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**“Cuba Got Health Care Right, and It’s About Time We Did the Same: An Analysis
of Primary Care in Cuba and the Possibility of Universal Primary Care in the United
States”**

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Providence College

Global Studies Senior Thesis

May 4, 2011

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INTRODUCTION

In the 1948 United Nations Declaration of Human Rights, Article 25 states that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.” Article 12 of the 1977 International Covenant on Economic, Social, and Cultural Rights identifies “the right of everyone to the enjoyment of the highest available standard of physical and mental health. [to be implemented by] the creation of conditions which would assure to all, medical service and medical attention in the event of sickness” (Project EINO). Both of these documents were signed by the United States. They were also both signed by Cuba. However, the degree to which these two countries have established and upheld the conditions of these treaties differs greatly.

EXECUTIVE SUMMARY

In this research review, I hope to demonstrate that in order to protect one's right to health, primary care must be the principal focus of a country's health care system. I will demonstrate the link between a strong primary care system and better health. There have been analyses of Cuba's health care system and the way in which its focus on primary care for all citizens has improved Cuba's health outcomes. Studies have looked into the link between a strong primary care focus and positive health outcomes in this developing country that has found itself among the ranks of developed nations' health indicators. The United States has been the focus of much research concerning its faulty primary health care system. The lack of access to primary health care is impeding the potential of more positive health outcomes here. Recent studies have placed the United States far down on the list of healthy nations compared to other industrialized countries. Recent health reform initiatives in the US seek to fix this failing system in part through restructuring primary care. Interestingly, the measures that the United States is trying to take to evaluate and restructure its primary care system mirror many of the characteristics of the Cuban system.

In analyzing the literature on this subject, I wanted to keep some questions in mind:

- How do primary care services promote health as a right and ensure better health outcomes?
- Does current health care reform in the US primary care sector mirror characteristics of the Cuban primary care system?
- What role does Cuba's specific primary care system play in facilitating Cuba's positive health outcomes?

- If the United States primary care structure were modeled off of the characteristics of Cuba's system, might that be the cure for our country's ailing system?
- Because Cuba and the United States differ in political and economic structure, what will be the key to implementing a Cuban-type primary care system in the US?

NARRATIVE OF THE LITERATURE

Section I: The Importance of Primary Care

First, I wanted to understand the importance of primary care and its connection to the promotion of health as a human right. I have chosen two United Nations declarations as my evidence of health being a right, along with the writings of the World Health Organization, the designated health authority of the UN, as a starting point of this analysis. Over the past 30 years, WHO has released various documents asserting the importance of health promotion for all individuals regardless of economic or social status, the duty government has toward its people to provide avenues for attaining and maintaining the status of good health, and the fact that primary care is the essential facilitator of these goals.

In September 1978, the International Conference on Primary Care was held in Alma-Ata in the former Soviet Union. The conference defined health as “the state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.” It is a basic human right which demands the attention not only of the health care sector, but the economic and social sectors as well. Like the gap in wealth between the developing and developed worlds, the gap in health is also widening. They argued that “people have the right and duty to participate individually and collectively in the planning and implementation of their health care.” They laid the responsibility for health on governments and stressed that primary care is the key to attaining “a level of health that will permit them to lead a socially and economically productive life.” However, primary care cannot and should not be universally defined or applied, but rather is a reflection of the “economic conditions and socio-cultural and political characteristics of the country.” They acknowledge the misdirection and mis-prioritization of

funds toward programs like the military in place of sufficient support for health care systems (The Declaration of Alma-Ata, 1978).

WHO has recently released statements and world reports about primary care, highlighting its role as the strengthening force behind building successful health systems. In August 2007, Dr. Margaret Chan, Director General of WHO, gave a speech at the International Conference for Health as Development in Argentina entitled “The Contribution of Primary Care to the Millennium Development Goals.” She argued that “primary health care is the best route to universal access, the best way to ensure sustainable improvements in health outcomes, and the best guarantee that access to care will be fair.” She also reiterated that there needs to be a more in-depth and evidence-based analysis into costs and benefits of different primary care models by looking into what has worked best where. Proof of successful programs comes from measuring both health infrastructure and outcomes, as she says “what gets measures gets done” (Chan, Buenos Aires 2007).

In November 2007 at the International Seminar on Primary Health Care in Rural China, Dr. Chan defends the innate interconnectedness of public health programs and primary care. Both educate populations about risks and dangers to their health, both are grounded in the moral tenant of health equity, and both focus on prevention as a means to avoid costly and resource-draining reactionary care. She notes the way in which globalization and the growing gap between the rich and the poor has also fueled gaps between health statuses in urban areas versus rural areas, and between privileged insurance-carriers versus out of pocket payers. However, evidence has shown that “a country’s income level is not an absolute determinant of health status in the population.” What is more critical is the organization and management of health services, even with limited resources. Evidence has shown that even poor nations have the capacity to

organize and manage a successful healthcare system, one that focuses on education, equity, and prevention, if they focus that system on primary care. It is through the examples of these healthy poor nations, that we see evidence that “health systems oriented towards primary health care produce better outcomes, at lower costs, and with higher user satisfaction.” No matter how limited a government’s resources may be, good governance will be seen as efficiently using those resources for even the most helpless and marginalized citizens, because they recognize the value of every single human life (Chan, Beijing 2007).

In WHO’s World Health Report of 2008 entitled “Primary Health Care: Now More Than Ever,” the organization dedicated itself to a set of reforms based the fundamental values of primary care and the demands of the people who have seen the health system fail them far too many times. Their goals include universal coverage reforms so that health equity and social justice are ensured, service delivery reforms so that health services are relevant to the needs and expectations of the people, public policy reforms to bolster national and global public health coordination with primary care, and leadership reforms so that health systems reflect the cooperation of both the government and the people. Though these goals are imperative for both rich and poor nations, she reiterates that globalization has created a world in which each country’s infrastructure, resources, and needs are distinct. Therefore, these reforms are not a “blueprint” and must be appropriately catered to each specific country’s circumstances (Chan 2008).

Section II: Comparing Cuba and the United States

In understanding the tenants of primary care and the potential it has to improve health outcomes, it is important to reiterate the hope it holds for countries of all economic conditions,

especially amidst globalization and its facilitation of an unequal distribution of wealth and resources. I have chosen literature that specifically focuses on health and primary care in the United States and in Cuba not only because of these two countries' stark political and economic differences, but because of their isolation from each other as a result of the US embargo.

The World Health Organization and the Medical Education Cooperation with Cuba have both researched the health expenditures of each country and the relation of health spending to positive health results. I chose to look at the statistics of these two organizations specifically because they both reflect the statistics of or include statistics contributed to the United Nations' data, and they use the specific health indicators on which the UN focuses. According to WHO, the United States' total expenditure on health per capita was \$6,714 in 2006, while the total expenditure on health as a percentage of GDP was 15.3%. In Cuba, the total health expenditure on health per capita was \$363 in 2006, while the total expenditure on health was 7.1% of GDP (WHO, 2010). According to the Medical Education Cooperation with Cuba, in terms of government expenditure on health as a percentage of total health expenditure, the Cuban government covers 87.8% of health care costs, while in the United States that percentage is only 44.7%. Cuba boasts 62.7 physicians per 10,000 people, while in the US that number is a mere 26.3. The United Nations Population Fund, the UN Development Program's Human Development Index, and the Cuban Ministry of Health have all released statistics that demonstrate the similar health statuses of the two countries, with Cuba even having a slight edge over the U.S. in some categories. There are more HIV/AIDS deaths in the US than in Cuba, with HIV prevalence being almost nine times higher here in this country. In 2006, Cuba had a lower infant mortality per 1,000 births compared to the United States (5.6 to 7 respectively), and was more or less equal to US statistics regarding life expectancy. The top three causes of death in

both Cuba and the United States are the same: heart disease, cancerous tumors, and cerebrovascular disease. Cuba was the first country to eliminate polio in 1962, the first country to eliminate measles in 1996, it has the lowest AIDS rate in the Americas, and boasts the highest rate of treatment and control of high blood pressure in the world (MEDICC, 2007).

What do these numbers indicate? Though Cuba spends much less on health care, it has succeeded in creating a more accessible system than that of the US and its health indicators are on par with if not better than a country that spends many more health dollars. What is even more estimable is that Cuba has achieved this in light of very limited domestic and foreign financial and physical health-service resources because of the US embargo. The last statistic presented regarding leading causes of death indicates that Cuba has achieved a health profile much like that of a developed, Global North nation.

NPR released a report on November 18, 2010 conducted by the Commonwealth Fund looked at eleven developed nations and compared their patient experience data. They analyzed factors such as costs, ability to pay bills, and interactions with insurance companies. What researchers determined was that “when it comes to health care, it's generally the case that the care in wealthy countries is better than in impoverished ones. But a country's GDP only goes so far in predicting how things will go.” The US found itself below Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom. For example, only 58% of Americans felt that they could afford sufficient health care. 20% of Americans claim to have trouble paying medical expenses, while the next highest percentage is a mere 9% in France. One-third of Americans paid \$1,000 or more out-of-pocket medical expenses, a total much higher than in the other countries. They note that insurance status affected minority populations more than whites, indicating that our insurance system may

increase health disparities. The only thing the United States scored high in was the availability of specialists (Barclay, 2010). Well, that certainly says a lot about our primary care system. We probably wouldn't see a report like this in Cuba.

Section III: Cuba's Achievements and Model of Primary Care

How has Cuba achieved all this? According to the World Health Organization, it is through their commitment to community-based, universal primary care. In a review published in 2008 entitled, "Cuba's Primary Health Care Revolution: 30 Years and On," WHO analyzes Cuba's primary care system and the way in which it has quite possibly become the world's "most effective and unique." For Cuban health officials, their country's notable health status is predominantly the result of their emphasis on preventive care. They have developed a primary care infrastructure that focus on universal access, quality, and the integration of services to guarantee cost and resource efficiency. In the 1960's, the Cuban government created a program that would ensure that even the poor, rural population had access to primary care. They contracted 750 physicians and medical students for part of their professional lives to work in the medically underserved communities. The Rural Medical Service provided "disease prevention and to revitalize health services for those most in need, whether because they are poor, in precarious health or live far from urban centres." Dr. Cristina Luna, Cuba's national director of ambulatory (primary) care, asserts that "we were conscious that prevention had to be a cornerstone of our system, and that people had to be understood in all their dimensions: biological, psychological and social [and] as individuals, within families, and within their communities" (Reed 2008).

This report highlights the polyclinic, the foundation of Cuba's primary care infrastructure. A polyclinic is composed of neighborhood-based primary care physician offices known as consultorios. Physicians and their primary care teams are responsible for a certain number of patients/families in a designated geographic neighborhood (Dresang et al 298). There are secondary care facilities including but not limited to emergency services, psychiatry, and rehabilitation to ensure accessibility for patients and the coordination of these services with primary care. Primary care includes family and internal medicine, obstetrics and gynecology, and pediatrics. Because polyclinics are community based, apart from foundational services each polyclinic may be different depending on the specific needs of their service population. Community screening is an integral part of primary care services, so that, for example, if there is a high hypertension rate among a community, doctors might step back and ask some important questions. Why do they have hypertension? Does it seem to be genetic? Are the sufferers heavy smokers? Is it something in their diet? They can then look into who in the population is predominantly affected and how to go about treating them most affectively. Primary care also addresses the issue of patient satisfaction. Luna argues that "we have to pay more attention to patient satisfaction... the day we think we're doing everything right is the day we've abandoned our patients, and also abandoned our commitment to the principles of Alma-Ata" (Reed 2008).

Section IV: The Family Doctor Model

José Díaz Novás, an assistant physician and Deputy Director at the Alamar Teaching Polyclinic in Havana, Cuba, and José A. Fernández Sacasas, a professor of medicine at the Higher Institute of Medical Sciences of Havana analyzed Cuba's current Comprehensive General Medicine model, calling this family medicine model "the highest expression of healthcare

delivery in the Cuban healthcare system.” The authors argue that the family as a whole becomes the focus of care because the realization is made that family problems may negatively affect health and the family unit holds potential for helping with preventive, curative, and rehabilitation methods. The fact that doctors live in the actual communities they are serving allows for better monitoring of social morbidity and environmental problems that could affect health. Such problems affecting their patients would also be affecting them, so they would work to alleviate health risks. They are also available all day, every day, not working on a set schedule but giving their services when and where they are needed. Close ties to both their patients and their patients’ families allows them to more closely assess risk factors and catch diseases early. Because doctors come to family homes, they can empower both their patients and their caregivers by teaching at-home care methods. Hospitals are embedded in the polyclinics, allowing primary care physicians to visit their patients, participate in differentials with the hospital physicians, and make treatment suggestions. They argue that based on these tenants, this family doctor system most successfully meets the present and future health needs of the Cuban people (Novás, Sacasas, 1989).

Section V: Public Health-A Joint Endeavor

This research seems to indicate that Cuban primary care ideology and services are concentrated in each of their local programs. Nevertheless, a joint WHO/UNICEF study done in 1975 presents Cuban doctors as linked in solidarity, committed to the overall health of the country and not just that of their own service communities. They note that everyone who works in the health sector belongs to the same union, which unites them in interest and responsibility. They also argue that “each health worker at every level has the same philosophy and a very clear

understanding of what his responsibility is in the accomplishment of the goals” (Djukanovic, Mach, 1975). Though the study was conducted over 30 years ago, I will argue that this philosophy is still pertinent to the passions of Cuban health professionals today.

The Cuban system reflects the ideas presented at the beginning of this review that argued the importance of primary care in its contribution to better health. The Cuban Constitution declares health care to be a right that every Cuban citizen has, and it is the Cuban government’s responsibility to ensure that its citizens are healthy (Campos, 2004). The founding of the United States was preceded by the colonists’ refusal to be taxed without representation: essentially taxed without their consent. However, as is noted by the activist organization Project EINO (Everybody In, Nobody Out), “there can be no doubt that this foundation of our nation is being violated by the denial of health care services to many millions of Americans, even though they pay hefty taxes to fund public health care.” They argue that 65% of our country’s total health care expenditure is provided through public funding (righttohealthcare.org). The goal of recent health care reform in the United States is to redesign primary care in a way that more fairly and successfully guarantees everyone the right to health. In this review, I wanted to specifically focus on one element of current primary care advocacy and reform, which is the Patient-Centered Medical Home model of primary care. I wanted to see if this model mirrored the polyclinic and family doctor model of Cuba in any way. I am also looking at primary care initiatives specifically targeting rural and underserved populations in this country to find any parallels with Cuban programs.

In March 2010, the Affordable Care Act was passed by the Obama administration. It “puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality

of health care for all Americans.” (Healthcare.gov, US Department of Health and Human Services). The government is trying to bridge the insurance gap, giving affordable coverage options to the over 32 million Americans who would otherwise completely go without. If you purchase or join a new insurance plan after September 2010, preventative services like newborn care, immunizations, and mammograms now need to be 100% covered by one’s insurance company. By 2014, a competitive insurance marketplace will be established in which small businesses and everyday Americans can buy affordable health care coverage through state-run health insurance exchanges. The government has also drawn up a Patient’s Bill of Rights aimed at protecting American’s from insurance company abuses (White House, 2010). This act tightens the reins on insurance companies by keeping premiums down and prevents unfair denials of care such as for Americans with pre-existing conditions. It also aims to address budget crises, “reducing the deficit by more than \$100 billion over the next ten years – and by more than \$1 trillion over the second decade – by cutting government overspending and reining in waste, fraud and abuse.” (Healthcare.gov)

The American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association have joined together to define both the concept and operational structure of a medical home and promote the understanding of its link to effective primary care and good health outcomes. They lay out seven key principles:

- that each patient has an ongoing relationship with a personal physician who provides them with ongoing, comprehensive care
- that this personal physician leads a team of individuals who work collectively at the practice level

- that the personal physician takes responsibility for providing for all the patient's health care needs or appropriate arranges care with other qualified professionals
- that services are is culturally and linguistically competent
- that quality and safety are assured and patient feedback and input is considered
- that access is enhanced through longer hours and improved means of communication between the practice and its patients
- that the medical home model is financially feasible and encouraged through rewards for quality and efficiency improvements

According to the four aforementioned groups, who together create the Patient Centered Primary Care Collaborative, the fundamental goal of a medical home is to provide “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care” (PCPCC, 2007).

To further elaborate on the Patient-Centered Medical Home idea, a 2006 study conducted through the Commonwealth Fund's Health Care Quality Survey demonstrates the importance of a medical home in promoting health equity:

[In] a medical home- defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers- racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. (Beal, et al, 2007)

We see evidence that the medical home exemplifies the three main tenants of primary care: education, equity and prevention. At first glance, the goals of the Patient-Centered Medical Home seem to parallel the goals of the polyclinic system and family doctor model of Cuba.

The National Health Service Corps, under the US Department of Health and Human Services, is a program that mirrors the same principles of the Rural Medical Service of Cuba. They offer scholarship and loan repayment options to new physicians in exchange for a designated number of years of service in Health Professional Shortage Areas (HPSAs). This program works to narrow the gap between those who geographically do not have proper access to medical care and those who do (nhsc.hrsa.gov). Community Health Centers also help in tackling the issue unequal access to primary care. The mission statement of the National Association of Community Health Centers is “to promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.” These health centers do not only provide services for people without insurance or without sufficient insurance coverage, but also specifically the elderly, homeless, farm workers, and public housing tenants (nachc.com).

These primary care initiatives in the United States all aim to close a gap that exists in our current primary care infrastructure. What I think is also important to consider, though, is closing the gap among physicians as well. Research has identified the solidarity of Cuban physicians. Does that solidarity exist among health professionals in the US? How is the US facilitating this type of “teamwork” in the primary care sector? Further research into our health reform initiatives seems to suggest that national measures for achieving improvements in primary care delivery by adapting medical home status seem to be the forces facilitating this solidarity. An

example of these measures would be the National Committee for Quality Assurance and its performance measure program that helps practices gradually adopt the medical home model. Therefore, all those in the primary care sector who align themselves with a plan like that of NCQA are united in their common passion for the patient-centered medical home and the improved health outcomes that it perpetuates.

Analyses have been done to understand the way in which Cuba could serve as a primary care example for the U.S.' primary health care system. For instance, Stanford University Physician Paul Drain has argued that the US should be dedicating more of its attention to understanding the structure and success of primary care in Cuba, but we have failed to do so thus far. Drain argues that their success starts in their medical education system. "Almost all their residents do family medicine. They focus on primary care for all ages. Once everybody learns primary care, about 35 percent go on and specialize. It's quite the opposite of what we have here." He points out that in the United States, only 7-8% of physicians go into family medicine. Education is paid for by the Cuban government, so students do not graduate with an overwhelming debt that might propel them toward a higher-paying specialty outside of primary care (which is the problem we face here in this country) (Drain, Wired Science, 2010). Preventive medicine also ensures that medical problems are detected early. That is why in Cuba, there is a low utilization of hospitals because all patients are receiving care from a primary care physician. Health problems are caught by a frequent review of medical history, screenings, and well-visits (Butterfield, 2010). We see the opposite in the US and an over-utilization of hospital services, as more and more people need to use the emergency room as their place of ongoing care because we do not have a system of universal access to primary care. (Fitz, 2011)

COMMON THEMES WITHIN THE LITERATURE

In researching both the concept and organizational structure of primary health care in both Cuba and the United States, certain themes have permeated the literature.

- Both the US and Cuba have signed international documents which declare health to be a human right.
- Primary care seems to be the most effective health service in guaranteeing health as a right through its most basic tenants of education, equity, and prevention.
- Successful primary care programs can be implemented in any country no matter their economic standing: meaning that even very poor countries are capable of achieving positive health outcomes and good overall health status.
- Wealth does not necessarily equate with a good health care system; we need to conduct more evidence-based analyses into the costs and benefits of different primary care models to determine what has worked and what has not worked
- Cuba has structured its health care system based on its commitment universal health care and its belief that primary health care is means of achieving optimal health.
- Recently, the United States has been working towards reforming its primary health sector so that health is less of a privilege and more of a right, as they promised to do in signing these international accords. The measures they are taking appear to have much in common with Cuba's primary care model.

FOCUS OF MY RESEARCH

What I aim to more effectively demonstrate in my personal research are the clear parallels between the principles and structural components of Cuba's primary care system and what we see being proposed for primary care reform in the United States. I will focus on the elements of the Cuban model that have proven to be most effective in promoting the three most fundamental tenants of primary care: education, equity, and prevention I will then compare these specific elements to their equivalents in the US.

Ultimately, I wish to propose what I think would be the most successful and accessible primary care infrastructure in the United States based on the admirable health status of Cuba. The Cuban model might be just what the doctor ordered for an ailing American primary care system that spends far too much money on services for only those who can pay for them.

Cuba got primary care right. It's about time that the United States did the same.

WHY AM I RESEARCHING THIS TOPIC?

Through my internship at the Rhode Island Department of Health in the Office of Primary Care and Rural Health, I have come to both understand and appreciate the importance of primary care in maintaining overall health. Through my projects at the Department, I have studied the unjust degrees of disparity within and lack of access to primary care services in the United States. Specifically, I have done research in regards to access problems for minority, low-income, and rural populations. For two summers, I worked as a clinical student in a pediatric primary care practice and directly observed the importance of well-visits, developmental and clinical screenings, education and counseling, and preventive measures like immunizations. Children can be assessed for risk factors starting from birth, and problems that could be disastrously detrimental to their health can be caught early and either treated or more effectively managed. I have observed the role of a primary care physician in the life of a child with a chronic illness. I have seen how difficult it often is to coordinate care between the primary care physician and other specialists and hospitals. In my research, as a culmination of my past experiences and observations, I aim to present the dominant role of primary care in improving health, the success of the primary care model in Cuba, and the current health care infrastructure and reform goals of the United States. How can we make the US health care system all that it has the potential to be? Does the United States have the infrastructure, the funds, and the facilities to create a system like that of Cuba? Or, is it more about a mentality, a philosophy of health that has created a very inefficient and disappointing US system?

METHODOLOGY

My research was primarily scholarly based with one lengthy interview and some participatory action research. My scholarly investigation was centered in past U.S. public health research initiatives, the Medical Education Cooperation with Cuba (MEDICC), and current US health reform policies and initiatives. My interview with interim Rhode Island Health Director and primary care advocate Michael Fine, MD will be described below in greater contextual detail. My participatory action research refers to my internship in the Office of Primary Care and Rural Health at the Rhode Island Department of Health. I have inputted data for the US Department of Health Resources and Services Administration for Health Professional Shortage Area (HPSA) designations, deemed so for “having a shortage of primary medical care” (HRSA). This data has given me insight into primary care capacity and need in Rhode Island specifically. Because of my work with this data, I have also had the honor of being named to a Primary Care Workgroup committee working closely with the Interim Health Director, Dr. Michael Fine. This committee will be conducting a primary care capacity and cost analysis in Rhode Island in support of efforts to redesign the provision of primary care in the Rhode Island to a population-based, cost efficient, and equitable system that will produce better health outcomes. This participatory research aligns closely with my scholarly investigation into the effectiveness of primary care infrastructure in Cuba and in the United States and what the US might be doing to reflect the effectiveness of Cuba’s system.

RESEARCH

Dr. Michael Fine, Population-Based Medicine, and the Scituate Health Alliance, Scituate, Rhode Island

Dr. Michael Fine is currently the Interim Health Director of Rhode Island and the Medical Programs Director at the Rhode Island Department of Corrections. He is a family physician and Managing Director of HealthAccessRI, which is the first statewide organization in the country to provide prepaid, reduced fee for service primary care available for people without employer provided insurance. Fine has experience in both urban and rural medicine, having practiced for 16 years in urban Pawtucket, Rhode Island, and rural Scituate, Rhode Island. He was the Physician Operating Officer of Hillside Avenue Family and Community Medicine, the largest family practice in Rhode Island, and Physician-in-Chief of the Rhode Island and Miriam Hospitals Departments of Family and Community Medicine, until December of 2008. He is Vice Chair of the Board of Crossroads RI, caring for Rhode Island's homeless, and Co-Chair of the Allied Advocacy Group for Integrated Primary Care ("Michael Fine, MD," 2007). I became interested in Dr. Fine's work when I learned about the Scituate Health Alliance. Fine is its founder. It is a community-based population-focused community nonprofit that, through its services, made Scituate Rhode Island the first community in the US to provide primary care to all town residents.

In my interview with him, Dr. Fine exuded his passion for primary health care and his frustration with the current US health care infrastructure. First of all, he said that the US doesn't have a health care system, "we have a marketplace." This further legitimizes my point that health in this country has become a privilege. Whoever can afford to pay into the marketplace can afford to be healthy. He also argues that health isn't just about health care access for

individuals; it is about seeing health care as a population-based initiative. Population-based primary care, therefore, is the only way to ensure that health outcomes aren't improved one drop in the bucket at a time, but rather through progress like a gushing faucet.

I asked Dr. Fine if he believed that the US health care system was based on the idea of health as a right:

Michael Fine: There is no US Health Care system. There is a market place. We do not have an organized approach to supplying a set of services to a population of people, which is how I would define a health care system. If we do not have an organized way to supply services, then we have no intelligent way to ask for outcomes. We suffer huge costs.

I went on to ask, then, if he believed that health is a right:

MF: I personally am a little weird on this issue. I don't think health care is a right, and I don't think it's a privilege either. I think health care as a rubric is a little broad. One wants to draw the distinction between health care services and primary care and individual health, which aren't well reflected in our policies because they all get mish-mashed together. I rely on the work of John Rawls who wrote *Justice As Fairness*. He looks at health care as being there to provide a reasonable level of health that is required for people to participate in a democracy. Working backward from that, one can argue that the purpose of a health care system is to deliver services that produce a reasonable level of health so that people can participate in a democracy. Those services which have to do with creating a reasonable functionality ought to be what we provide, and those services which don't ought to be privately obtained....

MF: I don't like the "right" thing. When you think about it the rights of life, liberty, and the pursuit of happiness are essentially freedoms guaranteed by a democratic government. Health and health care aren't freedoms that a democratic government can guarantee. Health care is a set

of services, some of which are meaningful and some of which are not. And health is clearly the interaction between, well, for me, health is the ability to function in the relationships appropriate to someone's life or lifestyle. And that is functionality not a right per se, so I don't think it's something that a government can actually guarantee, but it's necessary in order to have effective government with democratic participation. I think we need a health promotion movement that in my mind is similar to the civil rights movement because without people having equal access to health to what's needed to create functionality you don't have functional democracy, and when you don't have functional democracy you have the progressive split between groups and that leads to social instability. And that's different than saying that health care is a right. I'm just trying to be intellectually anal I suppose. It's not like something you get for being a citizen.

Me: So it's more like something you should just have.

MF: Yes, at a certain level. We've sort of crossed over to the other side as we've attempted to use health insurance to deliver health services. And the danger is, when you call it a right that under the umbrella of health insurance, all sorts of health care profiteering occurs in ways that are making health impossible. Health insurance should not be a right. I think health insurance is the problem not the solution. Let's build a health care system. Because when we build a system that carefully decides what services ought to be delivered to which people then we've got something. Getting into the right argument kind of covers that up.

Me: That's very interesting because I feel like everything that I've read, all of these international documents are focusing on the rights issue.

MF: And I know where they're coming from, and emotionally I'm on their side. But, I think they have to be careful because if you say it wrong, people exploit it and boy is that what's happening these days. We're bankrupting the country so that we can't afford education, housing,

protecting the environment in the service of what purports to be health care services but what have nothing to do with health. Big predictors of health are social determinants, not medical services; they're education and housing etc... have to be careful to sort it out so that you don't suffer the weight of unintended consequences.

Me: Yourself being a primary care physician (PCP), do you see the link between primary care and better health outcomes and what is the nature of that link and why is it so important?

MF: Get me wound up on this one, that's easy! Primary care is probably the only health care service that is strongly associated with health outcomes. The number of primary care physicians per 10,000 population, primary care supply, which is a very unsophisticated measure for health care but it's the best one we have. Is associated with every positive measurable outcome we have: infant mortality, heart disease mortality, cancer mortality, life expectancy, correlates positively with just the number of primary care physicians (PCPs) per 10,000 pop. Probably to a certain extent it's an epi-phenomenon, happens around population density, and who's a primary care physician and where there are a lot of PCPs. In rural areas, two things happen. One is if you get really sick you realize you're not going to survive you move to a city. You move to a place where there are a lot of specialists, not a lot of PCPs. We sort of have a negative effect of the measure of health outcomes because specialists attract sick people, more people at risk of illness and death. A corollary to that is that places with a lot of health people attract primary care physicians. So at the end of the day when you look around the world I think the evidence is pretty strong that it's the only service that really matters. There's probably some level of hospital care that you need. We don't know what that is. And there's probably some level of specialty care that you need. We don't know what that is. But we know that primary care actually matters. And any rational health care system needs to begin with primary care and I'm

not sure we know yet what else we need. The rest you could probably sprinkle in later, seasoning to taste.

Me: I'm going to use the Scituate Health Alliance and compare it to the polyclinics in Cuba to see how they're really similar in structure and in philosophy. Tell me more about why you started this model, your philosophy behind it, and what has resulted from it?

MF: Before I went to medical school I was a community organizer working in the housing movement in the south Bronx. It was a really devastated area. There's no place you can go in America that looks like that looked then. In those years, it was a burned out a place as you could imagine. Mostly Hispanic and African American. The housing stock had been abandoned by landlords. So basic services heat and hot water didn't exist. It was drug infested, the police were afraid to go there, half the buildings were burned down, and they were stripped by people looking for copper and wire. The organization I worked for did a lot of tenant organizing and began to look not just at each house, but at what a neighborhood was like and what kind of infrastructure you needed in a neighborhood to support reasonable human life. I ended up getting the health care portfolio because I was thinking about going to medical school. I ended up training local health care workers because there was nothing else. The more powerful thing was thinking about what about health was individual and what about health really came out of the many kinds of services functions that existed in the neighborhood. Can you have health without a sewage system? Can you have health without a pharmacy within two miles? Can you have health without a grocery store, with bad air, where crime is rampant? This multi-factorial nature of health presented itself to me. And in medical school, I took the epidemiology stuff fairly seriously probably because of that. I began to think about the denominator. When I was in the Bronx there was something called Service Areas. There was a whole health planning process

that existed in the late 70s and I got to see some of that process and see how you go about planning for a population as a whole. So, that kind of got me interested in the question of the denominator. The difference between individual health and public health is actually quite substantial. Public health when you think about it is outcomes expressed as they exist in over a denominator of people living in a geographic place. When we do public health, we do it to do exactly what you're doing, to compare places. Is the social organization of Cuba better than that of the South Bronx or of England or of France, or of Egypt? The real question how should we be together? If we try it this way what happens. The public health stuff is going to help us see the outcomes and then we reflect back on the organization. Individual health is completely different, it's partially subjective and has more to do with individual function. It doesn't have to do with comparisons from person to person. I became obsessed with the denominator. I became aware that we didn't have a mechanism for taking and impacting the denominator directly. If I come up with the best medicine in the world to treat high blood pressure and I give you that medicine because you have high blood pressure hopefully you will live a long time and that's nice. But unless I give it to everyone who has high blood pressure in a specific place, my ability to impact the outcome from a public health perspective is exactly zero. And that's where this notion of population based primary care developed. The notion that if you have primary care that is responsible for the care of everyone who lives in a geographic area that goes back to my Bronx experience. And if everyone in that geographic area has access to the same primary care facility, then you can in an organized way improve the measured health outcomes of a population. But if you don't have population based primary care you have no way to impact the health of the population and no way to do it in a way that's fair and gives everyone the same level of service. In the mid 90s, I stumbled on a number kind of on accident. How much it cost us to deliver care

to do primary care for all the people we care for expressed per person per year which is how we think about the costs of other services. And the number kind of blew my mind. In those years it was about \$100 per person. It was such an amazing realization. Even in those years the overall cost for health care per person per year was like \$3-4,000 and we're spending \$100 on the primary care piece and there was data emerging that the primary care piece was the only service that mattered. We were spending next to nothing on primary care and \$3,900 on nothing that mattered. I wondered how that compared to other services that towns and cities provided for themselves like roads, fire and police protection, so I got with an economist at Bryant and we made that comparison and found out that not surprisingly that primary care was affordable by communities because other things were that were similar. So, I really started thinking a lot about population-based primary care. I live in Scituate. In 1999, two insurers left RI inside of 6 weeks. It had to do with politics more than anything. Blue Cross Blue Shield at the time was corrupt and made a deal to get the state employee contract, the only lucrative business so other guys said this is a fixed deal I'm outta here. That freaked everybody out. [In Scituate], I had a bunch of patients on the town council, I asked if they wanted me to explain how health insurance works, they were really worried that their health insurance costs were going to go up (which they did) and that they'd have to raise taxes (which they had to). So, I explained how demand is driven by new technologies and utilization is driven by people with something to sell and I sort of mentioned this whole population-based primary care idea because I think if you guys really want to save money, build a primary care center that serves the entire town and you'll save money, outcomes will go up, you'll be able to contain the costs of your health insurance, what a deal! One of the members on the town council had been minority leader in the state house of representatives and he had spent his whole life trying to get Medical Savings Accounts into

Rhode Island law. He thought that was the solution to everything. And he said can you make this work with Medical Savings Accounts and I said let's do it and I made up how to do it on the spot. It seemed like one could use Medical Savings Accounts to fund a population-based primary care process.

Me: How do Medical Savings Accounts work?

MF: Basically, instead of spending \$6000 a year on health insurance you put that in a special pre tax savings account, you don't get taxed on this money. Out of this account has to come a payment for high deductible health insurance, \$2000-\$3000-\$4000. The thinking is that the high deductible health insurance, which is much less expensive than classic health insurance, will give you personal financial protection in case of illness or injury which is what people really want from their insurance. And then it sets those people up to be purchasers of all other services, and the conservative republican assumption is that they'll look competitively at those services and decide what they want. Because they're conscious of price it'll force prices down by being selected purchasers. And it makes a sort of sense. My critique has been who's likely to buy that? Essentially healthy people will buy that leaving poor people in the pool and health insurance for everyone else will become so expensive and unaffordable. Also, if people have to pay for everything themselves they won't get preventive health care. So we decided to solve most of those problems when we said lets redo Medical Savings Accounts and make it so you have to by the high deductible but you also have to spend \$200 per year on primary care bought through the town process. That creates a funding mechanism to build the primary care center for a town because it has a guaranteed inflow of money. (Now it's \$300 per person per year). So if you have to have primary care, if you have primary care that's prepaid whenever you get sick if you have to pay for everything else, the first thing you're going to do is go see your PCP. This

drives people to primary care. You've got a funding mechanism to pay for the primary care. And because of the self-insured portion, people will be cautious about the more expensive specialty services they might otherwise get and that will drive those prices down. And in fact that there has been some evidence that that happens. But no one has been able to put together this redone version of medical savings accounts marrying the required primary care component to the high deductible component. We thought we could. The town council said "Boy does that sound cool!" So they called a meeting and said see if you can figure out how to do it. The first cut was to try to do everything at once, to build the primary care center, to put up the medical savings accounts, I naively thought this would be the most grant fundable idea that's ever come down the pipe. We get a grant, we put up the center, we take that center and use it as the base for the medical savings accounts so its sustainable, the accounts would save the town money and everyone would live happily ever after. Now, none of that was easy. We couldn't find any grant funding. In those years, all people were funding was disparities stuff. Scituate was a middle class town. No one was doing research really on health services distribution, and they figured well Scituate ought to be able to pay for things themselves, but the council didn't want to front money for something that had never been tried before though they kind of liked the idea, it was kind of a big bite for them to sort of redo health policy in the US all by themselves. And so we weren't able to build that kind of dream. I still believe if we had had grant funding on the front end we would have an actual health care system in the US because it was going to work, the architecture was sound. And every health policy person I've talked to who knows what they're doing will tell you that it will work if it was politically possible, but it's not politically possible. It turns out you can't buy high deductible in Rhode Island so it is a little work...no health insurance company wants to sell it because it cannibalizes their business, because if you have to

choose between something that's \$400 a month and something that's \$100, you're going to choose the \$100 each time, but they live off those \$400 per month payments because they can carve off 20% to feed themselves. There were other people in the country selling high deductible insurance so we could have brought them in if we had been able to support the whole concept.

We started doing other stuff, little fundraising things to start to get us toward the goal. Bike a thon, walk a thon, health related things. I worked with the practice I was in then and developed, I mean after these ideas we used ideas to develop a product that allowed people to buy primary care directly from the practice for \$20 per month. I'll save you the whole practice economics piece but it turned out to be a great deal for us. Based on that, I worked with a bunch of other people and developed that into a network of practices that do that. No its \$25-30 a month.

HealthAccess RI was an outgrowth of the Scituate Health Alliance conceptualization. It fed back on itself because once HealthAccess RI was there, now there was a place for Scituate to buy primary care for all Scituate residents who don't have health insurance. Scituate Health Alliance got some community block grant funding, town funding to buy primary care for everyone in the town who doesn't have it using the HealthAlliance doctors and we can do that because the health alliance deal is a decapitated deal and we have predictable costs.

Me: So HealthAccess RI is kind of like a health insurance company?

MF: It's totally not a health insurance company. We help practices package and market the availability of primary care for \$25 month. Most people would never imagine they could get primary care for \$25 per month. It's the sort of first and necessary step in this transition to how to build a health care system from the ground up. It frees practices from the tyranny of fee for

service system. If we had half of a practice has people paying \$25 a month our practices would be in great economic condition.

Me: Now, that \$25 per month is enough to cover what they need?

MF: It is double their other income, double their insurance income. It's much better for practices to have a HealthAccess patient than it is to have a Blue Cross patient. Because of the way Blue Cross has used their hegemony to ground down their payments to primary care doctors. They're made to pay bills in a marketplace but they don't get to experience the marketplace themselves. They can't set their own prices they have to take whatever Blue Cross gives them. HealthAccess RI is a way to get them out from under that. HealthAccess RI isn't really the interesting point, what is is that it gave the Scituate folks the ability to go out and purchase primary care for everyone. And so that's what we did. And so Scituate, RI is the first place in the US where everyone has access to primary care regardless of health insurance or not. Which sounds better than it is, it's a good thing, but what we needed to do and still need to do is build the Primary Care Center what we ought to have is that basic architecture.

MF: If you go to a health center in Nicaragua, it's the most moving thing to me in the world, you know, me being who I am. In the health center I went to, if you go into the epidemiology room on the walls there are charts and graphs and maps with lists of all patients with this disease and pinpoint where they live. So what you have is a mechanism to be able to work w the population and improve the public health because somebody's got the responsibility for doing it, and that's where we want to get in Scituate. We played around with things but we don't have nearly the resources we need to begin to do it. It's a way from the ground up and a place where we have never been able to talk about infrastructure. The aim still is to build Primary Care Center. Finding a way to get it funded is the real difficult piece.

Me: What happened to specialty and emergency services?

MF: We have a state laboratory and large imaging company that has agreed to reduce prices for Health Access members to the lowest price they can legally offer and that's Medicare pricing in exchange for people paying at time of service. If you have no health insurance this is a much better deal. We have a prescription drug card that gets you discounts. But basically what this does is drives you to your primary care doctor, and your PCP is basically free and says whether you really need this or you really don't. So if you hurt your back, your primary care doctor tells you if you really need an MRI or you really don't because sometimes you really don't and it saves you money. What happens with health insurance is that when you go in and your PCP says go get an MRI because of liability issues. With our system, your PCP is incentivized to work with you to figure out what it is that you actually need. It creates an environment for shared decision making. It's exactly the right way to do this but without a primary care center. One can imagine a world in which the funding falls (maybe from Cuba!) and we can build a primary care center that is available to everyone in town and works w the schools and w the elderly and organizes exercise programs and just does a bunch of stuff because it becomes the health dept of the town of Scituate. The idea is that if we can do it in Scituate we can do it in other places. And when one town sees it and you see how it works, its transformational at the end of the day because if you're really doing this we have really good projections that suggest that when everyone has primary care the per person per year cost of health care drops by 30-50%. Nationally, that is a trillion dollar a year savings. It is like so much money its not to be believed. The converse of that is that the health care profiteers are draining this country dry stealing money that ought to be used for education, housing, and the environment, things that really matter for health, social determinants. Go to Israel, which runs a population based primary

care system, sort of, close. They spend about \$300-400 per year. The Spanish spend a little more than that.

Me: I actually studied abroad in Spain in the spring of last year and took a public health course that focused a lot on their universal health care system.

MF: The Spanish did this 10-15 years ago, moved to an actual health care system. They dropped their costs by 20% right off the top. This is so not rocket science. To see the United States' health care reform go off on a total tangent was a heartbreak. Here we spent how many days, weeks years debating and the dollars, arguing back and forth over something that doesn't actually matter. That's what's crazy. It does not matter. All health care reform, even when it is found unconstitutional or constitutional, it is not going to change this: what we need to do which is build a health care system.

Me: With universal access to primary care?

MF: Yes, it's more than universal access; universal deployment is a little stronger than access. And I think you want to say deployment because you want primary care centers that are responsible for the primary care and public health of everyone who lives in a specific geographic area.

Me: I've worked a lot with the Patient Centered Medical Home at my internship. Do you feel like at least that philosophy, that model of primary care, is moving in the right direction or is it not enough do we need to completely change our system from the ground up.

Me: I think it's not enough. I mean Chris Koller [Rhode Island's Health Insurance Commissioner] is a good friend, I've known David [the then Health Director of Rhode Island] for many years before he was the director, but I think the Patient Centered Medical Home model is way too weak and way too bureaucratic. What we are doing is we are trying to get more focus

and money to primary care practices and we are trying to get them to behave reasonably to the people they actually take care of, but that means that the reservoir of disease will begin to exist in the people they don't take care of. In Rhode Island, people can identify a Primary Care connection 80 something % of the time, however a good percent of those turn out to be in the Emergency Room. How many people have an established primary care relationship? Probably like 50-70%. So 30% do not. Where is disease going to happen? In the people who do not. We are not approaching deployment. We are saying we are going to do a better job with the people who have primary care. We're going to try to keep the primary care practices that are already there from totally blowing it with the Patient Centered Medical Home approach. But we are not going to think about the health of the population in a robust way and make sure that we have equal chances for everyone which is what I think the aim of a health care system ought to be.

After my interview with Michael Fine, MD, I visited the Scituate Health Alliance website:

The health of a community depends on many people and processes, and on people working together to take care of one another. Income, environment, culture, language, trust, tradition, religion, and cooperation - as well as services like education, police and fire protection, sanitation, and medical care - all coordinate to make a place and its people more or less healthy. Because the United States has no organized health care system as such, it is sometimes difficult for communities to organize the medical services that impact people's health. More difficult yet is the task of directing our health care that they focus on maintaining both the health of individuals and the health of the community as a whole.

Population-based primary care is a way to provide health services so that the health of both individuals and the community as a whole is maintained and improved. A population-based primary care practice is a medical practice that aims to provide 90 percent of the health services people need in a way that interests 90 percent of the people in a community in using that practice. Population-based primary care allows a medical practice to collaborate with other community organizations and business, such as town government, schools, health clubs, police, fire and rescue departments, at the same time as it makes sure all town residents receive all the health services they need. Population-based primary care does not exist in the United States –yet – though it does exist in other countries, other countries where costs are lower and people are healthier. Little Scituate, Rhode Island, aims to be the first place in the US to offer population-based primary care to all Scituate residents, and aims to be the healthiest place in the US as a result, a community of people who are healthy together. (Michael Fine, MD)

In 2009 in an interview with Andrew Villegas of Kaiser Health News, Dr. Fine more specifically describes the history and mission of the Scituate Health Alliance. Scituate funds the Alliance through the town itself, community block grants, even bake sales and walk-a-thons. Participating doctors are paid \$25 per patient per month. Every time the patient goes to see their PCP, they only have to pay \$10 per visit. The overall Scituate Health Alliance budget is around \$30,000:

Q: Could you explain how the program works?

A: It actually has two major components. One is a vehicle to provide primary health care and primary dental care to everyone who lives in the town of Scituate and doesn't have employer-provided or government-provided health insurance. So, if you're uninsured, the Scituate Health

Alliance gives you a voucher and you can take that voucher to one of 16 practices across the state that will provide you primary care and to a couple of dentists. We're also developing resources to be able to think about health in Scituate in a population-based way. ... To think about how to look at the incidents and prevalence of disease in a geographical way and then begin to build resources to address areas where different diseases are more common.

Q: Do you find that you've stretched the definitions of primary care?

A: We've tried to make a distinction between doing everything for everybody and doing what works for most people. I think we've sort of decided collectively to leave specialty care alone -- [to let] the reform process, the insurance process deal with that -- but to provide as a community the thing that matters.

Q: What do people participating in the alliance do if they get a serious condition like cancer?

A: Basically, the first thing those people have is a primary care doctor, who's a huge ally, because the primary care doctor knows what treatment options are available. There are some resources for people without insurance for cancer treatment. In Rhode Island, we have a wonderful women's cancer treatment program that's run through the [state's] department of health, so primary care doctors can connect people to that treatment program and get people cancer treatment in that way.

Q: These people are still, for all intents and purposes, uninsured. Is the primary care you provide intended to help ward off serious disease only?

A: It's more than that. If you look at health policy numbers, 50 to 60 percent or more of patient encounters per day in the United States are between a patient and a primary care physician, so the bulk of what the medical service people consume is primary care. So what we're providing is the medical service that people use. When you provide primary care, you are providing the

service people need and keeping them from having to go to places that are expensive and may be dangerous. You know, making sure specialty services are used when they're needed but aren't overused and don't drive up cost in the system.

Q: What do you think about the health care reform proposals in Congress?

A: I think the journey of a thousand miles starts with a single step. That we're trying to do something is a good thing. The basic pieces of health insurance reform [that are] moving us toward community rating is a good, if expensive, thing. But I also think we're leaving out a huge potential opportunity, which is, if we give primary care to all Americans and do just that, it would cost us an extra, depending on whose numbers you use, \$16 billion to \$24 billion per year. But it would probably save us \$200 billion to \$300 billion per year. Because people, if they had access to primary care — easy, free access — they'd use primary care first and not find themselves walking down the path of being over-treated and overdosed, which is what lots of what the health care system does.

Based on these two interviews, there are a few important conclusions to be made about the importance of primary care in improving and maintaining overall good health. Firstly, Dr. Fine made the argument that health and health care are not necessarily rights. I believe, however, that he was speaking in terms of political or civil rights, saying that health and health care are not examples of these specific kind of rights. “Health and health care aren’t freedoms that a democratic government can guarantee...not something you get for being a citizen.” I agree with that; you get them simply for being a human being. However, the government is not completely out of the health picture; you need services to ensure your health: services provided through the government in some way or another. Dr. Fine and his team were always looking for

funding, grant money, which one gets from the government. What would his vision look like if primary care were funded through the government like it was in Cuba?

Secondly, his experience in the Bronx enabled him to see the “multi-factorial” nature of health and the importance of the denominator when analyzing health. “Public health, when you think about it, is outcomes expressed as they exist in over a denominator of people living in a geographic place.” This point is exactly what the polyclinics in Cuba aim to address.

Thirdly, Dr. Fine acknowledges that his specific primary care philosophy and infrastructure in Scituate could be applied on the national level if it was politically possible, but it is not in this country. In Cuba, where health and health care are declared constitutional, human rights, and services are universally guaranteed by the government, such a system is possible. I think Dr. Fine recognizes, as I do, that health care reform in this country is not necessarily about changing infrastructure or finding funding. It is about changing the mentality and philosophy of health in the U.S. The Scituate Health Alliance mirrors much of what the Cuban polyclinic structure has accomplished. This town has universal primary care. It costs little to nothing. It is population-based. His Primary Care Center idea is much like what they have in Cuba. However, there are several issues which hinder the Scituate Health Alliance from succeeding like the Cuban polyclinic and keep it from expanding on wider scale. This Health Alliance is trying to function within the broader health care marketplace in this country. The entire health care infrastructure in Cuba is founded on this polyclinic system. In the United States, a polyclinic idea is the minute minority. The polyclinics and Cuban health care in general are also funded by the government (which we will look at in further detail later). Because the Scituate Health Alliance is a small case, government funding is very hard to come by. It is important to ask, then, if something like the Scituate Health Alliance can survive and flourish outside of this

marketplace system we have in this country. This reflects the ideals of the World Health Organization, which recognizes that we need to think on a population based level not just in terms of health care services, but for health care infrastructure as well; each country has specific political, economic, and social conditions to which an infrastructure must be adapted. If Dr. Fine wants his Scituate Health Alliance idea to work on a grander scale in this country, these conditions would have to change or his idea adjusted.

Cuba, The “Special Period,” and the Current U.S. Debt Crisis

To further investigate whether or not a system like Cuba’s would be feasible in the United States, I sought some information about the formation of Cuba’s health care system and the role of the Cuban government in terms of financial and philosophical support. Cuba has greatly improved and maintained the health of its citizens in spite of the limitations of the US embargo especially during what is known as the “Special Period” of the 1990s.

Fidel Castro came to power in Cuba in January 1959. He declared Cuba a socialist state in April of 1961, which propelled a 30 year alliance with the former Soviet Union (US Department of State, 2010). Because this was the Cold War era, relations between Cuba and the US began to fall apart practically as soon as the socialist declaration was made. Before Castro came to power, 75% of Cuba’s imports and exports were traded to or accepted from the US (Kuntz, 1994). However, in August 1960, Castro issued Resolution Number 1 under Cuban law 851 which ordered the expropriation of twenty-six American companies on Cuban soil. Two months later, the U.S. ordered an embargo on Cuba and diplomatic relations between the two countries were officially broken on January 3, 1961 (US Department of State). What is interesting to note is that this embargo did not originally include U.S. exports of food, medicine,

and medical supplies to Cuba. In 1964, however, these exports were added to the restricted list (Campos, 2004). Essentially all trade between the US and Cuba was dissolved. The US being the global political and economic superpower that it was, this was a significant cutoff.

Cuban trade, then, became dominated by exchanges with the former Soviet Bloc countries, with percentages maintained between 70%-90%. From 1975-1989, the Cuban economy maintained an annual growth rate of around 4%. However, in 1989 with the fall of the Soviet Union, their economic foundation crumbled from beneath them. By 1993, imports into Cuba declined by 75%. The Soviet Union had previously provided Cuba with their main source of energy, oil, and that import rate was cut in half. Though it had been increasing every year since 1965, their GDP decreased 2.9% in 1990, 10.7% in 1991, 11.6% in 1992, and 14.9% in 1993. Because of the Communist government structure and the almost complete government control of employment, Castro aimed to hold onto all jobs and maintain salaries during this economic crisis, which ballooned the budget deficit (Lopez-Pardo, Nayeri, 2005).

In March of 1992, then President George H.W. Bush signed the Cuban Democracy Act which made the US embargo even more paralyzing for Cuba. Third-party sanctions were enacted, meaning that now subsidiaries of American companies that existed outside of the US were also banned from trading with Cuba. This trade restriction included food and medical supplies. Also, ships that have docked in Cuba are prohibited from entering US ports until 180 days after their Cuban departure, which has either discouraged countries from importing to Cuba or has increased their shipping costs in an attempt to find another way to get them there (Campos, 2004). To dissuade the assumption that US was restricting the availability of any humanitarian aid to the island, they devised a kind of exception to their harsh policy. The US Treasury and Commerce Departments could technically sign for the individual sales of medical

supplies for humanitarian reasons. The problem was that in reality, this permission is so hard to obtain that US distributors were discouraged from even trying. In effect, this provision discouraged humanitarian aid without actually outlawing it (Campos, 2004). Another way in which the US has restricted aid to Cuba is through the denial of loans from the World Bank and the International Monetary Fund (Kuntz, 1994).

Cuba's economic crisis following the collapse of the Soviet Union is known as the "special period in peacetime." (Kuntz, 1994). Between the US embargo and the collapse of the Cuba's main source of trade, the Soviet Union, the Cuban economy suffered immensely during this period. The cutoff of food and medical supplies to the country is especially disturbing in terms of the implications for the Cuban people. In 1996 at the World Food Conference in Rome, Pope John Paul II harshly criticized the use of economic embargoes because they "cause hunger and suffering to innocent people." If what some US policy critics have said is true, that the US meant to target Castro's regime and not the Cuban people at large, then what has become of this embargo is the punishment of the wrong people (The Lancet, 1996). This reminds me of the way the uninsured, minorities, and the rural populations have inadvertently suffered because of our how health care system in the United States works. There is some inspiring data, however, that has come out of this Special Period. Though US policies had deprived Cuba of access to essential food and health service resources, they were able to overcome these obstacles and build a commendable health reputation for themselves.

How has Cuba managed to rebound from the damaging effects that this Special Period economic crisis has had on the nutrition and health of its people? The Cuban Constitution declares health care to be a right that every Cuban citizen has, and it is the Cuban government's responsibility to ensure that its citizens are healthy (Campos, 2004). This is quite the contrast to

the US health care system, where health has become a privilege and the private sector has dominated access to coverage and services. Cuba has stood by their constitutional affirmation regarding health and has overcome the challenges of the Special Period in inventive ways. The American Public Health Association (APHA) trip of 1993 noted ways in which not only the Cuban government but the average citizen was rebuilding the nation's health status. The APHA's commission noted that many people were planting more gardens to grow their own food, breastfeeding their babies instead of using formula, and bicycles are now much more common than cars. They concluded that "the economic dislocations have led to healthier lifestyles-reduced smoking, less fat and meat and more vegetable in their diet, more exercise, and cleaner air" (Kuntz, 1994).

When the crisis began, the Cuban government made a promise to its people that health care and education programs would not falter. Based on figures from the Cuban Ministry of Finance, the health sector budget allotted for more Cuban pesos and the percentage increase of GDP earmarked for health care came at the expense of spending for the military and government administration (Salud!). Because of the limited amount of hard currency, national evaluations were done weekly to decide which purchases were absolutely needed to as to use the limited funds they had efficiently. The film *Salud!*, who yields support from MEDICC, the Medical Exchange Cooperation with Cuba, credits the health care professionals, who worked "under the most stressful conditions, was without doubt, indispensable for the Cuban population to emerge from the worst of the crisis with their health status essentially intact." They also highlight what was probably the most positive contributor to rebounding Cuba's health care system: the community-oriented primary care network accessible to essentially every Cuban:

The family doctor-and-nurse teams, responsible for the health of some 150 families in a given neighborhood, concentrated their attention on health promotion, prevention of disease, environmental cleanup, priority attention to children and the elderly, prenatal care, and early detection of infection and chronic disease. Most of these activities required little in the way of material support, but they went a long way towards keeping the levels of disease from reaching the already over-extended hospitals wards and emergency rooms.

What Cuba lacks in material and financial resources it makes up for in medical knowledge and staff. They have recovered the crisis not only through focusing on their service structure, but on the education of medical professionals. The fact that the full six-year medical education and training program in Cuba is free has kept application numbers rising and is probably determinant of the 76% increase in physicians from 1990-2003 (Lopez-Pardo, Nayeri, 2005, Salud!). A lack of primary care physicians is something noted in the beginning of my research and something with the United States continues to struggle. With health statistics where they are today, it is interesting to think where they could be if lack of physical and capital resources were not an issue. Though the US embargo on Cuba had very detrimental effects on Cuban nutrition and health, it was the dedication and plan of that enemy Communist government that kept Cuba healthy. What the US is trying to do now in revising our health care system actually mirrors the efforts of the Cuban government during the Special Period.

Though the United States has many more material and financial resources than Cuba, it is not using these financial resources efficiently. The International Journal of Socialist Renewal published an article in January of 2011 highlighting the exorbitant costs and waste of the US health care system. They argue that only 4% of the money Americans spend on health care

actually goes toward keeping them healthy. As I have previously noted, Cuba spends much less money per person on health care but has achieved the same level of health for its people as the US. How has Cuba accomplished this while spending about 4% of what we spend? Some studies have argued that as much as 31% of the US' health care budget is spent on administrative duties, while CEO salaries, marketing initiatives, and sales commissions also take a huge chunk of our health money. This article also cites a *Health Affairs* study that blames insurance on much of our cost issues as well. Insurance has created the "marketplace" that is our system, as described by Dr. Fine. Individuals not in the marketplace (without health insurance) will most likely put off treatment, further exacerbating their illnesses and necessitating more expensive treatments than would have been needed if they had sought treatment originally. They are also more likely to seek care in an Emergency Room which is much more expensive (Fitz, 2011). This article argues that Cuba's health care system embodies the idea that health is a human right, and that services that protect this right should not be profited from. They also keep costs down by focusing about 80% of their medical care at the primary care level and only 20% at the hospital level.

As previously noted, the World Health Organization has called for a deeper, more evidential analysis of the costs and benefits of health care models, specifically of primary care. According to the US Department of the Treasury, Bureau of the Public Debt, as of April 18, 2011, the U.S. national debt was \$14,309,159,097,877.65 ("The Debt to the Penny and Who Holds It"). Our country is also in the midst of health care reform that began in May 2008 (WorldatWork). As was called for by the World Health Organization, costs and savings need to be weighed in any health care debate. Will it cost our country more money to improve our health care infrastructure, adding to our budget deficits, do the long term outlooks on savings

outweigh initial costs? I think we have a lot to learn from Cuba when thinking about this issue. They have proven that it does not cost a lot to build and maintain a successful health care system, especially when cheaper, cost-efficient primary care is at its center. Is it possible, though, for the United States to build a health care system that mirrors that of Cuba?

Primary Care Reform in Rhode Island

After I interviewed Dr. Michael Fine, he was named Interim Health Director for Rhode Island. He brought his passion for and philosophy of primary care to his new position. He created a Primary Care Workgroup on which I was asked to be along with three other prominent Department of Health employees. This Workgroup was created to analyze primary care capacity and cost in the state, in support of efforts to redesign the provision of primary care to Rhode Islanders into a population-based, cost-efficient, and equitable system that will improve health outcomes. One of the main issues we are focusing on is primary care physician (PCP) and practice capacity in geographic regions. How many PCPs need to be distributed geographically to match population needs? This reflects Dr. Fine's advocacy for population-based primary care and deployment of services to everyone, not just those who can afford to buy health. We also discussed how the quality of a successful primary care system is all about systems design, as opposed to a design based on individual physician behavior or patient health. Small-scale initiatives can be successful in improving primary access and quality, but what is better is when these initiatives are all united, working together to improve primary care for all and not only some. It seems that Dr. Fine is aware that his Scituate Health Alliance idea cannot be transposed into a state or national level at this time. What this Workgroup aims to do is work within the

system we have promoting the same philosophy of the Scituate Health Alliance but adjusting the concept so that it may be applied on a larger scale.

One of the questions this Workgroup asked was how we were going to make primary care investment more appealing to the state. We knew that appeasing the cost-worriers was going to be important. Look at our debt; no one is going to want to invest in an idea that will cost us more money. In the beginning stages of this workgroup, we read an article by Katherine Baicker and Amitabh Chandra entitled “Medicare Spending, The Physician Workforce, and Beneficiaries’ Quality of Care.” What Baicker and Chandra’s study found was that an important correlation between primary care and lower costs:

States with higher Medicare spending have lower-quality care. This negative relationship may be driven by the use of intensive, costly care that crowds out the use of more effective care...states with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality. Improving the quality of beneficiaries’ care could be accomplished with more effective use of existing dollars. (Baicker, Chandra).

This goes back to what I have been arguing from the beginning. The US spends an astronomically large amount of money on health care, which is not resulting in improved outcomes or increased patient satisfaction. Primary care saves money. With the budget crisis facing not only Rhode Island but our entire country, this fact needs to be heavily weighted in considerations over what to do about health care.

Another important point about this Workgroup’s plans is that we aim to figure out how many primary care physicians would be needed to address need. In the beginning of this research, I noted that Cuba has Cuba boasts 62.7 physicians per 10,000 people, while in the US

that number is a mere 26.3. Is Cuba's ratio something we should be aiming toward? More research needs to be done into where primary care physicians are needed in Rhode Island, how many we actually have to supply, and if we have the supply to match the need.

It's the Delivery System: Primary Care For All

The Cuban philosophy is primary care for all Cubans. Returning to Dr. Michael Fine, he co-wrote a paper with Shannon Brownlee, MS entitled "It's The Delivery System: Primary Care for All." The overall theme of the paper is that when we talk about what we need to do for health care in this country, it is not just about working out the kinks and changing little things that have not been working, but rather it is about actually creating a new health care system, an actual system that works: instead of plugging holes in a ceiling that is leaking, we need to replace the whole roof. We are talking about reform but we do not have a system to reform! They advocate a successful system founded in primary care, a service not only available to but actually delivered to the entire population (Brownlee, Fine). The way in which this system should be structured mirrors Cuba's system in many ways. It would be a bracketed system supported on national, statewide, and local levels. Primary care centers could be "patient centered, community focused, accessible to all, and effective at improving the health of the population" (Brownlee, Fine). Centered in these primary care centers, this new primary care infrastructure is very similar to the Cuban polyclinic/consultorio/family doctor model:

The primary care system we need is one that makes it exceptionally easy for people to contact, see, or be seen by a primary care physician practice when they are sick or have a health related question; one that gives all Americans a primary care practice that knows them, their families, their lives, and their communities over time; one that cares for as

many different health problems as possible, and one that helps people make good choices about other health and medical services by coordinating the health services people receive from the rest of the health care system. Primary care is a service most Americans use, all Americans need, and the only medical service associated with improving the health of populations while controlling costs. Other health services-specialty care, imaging, hospital care, hospice, and the like- can be layered on to a primary care base. (Brownlee, Fine)

This primary/secondary distinction is very similar to the Cuban health care infrastructure. Remember, a polyclinic is composed of neighborhood-based primary care physician office complemented by secondary care facilities including but not limited to emergency services, psychiatry, and rehabilitation within close proximity with care coordinated through primary care doctors. How would the primary care level specifically be structured? Brownlee and Fine want every American to have a primary care doctor close to their home. The local primary care practice would have more than just a primary care physician; there would be a team of health workers including a social worker or psychologist, a nutritionist, a visiting nurse, a physical therapist, a pharmacist, and whoever else might be deemed necessary for maintaining the health of a particular community. Brownlee and Fine argue that the goal of this set up is to “blanket the nation with robust primary care practices.” It is all about access: delivering the services to the communities so that they do not have to go seeking out services for themselves.

There are two other important points to note in this paper. “It is important to remember that the bulk of primary care services are already funded, although the existing incentives fail to produce needed outcomes” (Brownlee, Fine). By that statement, it seems as though we will not need to search for additional funds to create a primary care system. Between our government

and the private sector, we can fund it. This rebuilding will entail moving money around, directing it toward primary care and syphoning it from other more expensive and often unnecessary secondary services. Apart from financial resources, another point to ponder is how to supply this primary care system with enough primary care physicians. If there was universal access to primary care, the 50-75 million Americans who currently do not have access to primary care would need an additional 15,000-30,000 primary care doctors to meet their needs (Brownlee, Fine). How can we get that many new primary care physicians? Brownlee and Fine argue that the key to the recruitment and retention of PCPs is through restricting medical school education, increasing nurse practitioner and physician assistant funding, and ultimately restricting funding for specialty care residencies. All in all, they advocate the reformation of a system that puts specialty care at the center; our primary focus should, ironically, be on primary care, instilling in the hearts and minds of medical school students the importance of this medical field. This leads into two very important discussion points about primary care in the United States as compared to Cuba: the philosophy of primary care within the two countries and the reality of medical school and the higher ratio of students in the U.S. choosing specialty care over primary care.

Cuban Health Care through the Eyes of an American Medical School Student

I found an interview conducted with a second year Cuban medical school student, Christian Ramers. He said, “Imagine a society in which healthcare is the right of every citizen and the responsibility of the state. Imagine being able to see your doctor as often as you wanted, free of charge. Imagine a solid foundation of primary care and preventive medicine with clinics on virtually every other street corner” (Ramers). He noted that one need not look farther than 90

miles from our coast, in Cuba. He spent 5 weeks in Cuba through the MEDICC program and was able to submerge himself in their “efficient, community-based, prevention-oriented infrastructure.” He describes the actual health care infrastructure itself. The foundation and focus in primary care and the 20,000 consultorios, ironically calling them “primary care centers,” much like what Dr. Fine wanted to build in Scituate. Ramers also brought up an important note about Cuban primary care that again reflects its focus on population-based medicine. “Most physicians we met in consultorios grew up in the communities where they practiced, affording them both an awareness of their neighborhood's environmental conditions and a familiarity with the families under their care. When the power of this model was realized after its introduction in the 1960s, the Cuban government replicated it in virtually every city and town on the island.” He heard no talk about insurance, billing, or fees when he was observing in the consultorios because health care is completely sponsored by the government. Because the government is so integrally involved in health care, one cannot talk about health care in Cuba without discussing politics, economics, and ideology. Ramers notes that Cuba has clearly founded its medical ideology in primary preventive medicine. However, this ideology has had to find strength and substance amidst Cuba's economic isolation from the US embargo, as previously noted. On his trip, however, he was more compelled to observe the Cuban people than any effects of the political or economic policies or agendas:

Cuban doctors display incredible courage caring for patients without regard for money, working overtime in declining facilities, and making medical devices work that we would have thrown out long ago. It was inspiring to see the trust that Cuban physicians and patients shared in an environment devoid of financial expectations and heartening to see their compassion, offering time and energy without concern for reimbursement. In many

ways, these experiences demonstrated what it really means to be a physician. From the intimacy of a quiet patient interview to the vastness of international political jostling, if nothing else, Cuba offered a fresh perspective (Ramers).

What do this American's observations in Cuba tell us about primary care in that country? It seems that the Cuban government, Cuban physicians, and the Cuban people see primary care as the highest form of medicine, something that everyone is entitled to simply for being a human being. Primary care physicians do what they do almost because they have a moral obligation, regardless of monetary compensation, which probably is not anything substantial or what they might deserve.

How American Medical Students View Health Care

When we look at American medical students in this country, we see an opposite mentality about medicine. According to an article published in *USA Today* in August of 2009, "longer days, lower pay, less prestige, and more administrative headaches have turned doctors away in droves from family medicine, presumed to be the frontline for wellness and preventive care programs that can help reduce health care costs." (Sommer, 2009) According to the American Academy of Family Physicians (AAFP), since 1997 the number of U.S. medical school students choosing a career in primary care has dropped an alarming 51.7%. Looking even further into the future, the AAFP has estimated that we will be short 40,000 family physicians in 2020 when the Baby Boomer population begins to flood the health care system with increased older-age medical care. As of 2009, our health care system has 100,000 family physicians but we will need 139,531 to meet the demand of 2020. Emilie Sommer of *USA Today* blames the

shortage on our country's health care system by noting that the "current environment is attracting only half the number needed to meet the demand."

This environment is as much the medical school environment as it is the health care infrastructure in general. This *USA Today* article notes a figure from March 2009 that said US medical school graduates only filled 1,083 of the 2,555 family medicine residency positions, a mere 42%. 200 of these spots were ultimately left vacant (Somme, 2009). Why are so many students shying away from primary care? We should consider how much medical school costs and how much a starting primary care physician makes compared to a specialist. According to the Journal of the American Medical Association, a Radiologist's starting salary was \$350,000, while a Pediatrician's was \$125,000. Primary care specialties on average put forth salaries of about \$120,000-\$190,000, while specialists like surgeons and anesthesiologists make \$350,000 and up: way up. One might argue that those salaries are still well above median American income and a very sufficient amount on which to live. According to Merritt Hawkins & Associates who work to recruit and place doctors, the average cost of a medical school education is between \$140,000 and \$200,000 (Sommer). That is what a student might be left with after their 10 years of schooling and training. However, when \$200,000 of debt hangs over someone's head, it is understandable that one would choose a specialty that would bring them in enough money to pay off this heavy debt. They have worked so hard for so long, a high paying career stems from a kind of reward mentality. They deserve that prestigious job that will pay them extremely well.

Sameer Badlani at the University of Chicago blames the payment structure of our health care system for the increase in specialty care in comparison to primary care. "[In our payment model] the more procedures you do, the more money you make. That is why, in a procedure-

based specialty, a physician can make about four to five times the annual salary a primary-care physician can earn.” (Sommer, 2009). It is more about the quantity of care rather than the quality of care.

Surveyed graduates of the Alpert Medical School of Brown University in Providence, RI had an average debt load of \$137,000, and only 11% of them were planning on going into primary care (Phillips et al, 618). *USA Today* highlights the theory that this low percentage should be blamed on the universities themselves and not just the debt load. Dr. Bruce Bates, a primary care doctor from Maine interviewed for this article notes that US medical schools often promote higher-paying specialties or medical research fields, not only known for higher salaries but for the accompanying prestige. “I would put a lot of weight on the culture of the school being a big influence,” Bates says, adding that often doctors going into family medicine are often told “you’re too smart to be in primary care.” However, if these students are too good for primary care, who are the right candidates? The poor, less educated students who might wish to pursue careers in medicine but could never afford it? The ones in school are the ones we have been waiting for to save primary care. Another way universities are inadvertently pushing specialty care is the infrastructure of these schools. Eleven of the top allopathic medical schools in the country, including Harvard and Johns Hopkins do not have family-medicine departments (Sommer, 2009). There is no promotion of primary care in the universities like there is in Cuba.

Based on the interviews and statistics in this article, it seems like increasing the number of primary care physicians in this country will come about with a change in mentality about primary care itself. Dr Badlani says he tells his students not to let debt influence their career choices (Sommer). How will these students be convinced that they can survive with that debt on their shoulders? They would only choose primary care and live with the debt if they embraced a

new philosophy about primary care, seeing it as the foundation of our health care system and the most important form of care: the only one that really matters. While we saw that the Cuban government, Cuban physicians, and the Cuban people see primary care as the highest form of medicine, something that everyone is entitled to simply for being a human being, we see that this is not the case in the United States. While Cuban primary care physicians do what they do because they feel have a moral obligation, regardless of what they might deserve in monetary compensation, American medical students feel as though they have to go into specialties for the prestige and the salary. This demonstrates that the primary care philosophy and mentality in Cuba is different than in the United States, with Cuba seeing primary care as the most prestigious field uncorrelated with salary.

Medical Cooperation with Cuba

In 2005, a group of doctors sponsored by the University of Wisconsin Medical School traveled to Cuba with the Medical Education Cooperation with Cuba to study the country's primary health care system. They knew that changing the foundational structure of the US health care system was a feat that would not easily or feasibly be accomplished. Therefore, they wanted to see what theories and actions American family doctors could individually adopt at the practice level to create a system as successful as Cuba's (Dresang et al 297). "A Cuban family physician typically spends the morning seeing patients in the clinic adjoining his or her house and spends the afternoon making home visits to patients in the community immediately surrounding the clinic. Given the current structure and financing of the US health system, replicating this model is not feasible for most US family physicians. However, there are some practices of Cuban family physicians that US physicians may find valuable and achievable within their individual

practices” (297). Specifically, they argue for American doctors to implement a community-oriented primary care approach to treatment. In this philosophy, health is seen as a goal for an entire community and not just individuals. Community-oriented primary care is a “systematic approach to health care based on principles derived from epidemiology, primary care, preventive medicine and health promotion that has been shown to have positive benefits” in which “family physicians are required to look at patients in the context of family and community” (300).

Cuba makes health a community endeavor in several ways. They organize their medical records by family, not by last name. Health indicators are documented and reviewed at the community level frequently. They compile their data into charts and hang them on the walls of the consultorios or primary care offices. Public health officials work in cooperation with family physicians to address health concerns and draw up plans of action (Dresang et al 300-301). If family physicians in the U.S. applied this approach to their own individual practices, health could be improved on the community level and not just person by person. The physicians in this study argue that US physicians need to be “educated to look beyond the strict boundaries of medicine’s traditional physician-patient dyad” while also taking on a “more comprehensive role as caregivers to families and communities” (301).

CONCLUSIONS

In terms of US health care, our country has lost its ability to think systematically, to think about how all parts interact with each other and what the results say about these interactions. Systems thinking is particularly helpful when analyzing an issue, like health care, that involves recurring problems that has only been “made worse through past attempts to fix them.” (Aronson, 1996). We see the amount of money spent on health care yet we have not produced the health outcomes to match, our system is wasteful, and too many people still do not have access to this system. Covering those individuals as has been proposed in the Affordable Care Act seem like a viable solution to the insurance gap. The Patient Centered Medical Home model of primary care is trying to get primary care practices around the country to adopt characteristics known to improve health outcomes, like improving access to care through extended hours, routine preventive screenings, and management of chronic conditions. Our government is investing more money in Community Health Centers to improve access to care for the victims of health disparities. We are trying to recruit physicians to rural areas untouched by primary care by enticing them with medical school loan repayment. These are all important initiatives the U.S. is taking to bolster our health care system with primary care. Ultimately, however, we are just continuing to fix a system that is foundationally broken. We need to build one! Creating a new system may seem like an intimidating undertaking, particularly given the powerful vested interests in maintaining the status quo: but this system is not sustainable. Our primary care system is costly, stratified, and based on attention to individual care. We need to build a system of solidarity and population-based infrastructure and services.

Money should not be an excuse to prolong or dismiss a plan to build a primary care system in this country. The shortcuts we are taking right now to reform health care are like putting child-size Band-Aids on gushing wounds. We need to look elsewhere for ideas, as this paper has argued, and Cuba has given us an example of how to build and maintain a health care system on an extremely limited financial and material budget. What they lack in those resources they make up for in “people power.”

In the US, we definitely are not lacking in the health dollar department. 21% of the entire Federal budget goes toward Medicaid, Medicare, and the Children’s health Insurance Program (CHIP) (“Policy Basics,” 2011). Meanwhile, in the private sector, health insurance companies increased their profits by 56% in 2009, and the 5 biggest for-profit companies ended that year \$12.2 billion richer (Walker 2010). What we do lack, however, is the workforce that Cuba has, working in a primary care system based on universal access, not an insurance marketplace.

Primary care is not just an infrastructure; it is a philosophy. Through my research, I have learned that this philosophy must be the foundation of a health care system in order to ensure health as a right and to produce the best possible health outcomes. However, what I have also learned is that this philosophy has not created an exact blueprint infrastructure model of health care that can be used everywhere. A good primary care system must be population-appropriate. Cuba is a communist country. The United States is not. Does that matter? Does that mean that the US cannot have a universal health care system founded on primary care medical philosophy and with primary care as the main unit of care? No; it is possible to build a new kind of primary care system in the US using the lessons from Cuba. Our new system may be funded differently and not have the same polyclinic/consultorio structure, but the US can produce as efficient and effective a system as Cuba’s if it grounds itself in the Cuban philosophies of health as a human

right and the idea that primary care is the predominant health care service with all other services coordinate.

RECOMMENDATIONS

Cuba has given us an example to exemplify, success to admire, and the confidence to embrace a health reform initiative that on the surface may seem overwhelming, costly, or near impossible. Though it may not be feasible to use Cuba's primary care blueprint, I have illustrated in this paper that we have blueprints here in the US to guide us. If the US creates a universal primary care health care system, we will reduce wasteful spending and get much more out of every health care dollar we spend. If medical schools promote primary care specialties, we can increase our primary care physician workforce and meet the demand for primary care in this country. If we cannot eliminate health insurance in this system, then we need to create a system where every American can afford primary care services, whether or not that is through their insurance or some kind of medical savings account or annual primary care fee to their primary care practice. That kind of personal investment would be much less costly than what people without access to primary care shell out in out of pocket and hospital expenses. If we adjust where primary care physicians and practices are located, we can close the gap between those who have access to a PCP and those who do not. It is about deployment and delivery.

The Scituate Health Alliance in Scituate, Rhode Island is proof that a small scale, geographically targeted, primary care centered model can work in this country. This little Rhode Island town prides itself being a community of health. It has defied the injustices of the insurance marketplace and found ways to give everyone affordable access to primary care, recognizing that it is the most important health care service. They do this on a very small budget. Dr. Michael Fine's dream of a primary center is the ultimate goal of this population-based model. As he noted, if everyone in a geographic area has access to the same primary care facility, then you can organize services to most effectively improve the health outcomes of that

population. Without this infrastructure, the system is not fair and not everyone has access to the same level of service. Cuba has proven that this structure founded in a primary care philosophy works.

The Scituate Health Alliance's vision is to "develop a local health care service for all Scituate residents that can serve as a model for the United States" (Marchant). The US needed to find its own primary care blueprint: let the Scituate Health Alliance be our blueprint. We can make primary care universal in this country; we just have to make the choice to get health care right.

Bibliography

- Aronson, Daniel. "Overview of Systems Thinking." Thinking Page. 1996-1998. 27 April 2011
<http://www.thinking.net/Systems_Thinking/OverviewSTarticle.pdf>.
- "Background Note: Cuba." Bureau of Western Hemisphere Affairs. March 2010. US
Department of State. 4 Dec 2010 <<http://www.state.gov/r/pa/ei/bgn/2886.htm>>.
- Baicker, Katherine, Chandra, Amitabh. "Medicare Spending, The Physician Workforce, and
Beneficiaries' Quality of Care." Health Affairs. (2004).
- Barclay, Eliza. "Among Rich Countries, US Rates Worst for Patients." 18 Nov 2010. National
Public Radio. 8 Dec 2010
<<http://www.npr.org/blogs/health/2010/11/18/131416416/among-rich-countries-u-s-rates-worst-for-patients>>.
- Beal, Anne C, Davis, Karen, Doty, Michelle M, Hernandez, Susan E, Shea, Katherine K.
"Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From
The Commonwealth Fund 2006 Health Care Quality Survey." June 2007. The
Commonwealth Fund. 8 Dec 2010
<<http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Closing-the-Divide--How-Medical-Homes-Promote-Equity-in-Health-Care--Results-From-The-Commonwealth-F.aspx>>.
- Brownlee, Shannon, MS, Fine, Michael, MD. "It's a Delivery System: Primary Care for All."
Michael Fine MD. 2007. 26 April 2011
<http://fmec.net/pdfs/delivery_system_revised%20final_draft%2008%2018%2009.pdf>.
- Butterfield, Stacey. "Cuba is just across the water, but medically, a different world." ACP
Internist. September 2010. American College of Physicians. 8 Dec 2010
<<http://acpinternist.org/archives/2010/09/cuba.htm>>.

- Campos, Javier H. "The Impact of the U.S. Embargo on Health Care in Cuba: A Clinician's Perspective." Transnational Law and Contemporary Problems. 14.517 (2004): 517-528.
- Chan, Dr. Margaret. "Keynote address at the International Seminar on Primary Health Care in Rural China." World Health Organization. 1 Nov 2007. 8 Dec 2010.
<http://www.who.int/dg/speeches/2007/20071101_beijing/en/print.html>.
- Chan, Dr. Margaret. "The contribution of primary health care to the Millennium Development Goals." World Health Organization. 16 Aug 2007. 8 Dec 2010
<http://www.who.int/dg/speeches/2007/20070816_argentina/en/print.html>.
- "Declaration of Alma-Ata." International Conference on Primary Health Care. 1978. World Health Organization. 7 Dec 2010
<http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf>.
- Djukanovic, V, Mach, E. P. "Alternative Approaches to Meeting Basic Health Needs in Developing Countries: A Joint UNICEF/WHO Study." 1975. World Health Organization. 8 Dec 2010 <<http://whqlibdoc.who.int/publications/9241560487.pdf>>.
- Dresang, Lee T, Brebrick, Laurie, Murray, Danielle, Shallue Ann, Vedder-Sullivan Lisa. "Family Medicine in Cuba: Community-Oriented Primary Care and Complementary and Alternative Medicine." Journal of the American Board of Family Medicine. 18.4 (2005): 297-303 <<http://www.jabfm.org/cgi/reprint/18/4/297>>.
- Fine, Michael, Marchand, John. "Scituate Health Alliance." 2 May 2011
<<http://www.scituatehealth.org/histmiss.html>>.
- Fitz, Don. "Why Does Health Care in Cuba Cost 96% less than in the US?" International Journal of Socialist Renewal. 5 Jan 2011. 14 Feb 2011 <<http://links.org.au/node/2082>>.
- "Healthcare.gov." US Department of Health and Human Services. 2 May 2011

<<http://www.healthcare.gov/law/introduction/index.html>>.

“Joint Principles of the Patient Centered Medical Home.” Patient Centered Primary Care Collaborative. February 2007. 8 Dec 2010

<<http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>>.

Keim, Brandon. “What Cuba Can Teach Us About Health Care.” Wired Science. 29 April 2010. Condé Nast Digital. 8 Dec 2010 <<http://www.wired.com/wiredscience/2010/04/cuban-health-lessons/>>.

Kuntz, Diane. “The Politics of Suffering: The Impact of the US Embargo on the Health of the Cuban People, Report to the American Public Health Association of a Fact-Finding Trip to Cuba, June 6-11, 1993.” Journal of Public Health Policy. 15.1 (1994): 86-107.

Lopez-Pardo, Candido, Nayeri, Kamran. “Economic Crisis and Access to Care: Cuba’s Health Care System since the Collapse of the Soviet Union.” International Journal of Health Services. 35.4 (2005): 797-816.

“Michael Fine, MD: Family Doctor, Community Organizer, Author.” 2007. 1 May 2011 <<http://michaelfinemd.com/index.html>>.

National Health Service Corps. 2010. US Department of Health and Human Services, US Department of Health Resources and Services Administration. 8 Dec 2010 <<http://nhsc.hrsa.gov>>.

National Association of Community Health Centers. 2010. 8 Dec 2010 <<http://www.nachc.com>>.

Novás, José Díaz, Sacasas, José A. Fernández. “From Municipal Polyclinics to Family Doctor-and-Nurse Teams.” Revista Cubana de Medicina General Integral. 5.4 (1989): 556-564. <http://www.medicc.org/publications/medicc_review/II/primary/poly.html>.

Philips, Julie P, Weismantel, David P, Gold, Katherine J, Schwenk Thomas L. “Medical Student

- Debt and Primary Care Speciality Intentions.” Family Medicine. 42.9 (2010): 616-622.
<<http://www.stfm.org/fmhub/fm2010/October/Julie616.pdf>>.
- “Policy Basics: Where Do Our Federal Tax Dollars Go?” Center on Budget and Policy Priorities.
15 April 2011. 27 April 2011 <<http://www.cbpp.org/cms/index.cfm?fa=view&id=1258>>.
- “Primary Health Care: Now More Than Ever.” The World Health Report 2008. World Health
Organization. 8 Dec 2010 <http://www.who.int/whr/2008/08_overview_en.pdf>.
- Project EINO. The Right to Health Care...Now! 6 Dec 2010
<<http://www.righttohealthcare.org/Docs/DocumentsA.htm>>.
- Ramers, Christian. “Medicina Cubana: A Fresh Perspective.” Western Journal of Medicine. 175
(2001): 129-130.
<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071506/pdf/wjm17500129.pdf>>.
- Reed, Gail. “Cuba’s Primary Health Care Revolution: 30 Years and On.” Bulletin of the World
Health Organization. May 2008. World Health Organization. 8 Dec 2010
<<http://www.who.int/bulletin/volumes/86/5/08-030508/en/index.html>>.
- Salud! Medical Education Cooperation with Cuba. July 2007. 2 Dec 2010.
<<http://www.saludthefilm.net/ns/us-health-briefs.html>>.
- “Sanctions on Health in Cuba.” The Lancet. 348.9040 (1996): 1461.
- “Shortage Designation: HPSAs, MUAs & MUPs.” Health Resources and Services
Administration. US Department of Health and Human Services. 18 April 2011
<<http://bhpr.hrsa.gov/shortage/>>.
- Sommer, Emilie. “Doctor Shortage Looms As Primary Care Loses Its Pull” USA Today. 18 Aug
2009. 14 Feb 2011 <http://www.usatoday.com/news/health/2009-08-17-doctor-gp-shortage_N.htm>.
- “The Debt to the Penny and Who Holds It.” 18 April 2011. US Department of the Treasury,

Bureau of the Public Debt. 20 April 2011

< <http://www.treasurydirect.gov/NP/BPDLogin?application=np>>.

“The U.S. Embargo Against Cuba: Its Impact on Social and Economic Rights.” Amnesty International. September 2009. 6 Dec 2010

< <http://www.amnesty.org/en/library/asset/AMR25/007/2009/en/51469f8b-73f8-47a2-a5bd-f839adf50488/amr250072009eng.pdf>>.

“The White House: President Barack Obama.” The White House. 2 May 2011

< <http://www.whitehouse.gov/healthreform/healthcare-overview>>.

“Timeline of Current Health Care Reform Effort.” WorldatWork. March 2010

< <http://www.worldatwork.org/waw/adimLink?id=36249>>.

Villegas, Andrew. “Primary Care For All In This Rhode Island Town.” Kaiser Health News.

15 Dec 2009. 1 April 2011

< <http://www.kaiserhealthnews.org/Checking-In-With/dr-fine-scituate-rhode-island.aspx>>.

Walker, Emily. “Health Insurers Post Record Profits.” ABC News. 12 Feb 2010. 27 April 2011

< <http://abcnews.go.com/Health/HealthCare/health-insurers-post-record-profits/story?id=9818699>>.

Wolf, Robert. “Number of Uninsured Americans Rises to 50.7 Million.” USA TODAY. 17 Sept

2010. 27 April 2011 < http://www.usatoday.com/news/nation/2010-09-17-uninsured17_ST_N.htm>.

World Health Organization. 2010. 3 Dec 2010 < <http://www.who.int>>.