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The Legal Context of Medicine: Looking at Healthcare through a Bicultural Lens

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Medicine - the art of diagnosing, curing, and improving people's health - encompasses many dimensions of the academic world. It is a field that can be viewed through different lenses such as from the perspective of the patient, culture, the family, etc. Academic disciplines often overlap these varying views. Psychology can speak to the individual experience, the importance of our behaviors and minds on health or sociology to the effect of health on an organized group of humans or vice versa. After experiences with vastly different cultures with their own individual systems of regulations, I suggest that one of the most important perspectives through which to view medicine is through the laws that govern the society and, therefore, the medical system. The ideology that government embodies sets the stage for the later molding of health law. This paper serves to reflect upon the practices and investigate the effects of core government principles on healthcare in both the United States and Cuba. The differences in governmental styles, as well as resulting cultures, have led to a more collective, preventative healthcare model in Cuba versus an individual, reactive model in the United States. These nations' styles have led to different practices in both nations, each with their own strengths and weaknesses and their own focus on global healthcare. Besides a general look at the founding principles of each nation, this paper will specifically investigate key health areas, including national and individual implications, for the twenty-first century: women's rights, vaccination, and mental health laws.

A history of the United States' legal development can be centered around the debate regarding the existence of a strong centralized government. The founding fathers, as they struggled to develop a framework for the great American experiment, themselves struggled with this question. As many nations across the globe have shifted to a more encompassing

governmental structure, the United States has maintained the rights of individual states, and along with the states, the supreme right of the individual. Citizens of the United States, from the birth of the nation, have expected a certain level of autonomy and the freedom to choose what is best for themselves. In truth, the United States has rejected any platform for a political theory advocating for community regulation. Conservative entities within the nation scoff at the idea of governmental regulation especially when such regulation interferes with the advancement of the individual. However, rejection of such a communal theory allows for stratification of individuals based on economic status. Theorists believe socialist ideals fail to enter the United States based on the construction of the U.S. Constitution (Lowi, 1984). Indeed, the United States lacks the diverse parties often decorating the political landscape of other nations, in part due to an electoral system emphasizing a single winner. A collective legal atmosphere would require a strong national government - a notion not entirely established by the constitution. However, with the devastation of the Great Depression, the national government of the United States strengthened and began to develop new policies outlined within New Deal programs. These programs, yet, were checked by the states - maintaining the United States' conservative principles.

Nowhere can the United States' focus on individual rights be seen more clearly than within its health law. Healthcare practices are determined individually - each person can decide whether or not to utilize healthcare services and what provider to see. Healthcare law mainly focuses on insurance availability and protection of patients' confidential information. Current healthcare law mimics the United States' economic stance in that it is based off of competition and driven by the market (Porter & Teisberg, 2004). Competition typically drives innovation, lowers costs and improves quality - each important markers of effective healthcare. Healthcare

business has received much attention in the past years and has been a focus of healthcare reform. Previous reform has served to try to lower costs and increase patients' legal rights while current reform looks at patient choice of healthcare plans and the practices of providers. All of these reform objectives maintain the idea that healthcare should be viewed as a business where patients are consumers with the right to pick and choose what healthcare they individually need and how much they wish to spend on it.

Much like consumers typically purchase commodities when they need it, the consumer model of healthcare has led to U.S. medicine becoming more reactionary than preventative. Americans typically only use about half of the recommended rate of preventative health services (Preventative Health Care, 2013). Many devastating chronic conditions stem from behaviors, such as lack of physical activity, poor nutrition, and tobacco or alcohol use, that may be altered with preventative care (The Power of Prevention, 2009). From an economic standpoint, the cost individual consumers and insurance companies pay for chronic care could be offset with preventative methods. Chronic conditions cost hundreds of billions of dollars for the United States. These conditions are not only costly from a monetary standpoint, they are also harmful to individuals and society. Prevention services such as the Trust for America's Health campaign, a campaign focused on eliminating physical inactivity, nutritional deficiencies, and smoking, have had yields as high as \$5.60 per dollar spent. However, the consumer mindset again prefers focus on the momentary needs of the individual rather than healthcare's longterm goals.

Cuba adopted its own constitution, starkly different from the United States' model, in 1976. While some roots in each constitution sound similar such as rights for equal treatment in the eyes of the law, the method these two nations employ for equality stand opposed (Evenson,

2005) Cuba's socialist roots and communist ties have made it a community-focused nation with the idea of equality stemming from distribution of resources rather than ownership. In this model, equality results from capping individual wealth and ownership, while in capitalism, equality results from unlimited growth potential. Karl Marx developed this theory based on the struggles of a working class (Dolenec & Žitko, 2015). According to Marx, working class individuals should aim to benefit the whole. Through the socialist lens, private property becomes insignificant as all goods are considered resources for the benefit of the socialist community. According to the Cuban constitution, every individual is guaranteed a certain right to care as this will benefit the community and, by extension, nation as a whole (Evenson, 2005). While economically Cuba's stance has proved not ideologically equal for many members due to trade decline, when it comes to healthcare, Cuba appears to flourish (Spiegel & Yassi, 2004).

The focus on communal welfare has led to the development of specific laws aimed at protecting public health. Article 50 of the Cuban constitution states the all Cubans should have access to free medical care while other articles ensures no discrimination be found in healthcare, workers be protected in regards to health and safety, and elderly assistance be made available as well as maternal healthcare (Evenson, 2005). Article four presents guidelines for the organization of Cuban healthcare including: free health services being provided, prioritizing prevention, activating the community in health planning, furthering medicine through the scientific method, and providing international health assistance. A clear message can be found through each of these constitutional articles - healthcare is an undeniable right for not only Cubans, but all individuals no matter where they are from or who they are.

The commitment to full healthcare access for all in Cuba has led to an important health consequence within the nation: preventative care. All patients are visited at home once a year unless they develop conditions requiring more frequent monitoring (Campion & Morrissey, 2013). While prevention services range from vaccinations to prenatal care, Cuba also places great value on health education with it being a compulsory component to school curriculum. The availability of education in Cuba alongside its health focus has led to a plenitude of physicians being educated for the Cuban community. Not only are the physicians required to have adequate medical knowledge, they are also instructed to learn and consequently tend to the specific needs of their practicing community (Keck & Reed, 2012). In fact, the physician and her team are integrated within the community so that they might understand their community's needs and remain accessible in times of emergency (Spiegel & Yassi, 2004).

Women's Health

United States

Many healthcare agencies use infant and maternal mortality along with prenatal care as markers of healthcare effectiveness. These two factors are often intertwined as proper prenatal care can minimize the risk of pregnancy complications and help ensure a non-complicated birth. The United States has a multitude of resources for pregnant women if they visit their physician. Due to the development of a consumer based healthcare system, however, many women report barriers to prenatal care access (Phillippi, 2009). In fact in 2005, nearly thirty percent of women in the United States did not receive prenatal care until after the first trimester. Pregnant women within the United States identified finances, transportation, inconsistent providers, and the needs of older children as barriers to them successfully being able to receive prenatal care. These

barriers primarily deal with a woman's ability to go to see a physician. With the high cost of giving birth and raising a child, many women do not view prenatal care as worth their investment. Such concerns disproportionately affect people of lower socioeconomic status and individuals in rural areas. Although getting to and paying for the physician's services are the main barrier for certain classes of expecting mothers, researchers have found that clinical wait times disrupt prenatal care for privately-insured women as well. Likewise, educational deficiencies on the importance of prenatal care and the resultant lack of motivation by mothers to seek prenatal care also hinders prenatal care access. Despite these barriers to prenatal care, the United States has kept maternal mortality and under-five mortality low at twenty-eight per 100,000 live births and seven per 1000 live births respectively (United States of America: WHO statistical profile, 2015).

A highly disputed practice affecting women within the United States is the availability of contraception for sexual encounters and minor education on sexual health. Legally, the United States shies away from establishing a national sexual health curriculum in schools leaving states to individually develop their own programs (Weaver, Smith & Kippax, 2005). Many of the existing educational programs revolve around abstinence, claiming it as only way to avoid disease and pregnancy. According to the World Health Department, the lack of sexual education and focus on abstinence-only practices have resulted in a contraceptive prevalence of 76% (United States of America: WHO statistical profile, 2005). Despite a "hands-off" approach to sexual education, the United States has taken a "hands-on" approach to abortion services. Laws limiting services and placing distinct non-medical requirements on abortion have sprung from a conservative movement citing religious rejection of pregnancy termination. Many states require

24-hour waiting periods and/or counseling on the consequences of abortion before services can be obtained (Beckman, 2016). Even with such restrictive laws, abortion rate has increased by 1% between 2005 and 2008 to a total incident of 19.6 abortions per 1,000 women (Jones & Kooistra, 2011). The increase in abortion rate was found especially in poor and low-income individuals. As abortion incidence has risen, so too has antiabortion harassment involving picketing, blocking patient entrance, and Internet harassment.

Cuba

One of the most prominent foundations of the Cuban healthcare system is their commitment to newborn and maternal health. Legally, expecting mothers are required to cease working at 34 weeks with paid leave and are prevented from participating in harmful workplace actions (Evenson, 2005). Prioritizing prenatal care is due not only primarily to Cuba's commitment to public health but also to Cuba's view that each successful pregnancy might result in national success (Bragg et. al., 2012). The interventions Cuban physicians administer serve to reduce the maternal mortality rate, improve hygiene and nutrition, educate the mother, and make care accessible and regular. Physicians provide women categorized as having a high-risk pregnancy with a specific plan as well as either in-patient or outpatient care in a maternity home. The expecting, high-risk mother typically moves into the maternity home, leaving children with other relatives or a social worker, and receives nutritionist-planned meals, lab testing, fetal surveillance, activities, and a handful of other health benefits. Family members have visitation available for in-patient mothers. While admission is not considered mandatory, a vast number of pregnant Cubans use this service. These efforts have led to Cuba having a maternal mortality rate

and under-five mortality rate at 80 per 100,000 live births and six per 1000 live births respectively (Cuba: WHO statistical profile, 2015).

Cuba reaffirms its commitment to health literacy by placing importance on sexual health education. Health education not only occurs in schools, but also continues within the community. For example, women staying at maternity homes are taught what to expect during the prenatal period, are directed to contraception services, and taught about sexually transmitted diseases such as HIV/AIDS (Bragg et. al., 2012). Contraception, in fact, is free and suggested as an appropriate manner of family planning (Campion & Morrissey, 2013). While contraception use remains widespread, Cuba retains exceedingly high abortion rates (Bélanger & Flynn, 2009). Initial prevalence of abortion in Cuba can be traced back to limited contraception availability at the onset of the 1962 embargo. After being able to import contraceptives from other places, Cuba struggled to educate the population on contraceptive use. In order to further reduce the abortion epidemic, Cuba attempted to restrict abortion services leading to an increase in maternal mortality from unregulated, unsafe abortions. Finally in 2006 a statement made by the Cuban government conceded abortion is a justifiable option for women. Despite its rocky history, abortion levels in Cuba remain one of the highest in the world. Individuals with previous abortions claim widespread acceptance, lack of moral constraints, skepticism concerning contraception, and economic concerns as factors influencing their decision to terminate a pregnancy.

Comparison of Women's Health in the United States and Cuba

The United States and Cuba each take different stances when it comes to female reproductive health. Going along with its individualistic viewpoint, the United States considers

pregnancy a sort of “condition” to be treated at the patient’s will - an individual may use prenatal care if desired, however, there are no pressures for doing so. Likewise, with the expense of American healthcare, many women prefer to save funds for labor and cannot afford to take off work for extended periods of time. Conversely, Cuba suggests that pregnancy and prenatal care should be viewed as a public health concern (Bragg et. al., 2012). Cuba’s pregnancy care efforts, while diligent, present an interesting issue to Americans - should medicine interfere so far with life as to remove a pregnant woman from her job and family in order to protect the fetus and mother for the good of the nation. Many Americans would reject the idea of supreme monitoring over the course of a pregnancy, rather preventative education and expansion of risk definition so that more women can receive preventative services could positively influence U.S. maternal-fetal care. Such strides might improve the quality of care for many Americans, however, these methods do not seem to have as great of an impact on Cuban mothers as expected. In comparison to the United States, Cuba’s maternal mortality rate remains much higher (Cuba: WHO statistical profile, 2015). While infant mortality between the two nations is comparable, a limited quantity of resources could make all the difference for Cuba’s maternal mortality rate (Campion & Morrissey, 2013). Likewise, while education persists as a great component of Cuban healthcare, limited understanding of contraception and prominent use of more invasive techniques such as abortion remain prevalent (Bélanger & Flynn, 2009). In order for more widespread contraception use and improved pregnancy outcomes, a comprehensive sexual health curriculum involving contraception should be evaluated for each nation in order to dispel contraceptive myths and ensure successful pregnancy outcomes.

Vaccination

United States

Vaccines revolutionized the medical arena with their ability to prevent some of the most deadly illnesses encountered by children and adults. Many organizations have organized a global partnership to work and eradicate small pox, poliomyelitis, measles, and other diseases using vaccines (Duclos et. al., 2009). Immunization programs help to prevent millions of deaths each year and, therefore, are considered vital to any nation's public health plan. The United States alone has seen a 99% decrease in nine disease due to immunization (Andre et. al., 2008). While the federal government passed laws requiring vaccination for smallpox relatively quickly after the introduction of vaccines, the nation has faced waves of vaccination compliance and noncompliance (Omer et. al., 2009). Vaccine distrust led to the reappearance of smallpox until states began enforcing the federal government's mandate. However, with compulsory vaccination came heightened backlash resulting in multiple states abolishing vaccination law altogether. In 1905, the U.S. Supreme Court left immunization requirements up to each individual states, where many required vaccination prior to starting public school. Due to differing beliefs on vaccination in each states, the vaccination profile of the United States varies wildly, with many states allowing individual beliefs to exempt them from vaccination law. The rate of immunization exemption increased in recent years due to parental philosophical or personal opinions. Vaccine refusal increases the risk of contracting the target disease for the non-compliant individual and for community members to be at risk for the disease. Even with the widespread inconsistencies with vaccination law, measles immunization in the United States stays at 91% for one-year-olds, the diphtheria-tetanus-pertussis immunization for one-year-olds

remains above 90%, and the rate of death due to malaria is 0 per 100,000 people (United States of America: WHO statistical profile, 2015).

Cuba

Cuba's National Immunization Program, established in 1962, eliminated many diseases within the nation making it one of the nations with the lowest levels of vaccine-preventable diseases (Reed & Galindo, 2007). Quickly after the start of the immunization program, diseases such as poliomyelitis, diphtheria, measles, pertussis and rubella were eliminated and diseases including tetanus, *Haemophilus influenzae* type b, typhoid fever, and mumps were no longer considered a major health concern. The National Immunization Program operates with four goals in mind: not leaving out any member of the population, the importance of primary healthcare to vaccination, active community participation, and keeping vaccines free. The Cuban government has met its vaccination goals in part due to the development of its own vaccine-manufacturing companies (MacDonald et. al. 2006). Such programs have enabled Cuba to keep immunization compliance high with measles immunization at 99% for one-year-olds and the rate of death due to malaria at 0 per 100,000 people (Cuba: WHO statistical profile, 2015). The diphtheria-tetanus-pertussis immunization for one-year-olds, in 2015, was higher than 90%, however, between 2000 and 2005, immunization dropped to below 70%.

Comparison of Vaccination in the United States and Cuba

Immunization rates within the United States and Cuba remain fairly consistent with the majority of citizens receiving the recommended vaccinations and a large decrease in vaccine-preventable deaths. The people within each nation, however, retain differing perspectives on why to refuse vaccination. In the United States, many individuals choose not to vaccinate their

children due to personal beliefs such as the true need of vaccinations and their safety (Omer et. al., 2009). Such parents were also highly likely to research vaccines via the Internet and subscribe to groups that object vaccine administration. Gathering such information from unreliable sources leads many parents to believe that vaccines cause harm and to refuse to vaccinate. While much of the United State's hesitance to vaccinate stems from false research, Cuba's high vaccine compliance could be due to their lack of media and Internet access (Campion & Morrissey, 2013). Even with their high success rate in vaccination, the Cuban system remains far from perfect. Vaccines might treat many contagious diseases, however, crumbling infrastructure has lead to increases in certain diseases (Sixto, 2002). For both nations, the effectiveness of eradicating vaccine-preventable deaths requires further governmental action. Public education on vaccine benefits and a restructuring of current infrastructure would serve to bolster preventative methods in order to improve outcomes for the entire community.

Mental Health

United States

Modern medicine often places a great deal of importance on not only physical health but also accompanying mental health. Decreased mental health results in suffering, disability, early death, and emotional distress for patients and communities (Kohn et. al., 2004). Many mental disorders have an early onset, yet, treatment is often delayed due to stigma and treatment barriers. Focus on mental health has shifted in the past several years within the United States - more patients find themselves eligible for treatment and care services have grown (Wang et. al., 2005). Community programs have also been implemented to raise awareness and provide support for those with mental illness. While improvements have been made to mental health

care, mental disorders still limit millions of people from living a healthful life (Mechanic, 2012). Mental disorders still plague the United States because of the struggle federal and state governments experience to serve mental health patients. Insurance policies, with their many regulations, have made treating mental illness puzzling and left gaps in treatment. The advent of the Affordable Care Act (ACA) revived the United States' mental health policy, enabling providers to better treat mental illness. The ACA allowed for improvements in organization and cost, chronic disease treatment, coordinating treatment efforts with the needs of the homeless, bolstering preventative services, and supporting evidence-based treatments. One way the ACA hopes to improve mental health treatment is through health homes - a treatment plan for severe mental illness where integration of several services can occur. Substance abuse treatment makes up another vital component to the mental health section of the ACA. It recommends that services should be integrated for the whole individual while supporting education, employment, and harm-prevention among others. Such reform is especially vital due to the gaps in mental health services - only 47.8% of patients with disorders receive what can be classified as minimally adequate treatment (Wang et. al., 2005).

Cuba

Post-revolution, healthcare within Cuba changed drastically to become a model based on equality. With the reorganization of healthcare, psychiatric care shifted from an institutional model to a model based on the newly formed healthcare system (Basauri, 2008). This new mental health model was focused on four key principles: making psychiatric care available throughout the country, placing already present services in the new model, modernizing in-patient care, and expanding facilities while training new workers. Psychiatric units were built in

hospitals with special areas for crisis intervention and outpatient services. These units were preferred over institutionalization due to their being more cost effective and efficient for treating mental health. While initial treatment methods were based on the practice of medicine, later different perspectives were introduced leading to a more comprehensive model in practices. One hospital in Cuba, whose psychiatric unit responds to crises, admits patients most often for substance abuse disorders with an average inpatient stay of slightly over two weeks. A ward in the same hospital admits mostly affective disorder patients with more extended stays for patient treatment. Continuation of care occurs through the hospital's home care program where the mental health team and family physician coordinate care for the individual and their family. As in other areas of Cuban healthcare, mental health treatment begins at the community level with education and prevention focuses.

Comparison of Mental Health in the United States and Cuba

The United States' mental health landscape has drastically shifted within the past few years due to changes in the delivery of treatment and diagnostic changes (Wang et. al., 2005). Even with the improvements made to the mental health system, the United States still faces challenges to its mental health mission. Elderly individuals often face obstacles to care and many people fear being branded with the stigma of having a mental disorder. Treatment adequacy remains low potentially due to decreased training or lack of patient compliance. Differences in treatment rate also exist for racial and ethnic minorities suggesting barriers to care might be present. However, the increased outreach and standards for care designed within recent legislation suggest a bright future for U.S. mental health. Similarly, Cuba has experienced challenges to its mental health goals. Suicide remains a top-ten cause of death, and 25% of

individuals seeking health services have been diagnosed with depression (Gorry, 2013). Alcohol consumption has also risen in Cuban women indicating a potential for substance abuse disorders. In fact, many mental health workers indicate alcohol as their primary concern leading to accidents and violence. Treating substance abuse proves an additional challenge because of the scarcity of pharmaceuticals to lessen the severity of withdrawal. Another concern Cuba faces deals with its increasingly aging population. As the Cuban population ages, mental health providers must shift to provide for the care of elderly adults, a group often challenging to treat. Regardless of the concerns within Cuban mental healthcare, expansion of mental health services into primary care and the dedication to community awareness encourage the idea that Cuban psychiatric care will continue to improve.

Global Health

United States

The World Health Organization directs nations with well established health systems to support other nations' healthcare development in order to strengthen health for the global community (Bloland, 2012). The United States has made strengthening weaker health systems a priority by investing in systems with scarce resources. The U.S. Government has supported various programs within underdeveloped nations through its own investment and partnerships with the academic arena and private donors (<https://www.ghi.gov>). Specific programs in place include: The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), The President's Malaria Initiative (PMI), and Feed the Future. PEPFAR was developed to move the fight to eradicate HIV and AIDS from an emergency response to well-planned programs that strengthen the indicated nation's ability to take the epidemic into their own hands (<https://www.pepfar.gov>).

The program also works via its investment in medical services. Three of PEPFAR's main objectives include preventing HIV infections, providing care and treatment for over 4 million people, and supporting the nation's transition to a self-sufficient system. Meanwhile, PMI fights to reduce malaria mortality by 50% through practices and treatment involving insecticide-treated nets, indoor spraying, therapy administration, and preventative treatment for select groups in the population (<https://www.pmi.gov>). The final project, Feed the Future, has fought to end global hunger and improve nutritional status in women and children through investment in the agriculture sector(<https://www.feedthefuture.gov>). Current progress through this program includes a drop in poverty and child stunting along with assistance provided to over 9 million farmers. These programs, over a five year period, have received over \$50 billion in investment from the United States Government (<https://www.ghi.gov>). The investment made by the U.S. serves to fulfill the seven pillars of the Global Health Initiative: gender equality, country ownership, strengthening of health systems, partnerships, integration, evaluation, and research/innovation. Through its work, the United States has assisted the World Health Organization to strengthen global health.

Cuba

Equal access to healthcare remains a clear thread throughout Cuba's laws and governing perspective. In fact, Cubans do not only see healthcare access as an important right for themselves, but they also see healthcare as an important right for the rest of the world. Beginning with the onset of new Cuban leadership in the 1960's, Cuban doctors traveled across the globe providing medical care (De Los, 2005). The Cuban government has sent trained healthcare workers across the globe to assist during times of crisis and war. Others have been sent to

struggling countries in order to help set up medical facilities for impoverished regions. Besides solely traveling abroad, programs exist within Cuba itself where individuals from other nations may come for treatment. Near Havana, the Ciudad de Pioneros Tarara offers medical treatment for radiation victims specifically for children affected by the Chernobyl disaster. By sending healthcare teams abroad, Cuba has fostered a sense of good-will around the world while spread their socialist ideals (Blue, 2010). However, Cuba does not consider being on good-terms with a nation in need a qualifier for offering medical assistance - countries that have been critical of Cuba have still received assistance during disasters (Huish & Kirk, 2007). As part of Cuba's work to stand in solidarity with Central America, Cuban schools helped to develop the Latin American School of Medicine. The school offers scholarships and trains physicians to become active and involved medical practitioners within their home nations. Once again, by training medical professionals Cuba hopes to develop a sustainable model of healthcare throughout its own region and the globe.

Comparison of Global Health in the United States and Cuba

The United States and Cuba both serve to help improve medical care standards across the globe with effective, but contrasting, methods. The United States' investment into international healthcare has the doubled effect of improving many nations' general standards of living and bolstering their economies (<https://www.ghi.gov>). Though some trained individuals are sent globally to teach and serve, the majority of assistance the United States provides is an investment in pre-existing structures to allow the nation to become independently healthful. Cuba also provides assistance, however, their assistance requires medical professionals to depart from their island home to serve other nations. Such individuals find incentive for leaving Cuba due to

increased earnings in comparison to what they would make by staying in Cuba (Blue, 2010). The Cuban government takes advantage of the extra pay by imposing a 57% tax on earnings leaving the remainder for the physician to spend and enrich the Cuban economy. However, the incentive of such lucrative pay causes many healthcare workers to travel abroad and thus leave Cuba with a shortage of doctors to meet the nation's needs. Another incentive program for healthcare workers to remain in Cuba must be put in place if Cuba wishes to retain its high level of national care.

Conclusion

The United States and Cuba both run successful healthcare systems each resulting from a different governmental framework. As a nation built upon Marxist theory, Cuba places value on equality with laws built to redistribute wealth and level the playing field for education, healthcare, and resources. The United States places value on the availability of opportunity with laws focusing on minimizing governmental regulation and maximizing free choice. Each of these foundations have led to the development of healthcare systems that provide valuable care with different management styles. Though Cuba has found success in its available care, the system still faces challenges. Despite the family doctor's role of the first contact Cubans have with the healthcare system, over 25% of consultations occur within emergency departments (De Vos, 2005). Cuba's international mission also depletes the availability of family doctors by removing trained individuals from the countryside. Since Cuba's healthcare and economy are so intertwined, economical changes have a drastic impact on the functioning of the medical system. One such example of the consequences of an intertwined economy and healthcare system occurred in 1990 when Cuba faced economic crisis. During this time period, medical facilities

deteriorated and new equipment was not available. The economic recession, therefore, led to a direct decrease in medical advancement. Additionally, preventative practices in Cuba and the system's objective to pinpoint outside determinants to public health have not always been able to be implemented properly (Castell-Florit Serrate et. al., 2007). Cuba struggles to train individuals at a high enough pace to keep up with national demands and many individuals cannot devote the time such a health model needs. Despite these issues, Cuba has successfully monitored the needs of their nation and promoted health plans for the good of the people.

As the U.S. healthcare system continues to develop, progress has been found in expanding coverage and improving the existing system. With the reform program outlined in the Affordable Care Act, the medically uninsured population dropped by more than 20 million people (Obama, 2016). Despite this improvement, healthcare costs within the United States remains high (Porter & Teisberg, 2004). The competitive nature of healthcare business set up by current legislation fails to drive down costs and improve performance. The current competitive environment focuses greatly on reducing cost for employers and health plans. Research suggests that instead, competition should focus on outcomes in order to improve the value of healthcare rather than the amount the purchaser spends. In addition, the United States must focus on prevention to decrease medical costs and improve nation performance on health indicators such as life expectancy (Benjamin, 2011). Focusing on prevention will not only save billions of dollars on public health costs, but also will educate individuals to make healthful decisions, reducing current health disparities seen in the U.S. population.

Both Cuba and the United States would benefit from incorporating other health care methods into their own systems. In order to avoid excess use of emergency services and to keep

Cuban physicians at home, an incentive program must be put into place. Also, competition within the national system could increase quality of care for Cuban citizens while making them personally more invested in their own health. Finally, Cuba lacks a focus on personal choice when it comes to medicine that could make Cubans more passive healthcare consumers instead of actively "well" people. In contrast, the United States could take Cuba's development of an encompassing health policy mission as a starting point to shift its focus from medical care spending to the development of healthful practices (Keck & Reed, 2012). The Affordable Care Act has helped to move the healthcare conversation onto prevention and reorient the system back onto the patient. Also, public health concerns must be made a priority in order to build a medical framework capable of preventing chronic conditions and empowering individuals to take control of their own health. U.S. communities vary drastically in their healthcare needs, which lawmakers need to consider as a national healthcare plan develops.

During my own time spent in Cuba, I had the opportunity to critically look at a healthcare model different than the one I was accustomed to in my home of the United States. Through my trip, I spoke to physicians, lawyers, and citizens of Cuba and gathered an idea of what daily Cuban life was like. While I was glad to hear of the accomplishments Cuban medicine has made, I was amazed to see Cuban healthcare in operation. Much of the medical equipment was rusted and ancient-looking through my United States eyes. Bed sheets were stained and worn, medical records were in dusty piles, and the power had gone out with the lack of a back-up generator leaving us in the dark. In fact, this was the sense of the nation as a whole - covered in the dust of ideological practices that just do not quite fit my view of acceptable medicine. My United States eyes were once again horrified to see the living conditions in a maternity home. While many of

the pregnant women were glad to be there, the care they received was far greater than the care they would receive in their rural Cuban communities, I could not wrap my head around the fact that beds were lined up, stacked nearly on top of each other, in rows for the women to stay for months. Women in the United States would not take kindly to being forced into a crowded room with no air conditioning and insects buzzing around in order to receive adequate medical care. Clearly, though Cuba has implanted a strong national medical practice, care would not be up to the expectations of a patient in the United States. In this way, the United States' model of medicine has proven successful by maintaining high standards within all portions of the healthcare experience.

Healthcare law remains an important field for the development of healthful practices within a nation. The foundations of a nation can serve to direct the conversation of healthcare throughout a nation's history. By ensuring equal access to healthcare, focusing on the needs of the community, and using preventative practices, a healthcare system might better serve its constituents and improve the health of the nation. However, competition within the healthcare system might provide other benefits by improving standards of care. For this reason, it is suggested that healthcare policy be developed with the assistance of medical professionals in order to better serve the needs of both the population at large and the medical community. Cuba and the United States might improve the health of their own people by further transforming the policy framing their own healthcare system through knowledge of the nation's health needs and by looking into successful practices within neighboring nations.

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