-
risk people. Therefore, due to the adverse effects of loading costs and rate pooling, not all individuals, especially those who require the most insurance, can afford healthcare for themselves and their dependents.

While its intended purpose was to make health services more affordable, health insurance is unobtainable for many individuals and they are denied treatment in medical facilities nationwide. Despite efforts to make health care affordable for all citizens through managed care organizations, health care accessibility is once again divided between the “haves” and the “have nots” in the United States.

Despite the asymmetric accessibility of medical care for patients, physician training and collaboration in the form of physician-led medical societies remain an advantage indicative of the American healthcare system. Membership to county, city, or state medical societies is more common than membership to the national AMA society. In addition, physicians typically show more interest in their specialty society and would rather devote membership fees to this specific society. The benefits of these organizations greatly contribute to the quality of medical treatment provided to patients and the level of physician knowledge in the United States, as compared to other countries worldwide. These organizations allow physicians to meet their colleagues and share common skills and abilities. This helps to build a specialist’s private practice and it facilitates the referral of patients between practices. The exchange of intellectual information is often formalized in continuing medical education programs. Lastly, these societies provide organized representation of medical viewpoints on issues pertaining to both the population and the physicians themselves. This organized representation also facilitates
communication from government or industries to the individual physician. Despite these advantages, America still faces the challenge of providing medical care to rural populations. While Cuba and India addressed this problem by emphasizing community-based medicine and private hospital expansion respectively, the United States hopes to attract physicians to rural populations through medical education reimbursement programs and the opportunity for a quality of life higher than that available in more urban environments (Raffel and Raffel 1994, 83-84).

The Delivery of Medical Services

Apart from veteran affairs (VA) hospitals and military hospitals, the federal government plays virtually no role in the maintenance and regulation of hospitals within the United States. There are several different types of hospitals including: psychiatric hospitals, TB hospitals, chronic disease and rehabilitation hospitals, mental retardation hospitals, federal government hospitals (including VA and military), special hospitals, and short-term community general hospitals. The most common hospital is the community hospital. Here, physicians admit their patients for a short period of time in order to address acute care needs. The length of stay in such hospitals is less than 30 days. Smaller hospitals can have only six beds while larger, more urban community hospitals can have 1,000 beds. Some community hospitals are designated “teaching” hospitals in that they are responsible for training medical specialists. Medical school hospitals, which represent a specific type of community teaching hospital, are responsible for training medical school students for clinical practice. Due to their educational purposes, these hospitals are larger and contain sophisticated technologies. The full-time
salaried staffs of these facilitates are larger than non-teaching hospitals which employ few full-time salaried physicians apart from emergency department physicians. As opposed to teaching hospitals, small hospitals are being forced to close and merge with larger institutions because the costs of care are rising and the need for high-technology equipment is more frequent (Raffel and Raffel 1994, 166-167).

Community hospitals are nonprofit and privately regulated in that governance is controlled by a board of trustees, or directors. This board appoints medical staff and hires the administration to carry out hospital policies and manage the hospital’s everyday operational needs. These board members do not receive compensation for their services. The board’s primary responsibility is to set policies and oversee hospital operations, in addition to ensuring that financial resources are available to maintain the institution. The group of individuals that sponsors the hospital’s establishment is assigned the task of appointing board members. These hospitals can be run by state governments, or perhaps a local or private institution. In the case of state-run hospitals, the hospital must first gain approval through the issuance of a license. The state licensing body must approve that the hospital meets the standards laid out by the state. Hospital inspections are typically performed with emphasis placed on cleanliness, fire safety, and other physical plant matters. Debate is currently ensuing regarding whether the quality of the medical treatment provided by hospital employees should be inspected as well. Accreditation review by the Joint Commission on Accreditation of Healthcare Organization is practically essential in order to receive government funds and business from health insurance companies (Raffel and Raffel 1994, 166-167).
Specialty hospitals such as children’s hospitals, orthopedic hospitals, women’s hospitals, ENT (ear, nose, and throat) hospitals, eye hospitals, and rehabilitation hospitals are beginning to merge and affiliate with other institutions such as community hospitals. The rising costs of medical care represent one reason for these mergers. In addition, scientific advances can be shared between facilities as patients’ dependence on specialty services continues to rise. The increasingly integrated nature of medical treatment demands multi-specialty institutions that can meet their patients’ needs (Raffel and Raffel 1994, 166-167).

The recent increase in hospital closures and mergers speaks once again to the business of medicine within the United States. Reduced occupancy, high turn-over rates, and cost containment mark the growing shift in hospital management as the amount of health care spending drops rapidly. For instance, Medicare switched to a prospective payment system based on diagnosis-related groups in order to save money. In this system, hospital cases are to be assigned into a diagnosis-related group based on international disease classifications, procedures, age, sex, and the presence of complications, additional disorders, and diseases. Shorter hospitals stays and the establishment of outpatient services are additional results of this business-centered approach to health care service and delivery (Raffel and Raffel 1994, 166-167). As mentioned earlier, these changes in hospital care are accompanied by a growth in ambulatory care services outside of the hospital. Procedures which were previously designated for hospitals can now be performed in outpatient facilities at lower costs. New outpatient facilities such as surgery centers, diagnostic imaging centers, and cardiac
catheterization laboratories are emerging. These facilities operate on a for-profit basis and are managed by chains (Raffel and Raffel 1994, 166-167). While no significant benefits were evident after the shift to outpatient services, the amount of stress on hospital facilities and staff decreased. On the other hand, the lower occupancy rate in hospitals left the facility with higher costs as evidenced by the increase in per capita costs. For the patient, transportation costs arising from a geographically disconnected system causes further inequities in health care access and delivery.

Although the dilemma of how to treat mental illnesses plagues the United States, its mere recognition is far more progressive than ignorance which is evident in many developing countries. The conservative culture of many developing countries, such as India, prevents mentally ill patients from receiving the treatment they require. By failing to recognize that mental illness is a problem among the population, special facilities tailored to these patients’ needs are not established. While conservative cultural limitations do not create an obstacle for the United States, this country must move beyond the recognition phase in order to build services that meet this population’s growing demand. Government funds that support the care and treatment of the mentally ill are not adequate (Raffel and Raffel 1994, 178).

**Conclusion:**

An analysis of the health care successes and challenges of Cuba, India, and the United States indicates that each country excels in some areas and lags in others. (See Table 1 in Appendix for a summary of health and economic indicators for Cuba, India, and the United States.) This thesis has shown that for Cuba, success is two-fold.
Domestic achievements include community-centered medicine and greater awareness of health maintenance and prevention on the part of patients. Adopting these practices has been highly beneficial for this country hindered by asymmetric health care knowledge and distribution. For this developing country, success was achieved once the government took full ownership of its population’s health care needs. It has been shown that Cuba’s achievements in medical diplomacy have allowed them to extend their resources and educational facilities to their struggling neighbors.

From India, it was evident that private health services represent a booming industry motivated to tackle health care accessibility discrepancies. In this developing country with an emerging middle class, facilities that provide medical care of a higher quality and lower cost than what is provided by substandard government-sponsored hospitals could certainly help close the gap in unequal medical services.

Finally, the United States’ achievements in establishing rigorous medical institutions and setting high standards for continuing education are evident. Medical schools improve their quality of care by placing emphasis on the amount and diversity of clinical experience that physicians receive before entering practice. In addition, the standard certification and licensure approval processes indicative of the United States allows this country to better regulate their physician networks at a national level.

The results of this comparison point clearly to successes that translate from one country to the others. For instance, community-based medicine, a Cuban success story, can be easily adopted by India and the United States. By disseminating medical resources from the national level to local populations, Indian and American physicians in a given
area would be able to treat more people within that community. More personalized medical care could stimulate patients to take control of their own health management. In India and the United States, the governments arguably need to provide more subsidies for their health care systems. More subsidies also need to be provided for the cost of education in order to bring down the cost and reduce impediments for talented, financially strapped students.

In India and the United States physicians are both highly respected and highly paid. Unfortunately, in Cuba, doctors are revered but not well paid. In recent years Cuban doctors have been forced to seek jobs in the lucrative tourist sector in order to compensate for their low earnings from the state. In short, Cuba needs to find a way to better remunerate the country’s doctors. Revolutionary solidarity is a high ideal, but Cuban doctors should not have to moonlight as taxi drivers in order to make ends meet.

Health care discrepancies, including asymmetric distribution and quality, represent earlier dilemmas that are no longer acceptable. Governments are quickly realizing that successful health indicators, political stability, and economic development are interdependent, and success in one area can create a rewarding domino effect. Each country’s successes can be instructive to other countries throughout the world. This comparison of three countries’ experiences with health care is a small step in the process of searching for solutions.
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Appendix

Table 1. A comparison of health and economic indicators for Cuba, India, and the United States.

<table>
<thead>
<tr>
<th></th>
<th>Cuba</th>
<th>India</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>11,423,952</td>
<td>1,147,995,898</td>
<td>303,824,646</td>
</tr>
<tr>
<td><strong>Infant Mortality Rate</strong></td>
<td>5.93 deaths/1,000 live births</td>
<td>32.31 deaths/1,000 live births</td>
<td>6.3 deaths/1,000 live births</td>
</tr>
<tr>
<td><strong>Life Expectancy</strong></td>
<td>77.27 years</td>
<td>69.25 years</td>
<td>78.14 years</td>
</tr>
<tr>
<td><strong>Government Type</strong></td>
<td>Communist state</td>
<td>Federal Republic</td>
<td>Constitution-based federal republic</td>
</tr>
<tr>
<td><strong>GDP</strong></td>
<td>$51.11 billion</td>
<td>$2.965 trillion</td>
<td>$13.86 trillion</td>
</tr>
<tr>
<td><strong>GDP per Capita</strong></td>
<td>$4,500</td>
<td>$2,700</td>
<td>$46,000</td>
</tr>
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