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James Lester Schwar
University of Kentucky, jlschw3@uky.edu

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ABSTRACT OF DISSERTATION

James Lester Schwar

The Graduate School
University of Kentucky

2004

GLOBAL CHANGE, DOMESTIC POLICY, AND LIFE COURSE INFLUENCES
ON PERCEPTIONS OF HEALTH EQUITY AMONG OLDER CUBANS

ABSTRACT OF DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy
in the College of Public Health at the University of Kentucky

By
James Lester Schwar

Lexington, KY

Director: John F. Watkins, Professor of Geography

Lexington, KY

2004

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ABSTRACT OF DISSERTATION

GLOBAL CHANGE, DOMESTIC POLICY, AND LIFE COURSE INFLUENCES ON PERCEPTIONS OF HEALTH EQUITY AMONG OLDER CUBANS

Cuba's provision of free health services to the entire population via neighborhood-based family doctors produced dramatic health gains and achieved a relative state of health equality. Since 1989, however, the termination of Soviet trade, a grave economic crisis, intensification of the US embargo, welfare reductions, and population aging have placed Cuba's health successes and elder care services in jeopardy. Little independent research, though, has focused on the influence of post-Cold War circumstances on citizen attitudes about health programs and resources targeting Cuba's older population.

This research examined global and domestic factors since 1989 that have most influenced perceptions of the equitability and inequity of health resources among older Cubans. Its multi-layered design drew on new International Political Economy, crystallization, and aspects of Grounded Theory. In-depth narrative interviews were conducted with Cubans age 60 years or older, their families and community support group members, family physicians and other medical personnel, and key health and government informants.

Perceptions of health equity were found to correspond most with the geographic proximity and nearly unhindered physical access of older patients to their family doctors and the temporal availability of family physicians to their older patients. Conversely, perceptions of health inequity corresponded most with the older person's experience of medicine shortages and health resource rationing following global socio-political-economic change and domestic policy shifts after 1989. Furthermore, the life course influences of the pre- and post-revolutionary eras

and pre-1989 and post-Cold War period were seminal in shaping the perceptions and expectations of the older participants regarding health care, the leadership, and Cuban socialism.

The findings have added to the international health and cross-cultural gerontology literature. Decision-makers and health practitioners in Cuba and elsewhere have been informed about the importance of popular perceptions of the impact of health and elder policy change in an era of globalized social relations and capital. The research also has contributed a gerontological dimension and a narrative perspective to further the development of new International Political Economy.

KEYWORDS: Cuba, Cross-cultural Gerontology, Health Equity, Health Inequity, Political Economy

James L. Schwar

December 13, 2004

GLOBAL CHANGE, DOMESTIC POLICY, AND LIFE COURSE INFLUENCES
ON PERCEPTIONS OF HEALTH EQUITY AMONG OLDER CUBANS

By

James L. Schwarz

John F. Watkins
Director of Dissertation

John F. Watkins
Director of Graduate Studies

December, 13, 2004

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DISSERTATION

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University of Kentucky

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Dedicated to my love and my son.

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Chapter One

Introduction

The Issue of Aging, Health Equity, and Health Inequity in Cuba

Socialized health care and neighborhood-based family medicine are two hallmarks of the Cuban health revolution. Universal, cost-free health care and ultra-local family doctor coverage of the entire population have brought about dramatic improvements in population health status (Feinsilver, 1993; MacDonald, 1999; Nayeri, 1995; Pan American Health Organization, 1990). These achievements also have produced a relative state of health equality, wherein the citizenry has shared health benefits, risks, and costs equally (Susser, 1993). For example, a recent assessment of 191 world health systems ranked the Cuban model 39th in the world, just five positions lower than the US world rank; Cuba was ranked the highest of all Latin American nations, and, alongside Canada, as having the fairest health financing mechanism in the Americas (World Health Organization, 2000d). An analysis of 25 nations in the Americas, meanwhile, revealed that Cuba had Latin America's best health situation (United Nations Development Program, 1999b).

Table 1.1 highlights Cuba's health accomplishments by comparing recognized

Table 1.1. Select Comparative Health Statistics in the Americas

Country	Total Health Expenditure as % of GDP		Infant Mortality Rate Per 1000 Live Births		Life Expectancy at Birth (Both Genders)	
	1995	2000	1960-1965	1990-1995	2000	2001
Argentina	8.2	8.6	60	24	73.7	73.9
Bolivia	4.4	6.7	163	75	62.2	62.7
Canada	9.1	9.1	26	7	79.1	79.3
Costa Rica	6.3	6.4	81	14	76.4	76.1
Cuba	5.7	6.8	59	10	76.8	76.9
Mexico	5.6	5.4	88	34	74.2	74.2
Nicaragua	6.4	4.4	131	52	69.3	69.5
US	13.3	13.0	25	8	76.8	77.0
Uruguay	9.2	10.9	48	20	75.1	75.0

Adapted from "The World Health Report 2002: Reducing Risks, Promoting Healthy Life," by World Health Organization, 2002; "Health in the Americas: 1998 Edition: Vol. 1," by Pan American Health Organization, 1998.

international health indicators from select nations in the Western Hemisphere. Along with the US and Canada, Cuba led the Americas in low infant mortality and high life expectancy rates at the end of the 20th Century. Although Cuba has drawn nearer to the advanced nations of North America in important health measures, its health expenditure as a percentage of Gross Domestic Product (GDP) was nearly half that of the US and almost one-third less than Canada in 2000.

These enviable health achievements, which equal or surpass those realized by many of the world's developed nations, have been the key sources of domestic support for Castro, the Cuban government, and the nation's socialized health model (Butler, 1999; Kuntz, 1994; Schwar, 2002; World Health Organization, 2000d). Similarly, these health successes have enabled the Cuban leader to garner international prestige (Butler, 1999; Feinsilver, 1993; Stein & Susser, 1972; United Nations Development Program, 1999b; World Health Organization, 1998a). Because such great significance has been placed on health, Castro has pinned the legitimacy of the government and Cuban socialism largely on the population's satisfaction with health care services (Feinsilver, 1993). Furthermore, Cuba's obsession with health and, accordingly, citizen contentment with the health system, is now being focused on aging, the aged, and elder care (Sabo, 2004).

Demographic projections of Cuban population aging underscore the leadership's growing concern with regard to elder care. As shown in Table 1.2, Uruguay and Canada had the greatest percentage of the total population age 60 years or older in 2002, followed by the US, Puerto

Table 1.2. Growth Among Select Older Populations in the Americas: 2002-2050

Country	Number Age 60+ (in Thousands)		Percentage 60+ of Total Population		Percentage 80+ of 60+ Population	
	2002	2050	2002	2050	2002	2050
Argentina	5,087	12,773	13	23	14	19
Canada	5,340	12,314	17	30	18	29
Costa Rica	323	1,605	8	22	11	20
Cuba	1,612	3,657	14	34	16	29
Mexico	7,345	35,716	7	24	12	19
Puerto Rico	585	1,359	15	28	18	23
US	46,960	106,660	16	27	21	28
Uruguay	582	1,059	17	25	16	23

Adapted from "Population Ageing-2002," by United Nations, 2002.

Rico, and Cuba. However, Cuba's 60-plus population is projected to increase almost 127 percent between 2002 and 2050. By the mid-21st Century, the 60-plus demographic is expected to comprise more than one-third of Cuba's total population.

The population that is age 80 years or older is the world's most rapidly expanding birth cohort, especially in the developing nations (Apt, 1990). Persons in the so-called *oldest-of-the-old* demographic category require higher levels of more continuous medical care than any other age group (Clair, Yoels, & Karp, 2000). The United Nations forecasts that Cuba will record an almost 311 percentage increase in the 80-plus population between 2002 and 2050 (United Nations, 2002b). Thus, Cuba, which already is one of the oldest nations in Latin America, is predicted to share with Canada the distinction of being the oldest country in the Western Hemisphere by 2050 (Prieto Ramos, 2000). However, international and domestic socio-political-economic forces that have beset Cuba's health and social welfare model since the fall of the Berlin Wall have endangered the prospect of caring for its older population.

Globalization, Neo-liberalism, and Cuban Health Care

The demise of the Soviet trade bloc and tautening of the US embargo severed Cuba from an increasingly capitalist global market place after 1989. By 1991, Cuba had lost its transworld relationship with the Soviet bloc, upon which it was dependent for more than 80 percent of all trade (Mesa-Lago, 1993a). Despite a surprisingly responsive health care structure, the nation's economic model was unable to compensate for the abrupt 50 percent loss of all food imports and the nearly complete termination of imported medicine and health-related products (American Association for World Health, 1997; Flavin, 1997; Garfield & Santana, 1997; Pan American Health Organization, 1999). Consequently, Cuba's economic situation reached crisis proportions within a matter of months following the collapse of the Soviet community.

These unpredictable political and economic circumstances jeopardized the equality of Cuba's health care system and endangered more than three decades of population health gains, above all for its older citizens (Cuba In Evolution, 1998; Flavin, 1997; Garfield & Santana, 1997; Grogg, 2003; Kuntz, 1994; Nayeri, 1995; Pan American Health Organization, 1999; Schwar, 2001, 2002). For example, mortality among elderly Cubans from a range of non-communicable maladies, including heart disease and tuberculosis, increased at least 10 percent in the period 1993-1994 alone (Garfield & Santana, 1997). Facing a health disaster, as well as a socio-

economic catastrophe, Castro was forced to accept a more liberalized economic, health, and social welfare approach (Castro, 1996; Dilla, 1999; Ritter, 1994).

At the apex of the crisis in 1994, Castro came under intense pressure both internally and internationally to bring Cuba in line with a US-like *democratic civil society* by embracing the Neo-liberal political-economic model. Cost-containment, systemic efficiency, and the privatization of health, medical, and social services represent the economic dimensions of the Neo-liberal approach to health and social welfare (Gilson, 1998; Gonzáles Block, Sandiford, Ruize, & Rovira, 2001; Guerra de Macedo, 1989; Gutierrez, 1989; Hopton & Dlugolecka, 1995; World Health Organization, 1998c, 2002b). In what might be seen as movement toward Neo-liberalism, Castro privatized Cuba's tourism sector, reduced the public health budget by 30 percent, and instituted a number of welfare austerity measures, including health resource rationing (American Association for World Health, 1997).

Although accepting a degree of liberalization, the 78 year-old leader refused to surrender Cuba's socialist health design (Pérez-López, 1994a; Sabo, 2004; Tamayo, 2000). At the height of the crisis, for example, Castro declined to amend the constitutional proviso for universal health care. Instead, increased tourism receipts were expected to provide the convertible revenue necessary to preserve and grow the still socialized health and social welfare service system (J. Gordon, 1997; H. Thomas, 1998). Similarly, Castro followed through on his vow to expand the national Family Doctor Program, and boldly announced that Cuba would begin pursuing a sweeping national long-term elder care initiative regardless of the economic crisis (Castro, 1985c; Dotres Martínez, 1996b; Prieto Ramos, 2000; Reed, 2000a; Schwar, 2002).

Cuba's economy began to recover after the mid-1990s. Still, the lingering effects of the fiscal crisis and subsequent reforms are regenerating health inequalities and class divisions that were generally equalized after the Revolution, primarily among older individuals on fixed pensions with little or no access to tourism dollars (Cuba In Evolution, 1998; Flavin, 1997; Garfield & Santana, 1997; Pan American Health Organization, 1999; Roman, 1995; Schwar, 2001, 2002; P. K. Thomas, Plant, Baxter, Bates, & Santiago Luis, 1995). Furthermore, Castro and the leadership face an additional challenge in the coming years and decades of meeting the escalating health and socio-economic needs of a sizeable aging population with the limited resources of a developing nation that has yet to fully recover from economic depression (Prieto Ramos, 2000; Ritter, 1994). For these reasons, there are three future certainties for health and

social welfare in Cuba and, indeed, all nations of the world: 1) rising citizen expectations and demand for increased public expenditures; 2) continuing global expansion of the Neo-liberal model; and 3) mounting equality and equity concerns (Alonso, Donate-Armada, & Lago, 1994; Baker et al., 1994; Clair et al., 2000; Cornia, 2001; Diaz Novas & Fernandez Sacasas, 2001; Gertler, Locay, & Sanderson, 1989; Gilson, 1998; Guerra de Macedo, 1989; Kahl, 1981; Mechanic & Rochefort, 1996; Susser, 1993; United Nations Development Program, 1999a).

The potential to offset or circumvent the unfavorable, lasting effects of population aging, however, does not rest on a solitary socio-political-economic model for all countries. Instead, it is predicated upon social policy that is molded by each nation's unique history and culture (Alonso et al., 1994; Cornia, 2001; Donate-Armada, 1994; Doyal, 1979; Prieto Ramos, 2000; Stark, 2001; United Nations, 2002a; United Nations Development Program, 1999a; United Nations Population Fund, 2002; World Health Organization, 1998c, 2000c). If Cuba's obsession with health and present economic direction carry over into gerontological policy-making, the leadership may decide to pursue a long-term elder care model that simultaneously embraces socialist ideals and economic rationalism. Considering the prestige that Cuba has received from its past health achievements, the manner in which the developing island nation addresses the complex issues of caring for an aging population now and in the future is both domestically and internationally relevant.

The Need for Gerontological Research in Cuba

The macro-level impact of change in the immediate post-Cold War period on the Cuban health care system and population health status has been documented (American Association for World Health, 1997; Barrett, 1993; Garfield & Santana, 1997; Pan American Health Organization, 1999). Noticeably lacking, however, is a body of equity literature concerning the social implications of health and social welfare reform (Gilson, 1998). Similarly, only negligible research after the mid-1990s has examined the lingering impact of global and national circumstances on health and social welfare programs that serve Cuba's older population (Pan American Health Organization, 1999; Schwar, 2002). Furthermore, evaluations of citizen attitudes on issues of permanence, change, and allegiance to the Cuban leadership are practically non-existent, because of the near absence of government-sponsored public opinion surveys, the state's ban on quantitative field studies by non-Cubans, and restrictive policies that have

impeded independent studies by non-Cuban researchers, particularly those conducted by US researchers (Fuller, 1988; Mesa-Lago & Fabian, 1993; Robles, 2002).

In addition to gaps in the literature, the need for additional research on Cuba also stems from recent US policy changes (Roberts, Betancourt, Grenier, & Scheaffer, 1999; Robinson, 1995). The new directives call on the US government to promote nonviolent democratic change and the construction of a civil society in Cuba (U. S. Department of State, 1992, 1996). When US Cold War strategy focused primarily on the global implications of Castro's anti-imperialist activities, understanding the beliefs, opinions, and perceptions of ordinary Cubans was nonessential (Roberts et al., 1999). A deeper understanding of citizen views is now required to evaluate independently the recent US policy mandates and to inform international policy-makers.

Individual perceptions represent "a 'privileged' form of expertise about inequalities in health" (Popay, Williams, Thomas, & Gatrell, 1998, p. 621). Most important, lay knowledge regarding health inequality and health inequity may challenge the socio-political-economic order that generates inequalities and inequities in health (Popay et al., 1998). Lay perceptions of health equity and health inequity, therefore, can serve as proxies for more exacting opinion measures of socio-political-economic structure and authority.

Understanding the modern-day attitudes of ordinary Cuban citizens is now indispensable, because shifting international and domestic currents have affected the provision of universal health care, the impartial distribution of health, medical, and health-related resources, and the health of the people. The complex problem of conducting independent research in Cuba, though, has resulted in a dearth of outsider studies on the effects of global, national, meso-level, and local-level change since 1989 on the daily lives of ordinary citizens (Barrett, 1993; Fuller, 1988). Recently, however, the Cuban government has begun encouraging professionals, academics, and students from the US to engage in one-on-one exchanges with ordinary Cuban citizens in an effort to publicize the nation's economic and health-related difficulties and to positively influence US-Cuban foreign relations (MEDICC, 2004; People to People Ambassador Programs, 2003). Although politically contentious, research on the equitability and inequity of Cuba's system for elder health and long-term care with a qualitative, individual-level focus would help to fill the gap in the literature and might be important to the Cuban government, US policy-makers, and international foreign relations.

Cuba's revolutionary cohort is comprised of those individuals age 60 years or older, who

were at least 18 years of age at the time of the 1959 Revolution. Possessing a shared understanding of the nation's transformation, individuals in this cohort are considered to be among some of the most devoted supporters of Castro and Cuban socialism (Kahl, 1981). They personally experienced the "bitterness and corruption of the old society...[and] the inspiration of the long revolt against it" (Kahl, 1981, p. 352). Across much of the life course, members of the revolutionary cohort have never had to fear a catastrophic event, such as the loss of income due to a family wage earner's illness, for they received free health care and medicine, a salary continuance, and such other social welfare allowances as food, housing, and clothing (Alonso et al., 1994; Donate-Armada, 1994; Kahl, 1981). Therefore, a detectable shift in perceptions concerning the equitability of health, medical, and health-related resources among members of this more hard-line cohort would be significant in that it might offer one measure from which to conjecture the status of Castro, the government, and Cuban socialism.

This dissertation research asks what factors since 1989 have most influenced perceptions of the equitability and inequity of health, medical, and health-related resources among individual older Cubans. Although the foundation of the research is distinctly gerontological, its theoretical-methodological-analytical framework is multi-layered. The study borrows concepts and techniques from such fields of study as anthropology, economics, geography, public health and public administration, history, journalism, medicine, political science, psychology, sociology, and speech communications.

Two topics, though, should be addressed before proceeding. The first matter concerns the management of disparate researcher value preferences in the literature on Cuba. The second issue relates to the terminology used in the study.

Researcher Value Preferences

Qualitative researchers acknowledge that investigator subjectivity may influence data interpretation (Schoenberg & Rowles, 2002). Because of Castro's history of pro-Communist, anti-US, anti-capitalist activity, Cuba and its leader are inflammatory topics. Consequently, the incommensurate value preferences of Castro's proponents and opponents imbue much of the literature (Mesa-Lago, 1992; Valdéz, 1988; Zimbalist, 1988a). The polarization of viewpoints, which typically fall along ideological lines, is especially disconcerting, because so few researchers disclose their biases (Mesa-Lago, 1992). I accept Mesa-Lago's challenge (1992) that

researchers explicitly state their values concerning Castro and Cuba in the following paragraphs.

I am a Unitedstatesian, who was born into the age of McCarthyism and the Cold War Era. I embrace the social democracy aspects of Roosevelt's New Deal and Johnson's Great Society. My socio-political-economic leanings are biased toward a humanistic approach that balances the precepts of social justice and a US-like democracy with the feral aspects of brazen capitalism. I have never been drawn to Marxist, Marxist-Leninist, or Neo-Marxist ideology in any manner other than scholarly interest.

Despite scientific and journalistic training and months of preparatory library research, I stepped onto Cuban soil for the first time still influenced by four decades of anti-Communist, and anti-Cuban, anti-Castro socialization by the US government and US media. My preconceptions were of a society that was subjugated by merciless security forces loyal only to Fidel Castro.

Castro's Cuba was somewhat of a curiosity in that this was my first visit to a Socialist nation. Admittedly, I was drawn to Cuba by both my research interests and the allure of studying a once closed society. By the conclusion of my dissertation research, however, these initial biases were replaced by another set of value preferences.

I now perceive Castro to be a brilliant national leader with international appeal, who, soon after the Revolution, solidified his authoritarian position over the Cuban citizenry. Although I am convinced of Castro's commitment to the health of the Cuban people, I also believe that he and his government have and continue to manipulate the nation's health and elder care system for the purposes of social control and political gain. Nevertheless, the design of the Cuban health and long-term elder care approach, the pride that the Cuban people have in their care system, and the nation's incontrovertible health accomplishments intrigue me. I also believe, perhaps naively, that Castro is attempting to strike a balance between political expediency, economic efficiency, social equality, and health parity in the new elder care approach.

As Horowitz (1998) might assert, centrism is not necessarily equivocal to neutrality in terms of research. Although I have endeavored to generate a centrist dissertation, my citizenship, my moderately liberal-humanist tendencies, my recognition of the pretentiousness of Castro and the Cuban leadership, and acknowledged biases toward Cuba's approach to health and elder care also are present.

It also is important to note that fluctuating political tensions between Cuba and the US

since the early 1960s have created an ebb and flow regarding independent researcher access to the island and the availability of the Cuban literature (Fuller, 1988). Consequently, research data are unusually fragmented and spread out over numerous years and decades. For these reasons, readers will note the use of an unusually large number of in-text references in an effort to pull together indiscriminate data, to compensate for my value preferences and those of other researchers included in the literature, and to find a more common ground that promotes a greater objectivity or centrism in the dissertation research.

Definitions

Before moving on to the dissertation's theoretical context, it is valuable to touch on the second important issue regarding the terminology used in the research. This section defines and/or clarifies the terms society, macro-level and micro-level, state and government, public sphere, private sphere, welfare state, command economy, health equality, health inequality, health equity, and health inequity, long-term health care services system, and theory.

Society

Society is an all-inclusive term that refers to the global superstructure comprised of the public and private sectors, or the governmental and non-governmental spheres. It also denotes the cultural embodiment of a world region, an individual country, or a particular nation's citizenry.

Macro-level and Micro-level

Macro-level refers to the dialectic of global and national activities, including those at the meso-level, local-level, and sub-local level—regional, provincial, rural, municipal, and sub-municipal/rural activities. Micro-level references, meanwhile, denote the subjective perceptions of individuals.

State and Government

The state denotes institutionalized authority and laws, which embody the dominant socio-political-economic ideologies used to govern a nation. Government signifies the political agents, different organizations, and rules embedded in the state. As such, the state is much broader than

government. The state represents a structure for rules, norms, and governance in a society. This dissertation, however, will use the terms state and government interchangeably.

Public Sphere

The public sphere denotes the governmental system of public interests used to negotiate and satisfy society's wants. Most frequently, the term public sphere is linked with governmental social welfare activities at the national, meso, and/or local levels. Social welfare regime, however, may indicate an international typology and/or a specific nation's governmental social welfare structure (Esping-Anderson, 2000).

Private Sphere

The term private sphere refers to the private sector, or non-governmental system, which, like the public sphere, also may negotiate and satisfy society's wants. Such terms as market, private market, market place, and free market will be used interchangeably to describe the private sphere in both international and national environments. Additionally, the phrase civil society often is associated with the terms private sphere and free market. However, civil society refers to a capitalist-democratic system, in which individuals and groups of individuals engage in free market activities in a society with free elections.

Welfare State

Welfare state is defined as a state, in which a nation's power and resources are organized politically and administratively to intentionally modify the market forces of the private sphere via the governmental provision of a specified range of health and/or social services. The provision of state welfare can occur through either direct or indirect means, such as through legislative means rather than direct cash or in kind benefits (Briggs, 1967; Gough, 1978).

Command Economy

Command economy refers to a society, in which all financial, industrial, and production assets are publicly owned and all economic activity is controlled by the state—all decisions are made by a small group of people and carried out by a large bureaucracy rather than by private interests and market forces. The term command economy also is referred to as centrally planned

economy and is most often associated with socialist and/or Communist states.

Health Equality, Health Inequality, Health Equity, and Health Inequity

The literature is replete with various definitions of health equality, health inequality, health equity, and health inequity (Culyer & Wagstaff, 1993; González Block et al., 2001; Hopton & Dlugolecka, 1995; Low, Ithindi, & Low, 2003; Marmot, 1999; Moody, 2001; Pappas & Moss, 2001; Pereira, 1993; Popay et al., 1998; Sandifer, Shickle, Vuilo, & Hopkins, 1995; Starfield, 2002). For the purpose of this dissertation research, health equality is closely related to the principle of social justice and the goal that health benefits, risks, and costs are distributed fairly to achieve equal health status among all people in the community—health equity (Culyer & Wagstaff, 1993; Low et al., 2003; Sandifer et al., 1995). Conversely, health inequality refers to a deviation from the social justice principle and health equality goal, wherein the irregular distribution of health benefits, risks, and costs produces disparate health states for different individuals and sub-groups in the community—health inequity.

For the purpose of this study, health equity refers to the individual's positive, subjective perceptions of such health, medical, and health-related resources as medicine, institutional health services, physician care, and special health-related social welfare allowances. Health resources correspond to a range of social benefits that the individual recipient and the larger population have come to value. Alternatively, health inequity refers to the individual's negative, subjective perceptions of such resources. Individual perceptions, whether positive or negative, are consequent of the dynamic processes of socialization and personal and/or collectively-shared life-shaping occurrences across the course of life, all of which formulate one's past, current, and future expectations of health and health-related resources (González Block et al., 2001).

Long-Term Elder Care Services System

The long-term continuum of services for older Cubans embraces the notion of bio-psycho-social care across the later life course. The services continuum is integral to the social welfare schema of a centrally-controlled, locally-coordinated system of public health, medical, mental health, dental, social, and informal community, familial, and non-kin support services (Prieto Ramos, 2000; Reed, 2000a; Schwar, 2001, 2002). Accordingly, references to the long-term elder care services system entail all resources available to older Cubans.

Theory

The terms theory, approach, and perspective will be used interchangeably in reference to concepts and categories of ideas that facilitate explanations that provide a greater comprehension of social life. With the basic terminology now clarified, the next section introduces the theoretical context of the dissertation.

Theoretical Framework

New International Political Economy (IPE) is a promising approach to the study of globalization and transformation in the post-Cold War Era. Universal in scope, IPE embraces both orthodox, Western-oriented political economy and the critical approach. However, IPE moves beyond the exclusive disciplinary frameworks of politics or economics (Veseth, 2004).

IPE encourages and supports multi-disciplinary, multi-layered research designs that incorporate the modern approaches, methods, and analytical advances of all the social sciences (Flavin, 1997; Gamble, Payne, Dietrich, Hoovelt, & Kenny, 1996; Gills, 2001). Its chief goal is to more fully explain the dynamism of socio-political-economic activity in all political, economic, ethnic, and geographic settings on broad range of subjects, including health and aging in transitional and socialist environments (Gills, 2001). Thus, IPE assumes that, alone, politics and economics are incapable of providing a richer understanding of the global expansion of market structures on a range of social activities, and the contexts, contingencies, and complexities of the new world order.

One hopeful IPE research direction is the development of integral approaches to explore the complementarity of macro-level historical-institutional structures and the micro-level activities of individuals (Gamble et al., 1996). The addition of individual-level analysis in IPE studies provides evidence of the field's more recent identification of perspectives *from below*, as well as *above* and *in between*; such IPE research explores how and why international and domestic paradigms order the socio-political-economic lives and beliefs of individuals (Amoore et al., 2002; Cerny, 1999; Falk, 1997; Gills, 2001; Kiely, 2000; Pearson, 1998). For example, Pearson's work (1998), which integrates the critical and structural facets of IPE with the feminist, narrative, and life course approaches, provides a salient model for multi-disciplinary, multi-layered qualitative inquiry in Cuba.

IPE bridges the structural-individual, or macro-micro-level rift, via the incorporation of multiple disciplinary perspectives, methodological approaches, and analytical strategies. Its holistic and integrative characteristics are well positioned to inform examinations of the diverse and complex issues surrounding a political economy of health, health equity, health inequity, and aging from many dimensions and from disparate viewpoints. For these reasons, the dissertation's theoretical construct is based on the integrative, multi-layered ideal contained in the IPE approach.

Research Questions and Specific Aims

Cuba offers an exceptional setting in which to assess issues related to health and aging within the context of change in the post-Cold War Era. As one of the world's last bastions of traditional socialism, its uniqueness arises from a complex set of factors. These dynamics include the following: Castro's ascendancy to power in 1959 through a legitimate revolution; popular support of the peasantry and much of the middle-class; a mesmeric governing style, in which Castro is continually in touch with the people; continued mass support for Cuba's socialist achievements, such as universal health care and universal education; and a revolutionary history based on the resiliency of the population to external forces and domestic challenges—a national resolve to dictate the country's own future (Cockroft, 1996; Flavin, 1997; Mesa-Lago & Fabian, 1993; Nayeri, 1995).

The expansion of an integrative and comprehensive Cuban health system and the recent introduction of a sweeping national policy on aging are outcomes of a nearly 50-year process of experimentation, adaptation, and readjustment. Cuba's health and elder care policies have occurred either as forerunners of or in alignment with the World Health Organization's (WHO) challenges to governments worldwide. The WHO has called on nations to achieve *Health for All* through social policy innovations that are based on equitable and efficient primary health and long-term elder care service delivery models (World Health Organization, 1978, 1988, 1998b, 2000a, 2000c, 2002b).

Shifting international and domestic conditions since 1989, however, are endangering almost a half-century of Cuban health improvements, particularly among the older population. The almost complete cessation of trade and inability to import such critical items as food, medicine, and health-related materials brought the nation close to socio-economic collapse in the

early 1990s. By the mid-1990s, the state had instituted a series of moderately successful recovery policies that included limited economic liberalization and health and social welfare reforms.

The systems approach to health and social welfare reform, a model which Cuba appears to be pursuing, assumes that it is the state's responsibility to reform social policy in a manner that balances the principle of social justice and the goal of health equality with cost efficiency (Guerra de Macedo, 1989). However, as documented in other Latin American countries that have adopted the model, Costa Rica for example, egalitarian concerns quickly succumb to efficiency priorities resulting in notable public health declines (Gonzalez & Szayna, 1998; Lara, Barry, & Simonson, 1995; Navarro, 2002c; Nayeri, 1995; Salas & Miranda, 1997). Although Cuba's leadership has endeavored to maintain equality provisions in its reform program, significant changes in the long-term elder care services structure have begun to affect health, health equality, and health equity among the older population negatively. Furthermore, continuing socio-economic difficulties have led to speculation that the provision of existing levels of quality elder care are unsustainable (Kuntz, 1994; K. C. E. Macintyre & Hadad Hadad, 2002).

Demographically, Cuba is on the threshold of becoming one of the two oldest nations in the Americas (United Nations, 2002b). Most unsettling, however, is that the growing needs of a rapidly aging population will place insupportable burdens on a developing nation still grappling with the protracted consequences of the post-1989 economic crisis. This inauspicious environment has fueled suppositions of the imminent demise of Castro, his government, and Cuban socialism (Dilla, 1999; Feinsilver, 1993; Gonzalez, 1996a; Gonzalez & Ronfeldt, 1994; Gonzalez & Szayna, 1998; Linden, 1993; Mesa-Lago & Fabian, 1993; Ritter, 1994).

Within these contexts, the dissertation's key research question asks what issues are central to perceptions of health equity and health inequality among individual members of Cuba's revolutionary cohort. Through a critical, multi-layered examination, the study will explore macro-level factors since 1989 that have most influenced the micro-level perceptions of older Cubans. As previously stated, macro-level influences pertain to socio-political-economic dynamics at the global, national, meso, local, and sub-local levels. Micro-level perceptions of health equity and health inequality, meanwhile, involve the older person's subjective viewpoints regarding valued medical, health, and health related resources.

The dissertation research has four specific aims. The first aim is to establish those health resources valued most by the study's older subjects individually and collectively. The second aim is to determine the current status of those valued health resources. The third aim is to document and appraise the perceptions of older individuals with regard to the equitability and/or inequity of valued health resources. The fourth specific aim is to generate secondary source data in order to fulfill two objectives: 1) to explain and understand the development of the Cuban health and long-term elder care services system; and 2) to corroborate, dispute, and/or augment the principal subject responses.

The intent of this dissertation research is to help fill the gap in the literature and promote cross-cultural gerontology. The study can also inform interested governmental entities, decision-makers, and health practitioners in Cuba and elsewhere concerning their responses to the related issues of health and aging in an era of globalized social relations and capital. Furthermore, the research contributes to theory development and the inclusion of a gerontological perspective in new International Political Economy.

Dissertation Research Outline

Chapter One has established the issues of health, aging, health equity, and health inequity in Cuba. It also has addressed the management of disparate researcher values, defined the terminology, and outlined the theoretical framework, research questions, specific aims, and the study's relevance. Chapter Two will review the general theoretical literature, while Chapters Three and Four will evaluate the specific literature on Cuba. The dissertation research design and methods are presented in Chapter Five.

Understanding the elevated role of health, health care, and the health and elder care system in Cuban society is essential to appreciating the older person's health experiences and perspectives. As González Block et al. (2001) observed, micro-level perceptions of health equity and health inequity are, in part, socially constructed. In other words, one cannot correctly evaluate the older individual's perceptions without first comprehending the macro-level structures and dynamics that have shaped the older person's opinions, beliefs, and expectations of a health policy, a care system, and health resources. Accordingly, Chapters Six through Eight will present the secondary source findings regarding the development of Cuba's health and long-term elder care system. The principal and secondary subject findings are reported in Chapter

Nine. The final chapter offers a discussion and concluding remarks, in which the study's findings are synthesized, its implications and limitations are offered, and ideas for future research are raised.

Chapter Two

Theory and Approaches

Political economy theory explains interactions of the economy and politics (Caporaso & Levine, 1992). The literature, which emerged from 18th Century economics, was closely aligned with political science. However, the disciplinary separation of political science from the field of economics and other discipline-specific adaptations of the theory since the mid-1960s have expanded its conceptual boundaries, produced more elaborate definitions, and diversified its analytical utility in the study of economic, political, and social affairs (Amoore et al., 2002; Caporaso & Levine, 1992; Gills, 2002; Minkler, 1984; Peterson, 1991; Quadagno & Reid, 1999).

New uses of political economy aspire to an emerging paradigm for scientific inquiry that integrates theory and research to explain the complexities of modern social life from multiple disciplines and diverse perspectives (Flavin, 1997; Gills, 2001; McMullin, 2000). Political economy of social inequalities, for example, explores relationships between social class, health, and quality of life (Navarro, 2002c). Political economy of health provides an understanding of the social determinants of health and illness along with medicine's role in society (Doyal, 1979). Political economy of aging, meanwhile, is used to explain interrelationships of power among social institutions, the social construction and reproduction of age-related inequalities, and the influence of social structures on the aging process (Estes, Swan, & Gerard, 1984; McMullin, 2000; Minkler, 1984).

Each perspective offers discrete explanations of empirical findings and critical assessments of the world. Although the discipline-specific adaptation of political economy theory has revitalized its usefulness, positivism and a geo- and ethno-centricity still limit its full explanatory potential (Amoore et al., 2002; Dannefer & Uhlenberg, 1999; Doyal, 1979; Estes & Linkins, 2000; Estes et al., 1984; Farmer, 1999; Gills, 2002; Kahl, 1981; McMullin, 2000; Navarro, 2002c; Packard, Wisner, & Bossert, 1989; Passuth & Bengston, 1996; Quadagno, 2002; Walker & Wong, 1996). For example, the scarcity of individualistic or micro-level health equity literature concerning the lesser-developed nations underscores the need for additional research on the global impact of capitalism on social justice in the developing world from the perspective of ordinary people (Packard et al., 1989). The linchpin, then, is to choose suitable approaches that aptly frame the specific research, which, in this dissertation, requires a construct that is capable of bridging a macro- and micro-level methodological and analytical rift.

New International Political Economy (IPE) offers this potential in its acceptance of compound disciplinary methods regarding data collection and data analysis that might expound on the larger social structures and dynamics that influence the individual's opinions, beliefs, and expectations of the world. In order to address the research question and fulfill the specific aims of this dissertation, a multi-layered framework informed by the IPE ideal is used to explain the relationships between macro-level factors from the global-to sub-local levels and perceptions of the equitability or inequity of health, medical, and health related resources among older individuals in modern-day Cuba. Before such a multi-layered framework can be constructed, however, the fundamental aspects of political economy must be understood. Gills (2001), for instance, suggests it is necessary to first comprehend the role of Western political economy theory in fusing the modern world system that has shaped the social evolution and interactions of nation-states. Navarro (2002d), meanwhile, encourages a fundamental awareness of the early political economists to better understand the fabrication and maintenance of social inequalities.

This chapter recounts the development of the literature that contributes to the multi-layered approach used in this treatise. Following Navarro's suggestion, the first section of the chapter examines the classical perspective. The next three sections present the Keynesian and Neo-liberal, justice-centered, and Marxist approaches. The fifth section presents contemporary adaptations of political economy. Sections six and seven, meanwhile, detail two gerontological theories: the life course and critical approach of aging. Then, after evaluating the individualistic or micro-level concepts, the problematic issues of human agency and the gap between macro- and micro-level theory are criticized. The chapter concludes with a discussion of IPE.

Classical Political Economy

Classical political economy theory was developed to explain the industrializing world of 18th and 19th Century Europe (R. H. Campbell, Skinner, & Todd, 1981; Caporaso & Levine, 1992; Howard & King, 1985; Peterson, 1991; Strathern, 2001). Its chief goal was to inform policy-makers about the assignment of different tasks to the economic and political spheres in resource allocation decisions that attempted to negotiate and satisfy society's wants. The conflict over which sector is best suited to fulfill that role has been contested in the literature for more than two centuries. Today, the appropriate public-private configuration is elemental to the global debate over health care policy in every nation and socio-economic environment, whether it be

the capitalist-democracy of the US, Costa Rica's social democracy, or socialist Cuba (G. F. Anderson, 1998; Baker et al., 1994; Chapel, Stange, Gordon, & Miller, 1998; Cornia, 2001; Costich, 2001; Frech, 1988; Gough, 1978; Homedes & Ugalde, 2002; Mechanic & Rochefort, 1996; Mesa-Lago, 2000; Navarro, 2002c; Scharlach & Kaye, 1997; Smith-Mello & Watts, 2001; Stuart & Weinrich, 2001; Susser, 1993; Therborn & Roebroek, 1986).

Classical political economists advanced three key concepts that persevere in modern political-economic thought and are relevant to health equity research. The importance of the economic calculation concept involves public interventions believed necessary to augment constrained private resources and the market's inability to meet all of society's wants (Caporaso & Levine, 1992). Essential to the second concept of material provisioning is that the market's structural potency is "capable of influencing, forming, and even determining motivations and ways of thinking" (Caporaso & Levine, 1992, p. 27).

The economic approach, the third key concept, assumes that the unique position and depoliticized nature of the private sphere demands its institutional distinction from and dominance over the public domain. Thus, the classicists considered the market was best suited to satisfy all societal wants and achieve the social good, which the classical and Neo-liberal literature equates with economic and social growth (Caporaso & Levine, 1992; Pickel, 1998). These enduring classical ideas are embodied in the heralded Alma Ata Declaration, which states that:

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace (World Health Organization, 1978, p. 428).

Although classical theory asserted that public interventions limited the market by diverting capital to non-profitable activities, acceptable governmental intrusions were national defense, commerce enhancements, and education of the labor force. Smith (as cited in R. H. Campbell et al., 1981), however, maintained the public sphere was "in reality instituted for the defence [*sic*] of the rich against the poor" (p. 715). This sentiment was later refashioned in Marx's critique of bourgeois political economy to explain the unequal social relationship

between the world's wealth-holders and labor class (Caporaso & Levine, 1992; Eastman, 1932; Gills, 2002).

A key weakness in classical theory was the supposition that the self-correcting market was incapable of near or total economic stagnation (Caporaso & Levine, 1992). It was presumed that inevitable individual hardships resultant of the capitalist system would motivate disenfranchised persons to obtain new employable skills, while economic adversity would compel investors to pursue new activities that were in demand. As the literature has recorded, the Keynesian perspective and new classical or Neo-liberal approach attempted to correct classical theoretical inaccuracies, which many political economists believe contributed to the global depression of the 1920s and 1930s (Peterson, 1991).

Keynesian and Neo-liberal Political Economy

Keynesian and Neo-liberal theory advance two different solutions to market failure, “the master idea” (Caporaso & Levine, 1992, p. 97) that drives the two approaches. Keynesian theory contends public interventions are a long-lasting and essential prophylactic against the market failures of unemployment, fiscal stagnation, recession and, ultimately, economic depression. Neo-liberal political economy, on the other hand, views state activism as an impediment to economic and social development (Navarro, 2002e). The Neo-liberal caveat is that unless state welfare interventions are rigorously controlled, the public deficits used to finance them set off inflationary cycles (Navarro, 2002e; Peterson, 1991).

Although differing over the appropriate reach and exact beneficiaries of governmental activism, the common ground for both perspectives is the obligation of the state to intervene in times of market failure (Peterson, 1991). The appearance of the utilitarian group welfare claim in the Keynesian approach, along with the belief that the predominantly capitalist world and inter-state systems always produce social imbalances, however, represent an important turn in the literature (Caporaso & Levine, 1992; Doyal, 1979; Gills, 2002; Navarro, 2002b; Quadagno & Reid, 1999). The relationship between society's winners and losers under the capitalist structure and the mechanisms required to equalize the social inequalities it produces are fundamental to Marx's radical political economy critique, which will be covered later in the chapter.

In keeping with the idea of a more activist and powerful state, Weber's insights into the social influence of public bureaucracy have informed modern political-economic thinking and

directly relate to Castro's Cuba (Schuman & Olufs, 1993). First, Weber predicted that bureaucracy's direct political alliance with socialist interests would evolve social policy that strangled private capital acquisition, such as the nationalization of Cuba's private sector following the 1959 Revolution (Stillman, 1992). Second, Weber forecasted the indestructibility of an expansive and fully matured bureaucracy, which partly explains how the Cuban welfare state has endured a fifteen-year-long socio-economic crisis and the 40-year US embargo. Third, Weber's legal-rational typology for state legitimacy, in some measure, explains the population's continued loyalty to the "impersonal and functional purposes" (Schuman & Olufs, 1993, p. 100) of the revolutionary Cuban bureaucracy. Similarly, the charismatic authority typology, in which individuals and groups perceive and imbue a single person with strength, magnetism, and power, illustrates Castro's ability to provide a convincing vision Cubans continue to want to follow (Kapcia, 1996; Schuman & Olufs, 1993; Valdéz, 1988).

Justice-Centered Political Economy

The notions of equality, distributive justice, and social well-being rooted in the health equity concept form the basis of justice-centered approaches to classical political economy. A common theme in all justice-centered perspectives is the fair allocation of societal resources through the public realm's capacity to specify rights and intervene in private activities, even if the intrusion adversely affects the market (Caporaso & Levine, 1992). The Hegelian approach, for example, posits that it is society's responsibility to support those whose livelihoods are threatened by the private sphere, because the market prescribes their dependence on it (Caporaso & Levine, 1992).

The Hegelian perspective also advances the concept of universal equal regard, which suggests that if society's wealth-holders wish equal treatment, they must have an equal regard for the less fortunate. If wealth-holder activities deprive others of the right to satisfy basic wants, the state's social role is to intervene in the market, limit private capital accumulation through levies and taxation, then, produce or redistribute social resources to those whose rights have been violated. In this respect, the Hegelian approach moves political economy theory closer to the idea of social determination in the "deeper sense of social dependence" (Caporaso & Levine, 1992, p. 214) the world's citizens have on the market system.

Marxist Political Economy

With few exceptions, Marx's works on social relationships in the capitalist world are viewed as distinct from the classical literature (Caporaso & Levine, 1992; Howard & King, 1985; Navarro, 2002d; Peterson, 1991; Strathern, 2001). Marx's affiliation with classical theory, however, derives from the use of its methods to assess the bourgeois perspective critically. Marx offered three important departures from the classicists: state theory, the social democracy approach, and revolutionary politics (Caporaso & Levine, 1992).

State theory is the clearest expression of the classical public-private configuration. It stipulates the state's role is that of third party mediator of social conflict to protect and maintain the dominant class structure (Caporaso & Levine, 1992; Howard & King, 1985). Thus, the state sets the capitalist agenda for market interventions that assure the reproduction of the prevailing bourgeois social order.

Marx's second alternative of social democracy provides for the negotiated redistribution of resources to correct social inequities. Consistent with classical political economy is government's social role as adjudicator of unresolved disputes between wealth-owners and labor (Caporaso & Levine, 1992; Howard & King, 1985; Strathern, 2001). Unlike the state theory concept, however, the social democracy approach assumes the market's propensity to exploit labor is tamable.

The revolutionary politics option avows that wealth-holders or the owners of the means of production dictate the material circumstances of the labor class. The workers' stake in the global market system cedes to a collective realization that they will be denied access to greater wealth, which, in turn, fuels rebellious political action. Radical political action takes the form of a workers' revolution to achieve a state of socialism—labor's forcible seizure and ownership of the means of production to level social inequalities, the elimination of the need for corrective state intervention in the market, and, ultimately, the abolishment of government itself (Caporaso & Levine, 1992; Howard & King, 1985; Strathern, 2001).

Marxist political economy draws attention to the historic misallocation of social resources through the underlying relationship between wealth-holders and non-wealth-holders. As a global organizing structure, the capitalist system assigns individuals to different social groups and levels of socio-economic status vis-à-vis one's relationship to the means of production (Howard & King, 1985; Strathern, 2001). According to Marx, individuals are

relegated to either the wealth-holding class or the group that provides labor to the former (Caporaso & Levine, 1992).

One key weakness in the Marxist and neo-Marxist literature is the absence of a political-economic theory that explains how socialism generates economic and social development, which some of the scholarship perceives as compulsory to the attainment of such social objectives as health for all and the attenuation of health inequities (Mesa-Lago, 1992; Peterson, 1991; United Nations Development Program, 1999a). Empirical findings, for example, show current and former socialist nations with central state planning and nationalized private property rarely produced growth levels equal to those of the capitalist nations (Mesa-Lago & Fabian, 1993; Peterson, 1991). As the coming chapter will attest, Cuba seems to defy the Neo-liberal hypothesis of synonymy between advanced economic growth and the realization of bold social objectives, such as health and education for all (Breslin, 1998; Pickel, 1998).

Marx's most enduring postulate is the dialectic, which centers on historic processes of resource redistribution (Strathern, 2001). This process can be characterized as the macro-level synthesis of power relations among and within social institutions (Navarro, 2002a, 2002d). The synthesis of institutional power results in social policies that reconfigure social resource types and the manner in which people and groups access, receive, and use those material goods.

In capitalist-democracies such as the US, the process tends to replicate the dominant class structure. The outcome in social democracies such as Costa Rica may be a negotiated readjustment of the class structure and redistribution of social wealth within the capitalist mode. In a synthesis of power relations via revolutionary politics, as was the case in Cuba, the role of the socialist state might be the institution, enforcement, and achievement of social "equality, universal health care, and justice, ends that are not assured by the market" (Caporaso & Levine, 1992, p. 17).

The outcomes just described reflect general tendencies. Obviously, the dialectic process is far less rigid. For example, syntheses of institutional power relations in the US since the Great Depression have produced negotiated outcomes that are more reminiscent of Marx's social democracy concept than state theory. Nash (1979) observed that a convergence of public dissatisfaction, growing public belief in the value of non-commodified medical services, and the civil rights movements generated a dialectic in the 1960s analogous to the New Deal policies that created the US welfare state. US policy enacted in 1965, namely Medicaid, Medicare, and the

Older Americans Act, reallocated social resources in order to quell social unrest and reproduce a new social order that elevated the class status of at-risk and politically vocal older populations and their children (Emlet, 1998; Hudson, 1994; Marmor & Christianson, 1982).

The evolution of a Neo-Marxist scholarship since the mid-1960s signifies the adaptation of critical political-economic thought. Today, the critical framework is being applied to health research to explain how and why the synthesis of power relations among social institutions creates and reconstructs group differences in illness and disease patterns (Navarro, 2002c). Having appraised the classical, Keynesian, Neo-liberal, justice-centered, and Marxist perspectives, the critique that follows highlights a critical literature that has eclipsed the fields of economics and political science and diversified the utility of political economy through its assimilation into other social science currents.

Political Economy Adaptations

Socio-economic expansion attributable to activist government policy following the Great Depression lent credence to the Keynesian approach through the late 1970s (Navarro, 2002c; Peterson, 1991). One leading political economist (O. W. Anderson, 1972) ascribed national honor to the theory that supported the creation of a social surplus from which institutions such as health and medicine benefited. Cold War sentiments, however, prejudiced overt critical expressions in health studies through the 1980s. Some leading journals, for example, rejected research articles that advanced Neo-Marxist critique (Navarro, 2002c). Accordingly, critical theory development was mired.

In order to circumvent the ideological quandary and publish in the mainstream journals, some US researchers masked the use of critical theory in their research designs and subdued inflammatory explanations of health inequality (Frech, 1988; Marmor & Christianson, 1982; Marmor & Dunham, 1983; Navarro, 2002c). This literature generally concluded that health disparity was consequential of the medical establishment's dominance over health institutions and praxis. Thus, private medicine, rather than the broader capitalist system in which it resides, was held responsible for health inequality and health inequities.

Anderson's research (1972), which inferred a critical/justice-centered framework, was less constrained in its findings. It asserted that there would be no distributive justice or health equity in the US without the subordination of the private medical sphere through a public

universal health insurance policy. The study deduced the unlikelihood of global health care, however, because of private medicine's dominance over the US health structure. Hence, its prognosis was private medicine for the well off and those other citizens who looked to the public sphere for assistance.

The failure of this initial literature to link critical theory to empirical findings explicitly presented a mechanistic view of the complex and dynamic variables that influence differential health states among and within populations in the US. It also neglected to make full use of the theory's explanatory power to answer the larger question. How and why was the world's most economically advanced society unwilling or unable to provide adequate levels of medical service to all its citizens (E. R. Brown, 1979; Deacon, 1984; Ehrenreich & Ehrenreich, 1970)?

Starr's (1982) pioneering work is representative of the development of a more uninhibited radical critique. Although no theoretical framework was disclosed, it was argued that the relationship between independent physicians and physician groups, a citizenry dependent on private medicine, and sympathetic political agents contributed to the evolution and government protection of the private US health care monopoly. The analysis concluded that private medicine's failure to satisfy the wants of poor and older individuals during the Great Depression prompted state interventions that resulted in a social democracy solution—a synthesis of power relations among market, political, and labor interests that established the framework for a mixed public/private health care system within the capitalist-democratic model, a model that was fully realized in Medicaid and Medicare policy in 1965.

Frech's study (1988) is indicative of a trend by the end of the Cold War, in which the explicit use of critical theory yielded more uncompromising conclusions about the sources of health inequality and health inequity. It correlated the social undervaluing of health care with the ambiguities of modern, capitalist-democratic nations like the US. Health inequity among poor and older populations was a direct consequence of the espousal of health equality and social justice concepts, but adherence to individualistic and materialist behaviors.

Political Economy of the Social Determinants of Health

Social tumult in the 1960s fostered dramatic changes in the academy, which stimulated new directions in health research by the 1970s. The increasing acceptance of the critical political economy approach buoyed examinations of the social determinants of health pioneered by

William Farr in 19th Century Britain (Andersen & Newman, 1973; Brunner & Marmot, 1999; Doyal, 1979; Gwatkin, 2000; Krieger & Fee, 1996; Krieger & Moss, 1996; S. Macintyre, 1986; Marmot, 1999, 2000; R. G. Wilkinson, 1990). Two obstacles, though, hindered social determinants research in England, and, when combined with anti-Marxist ideological barriers, silenced like efforts in the US.

The first obstacle relates to the practical aspects of some social science fields, social epidemiology and public health for instance. These disciplines are geared to research topics that can produce functional interventions (Syme, 1998). Short of revolutionary politics, the challenge of alleviating health disparity in the industrialized world made the study of its social determinants impractical.

Second, social determinants research demands aggregate data on health status by economic position, age, gender, and race/ethnicity. No socio-economic classifications accompany US vital health statistics on birth and death rates, while the British exclude the race/ethnicity stratum from health data (Krieger & Moss, 1996; Whitefield & Hayward, 2003). Even when social class data are available, they generally are stratified separately rather than cross-tabulated with other crucial socio-economic variables (Krieger & Fee, 1996).

The Whitehall study produced the first major findings on the social determinants of health among British civil servants in 1975. Its generalized conclusion was that a social gradation to almost all health outcomes exists in much of the industrialized world (Brunner & Marmot, 1999; Marmot, 1999; Syme, 1998). Health disparities were explained by one's station in the social hierarchy and psycho-social modifiers, such as the locus of control over events that encroach upon the individual's life. Macintyre (1986), however, claims the use of the term social class in this literature is misleading. Social class in Britain refers to occupational grade, rather than age, gender, race/ethnicity, and economic classifications commonly associated with social class in the US.

New directions in the study of income and health complemented the British social determinants scholarship (Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Syme, 1998; R. G. Wilkinson, 1990). This research produced strong statistical correlations between socio-economic circumstances and health outcomes among and within capitalist countries, as modified by personal empowerment and the individual's sense of control. As with the social determinants literature, income and health research also favored discussions of useful actions and

interventions over a dialogue that would lead to systematic theory-building (Syme, 1998).

Scholarly critiques of this research literature beckoned a more vigorous approach to explain the wide-ranging sources of health inequality. Syme (1998), for instance, suggested that researchers also understand the influence of potent social and cultural structures on disparate income and health outcomes. So too, Macintyre (1986) called for explanations of the role of social systems and social processes in the creation of health disparity.

By the late 1970s, some researchers had begun exploring “specific forms of social production of health and illness and the social organization of medical care under capitalism” (Doyal, 1979, p. 22) in both the developed and lesser developed nations. This literature is indispensable for its application of an even more radical approach to health research. In terms of theory-building, however, a small group of scholars can be credited with the development of an ingeniously nihilist political economy perspective (Navarro, 2002c).

Radical Political Economy of Social Inequalities

The literature that appeared in the *International Journal of Health Services* beginning in the late 1960s introduced an overtly Neo-Marxist framework for studying social inequalities and health from a class analysis standpoint (Navarro, 2002c). The journal, and the initial scholarship that appeared in it, represents the work of a few US researchers. These avowed Marxist and Neo-Marxist academicians, including Brown, Fee, Guttmacher, Navarro, Waitzkin, and others, formed the Health Marxist Organization (Navarro, 2002c).

The specific purpose of the Marxist health group was the “theoretical, conceptual, and methodological” (Navarro, 2002c, p. 18) discussion of the study of class, health, quality of life, exploitation, and domination. The group’s published research findings and theoretical discourse, which initially was more widely accepted outside the US, eventually won over the mainstream journals. These actions furthered the development and new adaptations of the organization’s radical framework (Navarro, 2002c).

The political economy of social inequalities explains how individuals and solidarities acquire power through society’s institutions, and why the synthesis of relationships of power in the social hierarchy affects health and quality of life (Navarro, 2002c). The theory asserts that historic socio-economic events initiate a struggle for political-economic power and dominance within a society’s non-governmental, governmental, and bureaucratic structures. Once

institutional equilibrium is reached, the social hierarchy acts in concert to enact social policies and programs that construct and reproduce inequalities among and between individuals and groups through the incongruent channeling of such social resources as health and medical services, based on social class, age, gender, race/ethnicity, health status, and sexual orientation (McMullin, 2000; Navarro, 2002c; Quadagno & Reid, 1999).

According to the social inequalities perspective, the uneven quality of health mirrors disparate opportunities to access and use institutionally-directed social resources. In this respect, social inequalities research is similar to that of social epidemiology and medical anthropology. These sub-fields attempt to understand how social, biological, and cultural pathways influence individual biological development, alter illness and disease risks, and affect behaviors that may recursively shape the social mechanisms that produce and preserve health inequalities (Farmer, 1999; Marmot, 2000; Trostle & Sommerfeld, 1996).

The Health Marxist Organization produced analyses in two important areas in the period 1965-1985 (Navarro, 2002c). The first emphasis dealt with class relations, medicine, and the US health care system. For example, radical theory was used in the early 1980s to explain how and why the emerging Neo-liberal paradigm would reorient public medical institutions toward profit maximization and delegate the professional class of independent care providers to the status of a medical proletariat (Navarro, 2002c).

The organization's second focus was the global impact of capitalism, class relations, and poverty on health. Benyoussef and Christian (1977) illustrated how China, Cuba, India, Tanzania, Niger, and Sudan resisted the Neo-liberal health economics model promoted globally by the developed nations, and instituted unique approaches to health and social development. Another study (P. Brown, 1984) analyzed capitalism's influence over psychiatric and psychological health institutions worldwide. Profit-oriented mental health systems were found to have used psychiatric interventions to reduce costly medical resource consumption, expand insurance markets, and elevate an affluent class of mental health professionals based on the autonomous physicians' model described by Starr (1982) and Brown (1979).

The international focus of the social inequalities literature is particularly relevant to the study of health equity in socialist nations and transitional post-socialist environments. Navarro's (2002b) research in the former Soviet Union associated dramatic declines in most major health indices with the appearance of market mechanisms in the public and emerging private health

spheres. A “health Mafia” (Navarro, 2002c, p. 26) of former Communist leaders who spearheaded the Neo-liberal model in their countries also was found to have assumed control of health institutions throughout the former Soviet republics. The study concluded that a mix of corruption, redirected funding, and care provisioning under the more privatized health care model furthered the erosion of population health status in the Central and Eastern European nations of the former Soviet bloc (Navarro, 2002c, p. 26).

Two other studies validated these conclusions (Potucek, 1991; Tchernina & Tchernin, 2002). A chronic state of ill health and a dangerous slide in life expectancy in post-Communist Czechoslovakia and Russia were observed following the placement of harsh restrictions on state welfare interventions, the allowance of privately-owned health care institutions, and the adoption of market-oriented health economics and medical provisioning strategies. Comparable health trends have begun to appear in China and Cuba, where market-oriented strategies have been introduced as well (Castro, 1996; Navarro, 2002c; Rohde, 1983)

Some mainstream scholarship claims that unreliable data skew research findings from the current and former socialist nations (Cereseto & Waitzkin, 1986; Zimbalist, 1988a). Although the Cuban literature will be reviewed in the next chapter, Zimbalist (1988a) cites several non-liberal studies that questioned the validity of Cuban data collection and reporting. For example, Diaz-Briquets (as cited in Zimbalist, 1988a) alleged that Cuban health agencies falsified medical statistics concerning a Dengue fever outbreak, while another article (Eberstadt, 1986) charged the leadership with inflating health and education statistics to demonstrate national progress toward distributional equity.

Nevertheless, these censures have been rebuked. The World Bank was reported to have validated that aggregate data from the current and former socialist nations are on par with those of the capitalist nations (Cereseto & Waitzkin, 1986). Correspondingly, Susser (1993) and Santana (1988) found Cuban data collection, analysis, and vital health statistic reporting to be efficient, accurate, and subject to multiple forms of external corroboration by such organizations as UNICEF.

Political Economy of Welfare States

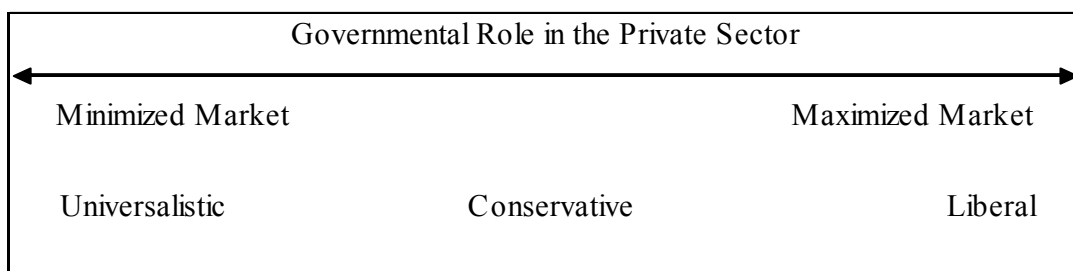
The long-standing concern of radical political economy with issues of social production and reproduction sets it apart from the classical and other more orthodox approaches (Pearson,

1998). The welfare state's role in social construction and replication of health figures prominently in radical theory and research. A further blurring of the once clear distinctions between the public and private spheres since the 1980s, however, has stimulated new studies of the impact of the Neo-liberal doctrine on health welfare state activities and health care at the global and national levels (Osborne & Gaebler, 1992).

Esping-Andersen's typology has become the most influential schema for categorizing the basic national political ideologies of welfare state regimes in capitalist-democracies (Lomax, 2002). According to the classification system, the distribution of social obligations among the public domain and the private sphere, which includes domestic or family activities, reveals three types of welfare states (Esping-Andersen, 1999). The liberal model categorizes welfare states in the Anglo-Saxon countries, such as the US. The Scandinavian countries, which presumably include such social democracies as Costa Rica, are classified as universalistic. Welfare states in Continental Europe are grouped as conservative or family-centered types.

Figure 2.1 presents an idealized conceptualization of welfare states, based on Esping-Andersen's (1999; 2000) typology and Anderson's (1972) political economy model for liberal-democratic projects. Nations categorized in the universalistic grouping entrust social service delivery to the state, thereby maximizing governmental interventions in the private sector and diminishing the market's social welfare role. Conservative welfare states rely heavily on public pension insurance and private, family-based sources for welfare services. Hence, nations of this type establish an "insider-outsider split in the labor market" (Esping-Anderson, 2000, p. 6) to balance governmental activism with the market's social welfare role for family-provided

Figure 2.1. Neo-liberal Welfare State Model Based on Three Worlds Typology



Adapted from "Health Care: Can There Be Equity?: The United States, Sweden, and England," by O. W. Anderson, 1972; "The Sustainability of Welfare States into the Twenty-First Century," by G. Esping-Andersen, 2002.

contributions, which classical political economy deems a private sector activity.

Liberal nations appear on the right side of the continuum of capitalist-democratic projects. This type of welfare state gives as much weight as possible to the market by curtailing governmental interventions. Although Marx's state theory contends the market establishes the public-private configuration via its influence over governmental agenda-setting, Anderson (1972) claims it is the electorate that determines the appropriate public-private mix through the free election of representative policy-makers.

The global trend toward Neo-liberalism has refocused political economy research on the inefficiency of the health welfare state, its role in escalating medical costs, and the need to reorganize public medicine based on market-oriented practices (Allman, Baker, & Maisiak, 2000). Guerra de Macedo (1989) notes that many Latin American political economists have embraced the health care systems perspective that first gained prominence in the US in the 1960s. As with other theoretical approaches, the systems perspective assesses aggregate health outcomes through a structural lens; its units of analysis are systemic efficiency, needs-based service delivery, and a state's commitment to health equity. The theory's equity component explains that a socially just care system is reflected by the extent of state policy actions designed to minimize health disparity (MacDonald, 1999). The efficiency and needs-based components are based on the Western managed care axiom, which ascribes inflated health costs and related deficits to the state's ineffective control of medical service overuse and misuse (Hollingsworth, 1986; Kronick, 1993).

The systems approach analyzes each public health welfare structure as an inter-locking network of unique medical programs, insurance schemas, training facilities, and personnel (O. W. Anderson, 1972; Backett, 1969; Kissick, 1968c; Navarro, 1969a, 1969b). The state's health policy, specific organizational structure, and degree of interference with private medicine are assumed to contribute to high health care costs, the rate of health care inflation, and disparate patterns of patient access and service use over time (J. G. Anderson & Heimann, 1975; Hollingsworth, 1986; Kissick, 1968a, 1968b; Kronick, 1993). The amalgam of these factors undermines the equitable delivery of medical services, which affects heterogeneous outcomes in morbidity, disability, and mortality (O. W. Anderson, 1972).

Costa Rica's social democracy model for universal health care exemplifies the attainment of improved systemic efficiency, physical quality of life, and maintenance of prior levels of

health equity via more judicious and locally designed Neo-liberal reforms in its state health welfare structure (Bahr & Wehrhahn, 1993; Gonzáles Block et al., 2001; Homedes & Ugalde, 2002; Lara et al., 1995; Mesa-Lago, 2000; Salas & Miranda, 1997; Terris, 1989). Its initial success can be attributed to what Cereseto and Waitzkin (1986) perceive as a delicate balance, in which nations that lack extensive economic resources can make substantial health progress through limited reform if they remain committed to justice-centered health welfare principles. Hertz, Hebert, and Landon (1994) agree that if “a country focuses its monies and efforts on health care and other social programs, even if its GNP/capita is relatively low, its population can have a higher quality of life” (p. 106).

In recent years, however, many lesser-developed nations have conceded to “efficiency as a priority objective” (Gutierrez, 1989, p. 189) due to persistent “monetary shortages and maldistribution of funds and services” (Hertz et al., 1994, p. 110). Such is the Costa Rican case, where increased fiscal stress in the early 1990s and embrace of international monetary agency policy forced the state to adopt a more privatized health welfare model, after which a gradual decline in population health status and increased health inequities occurred (Lara et al., 1995; Salas & Miranda, 1997).

Mechanic and Rochefort (1996) acknowledge that rapidly escalating medical costs narrow the options of all national leaders to maintain current health service levels and, therefore, their commitment to the health equality goal. The injudicious shift toward “market ideologies as a solution to their health care problems” (Mechanic & Rochefort, 1996, p. 245), which led to the “collapse of the health situation” (Navarro, 2002c, p. 25) in Central and Eastern Europe, illustrates the deleterious effects of unrestrained Neo-liberalism and indifference to the principle of social justice.

Biases and Limitations

Traditional public administration theory defines a welfare regime as a system, in which the state’s chief responsibility is the direct provision of comprehensive and universal welfare services that offer citizens health, economic, and social security (Briggs, 1967; Walker & Wong, 1996). However, such contemporary Western perspectives offered by Esping-Andersen and the Neo-liberal framework have modified this definition. The modern welfare regime is “a state in which organized power is deliberately used (through politics and administration) in an

effort to modify the play of market forces” (Briggs, 1967, p. 29) in direct or indirect social resource delivery through a combination of private and public institutions (Gough, 1978). Such nations as Cuba, China, and Vietnam have been excluded from contemporary welfare state analyses, however, because they are so atypical of these modern, Western perspectives that assume some level of market presence in health and social welfare services delivery (Baum, 1994; Gough, 1978; Morris, 1986; Walker & Wong, 1996).

The fundamental goal of universalistic-type welfare states is to marginalize the non-governmental sphere in social welfare provisioning (Esping-Anderson, 2000). However, if the market and/or electorate determines the appropriate public-private mix in state welfare service delivery, as the contemporary, Western approaches insist, then, Cuba again defies classification and analysis, because the state alone dictates social welfare roles and responsibilities. Critics (Packard et al., 1989; Walker & Wong, 1996), therefore, maintain that the dominant Western paradigms are biased toward the world’s developed regions and nations.

The radical political economy approach to state welfare attributes variations in welfare regimes to the specific economic, political, historic, cultural, and geographic conditions of a society (Eyles & Woods, 1983). The Western scholarship presumes that different social systems with dissimilar levels of economic and human development engender disparate outcomes in critical social measures, such as health status and life expectancy (Cereseto & Waitzkin, 1986). This literature further posits that variant levels of welfare state development, health service coverage, and population health status are tantamount to the level of industrialization and national affluence a society has achieved (Esping-Andersen, 1998).

Here, Pickel (1998) introduces a fundamental limitation to analyses based on the Western approach. The Western framework inextricably links economic and human development to national progress toward a state of democratic capitalism. Because all nations are compared, measured, and judged according to their specific stage of advancement, there is no alternative for socialist states such as Cuba other than their movement “towards capitalism, preferably combined with the holding of free elections” (Pickel, 1998, p. 75).

Packard’s (1989) multi-national Latin American and African study illustrates the Western predisposition. The analysis focused on capitalist influences that dominated welfare state growth in the study areas, rather than the level of industrial development and affluence achieved during periods of industrialization. It reached the alternative conclusion that the decidedly uneven

allocation of health care resources and disparate patterns of health and disease were a function of the dialectic between capitalist and popular factions, rather than superior levels of economic and human development associated with advanced industrialism.

With these limitations and biases in mind, Jameson (1981) proposes augmenting the dominant approaches in a manner that considers such intermediate regimes as Cuba and other Caribbean nations, based on external structural influences, internal political pressures, and regime stabilization policies. Walker and Wong (1996), however, appeal for a holistic political economy that explains welfare regimes worldwide and their role in creating social policy. Mechanic and Rochefort (1996), in the meantime, suggest a new framework, based on the premise of the shared exogenous burdens placed on welfare systems throughout the world. Still others (Gough, 1978; Navarro, 1991) argue that the Neo-Marxist perspective is best-suited to understand differences and commonalities in all state welfare regimes. New international political economy, which will be covered later in the chapter, incorporates many of these ideals to fulfill appeals for a more vigorous approach to welfare state, social inequalities, health, and gerontological analyses for all regions and nations of the world.

Gerontological Orthodoxy

The malleability of radical political economy to inform other social science research provides the opportunity for more dynamic explanations of social life. Its flexibility stems from an integrative quality. Morgan's (1993) treatise, for example, incorporates critical theory, medical anthropology, and symbolic politics to generate a potent international political-economic ethnography of community involvement in Costa Rican health policy. Similarly, Laws (1997) extracts insightful deductions about the gendered construction of space and mobility from a theoretical framework that integrates the critical, feminist, geographic, and gerontological life course perspectives. Numerous other unions with critical theory are found in gender analyses of health equity and rural health inequalities (Doyle, 2000; Schur & Franco, 1999), welfare state critiques (Emlet, 1998; Gough, 1978; Therborn & Roebroek, 1986), colonial/post-colonial studies (S. Hall, 1993; Whiteford, 1992), and nutritional anthropology research (Himmelgreen, 2002).

Social gerontologists embraced the early critical perspective to augment a traditional scholarship used to inform decision-makers about social policy on aging (Caserta, 1995; Human

Resources Corporation, 1976; Minkler & Estes, 1984; Wolinsky, Mosely, & Coe, 1986). Its development is consequent of both the appeal for a more radical framework to explain structural influences on age-related processes and a critique of the decidedly individualistic perspectives that dominated the field until the late 1970s (Dowd, 1981; Marshall, 1999; Marshall & Tindale, 1978; McMullin, 2000). Thus, a macro-micro-level rift underlines the advancement of the radical approach from a theoretical orthodoxy that presents in modern gerontological thought (Estes & Linkins, 2000).

Traditional theories on aging established the individual as the main unit of analysis (Minkler, 1984; Quadagno & Street, 1996). These approaches, which include the disengagement, activity, symbolic inter-actionist, and age stratification perspectives, attempted to understand heterogeneity and experiential diversity among older persons (Bengtson, Rice, & Johnson, 1999; Cumming & Henry, 1961; Dannefer, 1987; Dannefer & Uhlenberg, 1999; Havighurst & Albrecht, 1953; M. Kuhn, 1987; Lemon, Bengtson, & Peterson, 1972; Longino & Kart, 1982; Marshall, 1999; Palmore, 1981; Riley, 1971; Riley, Johnson, & Foner, 1972; Rose & Peterson, 1965; Trela, 1971). The age stratification approach is among the most named and applied perspectives that typifies the early theoretical conventions (Bengtson, Burgess, & Parrott, 1997; McMullin, 2000).

The stratification approach conceives aging as a life-long bio-psycho-social process (A. Foner, 1985). The problems of aging, however, are viewed as chiefly social in origin (Riley & Waring, 1978). Its basic assertion is that birth and historical cohorts, those members of a group who are born at the same time in history or who experience the same events within the same period of time, move in concert through society's dominant structures (Elder, 2002; Passuth & Bengtson, 1996). As a result of cohort flow, stratification explains the following: 1) the lives of individuals are organized into socially-constructed stages; 2) discriminate patterns of individual aging conform to a society's prescribed roles, expectations, and norms for childhood, kinship relations, socio-economic status, and retirement from the labor force; and 3) major shifts in individual behavior reconstruct the social hierarchy (Passuth & Bengtson, 1996; Riley, 1986a, 1986b; Riley, Huber, & Hess, 1988; Riley et al., 1972; Riley & Waring, 1978).

The capacity to explain aging as a dynamic, life-long process, in addition to age-related modifications to social structures, are the most powerful features of the stratification approach and its successor, the Aging and Society Paradigm (McMullin, 2000; Riley, Foner, & Riley,

1999). The continued appearance of stratification theory in the literature also is emblematic of the permanent imprint it has left on modern gerontological thinking. Recent applications can be found in cross-cultural research, international health studies, and international analyses of public policy on aging (Cherry & Magnuson, 1981; Cockerham, 1997; Dickerson-Putman, 1994; Wallace & Facio, 1992).

A major criticism of the approach, however, is that it ignores the influence of the institutional synthesis of power on the experience of aging (Minkler, 1984; Quadagno & Reid, 1999). Another constraint lies in the use of age to explain heterogeneous outcomes. The sole use of the age variable discounts other contributors to diverse patterns of aging, such as gender, social class, race/ethnicity, and sexual orientation (Irwin, 1999; McMullin, 2000).

A further criticism of orthodox theories on aging centers on semantics and the use of positivist frameworks and the individual as the main unit of analysis to generate so-called micro-level analyses (Dixon-Sinikka, 2001; Elias, Elias, D'Agostino, Silbershatz, & Wolf, 1997; Graham & Baker, 1989; McMullin, 2000; Sanders & Seelbach, 1981; Wolinsky, 1990; Wolinsky et al., 1986; Youmans, 1973). Studies based on multi-level modeling, for instance, claim to unite “macro-level and contextual factors” (O'Rand & Campbell, 1999, p. 73) with micro-level data. These research models are said to improve individual-level theorizing via rigorous statistical linkages between structural or historic variables and contexts, and disparate, aggregated individual characteristics (O'Rand & Campbell, 1999).

However, in the same way as the other social sciences apply critical political economy, the orthodox approaches of aging rarely consider subjective perspectives drawn from the daily lives of ordinary people (Dannefer & Uhlenberg, 1999; Passuth & Bengston, 1996). The individual's perceptions, opinions, and attitudes about issues such as “health, intelligence, . . . income, and lifestyle” (Dannefer & Uhlenberg, 1999, p. 307) also shape the unique experience of aging and heterogeneity. What is essential to this critique is that the conceptualization of the *micro-level* in this traditional gerontological research should not be confused with analyses that consider the subjective experiences of age and aging based on the individual's personal accounts of daily life.

Life Course Perspective

The life course approach, which is more of a conceptual framework than a theory of

aging has been used to explain the behavior-shaping influence of social norms (McMullin, 2000; Passuth & Bengston, 1996). The approach considers the impact of birth and historic cohort flow, biological and psychological processes, and social structure on the life-long experience of aging (Passuth & Bengston, 1996; Quadagno, 2002; Riley et al., 1999). The imprint of age stratification on the life course approach is found in the notion that the life-long process of behavior-shaping is a structural function (Passuth & Bengston, 1996).

The literature identifies two lines of analysis that distinguish the life course approach from the gerontological orthodoxy. First, its age-inclusiveness expands the unit of analysis beyond the narrow focus on only older people to all individuals (Riley et al., 1999). Second, is its elaboration of important life transitions as people age. The approach describes cultural norms embedded in social policy that articulate expectations for individuals to move in sequence and generally at specific ages through four main life-changing roles: education, work, family, and retirement from the labor force (Neugarten, Moore, & Lowe, 1996; Riley et al., 1999).

Recent studies underscore the capacity of the life course approach to better understand the functional aspects of behavior shaping. A study (Hamil-Luker & Uhlenberg, 2002) of non-traditional students, for example, found that adult education participation rates increased for all persons aged 30-74 throughout the 1990s. It concluded that younger adults were more likely than older adults to have returned to school, because of employer-funded training for younger workers.

The life course approach also has been applied to comparative international research on aging. O’Rand and Henretta (1999) concluded that the shift of such public life-long support programs as pensions and health insurance to private employers and families in several industrialized nations had endangered income security for younger adults, which was manifesting as new inequalities in old age. Another life course study (Katz & Marshall, 2003) examined the influence of social consumer norms and professional expertise in the construction of a new social script for older adulthood, which emphasized active sexuality as a function of positive and successful aging.

Still, the concept of a structured life course fails to explain deviations from the major, socially prescribed life roles. Thus, Riley (1999; 1996) offers the age integration concept to explain incongruous role transitions. The major focus of this type of research is to analyze structural changes that disrupt prior flows of social resources, power, and opportunities to people

in such arenas as family, work, education, retirement, and health care that affect disorderly role changes. Other scholars (Tulle & Mooney, 2002), however, claim the structural and functionalist assumptions of the life course approach limit analyses of perspectives from below—how the subjective actions of individuals across the life course defy the dominant discourse that constructs and reproduces the meaning of age, aging, and old age.

Critical Approach of Aging

The central orienting thesis of critical political economy of aging is that the social superstructure ordains unequal circumstances in later life via the ideology and resources it produces, assigns, dispenses, and reproduces (McMullin, 2000; Minkler & Estes, 1984). Hence, social structure, rather than the individual, is the unit of analysis (Quadagno & Reid, 1999). The critical theory also backtracks from the age-inclusive characteristics of the life course and age integration approaches. Its overarching design is to unearth structural forces that consider old age and older persons a social problem. As such, considerable attention is paid to welfare state policies and non-public activities that deal with practically all older people as a “single homogenous group” (Minkler, 1984, p. 10).

The literature offers both a private and public argument for the social construction and reproduction of age-based inequities, such as health status. The non-governmental argument centers on the creation of a private aging industry. The purpose of the aging enterprise is capital accumulation through the prescription and allocation of commodified services to remedy what the industry itself engineers as the special problems of age and the aged (Cole, 1992; Du-Boff & Navarro, 2002; Estes, 1979, 2001; Estes & Linkins, 2000). The enterprise reproduces itself through a cycle of newly conceived difficulties and solutions to age-related dilemmas. The private argument, therefore, unites the classical notion of the market’s power to form behavior and sway thinking with a Marxist-like class critique, in which older people, as a homogeneous social group that has been dissociated from the means of production, are treated as commodities and whose negative circumstances are dictated by the wealth-holding class (Caporaso & Levine, 1992; Estes, Wallace, Linkins, & Binney, 2001; McMullin, 2000).

The public argument within the critical theory of aging presumes that the state is the dominant structure in the public-private configuration. The critical approach draws on Marxist state theory to explain that class conflict between a society’s wealth-holders and non-wealth-

holders, as well as the state's efforts to retain its bureaucratic powers, epitomize government's ultimate role to protect wealth-holder interests and reproduce the existing social order through social welfare policies (Estes et al., 1984; Evans & Williamson, 1984; McMullin, 2000; Passuth & Bengston, 1996; Quadagno & Meyer-Harrington, 1989). Guillimard's (1983) study of the French welfare state, Olson's (1982) analysis of the US social security system, Quadagno's (1982) research on England's pension schema, and Esping-Andersen's (1999; 2000) social welfare examinations in the US, Europe, and Japan emulate the critical approach to show how social assistance flows from negotiated agreements between private employers, labor, political parties, and the bureaucracy in order to pacify older populations without making revolutionary adjustments to their existing socio-political-economic systems.

The role of the welfare state in the construction of age and age-related disparities, in addition to its responsibility to perpetuate the dominant social structure, is particularly relevant to health equity research in authoritarian socialist nations (Axinn & Stern, 1988; Esping-Anderson, 2000; Gough, 1978; Guillemard, 1982; McMullin, 2000; Minkler, 1984; Myles, 1984, 1989; Navarro, 1991, 2002e; Packard et al., 1989; Phillipson, 1982; Therborn & Roebroek, 1986; Townsend, 1985; Walker, 1980). The public argument maintains that the state manufactures dependency in later-life through welfare policies, which studies on aging most often cite as old age pensions and health and social welfare service entitlements (Estes & Linkins, 2000; McMullin, 2000; Phillipson, 1982; Walker, 1980). Bureaucratic hegemony renders the older population beholden to the state not only for the material, but the political and symbolic resources which individuals draw on in late-life (Estes, 2001).

The movement toward international comparative analysis and the globalization of aging is a very recent and important development in a critical gerontology. Estes and Phillipson (2003), for example, have begun studying the emergence of a global aging enterprise. Vincent (2003), in the meantime, applies the critical approach of aging to an analysis of the global transfer of age-based capital and private pensions to finance transnational acquisitions.

What of Human Agency?

Many of the theories discussed thus far offer positivist explanations of the structural contexts, complexities, and contingencies of state welfare regimes, social inequalities, health, aging, and so on. Structuration theory, however, posits that social institutions are not external to

human action, nor are they solely a proscriptive influence. Social structure is “both the medium and the outcome of human activities which it recursively organizes” (Giddens, 1987, p. 61).

Thus, the integrative constitution of the structuration approach embraces the duality and “complementarity” (Giddens, 1987, p. 60) of object and subject—of structure and individual.

Objectivists, determinists, and structuralists give society a great measure of dominance over the individual (Giddens, 1987). They also argue that integrative structural-individualistic frameworks are mutually incompatible (Neville, 1995). Other social theorists, meanwhile, seem to accept individual activities without theoretical clarification. These inconsistencies lead Dannefer and Uhlenberg (1999) to acknowledge the “remarkably unproblematic appearance” (p. 312) of references to human agency in the gerontological and other social science literature.

Critics of radical political economy of aging argue that its structural emphases preclude micro-level or individualistic, subjective analysis (Dannefer & Uhlenberg, 1999; Passuth & Bengston, 1996). In contrast, Estes (2001) defends its potential to draw associations “between the societal (macro-level), the organizational and institutional (meso-level), and the individual (micro-level) dimensions of aging” (p. 1). This potential has yet to be fully explored due largely to scholarly disagreement over the seemingly oppositional units of analysis and the meaning of *micro-level*.

Absent from the approaches discussed above is a subjective framework that illuminates the individual’s experience, interpretations, and meanings of daily life—social life from the actual perspective of the individual. What is needed are theoretical frameworks that embolden the systematic examination and explanation of both social structures, as well as perspectives from below that also beget human action (Geertz, 1983; Luborsky & Sankar, 1996; Ortner, 1984). The forthcoming critique examines several approaches that address this limitation.

Perspectives from Below

Some gerontological and social science research embraces the Modernist approach to the natural sciences. Positivist theory, scientific reasoning and method, and third-person commentary are used to explain social life, in which human beings are viewed as the objective physical constructions of exogenous institutional forces (Bengston et al., 1999). Post-Modernist, micro-level studies represent the unconventional approach toward subjective narratives and the local knowledge of individuals (Geertz, 1983; Spiro, 1992). Post-Modernists look to the feelings

and personal experiences of individuals—the subjectivity of the human subject (Rosenau, 1992; Spiro, 1992).

The post-Modernist focus resonates through the main social phenomenological approaches of aging, phenomenology, ethno-methodology, and narrative analysis (J. F. Gubrium & Holstein, 1999; Kenyon, Ruth, & Mader, 1999; Passuth & Bengston, 1996; Spiro, 1992). As a heuristic, these approaches signify a paradigmatic shift from the conventions, concepts, techniques, and applications of Modernist scientific investigation (J. F. Gubrium & Holstein, 1999; T. S. Kuhn, 1962). This literature emphasizes micro-social processes involved in the individual's awareness of social realities and negotiation of social discourse (e.g., social norms and prescriptions) that bring about human action (Garfinkel, 1967; J. F. Gubrium & Holstein, 1999; Passuth & Bengston, 1996; Schutz, 1967; J. M. Starr, 1982-1983).

Phenomenology

The behavior-shaping role of socio-linguistics in the lives of individuals has been a key focus of phenomenology research (Passuth & Bengston, 1996). Lynott's work (1983), for example, shows the life-changing impact of care-provider competency decisions that result from decision-maker interpretations of conversations with persons with Alzheimer's Disease. A later Alzheimer's study (J. F. Gubrium & Lynott, 1992) found the language and interpretation of quantitative measures of caregiver burden led to empirical misrepresentations of the meanings care-providers attach to their responsibilities. Paoletti's study (2001), meanwhile, unites socio-linguistic phenomenology, ethno-methodology, and the critical feminist perspective to show how socially-constructed images, identities, and individual actions among older Italian women influence a gendered policy language and delivery of adult social services.

Ethno-methodology

Ethno-methodology is the data driven, empirical study of the means that individuals employ to order, manage, and accomplish the daily activities of decision-making and reasoning (Coulon, 1947). Similar to grounded theory, ethno-methodology clarifies empirical data instead of explaining social life via *a priori* theory or such analytical variables as social class, age, gender, race/ethnicity, and so on (Strauss & Corbin, 1998). Through the treatment of social life as a working process of realization shared by a society's members, ethno-methodology is

unequivocal in its attention to the “socially contextual quality of subjectivity” (J. F. Gubrium & Holstein, 1999, p. 289).

The linkage between ethno-methodology and aging builds on Garfinkle’s work (1967), which deals with how people come to an individual and shared understanding of their actions and the contexts in which those activities occur. Two gerontological ethnographies demonstrate this stream of analysis. Gubrium (1997) shows how consigned, heterogeneous meanings of living and dying are produced by nursing home employees and residents. In the same way, Shawler, Rowles, and High (2001) demonstrate how differing perceptions of resident needs and desires among decision-makers leads to forms of nursing home care and treatment that contribute to the residents’ gradual withdrawal from autonomous decision-making despite their decisional capacity and locus of knowledge, information, and awareness of facility activities.

Narrative Approaches

Gubrium and Holstein (1999) point to narrative analysis of personal stories and story-telling as a third micro-level approach to explaining and understanding perspectives from below. The narrative contains two analytical strands. The subjective line assumes that the individual is the dynamic force in the construction of daily life experiences through story-telling (J. F. Gubrium & Holstein, 1999). Because life-stories affect the way individuals “think, perceive, and act” (Kenyon et al., 1999, p. 41), the narrative approach can further explore human agency.

The second analytical strand concerns exogenous forces that influence how and what the story-teller expresses, as well as the participant-observer encounter and data interpretation (Bertaux, 1981; Kenyon et al., 1999). In this regard, story conveyance might appear Modernist or structuralist, in that the narrative roots out subjective features of an objective reality that constructs the individual’s story, and influences the field experience and data analysis (Kenyon et al., 1999). For example, Bertaux (1981) recognizes that some narratives are the individual’s depiction of historical events that reflexively shape the telling and content of the story. Other Post-modernists maintain the researcher’s own story, scientific values, and value preferences embedded in a study design influence both the teller’s narrative and the investigator’s interpretation of data (Kenyon et al., 1999).

This argument raises two crucial and inter-related points. First, scientific study, whether quantitative or qualitative, is not purely objective. It then follows that investigator subjectivity

and, at times, investigator biases influence research (Kenyon et al., 1999; Luborsky & Sankar, 1996; Schoenberg & Rowles, 2002). As such, researchers are “accountable for what they see and what they fail to see, how they act and how they fail to act in critical situations....[for] it is the act of ‘witnessing’ [the investigator’s active voice] that lends our word its moral, at times almost theological, character” (Scheper-Hughes, 1995, p. 419).¹ The issue of researcher subjectivity and bias will be amplified in the first section of Chapter Three, which tracks the development of the Cuban political-economic literature.

The chief criticism of micro-level analysis, or what Dowding and Jindmoor (1997) term methodological individualism, is that it disregards the structural constraints imposed on human actions and individual agency. The purpose of a micro-level approach is to develop and analyze the individual’s beliefs, attitudes, perceptions, and expectations, rather than the structures that influence the individual’s perspectives of the world (Dowding & Jindmoor, 1997). However, this does not imply that social life must be described in completely individualistic terms, nor does it suggest all social outcomes are causally related to human action. Rather, a holistic analysis of social life ought to minimally include a narrative of the actions and thoughts of individuals in an attempt to comprehend those effects causally (Dowding & Jindmoor, 1997).

Bridging the Macro-Micro Level Rift

Disunity exists among and within the social sciences over opposing units of analysis—individual versus structure. This discord has impeded the development of integrative macro-micro approaches (Passuth & Bengston, 1996). The literature, however, suggests today’s world of globalized social relations is driving the trend toward multi-disciplinary, multi-layered methodological and analytical constructs that present perspectives from above, below, and in between (Cerny, 1999).

In term of integrative gerontological constructs, the storytelling, life-story, and reminiscence techniques have been recommended as means by which to synthesize individual meanings with the generalized, aggregated facts of aging through a marriage of narrative analysis and orthodox approaches (J. F. Gubrium & Wallace, 1990; Lamme & Baars, 1993). Sankar (1989) suggests an ethnographic-extended participant-observation framework to relate age-related processes of social and economic change from above to the experiences of individuals from below. Others gerontologists (Passuth & Bengston, 1996) believe a political economy-

social phenomenology construct is the most hopeful approach for locating the individual experience of aging within broader social contexts.

Multi-methodological blending used in a number of international comparative studies also have contributed to bridging the macro-micro-level rift by combining political economy with various public health research methods (Farmer, 1999; Kahl, 1981; Navarro, 2002c; Packard et al., 1989). Political economy of national development, for example, has been used to explain causal linkages between socialist morality, shifting domestic health policy, and demand for universal medical care among older Cubans (Kahl, 1981). Similarly, Packard (1989) combines political economy, structuration, and public health research methods to integrate community, neighborhood, household records with the individual's responses to health problems and illnesses in Africa and Latin America consequent of the global and nation-specific transformation of primary health care.

New International Political Economy

An uneasy peace struck between Keynesian and Neo-liberal theorists after the Great Depression ended in the late 1970s. Ronald Reagan and Margaret Thatcher shepherded the Neo-liberal political-economic project, wherein nation-states moved to abandon Keynesian policies, disassemble the public sector and raze social welfare programs, undercut organized labor, and embrace international treaty systems that narrowed state autonomy over capital activities and cleared a path for the global movement of capital (Gills & Rocamora, 1992; Murphy, 1999; Phillips, 2000; Robinson, 1995; G. Wright, 1999). The intensification of transnational corporate dominance over social life has restructured capitalism, so that it is more globalized today than at any time in the past (R. W. Cox, 1996; Robinson, 1995; G. Wright, 1999)

Analogous to the dissemination of the free market creed is the touchstone of the political Neo-liberal project—global democratization based on the 'Washington Consensus' (Phillips, 2000, p. 383). The literature characterizes the US-led movement as a collective imperative, in which the transnational elite are engaged in the international promotion of democracy with the hope of fusing national polities through the approbation of democratic-market forms of social control (R. W. Cox, 1979, 1996; Murphy, 1999; Robinson, 1995). A global US military aptitude is vital to support the project's ideological confrontation of the world's remaining authoritarian, dictatorial, non-democratic governments (Gills & Rocamora, 1992; Robinson, 1995).

The Asian, European, and Latin American financial crises in the 1980s, rising economic disparity among and within countries, the psychological inception of the post-Cold War Era in 1989, and the recent repudiation of the Neo-liberal thesis has spurred on efforts to classify and explain globalization and the passage to the new international economic order (Cerny, 1999; R. W. Cox, 1979, 1996; Phillips, 2000). One scholar (Shaw, 2000) argues that this academic clamber reflects an underlying theoretical and conceptual dilemma in the social sciences. The core fields appear bewildered by the recondite task of reforming themselves in global terms and envisioning their possible disciplinary intersections.

The emerging field of new International Political Economy (IPE), with its origins in comparative, international, orthodox, and critical theory, is aligned more with international relations and geography than economics or political science (Amoore et al., 2002; Gills, 2002; Shaw, 2000). It has become the vanguard of theorizing the new global spectacle (Shaw, 2000). Furthermore, IPE is leading an inter-disciplinary movement to tackle global subjects, which are less essential to the social sciences en bloc. IPE has appealed, welcomed, and now is being informed by the varied theoretical, conceptual, and methodological approaches of social science disciplines other than economics and politics, including Giddens' structuration approach for example (Amoore et al., 2002; Dowding & Jindmoor, 1997; Gills, 2001).

Heterodox IPE conceptualizes capitalism as a world encompassing phenomenon (Gills, 2001). It frames the individualistic-structural impasse as the historic interaction between subject and object within the social world of capital (Amoore et al., 2002). The dialectic of agent and capitalist structure manifests as "tensions and contradictions, as well as harmonisations [*sic*], being generated constantly between 'domestic' or national development and 'global development' across all times, places, and emerging spaces in the world today" (Gills, 2001, pp. 233-234).

There is a logic to the unfurling of the IPE literature. Ideologies and the New International Economic Order: Reflections on Some Recent Literature (R. W. Cox, 1979) is a watershed publication, which marked the inception of IPE radical criticism and charted a future course for post-Cold War research. Drawing on Gramsci's method of ideological analysis, Cox developed five schemas that described the basic structures and processes of the emerging order of world economic relations (R. W. Cox, 1979; Gramsci, 1957; Shaw, 2000).

Cox's work (1979) provided another salient framework that has since guided IPE

research. The study's sub-analysis of international political-economic discourse uncovered a negotiation process between the Northern and Southern powers of the world's developed and lesser-developed nations. Thus, Cox advanced the geographic concept of contrasting perspectives from above and from below (Gills, 2002; Walker & Wong, 1996). Recent IPE studies have refined the concept to include all geographic perspectives and to analyze the structure-individual nexus (Amoore et al., 2002; Cerny, 1999; Gills, 2001, 2002; Shaw, 2000).

A stream of articles in the period 1996-2002 illustrates attempts to build on the geographic and international dimensions of early IPE research. Cox (1996), for example, downsized his typology into three forms of hyper-liberalized business civilizations to explain the depolarization of post-Cold War global politics and economics. Similarly, the notions of empire and transnational social groups have been evoked to summarize and categorize the status of world historical development since 1989 (Hardt & Negri, 2000; W. I. Robinson, 2002b; Rustin, 2002).

Another strand of literature patterned after Cox's multi-level concept examines alternative geo-political-economic arrangements established during the 1990s (Breslin & Higgott, 2000). Phillips (2000), for example, investigates reconstituted regional alliances and the re-emergence of South American nationalism to challenge mainstream theories of globalization that forecasted the demise of territorialism, regionalism, and the retreat of the nation-state. Likewise, Breslin and Higgott's (2000) meta-analysis criticizes the mainstream for ignoring the body of regionalism literature produced in the 1990s. A persistent theme in much of this scholarship is that financial crises among the lesser developed nations, in Asia and Latin America, for example, have resulted in a backlash against the Neo-liberal project and increased the possibility of revolution, which annuls mainstream theoretical contentions that globalization produces social stability, economic growth, and US-like democratization.

IPE's embrace of other social science streams can be found in an expanding body of research, which addresses a variety of subjects: gender relations, ethnic diversity and the welfare state, post-colonialism, symbolic production and the international media elite, and the theology of Neo-liberalism (Birnbaum, 1999; Gills, 2001; Murphy, 1999; Pearson, 1998; Riggs, 2002; Rustin, 2002; Slater, 1998; G. Wright, 1999).² Moreover, the appearance of the continuity, new social movements, and historicized political economy theories illustrate the field's recent self-analysis, in which its radical critique is being re-conceptualized and re-theorized (Amoore et al.,

2002; M. Cox, 1998; Gills, 2002; W. I. Robinson, 2002a). This phase of disciplinary self-reflection provoked Cox (1998) to observe that the intellectual and political challenge for IPE theorists and scholars is not to “remain on the sidelines of history...where they have been for a very long time” (p. 461).

New IPE is a conscientious rejoinder to critical academic challenges regarding the limitations of mainstream and orthodox political economy. These limitations include an ethno- and geo-centricity, omissions of a radical feminist and post-colonial critique, and inattentiveness to meso- and micro-level analysis (Amoore et al., 2002; Gale, 1998; Gills, 2001; S. Hall, 1993; Kiely, 2000; Packard et al., 1989; Slater, 1998; Walker & Wong, 1996). Positivist inclinations and structural emphases, which downplay the individual perspective, are perhaps the most glaring deficiencies in the IPE research.

Although nascent in its application, the possibilities of individual- or micro-level IPE analysis are evident in the field’s admittedly gradual recognition of globalization from above and below—the interplay between international and domestic paradigms, and the economic, political, social, and cultural lives of individuals (Amoore et al., 2002; R. W. Cox, 1979, 1996; Falk, 1997; Gills, 2001; Kiely, 2000). For example, Slater (1998) speaks of the discipline’s “inner-directed gaze and a return to the national, regional, and local” (p. 650) viewpoint. Gale (1998) also cites the analytical credence of “intersubjective meanings...of the nature of social relations...and historical structures that confront individuals in their contemporary lives” (p. 271).

Despite the prioritization of the individual as one unit of analysis in IPE research, the field is just beginning to probe lower-level activities (Amoore et al., 2002; Cerny, 1999; M. Cox, 1998; W. I. Robinson, 2002a, 2002b). Ortiz (1997) found that the globalization of culture undermines the state’s hold over the meanings of social life, which, in turn, frees local actors from national cultural norms. Albeit a significant observation, the study fails to provide contextualized individual accounts of global enculturation. Falk’s (1997) research moves closer to individual-level analysis. It delves into the politics of resistance to globalization from the perspective of organized sub-groups, such as grassroots forces, labor, and consumer factions. Among the extant IPE literature, three prominent works (Cook, 1998; Pearson, 1998; Scheper-Hughes, 1992) stand out for their integrative frameworks that attempt to bridge the gap between macro- and micro-level units of analysis. Although implicit in its IPE orientation, Scheper-Hughes’s (1992) anthropological ethnography of the social production of apathy to infant death

in Brazil weds the radical political economy, critical feminist, life course, and narrative approaches. The study criticizes both the form of “dependent capitalism” (Scheper-Hughes, 1992, p. 275) that the global Neo-liberal project has imposed on the less developed nation and the construction of infant mortality as a global health measure by international, national, and sub-national public health organizations. Cook’s (1998) integrated research design, meanwhile, explicitly incorporated IPE and a more heterogeneous methodological construct, which included in-depth interviews with key informants, women’s group activities, and unionists in the European Union.

Pearson’s (1998) The Political Economy of Social Reproduction: The Case of Cuba in the 1990s is an explicit IPE analysis that is particularly significant to this dissertation in its design, methodology, and study site. The author constructs a framework of critical feminist, Marxist, socialist, and Neo-classical theory that also incorporates the narrative and life course approaches. From this model, Pearson weaves first-person accounts and a descriptive analysis of global, national, and sub-national influences on the construction, reproduction, and perpetuation of human labor.³

The synchronization of social structure and human agency compels reflexive adjustments; individual behavior adapts to structure and vice versa (Giddens, 1987). Maingot (2001), therefore, asserts that globalization requires a new understanding of the world, the national-, meso-, and local-levels of individual countries, as well as scholarly reports consequent of “one-to-one interactions with the people” (p. 147).

The foregoing critique concludes the need for a theory that informs a multi-disciplinary and integrative methodological and analytical framework in order to explain the inter-related dynamics of the structural-individual nexus. The assessment demonstrates the soundness of IPE to inform the development of a multi-layered research design to examine the Cuban problématique. The next chapter moves from the critique of the general political economy theories and individual-level approaches to an assessment of the Cuban political-economic literature and contextual evaluation of the island nation.

Chapter Three

Cuba in Context

It is my duty...to prevent, by the independence of Cuba, the United States from spreading over the West Indies and falling, with that added weight, upon other lands of our America....I have lived inside the monster and known its entrails—and my only weapon is the slingshot of David.

Unfinished last letter written by José Martí, father of Cuban independence, April 17, 1894 (Foner, 1977)

Before the Revolution, this region was the most underdeveloped of all. There was no medicine, public assistance, or social programs.

Dedication of Valle del Perú Polyclinic, Speech by Cuban Prime Minister Fidel Castro, January 1, 1969 (Castro, 1969)

So why has Cuba resisted? Because of its socialist system, because of its political system....The more Cuba resists the more it is respected, and Cuba is ready to win the respect of the whole world....We will not be ridiculed or be made fools of....There will be no transition toward capitalism....We will continue our fight with greater confidence than ever....Socialismo o muerte [socialism or death]....Patria o muerte [homeland or death]....Venceremos [we will win]!

“Cuba Vive” International Youth Festival, Speech by Fidel Castro, August 6, 1995 (Castro, 1996)

As the 21st Century neared, one scholar (Falcoff, 1998) asserted that Cuba was undergoing a protracted Byzantine-like death as a result of the total loss of Soviet support, combined with Castro’s rigid adherence to Martí’s vision and uncompromising pursuit of socialism at all costs. Heading a tattered “Marxist police state in partnership with Club Med” (Falcoff, 1998, p. 565), Castro was censured for undermining the Revolution’s enduring achievements in health care, education, and social equality.¹ Reacting to the potentially disruptive socio-political repercussions of the economic crisis of the 1990s, Castro had reverted to his most effective strategies for maintaining power and rallying the Cuban people: “defiance

of the United States and rejection of...the American way of life” (Falcoff, 1998, p. 565).

Some observers believe that any attempt to place Cuba into context must begin with Fidel Castro (J. I. Domínguez, 1978; Gonzalez & Ronfeldt, 1986). Valdéz (1988), however, asserts that this polemic concept highlights a storied Cuban scholarship that is unguided by “paradigm...explicit theory...method...and analytical logic” (pp. 184, 189). While the subject of Fidel Castro will be taken up in the next chapter, the critique that follows attempts to place Cuba into context by examining the political-economic literature first. The scholarship is arranged chronologically and in a manner that illustrates the paradoxical researcher values inherent in the literature.

Cuban Literature Development

The political and economic literature on Cuba has evolved in four stages: the pre-revolutionary phase, the early revolutionary period of 1959 through the mid-1970s, the late-revolutionary interval from the mid-1970s to the late 1980s, and the post-Cold War stage. A number of publications during the pre-revolutionary phase were carried out as part of broader US studies on Latin America (Fitzgibbon, 1935; Foreign Policy Association, 1935; Nelson, 1950; Wallich, 1950). Noticeably absent from the pre-revolutionary literature, however, is the insider’s perspective; almost all the scholarship before 1959 was published exclusively by non-Cuban researchers.

Very little US academic research on Cuba was undertaken in the two years following the 1959 revolution (J. L. Rodríguez, 1988a). Rodríguez (1988b) suggests two reasons for this curiosity. First, was the unavailability of federal grants and, second, the US Central Intelligence Agency (CIA) and US military believed the Revolution could be undermined swiftly and without an academic appreciation of change in Cuba.

US national security interests, however, rose following the 1961 Bay of Pigs operation and climaxed after the 1962 missile crisis (H. Thomas, 1998). Consequently, the Pentagon sought the first scholarly explanations of revolutionary Cuba from Cuban émigrés, who had relocated at American University, the Rand Corporation, and Pittsburgh University (Johnson, 1964; LaCharité, 1963-64; J. L. Rodríguez, 1988a). Throughout the second development phase, from 1959 through the mid-1970s, this scholarship nourished the unequivocal anti-Communist, anti-Castro position of the US government (J. L. Rodríguez, 1988a; Valdéz, 1988).

The movement toward a more normalized US-Cuban foreign policy after the mid-1970s encouraged other North American and European scholars to rejoin the conservative dialogue coming from Cuban-American scholars. Thus, a third stage of Cuban literature development was begun (J. L. Rodríguez, 1988a; Valdéz, 1988). One pivotal study (Commission on United States-Latin American Relations, 1975) conducted by such mainstream political economists as Mesa-Lago, Domínguez, and Huntington recommended the immediate and full normalization of US-Cuban relations.

The 1980 US presidential election and the creation of the Cuba-American National Foundation (CANF) in Miami, Florida revitalized a politically and economically Neo-liberal Cubanology. Cubanology refers to a specific political economy literature that is propagandized and orientated to the methodical confirmation of the infeasibility of Cuban socialism (Mesa-Lago, 1992; J. L. Rodríguez, 1988a). Unsurprisingly, the conclusions of the Neo-liberal Cubanology produced after the 1980s were invariably anti-Castro and anti-Communist (Valdéz, 1988). Philipson (1981), for example, described the Revolution as a novelty. Neo-liberal Cubanology commonly used the expressions “revolution betrayed...surveillance...harassment...moral pressure...forced mobilization...little free choice...regimentation...and authoritarian rule as a permanent feature” (Horowitz, 1981, p. 3) to describe Castro, Cuban socialism, and the revolutionary state.

At the close of the 1980s, a more sympathetic scholarship that emerged had begun applying the critical political economy framework to Cuban research designs and methods (J. L. Rodríguez, 1988a). For example, de Brun and Elling (1987) found that by the time the Berlin Wall had fallen, the fully matured Cuban welfare state had reversed many of the “negative effects of the previous market economy” (p. 681). Bengelsdorf (1988), meanwhile, validated Brundenius’s (1981) finding that Castro’s interpretation of Marxist political economy had narrowed the once disparate class structure through the abolition of private property, the reallocation of surplus labor, and acknowledgment of “basic human rights: the right to be literate and to be educated; the right to free and full health care; the right to a means of subsistence” (p. 125). Two works (Azicri, 1981; Bengelsdorf, 1988) during the late-revolutionary interval of the Cuban literature development are notable for their integrated critical feminist-political economy frameworks used to produce the first Cuban gender analyses.²

An ideological intransigence that runs the political gamut presents in nearly all of the

Cuban literature. A review of select works published over the last two decades reveals the major factors that have contributed to this partiality (Amnesty International, 2000, 2002a; Brundenius, 1988; J. I. Domínguez, 1983; Fuller, 1988; Mesa-Lago, 1992; Nichols, 1998; Pérez-Stable, 1991; Robles, 2002; J. L. Rodríguez, 1988a, 1988b; Schwar, 2004; Valdéz, 1988; Zimbalist, 1988a, 1988b, 1988c). Research subjectivity and distortions in the literature were found to associate with the following:

- much of the initial US literature was produced by Cuban émigré scholars, who directly or indirectly served US policy interests to subvert the Revolution and present to the world the likeness of a ruthless government and merciless dictator;
- academics sympathetic to Castro's cause have touted Cuba's social achievements in support of the Revolution and to further Castro's socialist aims;
- scholars who have attempted to produce impartial analyses face the tricky investigative, pragmatic, and principled task of contrasting Cuba's undeniable social achievements with the government's human rights abuses;
- the vacuity of insider analyses—critical studies of modern-day Cuba conducted in Cuba by Cuban scholars—fuel the Neo-liberal argument that the Castro government silences free and open academic discourse;
- the US travel blockade, a suspicious vetting of foreign investigators by Cuban authorities, and the ban on quantitative field surveys by non-Cuban investigators in Cuba obstruct independent researcher access to the island and more robust analyses of social life;
- explicit disclosure of theoretical and methodological research designs are rare to the vast majority of the literature; and
- scholars generally omit their political-economic values in published articles.

Zimbalist (1988a) cedes that the factors outlined above nurture analytical predispositions in the scholarship that produce a “superficial and distorted view of Cuban reality” (p. 1). The sympathetic Cuban scholarship generated after the late 1980s expands on Domínguez's (1978) argument that because classical and Neo-liberal political economy cannot explain socialism and the socialist state, the critical approach is the only theoretical perspective capable of rendering “an objective evaluation” (Note 1, p. 201) of Cuban political economy. However, Mesa-Lago (1992) asserts that the sympathetic faction's Marxist/Neo-Marxist leanings and friendly

relationship of with the Castro government have blinded its members to the sizeable body of research on socialism and socialist nation's using the orthodox approaches of classical and Neo-liberal political economy. All the same, Mesa-Lago (1992) admits that the validity of impassioned studies on either side of the political spectrum have been unduly influenced by a revolution, which has "polarized opinions and hence there might be less objectivity in this subject than others" (p. 25). Although Mesa-Lago (1992) recommends the inclusion of a disclaimer that informs the reader about the researcher's value preferences, few scholars have heeded this advisement.³

Post-Cold War Literature Development

A major Cuban policy reform, announced just three years before the fall of the Berlin Wall, brought all economic determinations under the control of President Fidel Castro (Mesa-Lago, 2000). In his public announcements, Castro assured citizens that he would quash any market-oriented reorganization of Cuba's command economic planning model (Mesa-Lago, 2000). Less than a decade later, however, Castro admitted publicly that although he would permit no transition to a capitalist Cuba, capitalist elements had been introduced into the economic system (Castro, 1996). The leader's reversal accentuates the radical shift in global circumstances and domestic affairs, along with an equally drastic revision of the Cuban political and economic literature after the collapse of the USSR in 1989.

The brisk termination of Soviet subsidization and aid, the dissolution of Cuban exchange with the community of Soviet bloc trading partners, otherwise known as the Council for Mutual Economic Assistance (CMEA), the refortification of the US embargo, and internal fiscal imperfections led to an enveloping economic crisis and social disorder (Castro, 1996; Gonzalez & Ronfeldt, 1994; Kuntz, 1994; Linden, 1993; Mesa-Lago, 1992, 1993b, 1993c; Pérez-López, 1994a; Svejnar & Perez-Lopez, 1993b; The White House, 1996; H. Thomas, 1998; Turits, 1987; U. S. Department of State, 1992, 1996; Zimbalist, 1993). Scholarly interest in the post-Cold War economic crisis, which denotes the current developmental stage of the literature, centers on Cuba's prospects for remaining one of the last sanctuaries of traditional socialism (Mesa-Lago, 1992)

In the early 1990s, both Neo-liberal and sympathetic academicians began advancing a series of political-economic scenarios that attempted to broach the subject of Cuba's uncertain

future (Betancourt, 1991; J. I. Domínguez, 1991; Espino, 1991; Gonzalez & Ronfeldt, 1994; Gunn, 1992; Hernández-Catá, 1991; Luis, 1991; Mesa-Lago, 1992, 1993a; Oppenheimer, 1992; Pérez-López, 1991, 1994a; Pickel, 1998; Pujol, 1991; Ritter, 1994; Sanguinety, 1991). The annexation scenario, for example, was patterned after the East-West German reunification model (Ritter, 1994). It predicted the US absorption of a post-Castro Cuba that would become either a new or a semi-autonomous state founded on the US capitalist-democratic paradigm. Acting on this scenario, scholars began designing a prototype to realign Cuba's health and social welfare regime based on Neo-liberal principles (Alonso et al., 1994; Donate-Armada, 1994; Ritter, 1994). Pérez-López (1994a) foresaw Cuba going the way of the Eastern and Central European nations of the former Soviet Union, which, as sovereign nations, also adopted the Neo-liberal approach.

Mesa-Lago (1992) offered a number of scenarios, the most striking of which hypothesized that citizen ferment over the internal economic crisis would lead to “Castro's downfall and the elimination of socialism” (Mesa-Lago, 1992, p. 36). Even Feinsilver (1993), a frequent contributor to the pro-Cuban dialogue, predicted that Castro and Cuban socialism most likely would not survive the socio-economic catastrophe. Unsurprisingly, magazine reporters in the US seized on the headline-grabbing scenario of Castro's downfall and a post-socialist Cuba (Ellison, 1990; Glancey, 1996). For example, it was reported that while Miami's half million Cuban émigrés joined journalists in the watch for Castro's demise, scholars at the CANF were formulating a post-Castro reform constitution (Ellison, 1990).

The continuity scenario was another possibility advanced in the Cuban scholarship (Mesa-Lago, 1992; Pérez-López, 1994a). This case scenario predicted the continuance of Cuban socialism under the extant political and economic structure. It was anticipated that Castro would attempt to increase Cuba's export base, find new foreign investment and revenue sources primarily from tourism, develop alternative energy supplies, and increase agricultural production to mitigate the dependency on foreign imports (Espino, 1991; Mesa-Lago, 1992, 1993a). However, the scenario further predicted that export expansion and the broadening of trade partnerships would require Castro to return Cuba to the global capitalist market, which was expected to stimulate research interests in Cuba either as a successful model of socialist convention or exemplar of its search for independence from Soviet domination (Mesa-Lago, 1992, 1993a). Indeed, Cuba has gone the way of this last case scenario, which is similar to the

limited market-socialism models being applied in Vietnam and China; retain the socialist political framework and make limited, market-oriented economic modifications (Alzugaray, 1995; Mesa-Lago, 1992; Pérez-López, 1994a; Pickel, 1998).

Despite ostensibly insurmountable barriers, and to the chagrin of some Neo-liberal scholars, Cuban socialism and its initiator prevailed (North American Congress on Latin America, 1997). The first evidence that Cuba's economic crisis was subsiding came in the mid-1990s. The gradual recovery was correlated with government-initiated liberalization of self-financing mechanisms in foreign trade enterprises, private ownership in the tourism sector, the introduction of Western-oriented export market techniques, the dollarization of the economy, and initiation of nearly all of the continuity scenario elements mentioned above (Zimbalist, 1993).

Economic reform, the likelihood of an economic recovery, and the possibility of political and social stabilization in Cuba encouraged the international business community (Kirby & Ezquerro, 1995). By the mid-1990s, more than a dozen newsletters began publishing latent investment opportunities and economic data that the academic literature had omitted, because of its questionable reliability (Kirby & Ezquerro, 1995). Because of Castro's check on the official release of pejorative data, some international business publications enlisted the aid of government whistle-blowers inside Cuba to covertly provide supposedly authoritative statistics (Seibel, 1993).

By the mid-1990s, international business magazines were presenting images of a nation that was stabilizing politically, economically, and socially under Castro's tutelage. Some academic research between 1994 and 1998, however, illustrates the tentativeness of Neo-liberal scholars to reconcile their anti-Castro homilies and Cuba's market-oriented trends. In Storm Warnings for Cuba, for example, Gonzalez and Ronfeldt (1994) noted Cuba's movement toward a more liberalized economic model, but one that was fixated on Castro's refusal to relinquish control, his devotion to the "old socialist vision" (p. ix), and intolerance of all dissident activity. Citing an upturn in popular unrest, including two examples of violent anti-government activity, the study (Gonzalez & Ronfeldt, 1994) offered four possible futures, the last of which was a violent revolt led by anti-Castro elements within the regime or through a "mass uprising" (p. 78).

Just two years later, however, Gonzalez (1996b) acknowledged that Castro appeared to have survived the gravest years of the economic crisis. In another study that same year (Gonzalez, 1996a), the researcher credited Castro's limited market reforms with reversing

Cuba's economic freefall and giving the leader a "residual source of political legitimacy and mass support" (p. vii). Still, it was concluded that the regime's permanence remained doubtful (Gonzalez, 1996b).

By the time Cuba and Lessons from other Communist Countries (Gonzalez & Szayna) was published in 1998, economic recovery and Castro's intransience were more certain. Since 1993, broad legal protections for foreign investment, a flood of international tourism dollars, remittances from exiled Cuban family members, authorization of free market agricultural operations, the establishment of domestic free trade zones, the enactment of price increases, the addition of new personal income taxes, and cuts in public service expenditures amplified Cuba's rebound (Dilla, 1999; Jatar-Hausmann, 1998; Peters, 1997). Economic output had increased modestly every year since the 35 percent 1989-1993 plunge, while the Gross Domestic Product (GDP) expanded by almost 4 percent in the period 1994-1998 (Jatar-Hausmann, 1998).

Peters (1997) provided evidence of the market-oriented recovery, in which the number of legally-licensed, self-employed Cubans was estimated to have mushroomed from about 10,000 to 15,000 in 1993, and to 170,000 in 1997, with an equal number of illegal operators. About 26 percent of all legally-licensed, self-employed, small business owners were older Cubans, who, as a result of the crisis, price increases, and reductions in the social safety net, found it necessary to supplement their social security incomes (Peters, 1997). Schwar (2001), meanwhile, reported that many older farmers regularly engaged in the black market sale of foodstuffs to citizens and foreign visitors on the rural outskirts of La Habana and along Cuba's rural highways.

As the 21st Century approached, Castro appeared to have defied his critics by challenging the long-held principles of orthodox political economic theory, namely the Neo-liberal approach (Falcoff, 1998). Hence, Neo-liberal scholars recoiled from the case for unseating the nation's aging revolutionary *caudillo* and refocused on the prospects of Cuba's transition to a model more in line with the Neo-liberal projects of Eastern and Central Europe.⁴ In chorus, various Neo-liberal article titles assumed the patriarchal forms of *lessons Castro could learn* and *what other transitional nations can teach Cuba*, while the sympathetic scholarship played off the theme of *what Cuba can teach others* (Anand, Pandav, & Kapoor, 2000; Gonzalez & Szayna, 1998; Jatar-Hausmann, 1998; Luis, 1991; Morawetz, 1980; Olshan, 1998; Pérez-López, 1994b; Svejnar & Perez-Lopez, 1993b).

It is important to point out the development of a significant insider literature produced in

Cuba by Cuban scholars, mostly after the late 1980s. Perhaps in response to Neo-liberal US research and/or to showcase its own health-related scholarship, the Castro government created an on-line library service called *Infomed*. Today, for example, dozens of Cuban journals featuring health, medical, and health economics research articles dating back to the 1980s are accessible via the worldwide web link to *Infomed*.⁵ Additionally, Emory University began publishing *MEDICC Review*, an electronic, on-line journal, and the first publication of Cuban medical research translated into the English language.⁶

Over the last 15 years, the growing body of non-Cuban Cubanology has eclipsed a minority of sympathetic outsider analyses that merely recite Cuba's past achievements or repeat the capitalist conspiracy argument promoted by Castro and the Cuban leadership (Clark & Barnes, 1991; Deere & Meurs, 1992; Dilla, 1999; Hinch, 1990; Keck, 1993; K. C. E. Macintyre & Hadad Hadad, 2002; Mechanic & Rochefort, 1996; Meerman, 2001; Meurs, 1992; Tancer, 1995; Turits, 1987). Two works (Feinsilver, 1993; Pickel, 1998), however, reflect a well-researched critical scholarship by non-Cuban investigators. Guerra de Macedo, the former Director-General of the Pan American Health Organization, states in Feinsilver's Healing the Masses: Cuban Health Politics at Home and Abroad (1993) that the researcher circumvents the pitfalls of simply distinguishing the nation's imperfections or by offering a supportive validation of the Revolution through a fairly objective explanation of the Cuban health experience.

The second work is Pickel's thesis (1998), Is Cuba Different? Regime Stability, Social Change, and the Problem of Reform Strategy. As if it were simply a critical political-economic analysis, the article begins with a disapproving critique of the Neo-liberal project. However, it quickly turns to an admonishment of the Castro government's failure to "go beyond a modest degree of local democracy" (Pickel, 1998, p. 88) and overhaul the Communist Party to ward off political stagnation. Pickel's economic reform proposal for Cuba called for increasing social welfare enhancements, active support for domestic private enterprise, a purging of universal enterprise subsidization, and allowing the means of production to be gradually "subordinated to market rules" (Pickel, 1998, p. 87).⁷

The preceding sections reveal two important trends in the development of the Cuban literature. First, one stream of averse scholarship in the 1960s and 1970s, which took on a Neo-liberal tenor after 1980, has continued to echo a Cold War, anti-Communist, anti-Castro sentiment. However, a more approving Marxist and Neo-Marxist scholarship that emerged after

the late 1970s has continued to present a supportive view of Castro, the Revolution, and Cuba's achievements, particularly in the arenas of health, education, and social justice. One consequence of this academic rivalry was a 143 percent increase in collective scholarly output on the subject of Cuban politics and economy in the period 1971-1989 alone (Mesa-Lago, 1992).

Indeed, the trend in the Cuban political-economic literature is indicative of a broader movement in the study of politics and economies in such lesser developed regions as Latin America (Deacon, 1984; Navarro, 2002d; Neysmith, 1991; Packard et al., 1989). It also can be argued that the two competing streams in Cuban scholarship reflect a growing argument over theoretical perspectives. At issue is which political economy approach is most effective in analyzing socialism and social life in such nations as socialist Cuba.

The cessation of East-West tensions after 1989 has created a new world order. Consequently, these historic changes have forced a rethinking of the theories previously used to explain the world of the Cold War Era. In the Cuban case, the orthodox approach initially offered a plausible explanation: Castro and Cuban socialism would fall, Cuba would go the way of Central and Eastern Europe, and the Cuban people would embrace the Neo-liberal political-economic model. However, Neo-liberal political economy has failed to explain the limited market socialism model that has evolved in Cuba, as well as in China and Vietnam (Baum, 1994; Gough, 1978; Morris, 1986; Walker & Wong, 1996).

Marx's social democracy alternative is a framework that might bring scholarship closest to understanding Cuba's post-Cold War transition. As the social democracy premise stipulates, however, the Cuban government has not become an adjudicator of unresolved disputes between wealth-owners and labor; citizens remain the primary owners of the means of production via the state (Caporaso & Levine, 1992; Howard & King, 1985; Strathern, 2001). Thus, the critical research since the mid-1990s has been mired in a pattern of reciting Cuba's socialist achievements with the added features of condemning the effects of capitalism and a retrenched US embargo on those accomplishments.

Amoore et al. (2002) posit that one of the most important facets of heterodox IPE is the use of history to place political economy developments in the context of an increasingly globalized world. Thus far, the chapter has employed a historiographic framework to place into context the theories and approaches used to generate a Cuban political economy literature. The next section employs a like approach to place Cuba, Castro, the Revolution, and social life in

Cuba into context.

A Short History of Cuba

Cuba is the major island of the Greater Antilles and the largest nation in the West Indies.⁹ It lies 90 miles from the US Floridian coastline and 75 miles east of Mexico's Yucatán Peninsula (see Figure 3.1). With a landmass of 10,860 square kilometers, it is slightly smaller than Pennsylvania, twelve times the size of Puerto Rico, and is the 15th largest island in the world (Central Intelligence Agency, 2003; H. Thomas, 1998).

Figure 3.1. Location Map of the Greater Antilles, Eastern Gulf of Mexico, and the Caribbean



From US Central Intelligence Agency.

Cuba's diverse topography consists of mostly low-to-rolling plains with a very flat southern region. The eastern end of the island is mountainous, with its highest peak rising to 6,560 feet. The terrain drops precipitously from the eastern mountains to both the Caribbean Sea and Gulf of Mexico. There are very few inland lakes and only one navigable river. This physical landscape is intimately connected to such various other characteristics as Cuba's demography, the spatial orientation and structure of its settlements, the types and distribution of agricultural activities, in addition to the development and evolution of its health and elder care services system. These characteristics will be covered later in this and subsequent chapters.

Rich soils, a semitropical climate, prevailing trade winds, and superior ports made Cuba an ideal Caribbean launching-point for Spain's conquest of the Americas, the African slave trade, and passageway for the transport of natural resources from the southern Americas to Europe (H. Thomas, 1998). Excluding a short-lived British occupation of the capital city of La Habana and the western part of the island in 1762, Cuba remained a Spanish colony until 1898.

Its first revolution, involving a 10-year war for independence, was crushed in 1878. The second war for independence began in 1895. During the second war, US forces invaded, subverted the rebel army, and made Cuba an occupied appendage between 1898 and 1902 (H. Thomas, 1998).

The US-engineered independent Cuban state took form as a result of Cuba's 1902 national election. However, before the end of the nation's second presidential administration and with an impending civil war endangering US assets, the US again intervened. In the period 1906-1909, US authorities established a new republicanism. For the next half century, Cuban democratic-capitalism bolstered a succession of US-backed administrations, the majority of which were corrupt and brutal. Hence, Cuba still was little more than a "North American dependency" (H. Thomas, 1998, p. 501) in December 1958.

The Revolutionary System

Fidel Castro and his rebel army marched into La Habana to throngs of cheering supporters on January 8, 1959 (Cockroft, 1996).⁹ Castro reflected on the three-year struggle to topple the Batista regime, the last US-supported Cuban president. In a national address, he told the Cuban people (as cited in Cockroft, 1996) that the revolutionaries had 'won only the right to begin' (p. 297). Although Philipson (1981) is correct that the Cuban elite and some middle-class elements had not championed the revolt, Cockroft (1996) notes that Castro and his followers did have the full support and input of two cohorts of students, some members of the middle-class, and most of the peasantry and rural and urban working class.¹⁰

In January 1959, Castro officially denied he was a Communist (H. Thomas, 1998). On October 11, 1960, fellow revolutionary, Ché Guevara, announced (as cited in H. Thomas, 1998) that 'We are Communist' (p.1298). The US embargo was enacted eight days later on October 19, 1960 (U. S. Department of State, 2000b).

Castro declared Cuba socialist on April 16, 1961, one day before the Bay of Pigs invasion

(H. Thomas, 1998). On December 2, 1961, eight months after Cuba's military victory at the Bay of Pigs, Castro revealed to the nation that he was a Marxist-Leninist and had been since he was a student at the University of La Habana (H. Thomas, 1998). During the same nationally televised speech, Castro further admitted that "he and his comrades had in the 1950s consciously disguised their radical views in order to gain power" (H. Thomas, 1998, p. 1373). Thus, scholars are faced with the analytical dichotomy of a key political leadership that is dominated by Communists and functions of state that are characteristically socialist.

Until the late 1980s, economic and military support from Moscow and the Soviet bloc's trade partnership called the Council for Mutual Economic Assistance (CMEA), in addition to other trade ties with Western Europe, China, Japan, Canada, and Latin America, enabled Castro to establish an authoritarian socialist state that has survived for almost a half-century (Borzutzky & Vacs, 1993; Central Intelligence Agency, 2003; Mesa-Lago, 1993a; Seligson, 1993). The Cuban people are governed through a five-tiered political structure, which includes state, regional, provincial, municipal/rural area, and sectoral local political bodies. As president, Castro is both chief of state and head of government. Castro was named president after the abolishment of the position of prime minister in 1976 (Central Intelligence Agency, 2000).

Castro also heads the nine-member Council of Ministers (cabinet), the 31-member Council of State, and the Cuban Communist Party (PCC). The PCC is the country's only legally recognized political party (Base de Datos Politicos de las Americas, 1992; Central Intelligence Agency, 2003). The president's brother, General Raúl Castro, is vice president, commands the nation's six military branches, and is the constitutional heir to the presidency (Base de Datos Politicos de las Americas, 1992; Central Intelligence Agency, 2003).

Under the president and vice president, which it elects, Cuba's national legislative branch is the unicameral Assembly of People's Power (Base de Datos Politicos de las Americas, 1992). Special commissions approve a slate of national candidates, from which voters elect the Assembly's membership—Cuba has universal suffrage for persons age 16 years or older (Central Intelligence Agency, 2003). Cubanas (Cuban women) hold almost a quarter of the Assembly's 609 seats (Cockroft, 1996).

The National Assembly of People's Power reelected both Castro brothers unanimously in the March 2003 ballot (Central Intelligence Agency, 2003). Despite only one legal political party, six percent of all Assembly seats went to non-PCC members in the 1998 election (Central

Intelligence Agency, 2000). The next ballot is scheduled in 2008.

In February 1959, one month after coming to power, the Castro brothers, Ché Guevara and other leaders of the armed revolt formed a new government and enacted the Fundamental Law of the Republic (National Bi-Partisan Commission on Cuba, 1998). The law amended and re-established the 1940 Constitution, which Batista had suspended seven years earlier in 1952 (National Bi-Partisan Commission on Cuba, 1998). A Soviet-like constitution, which was adopted in 1976 and replaced the Fundamental Law of the Republic, contained five critical articles that mandated state-provided universal health care and education and guaranteed a social safety net of welfare protections (Base de Datos Politicos de las Americas, 1976).

The post-Cold War economic crisis, however, forced a major constitutional change. The 1991 PCC Congress recommended to the National Assembly amendments designed to address and weather the economic depression without diluting Cuba's basic socialist ideology (National Bi-Partisan Commission on Cuba, 1998). The Assembly unanimously approved the 1992 Constitution, which improved state governing bodies, revamped foreign trade statutes, increased direct local participation in the electoral process, and provided for a state-directed, mixed public-private sector of tourism and economic development (Base de Datos Politicos de las Americas, 1992; Crespo & Negrón Díaz, 1997; Hoffmann, 2001).

Obviously, the last amendment flew in the face of Cuban socialism and the nation's anti-capitalist history. Revisions endorsed in 2002 included a special disposition, in which the "socialist character and the political and social system put forth...in all parts of the [1972] Constitution...are *irrevocable* [italics added]" (Base de Datos Politicos de las Americas, 2002). Thus, while retaining the economic strategies of the 1992 charter, the 2002 revisions certified Cuban socialism as inviolate (Institute for Cuban and Cuban-American Studies, 2002).

Socio-Demographic Profile

Cuba's population of 11.3 million resides in 14 provinces or administrative divisions and the special municipality of Isla de Juventud (Central Intelligence Agency, 2003; Pan American Health Organization, 1999). The World Health Organization reported a population growth rate of one-half of one percent during the 1990s (World Health Organization, 2001). Population growth was projected to decline to a rate of about one-third of one percent in 2003 (Central Intelligence Agency, 2003). Among the Caribbean nations, only Cuba, Barbados,

and Guadeloupe have sub-replacement fertility rates lower than the United States (Eberstadt, 2001).

Table 3.1 displays the nation's ethnic and religious composition. Today, slightly more than half of the population is of mixed Spanish-African decent. The remaining 49 percent of the population is white, black, or Chinese.

Even before Cristobal Colón's (Columbus) arrival in 1492, the island had a relatively small indigenous population (H. Thomas, 1998). Still, European diseases decimated Cuba's three main tribes. There is no remaining Indian population in Cuba.¹¹

Roman Catholicism is the island's dominant religion. It underwent a revival in the 1990s following a relaxation of religious practice under the 1992 Constitution and the Pope's 1996 visit (Azicri, 2000; U. S. Department of State, 2000a). Afro-Cuban devotees of Santeria, a mixture of African spiritualism and Catholicism, also play a significant role in Cuban social life, although official figures on their numbers are unavailable (Fletcher, 2003). Similarly, the Protestant, Jehovah's Witness, and Jewish faiths also are represented (Central Intelligence Agency, 2003).¹²

Table 3.1. Cuban Ethnic Groups and Religions

Ethnic Group	(%)	Religion	(%)
Mixed Origin ^a	51	Roman Catholic	85 ^b
White ^c	37	Protestant	-
Black ^d	11	Jehovah's Witness	-
Chinese	1	Jewish	-
Indian	-	Santeria	-

Note. ^a The CIA defines persons of mixed origin as mulatto. ^b CIA statistics gathered just prior to the 1959 revolution. ^c The term white refers to Cubans of Spanish decent and ^d black as those of African decent. Adapted from "The World Factbook 2003: Cuba," by Central Intelligence Agency, 2003.

Cuba's demography has always been metropolitan. 1953 census figures indicated that 57 percent of the total population was located in cities, a proportion that increased slightly to 60.3 percent in 1970, and to 69 percent in 1981 (Rodriguez, 1996; United Nations, 2000). Although not as dramatic as in the 1970s, the economic crisis of the 1990s initiated a major rural-to-urban

resettlement process. Most of the economically vibrant cities in the central and western provinces registered population gains due to in-migration from the less developed rural eastern provinces (Rodriguez, 1996). Between 1981 and 1995, for example, the share of the total urban population increased from 69 percent to 74.5 percent (Pan American Health Organization, 1999; United Nations, 2000). The rural exodus to cities like La Habana was slowed, though, by the enactment of state regulatory powers over internal migration in the early 1990s (The Economist Intelligence Unit, 2000). Today, 77 percent of all Cubans reside in 11 major urban centers, and 20 percent of all urban dwellers live in the nation's capital province of La Habana (Cuban Ministry of Health: Office of National Statistics, 2002; Pan American Health Organization, 1999).

The mass flight of so-called boat people largely to the US, which reached 2,000 persons per week during spring 1980, decreased to a total of 2,500 persons for all of 2002 (Central Intelligence Agency, 2003; Cockroft, 1996; J. L. Rodríguez, 1988a). However, the CIA (2003) estimated that one out-of-every 1,000 persons would leave the island in 2003. It is uncertain, though, what impact the Bush Administration's In-country Refugee and Special Cuban Migration programs would have on this estimate (Department of Homeland Security, 2003). More interesting, however, is Hernandez's (1992) argument that the international emigration of younger Cubans has contributed to the island's population aging process.

Demographically, Cuba already is one of Latin America's oldest countries (Prieto Ramos, 2000). Fourteen percent of all Cubans are age 60 years or older, three percent less than in the US (Cuban Ministry of Health: Office of National Statistics, 2002; United Nations, 1999; World Health Organization, 2001). Cuban females age 65 years or older outnumber elder males in the same demographic range by a ratio of 1-to-0.85 (Central Intelligence Agency, 2003). As with the general population, the spatial distribution of the older population is more urban than rural (Pan American Health Organization, 1999). Furthermore, nine percent of all Cubans age 60 years or older live alone, less than half the Costa Rican proportion (Acosta, 1998; Pan American Health Organization, 1990).

Socio-Economic Milieu

Cuba is considered a middle-income developing country (Pearson, 1998). Until the late 1980s, most domestic needs were met by exchanging mainly Cuban sugar for a host of imports

from its Soviet trade partners with the CMEA (H. Thomas, 1998). Eighty-five percent of all Cuban economic resources and half of all its protein and caloric foodstuffs originated from the Soviet bloc in 1989 (Barrett, 1993; Garfield & Santana, 1997).

For three decades, this trade arrangement buffered Cuba from the full impact of the US embargo (Cuban Pugwash Group, 2001a; U. S. Department of State, 2000a). It also enabled Cuba's social welfare schema and the achievement of health, class, and income equality aims. As previously mentioned, the safety net includes universal health and education, as well as a range of social benefits such as old age pensions, unemployment insurance, and food, housing, transportation, and day care subsidies (Alonso et al., 1994; Donate-Armada, 1994). Safety net expenditures accounted for 37 percent of Cuban GDP in the early 1990s (Alonso et al., 1994).

The Revolution's socialist principles and state-provided social security have been used to justify the national wage and income structure. The 1998 average per capita monthly income was 217 pesos or \$US10 (Acosta, 1998; Schwar, 2001). In spite of social welfare, researchers claim the safety net's cost, inadequate incomes, the need to supplement food rations, and high unemployment press virtually all Cubans into indigence (Alonso et al., 1994).

According to official reports, unemployment was six percent at the end of 1999, down two percent from 1995 (The Economist Intelligence Unit, 2000). However, non-Cuban sources suggest the combination of an under-used workforce and unemployment would push the 1995 rate to somewhere between 34 and 40 percent of the economically active population (The Economist Intelligence Unit, 2000). As in the US, official Cuban figures exclude black market operatives; unregistered workers also are excluded from official employment figures (The Economist Intelligence Unit, 2000).

Before 1989, just five percent of all jobs were outside the public arena. Since then, the proportion of non-public jobs has increased to nearly 25 percent of the total workforce (The Economist Intelligence Unit, 2000). Agri-cooperatives and family-operated tourism businesses legalized under the 1992 Constitution showed the biggest gains during the 1990s (The Economist Intelligence Unit, 2000).

Education

Cuba's education proviso has received international praise even from US diplomats (Earth Island Institute, 2001). Table 3.2 compares two educational indicators among select

nations in the Americas. As a percentage of GDP spent on public education, Cuba exceeds all eight other countries mentioned. The World Bank, however, places the Cuban statistic at about 10-to-11 percent, almost twice the level that the United Nations Educational, Scientific, and Cultural Organization (UNESCO) recommends as adequate (Gasperini, 2000).

Independently, the GDP statistic is a poor measure of systemic performance. Adult literacy, which is defined as persons age 15 years or older who can read and write, is considered a better measure of systemic performance (UNICEF, 2003; United Nations Development Program, 2003). Cuba's adult literacy rate of 95.5 percent was outmatched only by Argentina and Chile in 2000. Costa Rica had an equal literacy rate, but allocated about half of what Cuba spent on public education as a percentage of GDP.

Table 3.2. Education in Statistics by Select Nations in the Americas

	Adult Literacy Rate (%)	Public Education Spending (as % of GDP)
	2000	1998-2000
Cuba	95.5	8.5
Jamaica	87.0	6.3
Canada	81.8 ^a	5.5
United States	80.1 ^b	4.8
Bolivia	85.5	5.5
Brazil	85.0	4.7
Costa Rica	95.5	4.4
Chile	96.0	4.2
Argentina	97.0	4.0

Note. ^{ab} 1997 statistics. Adapted from "The State of the World's Children 2003: Monitoring and Statistics: Country Statistics," by UNICEF, 2003; "Human Development Indicators 2003: Priorities in Public Spending," by United Nations Development Program, 2003.

Enrollment is another recognized system effectiveness measure (UNICEF, 2003; United Nations Development Program, 2003). Cuba's primary school enrollment rate was 100 percent in 2000, compared to 95 percent in the US and 91 percent in Costa Rica (The World Bank, 2002). Furthermore, Cuban grade-schoolers outperformed those in Latin America and the Caribbean in language, math, and science (UNESCO/OREALC Laboratorio Latinoamericano de

Evaluación de Calidad de Educación, 1998).

Special Period of War in a Time of Peace

Only 15 percent of all Cuban imports came from non-CMEA nations in the late 1980s (Barrett, 1993; Pérez-López, 1995). By 1993, Cuba's economic life-line with Moscow and the Soviet bloc had been completely severed—the nation experienced an immediate and near absolute economic disintegration (Mesa-Lago, 1993c). GDP declined by between 48 and 60 percent in 1993 alone, one of the steepest declines ever recorded (Diaz-Briquets & Perez-Lopez, 1995; Garfield & Santana, 1997; Pérez-López, 1995). Exports plummeted 75 percent over the period 1989-1993 (Pan American Health Organization, 1999). Castro likened the extraordinary situation to special times of defense, when the nation planned for the possibility of war with the US. However, the collapse of Cuba's Soviet partnerships “obliged us to experience the special period during peacetime” (Castro, 1996, p. 73).

Petroleum import losses that resulted in transportation cutbacks and daily electricity blackouts, an almost weekly occurrence as late as 2001, were some of the most visible signs of the special period (Pérez-López, 1995; Schwar, 2002). As durable and non-durable goods, personal hygiene items, and clothing vanished from state-run stores, so too did a breadth of food staples that tracked with the downsizing of monthly food allowances (Pérez-López, 1995). More worrisome, however, was the real potential for a correlate health debacle, particularly among vulnerable, older individuals.

Health Impact of the Crisis

US government agencies (Bureau of Inter-American Affairs, 1998; U. S. Department of State, 2000a, 2000b) blamed the Cuban crisis on its dysfunctional command economy model and collectivized agricultural system. The catastrophe also was attributed to deficit-producing social welfare outlays (Alonso et al., 1994). With the social landscape crumbling, the US Congress widened the scope of the 1960 embargo via the Cuban Democracy Act of 1992 (U. S. Department of State, 1992) in an attempt to hasten Castro's downfall and the nation's movement toward a US market economy, preferably with democratic elections—the Neo-liberal political-economic model. The legislation blocked US trade in food, medicines, and medical supplies; more than 90 percent of Cuban trade was with US transnational subsidiaries in 1992 (U. S.

International Trade Commission, 2001).

As the nation slowly emerged from the worst of the special period, which was roughly 1990-1994, US lawmakers again reformed the embargo. The newly enacted Cuban Liberty and Democratic Solidarity (LIBERTAD) Act of 1996 (Helms-Burton Bill), in combination with the 1992 legislation, extended Cuba's hardships through prohibitions that severely restricted or halted food, pharmaceutical, and medical-related imports from third country sources (American Association for World Health, 1997; Kirkpatrick, 1996; Kuntz, 1994; Nayeri, 1995; Tancer, 1995; The White House, 1996; U. S. Department of State, 1996)

Health becomes a cherished value during times of crisis, especially for lesser developed nations that lack resources needed to confront immediate public health threats (Gutierrez, 1989; Roman, 1995; Susser, 1993). Thus, the Cuban health predicament terrified the world medical community. Dozens of articles, which were penned by both Cuban and non-Cuban medical and health scholars, were published in such notable periodicals as the *British Medical Journal* and *American Journal of Public Health*. The June 1996 issue of the *Journal of the American Medical Association*, for example, dedicated a series of editorials that were critical of the US and the embargo's role in the Cuban health tragedy.

One international health group, The World Federation of Public Health Associations General Assembly (1994), articulated the medical community's concerns in an indirect plea to the US. It called for an end to all embargos for the health risks they especially posed to vulnerable populations. By the end of the decade, the risk had become reality, which prompted Barry's (2000) commentary that US sanctions against Cuba "may have had an unintended but profound effect on the health and nutrition of vulnerable populations" (p. 151), including older adults.

Anti-Cuban US legislation, an agriculture-monoculture based almost exclusively on sugar cane, an almost total dependence on CMEA food imports, together with the Castro government's inability to quickly expand domestic food production capacity led to the rapid depletion of food supplies (American Association for World Health, 1997; Bureau of Inter-American Affairs, 1998; U. S. Department of State, 2000a). An international health study (American Association for World Health, 1997) concluded that these concurrent circumstances increased nutritional deficits and malnutrition. By 1993, per capita protein intake had fallen 25 percent and caloric intake by 18 percent (Garfield & Santana, 1997).

Consequently, the leadership was forced to institute an emergency food rationing program in early 1991 (Barrett, 1993). The program transferred rations already allocated to the general population to the most vulnerable groups, namely children and older persons. The food program had minimal success. Nonetheless, food intake among older Cubans still fell 30 percent in 1993 alone (Pan American Health Organization, 1999).

A host of studies concluded that malnourishment and resultant vitamin deficiency directly related to food shortages had contributed to an epidemic of peripheral and optic neuropathy during the worst years of the special period (Arnaud et al., 2001; Borrajero et al., 1994; Centers for Disease Control and Prevention, 1994; Lessell, 1998; Macias-Matos et al., 1996; Mas Bermeja, del Puerto Quintana, Barcelo Perez, Molina Esquivel, & Canas Perez, 1995; Mas et al., 1997; Mojon et al., 1997; N. J. Newman et al., 1994; Roman, 1994, 1995; Santiesteban-Freixas et al., 1999; The Cuba Neuropathy Field Investigation Team, 1995; P. K. Thomas et al., 1995; Tucker & Hedges, 1993). Between 1991 and 1994, the epidemic affected almost 51,000 Cubans, 30 percent of whom were age 65 years or older (Arnaud et al., 2001; Centers for Disease Control and Prevention, 1994; Mojon et al., 1997; Roman, 1994, 1995; P. K. Thomas et al., 1995). When the outbreak entered an endemic stage in late 1994, non-Cuban scientists commended the responsiveness of the public health system. Family doctor-nurse teams, recently graduated as part of the Comprehensive Family Medicine Program of 1985, had implemented early detection methods, directed the flow of emergency food rations to high-risk groups, and distributed vitamin supplements door-to-door to vulnerable individuals, including the nation's older adults (Chelala, 1998; Keck, 1993; Sadun & Martone, 1995).

Crisis-related nutritional deficits had a marked effect on other health indicators. Garfield and Santana (1997) found that mortality from asthma, diarrhea, heart disease, influenza, pneumonia, suicide, and tuberculosis each rose by at least 10 percent among the older population between 1992 and 1993. A Cuban study (Guanche-Garcell, Zayas-Somoza, & Gomez-Hernandez, 2000), meanwhile, found that 17 percent of older persons who came to be diabetic had a predominance of hypertension coupled with dietary shifts toward increased sugar consumption after 1989.

Steep declines in food imports led to sharp drops in food consumption and, in turn, dramatic reductions in per capita protein and caloric intake (Barrett, 1993; Pérez-López, 1995). Two independent studies (American Association for World Health, 1997; Pan American Health

Organization, 1999) discovered that food intake among the older population decreased 30 percent, per capita protein intake fell 25 percent, and caloric intake decreased 18 percent in 1993 alone. These reductions, in addition to the loss of other dietary supplements, were directly correlated with immediate and widespread chronic energy deficiency and underweight (Pan American Health Organization, 1999). Strangely, only one of three major mainstream political economy studies (Linden, 1993; Mesa-Lago, 1993b; Mesa-Lago & Fabian, 1993; Svejnar & Perez-Lopez, 1993a) mentioned the embargo's impact on Cuba's economic situation and none addressed the health implications of the US foreign policy.

Inarguably, the special period endangered decades of health improvements among the general and older populations (Acosta, 1998). Even at the height of the catastrophe, though, detractors acknowledged the effectual provision of global health coverage, Castro's commitment to health equality, and his general capacity to meet citizen health expectations (Alonso et al., 1994). Other literature (Butler, 1999; Chelala, 1998; World Health Organization, 2000b, 2000d) points to the resiliency of the Cuban approach to health and medicine in maintaining longer-term health indices.

Table 3.3 shows Cuban mortality by the leading causes of death and percentage change

Table 3.3. Morbidity by Cause and Percentage Change for Years 1990 to 1993

Cause	1990	1991	1992	1993	(%) Change
Accidents	45.0	46.8	45.8	44.8	-0.4
Bronchial Asthma	3.8	4.8	4.9	3.9	2.6
Cancer	113.0	114.7	115.5	109.0	-3.5
Cerebrovascular Disease	57.0	58.0	60.9	55.6	-2.4
Diabetes ^a	9.9	9.3	9.3	9.1	-8.0
Heart Disease	168.0	172.5	173.4	160.6	-4.5
Suicide	20.0	19.5	19.2	19.0	-5.0

Note. Per 100,000 persons. ^aAll persons aged 15-64. Adapted from "Interrelación de la Epidemiología con la Economía de Salud," by I. Carbonell García and R. Lambert Matos, 1996, *Revista Cubana de Higiene y Epidemiología*, 34(2).

from 1990-1993. It also provides a general indication of state efforts to cushion the health pattern occurred during the interval. The most dramatic reversal was in diabetes-related deaths, which declined without interruption.

In allaying a more grave health disaster, Barrett (1993) mentioned physician efforts after 1990 to conserve extant drugs and direct those medicines to the chronically ill, older persons, pregnant and nursing women, and young children. MacDonald (1999) cites Castro's flexible macro-economic approach as another factor. As with prior emergencies, the president ordered special transfers previously designated for other sectors to the public health budget. Between 1989 and 1993, the government increased health care spending as a proportion of GDP from 5.5 to 11.7 percent (Alonso et al., 1994). Although resurgent economic hardship forced a 2.1 percent expenditure reduction in 1996, Cuba still outspent Australia, Canada, France, and the United Kingdom in the proportion of GDP dedicated to health care (G. F. Anderson, 1998; Pan American Health Organization, 1999).

Rationing and the Special Period

In 1982, a US Congressional committee agreed that Cuba's then 20 year-old food ration program had eliminated almost all hunger and malnutrition (Benjamin & Collins, 1985). Discounting trans-shipment, processing, and marketing costs, agriculture-related deficits used to finance the food program totaled as much as 800 million pesos (\$US38m) just prior to the Soviet bloc's demise (Donate-Armada, 1994). The total safety net deficit was 37 percent of GDP in 1992 (Donate-Armada, 1994).

Before the special period, the universal, comprehensive social welfare program, including its food ration function, benefited the general population equally, rather than targeting such specific vulnerable groups as elderly individuals. Retail food subsidies and state-provided meals in workplaces, schools, hospitals, child day care centers, and elder care facilities were designed to supplement the subdued wage and pension income structure (Donate-Armada, 1994). Per capita food subsidies in 1980 were approximately 10 percent of the average monthly wage and provided about 20 percent of the population's nutritional and caloric intake (Donate-Armada, 1994).

The holistic concept of bio-psycho-social human development is embedded in Cuban social welfare policy and public health law (Justiz Gonzáles, Ochoa Soto, & Reyes, 1999; Reed

& Frank, 2000). Although the Cuban Constitution mandates citizen co-participation in the developmental dialectic, it is the state's assigned responsibility to provide citizens "access to the resources necessary to attain a decent life" (Justiz Gonzáles et al., 1999, p. 132), including food, health, medical, and other social services.

In spite of post-1989 conservation efforts, the disintegration of its import base and safety net deficits rendered the existing welfare structure unsustainable. With the system under stress, the once noble model became problematic for the socialist principles of the Revolution (Benjamin & Collins, 1985). The leadership was required to cut social services.

The re-creation of inequities in health and other social states is an inherent risk for state welfare regimes that, due to constrained resources or emergencies, afford sub-groups and individuals dissimilar levels of access via social service rationing (Gertler et al., 1989). Gertler et al. (1989) found that Latin America's financial crisis in the 1980s forced governments to abandon their near universal health care approaches and institute Neo-liberal rationing mechanisms to recover service provision costs. Such was the case in Argentina, Brazil, Chile, Columbia, Costa Rica, Ecuador, Mexico, and Peru (Gertler et al., 1989; Homedes & Ugalde, 2002; Lara et al., 1995; Howard Waitzkin, Iriart, Estrada, & Lamadrid, 2001).

Rationing and/or expanding protections for specific populations at the expense of other groups are market-oriented devices commonly used in non-socialist nations to correct inefficiencies in health and food welfare programs (Esping-Andersen, 1999; Mechanic & Rochefort, 1996; Scharlach & Kaye, 1997; Stanford & Stanford, 2000). Mechanic and Rochefort (1996) define these activities in terms of their explicit and implicit forms. Explicit rationing refers to centralized macro-level decisions about social welfare budgets, service coverage and non-coverage, geographic distribution or location of services, and so on.

Cost-sharing, such as out-of-pocket fees attached to prescription drugs, is the implicit form. Implicit rationing creates barriers that prevent those with fewer personal assets from accessing resources like medicine. In turn, implicit rationing generates health disparities among various social groups according to their differential resource levels. Explicit rationing via geographic social service distribution further hinders access and creates health-related discrepancies (Gertler et al., 1989).

Although the long-term health care service system will be detailed in Chapter 5, it is important to note that Cuba's preventive-primary care structure is a "low-technology service and

relatively inexpensive” (Mechanic & Rochefort, 1996, p. 258). Thus, pharmaceuticals constitute one of the state’s largest health welfare expenditure categories. During the special period, the state lacked convertible currency needed to purchase medicine from the world market and was further restricted by the embargo to import medicine or attain raw materials for domestic pharmaceutical production. Consequently, a 50 percent decrease in medicines quickly purged hospital, clinic, and pharmacy supplies (American Association for World Health, 1997; Tancer, 1995).

As mentioned above, explicit rationing can occur through coverage and non-coverage decisions. The physician, for example, “is a gate-keeper who controls access to specialist and inpatient care” (Mechanic & Rochefort, 1996, p. 258) in most health settings. Family doctor-nurses teams are the key decision-makers in the allocation of Cuba’s health resources. So too, Gerontology Boards are responsible for placing older Cubans in long-term care homes, daytime medical care facilities, and adult day care centers (Prieto Ramos, 2000). Although no official information is available, these gate-keeping bodies could provide another measure of health service rationing.

The literature confirms the association between Cuba’s dismal economy and the introduction of corrective rationing techniques and strategies to diminish health and social welfare dispensations (Mechanic & Rochefort, 1996; Susser, 1993). However, Deacon (1984) would disagree with Benjamin’s (1985) inference that any market-oriented rationing device represents a violation of socialist principles. According to Deacon (1984) rationing does fit with the socialist welfare paradigm, but only if it is accompanied by the state’s minimization of the market’s presence and assurance that incomes are “more-or-less equalized” (p. 459).

The Neo-liberal, market-oriented justification for rationing lies in the realization of public budgetary solvency and reinvested cost savings in the private sector in order to buffer individual sacrifice in the long run (Donate-Armada, 1994; Gertler et al., 1989; Salas & Miranda, 1997). Numerous Costa Rican health studies, however, illustrate the flawed Neo-liberal premise (Homedes & Ugalde, 2002; Lara et al., 1995; L. M. Morgan, 1993; Pan American Health Organization, 1990; Salas & Miranda, 1997; Seligson, 2002). Countering the findings of Homedes and Ugaldes (2002) that the introduction of market processes in the 1980s had resulted in a more equitable and efficient health system, Salas and Miranda (1997) noted a reversal in health gains and an outpatient care system in crisis.

Regressive rationing methods without accompanying social security increases placed older Costa Ricans at particular risk. A 1993 study (Pan American Health Organization, 1990) reported that the majority of older Costa Ricans were not employed and, therefore, unable to supplement pension incomes, which were provided to “only about half of all men and just over one-third of women” (p. 22). Perceived health and economic needs, therefore, were the most important problems facing the older population. Seligson (2002) concluded that public discontent over diminished social welfare benefits and out-of-pocket cost increases on a range of goods and services threatened the legitimacy of the Costa Rican political system.

Although the Cuban crisis prompted Castro to institute market-like methods to reduce social welfare services, he has done so “with a human face” (Ritter, 1994, p. 88) by accentuating equity over efficiency. Reforms designed to affect systemic cost savings also included targeted social service increases for vulnerable populations, including older persons. Still, the government lacked the revenue necessary to adequately fund targeted welfare programs and, combined with the re-distribution of social resources from the general population to at-risk groups, has begun to recreate health, income, and class disparities that the 1959 Revolution sought to mitigate (Schwar, 2001).

Cubanas, Crisis, and Household Political Economy

The varied social outcomes mentioned above focus on the peak years of the special period, generally 1990-1994. Although the crisis began to ease somewhat around the mid-1990s, its effects were felt throughout the decade and into the new millennium (Schwar, 2001). As with nutritional and health status, the social lives of women and families provide another window from which to examine both the immediate and longer-term effects of the calamity.

The PCC initiated a national dialogue on the issue of Cubanas in the early 1970s (Bengelsdorf, 1988). Until then, equality between the sexes was non-existent, despite the presence of the Cuban Women’s Federation (FMC), which was founded in 1960. Mainstream Cubanists claim the FMC, one of Cuba’s seven mass organizations, is a functionary of Castro’s inside circle that carries out the state’s objectives on women’s issues (Azicri, 1981; Navarro, 1972b). Its leader, Vilma Espin Guillois, was a member of the PCC Central Committee until the 1990s and is the spouse of Raúl Castro (Azicri, 1981; Organization of American States, 1996). In contrasting the Cuban women’s movement to that in the West, Espin once stated (as cited in

Bengelsdorf, 1988) that we are ‘feminine, not feminist’ (p. 119).

Azicri (1981) argues that the FMC “became the social and political structure that made possible the release of latent female energy” (p. 278), which the state directs toward mass mobilization activities. For example, more than half of the 100,000 adolescents who participated in the 1961 campaign for literacy were young girls (Bengelsdorf, 1988). Many of these young women later joined the FMC.

Cuba’s family structure also was overlooked until the 1970s, when notions of the socialist family emerged as part of a dialogue on juvenile delinquency (Bengelsdorf, 1988). The leadership recognized state’s limits in the socialization of the younger population. Thus, the enactment of the Family Code in the mid-1970s established a key family life prescription: Cubanos (Cuban males) were ordered to share equally with spouses in both the care of children and domestic work (Bengelsdorf, 1988; Cuban Ministry of Justice, 1975; Jennissen & Lundy, 2001). The concept of the socialist family was included in the 1992 Cuban Constitution.

Cubanas have benefited from codified family life in a number of ways. Women were given legal access to jobs, prenatal health care, and family planning services (Jennissen & Lundy, 2001). At the height of the crisis, 40 percent of the total workforce and half of all doctors were women (Jennissen & Lundy, 2001).

These legal avenues, however, were ineffective in the reversal of the “persistence of *machismo* in Cuban culture” (Jennissen & Lundy, 2001, p. 187). Jennissen and Lundy’s analysis (2001) cited Cuban women, who acknowledged the tenacity of orthodox divisions of domestic labor. Many of the study’s female study participants said they still did most of the housework, the shopping, and child rearing.

The crisis of the 1990s disproportionately affected women’s lives (Jennissen & Lundy, 2001; Pearson, 1998). When once it was generally a woman’s choice to seek work outside the home, worsening economic conditions necessitated that women supplement spousal incomes (Jennissen & Lundy, 2001). Because most of the shopping responsibilities were borne by Cubanas, consumer, food, and transportation shortages, in which one-to-two hour waits for buses were commonplace, upset family life and placed added physical and psychological stresses on women (Jennissen & Lundy, 2001). Inadequate childcare also disrupted family life. Only one out-of every five mothers had access to daycare services in the mid-1990s due to cutbacks and the government’s inability to keep pace with demand (Jennissen & Lundy, 2001).

Cuban gender studies also found that market reforms unduly affected women throughout the 1990s (Jennissen & Lundy, 2001; Pearson, 1998). The introduction of material enticements designed to stimulate productivity, a critical break from the Guevarist political economy model for moral incentives, de-prioritized the role of working women (Guevara, 1971; Pearson, 1998). Female job displacements followed abrupt increases in unemployment, whereupon new job openings, particularly in joint-venture tourist facilities, were awarded to men; the state conferred select tourism-related openings to male, ex-military personnel and well-placed sobrantes (unneeded workers), who were retrained or transferred to downsize the number of governmental jobs (Gonzalez, 1996a; Mesa-Lago, 1993a; Schwar, 2001). Pearson (1998) found an over-representation of women in the unemployed ranks and significant departures of women over the age of 40 from the workplace.

Schwar (2001), meanwhile, raised gerontological questions concerning female employment trends, supplemental family income needs, and adult day care reductions in Cuba. Studies (Acosta, 1998; Apt, 1990; Jennissen & Lundy, 2001; Siddharthan & Sowers-Hoag, 1989) show a predominance of multi-generational living arrangements in Cuba, and strong intergenerational bonds throughout Latin America and among Cuban-American émigrés. Researchers, therefore, should be able to observe increased pressure on working Cubanas to provide care for older family members due to the culture of machismo and the above-mentioned factors.

The first two sections of this chapter focused on the development of the Cuban political-economic literature. The remainder of the chapter has profiled Cuba's history and socio-political-economic landscape since 1989, particularly during the period 1990-1994. Next, Chapter Four explores Cuba's bewildering recovery after the mid-1990s, in addition to persistent issues, such as human rights and its charismatic patriarch, Fidel Castro.

Chapter Four

The Recovery, A New Internationalism, and Lingering Issues

The loss of exogenous support after 1989, the strengthening of the US embargo in 1992, and the government's feeble response to the resulting economic depression decimated Cuban social life in a matter of years. The budget deficit nearly tripled to 50 percent of GDP by 1993 (Mesa-Lago, 1993b; Pérez-López, 1995; Suárez Salazar, 1995). Castro pursued alternative remedies, however, only when the crisis began undermining the state's legitimacy. The president authorized minimal political adjustments, social welfare reductions, and cautious liberalization chiefly in the tourism sector (American Association for World Health, 1997; Pickel, 1998; Ritter, 1994; Schwar, 2001; H. Thomas, 1998).

Tourism rescued Cuba from complete socio-political-economic ruin. The acute phase of the special period subsided in 1994 (Pan American Health Organization, 1998b). Modest growth occurred the following year (U. S. International Trade Commission, 2001). By 1996, tourism had replaced sugar as the main foreign exchange revenue source (Crespo & Negrón Díaz, 1997; L. Newman, 2002; The Economist Intelligence Unit, 2001).

This chapter analyzes the literature on Cuba's post-Cold War economic revival. It appraises the nation's reinsertion into the global market place via a stratagem of limited market socialism, demilitarization, scientific development, and international medical humanitarianism. The problematic issue of human rights also is examined. The chapter concludes with a profile of Fidel Castro and his importance to a renewed Cuban nationalism in the post-Cold War Era.

Forget the Guns; Keep the Butter and the Tourists

Tourism is the only economic sector in which developing nations consistently realize trade surpluses (The Worldpaper, 2002). It accounts for two thirds of all service export revenues in the developing world (The Worldpaper, 2002). Thus, Castro recognized Cuba's tourism industry as decisive to the recovery and future national development (Jenkins, 1995).

Before 1959, mostly affluent Unitedstatesians were drawn to Cuba's inviting climate, impeccable colonial architecture, and an infrastructure of luxurious hotels, gambling casinos, and sex trade operated by US crime syndicates (H. Thomas, 1998).¹ Today, Cuban tourism harkens back to the pre-revolutionary era when the island was the Caribbean's principal travel destination (Caribbean Quarterly, 2002; Jayawardena, 2003). Due largely to exacting policy reform, the

infusion of foreign capital, lucrative joint-venture agreements, and creative marketing, the modern state-directed tourism enterprise is credited with reversing Cuba's fiscal predicament of the 1990s.

Tourism Development Program

Unlike its Latin American neighbors, Cuba's strict tourism policy blocks transnational corporations from gaining control over capital, tourism development types, and labor (Sonmez, 2002; U. S. International Trade Commission, 2001). Law 77 mandates that all joint venture capital be provided "solely by the foreign company" (U. S. International Trade Commission, 2001, p. 3-22) to finance expansion. Law 50, meanwhile, stipulates that investors remain minority partners and employ only Cuban workers to ensure state jurisdiction over enterprise types and to prevent the importation of a foreign labor force (U. S. International Trade Commission, 2001).

Cuban tourism development policy requires investment partners to funnel employee wages paid in \$US directly to the state.² Wages are then redistributed at a lower amount in domestic currency to Cuban workers (Schwar, 2001). Joint venture agreements oblige foreign partners to equally share all profits (\$US) with the state, in addition to paying monthly leasing fees (Schwar, 2001). The following paragraphs illustrate how the policy has supported the reproduction of the tourism industry, averted the need for additional health and social welfare adjustments, and has begun to revitalize the public health system (Crespo & Negrón Díaz, 1997; Loomis, 2003).

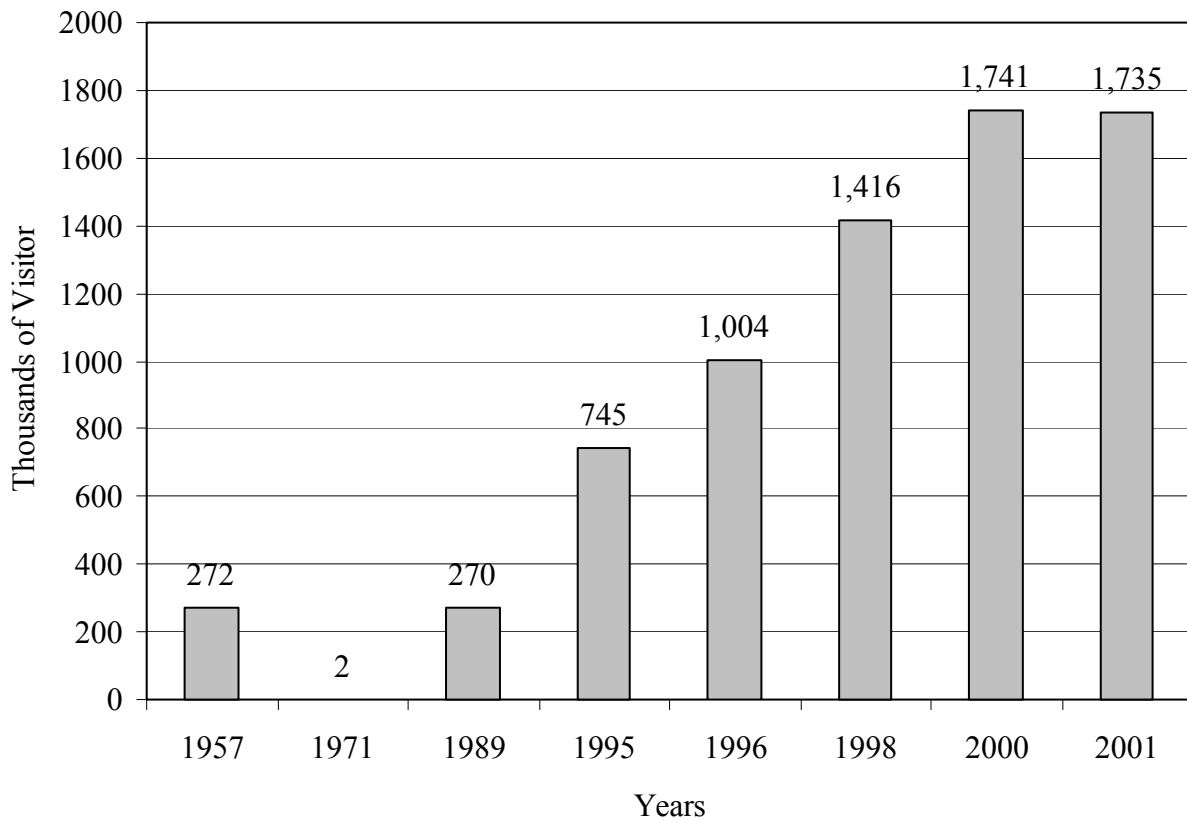
Marketing Tourism

Foreign travelers avoid destinations they perceive as hazardous (Sonmez, 2002). Cuba, however, promotes the island as a safe haven for visitors. The strategy has allowed Cuba to profit from Middle Eastern and European tensions and the global depression in foreign travel after September 11, 2001 (Jakarta Post, 2003).

Figure 4.1, which profiles foreign arrivals since 1957, underscores the importance of tourism to Cuba's economic recovery of the 1990s. Domestic instability, US-Cuban confrontations, and the initial enactment of the US embargo reduced arrivals mostly from the US to a negligible level within a year of the Revolution, after which the industry stagnated for two

decades (U. S. International Trade Commission, 2001). Although many US citizens violate the current US ban on Cuban travel, the Castro government began developing an alternate market in the late 1980s that today consists of mainly Canadian, Eastern European, German, Italian, Latin American, and Spanish visitors (Sonmez, 2002; U. S. International Trade Commission, 2001).

Figure 4.1. Foreign Tourist Arrivals by Select Years



Note. Adapted from "Tourism," by Cuba: The Website of the Government of the Republic of Cuba, 2003; "Market, Socialist, and Mixed Economies: Comparative Policy and Performance," by C. Mesa-Lago, 2000; "The Economic Impact of U.S. Trade Sanctions with Respect to Cuba," by U. S. International Trade Commission, 2001.

Tourist arrivals increased by 475,000 persons or about 57 percent between 1989 and 1995. In the following year, however, the proportion of arrivals rose a startling 41 percent. Tourism receipts totaled \$US 1.4 billion in 1996, an almost 27 percent increase over 1995 (Crespo & Negrón Díaz, 1997). Revenues continued to increase by at least 20 percent annually

throughout the later half of the 1990s (Crespo & Negrón Díaz, 1997; U. S. International Trade Commission, 2001).

Worldwide travel declined 10 percent in the months immediately following the September 11th terrorist attacks in the US in 2001 (International Labour Organization, 2002). Cuba's industry was only minimally affected, however. The government reported just 6,000 fewer foreign arrivals in 2001 than in the previous year (Cuba: The Website of the Government of the Republic of Cuba, 2003). Cuba also has benefited from steep reductions in air travel after 2001 (International Labour Organization, 2002; World Tourism Organization Marketing Intelligence and Promotion Section, 2002). Sixty Caribbean cruise liners ported in La Habana's harbor in 2002, a number that was expected to double in 2003 (Nagle Myers, 2003).

Although the effects of global terrorism and the second US-Iraqi war could influence projections, the island's geographic location and marketing efforts are expected to produce addition gains in the coming years (Jakarta Post, 2003; The Worldpaper, 2002). One study (Crespo & Negrón Díaz, 1997) predicted that the number of tourists would more than double to four million in the period 2003-2007. Fearing estimates that Cuba's market share will soon double, its Caribbean neighbors now view the Cuban island destination as a direct threat to their future economic viability (Caribbean Quarterly, 2002; Crespo & Negrón Díaz, 1997; de Holan & Phillips, 1997).

Crespo and Negrón Díaz (1997) reported that by 1997, tourism revenues were keeping the nation afloat. Macro-economic indicators presented in Table 4.1 offer additional evidence of the tourist-driven recovery. National revenue from all sources increased steadily after 1994. A dramatic reduction in Cuba's national debt also occurred after 1994 (Mesa-Lago, 1998).

The deficit as a proportion of GDP diminished from its peak in 1993 to 7.4 percent in

Table 4.1. National Macro-Economic Statistics for Years 1994 to 1999

	1994	1995	1996	1997	1998	1999
GDP Growth (percent)	0.7	2.5	7.8	2.5	1.2	6.2
Inflation (percent)	-	-9.8	-7.3	-1.1	2.9	-2.9
Revenue (\$US millions)	850	1,100	1,350	1,546	1,816	-

Note. Adapted from "The Economic Impact of U.S. Trade Sanctions with Respect to Cuba," by U.S. International Trade Commission, 2001; "Health in the Americas: 1998 Edition (Vol. 2)," by Pan American Health Organization, 1998.

1994 and 3.5 percent in 1995. The figure dropped another 1.4 percent in 1996. Cuba's deflationary spiral also began to ease after 1997. Modest growth in national output returned by 1999, following a three-year decline that has been attributed to the 1996 Helms-Burton Bill, infrastructure rebuilding, high interest rates, and unemployment levels that rose by about 300 percent in both 1994 and 1995 (Mesa-Lago, 1998; U. S. International Trade Commission, 2001). As already mentioned, food, medicine, and an array of imports, including health-related raw materials for domestic pharmaceutical production, were severely constrained, or altogether blocked under the Helms-Burton provisions added to the US embargo in 1996.

The Recovery and Health Care

Despite Castro's fidelity to health care and designation of medicine as one of two national priority funding areas, the crisis had a devastating effect on the nation's wholly public health services system (K. C. E. Macintyre & Hadad Hadad, 2002). In 1989, the health budget stood at \$US 227 million (Pan American Health Organization, 1999). Five years later, it had been reduced by 60 percent to \$US 90 million (American Association for World Health, 1997).

A 1995 reform, however, permitted direct transfers of tourism receipts to the health budget (K. C. E. Macintyre & Hadad Hadad, 2002). By 1996, tourism transfers boosted the health account to \$US 126.5 million, where it hovered for the next five years (Jorge Hadad Hadad, personal communication, June 29, 2001). Although the budget was still insufficient to meet the nation's overall medical needs, fiscal improvements throughout the late 1990s provided seed funds for a new long-term elder care initiative that Castro had announced unexpectedly to the nation and the world in 1992 (Pan American Health Organization, 1999; Prieto Ramos, 2000; Schwar, 2001, 2002).

Projected transfers were expected to boost the 2001 health budget to \$US 173 million (Jorge Hadad Hadad, personal communication, June 29, 2001). National health officials believed the health account would be restored to its 1989 pre-crisis level by 2002 (Jorge Hadad Hadad, personal communication, June 29, 2001). The leadership also anticipated an infusion of \$US 17.5 million from non-governmental Latin America and European contributors in 2002 (The Economist, 2000).

Hazards of the Recovery

In contrast to health care, crisis period reductions in education, defense, and internal security budgets may not yet have been recouped (Mesa-Lago, 1998). Troublesome social consequences also have beleaguered the recovery. As noted in the last chapter, unfavorable trends in both the employment and domestic spheres have unduly affected daily life for Cuban women and families. One disturbing trend related to tourism and the influx of foreigner visitors is a revival of the illegal sex trade (Espino, 2001; Henken, 2000; Rundle, 2001; Sonmez, 2002; Trumbull, 2001).

Poverty, unemployment, and the scramble for US dollars has forced many women and children to rely on prostitution to fulfill basic needs once satisfied by the state (Espino, 2001; Henken, 2000; Rundle, 2001; Sonmez, 2002; Trumbull, 2001). A recent article in *Granma*, Cuba's Communist Party newspaper, acknowledged the social problem via deflection (Elizalde, 2003). It pointed to the increase in sex tourism in other popular Latin American destinations, such as Costa Rica. It also condemned pedophilia in the US in response to Bush Administration accusations that prostitution was rampant among young Cubans. The article concluded with a laundry list of anti-prostitution statutes and penalties for citizens and foreigner visitors.

Sonmez (2002) and Lee (1998), meanwhile, examined associations between Cuban tourism, and increases in violent crime and drug trafficking. For example, a popular tourist nightspot was closed for having become what state officials described as a hub for 'prostitutes, black marketers, and anti-social elements' (Sonmez, 2002, p. 167). More serious, however, were the 1997 bombings of several tourist hotels (Sonmez, 2002).

The 1997 incidents may have been related to severe tourism policy restrictions that have been placed on ordinary Cuban citizens. One US government report (U. S. International Trade Commission, 2001) inferred that while Cuba's citizens bore the brunt of food shortages during the 1990s, the state imported large amounts of food unavailable to the general population to stimulate tourism by attracting foreign visitors to exotic cuisines. All Cuban tourist hotels offer extravagant dining buffets with foodstuffs that the state has ruled unlawful for ordinary citizens to possess (Schwar, 2001). Furthermore, all citizens, with the exception of Cuban tourism employees, are restricted from even entering tourist facilities (Schwar, 2001).

Unlike any other leader in the developing world, Castro has used his nation's foreign military might, health accomplishments, and international humanitarian programs to sustain his

and his country's role as a major global Cold War actor (Feinsilver, 1993). After 1989, however, Castro's international visibility waned along with the Cuban economy and the Soviet community, which he had relied on for economic, organizational, technical, and ideological support (Blasier, 1993; Borzutzky & Vacs, 1993; J. I. Domínguez, 1993; Feinsilver, 1993; Linden, 1993; Seligson, 1993). During the 1990s, Castro parlayed tourism into economic recovery. Similar marketing strategies now are being used to increase Cuba's share of the global medical tourism market and to expand its humanitarian medical diplomacy initiative. These actions symbolize a new internationalism designed to reinsert Castro and his nation into the global arena of the post-Cold War Era.

Cuban Internationalism

Shortly after the first US-Iraqi war, the head of the US Joint Chiefs of Staff cited Cuba as one of the last remaining enemies of the United States (Alzulgaray, 1995). As with Iran and Syria, the US considers Castro a foremost sponsor of global terrorism (Goodman, 2003; L. Robinson, 2002). The US has alleged that Cuba's scientific apparatus has the potential to manufacture biological weapons (Xinhua, 2002). Goodman (2003), however, argues that attempts to isolate Cuba from the global economy make it appear as if the US war on Cuban terrorism is simply a war with a government it detests.

The exportation of revolutionary socialism was strategic to Castro's military challenge of the US throughout the Cold War Era. It also was key to the development of international political and trade alliances and Cuban nationalism (Hoffmann, 2001; Seligson, 1993). Until 1985, Castro supplied economic aid, military supervisors, and Cuban troops to his allies in Central America, the Leftist countries of the Southern Cone—Argentina, Brazil, Chile, and Uruguay—and the African nations of Angola and Ethiopia (Borzutzky & Vacs, 1993; Eckstein, 1988; Feinsilver, 1993; Fernández, 1994; Gonzalez, 1995; Philipson, 1981; Seligson, 1993).

International realignments after 1989 and the domestic economic crisis, however, ended Cuba's foreign military assistance program, displaced Castro's global visibility, and weakened his ability to generate domestic support (Eckstein, 1988). Consequently, the president sought new ways to reestablish himself and his nation in the new world order (Alzulgaray, 1995; Delgado, 1995; Feinsilver, 1993). The following examples represent the main challenges to Castro's vision for a new Cuban internationalism: 1) he was no longer able to play on Cold War

tensions; 2) he needed to circumvent the US embargo and diffuse US attempts to isolate Cuba from global political and economic affairs; and 3) his military budget was fiscally untenable (Alzulgaray, 1995; Eckstein, 1988; Feinsilver, 1995; Gonzalez, 1995; Klepak, 1995; Seligson, 1993).³

The Military-Tourism Connection

Cuba's foreign military offensives and significant national defense expenditures were abridged following the disintegration of the Soviet community and its economy (Central Intelligence Agency, 2003). In the Cold War's aftermath, Cuban military expenditures were cut from almost \$US 1.4 billion to \$US 630 million (U. S. Department of State, 2003b). By 1993, large numbers of personnel were being transferred into the tourism sector to offset severe military budget cutbacks and possible unemployment and insurrection among the military ranks (Associated Press, 1998; J. I. Domínguez, 1994; Fernández, 1994; Klepak, 1995; Pérez-López, 1994b).

An experimental system of Japanese-style management was unveiled in Cuba's military enterprises in 1987 (Mesa-Lago, 1993b; Zimbalist, 1994). The so-called enterprise management program experimented with participatory decision-making and consensus management, rotating job assignments, group work, and quality control circles in a number of military operations (Zimbalist, 1994). When the armed forces budget was cut after 1989 and former military personnel were transferred into civilian tourism jobs, these same Japanese management techniques were then applied to the nation's tourist operations. Although Castro refused to fully integrate the Japanese management system into all economic sectors in 1992, these market-oriented methods, especially in marketing, continue to influence Cuban tourism policy and are particularly evident in its growing health sciences research and medical tourism industries (BBC News, 2002; Faria, 2002; Sociedad Cubana de Gerontología y Geriátría, 2003; Zimbalist, 1994).

The National Health Sciences Strategy

The pursuit of domestic substitutes for health-related products that Cuba could no longer afford or obtain on the world market was the direct result of the loss of Soviet subsidies, internal currency problems, and the retrenchment of the US embargo (American Association for World Health, 1997). Despite a radical system-wide economizing, Castro gave the pharmaceutical bio-

technology and medical sectors an investment preference equal to tourism (Feinsilver, 1994; Kuntz, 1994). The scientific development plan called for Cuban researchers to develop and manufacture new products for export and domestic use to meet the grave need for medicine, to generate desperately needed convertible currency revenue, and to ensure the government's survivability (Feinsilver, 1994).

Cuba's notoriety as a Cold War medical power was augmented by its emergence as a global bio-technical competitor with wealthier nations after 1993 (Feinsilver, 1992, 1994; Kuntz, 1994; North American Congress on Latin America, 2002). Between 1993 and 1998, scientists created at least 160 new bio-medical products, including three anti-cancer treatments, a cancer vaccine, anti-meningitis B and anti-hepatitis B inoculations, a recombinant streptokinase remedy for heart attacks, and tropical anti-fungal and anti-bacterial therapies (ABCNEWS.com, 1999a, 1999b; P. Brown, 1999; Cuban Pugwash Group, 2001b; Feinsilver, 1994; Siringi, 2001; The Economist (US), 1999a). Cuban scientists also made important Alzheimer-related discoveries and launched clinical drug trials on a possible AIDS cure (North American Congress on Latin America, 1997). For Castro, medical tourism was a logical extension of the national scientific and tourism development strategies (Feinsilver, 1994).

Medical Tourism

Cuban medical tourism is not a recent development. From the end of World War II through 1959, advertisements placed in US publications drew clients to private clinics in Cuba that offered such services as radical cosmetic and restorative plastic surgery, penis implants, weight loss programs, and hormone treatments at significantly lower prices than in the developed countries (MacDonald, 1999). The nation's plastic surgery center, one of the premiere facilities in the Americas, had already generated \$US 5 million at the time of the Revolution (MacDonald, 1999). What is new, however, is the industry's expansion and development of alternative international markets.

Cuba's world-class health system was converted into a medical Disneyland after the 1980s. Today, thousands of persons from more than 60 countries travel to Cuba annually for medical vacations (North American Congress on Latin America, 1997). The nationwide system features health spas, neurological restoration and ophthalmology centers, and tourist hospitals that offer transplants, surgeries, and therapeutic programs for everything from hypertension to

diabetes (BBC News, 2002; North American Congress on Latin America, 1997; Possehl, 1998). In 1996 alone, 7,000 medical tourists generated \$US 23 million dollars, all of which was redirected into public health projects (North American Congress on Latin America, 1997).

Servimed, a subsidiary of the state-run *Cubanacan* tourist agency, was created in 1989 to manage the national medical tourism operation and market the industry and Cuban medical products abroad (Caribbean-trip.com, 2003; Faria, 2002). Furthermore, *Servimed* recently was expanded to include an aging medical tourism enterprise. The *Cuban Geriatric and Gerontology Society* web page advertises the island as an:

Ideal tourist destination for the older adult because of the country's tranquility and security, its kind climate, historic tradition, the quality of the health system and community hospitality.... We render urgent [care] services 24 hours-a-day in all medical specialties...surgeries for the older adult and...a series of special programs at very favorable prices. (Sociedad Cubana de Geriatría y Gerontología, 2002)

The on-line advertisement describes one La Habana complex geared to elderly medical tourists as a 22-room facility that includes a pharmacy, private baths, air conditioning, radio, TV, video, FAX, telephone, and a staff of geriatric specialists, who provide comprehensive evaluations, psychiatric-psychological services, stomatology, and cultural tours of the city (Sociedad Cubana de Geriatría y Gerontología, 2002).

Cuban medical tourism has achieved its primary objectives to support internationalism, showcase its world-class approaches to bio-technology, medicine, and tourism, and generate convertible currency from foreign visitors seeking superior and affordable medical care. It also has produced negative outcomes. Faria (2002) accuses Castro of supporting medical apartheid, in which new discoveries are withheld from all but foreign patients and a political and medical elite, who are awarded jobs and special health treatment in the discrete tourist care structure.

Medical Diplomacy

Humanitarian assistance was fundamental to Castro's strategy for world prominence throughout the Cold War Era. Although cutbacks during the 1990s reduced Cuba's international outreach efforts, the doctor or medical diplomacy program remains a vital part of the leader's post-Cold War plan for the nation's global reinsertion and economic recovery. An examination of the concepts and history of the Cuban approach to humanitarianism underscores the

significance of medical diplomacy to the new Cuban internationalism.

Guevaran Volunteerism

Cuban volunteerism differs from Western notions of philanthropic citizen participation. Ché Guevara, a medical doctor and Castro aide-de-camp, promoted the moral emancipation concept, whereby a state-organized volunteer labor force of committed, politically conscious, self-sacrificing citizens would battle inequality and discrimination worldwide (Clark & Barnes, 1991; Wittmann, 2002). Guevara believed this form of volunteer activity would lead to the revolutionary transformation of one's material interests into a moral work imperative, thus, creating the *New Man* (Guevara, 1971).

Attainment of World Medical Power Status

The validity of medical diplomacy and world recognition of a nation as a medical power rest on its accomplishments (Feinsilver, 1993). The impetus of Cuban medical diplomacy and the source of its materialization as a global health power are located in what Feinsilver (1993) describes as the moral architecture of its health approach. Throughout the course of the Revolution, Castro has embraced the World Health Organization's (WHO) medical canons as gospel (Feinsilver, 1993; World Health Organization, 1948, 1978, 1998b). Its doctrines assert that the provision and protection of health for all the world's citizens is a human right and a governmental responsibility (Susser, 1993; World Health Organization, 1978, 1998b). Using WHO and Guevaran principles as a guide, Castro ordered health officials in 1961 to develop a physician-citizen-based model, which other developing countries could emulate (Feinsilver, 1993).

By the 1980s, Cuba had secured universal population health coverage and established the Family Doctor Program, which placed family physician-nurse teams on every city block and rural area throughout the country (Schwar, 2001). Although Chapter Seven will cover this health care approach, significant population health improvements consequent of family doctoring, as well as international commendations of the family doctor model, validated Cuba's role as an international medical power and global health example (World Health Organization, 1998a, 2000b, 2000d).

Evolution of Medical Diplomacy

Begun in the 1960s, Cuba's humanitarian aid program to guerilla movements in the developing nations translated Guevara's ideology into practice (Beato-Nunez et al., 2000; E. Pollack, 2001). One decade later, the program had been transformed into a vast international assistance effort that ranked among Cuba's top civilian enterprises (Alzulgaray, 1995; Beato-Nunez et al., 2000; Eckstein, 1988; E. Pollack, 2001). Tens of thousands of volunteers that were stationed in some 50 nation's offered educational, construction, agricultural, disaster, and public health assistance by the 1980s (Eckstein, 1988; Kuntz, 1994; The Economist, 2000).

The antecedent of Cuban medical diplomacy was a humanitarian mission in 1960. Castro sent a doctor entourage to assist in Chilean earthquake relief efforts (Feinsilver, 1993). The program was formalized after the mid-1970s to complement its other international humanitarian and military assistance initiatives (Feinsilver, 1993).

A Market Approach to Medical Diplomacy

The economic disaster of the 1990s crippled the island nation's ability to continue its broad foreign assistance program (Nayeri, 1995). Castro, however, decided to continue funding the medical diplomacy initiative. Doctor diplomacy, the most visible of all Cuban humanitarian activities, was seen as a potential generator of political capital, as well as hard currency (Alzulgaray, 1995; Beato-Nunez et al., 2000; Feinsilver, 1993; E. Pollack, 2001; Suárez Salazar, 1995).

Passage of the 1998 Comprehensive Health Program for Central America, the Caribbean, and Africa added an important dimension to Cuba's new internationalist strategy and economic diversification efforts. The program authorized the leadership to negotiate medical aid contracts with host nations (Beato-Nunez et al., 2000; Eolis, 2001; MEDICC Review, 1999; Wakai, 2002). In addition to reinforcing diplomatic and trade relations, Cuba's medical diplomacy ventures are generating millions of dollars (\$US) in new revenue and symbolic capital (Beato-Nunez et al., 2000).

About 4,000 medical diplomats are now located in 80 countries around the world (MEDICC Review, 1999). Half of the international health force is under paid contracts with 18 nations (Wakai, 2002). The agreement with Zimbabwe, for example, stipulates that Cuba be paid a monthly fee of \$US 1.2 million (E. Pollack, 2001). Mirroring tourism joint venture

contracts, host nations channel to the Cuban government as much as \$US 1,500 per doctor diplomat each month, which, in turn, the Cuban Ministry of Health (MINSAP) redistributes in the form of lower salaries in Cuban pesos to its overseas physicians (Ahmad, 2000; Beato-Nunez et al., 2000; Wakai, 2002).

The program's successes are undeniable. It provides developing host countries an expedient way to fill critical doctor and health worker shortages. Its medical benefits are equally noteworthy. Some 500 Cuban medical diplomats are credited with reducing Guatemala's infant mortality rate by 46 percent in just one year (Wakai, 2002).

However, Castro's medical diplomacy program has been criticized for undercutting host country physicians (Ahmad, 2000). Zambian doctors recently struck over pay disparities, in which the salaries awarded to Cuba's better-trained doctors were 21 percent higher than paid to junior public health service physicians (Ahmad, 2000). As Robinson (1995) might argue, Cuba's command over a desired technology and the political capital accrued from its world class health apparatus fits nicely with the new international political economy of the new world order, wherein capital seeks out the most advantageous conditions without regard for borders or political allegiances.

The medical diplomacy initiative also has provided Castro a benign weapon in which to extend his life-long confrontation of the US. In 2000, he restated an offer to send doctor diplomats to Mississippi (The Economist, 2000). The Cuban president took special note of the Southern state's resemblance to the lesser developed world—its physician shortage and significant medically underserved population (The Economist, 2000). Predictably, the US government dismissed the offer as emblematic of the Cuban leader's ongoing propaganda campaign, in which Castro has attempted to associate social inequalities in the US with its capitalist system (The Economist, 2000).

Reverse Medical Diplomacy

The new Latin American School of Medical Sciences in La Habana was created to further Castro's goals for Cuban internationalism and the medical diplomacy initiative (Cuban Embassy, 1998; Eolis, 2001; MEDICC Review, 1999). As part of the Comprehensive Health Delivery Program, the government now offers free general basic practitioner training in primary health care to thousands of medical students from 27 different ethnic groups and 18 countries, including

500 annual scholarships to US minorities (Beato-Nunez et al., 2000; Cuban Embassy, 1998; A. Gordon, 2001; Romano, 2002; Shepard, 2001; The Economist, 2000). In return for training, tuition, room and board, and a small monthly stipend, students vow to practice medicine for six years in impoverished or underserved areas in their home countries (Romano, 2002; The Economist, 2000).

Critics (Beato-Nunez et al., 2000; Romano, 2002; Shepard, 2001), however, view the program as an extension of Castro's propaganda campaign against the US in two ways. First, it takes advantage of a loophole in the US embargo that allows US undergraduate and graduate students to travel to Cuba for "participation in a formal course of study at a Cuban academic institution...for credit towards the student's degree" (U. S. Department of the Treasury Office of Foreign Assets and Control, 2003a, p. 9). Second, the program accents health inequality and discrimination in the US by encouraging its US medical graduates to serve in areas of the US that the government and private physicians characteristically have ignored.

Critics in the US insist that US graduates of Cuba's internationally recognized medical training program will face licensing obstacles at home, because the US medical community has not accredited the program (Beato-Nunez et al., 2000; A. Gordon, 2001). Additional condemnations center on its ideological framework (Beato-Nunez et al., 2000; A. Gordon, 2001). Student physicians are instructed in the concept of their debt to society for receiving a free education (Beato-Nunez et al., 2000; A. Gordon, 2001). It is alleged that students must agree to be like Ché Guevara and, upon graduation, pledge to improve their skills as humanist-activist-physicians (Beato-Nunez et al., 2000; A. Gordon, 2001). The greatest fear among the critics, however, is that the program will turn out a new generation of anti-US dissidents (Beato-Nunez et al., 2000; A. Gordon, 2001).

Human Rights

The abuse of Cuban medical diplomats and dissident physicians tracks with a long history of other human rights charges leveled against Castro, his government, and such state-sponsored civilian groups as Committees for the Defense of the Revolution (CDR) and so-called rapid response brigades (Inter-American Commission on Human Rights, 1983). The majority of these violations have been independently corroborated (Amnesty International, 1996, 2000, 2002a; Amnesty International Australia, 2001; J. I. Domínguez, 1994; Human Rights Watch,

1998b, 1999; United Nations Commissioner for Human Rights, 2003). However, some are mere exaggerations (Faria, 2002; Zimbalist, 1988a). As common to the Cuban literature previously reviewed, a number of substantiated human rights reports also have been propagandized (Alzulgaray, 1995; San Martin, 2003; The White House, 2003a, 2003b; U. S. Department of State, 2003a; Zimbalist, 1988a)

Human rights violations concerning the medical diplomacy program center on allegations that Cuba's international doctors are forced into service indentures (Faria, 2002). Faria (2002) also cites the government's wage arrangement as a human rights violation. However, this contention fails to acknowledge that citizens enter the health professions by choice and with full-knowledge of the state's mandatory service and pay provisions (Schwar, 2001, 2002).

A specific Cuban human rights violation related to the medical diplomacy initiative involved the defection of two physicians stationed in Zimbabwe in 2000 (Beato-Nunez et al., 2000; Burns, 2000; Gaither, 2000; Gaither & Marques Garcia, 2000; Sapa, 2000). National security agents and Cuban diplomats abducted doctors Noris Peña and Leonel Córdova Rodriguez following their published criticism of Castro. US authorities, however, intervened and awarded them refugee asylum in the US before Cuban officials could forcibly return the physicians to the island.

Two other physician cases illustrate Castro's desire to safeguard his international prestige. Physician-activist Mario del Pozo Marrero, arrested during an anti-government demonstration in Cuba, received a 15-year sentence for divulging state secrets, while physician-health advocate Desi Mendoza Rivera received 8 years in prison for alleging the falsification of Cuban health records publicly (AAAS Human Rights Action Network, 1998; Amnesty International, 1996; Amnesty International Australia, 2001; Beato-Nunez et al., 2000; A. M. Gordon, 1995; Reiner, 1998; Reuters, 1998; Zimbalist, 1988a). Castro's order that released and exiled both physicians followed Pope John Paul's Cuban visit in January 1998, during which the pontiff asked the president to grant clemency to all prisoners of conscience (AAAS Human Rights Action Network, 1998; Reuters, 1998).

The Human Rights Quagmire

The 1976 Cuban Constitution extended the right for all citizens to direct complaints and demands to the appropriate authority (Base de Datos Politicos de las Americas, 1976). The

provision, however, was made contingent by Article 62 of the 1992 charter, in which the exercise of those freedoms could not oppose Cuban socialism or Communism (Base de Datos Politicos de las Americas, 1992; Gonzalez, 1995). Thus, Gonzalez (1995) asserts the state gave itself legal entitlement to harass any citizen, who openly admonished or opposed the government.

The passage of qualified constitutional freedoms and the state's crackdown on citizen dissidents encouraged the US Congress to strengthen the US embargo in 1992 and, then, extend new sanctions internationally in 1996 (Alzulgaray, 1995; Cohen, 2003; Ritter, 1995; U. S. Department of State, 1992, 1996). However, the UN maintains that all embargos violate international human rights law, which weakens the US case against Cuba (Carnell, 2001; The Office of the High Commissioner of Human Rights, 1948). Furthermore, documented US government human rights violations have allowed Castro to divert attention from abuses at home and maintain his anti-US discourse (Amnesty International, 2002b, 2002c; Carnell, 2001; MacDonald, 1999).

International leaders also are to blame for the Cuban human rights quagmire. The world community has failed to bring Castro into the global dialogue on human rights repeatedly. For example, Cuba was the only nation excluded from the 34-country human rights summit of the Americas in 1998 (Human Rights Watch, 1998a).

Castro and Neo-liberalism Revisited

The US-directed Neo-liberal project heralds the ideological substitution of the term global democracy for economic development, particularly for developing nations and those in transition from authoritarian to more liberalized political-economic models (Barry, 2000). Despite limited market-oriented reforms, Castro's refusal to embrace the US governance form and remain outside the US geo-political orbit has exacerbated US-Cuban tensions (Cohen, 2003; Kuntz, 1994; Robinson, 1995). A number of factors have inspired the Cuban leader's defiance of the new world order.

Cuba's unique brand of market-socialism has revitalized the economy. At the same time, Castro was able to cite the disastrous effects of privatization in Argentina, Brazil, Costa Rica, and the former Soviet bloc (Cohen, 2003; Navarro, 2002c; Salas & Miranda, 1997; Seligson, 2002). Domestic improvement and these contrasting outcomes in other Latin American nation's rehabilitated citizen belief in Castro, the political legitimacy of his government, and the still

dominant state-controlled economic planning model (Gonzalez, 1996a).

In a similar manner, Castro's declared allegiance to social equality, along with public pressure to retain the socialist system of universal health, education, and social welfare, have strengthened the leader's position (Cohen, 2003). However, Cuba's nationalist tradition is perhaps the most important factor in Castro's obstinacy. After all, the image of their leader standing up to nine US presidents remains an enduring source of popular support for the enigmatic Castro (Breene, 1998; Hilton, 2000; T. Miller, 1992). The next section touches other major bases of Castro's magnetism and vision that much of the Cuban population continues to want to follow.

Idolatry, Charisma, and El Jefe

Fidel Alejandro Castro Ruz is the Cuban Revolution's *Comandante en Jefe* (commander-in-chief)—his followers simply call him *el Jefe*, which means *the chief* or *boss* in Spanish (Blasco et al., 2002; Hoffmann, 2001; T. Miller, 1992). Although never in public and rarely mentioning him by name, some Cubans indirectly speak derogatorily of Castro when recounting the hardships of the special period (Schwar, 2001, 2002). Even during the worst years of the crisis, however, international news organizations reported that the leader would have registered an electoral sweep if he had chosen to call a free vote and permitted an open challenge to his presidency (Cable News Network, 2003).

Volumes have been written on Castro's charisma and oratorical prowess. His lasting popularity revolves on the health, educational, and redistributed social benefits that he has provided the Cuban people a propos the Revolution (Cable News Network, 2003; Hilton, 2000; Hunt, 1998; Schwar, 2001, 2002). The ability to envision Cuba's possible futures, convey those ideas, persuade the nation to follow his imaginings, and make good on his promises may be Castro's greatest talent.

Consider the following excerpts from speeches delivered during the 1980s as examples of Castro's convincing governance style. In the mid-1980s, he informed the nation that:

the family doctors' institution...is another idea with a great future. We will employ 20,000 doctors in this area during the next 15 years....every family in this country will have its own doctor in addition to the entire hospital network and the special hospitals. (Castro, 1985c)

In anticipation of a looming crisis, Castro still maintained in 1989 that:

The family doctor program will continue. Those programs that provide services to the community have priority. We were the first ones to develop this family doctor concept in primary care. We complement this with the polyclinic network and, at another level, with the clinical-surgical and specialized hospitals. (Castro, 1989b)

The secondary source findings on Cuba's health care services system, which will be reported beginning with the next chapter, will show that by the mid-1990s Castro met and, in fact, exceeded the assurances noted above.

Much in the same way Castro unveiled the Family Doctor Program, the leader offered a spontaneous description of a concept under development during the 1987 dedication of a new Cuban elder care facility. The president told a crowd that:

this center...is not an institution in which only 160 [older] people benefit but an institution in which thousands of people benefit because they are happy that those 160 people with serious problems are solving them. Some time ago, we started to work on the idea to develop these services. We thought it was important. Every day we convince ourselves more of their importance. (Castro, 1987)

Two years later, the president clarified these ideas and a concept that would become the foundation for sweeping national elder care initiative. Castro predicted that:

the day will come when we will also have the answer for the needs of all our elderly people. There are extensive and ambitious plans in this field. We will definitely have top-rate services covering the whole age spectrum, from children all the way to the elderly (Castro, 1989b).

As noted earlier in the chapter, Castro announced the long-term elder care initiative in 1992. He began funding the care program for older adults in 1997 once the recovery was assured and despite continued shortfalls in the general public health budget.

Much of the Cubanology and other anti-Castro literature suggest that the president conceals from the population his desire to generate symbolic capital from the health system. Castro's speeches, however, indicate otherwise. As early as 1989, the Cuban leader explained to the nation that:

Naturally, this [Family Doctor Program] is going to put our country's population...in a privileged position regarding medical services. We will even be able to say then that it

has the best medical services in the world. We are truly on the path toward becoming a medical power. Yes, we will be a medical power. Which country in the world has the family doctor program? Which of these cities have those services there, 20 meters, 30 meters, or 100 meters from the home? What place provides each family, father, mother, child, adolescent, [and] elderly person with a family doctor who is available day and night? This is part of our primary health care network which will be completed in December of this year. (Castro, 1989b)

Castro is among the 20th Century's greatest orators (Ara & Chekmayan, 2003). His public speaking technique has been described as near magical (Valdés, 2003). The forgoing excerpts also illustrate how the leader uses unprompted extrapolations to refine his message and vision for the nation over time (Valdés, 2003). However, recent published reports of changes in Castro's public behavior have raised questions about his health, age, and governing capacity.

Cuba's Caudillo and Ageism

The physical and cognitive health of every head-of-state is subject to press and national intelligence agency scrutiny (Tamayo, 2000). This is especially true when an unexpected health event or a noticeable physical or behavioral change occurs. Following Cuba's economic revival after the mid-1990s, Castro's age and health were made part of the discourse on the future of Cuban socialism (Associated Press, 1998; Cable News Network, 2001; de los Angeles Torres, 1997; Ellison, 1990; Glancey, 1996; Reuters, 2000; Tamayo, 2000).

Research on presidential succession in Cuba first surfaced in the mid-1980s (J. Domínguez, 1885; Valdéz, 1988). The nation's unpredictable transition after 1989, however, dispatched new conjectures about a Cuba without its revolutionary leader (de los Angeles Torres, 1997; Glancey, 1996). Castro, who turned age 78 in 2004, himself had begun discussing succession in the mid-1990s (de los Angeles Torres, 1997). Furthermore, more frequent public appearances by the vice-president, Castro's younger brother, Raúl, fueled speculation that the elder Castro brother was considering stepping down (Associated Press, 1998). Journalists also suggested that Castro might be tiring after 40 years in office or had begun reflecting on his mortality (Associated Press, 1998).

The US State Department, meanwhile, ordered the CIA to revise its psychological profile of Castro in 2000 (Tamayo, 2000). US officials cited repetitive phone calls to diplomats,

rambling letters, bizarre actions, and evidence of instability as reasons for the query into the leader's age and health. One university scholar, in the meantime, argued that Castro was suffering from geriatric overexertion (Tamayo, 2000).

According to the academic, the age-related health state of geriatric overexertion was common among older Communist leaders, who engaged in hasty and audacious actions in an attempt to recapture their revolutionary pasts (Tamayo, 2000). The scholar cited Mao's launching of China's Revolution at age 73, Brezhnev's decision to invade Afghanistan at age 72, and Khrushchev's Cuban missile deployment at age 68. Similarly, US officials feared that Castro might also begin pursuing more dangerous policies instead of "*mellowing*" (Tamayo, 2000) in old age. These observers, however, failed to question whether older non-Communist world leaders had suffered from the same condition. Ronald Reagan, for example, initiated US military actions throughout Central America while in his mid-70s.

The university professor mentioned above also was the primary source for a 2003 *Miami Herald* article (San Martin, 2003) that reiterated the Castro age-health question. The story revealed that the scholar was a retired, senior CIA analyst on Cuban affairs. The report quoted the academic's belief that Castro's recent decision to clamp down on dissident activities was a direct outcome of his age, failing physical health, and increased cognitive impairment.

The literature on coping and emotion regulation, however, nullifies the geriatric exhaustion hypothesis (Labouvie-Vief, 1999). Although impulsive and aggressive behavior among older individuals has been linked to dementia, these conditions do not manifest exclusively in older demented Communist leaders (Leger et al., 2000).⁴ Even if the Cuban leader's recent behavior is allied with dementia, these above mentioned reports suggest that age-stereotyping now has been made part of the anti-Castro lexicon (Schwar, 1998).

The Cubanology is replete with commentary on Castro's *personalismo* or insidious penchant to distort (Zimbalist, 1988b). Castro also has been accused of megalomania, an example of which was the leader's centralization of personal decision-making authority over all state affairs in the late 1980s (J. I. Domínguez, 1994; Mesa-Lago, 1993b). This argument tracks with the totalitarian model that has been used to explain Castro's need to dominate all aspects of Cuban social life (Valdéz, 1988).

Valdéz (1988) also discusses the presence of a "biological model" (p. 200) in the Cuban literature regarding Castro. Applying an age stratification-life course approach, this scholarship

associates different stages of the leader's behavior with age (Valdéz, 1988). As such, it is argued that Castro's youthful opportunism and idealism have given way to a mature pragmatism in older adulthood. However, if one surveys Castro speeches since 1959, those accounts reveal a distinct pattern of idealistic-pragmatism throughout his entire public life.

A health episode during a 2001 address instigated additional speculation about Castro's age and medical status. One international news outlet (Cable News Network, 2001) reported that the president fainted at the podium and was escorted from the stage.⁵ A similar incident was reported during the leader's 2003 visit to Argentina (San Martin, 2003). Furthermore, the Cuban president tripped on a step while exiting a stage following an October 2004 speech and fractured his knee and arm (Snow, 2004).

Despite suppositions about his age and health, the Cuban president remains a defiant revolutionary. Having given up smoking cigars in 1995, Castro informed reporters in late 2000 that he was not overlooking his health (Glancey, 1996; Reuters, 2000; Shanken, 2003). He declared that it was his obligation to be more regimented, exercise regularly, and capitalize on his health if only to humiliate his critics (Reuters, 2000).

In sum, Chapter Four has traced the bases of Cuba's socio-economic-political recovery. The pro-Cuban scholarship credits the revival to Cuba's revolutionary patriarch, the flexibility of the Cuban system and citizenry, cautious reforms, medical tourism, and what Weber might describe as the tenacious character of Cuba's fully matured welfare state (Stillman, 1992; Zimbalist, 1993). The strategy for a new internationalism, and questions concerning human rights abuses, Castro's age, and the Cuban leader's health also have been presented. Despite ostensibly insurmountable barriers and to the vexation of many detractors, Cuban socialism, its architect, and the Cuban people have prevailed (North American Congress on Latin America, 1997; Zimbalist, 1993).

Cuba has reduced inequities in health and other social markers more than has any other developing country, as well as the majority of the developed nations (de Brun & Elling, 1987; Navarro, 2002c). Although Castro stresses health care and the health of the people perhaps more than most of the world's leaders, redistributed social resources as a result of the crisis are recreating health and social disparities that the Revolution sought to eliminate (Feinsilver, 1993; Mesa-Lago, 1998; Schwar, 2001; Tesh, 1986). Still, numerous studies (de Brun & Elling, 1987; Deacon, 1984; Eyles & Woods, 1983; Heggenhougen, 2000; Packard et al., 1989; H. Waitzkin,

1981; Wise & Pursley, 1992) have concluded that the Cuban health approach transcends the Western, medicalized, market-based health care paradigm in its influence on all aspects of social life—a holistic preventive primary health model that has repeatedly proven successful in decreasing the longer-term risks of illness and disease.

The preceding chapters have advanced the dissertation's theoretical framework, research questions and specific aims, and perquisition of the political economy and contextual literature on Cuba. The enterprise now moves to Chapter Five and the study's design and methods.

Chapter Five

Design and Methods

The legitimacy of Cuba's socialist experiment has rested largely on the health of its citizens and the fair distribution of resources under a universal care provision. The Castro government recently implemented a wide-ranging program to address population aging, to gratify citizen demands for improved elder care services, and answer world appeals for the creation of national long-term elder care policies (World Health Organization, 1998c, 2000a, 2002a, 2002b). Few outsiders, though, have investigated the influences of such post-Cold War changes as globalization, the US embargo, the new national strategy on aging, and other domestic policy shifts on perceptions of health equity and health inequity among older Cubans.

This chapter tenders the research design and methods used to examine these issues. The first section summarizes the research design. A comparison of the quantitative, qualitative, mixed, and triangulation perspectives prefaces the third section, which establishes the study's chosen data collection method—the crystallization technique. Sections four and five discuss principal subject, secondary subject, and other secondary data sources. The next two segments present the sample and study site selection strategies. Section eight details the study processes: Institutional Review Board issues, requisite authorizations, and discrete procedures for overcoming inherent methodological encumbrances. The ninth and final section charts the plan for data analysis, integrating the theoretical framework, and reporting the findings.

Design

This study adopted a mixed methods approach. The crystallization technique, a multi-disciplinary, mixed methods form of triangulation, guided the processes of principal and secondary data collection, data analysis, and reporting of the findings. Drawing on the theoretical sampling method, an opportunity sample of principal and secondary subjects was constructed. In-depth interviews and a focus group discussion were conducted with older citizens to generate principal subject data during two field visits to Cuba. Secondary contextual and supporting data were generated from in-depth interviews with the principal subjects' informal support network members, their family doctors and other health personnel, key health and government informants, in addition to published and unpublished information sources.

Health event analysis and health care quality assurance assessments were conducted to

further substantiate the accuracy of principal and secondary information, to generate additional principal subject and secondary source data, and add a richer contextual dimension to the study. These two approaches entailed direct observation of care-giving events, pre- and post-episodic interviews, and medical record reviews with regard to the settings, processes, and outcomes involved in the provision of elder care at various levels of attention.

Open-axial coding, a content analysis-like method, was used to sort and classify principal and secondary data, explore relationships among data items, and create simple explanatory statements of the findings. Selective coding was used to further expand the data properties, draw out the finding's biographical features, generate more precise story-lines, and inform the theoretical construct. A conditional matrix was created as a scaffold for the coding processes, in which data were organized into discrete categories and domains. The placement of micro- or individual-level data along the matrix's vertical axis and macro-level information across the horizontal axis provided a configuration for data integration and analysis. The crystallized writing and case study approaches were used to illustrate and report the findings.

Methods

Quantitative methods provide aggregate, accurate, and dependable information that is tacitly objective, measurable, generalizable, and replicable (Groger & Straker, 2002; Scrimshaw, 1992; Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). The use of quantitative methods in behavioral health study designs generally consists of a preset range of causally-related variables (Steckler et al., 1992). This type of research attempts to quantify associations between cause and effect variables to predict behavioral outcomes (Steckler et al., 1992).

Alternatively, qualitative methods provide an opportunity to examine the real-world beliefs and actions of individuals and groups in a manner that eludes controlled studies in clinical and laboratory environments (Ball, Wadley, & Roenker, 2003; Groger & Straker, 2002; Steckler et al., 1992). Using an admixture of commanding strategies, qualitative approaches assume that there are multiple theories, methodologies, empirical resources, and viewpoints for obtaining, deciphering, and reporting information (Ball et al., 2003; N. K. Denzin & Y. S. Lincoln, 2002; Groger & Straker, 2002; Patton, 2002; Richardson, 2002). The rigorous generation of a complex breadth of non-generalizable, non-replicable, subjective viewpoints provides an alternative validation of the information (Ball et al., 2003; N. K. Denzin & Y. S. Lincoln, 2002; Gonzáles

Block et al., 2001; Groger & Straker, 2002; Patton, 2002; Peltó & Peltó, 1978; Scrimshaw, 1992; Warman, 2001; Wenger, 1999).

As an active participant, the researcher's own socially-constructed values are entwined in all qualitative research processes, particularly in field interactions with study subjects (Kenyon et al., 1999; Schoenberg & Rowles, 2002). The simple acknowledgment of possible investigator subjectivity, however, does not satisfy the basic scientific tenet for objectivity (Schoenberg & Rowles, 2002; Scrimshaw, 1992; Warman, 2001; Wenger, 1999). Hence, every attempt was made to prevent the imposition of researcher biases on the collection of information and interpretation of the findings and, when applicable, to explicitly note the investigator's personal value preferences (Scrimshaw, 1992; Warman, 2001).

Mixed Methods

Mixed study designs can be defined as the amalgamation of quantitative and qualitative methods within a single research project (Groger & Straker, 2002; Morse, 1991; Peltó & Peltó, 1978). Although numerous models exist, the overarching purpose of a mixed methods design is to cross-examine, complement, enhance, and validate data obtained via the application of multiple theories, methods, strategies, and practices (Groger & Straker, 2002; Morse, 1991; Peltó & Peltó, 1978; Steckler et al., 1992). Major concerns, however, center on the integration of numeric and textual data, and the construal of results from differing methodological outcomes; disparate weighting of data, the contribution of each method during analysis and integration, and the versatility of other researchers and audiences to understand and use mixed methods designs (Groger & Straker, 2002; Morse, 1991; Steckler et al., 1992; Wenger, 1999).

Triangulation

Triangulation is one of the most common and powerful mixed methods strategies (Beebe, 1995; N. K. Denzin & Y. S. Lincoln, 2002; Groger & Straker, 2002; Manderson & Aaby, 1992; Rodríguez Jústiz & Zayas Vinent, 1997). A triangulated research design involves the systematic and conscious selection, delineation, and integration of multiple theories, methods, and data (Beebe, 1995; N. K. Denzin & Y. S. Lincoln, 2002; Groger & Straker, 2002; Manderson & Aaby, 1992; Richardson, 2002). Its goal is to offer a cross-checking mechanism that enhances the quality and relevance of certain data types collected in advance and in the field through

library research, interviews, focus group discussions, and direct observation of individuals, groups, and activities (Beebe, 1995; Groger & Straker, 2002; Manderson & Aaby, 1992; Rodríguez Jústiz & Zayas Vinent, 1997; Scrimshaw, 1992; Scrimshaw, Carballo, Ramos, & Blair, 1991; Scrimshaw & Hurtado, 1984).

Triangulation can be used in a number of ways (Groger & Straker, 2002; Morse, 1991; Rodríguez Jústiz & Zayas Vinent, 1997). Theory triangulation applies a number of theoretical perspectives to data interpretation; methodological triangulation uses at least two methods to examine an identical study problem; data triangulation draws on multiple data sources; textual triangulation employs a mixture of writing genres; and the division of labor between numerous researchers is termed investigator triangulation (N. K. Denzin & Y. S. Lincoln, 2002; Groger & Straker, 2002; Morse, 1991; Richardson, 2002).

A triangulated, mixed methods research design may not necessarily be quantitative in the strictest sense. For example, statistical and associative data analyses may not be employed (Groger & Straker, 2002; Steckler et al., 1992). Quantitative dimensions, though, may encompass such calculations as the number of patients that use a health facility, the number and types of services rendered, the distance traveled to access health care services, and so on (Groger & Straker, 2002; Morse, 1991; Peltó & Peltó, 1978; Steckler et al., 1992). However, the inclusion of frequency data and descriptive statistics in a triangulated, mixed methods design does not make it a quantitative study (Morse, 1991; Steckler et al., 1992).

Modernist, quantitative gerontological research deductively applies an *a priori* theoretical construct to generate the facts and findings used to accept or reject hypotheses about the research problem (Kenyon et al., 1999; Morse, 1991; Peltó & Peltó, 1978). Conversely, post-Modernist, qualitative aging studies use data and findings to inform or develop the theoretical framework (Kenyon et al., 1999; Morse, 1991). Likewise, methodological and data triangulation designs use multiple methods to generate a breadth of information and findings for the purpose of informing and building on the theoretical framework (Kenyon et al., 1999; Morse, 1991).¹ A common mistake and, perhaps, the greatest concern for studies that adopt such mixed methods designs as triangulation, is the failure to adequately explain the multiple concepts used and how the different approaches will be incorporated (Groger & Straker, 2002). The following section introduces this study's dominant strategy—the crystallization technique.

Crystallization

The crystallization technique expands on triangulation (N. K. Denzin & Y. S. Lincoln, 2002; Janesick, 2002; Richardson, 2002). The chief difference is its multi-disciplinary focus, which can be used to complement the goal of gerontological research—to understand the intrinsic complexities of the aging experience (Bengston et al., 1999; Birren, 1999; Creswell, 1998; Groger & Straker, 2002; Janesick, 2002; Patton, 2002). The technique demands the integration of multiple disciplines, such as anthropology, economics, geography, history, politics, public health administration, and sociology, to broaden a study's substance, inform methodological selection, collect and analyze data, and report the findings.

In examining Cuban health equity and health inequity issues, it was determined that a primarily qualitative, mixed methods approach was best-suited to address the gap in previous research, integrate prior quantitative and qualitative findings, further examine and explain the phenomenon, and to inform and revise the International Political Economy theoretical construct outlined in Chapter Two (Morse, 1991; Steckler et al., 1992). Thus, the research issue informed the study's design and methods (Kenyon et al., 1999; Morse, 1991). Crystallization was selected as the study's methodological foundation, because of its versatility to support an inductively driven research process, to complement a mixture of strategies, and to enhance theory development (Groger & Straker, 2002; Morse, 1991).

It must be noted that the quantitative methods incorporated in this study do not encompass advanced inferential statistical computations nor quantitative hypothesis testing (Steckler et al., 1992).² However, quantitative secondary source information gathered from published research, libraries, and so on, in addition to the frequency and descriptive quantitative data collected in the field do provide a richer understanding of the factors that influence the older individual's perceptions of health equity and health inequity. Thus, qualitative information was used to clarify, enrich, and contextualize the quantitative data, while the quantitative data supported the alternative validation of the qualitative findings, which, together, provided a more vivid comprehension of the day-to-day lives of older Cubans, their health experiences, and their perceptions of health equity and health inequity.

Crystallization Applications

The project's design was based on a three-fold, overlapping, and continuous process of

data crystallization conducted in the US and during two separate Cuban visits. The initial process entailed the advanced collection of secondary supportive and contextual information from sources in the US. Secondary source data also were gathered during both field visits to Cuba.

Triangulation customarily involves obtaining materials in advance of fieldwork from such sources as academic papers, reports, archives, and so on (Beebe, 1995; J. M. Swanson, 1987). This information may provide deeper insights into the project. The incorporation and application of the crystallization technique also permitted the gathering of secondary data from the following sources: academic papers, published and unpublished research, annual reports, government and community health service records and statistics, newspaper and magazine articles, and speeches from library, electronic (Internet), and other sources in the US and Cuba.

These secondary data sources were used as a launching point, from which to collect additional information on a range of chosen topics from many disciplinary perspectives. For example, quantitative and qualitative academic research on the global, socio-demographic, economic, political, epidemiologic, and behavioral implications of the Cuban health approach was gathered. This information enabled the placement of the Cuban health and elder care services system into a more holistic local context and to contrast it with other international, regional, and national initiatives. Furthermore, the various disciplinary data perspectives supported a comparison and selection of additional methods to improve the study's utility—methodological crystallization.

The collection of secondary supportive and contextual data, however, was not limited to the study's advanced phase. These inquiries continued throughout the entire project as new topics and issues emerged that required additional clarification and cross-checking. The influence of the September 11th terrorist attack on Cuban tourism and new Cuban studies on patient satisfaction with the health and social services system are two examples.

The project's next two processes concerning data crystallization applied the technique in the field. These two processes involved the collection of principal and secondary data from two groups of subjects. Although the two groups of study subjects will be discussed below in detail, principal subjects consisted of Cubans age 60 years or older, while the pool of secondary subjects was composed of the older person's informal support network members, family doctor and other care-providers, in addition to key health and government informants.

Formal and informal interviews and conversations took place with principal and secondary subjects during both visits to Cuba. However, the bulk of the interviews and follow-up discussions occurred with both sets of subjects during the second visit. An impromptu principal subject focus group discussion also was conducted during the second visit. Principal subject data were collected from the researcher's interactions with the study's older participants. Contextual and supporting data, meanwhile, were gathered from the researcher's interactions in the field with the pool of secondary subjects.

Data crystallization has a flexible, iterative dimension amenable to unexpected feedback and discoveries that permit the investigator to invoke alternative directions and pose supplementary interview questions as new information emerges (Beebe, 1995; Scrimshaw, 1992). Additionally, the technique supports the incorporation of multiple methodologies—methodological crystallization. Take the direct observation strategy, for example. Information garnered through the direct observation of care-giving events can be invaluable in the substantiation of data collected in advance of the fieldwork, provide a mechanism to cross-check subject data gathered during field interactions, and direct the researcher to new potential interviewees (Beebe, 1995; González Block et al., 2001; Manderson & Aaby, 1992; J. M. Swanson, 1987; Warman, 2001). The technique's iterative and inclusive facets, therefore, are designed to provide a degree of methodological strength usually associated with traditional quantitative approaches and, in general, offer a reflexive complementarity to all aspects of the study (Beebe, 1995; Groger & Straker, 2002; Manderson & Aaby, 1992).

Before moving on to a discussion of principal subject data collection, a few additional explanations of the advanced study process and two field research stages are needed. Both the advanced study process and two fieldwork stages were segmented into periods of time devoted to collecting information, considering and reconsidering gathered data, and conscious decision-making with regard to new options that might improve the efficacy of the research. The decision-making processes, which were guided by the crystallization technique, encompassed such things as altering methods and adding new strategies, determining how and where to expand data collection in the field, appending new interview sub-topics and queries to the primary instrument, and locating new potential subjects (Beebe, 1995).

Principal Subject Data Sources

Lay theorizing about social inequalities in health has been a thriving qualitative research area in Britain for several decades, particularly among vulnerable individuals and groups whose perceptions of health are dissimilar to other sub-populations (Blaxter, 1997; Popay et al., 1998). The study of lay perceptions of health inequality in the lesser developed world and many other Western industrialized nations, however, is largely unexplored (Blaxter, 1997). This study is interested in the lay perceptions of health equity and health inequity with a specific focus on individual Cubans age 60 years or older. The principal subject age criterion was based on Cuba's Social Security eligibility requirement for male retirees, the accepted definition of the older adult population among Cuban academics and health professionals, and the age qualification stipulated in Cuba's national policy of aging (Centro Iberoamericano para la Tercera Edad, 2003; Delgado García, 1996b; Donate-Armada, 1994; María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Perdoma Victoria, Torres Páez, & Astraín Rodríguez, 1999; Pérez, 1998; Prieto Ramos, 1999b, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003).

The historic period in which one was born is a crucial facet across the individual's life course (Clair et al., 2000). The idiosyncratic economic, socio-political, and psychological events experienced and shared by individual members of roughly the same age station in youth mold the distinctive collective memory of that cohort (Clair et al., 2000). The cohort's collective memory is qualitatively unlike that of each preceding and successive cohort and, therefore, potentially results in dissimilar attitudes about the world (Clair et al., 2000).

At the time this study was conducted, the principal subjects were part of the cohort born in 1941 or before. The cohort's members were at least 18 years of age when the revolution occurred. Because this cohort's pool of experiences reflected events in both the pre-revolutionary and post-revolutionary eras, it is quite unlike other cohorts.³ Moreover, because individual members of this cohort generally have been among the regime's most staunchest proponents, and have enjoyed universal health and other social welfare services longer than all other cohorts, any noticeable shift in perceptions of health equity and health inequity as a consequence of recent events and change would represent a significant development.

Exclusion of Potential Principal Subjects

The World Health Organization (2002b) posits that disability is an all-encompassing term that generally refers to one's "experience of functional limitation at the level of the body or organ system, person, and society" (p. 2). The experience of disability is reflective of both a person's health state and social context. Social context is composed of demographic and educational variables, and such other exogenous factors as social policy and services, cultural mores and norms, technologies, personal support, and the natural environment.

Chronic disability has been defined as the limitation of activity (World Health Organization, 2002b). Activities in the context of disability may include the following: immobility (to walk or transfer from one location to another); incapacity (to self-care or communicate); and other intellectual or cognitive impairments (World Health Organization, 2002b). This study excluded potential principal subjects with mild-to-more severe cognitive impairments and those whose disability prevented direct communications with the researcher. The later provision was based on the need for an intermediary interpreter, who might potentially contaminate the older subject's exact response. All exclusion decisions, however, were made in consultation with and input from the older subject's family doctor.

Secondary Subject Data Sources

In addition to secondary contextual and supporting data collected from such US and Cuban sources as libraries, other information was gathered from a pool of secondary subjects. The secondary pool consisted of the principal subjects' informal support network members, their family doctors and other personnel involved in the provision of health and social services, as well as pertinent informants and knowledgeable persons at the local, regional, provincial, and national levels of the health system and government. Secondary source data also were collected via the application of two direct observation methods. The sub-sections that follow expound on the individuals and characteristics that comprise the various secondary data sources.

Informal Support Network

As will be noted in succeeding chapters, community participation is a critical element in the utility of the Cuban health and social system. The institution of a national policy on aging after 1992 attached an even greater importance to informal networks of citizen assistance to

augment a continuum of formal elder care services included in Cuba's health and social welfare schema. An informal social support network provides instrumental assistance through a configuration of emotionally-involved relatives and non-kin, and bureaucratic agencies with no emotional ties that all are within the recipient's real or perceived social web (Bott, 1957; Rundall & Evashwick, 1982; Wacker, Roberto, & Piper, 1998; Wenger & Scott, 1994). Generally, an informal network's non-bureaucratic members base assistance to the recipient on social exchange, or reciprocity for some past help they received free of charge from the individual (Wacker et al., 1998).

In the US, informal elder care-providers traditionally are the female members of the older person's family or extended family (Holstein & Mitzen, 2001). Historically, extended kin networks in the developing countries of Latin America, Africa, and Southeast Asia represent a multi-generational system of family members living in the same home (Apt, 1990). Thus, both modern welfare states and developing nations that maintain strong gendered social constructions commonly rely on working and non-working female family members to care for an older relative (Apt, 1990; Pearson, 1998; Quadagno & Reid, 1999; World Health Organization, 2002b).

Collective family support, however, is more common to such Latin American countries as Panama and Guatemala and the Caribbean nation of Jamaica (Apt, 1990). Age-stratified assignments typically take the form of young family members performing minor tasks for and providing companionship to the older family member (Apt, 1990). In the same way, the older family member, typically female, assumes housekeeping, childcare, and informal child schooling responsibilities (Apt, 1990).

Cuba's Family Code stipulates that both male and female family members care for the entire family (Cuban Ministry of Justice, 1975; Jennissen & Lundy, 2001). A study of older Cuban emigrants to the US indicates that informal support network care in Cuba also includes close friends (Siddharthan & Sowers-Hoag, 1989). Mass organization members, particularly the Federation of Cuban Women and female members of Committees for the Defense of the Revolution, also must be considered part of the informal network (Bengelsdorf, 1988; Danielson, 1975; A. V. Domínguez, 1977; Feinsilver, 1993; Froines, 1993; Galindo, 1999; Greene, 2003; Jennissen & Lundy, 2001; MacDonald, 1999; Reca, 1992). Therefore, the secondary pool of informal support network subjects in this research encompassed the older subject's immediate and extended family, friends and neighbors, and local mass organization members directly or

indirectly assisting older persons.

Family Doctors

The collection of secondary subject field data involved formal and informal interactions with the older persons' family doctors. Based on Cuba's health team model, nurses attached to the nation's family doctors and other health personnel that might be involved in the direct or indirect provision of care to the principal subjects also were included in the secondary subject pool. This secondary pool of local experts included social workers, pharmacists, polyclinic specialists, laboratory technicians, health educators, and local public health and government administrators.

Key Informants

The importance of strategic informant assistance at all levels of the Cuban health and governmental system to the success of this project will be elaborated in the next section on the selecting the sample. These key experts, however, also contributed to the gathering of secondary contextual and supporting data. Included in this secondary subject pool were major health advisor's to President Castro, directors of the nation's epidemiologic surveillance and health statistics agencies, MINSAP administrators, faculty and researchers with the National School of Public Health, as well as a host of provincial, regional, and municipal/rural public health administrators and civic leaders.

Health Event Analysis and Health Care Quality Assessment

A health system is theoretically organized into three general categories: structure, process, and outcome (González Block et al., 2001; Tansella & Thornicroft, 1998). Health system outcomes are consequent of structural inputs, systemic processes, and human agency (González Block et al., 2001; Tansella & Thornicroft, 1998; Tulle & Mooney, 2002). These outcomes include such issues as the individual's attitudes about health system equality (fairness), patient confidence in the quality of services rendered, doctor-patient communications, and the effectiveness of care-giving processes (Dignan, Michielutte, Sharp, Young, & Daniels, 1991; González Block et al., 2001; Green-Weir, Nerenz, & Zajac, 1996).

Other macro-level factors, such as global and domestic economics, national political

structures, and internal social policy, also affect such outcomes as patient access to and availability and use of health resources (Andersen & Newman, 1973; Gertler et al., 1989; Gonzáles Block et al., 2001; Schur & Franco, 1999; Scrimshaw & Hurtado, 1984; Syme, 1998; Yee, 1994). In addition to macro-level elements, the individual's behavioral characteristics affect the use of health resources (Andersen & Newman, 1973; Gonzáles Block et al., 2001; Green-Weir et al., 1996; Popay et al., 1998; Scrimshaw & Hurtado, 1984; Syme, 1998). In combination, these factors influence patient satisfaction and/or dissatisfaction with a health policy, the care system, and services, which, in turn, contribute to one's perceptions of health equity and/or health inequity (Gonzáles Block et al., 2001; Green-Weir et al., 1996; Schur & Franco, 1999; Yee, 1994).

Health event analyses and health care quality assessments are two effective methods that focus on the care-provision event from the participants' standpoint to examine health system structures, processes, and outcomes (Andersen & Newman, 1973; Dignan et al., 1991; Gonzáles Block et al., 2001; Scrimshaw, 1992; Steckler et al., 1992). Direct observation of the care-giving episode, formal interviews, informal discussions with the involved parties, and medical record reviews represent the main strategies for information gathering. The types of data collected and documented are: the service setting, service type, involved parties, and quantity of services offered; patient health conditions, diagnoses, treatments, and compliance levels; referral patterns and care continuity; inter-personal relationships; sources of care-seeking delays and obstacles; and, most important, patient attitudes and perceptions of the care experience (Andersen & Newman, 1973; Dignan et al., 1991; Gonzáles Block et al., 2001; Green-Weir et al., 1996; Kayser-Jones et al., 2003; Schur & Franco, 1999; Scrimshaw, 1992).

The two approaches also embrace alternate data collection strategies. For example, the researcher might accompany the patient to other health assistance sources, such as doctor re-consultations, testing laboratories, and the pharmacy. Furthermore, the crystallization technique opens up the two approaches to the incorporation of such other methods as health geography, in which the distance and time required for a person to access health providers might be calculated (Ricketts, Savitz, Gesler, & Osborn, 1998; Scrimshaw, 1992).

The variety of qualitative and quantitative strategies that present in the health event and care assessment methods were adopted and applied to this project for two reasons. First, they complemented the other investigative devices used to understand the factors that contribute to

the older adult's perceptions of the equitability and/or inequity of the health and health-related resources distributed via the nation's health policy and care system. The data generated through the two approaches was used to corroborate, clarify, and augment other information gathered from the two pools of subjects and secondary data sources (Dignan et al., 1991; Gertler et al., 1989; González Block et al., 2001; Jiménez Cangas, Báez Dueñas, Pérez Maza, & Reyes Álvarez, 1996; Sala, Nemes, & Cohen, 1998; Schur & Franco, 1999). The second and, perhaps, most important reason centers on the prior implementation, validation, and refinement of the two approaches by Cuban health researchers in a number of health care settings, most notably primary care environments (Jiménez Cangas et al., 1996; Sala et al., 1998).

Sample

Theoretical sampling is analogous to data crystallization in its goal to generate multiple points of view from a breadth of subjects; to capitalize on opportunities that, with regard to this study, would uncover conceptual dissimilarities, contingencies, and contexts that might influence the older individual's perceptions (Creswell, 1998; Glaser & Strauss, 1967; Patton, 2002; Scrimshaw, 1992; Strauss & Corbin, 1998). The basis of an adequate representative sample size lies in the diversity of subjects and a range of different observations in different situations and environments (Creswell, 1998; Scrimshaw, 1992). An ample representative sample—theoretical saturation—is attained when data generated are repeatedly observed to the 'point of redundancy' (Patton, 2002, p. 246).

The theoretical sampling approach was used in this study to construct an opportunity sample of principal subjects age 60 years or older (N=86; N=47 rural; N=39 urban). The technique also was used to construct an opportunity sample of secondary subjects, which included the older person's informal support network members, family doctors (N=34; N=21 rural; N=13 urban) and other health personnel, in addition to important health and governmental experts (N=31; N=13 rural; N=18 urban). Although limited economic resources and time constraints influenced sample size, this fluid technique permitted appropriate modifications and ongoing adjustments, in which new potential principal and secondary subjects and settings were included as new relevancies emerged (Scrimshaw, 1992).

Theoretical saturation maximizes the prospect that the sample of principal subjects will mirror the general population (González Block et al., 2001; Strauss & Corbin, 1998). Still, the

technique's somewhat unruly approach might inhibit cross-checking the characteristics of consenting principal subjects with non-participants and, therefore, create a bias in sample representativeness (Ball et al., 2003; Gonzáles Block et al., 2001; Harris, Jerome, & Fawcett, 1997). Characteristic information on specific populations, however, can be obtained through a variety of means, including public records (Ball et al., 2003). In order to improve the validity of this research and demonstrate the similarities between the principal participants and those who assented, family doctors were used to gain access to aggregate neighborhood socio-demographic and health information and, when permitted, brief interviews were conducted with older non-participants to generate applicable comparative characteristics.

In a further attempt to diminish potential sample selection biases, the two primary study sites were enlarged to include various other locations with diverse geographic and socio-demographic characteristics (Harris et al., 1997). Here, I sought out potential principal subjects with differing resource levels and life circumstances (Harris et al., 1997). Moreover, the two field visits were conducted during three different seasons in an attempt to address other sampling weaknesses that might account for seasonal deviations in the lifestyles and activities of the older subjects (Scrimshaw, 1992).

Secondary Subjects and Key Informants

The establishment of collaborative linkages with key informants and experts in such sensitive research terrains as Cuba is helpful in the development of the investigator's understanding of the language, dialect, and culture, and was lawfully necessary for me to gain access to pertinent study sites and likely subjects (Ball et al., 2003; Creswell, 1998; Fuller, 1988; Scrimshaw, 1992). The first visit to Cuba enabled me to identify and win the confidence and trust of a constellation of local-to-national health and governmental experts. These contacts, some of which were enlisted as secondary subjects, provided the requisite authorizations to conduct field research during the first visit (Schwar, 2001).

Continued discourse solidified collaborative relationships with many of these initial contacts to lay the foundation for more substantive field research during the second visit. These contacts assisted in the identification of additional expert resources, lay community leaders and neighborhood activists, provided me direct access to potential principal recruits, and helped broaden the secondary subject pool. For example, a number of family doctors and health facility

administrators befriended during the first visit extended invitations to return, use their offices and facilities as research bases, and solicit the participation of their older patients during the second field study visit.

Since the economic crisis of the 1990s, some MINSAP administrators have been reticent to divulge official internal records and documents to US researchers (Barrett, 1993; Schwar, 2001, 2002). Therefore, much of the secondary source information in the field was obtained from unofficial informants, and to a lesser degree, from official sources. However, officials with the National School of Public Health and health facilities in La Habana and the Ché Guevara Medical School in Piñar del Rio Province granted me access to official data, as well as experts on staff.

Study Sites

Primary and secondary subject data and certain secondary source information were gathered during four months of fieldwork spread over two trips to Cuba in 2001. Rural Piñar del Rio Province and the urban province of La Habana were selected as the two main study sites. The sites were chosen based on prior international research, in which the American Association for World Health determined the two areas representative of the nation's rural and urban geographic, demographic, and socio-economic characteristics (MacDonald, 1999). Piñar del Rio, Cuba's westernmost province, is situated 43 miles west of La Habana. It has a population of 734,558, of which 12 percent or 85,106 inhabitants are age 60 years or older (Oficina Nacional de Estadísticas, 2002). La Habana is Cuba's main city province. Fifteen per cent (336,433 persons) of the municipality's total population (2,185,072) is age 60 years or older (Oficina Nacional de Estadísticas, 2002). In addition to the two main study sites, principal and secondary subject data, as well as other secondary source information, were collected from principal and secondary subjects in their homes, offices, and other community and official health and governmental settings in rural communities, urban centers, and remote regions throughout the island.

Study Processes

With the research design and methodological framework now outlined, this section broaches the project's operational and implementation processes. It begins with an examination

of Institutional Review Board (IRB) and funding considerations, and then deals with US-Cuban licensing and approval issues. The section ends with a comprehensive analysis of the distinct research procedures.

IRB and Funding

Project protocol was approved by the University of Kentucky Office of Research Integrity IRB in a two-pronged certification process. The IRB first determined that the protocol met US criteria to qualify as an exempt study. As a precautionary measure, however, I sought a full Non-medical IRB review, upon which the protocol was certified. During the full review process, the board voiced three concerns: 1) the need for an expert Cultural Consultant to review the translated protocol; 2) obtaining individual site references from Cuban authorities; and 3) securing the written consent of study participants.

I satisfied the first concern by obtaining an expert Cultural Consultant from the University of Kentucky Office of International Affairs, who had visited Cuba on a number of occasions and had traveled the island extensively. Furthermore, I secured the assistance of an experienced Spanish-language educator, who also had visited Cuba and reviewed the protocol and interview instrument syntax. In reference to the second concern, I received a letter of support from the Director of Cuba's Care Program for Older Adults. Subsequent to a discussion, in which I detailed Cuban security surveillance issues and participant safety concerns, the board issued a written consent waiver that granted me permission to obtain the verbal consent of the principal subjects to participate.

Licensing and Approval

The notion of Cuba as a forbidden research terrain was introduced one year before the psychological onset of the post-Cold War Era (Fuller, 1988). Forbidden research terrains refer to entire areas of "potential investigation, which may be geographically, institutionally, or intellectually defined, where...scientists are strongly discouraged from pursuing research...by state initiative" (Fuller, 1988, pp. 99-100). Hindrances concerning this study's forbidden research destination spring from politically-inspired legislation and practices from both outside and within Cuba (Fuller, 1988).

The First and Fifth Amendments and two key Supreme Court rulings upholding US

citizen rights to travel freely notwithstanding, four legislated barriers have sustained the US government's position on Cuba as a forbidden research terrain: the 1917 Trading with the Enemy Act, the 1992 Cuban Democracy Act, the 1996 Helms-Burton Bill, and the State Department's licensing guidelines (Department of Homeland Security, 2003; Fuller, 1988; Nichols, 1998; Seattle Times News Service, 2003; U. S. Department of State, 1992, 1996; U. S. Department of State Bureau of Consular Affairs, 2003; U. S. Department of the Treasury Office of Foreign Assets and Control, 2003a, 2003b; U. S. Department of the Treasury Office of Public Affairs, 2003; Welch, Gruhl, Steiman, & Comer, 1991). Although full-time academic researchers, universities, and certain non-governmental organizations (NGOs) may apply for travel licenses on a case-by-case basis, stringent definitions contained in US licensing rules, prohibitive delays, and often arbitrary decisions inhibit the pursuit of research in Cuba (Fuller, 1988; Nichols, 1998; U. S. Department of the Treasury Office of Foreign Assets and Control, 2003a, 2003b). US citizens who travel to Cuba without a permit, or illegally use the license, meanwhile, face prosecution, fines, and jail terms (Fuller, 1988; Nichols, 1998; U. S. Department of State Bureau of Consular Affairs, 2003; U. S. Department of the Treasury Office of Foreign Assets and Control, 2003a, 2003b). Furthermore, the Bush Administration hardened its stance on the Castro government following the 2001 terrorist attack on the US and, in early 2003, fortified efforts to discourage US citizen travel to Cuba (Department of Homeland Security, 2003; Seattle Times News Service, 2003).

Cuban government agencies also have established a demanding protocol that discourages the pursuit of outsider research on the island (Fuller, 1988). An educational visa first must be obtained to gain entry to the country. Authorization also requires submission of an application that outlines the proposed travel dates, a point-by-point presentation of the study's goals and objectives, use of the findings, proposed site visits, specific officials with whom the researcher wishes to speak, a curriculum vitae, and other supportive information. In some instances, certain projects require several preparatory visits that may delay application approval for years (Fuller, 1988). Varying internal and external relations and policies, such as those following the 9-11 incident, further destabilize the research environment for outside investigators.⁴

The two Cuban visits that pertain to this study were made in the months just prior to the September 11th attack on the US and US citizen travel crackdown (Department of Homeland Security, 2003; Seattle Times News Service, 2003). I obtained a US travel license for the first

visit through the People to People Ambassador Programs, a US-based NGO that sponsors educational exchanges to Cuba for the purpose of one-on-one interactions between US professionals and Cuban citizens. The organization's established relationship with the appropriate Cuban approval agencies resulted in the swift issuance of the researcher's Cuban visa and authorization to speak freely with any Cuban citizen.

In the same way, the investigator obtained a second US travel license for the subsequent visit. US authorities had awarded the Medical Education in Cooperation with Cuba (MEDICC) a permit, under which the researcher was licensed to travel to Cuba. MEDICC is a US-based NGO that offers educational opportunities in Cuba to students in medical and health-related fields. As a sponsored student, the organization's agreement with Cuban authorities granted the researcher access to libraries and electronic databases at the National School of Public Health and Ché Guevara Medical School and permission to speak freely with any Cuban citizen.

Cuban law strictly forbids unauthorized outsider field studies (Fuller, 1988). Even if a project is authorized, the administration of formal quantitative instruments to citizens in public is illegal (Robles, 2002). However, no special case approval was required to conduct qualitative research in public and in private among the principal and secondary subjects included in this study, because my two sponsoring organizations had obtained the appropriate Cuban authorizations. The following sub-section presents the intrinsic methodological issues and solutions related to the other public-private investigative dilemmas, as well as other quandaries associated with conducting research in this forbidden terrain.

Solutions to Intrinsic Methodological Obstacles

In even the least sensitive territories, an acute awareness of the specific culture and mobilization of inventive methods are needed to approach, enroll, and interview participants (Ball et al., 2003; Myers, 1977; Steckler et al., 1992; Warman, 2001). The researcher also must minimize potentially inauspicious settings in order to capitalize on solicited information (Ball et al., 2003; Myers, 1977). This is especially true for foreign researchers in Cuba, whose site visits must be pre-approved, and who are assigned government chaperones to accompany researchers on officially sanctioned and scheduled site visits (Schwar, 2001, 2002).⁵

Because security surveillance is so deep-rooted in Cuban society, there is a heightened need to safeguard potential and consenting participants from possible reprisal (Myers, 1977;

Schweimler, 2001). For example, the investigator must employ extraordinary methods to shield consenting subjects from possible identification in field notes upon exiting the country. There also is a need to insulate the researcher from potential harassment (Fuller, 1988). Consequently my passport, US travel licenses, Cuban visas, Cuban organization identity cards (e.g., National School of Public Health ID), and other relevant documents were carried at all times.

Misinterpretation of verbal and non-verbal communications is a significant obstacle for research that involves persons of differing cultures and ethnic traditions (Myers, 1977; Scrimshaw, 1992; Strauss & Corbin, 1998; Warman, 2001). I have more than a decade of training and practice in verbal and written forms of Spanish, and have traveled extensively throughout the Spanish-speaking world, Latin America in particular. The first Cuban visit afforded me direct experiences of Cuban society and culture, in which a working knowledge of verbal and non-verbal idiosyncrasies was acquired; I also completed a language course for medical and health care professionals in the Cuban dialect. Moreover, I received specific instructions from US diplomats, professionals, and educators on appropriate cultural and political protocol with a explicit focus on where and how to speak with ordinary citizens as not to place them at social, political, or legal risk.

The exploration of perceptions of health equity, health inequity, and health-related behavior requires the use of judicious and culturally sensitive methods that foster subject willingness to share information candidly (Scrimshaw, 1992; Warman, 2001). In instances where I came into first contact with a Cuban citizen, the conversation was kept light-hearted. Only general topics that might be discussed in normal every-day conversation were raised. If asked, however, I voluntarily outlined the purpose of traveling to Cuba and the research project. As previously discussed, the family doctors of all potential principal subjects were consulted before enrollment to determine if the older individual was cognitively or communicatively disabled and, therefore, subject to exclusion from the study.

Once I decided to solicit the participation of a potential subject, the study's general purpose, use of information, interview topics and questions, confidentiality parameters, and risks/benefits were outlined, after which verbal consent to participate was sought (Christians, 2002; Fine, Weis, Weseen, & Wong, 2002; Patton, 2002). Verbal consent was taken in lieu of written consent to avoid potential risks and breaches of confidentiality (Patton, 2002). Each potential subject was informed that pseudonyms of proper names in field notes and published

reports could be used if the individual so requested (Patton, 2002). However, I autonomously invoked this precautionary measure any time sensitive information was divulged. Subjects also were informed of their right to assent prior to, or withdraw at any time during the study, upon which all records of their involvement were destroyed (Creswell, 1998; Patton, 2002).

Obtaining views about health equity and health inequity, which are inherently problematic for qualitative behavioral health studies, are further complicated in Cuba where universal health care is a constitutionally guaranteed equal right. The nuances that distinguish the extremely similar terms of beliefs, attitudes, and perceptions in the Spanish language also are problematic (Scrimshaw & Hurtado, 1984). Thus, considerable time with each principal subject was spent explaining the different terms and interpretations via example.

The example used to explain perception was ‘you do or do not *have* something’; the example for an attitude was ‘you do not *want or choose* something’; and the clarification of a belief was ‘something *is* or some things *are*’ (Scrimshaw & Hurtado, 1984). The terms health equity and health inequity were described in accordance with definitions identified in the literature and accepted by the 2000 Meeting of the International Society for Equity in Health in La Habana (Ferrer, 2002; Scrimshaw & Hurtado, 1984; Starfield, 2002; Stronks, Strijbis, Wendte, & Gunning-Schepers, 1997; Susser, 1993; Syme, 1998). Health equity was explained as conditions in the health and social welfare system that allowed a person *to receive* an adequate level of health and health-related resources that met the person’s needs, while health inequity was explained as conditions that *restricted the receipt* of such resources (Starfield, 2002).

Principal Subject Interviews

Semi-structured, in-depth interviews were conducted face-to-face with the study’s principal subjects. It was assumed that each interview would occur under different circumstances and in different settings (Myers, 1977). In order to diminish the problem of culturally insensitive questions, this study’s instrument (see Appendix A) was based on models that were previously tested for reliability and validity, and conformed to gerontological cultural, linguistic, and socio-demographic characteristics identified in the Cuban, Latin American, and rural health literature (Bernard, 1995; Cortes Alfaro, Garcia Roche, Fullerat Alfonso, & Fuentes Abreu, 2000; Davies & Ware, 1991; Ferrer, 2002; Fillenbaum, 1984, 1990; Gertler et al., 1989; Green-Weir et al., 1996; Medina Lorente, Vargas Torres, Rolando Romero, Cresbo Bello, &

Lemez Baez, 1998; Pan American Health Organization, 1990; Pan American Health Organization & University of the West Indies, 2003; Schur & Franco, 1999; Scrimshaw, 1992; Scrimshaw et al., 1991; Scrimshaw & Hurtado, 1984; Stewart, Morales, Nápoles-Springer, Gregorich, & Hays, 2003).⁶ As mentioned above, each fixed interview question was reviewed and approved by two US experts with considerable backgrounds in Cuban customs and dialect.

Appendix A contains the Spanish and English translations of the open-ended questions used in principal subject interviews. The questions remained fixed throughout the study. They included such topics as residential proximity to pertinent care settings, service use, out-of-pocket health-related expenses, and self-perceived health status.

Self-reported health status has been found to be a poor indicator of the individual's actual health state (Maddox, 1962; Pan American Health Organization, 1990). Therefore, cross-verification of the principal subject's health status was sought from the individual's family doctor and/or, when possible, the patient's medical record was reviewed. Self-perceived health status, however, is a relatively good indicator of health care use and, for this reason, was employed to cross-validate relevant principal interviewee data and direct care-event observations (Fillenbaum, 1984; Pan American Health Organization, 1990; Scrimshaw, 1992).

In an effort to elicit more comprehensive responses to the formal queries, impromptu follow-up questions were posed a number of times in sundry forms and in disparate contexts (Blaxter, 1997; Janesick, 2002; Patton, 2002; Scrimshaw, 1992). Follow-up questions, however, were used only to clarify and cross-check formal interview data (Scrimshaw, 1992).

All formal interviews were scheduled to accommodate the subject's daily routines. Sensitivity to the person's immediate necessities, particularly for infirm older subjects, guided the flow of the exchanges (Myers, 1977). No time constraints were placed on the responses of either principal or secondary subjects and all responses were in the subject's own words (Myers, 1977). Respondents also were free to offer unsolicited information at any time during scheduled and/or spontaneous exchanges.

Direct Observations

Direct observation of care-giving episodes involved the principal subjects, their doctor(s), and other formal and informal health-providers. Table 5.1 provides an indication of the topics and activities that were considered during each observation and discussed with the involved

persons during pre- and post-event interviews. For example, the topics included the health setting, health issue(s), patient inclusion in decision-making, inter-personal communications, and patient/doctor satisfaction. When possible, the researcher attended additional medical consultations and accompanied older subjects and their family doctors to subsequent care service levels, such as the polyclinic testing laboratory and the local pharmacy.

Table 5.1. Health Event Analysis and Care Quality Assurance Assessment Issues

Category 1 Context	Category 2 Work Processes	Category 3 Outcomes
Care-setting	Care-giver/receiver activities	Doctor/specialist consultation
Actors involved	Equipment and objects used	Bio-psycho-social aspects of diagnosis and treatment
Health issue(s) and associated factors	Working means at different moments in the interaction	Inclusion of patient opinions and preferences in diagnosis and treatment plan
Care-giver/patient orientation	Patient involvement	Treatment plan service delivery
Climate of confidence established	Inclusion of patient opinions and preferences	Patient referral to subsequent care level(s)
	Patterns of problem-solving	Patient/doctor satisfaction
	Courses of proposed action	Medical record review
	Duplicative or over-lapping service provision	

Adapted from "Use of Process Evaluation to Guide Health Education in Forsyth County's Project to Prevent Cervical Cancer," by M. B. Dignan, R. Michielutte, P. C. Sharp, L. D. Young, and L. A. Daniels, 1991, *Public Health Reports*, 106(1), 73-77; "Satisfacción de la Población con el Médico de Familia," by G. M. Medina Lorente, J. M. Vargas Torres, V. R. Rolando Romero, E. M. Cresbo Bello, and J. J. Lemez Baez, 1998, *Revista Cubana de Medicina General Integral*, 14(6), 571-580; "Metodologia de Avaliacao do Trabalho na Atencao Primaria a Saude," by A. Sala, M. I. B. Nemes, and D. D. Cohen, 1998, *Cadernos de Saúde Pública*, 14(4), 741-751; "Access to Health Care," by C. L. Schur, and S. J. Franco, 1999, In T. C. Ricketts (Ed.), *Rural Health in the US* (pp. 25-37), New York: Oxford University.

Prior to all direct observations, I obtained permission to gain access to informal and formal care settings, the older person's residence or local polyclinic, for instance (Creswell, 1998). Even if prior consent was given, I again sought the verbal consent of older subjects, their family members and doctors, in addition to other health-providers before the observation. In sensitive circumstances, neighborhood, community, facility, and health agency pseudonyms were used to ensure participant confidentiality and protection.

The influence of research value preferences and Cuban data gathering and reporting mechanisms on the validity of secondary contextual and supporting data has been raised and answered in previous chapters (American Association for World Health, 1997; Cereseto & Waitzkin, 1986; Susser, 1993; Zimbalist, 1988a). Consequent of these potential biases, an even greater degree of data crystallization and corroboration is required. Thus, readers will note the sometimes excessive citation of multiple references in the dissertation's text, in which I have attempted to provide a consensus opinion on sensitive issues, or textually present and cite the authors whose remarks appear to be polarized or biased.

With regard to the surveillance issue, however, it is not uncommon for ordinary citizens and professionals, particularly health care personnel, to state the party line on delicate topics in public, but confess the realities of daily life in private (Barrett, 1993; Schwar, 2001, 2002). Thus, the questionable reliability of secondary field data gathered from these sources represents a critical issue in this forbidden research terrain. As such, a different field strategy is required.

Only generic and non-assuming questions were posed to principal and secondary subjects in public settings, such as the family doctor's daily routine. Additional meetings were scheduled in the privacy of subject's home or behind closed office doors, where more sensitive and potentially incriminate issues were raised, such as the older individual's personal health expenses, access barriers, and perceptions (Fine et al., 2002). I adhered to a policy of never asking a person to offer an opinion of Castro or the government, although, voluntary admissions were duly recorded. A subject's refusal to divulge information was respected.

Field Notes

A hand-written record of all formal responses, direct observations, unsolicited and anecdotal remarks, and researcher annotations was made at the time of each formal interview and observed activity, or shortly after spontaneous exchanges. A field note pre-coding system that

clearly specified the various information sources, settings, and circumstances was developed to aid subsequent deciphering (Patton, 2002). Additional investigator observations were recorded privately before and/or immediately following exchanges. All collected data were recorded in a style of shorthand known only to me. No taped or video recordings were made to avoid potential difficulties with Cuban customs upon exiting the country. However, photographs were taken with the consent of an individual or group; undeveloped film was kept on my person while exiting the country and developed after each return to the US.

All hand-written field notes were reviewed daily (Bernard, 1995). I transposed and typed all hand-written field notes word-for-word into a computerized word processing software program after returning to the US from each visit (Creswell, 1998). Firewalls and passwords were created to protect electronically stored data and hand written field notes were placed in a locked file cabinet accessible only to me (Creswell, 1998). Hand-written field notes were frequently reread and crosschecked with the computerized transcription to ensure accuracy and for me to become absorbed in the data (Creswell, 1998). The next section diagrams the methods and process used to assimilate and analyze this information, integrate the theoretical construct, and report the findings.

Analysis, Theoretical Integration, and Reporting

Drawing on elements of grounded theory, the data were analyzed in two stages: open-axial coding and selective coding (Creswell, 1998; Patton, 2002; Strauss & Corbin, 1998). Figure 5.1 shows the 3 x 3 conditional matrix that was created to serve the two coding processes, visually depict the data classifications and properties, integrate the information, interpret the findings, and generate story-lines (Creswell, 1998; Patton, 2002; Ryan & Bernard, 2002; Schur & Franco, 1999; Scrimshaw, 1992; Strauss & Corbin, 1998; Tansella & Thornicroft, 1998). The matrix features three macro-level categories and three micro-level domains that were informed by the study's theoretical construct and select methodologies, namely the event analysis and care quality assessment approaches. The data were arranged so that micro-level information regarding socio-demographics, health status, and perceptions appeared on the vertical axis, while macro-level data were placed along the horizontal axis according to milieu, process, and outcome.

Open-Axial Coding

The initial step in the first stage of data analysis applied open-axial coding, which is similar to the content analysis method (Patton, 2002; Ryan & Bernard, 2002; Strauss & Corbin, 1998). An individual matrix worksheet was made for each data source. All data were examined line-by-line, sorted into the two broad groupings of principal or secondary contextual and supporting data, sub-typed, and assigned general properties (Patton, 2002; Ryan & Bernard, 2002; Strauss & Corbin, 1998).

Figure 5.1. Conditional Matrix

<u>Domains</u>	<u>Categories</u>		
	Milieu	Process	Outcome
Socio-Demographics			
Health Status			
Perceptions			

Adapted from "Qualitative Inquiry and Research Design: Choosing among Five Traditions," by J. W. Creswell, 1998, Thousand Oaks, CA: Sage; "Qualitative Research and Evaluation Methods (3rd ed.)," by M. Q. Patton, 2002, Thousand Oaks, CA: Sage; "Data Management and Analysis Methods," by G. W. Ryan and H. R. Bernard, 2002, In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of Qualitative Research (2nd ed., pp. 769-802), Thousand Oaks, CA: Sage; "Access to Health Care," by C. L. Schur and S. J. Franco, 1999, In T. C. Ricketts (Ed.), Rural health in the US (pp. 25-37), New York: Oxford University; "Adaptation of Anthropological Methodologies to Rapid Assessment of Nutrition and Primary Health Care," by S. C. M. Scrimshaw, 1992, In N. S. Scrimshaw & G. R. Gleason (Eds.), Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes (pp. 25-38), Boston: International Nutrition Foundation for Developing Countries; "Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory (2nd ed.)," by A. Strauss and J. Corbin, 1998, Thousand Oaks, CA: Sage; "A Conceptual Framework for Mental Health Services: The Matrix Model," by M. Tansella and G. Thornicroft, 1998, Psychological Medicine, 28, 503-508.

The following hypothetical case illustrates initial coding of a family doctor interview. The translated field notes first would be examined line-by-line, during which the researcher classified group, sub-type, and general properties. In this instance, the data would be classified

as secondary, sub-typed as an interview, and might note the following general properties: *family doctor; female; licensed family medicine specialist; regular in-office blood pressure checks; home-visit exams for non-ambulatory disabled older individuals; reports burdensome administrative duties.*

Figure 5.2 provides a simplistic illustration of the matrix-configured data. Note how the delineation of general properties establishes elementary linkages between and among the different categories and domains. Axial coding of this data would involve filling gaps, expanding the general properties, refining the correlations, and generating additional explanatory statements and interpretations. This process is repeated during selective coding and the second data analysis phase to begin developing simple story-lines from the findings.

Figure 5.2. Hypothetical Matrix Configuration of Data from Family Doctor Interview

Domains	Categories		
	Milieu	Process	Outcome
Socio-Demographics	2 ^{cd} /intv/fm dr/f licensed F. M. S. consultorio older patient homes	regular B.P. checks exams/older disabled	preventive care aging in place
Health Status	—	—	—
Perceptions	—	—	burdensome adm. duties

Source: Author.

Weighting Perceptions of Health Equity and Health Inequity

An important coding function is the meticulous attention paid to unanticipated or deviant categories that might emerge (Patton, 2002). The issue of weighting perceptions was a major category in this study (Patton, 2002). All principal participants, regardless of health status, were given an equal opportunity to respond, their perceptions of health equity and health inequity above all. However, variant health states may produce differential perceptions based on the person's unique needs and circumstance (Hopton & Dlugolecka, 1995; Sandifer et al., 1995). Perceptions also may vary between respondents with similar health states, depending on the condition and the person's wherewithal. Although equal weight was given to all responses concerning perceived health equity and health inequity, the subject's health status, which was

cross-checked via other sources, and socio-economic information helped clarify perceptive distinctions, which were noted in the researcher's memos and unerringly reported (Hopton & Dlugolecka, 1995; Sandifer et al., 1995).

Selective Coding

This first stage of data analysis included the final step of compiling individual matrix worksheets and placing those data into the respective categories and domains of a master worksheet. Selective coding, the second stage of analysis, was applied to the information contained in the master worksheet to fully develop the information (Creswell, 1998). In 'making it all come together' (Strauss & Corbin, 1998, p. 144), the data were revisited and reinterpreted. Gaps were identified and filled, more exacting properties were assigned, basic linkages were clarified and expanded to unearth possible convergent and divergent interactions, culminating findings were noted, and simple explanatory statements were formulated (Patton, 2002; Ryan & Bernard, 2002; Strauss & Corbin, 1998). These simple explanatory statements, or elementary story-lines, which formed the basis of the study's final narrative, were drawn out in order to fully develop the biographical dimensions of and narrative relationships among the findings across the multiple groupings (Ryan & Bernard, 2002).

Once the study's findings were secured, they were carefully reconsidered according to the principles for maintaining methodological and interpretive validity, based on the researcher's knowledge of each method, skills, judgment, insight, and creativity (Morse, 1991). This process also enabled the detection of gaps in the logic of the findings and storied explanations (Strauss & Corbin, 1998). When inconsistencies arose, I returned to the raw data to determine if any information had been omitted and, if needed, the coding applications were repeated (Strauss & Corbin, 1998). Additionally, this cyclical application formed the basis of an extended analysis of the data, from which supplementary results were drawn.

In sum, the methods and strategies just described were used to arrange and display the data in a manner that facilitated the analysis. The analysis explored and developed relationships among the items to generate the findings, from which nominal story-lines were constructed and the narrative scope of the findings was broadened. It is at this precise juncture that theoretical integration occurs (Morse, 1991).

Theoretical Integration

It is important to reconsider the complementary, yet separate functions of the theoretical construct in this inductively driven research design. From the project's inception through data analysis, its sole use was to inform methodological and data crystallization—the selection of multiple methods, techniques, and strategies for gathering information and analyzing the data. The nuance is that the construct had no direct bearing on the facts and findings.

However, the framework was not simply discarded following the methods selection. Once findings were generated, these results were applied to inform, develop, and amend the construct (Beebe, 1995; Groger & Straker, 2002; Kenyon et al., 1999; Morse, 1991). Therefore, theoretical integration is the direct product of the findings, the implications of which were reported in the final chapter.

Narrative Development

Narrative representation is itself a method of inquiry and, as such, this dissertation's storied findings cannot accurately and thoroughly relate all of the macro-level factors that influenced perceptions of health equity and health inequity among the older individuals under study (Richardson, 2002). However, the post-Modernist narrative approach adopted here—crystallized, descriptive writing—uses a mixture of scientific, literary, and artistic genres to present the findings from multiple perspectives in an effort to minimize potential inaccuracies and inconsistencies (Creswell, 1998; Richardson, 2002). Thus, the crystallized writing approach complements the rich, complex, albeit, partial data in order to report the findings in the most precise and truthful manner possible.

Reporting

The dissertation research findings are presented within the following four chapters. Chapters Six through Eight offer findings from secondary data sources concerning the development of Cuba's health and long-term elder care services system. The outcomes presented in these three chapters are reported chronologically, and include a substantive level of detail and analysis.

The principal subject findings are reported in Chapter Nine. These findings are reported in two narrative forms. First, the results among the principal subjects are presented as

unambiguous descriptions of the settings, events, and circumstances that influenced the older individual's perceptions of health equity and health inequality. The information is related judiciously, factually, and interestingly at a suitable level of detail and without invasive and extensive analysis. When applicable, secondary subject responses are used to complement and provide context to the principal subject findings. A similar narrative structure is used to report the findings of a focus group interview.

Case studies, the second narrative structure, also are used to augment findings among the principal subjects. The case studies explore important daily, health-related individual and group events. Their purpose is to reveal differing and corresponding viewpoints and interactions related to the study's central themes.

With the study's design and methods now outlined, the three chapters that follow offer an important context framework into which the principal subject, focus group, and case study findings will be placed. Chapters Six through Eight track the development of Cuba's health services system from the pre-revolutionary Era to the present day configuration, including the Family Doctor Program and new long-term care initiative for older adults. Chapter Six begins with a profile of the pre-revolutionary health structure.

Chapter Six

Findings on the Development of the Health Care Services System through the Early 1980s

Orthodox medicine defines health as the absence of disease or infirmity (Leavell & Clark, 1958). In 1948, the World Health Organization (WHO) offered a holistic interpretation that health was a state of complete physical, mental, and social well-being (World Health Organization, 1948). The WHO urged nations to protect “not just the somatic and psychological but also the social well-being of the individual and the collectivity” (Navarro, 2002c, p. 14).

The bio-psycho-social health perspective was designed to inspire a new paradigm. The hope was that a greater value would be placed on “the health of the individual, whether as a right under a democratic state or as a means of increasing productivity in a dictatorship” (Leavell & Clark, 1958, p. 9). By the late 1950s, however, few nations were stirred by the possibility of health care delivery models that integrated the bio-medical and psycho-social approaches.

The 1978 Alma-Ata Declaration asserted that health was a fundamental human right (World Health Organization, 1978). It established a framework for governments, professionals, and individuals to achieve health for all the world’s citizens by the year 2000 (World Health Organization, 1978, 1988). Its key provisions were a nation-state’s obligation to provide for and promote the health of all citizens, that citizens had the right and responsibility to participate actively in health planning and implementation, and that primary care was essential to the realization of these goals and the achievement of social justice. The decree linked health to overall human development rather than economic progress alone (Mahler, 1978).

One of the main features of the Community-Oriented Primary Care (C-OPC) delivery model was the provision of health care to a defined population. Initial experimentation with the model through the early 1960s occurred in a few industrialized and lesser developed nations: Brazil, Canada, Columbia, the Dominican Republic, Israel, South Africa, Wales, and in the United States in the Four Corners region, East Harlem, and Martin County, Kentucky (Abramson, 1988; Deuschle, 1982; DeVries & Sparks, 1989; Kark, Kark, & Abramson, 1993; Longlett, Kruse, & Wesley, 2001; Tollman, 1991). Each of these projects was credited for generating significant health gains. However, the model’s nation-wide implementation in the industrialized countries was dismissed on the basis that C-OPC was either a luxury or the exclusive alternative for underserved rural areas and poorer nations.

Based on the holistic definition of health, Cuba’s post-revolutionary care approach was

both archetypical of the 1978 WHO declaration and reminiscent of C-OPC (Danielson, 1975; Greene, 2003; Keck, 1993). Navarro (1972a; 1972b) found that by the early 1970s, nearly the entire Cuban population was provided health, social, pharmaceutical, and rehabilitative services virtually free of charge. This chapter presents the secondary source findings regarding the development of Cuba's health care model through the early 1980s. The first section reports the findings on the system's pre-revolutionary antecedents. The second section details the obstacles that hindered initial development of the revolutionary health care services system. The third segment traces systemic development between 1959 and 1969, and highlights the importance of citizen participation in health and health-related activities. The second developmental sequence from 1970 to 1974 is covered in the fourth segment. The findings regarding the system's development between 1975 and 1984, including the 1976 Medicine in the Community Program and model for Community Medicine in the polyclinic, are offered in the fifth and final section.

The Pre-revolutionary Medical System

Cuban research of health care during the Colonial era deals almost exclusively with the public side of medicine before 1898 (Bouza Suárez, 2000; del Carmen Amaro Cano, 2001; Delgado García, 1996a; López Serrano, 1995). Likewise, post-colonial Cuban health histories typically begin with the socialist transition after 1959 (Cuban Ministry of Health, 1996a, 1996b, 1996c; del Carmen Amaro Cano, 2001; Delgado García, 1996b). Castro's speeches, meanwhile, inevitably censure the post-colonial capitalist approach in the period 1898-1958 and extol the revolutionary model (Castro, 1983b, 1985c, 1987, 1989b, 1996). With the exception of a seminal report (Foreign Policy Association, 1935) on the mixed post-colonial system of the 1930s, these insider perspectives regularly offer incomplete depictions of Cuba's pre-revolutionary health care structure. The following section attempts to clarify the health services system before 1959.

The Colonial and Post-Colonial Medical Systems

Under the Spanish Crown, the Catholic Church was the chief source of medical care in Colonial Cuba. By the mid-16th Century, a public system of hospitals, doctors, and nurses had been created to serve the island's Spanish colonists (Bouza Suárez, 2000; Delgado García, 1996a; Garfield, 1981; López Serrano, 1995). A private medical school was founded at the

University of Habana in 1728 to meet the colony's increasing health needs (Garfield, 1981; Medina García, Pérez Rodríguez, Cruz Sánchez, & Sánchez Guillaume, 2001). By the mid-19th Century, however, private physicians were being hired to care for Cuban laborers on large sugar estates and smaller neighboring plantations (Garfield, 1981; H. Thomas, 1998).

The church's health role diminished after the Spanish-American War of 1898. Through the first half of the 20th Century, it operated a few charitable medical facilities that served small numbers of urban poor (MacDonald, 1999). The medical school, which became a public institution after the Spanish-American War, continued annual graduations of about 300 private physicians per year until the 1959 Revolution (Garfield, 1981).

Mutualist Organizations

At the turn of the 20th Century, Spanish ethnic groups began forming mutual aid societies that offered pre-paid comprehensive health care to their memberships (Alonso et al., 1994). Resembling modern-day Health Maintenance Organizations, mutualism was a pioneering health delivery approach (Alonso et al., 1994). As many as 40 smaller mutualist clinics complemented six large hospital-based operations exclusively in Cuba's urban centers (Danielson, 1975). Some mutualist programs functioned as cooperatives, while others were owned and operated by small groups of private physicians (Danielson, 1975). Mutualist health organizations provided the bulk of the nation's medical services through the late 1950s (Danielson, 1975).

Public Health System

Administered by the Health and Social Assistance Ministry, 54 public hospitals and a network of small out-patient clinics provided the second greatest share of Cuban medical services after 1898 (Alonso et al., 1994; Valdéz, 2003). Patients admissions were based on a range of socio-economic and health qualifications (Danielson, 1975; MacDonald, 1999). The School of Public Health was founded in 1928 and graduated fewer than 100 physicians, nurses, and health auxiliaries annually in the three decades preceding the Revolution (Stein & Susser, 1972). The majority of the School's physician graduates, however, received political and administrative appointments rather than practicing medicine in public health facilities (Stein & Susser, 1972).

System of Private Medicine

Two camps of private doctors operated on the island through the late 1950s. A small number of physicians, who owned some of the mutualist health groups and held appointments in public medical facilities, also operated independent ambulatory patient clinics that served an exclusive suburban clientele (Danielson, 1975). A second larger group of less prominent doctors, meanwhile, owned small inner city practices (Danielson, 1975; MacDonald, 1999). Hence, a small group of prosperous doctors, who were part of Cuba's aristocracy, wielded considerable political power with the national leadership, and cared for the most affluent urban clients, overshadowed a larger, less powerful, less affluent practitioner class (MacDonald, 1999).

The proliferation of health tourism clinics and surgery centers was indicative of the medical specialties in the years leading up to the 1959 Revolution. However, the constitution of the specialties and exact number of specialists is imprecise. More certain is that specialists also were regarded with the same esteem as the prosperous physician class and concentrated in the nation's major urban centers, where the most advanced health facilities, other supportive medical resources, and affluent patients were available (MacDonald, 1999).

Cuba's first nursing school opened in 1899, when US administrators assumed post-war control over all national affairs (Garfield, 1981; H. Thomas, 1998). The development of a national nursing system soon followed (Garfield, 1981). Nurses and para-medicals, or health auxiliaries, worked in public and private hospitals, mutualist health facilities, and in the clinics and offices of private practitioners (Garfield, 1981; MacDonald, 1999; J. M. Swanson, 1987). Cuban nurses also ran many of the public out-patient clinics that were located in the country's remotest areas (Garfield, 1981)

State of the System in 1958

The US health model was the main influence on Cuban medicine between 1898 and 1958 (Nayeri, 1995; Stusser, Kriel, Dickey, & Krach, 2003). As in the US, private physicians dominated a highly capitalized, hospital-based, fee-for-service system of public and private facilities, mutualist organizations, the schools of medicine and nursing, and health policy-making (Danielson, 1975; Garfield, 1981; MacDonald, 1999; P. Starr, 1982; J. M. Swanson, 1987; Werner, 1983).

Professional and economic opportunities drew health professionals and medical

personnel of all types to the island's major urban centers, where state planners historically had directed most national health resources (Danielson, 1975; Foreign Policy Association, 1935; MacDonald, 1999). Cuba's total population was around 6.5 million in the 1950s, 57 percent of which was urban with 20 percent located in La Habana (Garfield, 1981; United Nations, 2000). Although there were 6,000 practicing doctors and as many as 1,000 trained nurses at the time, about 60 percent of all providers were located in the nation's capital (Garfield, 1981; MacDonald, 1999; Valdéz, 2003). Another five percent of all doctors were in Santiago, the country's second largest city (MacDonald, 1999). Therefore, Cuba's pre-revolutionary medical system was disproportionately skewed toward La Habana and Santiago, which left residents in the nation's smaller urban centers and rural areas medically underserved or not served at all.

The condemnations of the state of post-colonial health care and the medical system aside, the capitalist approach to medicine had produced significant health gains before Castro came to power in 1959. Cuba had the fifth largest doctor per capita ratio in the Americas, and recorded infant mortality and life expectancy rates that were surpassed only by the US and Canada (Alonso et al., 1994; J. I. Domínguez, 1978; Inter-American Commission on Human Rights, 1983; United Nations, 1960, 1967). These statistics, however, do not reflect the distribution, accessibility, and affordability of health care before 1959 (Inter-American Commission on Human Rights, 1983).

Cuba had a population of 6,630,921 in 1958. There were 35,000 hospital beds nationally, which met WHO recommendations for the developed countries of 1 bed for every 200 persons (Contacto Magazine, 1998; MacDonald, 1999; Wills, 2003). In contrast, the US had about half the number of hospital beds per capital than had Cuba; 1 bed for every 109 individuals in 1960 (Contacto Magazine, 1998).

With a total of 79 hospitals, 25 private and 54 public, more than 60 percent of all hospital beds were located in La Habana (Garfield, 1981; Valdéz, 2003). Although 43 percent of the population was rural, Cuba had only one 10-bed rural hospital in 1958 (MacDonald, 1999; United Nations, 2000; Valdéz, 2003). Consequently, small city dwellers and rural residents were forced to travel to mainly La Habana or Santiago to obtain hospital procedures or forgo hospital care altogether.

The private, self-financed mutualist operations, meanwhile, depended on a large base of middle-to-high income members in order to offer the level of services needed to compete with

private, independent health providers (Alonso et al., 1994; Feinsilver, 1993; Foreign Policy Association, 1935; Nayeri, 1995). The model, therefore, was unworkable in poor and sparsely populated areas. Funded at twice the level of public health, mutualist groups served about half of La Habana's population in 1958; mutualist organizations controlled about 40 percent of the nation's hospital beds, the majority of which were in the capital (Feinsilver, 1993; Garfield, 1981; Nayeri, 1995).

The urban orientation of the pre-revolutionary health structure left most smaller municipalities and rural areas bereft of physician care (MacDonald, 1999). Public regulations stipulated that each small city and rural community be assigned at least one physician (Foreign Policy Association, 1935). In reality, however, doctor services in these areas were inadequate or absent due to institutional sinecurism, improbity, and because physicians were unable to earn sufficient wages there (Danielson, 1975; MacDonald, 1999).

The Ministry of Health and Social Assistance, which was responsible for all public health activities and later became the Ministry of Health (MINSAP), was typical of most other public agencies in terms of graft in pre-revolutionary times. Political leaders padded budgets to embezzle funds for personal enrichment. Another widespread practice involved private physicians, who would demand a patient's voting card in exchange for admission to a public hospital or clinic, bed space, and medical services. In turn, doctors would receive special health appointments and political favors for turning voting cards over to elected officials, who then would use the cards to fraudulently garner votes (MacDonald, 1999).¹

Affordability

As early as 1935, Cuba's entire rural population was unable to pay even minimal fees for hospital and medical services (Foreign Policy Association, 1935). Health care was equally unaffordable for the urban poor (Inter-American Commission on Human Rights, 1983; MacDonald, 1999). Throughout the first half of the 20th Century, Cuba's indigent population consisted of a large rural peasantry of mainly small farmers, sugar cane laborers, and their families, and a large urban population of permanently unemployed or semi-employed, half of which was made up of "would-be rural workers, or at least country men" (H. Thomas, 1998, p. 1109), who lived in the shanty towns of La Habana and Santiago. MacDonald (1999) projected that widespread indigence prevented 90 percent of the citizenry from receiving any form of

medical care at the time of the Revolution. Despite the aggregate health gains mentioned above, the inability to pay for or reach medical services, especially among the rural poor, created widespread health problems, such as illness and death from infectious and parasitic diseases (MacDonald, 1999).

Toward a Comprehensive Health Care Services System

Shaped predominantly by market forces and private medicine, the revolutionary government inherited a mixed, hospital-based, and largely metropolitan health apparatus (Alonso et al., 1994; Danielson, 1975; Delgado García, 1996b; MacDonald, 1999; Reed & Frank, 2000; Werner, 1983). As early as the mid-1930s, the Foreign Policy Association (1935) asserted that Cuban health policy served “opportunities for the professional, social and financial advancement of the physician” (p. 117) rather than the population’s medical needs. Even though the national health policy was designed to benefit private doctors, it also was projected that the majority of newly graduated physicians would have “little or no opportunity to enter their profession and secure a reasonable income” (Foreign Policy Association, 1935, p. 117), because the entire health structure had been placed under the control of a small, affluent physician class.

Public officials, meanwhile, were warned that there was no general plan or model to address the misdistribution of health care services; the “whole mass of people in the interior of Cuba cannot pay even nominal medical and hospital fees....They go instead to charlatans and herb doctors for relief” (Foreign Policy Association, 1935, p. 118-119). It was concluded that the rural health care structure and economy, which remained largely unchanged until the Revolution, had resulted in a “relative scarcity of physicians in the interior where need of medical care is greatest, and a great overabundance of physicians in the capital” (Foreign Policy Association, 1935, p. 118). Although the pre-revolutionary medical system produced substantial aggregate health gains, it also had created severe health inequalities due to geographic and socio-demographic gaps in service delivery (Danielson, 1975; Feinsilver, 1993; Guttmacher & Danielson, 1979). To remedy these deficiencies, Castro and his followers proposed a radical alternative to guide the development of a new system for universal health provisioning.

Revolutionary Health Ideology

In 1959, Cuba’s revolutionary leaders adopted a health creed that was articulated two

decades later in the Alma-Ata Declaration. It asserted that the state was obliged to provide health care as a basic right to all citizens (Feinsilver, 1993). This philosophy presents in the five principles of Cuban health care that were formalized in the 1976, 1992, and 2002 Constitutions (Base de Datos Politicos de las Americas, 1976, 1992, 2002).

Constitutionally assured universal coverage and access to medical and dental care without discrimination was the founding principle of the revolutionary health ideology. Active citizen participation and the state's responsibility to provide for every person's health without discrimination were two other standards. A fourth tenet advanced primary care as the main goal of health care. The fifth principle was the attainment of equitability between health, economic, and social development—what the UN now defines as human development (Justiz Gonzáles et al., 1999; Santana, 1987; United Nations Development Program, 1999a, 1999b, 2003). The Castro government, however, had to overcome a series of elementary difficulties in order to pursue its new health ideology.

The Physician Exodus and the Educational Crisis

Foreseeing Cuban socialism and the demise of private medicine, scores of physicians and other health professionals joined a mass exodus of largely affluent and middle-class citizens from the island after 1959 (Danielson, 1975; MacDonald, 1999; K. C. E. Macintyre & Hadad Hadad, 2002; Reed & Frank, 2000; J. M. Swanson, 1987; H. Waitzkin & Britt, 1989; Werner, 1983). By 1964, about half of the nation's 6,000 doctors had emigrated mostly to the US (Castro, 1985c; MacDonald, 1999; Reed & Frank, 2000; Werner, 1983). Of the medical school's 140 senior faculty, all but five had left the country; there were 157 medical professors in 1955, of which only 16 remained behind in 1962 (Castro, 2002b; MacDonald, 1999). Thus, a deficient medical work force was the main barrier to implementing the new health care doctrine.

The leadership sought replacement physicians among the group of marginalized private doctors, who remained on the island following the Revolution (Danielson, 1981, 1985). Government leaders also recruited nurses who had joined the guerillas during the rebellion, in addition to those who had worked in the nation's clinics (Garfield, 1981). Another stopgap measure was to train the lay community as nurses and para-medical or health auxiliaries. With the passage of anti-prostitution laws and the collapse of tourism after 1959, many of these trainees were former sex workers (MacDonald, 1999).

Before the Revolution, the American Medical Association had recognized Cuba's medical school as on par with medical schools in the US (MacDonald, 1999). The diaspora of medical faculty, however, threatened the institution's integrity and the quality of its future graduates (MacDonald, 1999). Circumventing the newly enacted 1961 US embargo, which blocked US doctors and nurses from assisting the new Cuban government, Castro negotiated medical aid treaties with Canada, Czechoslovakia, East Germany, France, Poland, and Russia (Danielson, 1975; MacDonald, 1999). Foreign health volunteers, who held prestigious appointments in their respective countries, provided faculty and technical assistance during this initial transition (Danielson, 1975; MacDonald, 1999).

The urgency and expense of training new physicians and nurses deferred implementation of the primary health care doctrine (Santana, 1987; Werner, 1983). Unable to secure non-Western training materials and institute a new curricula, the medical school relied on existing textbooks from the US and course designs based on the traditional, Western-oriented, curative bio-medical model (Garfield, 1981; MacDonald, 1999). Health services, therefore, remained medicalized and hospital-based until the mid-1970s, when the doctor shortage eased and the medical curriculum was revisited (MacDonald, 1999; Santana, 1987; Werner, 1983).

Until 1963, the medical school selection process, which focused on the social applicability of the student rather than the individual's academic qualities, crippled efforts to produce new doctors. In 1959, for example, 63 applicants competed for 40 medical school slots and, of the 38 selected, 14 dropped out by year's end (MacDonald, 1999). In 1963, selection criteria were improved and the basic medical curricula was compressed from six to four years to speed the training process (Garfield, 1981).

Reaching a training peak in 1970, about 25 percent of all university students were enrolled in medical school (Garfield, 1981). By 1972, the shortage eased as the number of physicians reached 7,200 (Werner, 1983). With three newly constructed medical schools, 1,000 practitioners and 300 specialists were graduated annually to increase the number of physicians to 10,000 by 1976 (MacDonald, 1999).

The health worker exodus during the 1960s also required the creation of expedient nurse and health auxiliary training programs. However, some of these courses for lay community members were laughable. For example, graduates often were sent into the field with a first aid manual and one week's training (MacDonald, 1999). Thus, many newly trained nurses and para-

medical auxiliaries left their posts to enroll in formal nursing programs; there were six nursing schools by 1958 (Garfield, 1981).

The professional nursing school curricula was expanded in 1963 to include regular and auxiliary nursing tracks (Garfield, 1981). Graduates of a three-month course received a temporary nursing certificate and qualified for the three-year general nurse training module (MacDonald, 1999; J. M. Swanson, 1987). General nurse trainees also could pursue nursing specialties, which required additional clinical rotations in pediatrics, obstetrics, and so on (Garfield, 1981; J. M. Swanson, 1987). The emergency assistant nurse track was a two-year course of classroom studies and hospital internships (MacDonald, 1999). Its top graduates were eligible for the registered nurse training program (MacDonald, 1999). Because all tracks emphasized community health practices and preventive-primary care, Cuba's nurses became the vanguard of the new health ideology (J. M. Swanson, 1987; K. A. Swanson, Swanson, Gill, & Walter, 1995).

In the early 1960s, Castro encouraged all eligible students to enter medical school (Garfield, 1981). Since coming to power, the president also had avowed gender and racial equality (A. V. Domínguez, 1977; P. S. Foner, 1985; Jennissen & Lundy, 2001). Accordingly, some qualified female nurses began training as physicians. Two inter-related factors, however, stifled large numbers of Cubanas from pursuing the profession: 1) the pervasive culture of machismo; and 2) a 1962 edict that restricted the nursing field to women (Garfield, 1981).

Early Primary Care Provision

Lacking physicians trained in primary care techniques, implementation of the progressive health creed fell on nurses, who were called upon to become the pallbearers of the community and preventive-primary health approaches (Garfield, 1981; Navarro, 1972b; J. M. Swanson, 1987). Doctors provided all curative services, while nurses were responsible for everything else: administration of preventive health education clinics, the provision of in-home care for non-ambulatory patients, vaccination campaigns, and follow-up services. As a result of professional burn-out, however, the number of female health workers entering the work force for the first time equaled the number of those who returned to the domestic sphere (Garfield, 1981).

These initial obstacles aside, restructuring of the extant health care services system progressed. The first of five developmental sequences occurred between 1959 and 1969 (Garfield, 1981; Iatridis, 1990; Navarro, 1972b; Reed & Frank, 2000; Santana, 1987; Schwar,

2001). The successive phases from 1970-1974, 1975-1884, 1985-1992, and 1992-present reflect the institution of annual and multi-year planning cycles (Danielson, 1985). The chapter sections that follow report on the first three developmental sequences leading up to the institution of a more integrated community health model in 1985 and the incorporation of a matrix of care services for the nation's older population in the early 1990s. The findings on the two later developmental stages will be presented in Chapters Seven and Eight respectively.

First Developmental Sequence, 1959-1969

Reorganization of the pre-revolutionary health system began in 1959. The first sequence featured a decade-long process of rationalization. The rationalization strategy included a three-pronged approach for systemic nationalization, regional equalization, and community re-orientation (Navarro, 1972a, 1972b; Santana, 1987).

Early on, Castro argued that medicine alone was incapable of generating overall health progress and eradicating the associated problems of human under-development, such as illiteracy, hunger, and social inequality (Feinsilver, 1993). Thus, a corollary social welfare program was launched to support health system reorganization efforts. Education, nominal food rations, unemployment and pensioner social security, housing subsidies, and other social grants were provided universally (Alonso et al., 1994).

Nationalization

One early reform measure designed to reorganize the health care services system nationalized all private hospitals, clinics, and mutualist facilities (Delgado García, 1996b; Inter-American Commission on Human Rights, 1983; Jennissen & Lundy, 2001; Santana, 1987; Werner, 1983). Nationalization had two aims: 1) economize available resources; and 2) do away with private medicine (Danielson, 1985). As the state assumed control of private health facilities, the exodus of private doctors and a new graduate cohort of public doctors reduced the number of full-time private practitioners to 80 by the end of the 1960s, a number that remained about the same in 2002 (Danielson, 1975; K. C. E. Macintyre & Hadad Hadad, 2002; Santana, 1987)

Regional Equalization

Replacing the pre-revolutionary Ministry of Health and Social Assistance, the newly created Ministry of Public Health (MINSAP) began a program of regional equalization, in which larger hospitals were constructed mainly in the poorer and rural provinces and existing facilities were expanded (Danielson, 1975, 1985; Delgado García, 1996b; Navarro, 1972b; Santana, 1987). At the same time, many smaller hospitals, the majority of which were urban, were closed or refitted as ambulatory clinics (Danielson, 1975, 1985; Navarro, 1972b). Although the regional equalization process decreased the total number of facilities, about two-thirds of all hospital beds were new and their numbers had been increased from about 4 to 5 per 1,000 persons (Danielson, 1975; Navarro, 1972b).

Community Re-orientation

Law 723, which was enacted in January 1960, created the Rural Medical-Social Health Service. Under the law, MINSAP implemented plans set forth the previous year to build a network of ambulatory, out-patient health centers and dispensaries in outlying areas (Danielson, 1975; Delgado García, 1996b; A. V. Domínguez, 1977; MacDonald, 1999; Reed & Frank, 2000). The law also mandated a rural service requirement for all newly graduated public physicians and the posting of nurses anywhere on the island (Danielson, 1981; MacDonald, 1999; Reed & Frank, 2000). By 1965, rural health centers operated autonomously of provincial hospitals, but were linked with hospital clinical and specialty services (Danielson, 1975, 1981).

During this same developmental period, smaller hospitals and mutualist clinics were transformed into the urban counterpart of the rural ambulatory health center (Danielson, 1975). As with all rural health centers, MINSAP linked urban clinics with nearby hospital and specialty services, but kept them administratively independent (Danielson, 1975; Navarro, 1972b). The community re-orientation aspects of Cuba's regional equalization program approached the administration of the nation's health centers, otherwise known as polyclinics, differently than models from elsewhere in Latin America. In Chile and Puerto Rico, for example, hospital-based physicians directly administer all ambulatory health center activities (Navarro, 1972b). The Czechoslovakian polyclinic model, meanwhile, is perhaps the "most directly relevant socialist" (Danielson, 1975; 1981, p. 242) representation of Cuba's approach to an autonomously operated health center.²

MINSAP's 1965 decision to assign all preventive-primary care responsibilities to the network of urban and rural ambulatory clinics represents a major turning point (Danielson, 1975, 1985; Navarro, 1972b). A decade later, these facilities became the prototype for Community Medicine in the polyclinic and the nuclei of a truly community-oriented health care services structure (Danielson, 1985).

Community Participation

Large-scale citizen mobilization was critical to the reconstitution of Cuban society after 1959 (Danielson, 1975; Navarro, 1972a, 1972b). In the 1960s, for example, citizens were called upon to affect land reforms, urban development, and sanitation improvements. The island-wide literacy and health campaigns represent some of the most successful efforts to inculcate the notion of community participation to attain the Revolution's broad social objectives (Danielson, 1975; de Kadt, 1983; A. V. Domínguez, 1977; Garfield, 1981; MacDonald, 1999; N. Miller, 2003; Navarro, 1972a, 1972b; Santana, 1987).

The Literacy Campaign of 1961

In 1953, more than half of all Cuban children were unschooled (Writing System Alternatives, 2000). The overall population illiteracy rate that same year was 23.6 percent (Writing System Alternatives, 2000). Even though Cuba's illiteracy rate had risen to 26 percent by 1959, it was still the lowest of all the Spanish-speaking nations of the Americas (MacDonald, 1999). This aggregate figure was misleading, however, because it was skewed by the more educated professional sub-populations that resided in La Habana and Santiago (MacDonald, 1999). Illiteracy was almost total among Cuba's rural population and higher among women in all regions (Garfield, 1981; MacDonald, 1999).

The mass exodus of mainly persons with higher incomes had a marked effect on illiteracy rates in the first 20 months of the Revolution. Before the UN in September 1960, Castro stated that the rate had climbed more than 11 percent to 37.1 percent (Dedomenico, 2002; Keeble, 2001). In the same speech, however, the leader boasted that his nation would completely eliminate the social problem in one year (Dedomenico, 2002; Greene, 2003; Keeble, 2001).

Castro informed the country in early 1961 that 280,000 teachers, adult volunteers, and young people had been mobilized to combat illiteracy as part of a nation-wide campaign (Castro,

1961; Keeble, 2001). Cuba's teaching brigades used a lesson manual that featured politicized words containing all letters and speech sounds (Writing System Alternatives, 2000). Fifteen phrases were divided into syllables, from which new words and sentences could be fashioned (Writing System Alternatives, 2000). These phrases included the slogans, *the revolution that wins all the battles, the people at work, and healthy people in a free Cuba* (Writing System Alternatives, 2000).

Although Castro's target of eliminating illiteracy was not met, the United Nations Economic, Social and Cultural Organization (UNESCO) lauded the 1961 campaign for reducing the rate to 3.9 percent in one year (Dedomenico, 2002; Keeble, 2001). The campaign was later expanded to offer elementary education to adults and children in poor and rural areas (Garfield, 1981). It also was the first of many crusades that promoted mass involvement in national initiatives regardless of gender, socio-economic status, and age (Dedomenico, 2002). 100,000 children were enlisted as instructors and, for the first time in Cuban history, Cuban women were permitted to engage actively in public life (Garfield, 1981; Keeble, 2001).

Castro asserted that Cuba's great scientific and economic projects were dependent upon a literate population and that it was impossible for people to fulfill their social obligations without education (Castro, 1961). His remarks harkened back to the 1957 insurrectionary manifesto, in which rebel leaders advocated that revolution and education were identical (Writing System Alternatives, 2000). Thus, the literacy movement of 1961 instilled the conviction that revolutionary idealism and education were inseparable from the citizenry's obligation as a community to actively participate in remedying social ills (MacDonald, 1999). This combination of pragmatic idealism blossomed with the great health campaigns of the 1960s.

Health Campaigns of the 1960s

Throughout the first half of the 20th Century, almost every Latin American nation, including Cuba, had high morbidity and mortality levels associated with acute infectious and parasitic diseases, many of which were curable (Danielson, 1975; Garfield, 1981; MacDonald, 1999; Navarro, 1972a, 1972b; Santana, 1987; Susser, 1993; H. Waitzkin & Britt, 1989; Werner, 1983). However, Cuban health statistics prior to the mid-1960s must be viewed warily, as should be epidemiologic figures from most developing countries. Underreporting is considered the main source of imprecise Cuban health data into the early revolutionary period (Inter-

American Commission on Human Rights, 1983; Navarro, 1972b; Valdéz, 2003).

Improvements in the epidemiologic surveillance system, particularly after 1965, though, were reflected in vital statistics that had been verified by such independent health groups as the Pan American Health Organization (PAHO) and UNICEF (Cereseto & Waitzkin, 1986; Iatridis, 1990; Navarro, 1972b; J. L. Rodríguez, 1988b; Santana, 1988; Susser, 1993). One impartial study (Inter-American Commission on Human Rights, 1983), for instance, found that although the number of Cuban tuberculosis cases rose 261 percent from 1958 to 1965, that proportion decreased to its lowest point on record after the mid-1960s. A similar illustration of more effective surveillance after 1959 can be seen in morbidity and mortality figures. Statistics increased dramatically for nearly all causes between 1959 and 1967, after which steady declines were recorded (Navarro, 1972b; Susser, 1993; Valdéz, 2003).

In 1959, at least 14 percent of all rural residents were reported to be suffering from or had suffered from tuberculosis (Valdéz, 2003). Furthermore, almost 72 percent of all Cubans and over 86 percent of the rural population suffered from parasitism (Inter-American Commission on Human Rights, 1983; Valdéz, 2003). High morbidity and mortality rates also associated with acute diarrhea, malaria, tetanus, diphtheria, and poliomyelitis (Inter-American Commission on Human Rights, 1983; MacDonald, 1999; Werner, 1983).

The new Cuban government responded to the health situation by incorporating a dual mission into the 1961 literacy campaign. Health promotion efforts were designed to target rural and poor mothers and infants (MacDonald, 1999). Nurses, who accompanied the brigades, taught classes on personal hygiene and environmental sanitation to prevent the spread of such infectious waterborne diseases as gastroenteritis, the leading cause of infant death between 1959 and 1962 (Garfield, 1981; Inter-American Commission on Human Rights, 1983; MacDonald, 1999; Navarro, 1972b).

Placing a greater importance on prevention, mass mobilization of the lay community became the cornerstone of subsequent health promotion efforts. Patterned after the literacy initiative, numerous projects were launched to deliver vaccinations against such communicable diseases as tuberculosis, tetanus, and typhoid fever (Inter-American Commission on Human Rights, 1983). Cuba's polio campaign provides a case in point, and one that would continue across subsequent developmental sequences.

Since the creation of an oral vaccine in the 1961, world health leaders envisioned the

global eradication of the wild poliovirus (Centers for Disease Control Advisory Committee on Immunization Practices, 2002; Ward, Milstien, Hull, Hull, & Kim-Farley, 1993; World Health Organization, 1999). The main hindrance for developing nations, however, was an affordable mass administration model (Ward et al., 1993). An inventive strategy was required to deliver the vaccine cheaply and directly to the populations of the lesser developed nations during specific time frames (Sabin, 1984, 1986)

During the 20th Century, poliomyelitis in Cuba acquired an endemo-epidemic makeup of peaks and cycles (González Ochoa, Borroto Gutiérrez, Armas Pérez, Díaz Bacallao, & López Serrano, 2003; Rodríguez Cruz, 1984). The first island-wide campaign in February 1962 eliminated this characteristic (Cué Brugueras, 2000; Más Lago, 1999; Rodríguez Cruz, 1984). Health brigades reached 87.5 percent (2 million) of all persons age 15 years or younger with two oral doses; vaccinations were administered over the course of one week with a one-month intervening period (Más Lago, 1999; Navarro, 1972b). Seven years later, another polio initiative was completed in 72 hours and, in 1970, this feat was accomplished in a single day (Navarro, 1972b).

There have been some 39 national polio vaccination campaigns in Cuba since 1962, each of which was preceded by serologic studies and follow-up quality assurance surveys (Cué Brugueras, 2000; Rodríguez Cruz, 1984). Only seven sporadic cases were diagnosed after 1962 (Ochoa & Lago, 1987). The last Cuban case was reported in 1979, the same year the US reported its last case of transmitted wild-type polio (Centers for Disease Control Advisory Committee on Immunization Practices, 2002; Ochoa & Lago, 1987; Stagg Elliot, 2002).

During the initial developmental sequence of Cuba's health care services system, large scale public health campaigns that featured mass mobilization of lay volunteers were unprecedented (World Health Organization, 1999). Thus, Cuba, along with Czechoslovakia and later Brazil, provided the techniques for which health advocates had been searching (Ward et al., 1993). Cuba demonstrated that "wild poliovirus can be eliminated in large geographic areas" (World Health Organization, 1999, p. 9) without significant public health personnel outlays. Its model "helped bolster the worldwide strategy of using mass campaigns...for the global eradication of poliomyelitis" (Más Lago, 1999, p. 683).

Adaptation of the polio model to battle other diseases shifted Cuba's epidemiologic profile (Diaz Novas & Fernandez Sacasas, 2001; Garfield, 1981; Más Lago, 1999). Table 6.1

suggests declines in a number of acute infectious diseases between 1958 and the mid-1980s as a result of other major island-wide health campaigns. Diphtheria and malaria disappeared by the mid-1970s. Tuberculosis and tetanus, along with pertussis and yellow fever, were virtually eliminated by 1985 (Inter-American Commission on Human Rights, 1983). Susser (1993) found that although disease eradication initiatives in such other nations as Costa Rica had produced similar downtrends, the levels of improvement in Cuba were “seen in no other Latin American country” (p. 424).

Table 6.1. Select Cuban Morbidity and Mortality Data for Years 1958 to 1985

	1958	1965	1970	1975	1985
Diphtheria ^a	600	–	–	0	0
Malaria ^a	3,000	–	–	0	0
Measles ^b	–	118.8	–	–	28.6
Meningococcal Meningitis ^b	–	0.3	–	–	8
Poliomyelitis ^a	300	0	0	0	0
Tetanus ^b	–	6.5	–	–	0.1
Typhoid Fever ^b	–	3	–	–	0.06
Infant Mortality ^c	60	–	38.7	28.9	16.5
Maternal Mortality (Direct) ^d	118.2	–	70.4	–	31.3
Tuberculosis Mortality ^d	18.8	13.7	7.2	2.4	0.6
Gastroenteritis Mortality ^e	4,000	–	–	761	–

^aCases per year; ^bIncidence per 100,000 population; ^cRate per 1,000 live births under age one year; ^dRate per 100,000 population; ^eDeaths per year. Adapted from "Mortalidad por Tuberculosis en Cuba, 1902-1997," by E. González Ochoa, S. Borroto Gutiérrez, A. Armas Pérez, C. Díaz Bacallao, and E. López Serrano, 2003; "A Developmental Analysis of Cuba's Health Care System Since 1959," by T. H. MacDonald, 1999; "The Cuban Health Care System: Responsiveness to Changing Population Needs and Demands," by S. M. Santana, 1987.

By 1969, all but a few medical institutions and services had been nationalized and centralized within the new socialized public health system. The regional equalization and community re-orientation initiatives fostered the construction and/or expansion of large urban and rural hospitals. Basic preventive-primary care services were extended to a national network

of out-patient clinics by refitting small existing city hospitals into ambulatory units and building new rural health centers. Furthermore, all public hospitals, urban clinics, rural health centers, and medical personnel were administratively unified under MINSAP by the end of the 1960s (Danielson, 1985; Feinsilver, 1993; Garfield, 1981). Through its local appointees, the national health agency was designated as the central planning authority for implementing all health policy decisions that most likely originated with Castro and his trusted advisors (Feinsilver, 1993; MacDonald, 1999). Equally important to this first sequence was the mass mobilization of the population into island-wide campaigns, which, by the late 1960s, had reduced illiteracy dramatically and brought most infectious and parasitic diseases under control. Building on these health successes, a second sequence in the development of Cuba's health care services system was initiated.

Second Developmental Sequence, 1970-1974

Castro launched the so-called Revolutionary Offensive in March 1970 (Mesa-Lago, 2000). The directive signaled a second developmental sequence between 1970 and 1974 that can be characterized more as a period of coalescence than expansion. Castro's pronouncement called for all remaining private assets to be collectivized, including the last of Cuba's private hospitals (Danielson, 1985; Garfield, 1981; Mesa-Lago, 2000). Some 58,000 enterprises were brought under direct state control, while others were handed to "housewives who were members of the Committees for the Defense of the Revolution" (Mesa-Lago, 2000, p. 210) and Federation of Cuban Women.

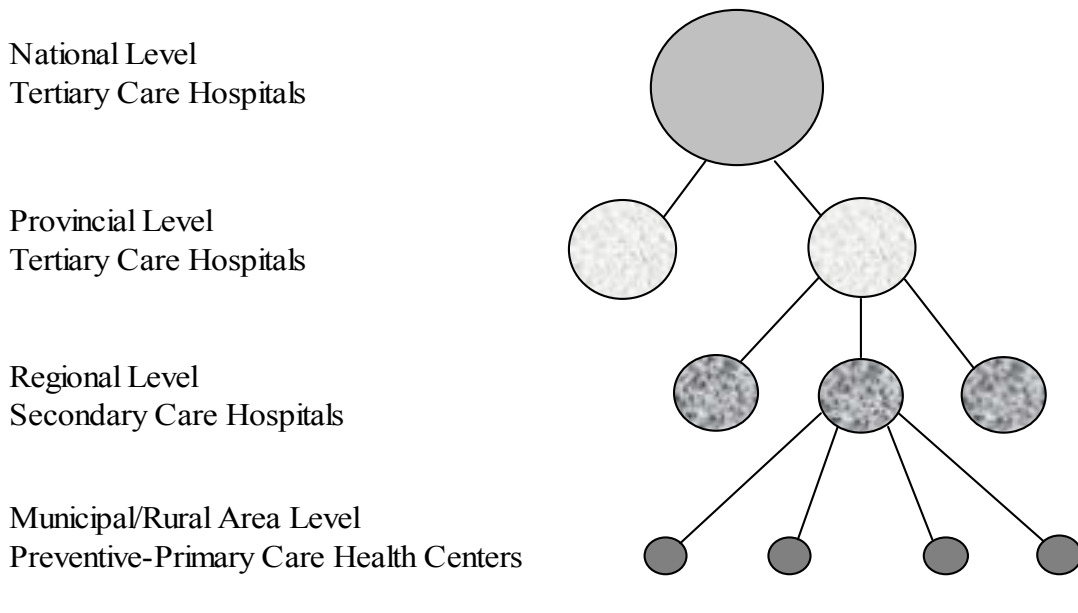
MINSAP's role in the 1970 campaign was to solidify initiatives first undertaken in the 1960s. The agency further centralized in-patient and other institutional care facilities. It also continued to enhance preventive-primary care services in the nation's urban and rural ambulatory care units, or so-called polyclinics.

A second initiative streamlined and formalized the medical and health services delivery structure to reduce duplication and to increase efficiency (see Figure 6.1). All medical and health services were typed as either tertiary, secondary, or preventive-primary. Tertiary and secondary care services were designated as the more institutionally-oriented service types, such as specialty physician care, high technology diagnostics, and the costliest medical treatments. The more community-oriented services, such as regular patient examinations and low technology

treatments, were made part of the preventive-primary health care type.

The delivery of services was then relegated to specific institutions and providers at the national, provincial, regional, and municipal/rural area levels. Tertiary and secondary services were to be provided by medical personnel working in hospitals at the national, provincial, and regional levels. Preventive-primary care services, meanwhile, were assigned to polyclinic physicians and health staffs at the municipal-level and in the nation's rural areas. In addition to structural streamlining, two other major activities undertaken during this second developmental stage centered on the vital statistics system and family-oriented health programs.

Figure 6.1. Health Care Structure: Pre-1976 Levels and Service Types



Adapted from "Nursing, Health Care and Professionalism in Cuba," by R Garfield, 1981; "Cuba's Health Care Policy: Prevention and Active Community Participation," by D. S. Iatridis, 1990; "On the Situation of Human Rights in Cuba: Seventh Report: Chapter XIII (Doc. 29 Rev. 1)," by Inter-American Commission on Human Rights, 1983; "Health, Health Services, and Health Planning in Cuba," by V. Navarro, 1972; "Health in Cuba: Pre 1959-1982," by N. P. Valdéz, 2003.

Improving Epidemiologic Surveillance

Between 1970 and 1974, MINSAP perfected statistical and information controls that it had established as part of the epidemiologic data gathering and reporting mechanism during the later half of the 1960s. Navarro (1972b) cited death registration as an example of improvements

made to the system during this period. Whereas national surveillance only captured an estimated 53 percent of all probable deaths in 1956, and only 30 percent of all probable deaths in rural areas that same year, 98 percent of all probable deaths were being documented after 1969 consequent of a more robust local system for issuing official medical certificates and reporting mortality data (Inter-American Commission on Human Rights, 1983; Navarro, 1972b). Likewise, Santana (1987) found that the local registration of vital health indicators and the system of reporting morbidity and mortality figures to MINSAP was nearly universal by the mid-1970s.³ Maternal-infant care was a second health activity area of the 1960s that the agency attempted to improve upon during the 1970-1974 developmental sequence.

Maternal-Child Health Initiative

Advances in maternal-infant health mirror a society's long-term commitment to human dignity (MacDonald, 1999; United Nations, 1966). Toward this end, the UN General Assembly ratified UNESCO's global family rights covenant in 1966, which outlined four key maternal-child health propositions: 1) treatment, control, and prevention of epidemic, endemic, occupational, and other diseases; 2) improved environmental hygiene; 3) assurance of all medical services and attention in the event of sickness; and 4) reductions in infant mortality and healthy child development (United Nations, 1966). Cuba already had begun to address these types of family health issues by the early 1960s. For example, communicable disease vaccinations, sanitary hygiene education programs, social services to increase nutritional intake and water supplies, and expanded medical services resulted in notable declines in maternal and infant mortality (Corteguera, Garcia, & Lazo, 1976; Danielson, 1975; Navarro, 1972b).

The emergence of the socialist family concept in the early 1970s, strengthened family-based programs begun the previous decade (Azicri, 1981; Bengelsdorf, 1988; Cobas Selba, Valdespino Breto, & Suárez Cobas, 1999; Froines, 1993; Reca, 1992). One example is the Comprehensive Child Care Program of 1967 (Corteguera et al., 1976). MINSAP re-emphasized the program's goals in the early 1970s to increase the number of institutional births and enroll newborns and mothers in a range of newly created care programs (Cobas Selba et al., 1999; Corteguera et al., 1976; Galindo, 1999; Reed & Frank, 1997). Consequently, the nation's infant mortality rate declined even further. Table 6.1 displays an infant mortality rate reduction for children under the age of 1 year from 60 per 1,000 live births in 1958 to 28.9 by 1975.⁴

Despite the significant impact that the revitalization of family-oriented health activities had on infant mortality, Werner (1983) argued that one aspect of MINSAP's initiative was antiquated. Consequent of a re-emphasis on the Child Care Program's mandate for doctor-hospital childbirths in the early 1970s, 99 percent of all deliveries were taking place in hospitals under physician-supervision (La Dirección Nacional de Estadística del Ministerio de Salud Pública de Cuba, 2001; Reca, 1992; Werner, 1983). Cuban health professionals believed the practice was safer and better than other alternatives, such as midwifery (Demers, Kemble, Orris, & Orris, 1993). Medicalized childbirth, however, ran counter to scientific evidence at the time that mid-wife home delivery was as safe for low-risk mothers and less costly than the institutional model (Werner, 1983).

The maternal-child health directive typifies the medical orthodoxy's continued influence over MINSAP's health policy decisions through the early 1970s. For example, although publicly supporting the preventive-primary care concept, the furtive activities of Cuba's medical association often contradicted the new revolutionary health ideology in the form of more hospital-oriented policy decisions (Danielson, 1985). As the next section will illustrate, Castro intervened directly to circumvent Cuba's medical traditionalists and personally advance a new preventive-primary care framework after 1975.

Third Developmental Sequence, 1975-1984

Some progress had been made during the 1960s and the early 1970s to institute the health model for holistic preventive-primary care. However, the system-wide re-orientation of Cuban health care toward the revolutionary philosophy basically was unrealized. The medical orthodoxy still controlled the largely curative, hospital-based health care structure in early 1975 (Garfield, 1981; Inter-American Commission on Human Rights, 1983; Werner, 1983).

Actualization of the revolutionary health ideology required unrelenting community involvement, vigorous governmental prodding, and the abiding support of medical professionals. Effective community mobilization to affect sweeping health objectives was best achieved through organization, training, and professional guidance at the local level (Sabin, 1986). Such Latin American nations as Costa Rica were unable to sustain this dynamic (DeVries & Sparks, 1989; L. M. Morgan, 1993).

Cuba's early health and social successes, however, have been ascribed to a different

mobilization model. Rather than top-down direction, local coordinating bodies known as mass organizations were responsible for training and guiding the citizenry at the neighborhood-level (Danielson, 1975; A. V. Domínguez, 1977; Feinsilver, 1993; Greene, 2003; Navarro, 1972b; Rodríguez Cruz, 1984). It was this model and the momentum generated from the great health campaigns of the 1960s that Castro had hoped to sustain into the decade of the 1970s in order to affect the revolutionary health philosophy throughout the entire care system.

Mass Organizations and Health Commissions

The Cuban Women's Federation (FMC) and Committees for the Defense of the Revolution (CRD) were established in 1960 to engage all citizens age 16 years or older in revolutionary activity (Bengelsdorf, 1988; Feinsilver, 1993; Jennissen & Lundy, 2001; MacDonald, 1999; Reca, 1992). By the beginning of the third developmental sequence in 1975, Cuba had six mass organizations: the FMC, the CDR, the Association of Small Farmers, the Confederation of Cuban Workers, the Union of Young Communists, and the Cuban Communist Party (Chilcote, 1992; Danielson, 1975; Navarro, 1972b). All of the nation's mass organizations, however, were placed under the leadership of the Partido Comunista de Cuba (PCC), the Cuban Communist Party (Navarro, 1972b).

Although the FMC and CDR were perhaps the most active, health-focused mass organizations, members of each mass organization were expected to participate in the health field in some manner (Froines, 1993; MacDonald, 1999; Navarro, 1972b; Tesh, 1986). For example, Trade Union members were involved in occupational health promotion activities, while the agricultural group represented the interests of small farmers in rural health campaigns (Danielson, 1975; Navarro, 1972b).

The FMC played a major role in the 1961 literacy campaign. Through the mid-1970s, however, it spearheaded such family-oriented issues as infant-maternal health, child-care, and labor force integration (Danielson, 1975; A. V. Domínguez, 1977; Froines, 1993; MacDonald, 1999; Navarro, 1972b; Reca, 1992). As part of MINSAP's re-emphasis on family-oriented programs during the second developmental sequence, the FMC also was designated to assist health professionals in what may have been the most comprehensive national study on child development of its time (Danielson, 1975; Stein & Susser, 1972).

The CDR, meanwhile, had more than 3 million members in 1975 (Navarro, 1972b).

Initially established for the purpose of state surveillance and mustering citizens against external and internal security threats, each committee was headed by one person, who was elected by about 30 residents of individual housing blocks (Feinsilver, 1993; Greene, 2003; MacDonald, 1999; Navarro, 1972b). As major participants in the 1961 illiteracy crusade, CDR members were assigned near total responsibility for carrying out the polio campaigns after 1962 (Danielson, 1975). By the mid-1970s, the CRD were made responsible for vector control, street sanitation, and neighborhood immunization record-keeping (Danielson, 1975; Tesh, 1986).

People's Health Commissions were created in 1961 to provide a horizontal, inter-organizational structure composed of non-professionals to liaise the FMC and CDR affiliates in MINSAP's large-scale health projects (Danielson, 1975; A. V. Domínguez, 1977; Feinsilver, 1993). The FMC and CDR were responsible for forming the commissions (Navarro, 1972b). As such, the health commissions also came under the PCC leadership (Navarro, 1972b).

The health commissions originally were designed to kindle citizen participation in health discussions, planning, and decision-making. Although highly successful during the 1960s, the lay backgrounds of non-medical commission members down-graded their involvement to a perfunctory role during the second development sequence of the early 1970s (Feinsilver, 1993). Consequently, a re-examination of the mass participation model during third developmental sequence, led to the creation of Cuba's seventh mass organization—Poder Popular (people power).

Poder Popular

Democracy has been defined as the amalgam of citizen participation in dialogue, decision-making, and execution of determinations that benefit the society-as-a-whole through effectual social change (Carranza Valdéz, 1992; Irvin & Stansbury, 2004). Until 1975, policy-making sited with the revolutionary council, whose members frequently were appointed by Castro himself (MacDonald, 1999). Citizen participation in health actions, for example, was limited to implementing council pronouncements as filtered through MINSAP, the PCC, health commissions, various mass organizations, and medical professionals. The installation of Poder Popular, however, raised the possibility of a more democratic construction, particularly in national health care policy decisions (Hernández & Dilla, 1992; MacDonald, 1999).

Perhaps in an attempt to circumvent Cuba's medical orthodoxy and sustain citizen

activism in health, Castro launched a decentralization-democratization program in the mid-1970s that coalesced in the establishment of Poder Popular Assemblies (Carranza Valdéz, 1992; Chilcote, 1992; Danielson, 1975; Feinsilver, 1993; Hernández & Dilla, 1992). Since the first national ballot in 1976, the grass-roots election of representatives to the National Parliament and the provincial and municipal assemblies offered the potential for broader lay participation in such social processes as health care policy and planning decisions, and local control over medical facility operations (Delgado García, 1996b; Feinsilver, 1993; Hernández & Dilla, 1992; MacDonald, 1999). The advent of the Medicine in the Community Program and the Community Medicine in the polyclinic model, which will be discussed below, were direct outcomes of citizen input and Poder Popular democratization processes (Garfield, 1981; Santana, 1987).

Although less faith was placed in Cuba's mass organizations after the mid-1970s, MacDonald (1999) asserted that the FMC was more in touch with public sentiment than the leadership and, therefore, was the driving force in the establishment of Poder Popular.⁵ Its leader, after all, was the spouse of Vice-President Raúl Castro and long-time member of Fidel Castro's inner circle. Indicative FMC lobbying of MINSAP and Poder Popular representatives in the early 1970s, the Family Code of 1976 became the first major health-related legislation passed by the National Assembly (Froines, 1993; MacDonald, 1999; Reza, 1992).⁶

Poder Popular increased citizen involvement in social discourse on health between 1975 and 1984. More than 5 million Cubans, or about 70 percent of the population age 16 years or older, attended some 21,000 neighborhood assembly meetings (Hernández & Dilla, 1992). Many of the 100,000 ideas advanced to the provincial and national levels via the municipal bodies expressed dissatisfaction with the state of the medical system and health services (Diaz Novas & Fernandez Sacasas, 2001; Garfield, 1981; Hernández & Dilla, 1992; Petras & Morely, 1985; Susser, 1993).

Poder Popular, however, was less successful in democratizing health planning decisions. Assembly members involved in health strategy sessions faced the same impediments as those seeking to inject citizen demands into other social arenas (Hernández & Dilla, 1992). For example, MINSAP officials frequently resisted the tangible contributions of lay representatives to expand the revolutionary health ideology to other institutions (Feinsilver, 1993; Hernández & Dilla, 1992). Consequently, health policy followed a bureaucratized, orthodoxical sameness.

Concurrent Health Developments

With regional equalization nearly complete and service types already assigned to four specific care levels (see Figure 6.1), Castro ordered MINSAP to again emphasize decentralization in 1976 (Farag, 2002; Inter-American Commission on Human Rights, 1983; Martínez Calvo, 1997). The number of health provinces was expanded from six to eight to include rural zones that generally were medically under-served or had fewer hospitals (see Figure 6.2).

Figure 6.2. Cuba's 14 Provinces after 1976



Source: www.casaparticular.com (2003).

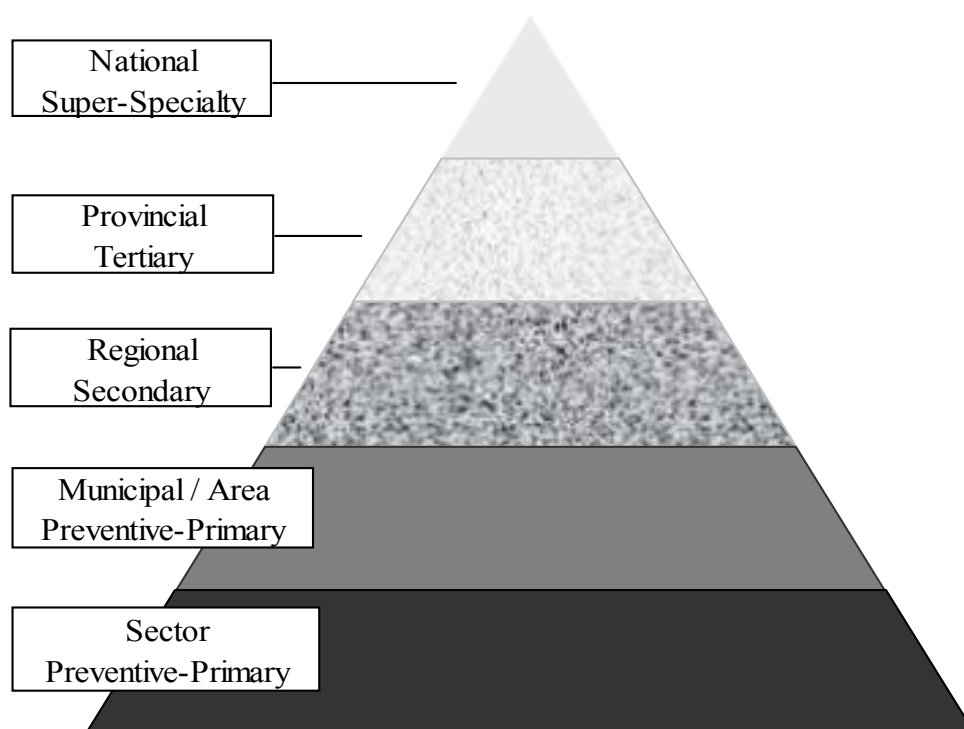
Another major change during this third developmental sequence was the addition of a quaternary or super-specialty category to the three existing medical service forms (Farag, 2002; Iatridis, 1990; Inter-American Commission on Human Rights, 1983; Martínez Calvo, 1997; Valdéz, 2003). Figure 6.3 shows the various levels and service types consequent of Castro's 1976 directive. This model remained in place until the family doctor-nurse model was inaugurated in the mid-1980s.

Under the new configuration, super-specialty services were placed at the national level. Tertiary services were assigned to the provincial level. Secondary medical service types were dispensed through the regional domain. As before, however, preventive-primary services remained with the polyclinics at the municipal and rural area levels.

In-patient hospital services, whether quaternary, tertiary, or secondary, were distributed among the national, provincial, and regional levels (Inter-American Commission on Human

Rights, 1983; Valdéz, 2003). Generally, each province contained a 600-bed provincial hospital that served about 1 million residents (Iatridis, 1990; Inter-American Commission on Human Rights, 1983; Valdéz, 2003). The provinces were sub-divided by geography and population density into medical regions (Inter-American Commission on Human Rights, 1983; Valdéz, 2003).

Figure 6.3. Care Structure by Health Levels and Service Types, 1976-1984



Adapted from "Nursing, Health Care and Professionalism in Cuba," by R Garfield, 1981; "Cuba's Health Care Policy: Prevention and Active Community Participation," by D. S. Iatridis, 1990; "On the Situation of Human Rights in Cuba: Seventh Report: Chapter XIII (Doc. 29 Rev. 1)," by Inter-American Commission on Human Rights, 1983; "Health, Health Services, and Health Planning in Cuba," by V. Navarro, 1972; "Health in Cuba: Pre 1959-1982," by N. P. Valdéz, 2003.

The realignment increased the number of medical regions to more than 44 zones (Inter-American Commission on Human Rights, 1983; Valdéz, 2003). Each region featured a 350-bed municipal hospital (Inter-American Commission on Human Rights, 1983; Valdéz, 2003).

Regions were subdivided into municipal/rural area health zones (Inter-American Commission on Human Rights, 1983; Valdéz, 2003). Each municipal/rural area zone had at least one polyclinic that offered preventive-primary care services (Inter-American Commission on Human Rights, 1983; Valdéz, 2003). More than 330 municipal/rural area health zones were created by 1976, each of which served an average 30,000 persons (Danielson, 1985; Iatridis, 1990; Inter-American Commission on Human Rights, 1983; Valdéz, 2003).

Advent of the Sector Health Service Catchment

The final structural change involved the sub-division of municipal-area zones into health service sectors. More similar to the C-OPC model and the community re-orientation initiative of the 1960s than decentralization, this alteration further localized preventive-primary care delivery by creating a services overlap between the municipal / rural area level facilities and the newly created sectoral health service catchments. Under the direction of a specialist physician, medical teams were dispatched into the catchments from their base polyclinic to care for a defined population of about 5,000 sectoral residents (Danielson, 1985; Iatridis, 1990; Inter-American Commission on Human Rights, 1983; Santana, 1987; Stein & Susser, 1972; Valdéz, 2003). By late 1976, MINSAP had established more than 2,300 sectors with an average 8 zones per municipal-area catchment (Danielson, 1985; Inter-American Commission on Human Rights, 1983; Valdéz, 2003).

Under the 1976 decentralization plan, MINSAP retained its authority to oversee the expanded health care services structure. However, its managerial responsibilities were confined to the national domain (Inter-American Commission on Human Rights, 1983; Valdéz, 2003). Instead, sectoral health commissions were formed. Chaired by the physician-director of the local polyclinic, these commissions were composed of MINSAP appointees, other health professionals, and mass organization and Poder Popular assembly representatives (Danielson, 1975, 1985). The commissions were made responsible for all administrative and operational health activities at the municipal/rural area and sectoral catchment levels (Danielson, 1975, 1985). Despite these administrative changes, encumbrances to the full implementation of the more localized preventive-primary care model intensified in these sectoral health commissions and the polyclinics which they managed (Danielson, 1975, 1985).

Community-Oriented Primary Care Model

A small health movement occurred following World War Two that challenged traditional bio-medical ideology and a medical orthodoxy that ignored both the bio-psycho-social orientation advanced by the WHO in 1948 and the world's medically underserved populations (Geiger, 1984). A small group of health advocates, however, had begun promoting a new service delivery model designed to correct these deficiencies—Community-Oriented Primary Health Care (Geiger, 1984; Kark et al., 1993).

Community-Oriented Primary Health Care (C-OPC) was an organizational design for the purposes of improving health outcomes and increasing population access to preventive-primary care services; it is not a theory or concept (Farag, 2002). The C-OPC design had three key features: 1) it shifted costly and unnecessary tertiary and secondary service provision to more economical preventive-primary out-patient health centers; 2) ambulatory health centers were to be staffed with multi-disciplinary teams of doctors, nurses, and lay community recruits; and 3) the out-patient units and their staffs would care for defined populations or communities (Abramson, 1988; Deuschle, 1982; DeVries & Sparks, 1989; Geiger, 1984; Kark, 1981; Kark & Kark, 1983; Kark et al., 1993; Longlett et al., 2001; Mullan & Kalter, 1988; Nutting, 1986; Tollman, 1991). By extending its responsibilities beyond the traditional hospital service base, the C-OPC health center was viewed as a potential focal point for social change (Geiger, 1984). It held the possibility of carrying unconventional health activities at the community level into other social domains (Geiger, 1984). Castro, however, anticipated that Cuba's approach could achieve these ends and much more (Danielson, 1985; Diaz Novas & Fernandez Sacasas, 2001).

Cuban Polyclinic

The urban and rural ambulatory or out-patient facilities of the 1960s embraced the functional aspects of C-OPC (Farag, 2002). Unlike C-OPC, however, Castro foresaw the need for Cuba's model to include a special type of physician (Alemañy Perez, Otero Iglecias, Borroto Cruz, & Díaz-Perrera Fernández, 2002b). Via the so-called polyclinic, an integral general practitioner would be trained to provide both curative and preventive-primary care, deliver bio-medical/clinical, psychological, social, and environmental services, remake the local out-patient health center into mini-medical training facility, and coordinate all community-level health promotion and epidemiologic activities (Cardelle, 1994; Danielson, 1975, 1985; Farag, 2002).

In 1964, the Aleida Fernández Chardiet clinic in La Habana's Marianao suburb began experimenting with the new polyclinic form (Martínez Calvo, 1997).⁷ The Marianao community is a 21 square kilometer La Habana suburb in the southwest portion of La Habana province. It had about 5,000 families and a population that was about half female circa 1976 (IslaGrande, 2003; Soberats, Aycaguer, & Suárez Jimenez, 1999).

Figure 6.4. Marianao Community, La Habana, La Habana Province, Cuba



Adapted from "Municipios de Ciudad de La Habana: Marianao," by IslaGrande, 2003.

Under the new model, the local polyclinic's bio-medically trained staff received additional instruction in preventive-primary care techniques and the range of public health activities described above (Martínez Calvo, 1997). The initial experiment was expanded to two newly constructed La Habana polyclinics in 1972 (Danielson, 1981). Five such facilities were in place by 1976 with a target of 20 more by 1980 (Danielson, 1981). Almost 400 integral polyclinics were in operation in 1984, when the Comprehensive General Medicine Program and the family doctor-nurse approach were instituted (MacDonald, 1999).

The polyclinic model offered a tacit critique of Cuban health care (Danielson, 1981, 1985). It underscored the need for new forms of medical training, work practices, and community partnering (Danielson, 1975). One of the most distinguishing features was that the polyclinic and its staff were *part of the community* rather than a health institution whose personnel simply provided health care services to the community.

Danielson (1975) described the model's 'community interface' (p. 92) as the main differentiation between pre- and post-revolutionary health care in Cuba and the system after

1975. Castro also recognized its significance as early as 1969, when he stated that “with this polyclinic...a new development is beginning....it is an advanced hospital; it is now the medicine of the year 1980....the medicine of communism....the vanguard of our revolution” (Castro, 1969). Once again, the leader’s public pronouncement foretold the coming of Community Medicine Program in 1976, and the eminent role the polyclinic and the integrally trained physician would play in the new health initiative.

Medicine in the Community

Three convergent issues during the 1976-1984 developmental sequence led to the institutionalization of the Community Medicine Program in 1976. The most important driver was citizen discontent with the medical orthodoxy (Diaz Novas & Fernandez Sacasas, 2001). As early as 1972, doctoring in the nation’s ambulatory facilities was found to be impersonal (Stein & Susser, 1972). Stein and Susser (1972) were unconvinced that doctors actually knew their patients. Most physicians viewed their posts as a temporary necessity in order to enter the medical specialties (Gilpin, 1989; Stein & Susser, 1972; H. Waitzkin & Britt, 1989). There also was a disjoint between hospital specialists and those in the polyclinics with whom they were supposed to consult (Diaz Novas & Fernandez Sacasas, 2001; Stein & Susser, 1972).

A MINSAP commission found that health professionals also were disgruntled (Danielson, 1981). The list of complaints included the following: regional and provincial hospital emergency rooms were overloaded and services were being overused by patients, whose health needs could be met in non-urgent, out-patient care facilities; the overall number of health facilities was inadequate; patients were shuffled among numerous hospitals for laboratory tests and technological support; waiting lists, appointment cancellations, and multiple referrals led to a discontinuity in physician care; physicians were rushed and often ill-tempered (Danielson, 1981; Diaz Novas & Fernandez Sacasas, 2001; Gilpin, 1989).

The second driver of the Community Medicine Program was that large numbers of new physicians were needed to replace those involved in international medical diplomacy service (Feinsilver, 1993). The expense of maintaining the hospital system and constructing new biotechnical institutes was the third issue (Cardelle, 1994; Iatridis, 1990; Limonta Vidal & Padrón, 1992; Reed & Frank, 2000). To the public, the government appeared to support a costly system that was unresponsive to the health priorities of the new decade (Cardelle, 1994; Diaz Novas &

Fernandez Sacasas, 2001; Gilpin, 1989).

Non-communicable maladies, incurred mostly by the older population, had replaced deadly infectious diseases due to the great health campaigns (see Table 6.2). By the early 1970s,

Table 6.2. Ten Major Causes of Death in Cuba between 1970 and 2000*

	1970	1980	1987	1991	2000
Heart Disease	148.6	166.7	185.5	195.6	181.1
Malignant Neoplasm	98.9	106.6	119.7	129.6	146.8
Cerebrovascular Disease	60.3	55.3	64.7	68.7	72.8
Influenza and Pneumonia	42.1	38.6	39.3	35.6	51.3
Accidents	36.1	38.0	43.6	49.7	44.3
Respiratory Diseases ^a	12.2	7	7.7	9.3	–
Suicide & Self-Inflicted Injury	11.8	21.4	22.4	21.1	16.5
Arterial Disease ^b	–	–	–	–	33
Diabetes Mellitus	9.9	11.1	17.0	22.5	13.5
Liver Disease & Cirrhosis	6.7	5.8	–	8.7	8.8

* Rate per 100,000 population for all ages. ^aBronchitis, emphysema, and asthma.

^bArteries, arterioles, and capillary vessels. Adapted from "Principales causas de mortalidad en Cuba: Año 2000," by J. N. Fernández González & G. Fernández Ychaso, 2003, *Revista Habanera de Ciencias Médicas*, 2(5); "A Developmental Analysis of Cuba's Health Care System Since 1959," by T. H. MacDonald, 1999; "Primary Care in Cuba: A Public Health Approach," by K. A. Swanson, J. M. Swanson, A. E. Gill, & C. Walter, 1995, *Health Care for Women International*, 16(4), 299-308.

such chronic conditions as heart disease, cancer, and cerebrovascular disorders predominated (Fernández González & Fernández Ychaso, 2003; MacDonald, 1999; K. A. Swanson et al., 1995). Although Cuba's costliest institutions, such as its national and provincial hospitals, were well equipped with the high technology services necessary to diagnose and care for individuals once a chronic disease had manifested, they were incapable of addressing effects of the nation's epidemiologic transition pro-actively (Cardelle, 1994; Cuban Ministry Of Health, 2001; Diaz Novas & Fernandez Sacasas, 2001; Limonta Vidal & Padrón, 1992; Martínez Almanza et al.,

2000; Santana, 1987; K. A. Swanson et al., 1995).

Community Medicine in the Polyclinic

The piloting of a few Cuban polyclinics as research centers after 1970 began to uncover the systemic and organizational deficiencies triggering citizen and physician discontent (Danielson, 1981, 1985; Diaz Novas & Fernandez Sacasas, 2001). These findings were used to develop new theoretical models for medical education, health work, and community partnering (Danielson, 1981, 1985; Diaz Novas & Fernandez Sacasas, 2001). In 1972, the newly constructed Plaza Polyclinic in central La Habana, whose patients had not yet been introduced to the polyclinic concept, was used to test these innovations (Cuban Ministry of Health, 1976; Danielson, 1981, 1985; Fernández, 1994; Martínez Calvo, 1997; Ordóñez, 1976). The experiment was replicated at a second facility that same year.

Based on citizen and physician dissatisfaction and the successes of organizational and systemic changes that were piloted in the two experimental polyclinics, Castro concluded that a macro-solution was now required (Santana, 1987). Within a Marxist-Leninist-Socialist framework, the Community Medicine approach was introduced into the national network of polyclinics in 1976 (Cuban Ministry of Health, 1976; Danielson, 1981, 1985; Fernández, 1994; Martínez Calvo, 1997; Ordóñez, 1976).⁸

Community Medicine in the polyclinic was conceived as a holistic delivery system to provide universal, comprehensive, health and social services coverage to defined panels of residents in the communities in which they lived (Garfield, 1981; Gilpin, 1989; Santana, 1987). The Cuban polyclinic differed from the organizational design of the Czech and Western C-OPC models. The Czech and Western C-OPC approaches grouped the various specialty services in a facility and dispensed care in a single-service manner to patients who were forced to access the facility on their own; the Cuban model organized specialty services around the community's specific epidemiologic profile and dispensed those services both passively and actively to the entire community of healthy and sick patients (Abramson, 1988; Danielson, 1975, 1985; Deuschle, 1982; Geiger, 1984; Kark, 1981; Kark & Kark, 1983; Kark et al., 1993; Navarro, 1972a, 1972b).

In addition to polyclinic-based service provision, mobile medical teams were accountable for all residents in the polyclinic's municipal/rural area service zone (Danielson, 1981; Santana,

1987). Outreach teams were composed of specialists, nurses, medical auxiliaries, social workers, and other lay community participants. Dispatched into sector catchments, the teams became the primary access point through which individuals and families gained vertical entry into the hierarchical medical and social welfare structures (Cardelle, 1994; Danielson, 1975, 1981, 1985; Demers et al., 1993; Escuela Nacional de Salud Pública, 2001; Feinsilver, 1993; Keck, 1993; MacDonald, 1999; Reed, 2000a; Santana, 1987). Polyclinic staffs, therefore, were supposed to become thoroughly acquainted with the community members for whom they cared (Garfield, 1981; Nayeri, 1995).

The new model went beyond systemic reorganization. It was the product of Cuba's unique brand of socialism and democracy (Danielson, 1981). Much like the great campaigns of the 1960s, the leadership expected polyclinic staffs to work in tandem with Poder Popular assembly representatives, mass organization members, and all citizens to re-energize the Revolution and re-invent the nation's social and health structures (Danielson, 1981; Santana, 1987).

Outcomes

The new health approach had a mixed effect. Table 6.3, for example, indicates that the number of emergency care visits to both hospitals and polyclinics doubled between 1970 and 1980. However, the percentage distribution of urgent care patients among hospitals and polyclinics remained at 80.2 percent for the years 1970 and 1980. The proportion of overall

Table 6.3. Urgent Care Visits by Number and Percentage* for Years 1970 and 1980

	1970		1980	
	Number	(%)	Number	(%)
Urgent (Emergency) Care ^a				
Hospital	6,255,291	80.2	12,160,548	80.2
Polyclinic	1,474,201	18.9	2,870,210	18.9
Other	65,949	0.9	134,700	0.9
Total	7,795,441	100	15,165,458	100

* Percentage Distribution. ^aNumber in millions. Adapted from "A Developmental Analysis of Cuba's Health Care System Since 1959," by T. H. MacDonald, 1999.

polyclinic visits, though, increased by more than 276 percent between 1964 and 1979 (Danielson, 1985). In sum, Community Medicine in the polyclinic had only a modest impact on systemic efficiency, while dramatically increasing health coverage (Gilpin, 1989; MacDonald, 1999).

Between 1970 and 1980, ambulatory patient coverage by all physician specialties increased by about 24 percent (see Table 6.4). The model also produced a discernable shift from internal specialty medicine toward general medicine. Nevertheless, Community Medicine in the polyclinic failed to meet expectations that medical teams from small, free-standing polyclinics could produce revolutionary social change and achieve the level of community integration required of a truly localized preventive-primary care approach (Santana, 1987).

Table 6.4. Specialty Ambulatory Visits Per 100 Population and Percentage Change for the Years 1970 and 1980

	1970	1980	% Change
Specialty Ambulatory Visits			
Internal Medicine	5.0	3.7	-26
General Medicine	94.7	107.4	13.4
Total Specialty Medicine	118.8	147.5	24.1

Adapted from "A Developmental Analysis of Cuba's Health Care System Since 1959," by T. H. MacDonald, 1999.

Flaws in the Model

Community Medicine in the polyclinic threatened the medical orthodoxy. It drew resources from high-technology institutes, hospital-based services, and the medical specialties (Alemañy Perez et al., 2002b; Castro, 1985a, 1985e, 1985f). It also required that large numbers of physicians be trained or retrained in preventive-primary care techniques (Danielson, 1981). Because general family doctor practices had vanished during the 1960s, the highly-trained specialists that took their place and long resisted the revolutionary health ideology, also opposed the model (Alemañy Perez et al., 2002b).

MINSAP officials, meanwhile, were convinced that specialists, if trained in preventive-primary treatment techniques, could provide even higher standards of care than previously

offered (Gilpin, 1989; Santana, 1987). However, it was decided that the addition of preventive-primary medical training would be required of only new medical students rather than the nation's existing medical specialists to avoid political confrontation (Danielson, 1981, 1985).

Consequently, polyclinics staffs remained in the hands of five specialist types, pediatricians, obstetricians, gynecologists, internists, and dentists (Garfield, 1981; Santana, 1987).

Specialists also balked at the Community Medicine multi-disciplinary team concept. They feared that acquiescence to the wishes of non-physician team members would diminish specialty practice to that of a vocation (Danielson, 1981; Garfield, 1981). Furthermore, the model's outreach component required pro-active service delivery in such non-institutional settings as the patient's home. No longer were Cuba's doctors allowed to passively wait for patients to seek out their care (Garfield, 1981).

Ordinary citizens also weakened the model's efficacy. Since before the Revolution, Cubans perceived that hospital-based specialists offered the best care (Castro, 1985e; Gilpin, 1989). This long-standing patient behavior remained largely unaltered until the introduction of family doctor-nurse teams after 1984 (Santana, 1987).

It was apparent by 1984 that the new approach had not moderated the dominant medical paradigm. Well-placed physicians within MINSAP's advisory panels continued to direct resource streams toward hospitals and technologies that served the medical specialties (Danielson, 1985). Although courses in community-based preventive-primary care were added to the medical school training curriculum, they failed to diminish the allure of the clinical specialties among medical students (Castro, 1985e; Gilpin, 1989). What's more, heavy patient-loads and staff turnover diluted polyclinic-based instructional courses in effective, longitudinal, inter-personal doctor-patient communications (Gilpin, 1989; H. Waitzkin & Britt, 1989).

The bio-medical leanings of specialist physicians undermined the model's corresponding emphasis on the psycho-social and environmental dimensions of the revolutionary health ideal (Danielson, 1981, 1985). Two chief complaints were that Community Medicine failed to promote healthy lifestyles and that medical attention focused largely on the individual patient rather than community and family care (Diaz Novas & Fernandez Sacasas, 2001).⁹ Even when community and family services were offered, divisions of labor between the various specialists resulted in discontinuous care provisioning (H. Waitzkin, Wald, Kee, Danielson, & Robinson, 1997). As a result, many of the same deficiencies that presented in the first two developmental

sequences mired implementation of the revolutionary health ideology and the preventive-primary care approach between 1976 and 1984 (Diaz Novas & Fernandez Sacasas, 2001). For these reasons, another radical change was set in motion that steered a fourth stage in the development of Cuba's health care services system. The secondary source findings on the developmental sequence between 1985 and 1992 will be reported in the next chapter.

Chapter Seven

Findings on the Development of the Health Care Services System through the Early 1990s

Mirroring the democratic process of the mid-1970s, Castro quickly responded to public complaints about the polyclinic-based Community Medicine approach. In 1985, the leader established a markedly innovative health approach for a never-before imagined type of physician specialist to delivery hyper-localized, family-oriented, preventive-primary care services to every citizen (Gilpin, 1989; Medina García et al., 2001; Schwar, 2001, 2002). This chapter reports the secondary source findings on the two core developments that evolved during the fourth sequence of Cuba's health care services system: the Comprehensive Family Medicine Program and the model for neighborhood-based family doctor-nurse care.

Fourth Developmental Sequence, 1985-1992

MINSAP was given administrative control over Cuba's medical schools under the Community Medicine Program (Reed & Frank, 1997). Democratization via Poder Popular and the creation of local health commissions, in the meantime, provided lay individuals a voice in health decisions. However, MINSAP administrators and other medical professionals frequently excluded popular interests from health policy decisions (Iatridis, 1990).

In response to citizen complaints, Castro excluded MINSAP representatives from a special commission of medical professors created in 1981. The academic panel was asked to develop a new physician training curricula and service delivery model intended to meet citizen demands by accentuating preventive-primary, psycho-social, and epidemiologic approaches to community-based care (Castro, 1981; Medina García et al., 2001). One major issue at the time was a medical training system that had produced "extremely specialized doctors who would know only about the little finger of the left hand, for example, and about nothing else, nothing about the knee, the elbow or anything else" (Castro, 1981, p. 17).

Castro also authorized the panel to design a strategy that permitted the care system to be redeveloped from "the bottom up and from the top down" (Santana, 1987, p. 121). The commission was directed to strike a balance between MINSAP's centralized, bureaucratic, and orthodox leanings, and the decentralized autonomy of lay community members over local health care planning, decision-making, and implementation (Schwar, 2001; H. Waitzkin & Britt, 1989). Perhaps more significant, Castro's envisioned a new type of physician, who would become a

“health militant...the citizen's adviser...the family's adviser, on everything that affects health, everything that could contribute to improving the living conditions, prolonging life” (Castro, 1983a, p. 1). Two years later, Castro made the training of a new hybrid family doctor a national priority (Castro, 1983b).

Comprehensive General Medicine Program

Castro's decision to exclude MINSAP representatives from the study commission resulted in 'a fight' (Alemañy Perez et al., 2002b, p. 234) between preventive-primary care proponents, and MINSAP administrators and medical specialists, who feared potential job losses consequent of the new health care direction. Consequent of democratization, however, the National Assembly adopted the commission's report and a new public health law in 1983 (Castro, 1983a; Diaz Novas & Fernandez Sacasas, 2001; MacDonald, 1999; K. C. E. Macintyre & Hadad Hadad, 2002; Martínez Calvo, 1997; Petras & Morely, 1985; Susser, 1993). Designed to rectify shortfalls in the community medicine approach, the Comprehensive General Medicine Program brought about a fourth systemic development that today embodies Cuba's approach to health care (Delgado García, 1996b, 1998; Diaz Novas & Fernandez Sacasas, 2001; Farag, 2002; Martínez Calvo, 1997; Reed & Frank, 2000; Santana, 1987; Schwar, 2001; H. Waitzkin et al., 1997).

The new program had three global objectives. First, it established the state's overall responsibilities and actions to protect citizen health (K. C. E. Macintyre & Hadad Hadad, 2002). Second, it reorganized the sectoral health level to create a synergy between institutional and community-based family care services on a neighborhood scale (Feinsilver, 1993; K. C. E. Macintyre & Hadad Hadad, 2002; Reed, 2000a). The family doctor-nurse team was the inventive mechanism through which the second objective was to be actualized.

Castro ordered the training and placement of 20,000 family doctor-nurse teams in consultorios in almost every neighborhood and rural community on the island (Castro, 1981, 1985c, 1985e; Eisen, 1996; Feinsilver, 1993; Gilpin, 1989; Iatridis, 1990; K. C. E. Macintyre & Hadad Hadad, 2002; Reed, 2000a; J. M. Swanson, 1987; K. A. Swanson et al., 1995; Veeken, 1995). The physician's consultorio was a combined residence and medical office (Schwar, 2001, 2002). Each team was assigned to care for the individual within the contexts of the family, the neighborhood, and the community (Reed, 2000a). It was anticipated that the hyper-localized

model would further involve neighborhood residents in health activities as a means of improving the health of the population as-a-whole (Reed & Frank, 2000).

The third objective to enact sweeping changes in the medical school curricula was designed to produce a new hybrid family physician. The new curricula integrated bio-medical/clinical, psycho-social, and primary care theory and practice with preventive and community health approaches to epidemiology, hygiene, health education, and health promotion (Feinsilver, 1993; Nayeri, 1995; Reed, 2000a; Santana, 1987). Furthermore, medical residents were required to complete general family medicine training before selecting other specialty career tracks (Alemañy Perez et al., 2002b; Cardelle, 1994; H. Waitzkin et al., 1997).

Family Medicine Curricula

A select group of 10 doctors began piloting the new curricula in early 1984 in La Habana (Alemañy Perez et al., 2002b; Castro, 1983b; Medina García et al., 2001). By year's end, physician training in integral family medicine was required for nearly all first-year students in the nation's 22 medical schools (Castro, 1985e; Demers et al., 1993; Keck, 1993; MacDonald, 1999; Parkerson, Pepper, Pavlik, & Spann, 2001). The most significant change made to the academic program was the elevation of the professional status of family medicine to that of the other traditional medical specialties (Alemañy Perez et al., 2002b; Castro, 1984b; Medina García et al., 2001).

The curricula's two modules, which remain in place today, are outlined in Table 7.1. The Basic General Physicians (MGB) module was the six-year, pre-doctoral family medicine training program (Alemañy Perez et al., 2002b; Nayeri, 1995; H. Waitzkin et al., 1997). It imparted a "preventive-prophylactic-epidemiological" (Gilpin, 1989, p. 462) medical perspective.

The MGB module was divided into 3 cycles of basic science and clinical training. However, its introductory course examined the living patient within a framework of preventive-primary care theory and community health concepts (Cardelle, 1994). *Sociedad y Salud* (Society and Health) also emphasized the practical aspects of medicine. This initial course exposed students to problem-solving and the daily health routines of family doctors in the local contexts of the family, workplaces, schools, and community (Cardelle, 1994; Gilpin, 1989).

The second cycle featured two semesters of classroom instruction in basic clinical medicine. The third cycle was divided between upper-level class work, including instruction in

Table 7.1. Physician Curricula in Comprehensive General Medicine: Pre-Doctoral and Medical Residency Training

Module	Year	Description	Semesters
Basic General Physicians (MGB)	1		
Cycle One			3
Basic Sciences		Introductory Course in Society and Health Surveys: bio-medical, social, psychological, and community health techniques; health administration, clinical epidemiology, sanitary hygiene, and problem-solving; preparatory work for daily family doctor health routines.	
Cycle Two			
Basic Clinical	2-3	Classroom instruction in: pathology, clinical methods, medical laboratory, radiology, medical psychology, bio-statistics (2 nd level), and computer science.	2
Cycle Three			
	2-6	Classroom instruction in: public health administration, integrated general medicine (3 levels), sanitary hygiene (upper-level), epidemiology, and traditional and natural medicine.	3.5
		Clinical specialty rotations in: internal medicine, obstetrics and gynecology, pediatrics, dentistry, and ^a geriatrics; elective rotations in some 50 other specialties.	3.5
Sub-Total	6		12
Comprehensive General Medicine			
Public Service Clerkship	1-3	Generally in rural community health settings.	2-6
Sub-Total	1-3		2-6
Medical Residency			
	1-2	Generalist family medicine training in the five basic specialties; hospital urger care practicum; operates as a solo practitioner.	4
	3	Hospital rotations.	2
Sub-Total	3		6
Total	10-12		20-24

Note. ^aGeriatric medicine became a sixth basic specialty area and part of the mandatory clinical rotations in the early 1990s. Adapted from “El Pensamiento de Fidel Castro Ruz sobre el Modelo del Especialista en Medicina General Integral,” by E. J. Alemañy Perez, J. Otero Iglecias, R. Borroto Cruz, and G. M. Díaz-Perrera Fernández, 2002, *Revista Cuba de Educación Médica Superior*, 16(3), 231-248; “The Preeminence of Primary Care within Cuban Predoctoral Medical Education,” by A. J. F. Cardelle, 1994, *International Journal of Health Services*, 24(3), 421-429; “Family Practice in Cuba: Evolution into the 1990s,” by R. Y. Demers, S. Kemble, M. Orris, and P. Orris, 1993, *Family Practice*, 10(2), 164-168; “From Municipal Polyclinics to Family Doctor-and-Nurse Teams,” by J. Diaz Novas and J. A. Fernandez Sacasas, 2001, *MEDICC Review*, 2(3), Retrieved April 11, 2001, from <http://www.medicc.org/Medicc%20Review/2000/winter/poly.html>; “Cuba: On the Road to a Family Medicine Nation,” by M. Gilpin, 1989, *Family Medicine*, 21(6), 405-407, 462, 464, 471; “Cuba's Health Care Policy: Prevention and Active Community Participation,” by D. S. Iatridis, 1990, *Social Work*, 35(1), 29-35; “Special Report: Health for All: A Dream Realized in Cuba,” by C. W. Keck, 1993, In 1994 *Medical and Health Annual* (pp. 357-362), Chicago: Encyclopedia Britannica; “A Developmental Analysis of Cuba's Health Care System since 1959,” by T. H. MacDonald, 1999, Lewiston, NY: Edwin Mellen; “The Cuban Health Care System and Factors Currently Undermining It,” by K. Nayeri, 1995, *Journal of Community Health*, 20(4), 321-333; “El Plan de Estudio para la Formación de Médico General Basico en Cuba: Experiencias de su Aplicación,” by M. Pernas Gómez, L. Arencibia Florez, and M. Ortiz García, 2001, *Revista Cuba de Educación Médica Superior*, 15(1), 9-21; “The Cuban Health Care System: Responsiveness to Changing Population Needs and Demands,” by S. M. Santana, 1987, *World Development*, 15(1), 113-125; “Primary Care in Cuba: Low- and High-technology Developments Pertinent to Family Medicine,” by H. Waitzkin, K. Wald, R. Kee, R. Danielson, and L. Robinson, 1997, *The Journal of Family Practice*, 45(3), 250-258; “Living the Revolution: Cuban Health Workers,” by A. Warman, 2001, *Journal of Clinical Nursing*, 10(3), 311-319.

traditional and natural medicine, and clinical rotations in the five basic specialties (Pernas Gómez, Arencibia Florez, & Ortiz García, 2001; H. Waitzkin et al., 1997). Students also were permitted an elective to rotate among some 50 other specialty areas (Cardelle, 1994; Gilpin, 1989). A quarter of the time spent in rotations was devoted to hands-on public health and primary care instruction from medical faculty in teaching polyclinics (Cardelle, 1994).

New texts were developed to integrate clinical, behavioral, and social science theory and methods with population-based epidemiologic approaches (Castro, 1984c; Gilpin, 1989; Pernas Gómez et al., 2001). Public service clerkships (internships) and medical residencies also were instituted to offer practical field experiences in treating the most common health states (Gilpin, 1989). Furthermore, continuing education programs were designed to provide family doctors a deeper awareness of more complex health problems and treatment regimes (Gilpin, 1989).

Once students completed MGB requirements, they began the Comprehensive General Medicine (MGI) module (Diaz Novas & Fernandez Sacasas, 2001). MGI first entailed an obligatory one-to-three year public service clerkship, in which students were generally assigned to health work in a rural community (Demers et al., 1993; Gilpin, 1989; Keck, 1993). A three-year medical residency in generalist family medicine then followed (Demers et al., 1993; Diaz Novas & Fernandez Sacasas, 2001; Iatridis, 1990; MacDonald, 1999; Santana, 1987; Warman, 2001).

All three years of the general family medicine residency were spent in the community, where the medical resident operated as a solo practitioner (Demers et al., 1993). Here, the practicing medical resident was assigned to care for the "same panel of patients" (Gilpin, 1989, p. 464). Although receiving less supervision than medical residents in the US, the local polyclinic staff supported the solo practitioner/medical resident on an as-needed basis (Demers et al., 1993). The polyclinic support team, which consisted of physicians licensed in the five basic specialties, a medical psychologist, and a licensed registered nurse, were the medical resident's core teaching faculty and acted as backup consultants for the solo practitioner's difficult cases (Demers et al., 1993; Veeken, 1995). Additionally, the medical resident completed training in the five basic specialties, worked a weekly evening hospital emergency room shift, and performed hospital rotations in the final year (Diaz Novas & Fernandez Sacasas, 2001).

Cuba's pre-doctoral sequence was readjusted back to a six-year program after the doctor shortage eased in the mid-1970s. Thus, the new curricula extended the training model to as

many as twelve years of classroom and field practice (Demers et al., 1993; Gilpin, 1989). It established two categories of family doctors: the medical resident/solo practitioner, or generalist family medicine physician, and the family medicine specialist. The generalist family doctor had to complete the three-year MGI module and a final assessment to be licensed as a family medicine specialist (Demers et al., 1993; Eisen, 1996).

Cuban medical students were tested upon completion of each course and rotation (Alemañy Perez, Otero Iglecias, Borroto Cruz, & Díaz-Perrera Fernández, 2002a; Demers et al., 1993). Contrary to standards in the US, comprehensive exams were not required before the MGB graduate began a solo practice/medical residency (American Association of Pre-medical Students, 2003; Demers et al., 1993; E. P. Wilkinson, 2002).¹ All generalist family doctors seeking licensure as family medicine specialists, however, had to pass a national exam and submit a written dissertation (Alemañy Perez et al., 2002a; Demers et al., 1993; Parkerson et al., 2001). Furthermore, licensed family medicine specialists were required to make a minimum five-year service commitment to a single community before they were permitted to apply for a second specialty training program (H. Waitzkin & Britt, 1989). A separate three-year residency had to be completed before the licensed specialist family doctor was allowed certification in another specialty area (H. Waitzkin & Britt, 1989).

Political considerations undergirded the student selection process. Medical school applicants had to “present evidence of their communities’ support” (H. Waitzkin et al., 1997, p. 252) to MINSAP for review. In other words, past public service most likely entailed prior community service with the Union of Young Communists or some other PCC-controlled mass organization.

Similarly, MINSAP had final decision-making authority over all licensed family medicine specialists seeking an additional specialty. The number of applicant slots were “strictly controlled and based on national health manpower priorities” (Demers et al., 1993, p. 167). The agency also regulated specialist career moves. Its screening process awarded the most prestigious promotions to regime and party loyalists (Demers et al., 1993).

Cuba’s latter-day family practice movement began with the piloting of the new medical curricula in early 1984 (Demers et al., 1993; Feinsilver, 1993; MacDonald, 1999; Nayeri, 1995; Reed & Frank, 2000; Santana, 1987; K. A. Swanson et al., 1995). However, it was Castro who first conceived the new type of hybrid physician—the family medicine specialist (Alemañy Perez

et al., 2002b; Diaz Novas & Fernandez Sacasas, 2001; Dotres Martínez, 1996c; Feinsilver, 1993; Medina García et al., 2001; Medina Lorente et al., 1998). The next section presents the finding on the development of the family doctor concept and its influence on the health care services system between 1985 and 1992.

Family Doctor-Nurse Model

The family doctor-nurse experiment corresponded with the piloting of the new physician training program in the Luyano neighborhood of the Lawton Polyclinic service area (Castro, 1984a; Delgado García, 1996b; Demers et al., 1993; Diaz Novas & Fernandez Sacasas, 2001; Feinsilver, 1993; MacDonald, 1999; Nayeri, 1995; Reed, 2000a; Reed & Frank, 2000; K. A. Swanson et al., 1995). The polyclinic service catchment was specifically selected, because many of its personnel had been WHO delegates and had extensive community health backgrounds (MacDonald, 1999). Furthermore, the facility was closely associated with the Department of Social and Preventive Medicine at the University of La Habana (MacDonald, 1999).

Most secondary sources asserted that the family doctor movement began with the 1984 Lawton pilot project. Castro, however, claimed that there actually was a second pilot project in the central island municipality of Sancti Spiritus (Castro, 1994). Santana (1987) also confirmed that two pilot programs, one urban and another rural, marked the beginning of family doctoring in Cuba. At the time, Sancti Spiritus was one of the country's most underdeveloped rural provinces (Castro, 1981).

The initial 10-member physician pilot group was composed of six females and four males (Castro, 1984a). By late 1984, 39 other physicians had joined the Lawton group to field test the new approach in 19 other La Habana polyclinic service catchments (Castro, 1984b, 1985e; MacDonald, 1999; Santana, 1987). One influential decision consequent of the group's discussions with Castro was to centralize doctor residences and medical offices (Castro, 1985e). The prototype consultorio situated the family doctor's medical office and residence on the first and second floors of the same structure (Castro, 1985e; Feinsilver, 1993; Gilpin, 1989; Santana, 1987). Castro noted that families were asked to donate a small room or a garage during the initial field tests, because new neighborhood medical facilities had not yet been built (Castro, 1985e, 1994). Later, the Cuban leader called on mass organizations to form social brigades and

build consultorios for family doctors nation-wide (Castro, 1985e; Hernández & Dilla, 1992; Iatridis, 1990; Mathey, 1988; Rodríguez García, 1992; Warman, 2001).²

Neighborhood Configuration

The success of the pilot projects and the island-wide implementation of the family doctor-nurse model in 1985 signaled the official beginning of the fourth sequence in the development of Cuba's health care services system. Castro projected that 20,000 physicians were to be trained to care for every family by the year 2,000 (Castro, 1985b, 1985c; Delgado García, 1996b, 1998; Diaz Novas & Fernandez Sacasas, 2001; Santana, 1987).³

A licensed registered nurse and often a social worker were assigned to each general family medicine doctor, after which the team was placed in an urban neighborhood or rural community anywhere on the island (Gilpin, 1989; Iatridis, 1990; K. C. E. Macintyre & Hadad Hadad, 2002; Martínez Calvo, 1997; Santana, 1987; H. Waitzkin & Britt, 1989). Other family doctor-nurse teams were assigned to schools, employment settings, child and adult day care facilities, and tourism centers (Cuban Ministry of Health: Office of Ambulatory Care, 1995; Gilpin, 1989; MacDonald, 1999; Reed, 2000a; Santana, 1987).

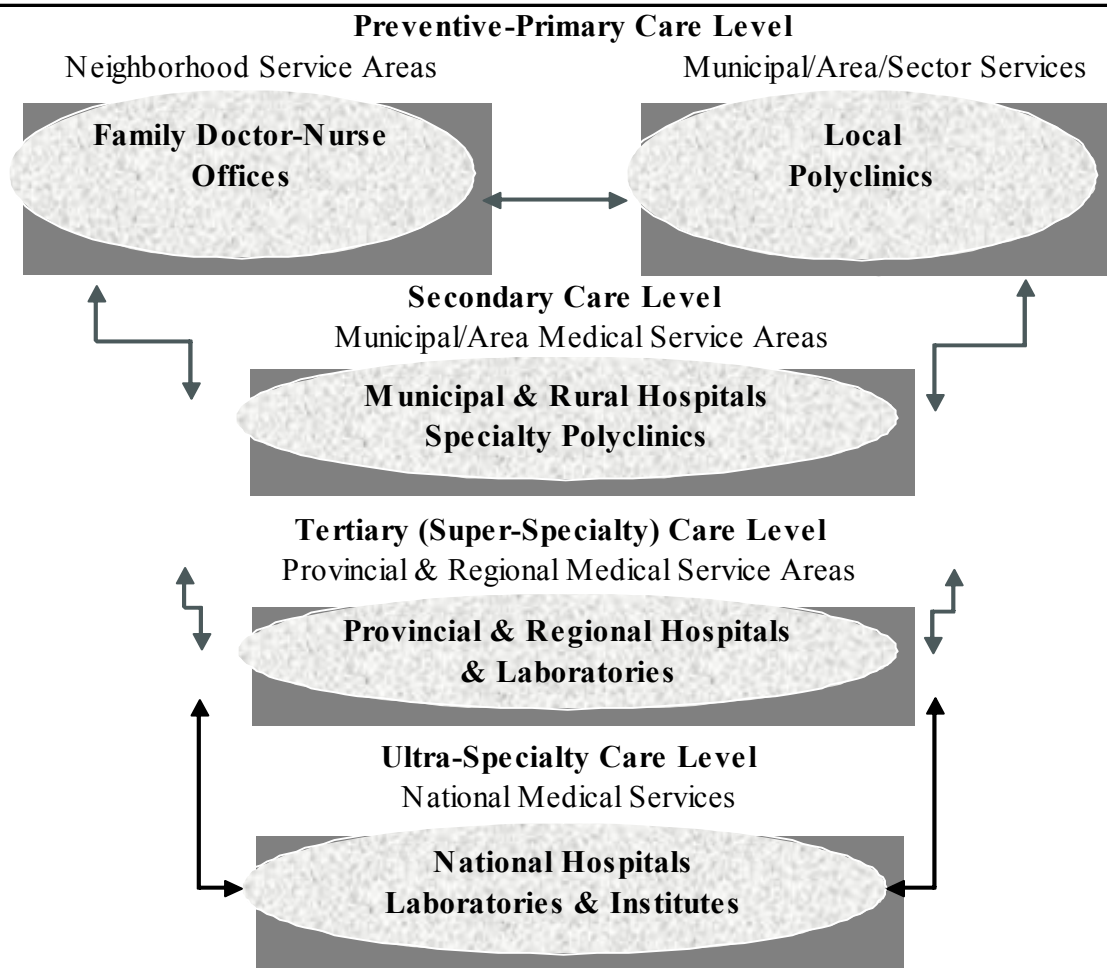
Each team was provided a “fully equipped office and family lodging...geographically situated in the centre [*sic*] of the families served by the practice” (Demers et al., 1993, p. 167). The consultorio generally was located in the same area where the family doctor's medical residency was completed (Demers et al., 1993). The neighborhood consultorio embodied the team's service catchment (Schwar, 2001). In support of the family doctor consultorio, the municipal/rural area structure was re-fortified via newly constructed hospitals, specialty polyclinics, maternity facilities, dental clinics, and homes for older adults and disabled persons (Feinsilver, 1993; Pan American Health Organization, 1999).

Figure 7.1 depicts the re-configuration of health levels and medical service types adopted during the fourth developmental sequence of 1985 to 1992, and which reflects the modern-day health structure. The new geographic arrangement sub-divided municipal/area polyclinic service catchments into neighborhood consultorio zones. Each polyclinic catchment was reorganized to support 30-to-40 family doctor-nurse consultorios (Keck, 1993). Consultorio catchments were arranged into two-to-three block square zones and, therefore, patients resided within several hundred meters of the family doctor's medical office/residence (Castro, 1985e; Keck, 1993;

Schwar, 2001, 2002).

The family doctor and nurse were made responsible for approximately 150 households, or about 600-to-800 residents living in the consultorio service catchment (Alonso et al., 1994; Demers et al., 1993; Diaz Novas & Fernandez Sacasas, 2001; Duran Gondar & Chávez Negrin, 2000; Eisen, 1996; Feinsilver, 1993; Fernández Larrea, Ibarra Salas et al., 2000; Gilpin, 1989; Nayeri, 1995; Pan American Health Organization, 1999; Reed, 2000a; Santana, 1987; Schwar, 2002; Veeken, 1995; Ventres & Hale, 1993; H. Waitzkin et al., 1997). Replacing the Community Medicine polyclinic as the pillar of the health system, the neighborhood-based team

Figure 7.1. Comprehensive General Medicine Health Services Structure, 1984 to Present



Adapted from "Healing the Masses: Cuban Health Politics at Home and Abroad," by J. M. Feinsilver, 1993; A Developmental Analysis of Cuba's Health Care System Since 1959," by T. H. MacDonald, 1999.

now became the main patient entry point to each successive care level and service type, including ultra-specialty and health-related social services, in addition to a newly added in-home care services type (Demers et al., 1993; Diaz Novas & Fernandez Sacasas, 2001; MacDonald, 1999; K. C. E. Macintyre & Hadad Hadad, 2002; Reed & Frank, 2000). Castro touted the home-care aspects of the family doctor-nurse model in 1985, in which he stated that:

the entire country is like a hospital...all the beds in the country are hospital beds....This is such a revolutionary concept that we can ask how that affects the economy...How does it affect the humanization of medicine?...The [family doctor] program makes it possible for many patients to receive attention at the home instead of at the hospital...There are so many who need to have their blood pressure taken every day, and they are hospitalized to make it possible to do so; or because they require a certain injection of what-have-you. (Castro, 1985e)

With the individual and family positioned as the main units of attention, Cuba's entire health perspective was altered so that problems of health were considered inter-related with and indivisible from individual, familial, neighborhood, and community environments (Diaz Novas & Fernandez Sacasas, 2001; Reed, 2000a).

Linkages

Building on the out-patient health center and Community Medicine in the polyclinic approaches instituted during the first and third developmental sequences, the Comprehensive General Medicine Program placed the family doctor-nurse team in consultorios nearest to those for whom they were assigned to care (Delgado García, 1998). Functioning simultaneously as a horizontal and vertical delivery model, the neighborhood team, as the care system's gate-keeper, had the entire health services structure at its disposal (MacDonald, 1999; Reed, 2000a). At the community level, the team worked closest with local polyclinic staffs and hospital specialists (Eisen, 1996).

The 1985 program designated that local polyclinic staffs provide backup care and consultatory services to the neighborhood-based team. Polyclinic services were readjusted to offer integral out-patient services for difficult cases that exceeded the neighborhood team's medical expertise or resources (Gilpin, 1989; MacDonald, 1999; Nayeri, 1995; Santana, 1987; Veeken, 1995). The local polyclinic was expected to perform diagnostic procedures, laboratory

tests, and act as a mini-medical school and continuing education site, in which medical faculty were charged with providing educational services to family doctors, nurses, and medical auxiliaries (Eisen, 1996; Feinsilver, 1993; Nayeri, 1995; Santana, 1987). Still, Cuban researchers (Soberats et al., 1999) found that the educational functions and the organization of instructional activities in the nation's polyclinics in the early 1990s was "far from being best" (p. 363).

Family Doctors and Other Health Service Levels

As previously stated, Cuba was criticized for over-emphasizing hospital-based, curative services during the first three sequences in the development of the health care system, even though this pre-occupation created a world-class high-technology health services infrastructure. At the time the family doctor program was launched and the system was reconfigured, most secondary, tertiary, and quaternary facilities offered CAT scans, organ transplant programs, and a breadth of ante-natal and infant-maternal technological services (Eisen, 1996; Nayeri, 1995; Reed & Frank, 1997; Santana, 1987). Cuba installed Latin America's first nuclear Magnetic Resonance Imaging equipment during this development period (Reed & Frank, 1997).

The family medicine initiative provided that specialty polyclinics and secondary, tertiary, and ultra-specialty hospital staffs work closely with the neighborhood physician in the provision of curative and high technology patient services (Eisen, 1996; Nayeri, 1995; Santana, 1987). Thus, the fourth sequence provided for the expansion of a low-technology, preventive-primary care infrastructure alongside an already well-developed sub-system of institutionalized bio-medical services. While health officials have emphasized that all upper tier services were free to everyone and that no individual was denied treatment based on a pre-existing medical condition, MINSAP required that family doctors provide certifications of medical need for in-patient admittance and receipt of high-technology services (Demers et al., 1993; Schwar, 2001, 2002).

Team Functions

In the general scope of required duties, the family doctor-nurse team was held responsible for integrating various medical, health, and social service types in the provision of comprehensive care to all individuals residing in the team's neighborhood catchment (Iatridis, 1990; Keck, 1993; Reed, 2000a). Working closely with such local mass organizations as the

FMC and CDR, family doctors also were responsible for conducting health education, environmental, and health prevention projects designed to alter high-risk behaviors and improve sanitary hygiene (Diaz Novas & Fernandez Sacasas, 2001; Eisen, 1996; Gilpin, 1989; Iatridis, 1990; Keck, 1993; Reed, 2000a; Santana, 1987). Local mass organizations provided the medical auxiliaries and lay volunteers that assisted the team in such health promotion activities.

The service commitment associated with the family-doctor nurse model rooted the team in a neighborhood for many years (Castro, 1985e; H. Waitzkin et al., 1997). It is difficult to quarrel with the model's compassionate design, in which services were designed to be offered longitudinally by a care team that was well-known to its neighbors/patients. Furthermore, the health education stipulation, which was intended to shift patients from hospitals to local polyclinics, neighborhood consultorios, and in-home care, was socially responsive, humane, and, in the long-run, pragmatic in its health, social, and economic potentials (Castro, 1985e; Feinsilver, 1993; Santana, 1987, 1988; Ventres & Hale, 1993; R. Wright, 1993).

The political function of health education, however, is to dictate the appropriate relationship between society and the individual through a society's institutions (Tesh, 1986). In Cuba, as in Communist China, strong leadership and mass organizations have been the social structures used to alter such long-standing patient behaviors as seeking out hospital services for simple primary care needs, abstinence from health promotion activities, and non-compliance with preventive health monitoring (Morley, Rohde, & Williams, 1983; J. L. Rodríguez, 1988b). Cuba's national program to combat chronic diseases, for example, relied entirely on changing individual behavior through the involvement of mass organization memberships in intensive health education campaigns rather than advocating individual responsibility, as has been the policy in the US (Tesh, 1986; Wills, 2003).

Critics might be tempted to cite Cuban health promotion efforts as yet another demonstration of state authoritarianism, coercive social engineering of the masses, and Castro's autocratic personality (Werner, 1983). Castro's speeches, for example, illustrate the politics of health education and how the judicious use of semantics have made his wishes known to the citizenry. Restrict attention for the moment to the president's assurance that under the family doctor model citizens were free to:

go to the polyclinic—no one forbids it—to see the specialist directly. He does not have to go to his [family] doctor, he can go to the polyclinic, or he can do what he has been

doing until recently. He can go straight to the hospital [Castro laughs]....We try to impose order, discipline, but the citizens have a lot of power in this country; they do not have to see a specific doctor. (Castro, 1985a)

As mentioned in Chapter Three, one's interpretation of whether Castro's remarks provide evidence of strong leadership or the political ideology of health education and state control depends on the observer's value preference.⁴

It is in the family doctor model's community partnering matrix that the important dimensions of health education appeared. The family doctor and nurse were mandated to teach residents to become their partners in health advocacy (MacDonald, 1999). Thus, an individual's untreated health issue might first have surfaced during a mass organization meeting, after which the family doctor was called upon (MacDonald, 1999). Other beneficial community partnering activities have included door-to-door immunization campaigns, condom distribution, informing families about infant-maternal care programs, and the resolution of long waiting periods, equipment and supply shortages, and doctor-patient discontinuities (Iatridis, 1990; Keck, 1993; MacDonald, 1999). More serious examples, though, have involved neighbor-reported self-neglect or the exploitation of an older community member.

Questionable aspects to the advocate-partnering function, however, have confounded the community health education mandate. For example, the family doctor was expected to rely on community volunteers, who made sure that patients kept their scheduled medical appointments and attended neighborhood health presentations (Iatridis, 1990; MacDonald, 1999). Similarly, the team's mandate to respond to the rehabilitative needs of physically and cognitively impaired persons also involved the use of volunteers, who made certain that families participated in therapeutic treatment (Diaz Novas & Fernandez Sacasas, 2001; Feinsilver, 1993; Gilpin, 1989; Keck, 1993; MacDonald, 1999)

Epidemiologic Surveillance

One of MINSAP's most important family medicine stipulations was for the family doctor-nurse team to conduct epidemiologic surveillance as a means of preventing disease through early detection, continuous diagnosis, and treatment (Batista Moliner, 1997; Batista Moliner & Gonzalez Ochoa, 2000; Diaz Novas & Fernandez Sacasas, 2001; Feinsilver, 1993; Gilpin, 1989; Keck, 1993; Reed, 2000a; Santana, 1987). The stipulation called for a rigorous

accounting of all individual and family data across the life course (Reed, 2000a; Santana, 1987; H. Waitzkin et al., 1997). According to age, gender, risk factors, and socio-economic conditions, the team was expected to record each resident's bio-psycho-social status and all preventive-primary care services received (Santana, 1987; Schwar, 2001, 2002; H. Waitzkin et al., 1997). MINSAP further stipulated that the team closely monitor and record the following: ante- and neo-natal-maternal progress, mammography screening and Papanicolaou smear results, immunizations, nutritional needs, familial- and work-related psycho-social stressors, such risk factors as smoking, sedentarism, obesity, alcohol intake, and hypertension, and chronic care follow-up services (Gilpin, 1989; MacDonald, 1999; H. Waitzkin et al., 1997). Under the supervision of a polyclinic-based family medicine specialist, the neighborhood doctor then was expected to review and revise each resident's surveillance record at least monthly, from which a long-term, comprehensive, individually-tailored care plan was constructed or re-adjusted (Fariñas Reinoso & Bouza Suárez, 1999; Reed, 2000a; Schwar, 2001; Valdivia Onega & Zacca Peña, 1999; Veeken, 1995; H. Waitzkin et al., 1997).

MINSAP's surveillance program also entailed the aggregation of patient records to assess the health, social, and environmental needs of each consultorio and sector. Senior polyclinic staff were responsible for compiling all family doctor records, researching timely morbidity, mortality, and environmental trends, and identifying community needs at the municipal/area level (Batista Moliner, 1997; MacDonald, 1999; K. C. E. Macintyre & Hadad Hadad, 2002). In that members of the CRD and FMC, house-wives, and social brigades were expected to assist the team and polyclinic epidemiologists in collecting data, the lay participant became an epidemiological activist (Batista Moliner, Gandul Salabarría, & Lázara Díaz González, 1996).

It has been estimated that family doctors generated about 80 percent of Cuba's national vital health statistics (Batista Moliner, 1997). Polyclinic epidemiologists compiled and forwarded community profiles to appropriate provincial and national health agency analysts (Batista Moliner, 1997). High-level analysts and administrators then used this information to map disease patterns, forecast long-term trends, develop policy responses, secure resource allocations, and respond to specific health events (Batista Moliner, 1997; Gilpin, 1989; K. C. E. Macintyre & Hadad Hadad, 2002; H. Waitzkin et al., 1997) (Theresa Froletas, personal communication, June 28, 2001). MINSAP, however, required that the family doctor report critical or unusual neighborhood health events directly to the National Department of Statistics

and Analysis within 24 hours via telephone, fax, and, in some cases, electronic mail (Batista Moliner, 1997).

The Comprehensive General Medicine planning model called for the gradual extension of the national-provincial computerized network to municipal/area level polyclinics (Batista Moliner, 1997; Santana, 1987; H. Waitzkin et al., 1997). Future plans also called for family doctor consultorios to be linked to the network (Schwar, 2001). Once established, it was envisioned that health professionals would have in-office access to a data-base of national-to-neighborhood level health data, or what Santana (1987) described as an “epidemiologist’s dream” (p. 118). As with its polio vaccination model, it was predicted that Cuba’s prototype would offer the developed and developing nations an example of advanced epidemiologic surveillance (Davis, 1998; H. Waitzkin et al., 1997).

In partnership with local epidemiological activists, the family doctor-nurse team was required to make an annual presentation on the neighborhood’s health situation to residents living in the catchment (Eisen, 1996). As part of the presentation, local health risk factors, morbidity and mortality characteristics, social and hygienic information, and the outcomes of health promotion activities were recounted (Eisen, 1996). Based on this information, residents then decided the best-approaches to address the neighborhood’s future health needs (Eisen, 1996). The meetings also served as neighborhood balloting sites, in which residents elected delegates to local health commissions (Eisen, 1996).

Results of Surveillance

Building on improvements made after 1965, the family doctor epidemiologic surveillance model was found to have filled gaps in local morbidity and mortality statistics and generated new data on neighborhood-level health behaviors (Iatridis, 1990). Consequently, the localized system improved the quality of national vital health statistics (Iatridis, 1990). Thus, the surveillance function was well-positioned to address Cuba’s epidemiologic transition, as well as emergent and re-emergent communicable diseases (Batista Moliner et al., 1996).

Insufficient training designs, however, were found to have created ineffective community partnering models, which were used to enlist local volunteers in the collection of neighborhood and community health data (Fariñas Reinoso & Bouza Suárez, 1999; Pérez Cardenas, 2002; Rodríguez Jústiz & Zayas Vinent, 1997). Additionally, local health professionals often failed to

include the lay community in surveillance activities, even when they had been enlisted to participate (Rodríguez Jústiz & Zayas Vinent, 1997). Nevertheless, these deficiencies affected the comprehensiveness of local data more than the reliability of national vital health statistics reported during the period 1985-1992 (Rodríguez Jústiz & Zayas Vinent, 1997).

Medical Histories

The aggregation and reporting of patient medical histories was considered fundamental to family doctor surveillance. For example, MINSAP required that each family physician keep patient medical records of primary care services rendered at the local polyclinic on file in the consultorio when possible (Cuesta Mejías & Presno Labrador, 1997). Family doctors, however, reported this administrative task to be inconvenient (Cuesta Mejías & Presno Labrador, 1997).

The finding implied that family doctors simply were free to ignore the directive. In that polyclinics also kept and forwarded this information to the national level, the problem was not believed to have threatened the reliability of vital health statistics. However, duplicative record-keeping consequent of the Family Medicine Program underscored the administrative excesses that were found to have overtaxed the local practitioner and contributed to professional apathy toward comprehensive record-keeping (Fariñas Reinoso & Bouza Suárez, 1999).⁵ Furthermore, MINSAP's surfeiting requirements represented an inefficient use of the family doctor's resources that contributed to systemic costs. These types of inefficiencies became a central concern for the leadership almost immediately following the collapse of financial and trade ties with the former Soviet bloc in 1989 and the onset of the economic crisis of the special period.

Care Regime

The family doctor-nurse approach assimilated and further developed the Community Medicine in the polyclinic approach to evoke a new direction in preventive-primary care (Diaz Novas & Fernandez Sacasas, 2001). Under the Comprehensive General Medicine Program, MINSAP was made responsible for legislating the duties, functions, and care regimes of the neighborhood team. These official schedules were detailed in the manual, The Work Program of the Family Doctor and Nurse, Polyclinic, and Hospital (Feinsilver, 1993).

The national health agency obliged family doctors to enroll all residents in the team's catchment, regardless of the person's health status (Keck, 1993). It further required that the team

conduct at least two comprehensive annual examinations of every resident; one in the consultorio and one at home (Keck, 1993; K. A. Swanson et al., 1995; Veeken, 1995; H. Waitzkin et al., 1997).

There were no restrictions placed on the number of patient-initiated visits to the consultorio (Feinsilver, 1993). Consultorio-based care visits encompassed both scheduled and walk-in patients (Demers et al., 1993). On average, the team saw as many as 15 patients during morning office hours and engaged in as many as 35 daily consultations (Demers et al., 1993; Veeken, 1995). Residents were permitted to visit any family doctor in the local polyclinic's service area if they were dissatisfied with their assigned neighborhood physician (Keck, 1993). Moreover, Poder Popular granted residents the authority to vote out a family doctor with whom a majority of residents in the neighborhood catchment were displeased (Keck, 1993)

MINSAP operations regime stipulated that family doctors see patients in the medical office every weekday morning, one evening each week, and one Sunday morning every month (Demers et al., 1993; Feinsilver, 1993; Gilpin, 1989; Keck, 1993; Santana, 1987; K. A. Swanson et al., 1995). Despite its established hours-of-operation, the health agency gave the neighborhood team the flexibility to accommodate the needs of the patient rather than forcing the individual to conform to the team's fixed schedule (Feinsilver, 1993). Thus, family doctors were obliged to be on call 24 hours-a-day, 7 days-a-week, although the local polyclinic staff was responsible for providing backup and vacation coverage (Castro, 1985e; Demers et al., 1993; Diaz Novas & Fernandez Sacasas, 2001; Feinsilver, 1993; K. A. Swanson et al., 1995).

Castro addressed the potential problems of patient over-utilization and possible abuse of family doctor time in a 1985 speech (Castro, 1985e). After conferring with doctors on the subject, Castro was informed that the "people who take the best care of the doctor are the neighbors" (Castro, 1985e, p. 9). Conveying the implicit intention of MINSAP's directive, however, the president also informed citizens that:

the neighbor may want to see the doctor at 0300, 0400, 0600 [3am, 4am, 6am]...Instead of a lack of consideration toward the doctor, what they want least is to bother him. What they want most is for the doctor to be happy. We are sure that none of these persons is going to wake up a doctor except under exceptional circumstances, because they are going to take care of the doctors. And besides, the serious cases are going to decrease because they have the diagnosis, and they know what the treatment is. So we do not

believe that the fact that they [patients] live there [in close proximity to the consultorio] is going to become a grave problem for any doctor. (Castro, 1985e. p. 9)

Veeken (1995) found that family doctors were rarely asked to make night or emergency calls, because of the availability of 24-7 urgent care services at local polyclinics and municipal/rural area hospitals. Santana's research (1995), meanwhile, confirmed that community health education efforts further reduced the need for urgent family doctor care.

In-Home Care

The provision of in-home examinations and other care services, particularly for non-ambulatory patients, persons undergoing rehabilitation therapy, the chronically ill, and older individuals, was clearly articulated in MINSAP's work manual (Castro, 1984b; Demers et al., 1993; Reed, 2000a; H. Waitzkin et al., 1997). The team was obliged to provide close daily supervision to all home-care patients (Demers et al., 1993; Santana, 1987). Furthermore, every individual or family request for a home visit was expected to be granted (Veeken, 1995).

The in-home visitation regime called for the team to make house calls on weekday afternoons (Demers et al., 1993; Feinsilver, 1993; Gilpin, 1989; Keck, 1993; Santana, 1987; K. A. Swanson et al., 1995). Some home visits provided same-day follow-ups to patients who had visited the consultorio in the morning (Demers et al., 1993; Santana, 1987). Both ambulatory and non-ambulatory chronically ill individuals were seen at home on a monthly basis, while high risk patients were to receive weekly home examinations (K. A. Swanson et al., 1995). As will be detailed in Chapter Eight, a new program announced in 1992 expanded the family doctor's specific responsibilities to attend to the special care needs of older individuals (Bertera, 2003; Feinsilver, 1993; Prieto Ramos, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003; Schwar, 2001, 2002).

The ability to observe patients in their home also provided family doctor-nurse teams the opportunity to evaluate other aspects of the domestic environment. Here, MINSAP regulations stipulated that the team assess psycho-social factors that might contribute to individual and family health maintenance or improvement (Castro, 1985e; Demers et al., 1993). During one of these home-visits, for example, the team may have determined that the individual or family required health education information, needed such social services as food, clothing, or transportation, or, in the case of substance and domestic abuse, offered intervention and

counseling services (MacDonald, 1999; Schwar, 2002).

Veeken (1995) discovered that some family doctor home visits were made unannounced. The researcher noted that these 'surprise visits' (Veeken, 1995. p. 2) served to keep the doctor in touch with the family and patient. They also were believed to be valuable in the detection of self-neglect or isolation among older individuals. For Castro's critics and the average Western observer, however, this specific family doctor activity raises concerns about invasion of privacy.

Longitudinal Care Duties

As part of the gate-keeper role, the neighborhood physician also was expected to be a patient advocate (Feinsilver, 1993). The family doctor was mandated to regularly visit the hospitalized patient, engage in inter-consultations with polyclinic and hospital specialists, and was made responsible for coordinating care services no matter what the health problem, the degree of required medical attention, or the service level to which the patient was referred (Diaz Novas & Fernandez Sacasas, 2001; Feinsilver, 1993; Keck, 1993; MacDonald, 1999; Reed, 2000a; Veeken, 1995; H. Waitzkin et al., 1997). When possible, the family doctor was to accompany the patient to far-away health facilities to assist in the formulation of hospital treatment regimes (Castro, 1984b; Demers et al., 1993; Diaz Novas & Fernandez Sacasas, 2001; Keck, 1993; H. Waitzkin et al., 1997). Should the patient have decided to bypass the family doctor and accessed emergency hospital services directly, MINSAP's instructions to hospital staffs specified that the family doctor be contracted in order to follow-up on the urgent care visit (MacDonald, 1999).

Throughout the development period 1985-1992, the neighborhood catchment was designated the main service domain of the family doctor. As such, visits to hospitalized patients were generally social (Demers et al., 1993). Although given the responsibility of service coordination, MINSAP prohibited the family physician from writing hospital orders (Demers et al., 1993).

Following a hospital discharge, however, the family doctor was expected to attend to the patient's long-term reintegration into the home and neighborhood by orchestrating and managing post-hospitalization health and social services (Castro, 1984b; MacDonald, 1999; Reed, 2000a; H. Waitzkin et al., 1997). Reintegration also required the family doctor to involve the nurse, social worker, medical auxiliaries, and lay community members in such other health-related

issues as work, finances, and family dynamics (H. Waitzkin & Britt, 1989). Thus, the mandate for continuous involvement permitted the physician to remain a key actor in the individual's entire life schema (Diaz Novas & Fernandez Sacasas, 2001; Gilpin, 1989; Iatridis, 1990; MacDonald, 1999; H. Waitzkin et al., 1997).

Medical Discourse

The family doctor-nurse approach radically altered traditional forms of care provisioning (H. Waitzkin & Britt, 1989). It established a reciprocal environment, in which the health team, the patient, family members, and neighborhood residents were expected to work together to identify and resolve individual and family problems (Diaz Novas & Fernandez Sacasas, 2001; Susser, 1993; H. Waitzkin & Britt, 1989). As a united community, residents also were expected to ameliorate social problems that influenced health outcomes, such as sanitation and vector control (Diaz Novas & Fernandez Sacasas, 2001; H. Waitzkin & Britt, 1989).

The physician-as-neighbor concept and state-dictated income schedules, meanwhile, were designed to abridge socio-economic conditions that might otherwise have separated the patient from the doctor (Santana, 1987; Schwar, 2001, 2002; H. Waitzkin et al., 1997). At the interpersonal level, the longitudinal aspects of the holistic care approach and the model's participatory dimension also served to bring the patient and doctor nearer. In direct contrast to the Western approach to doctor-patient relations, both the context and structure of the Cuban health encounter were modified to create a more suitable environment for an intimate patient-doctor relationship (Feinsilver, 1993; Iatridis, 1990; Santana, 1987; Schwar, 2002; H. Waitzkin & Britt, 1989).⁶

The medical discourse aspects of the family doctor model were remarkably similar to the Chinese approach during the Cultural Revolution (H. Waitzkin & Britt, 1989). Chinese health teams that included barefoot doctors, traditional healers, para-professionals, community advocates, and political representatives carried revolutionary activities into the health domain (Benyoussef & Christian, 1977; Osborn & Ohmans, 1999; H. Waitzkin & Britt, 1989). Consequently, patients assumed a more egalitarian and activist role in the medical encounter, demanded more information from physicians, and asserted more control over medical decisions (H. Waitzkin & Britt, 1989). As in Cuba, Chinese health teams also attended to socio-economic issues related to patient health (H. Waitzkin & Britt, 1989). Unlike Cuba, however, Mao's

passing, the end of the Cultural Revolution, and globalization resulted in China's return to the Western paradigm of a more marginalized patient-doctor relationship in the 1980s (H. Waitzkin & Britt, 1989).

The nascent medical culture of the Cuban family doctor approach did not completely remove the obstacles to effective inter-personal patient-doctor communications. Between 1985 and 1992, most family physicians were young and lacked the life experiences, communications skills, and psychological tools necessary to fully develop egalitarian doctor-patient relationships (Feinsilver, 1993; Gilpin, 1989). Still, family doctor training, which was founded on a socio-political, ethical, and moral structure of solidarity, public service, and humanism, was inclined to minimize the care-giver's socio-economic and professional dominance over the patient (Did Núñez, 2000; Dotres Martínez, 1996c). Living and working in the same neighborhood as the patient also imparted a value system that supported a more egalitarian and effective health encounter (Did Núñez, 2000; Gilpin, 1989; Santana, 1987).

The majority of Cuba's initial cohort of family doctors were peasants and laborers born in the 1960s, whereas, prior physician cohorts came from the more affluent families of the pre-revolutionary period (Feinsilver, 1993). Furthermore, the 1985 educational reforms discarded the Western-oriented medical training model. As a result, the family doctor approach moved the nation nearer to Castro's vision for a new type of physician in the technical sense of everyday doctoring and in the ideological framework of a neighborhood health activist-advisor to citizens and families (Feinsilver, 1993).

Outcomes of Comprehensive Medicine and the Family Doctor-Nurse Model

Maturation of Cuba's health system between 1985 and 1992 revamped medical education, produced a new family medicine specialty and a new type of hybrid physician—the family doctor—and injected a sub-layer of integral curative-preventive-primary care services deep into each polyclinic service catchment (Feinsilver, 1993). Both the Comprehensive General Medicine Program and the family doctor-nurse model advanced a holistic, life course approach to family care and human development (H. Waitzkin et al., 1997). Swanson et al. (1995) observed that the community orientation, public health, and epidemiologic surveillance aspects of family doctoring realigned the health system more with nursing than with the theories, concepts, and practices traditionally used to formulate institutional, curative, physician-based

care models.

After years of invariable change, the family doctor approach stabilized the health system and satisfied patient demands (Castro, 1985e). The neighborhood-based consultorio design, along with the public service and medical residency requirements offered the potential for the family doctor to live in the same neighborhood and provide around-the-clock care for the same patients (Demers et al., 1993; Gilpin, 1989). Guaranteed housing and the equalization of all medical specialist salaries provided additional incentives for family doctors to remain in the same community and same panel of patients for many years (Gilpin, 1989; H. Waitzkin & Britt, 1989). Thus, family doctors and nurses established long-lasting and intimate relationships with their neighbor-patients to improve health encounters through a longitudinal approach to comprehensive care (Gilpin, 1989; Iatridis, 1990; Schwar, 2001, 2002).

Health Outcomes

Increased access to preventive-primary care services was one of the most stunning improvements consequent of modifications to the health structure after 1985 (Carbonell García & Ramón Lambert Matos, 1996; Keck, 1993). A ten-fold increase in the number of family doctor consultations was recorded between 1986 and the early 1990s (Carbonell García & Ramón Lambert Matos, 1996). Furthermore, the holistic approach of bio-psycho-social care, comprehensive examinations, health promotion efforts, in-home services, and more intimate doctor-patient consultations supported the family doctor's attendance to about 95 percent of all health issues (MacDonald, 1999). Polyclinics and hospitals, therefore, were at liberty to concentrate on more serious health needs that exceeded the abilities and resources of the neighborhood team (Gilpin, 1989; Keck, 1993; Veeken, 1995).

These factors produced an inverse relationship between family doctor and polyclinic visits (Feinsilver, 1993; Santana, 1987). Similarly, as the number of patient visits to the family doctor increased, hospital admissions declined; a 30 percent decrease in hospital admissions by the early 1990s had the added effect of reducing the number of laboratory tests and X-ray services (Eisen, 1996; Santana, 1987). Castro specifically noted reductions in hospital bed use, X-ray film and laboratory test expenditures, and the unnecessary prescription and use of medicines during the first year that family doctors offered preventive in-home health services (Castro, 1985e). What is more, shorter hospital stays, and fewer referrals to in-patient care

facilities and to urgent care units were recorded after 1985, particularly at the secondary services tier (Carbonell García & Ramón Lambert Matos, 1996; Gilpin, 1989; Keck, 1993; MacDonald, 1999).

In a comparison of regions with and without family doctor-nurse teams just four years after the introduction of the model, Gilpin (1989) found the following: infant mortality rates were reduced significantly; morbidity from mumps, measles, and German measles decreased; and rates (per 1,000 persons) of diagnosed hypertensives, diabetics, and asthmatics increased by more than 100 percent, 37 percent, and 231 percent respectively. All of these improvements were ascribed to improved comprehensive screening and follow-up techniques (Gilpin, 1989). Another independent study (Santana, 1987) of neighborhood surveillance activities, meanwhile, found that improved medication management reduced over-prescribing and unnecessary patient medication use in just two years after family doctors began practicing.

Qualitative Outcomes

Throughout Cuba's three former developmental sequences, systemic effectiveness was gauged exclusively by quantitative health measures (Diaz Novas & Fernandez Sacasas, 2001). Under the Comprehensive General Medicine initiative, however, MINSAP began using a mixed methods approach, in which more qualitative, results-oriented indices and benchmarks were introduced to measure family doctor achievements (Cortes Alfaro et al., 2000; Diaz Novas & Fernandez Sacasas, 2001; Feinsilver, 1993; Jiménez Cangas et al., 1996; Sala et al., 1998). Within the qualitative rubric, the psycho-social dimensions of patient satisfaction took on a new importance (Batista Moliner, 1997; Feinsilver, 1993; Gilpin, 1989).

Numerous studies (Eisen, 1996; Feinsilver, 1993; Gilpin, 1989; Keck, 1993; Medina Lorente et al., 1998) credited the family doctor program with garnering high levels of user satisfaction. In comparison to the previous approaches, for example, a large majority of users reported in 1989 that they enjoyed the family doctor program, the security it offered, and had more confidence in the team approach (Eisen, 1996). Equally important, a 1991 study (Borroto Cruz & Reinoso Medrano, 1991) linked the model to increased citizen satisfaction with the government.

Castro's interests in citizen perceptions of the new health approach were evident in a series of speeches delivered soon after the model's implementation in 1985. In one speech, the

president stated that:

This is something that was of great concern to families, the increasingly growing distance between the doctor and the citizen...because the citizen has a doctor in the factory for any kind of problem...the worker feels safer...If that worker is at home, his family is at home, they also have the doctor there...But this is not a doctor they have to visit to receive attention, the doctor comes to the house. If it is a problem of depression, of diabetes, or a cardiac nature, then the doctor knows he has to go see him. They get accustomed to this service...They may give him an injection, but at least the doctor is there, and this greatly increases the sense of security. (Castro, 1985d, p. 9)

Castro later observed that “the first big battle was winning the trust of the people, trust in the family doctor and trust in this institution” (Castro, 1989a, p. 2). Returning to the subject in early 1990s, Castro noted the behavioral changes in patients brought about by a new sense of security in the family doctor, when he remarked:

It was obvious since the beginning that the people welcomed the family doctor with confidence...They no longer went to the polyclinic...In fact, one of the serious problems we had at the time was that no one trusted the polyclinics...They knew that personnel with more experience, meaning the professors, were at the hospitals...The hospitals’ outpatient facilities were crowded...Based on that experience, we saw that instead of going to the polyclinic, the people went to visit the family doctors. (as cited in Alvarez & Mariela Diaz, 1994, pp. 1-2)

Patient Satisfaction and the Immediate Post-Cold War Economy

Global events after 1989 had a deleterious impact on health and the health care system (American Association for World Health, 1997; Barry, 2000; Garfield & Santana, 1997; Keck, 1993; Kuntz, 1994; Nayeri, 1995; Reed & Frank, 1997; The World Federation of Public Health Associations General Assembly, 1994). As detailed in previous chapters, the collapse of the Soviet trade bloc immediately isolated the tiny island nation from world markets. By the end of the fourth developmental sequence in 1992, the leadership faced both an economic and health tragedy as Cuba’s export base disintegrated, food imports were cut in half, the flow of almost all imported medicine and health-related products to the island ceased, and skyrocketing deficits in health care and social welfare budgets made deep program cuts inevitable (American Association

for World Health, 1997; Flavin, 1997; Garfield & Santana, 1997; Pan American Health Organization, 1999). However, although elder health status had deteriorated by the early 1990s, the family doctor model was credited for mitigating a more acute and widespread health disaster (Chelala, 1998; Reed & Frank, 1997).

Ninety-eight percent of the respondents surveyed in 1991 reported that they were satisfied with the family doctor care they received (Diez Córdoba et al., 1991).⁷ However, users were most dissatisfied with family doctors regarding the distribution of pharmaceuticals. Eighteen percent of all patients in need of medicine were unable to obtain prescriptions from their neighborhood physicians (Diez Córdoba et al., 1991). By 1991, the loss of imported medicine and raw materials already had begun to deplete national pharmaceutical reserves. Patients, therefore, projected their dissatisfaction onto the health provider with whom they had the most contact.

User Knowledge

Community participation in health was another index that MINSAP used to measure family doctor achievements. Inadequate training, however, was found to have prevented neighborhood physicians from developing effective partnering models that inspired voluntary participation in health activities (Fariñas Reinoso & Bouza Suárez, 1999). Even so, MacDonald (1999) concluded that the family doctor model had developed greater participatory-advocacy skills among residents. Likewise, Warman (2001) found that the model had produced a well-informed citizenry on such topics as diseases, treatments and, in many instances, precise medicines required to treat specific conditions.

World Acclaim

International praise for Cuba's accomplishments appeared soon after the institution of the neighborhood-based health team concept. In 1985, for example, the American Public Health Association recognized the Castro government for having achieved the WHO goal of *Health for All* a quarter century before the year 2000 target date (American Public Health Association, 1985). The then-director of the WHO visited Cuba in 1985, after which the organization and numerous other health groups followed suite and acknowledged the family doctor approach as a landmark development and a major contributor to global health advancements (Castro, 1985d; World Health Organization, 1998a, 2000b, 2000d).

World acclaim also piqued academics (MacDonald, 1999; Reed & Frank, 2000). As this dissertation already reported, various comparative studies placed Cuba on par or as having superceded the health accomplishments of many developed nations, let alone the developing world. One such study (Roemer, 1993) concluded that Cuban family medicine had changed mortality patterns to achieve health equality and a level of health equity without the socio-economic or racial/ethnic disparities produced under the British family medicine model.

Scholarly presentations on the Cuban approach made at world health conferences provided additional evidence of the legitimacy of the family doctor model among academics. One of the earliest examples was the 2nd International Seminar on Primary Health Care in 1988 in La Habana, in which health representatives and scholars from the Americas, the former Soviet bloc, Scandinavia, and global health organizations offered both formal and informal acclamations about the model's contributions (Castro, 1988; Feinsilver, 1993).

Strength in Numbers

The doctor-patient quotient achieved under the Comprehensive General Medicine Program was one of the key reasons that international entities lauded Cuba's family doctor model. The WHO had recommended that every nation should have 1 doctor per 1,000 population (Wallerstein, 2000). Cuba, however, had established a ratio of one physician for every three hundred citizens by 1990 (Keck, 1993; MacDonald, 1999). The US physician per capita ratio that same year was 1:463 (Keck, 1993).

Within one year of Castro's 1985 promise to train and deploy 20,000 family doctors throughout the island, more than one million Cubans or about 10 percent of the total population had been brought under the care of some 2,500 family doctor-nurse teams (Feinsilver, 1993). Sixty percent of the population was under the care of almost 12,000 family practitioners by 1990 (Feinsilver, 1993; Gilpin, 1989; Iatridis, 1990). Independent research (Feinsilver, 1993; MacDonald, 1999) found that by the end of the fourth development sequence in 1992, Castro had met and, in fact, surpassed his 1985 promise.

Cost/Benefit

Apart from the benefits of universal health coverage and family doctor services, researchers outside Cuba questioned the wisdom of maintaining such a large number of

physicians, particularly as the nation appeared to be entering the worst of the special period in 1991 (Alonso et al., 1994; Feinsilver, 1993; Iatridis, 1990; Veeken, 1995). The leadership had anticipated significant increases in health, educational, and social service expenditures associated with implementing and expanding the family doctor model nationally (Castro, 1985e; Diaz Novas & Fernandez Sacasas, 2001). Due to modest family doctor salary schedules dictated by MINSAP, however, the direct costs of physician labor were found to be relatively small compared to supply, equipment, housing construction, and educational outlays (Santana, 1987). A Cuban hospital director, for example, received about the same \$400 (peso) monthly salary (\$US20) as a state-paid agricultural worker in the early 1990s (Mesa-Lago, 1993a; Veeken, 1995). The average monthly income for a self-employed farmer, meanwhile, would have been as many as three times that of a Cuban physician (Mesa-Lago, 1993a). Monthly family medicine specialist salaries, which were equivalent to those of other physician specialists, also were around \$US20 (Demers et al., 1993; Schwar, 2001; K. A. Swanson et al., 1995).

Because almost 75 percent of all health-related outlays in the late 1980s went to hospitals, long-term savings via reductions in the number of hospitalizations and high-technology services related to chronic disease treatment were expected to offset expenditures on the family doctor program (Gilpin, 1989; Santana, 1987). As early as 1984, however, offsetting savings and expenditure projections fostered the belief that the system easily could accommodate 65,000 family doctors (Castro, 1984b). Furthermore, Castro suggested that:

this movement to train doctors has been so strong that no matter how extensive and ambitious our plans, there will come a time when we will have [*sic*] surplus of doctors... We are not there yet... We will go as high as 75,000.... This includes the replacement doctors for the sabbatical year. (Castro, 1989b, p. 2)

Although concerns over rising labor costs heightened as the economic crisis worsened in 1991 and 1992, Castro's sabbatical strategy remained part of the policy debate, because it partially addressed other worries about administrative stresses that already were taxing family doctors.

The Cuban people, however, were the most important consideration in the cost/benefit models that MINSAP circulated into the early 1990s. The general consensus among citizens was that the right to universal health care, the state's obligation to provide those services, and a more humanistic medical structure took precedence over health cost savings, as well as other social expenditures (Iatridis, 1990; Santana, 1987; The Economist (US), 1999a). Cuban citizens openly

expressed an unwillingness to sacrifice the benefits they had gained under family doctor care, even if it meant sacrificing other social amenities (Feinsilver, 1993).

Cuba's Comprehensive General Medicine Program and the family doctor-nurse approach rehabilitated patient trust in the health care services system. Systemic developments between 1985 and 1992 placed the responsibilities of gate-keeping and preventive-primary care service delivery with the family doctor (Feinsilver, 1993). However, because traditional specialists still out-numbered new family medicine specialist graduates in the early 1990s, the health care system at the time remained largely "in the hands of internists, pediatricians and obstetricians" (Demers et al., 1993, p. 167). The medical orthodoxy, therefore, continued to enjoy more prestige among the health professions than family doctors (Gilpin, 1989; Veeken, 1995).

Given its short history, even the calcitrant observer must admit the remarkable systemic and health changes that occurred under the family doctor model in the period 1985-1992. Cuba was one of the few nations embarked on a path toward comprehensive, longitudinal, neighborhood-based family medicine. Although the family doctor approach effectively prevented an insidious health catastrophe, the economic crisis after 1989 inarguably impeded its development (Frag, 2002). The struggle to preserve family medicine and the nation's other public health achievements remained Cuba's most pressing issues in 1992 (Castillo Guzmán & Arocha Mariño, 2000; Delgado García, 1996b; Gunn, 1992; Pérez Hoz, del Rosario Morena Lazo, Rodríguez Fontes, Pérez Murguía, & Santos Benacourt, 2001).

Despite the setbacks and obstacles the presented in the early 1990s, however, Castro announced a new initiative in 1992 to explicitly address the needs of older Cubans (Delgado García, 1996b, 1998). With the creation of the Central Latin American Institute for the Third Age (CITED), a new cohort of gerontologists were asked to design an original approach that brought all prior elder care programs and services under a single policy umbrella (Delgado García, 1996b, 1998; Schwar, 2001, 2002). Chapter Eight presents the secondary source findings on the fifth and final sequence in the development of the health system—Cuba's long-term elder care services system and the National Comprehensive Care Program for Older Adults.

Chapter Eight

Findings on the Development of the Long-Term Elder Care Services System

Public health policy in the developing world specifically targeting older individuals was largely non-existent before the 1970s (Apt, 1990; Dotres Martínez, 1996b; Duran Gondar & Chávez Negrin, 2000). Cuba, for example, had almost no pre-revolutionary gerontological health tradition (Bertera, 2003; Dotres Martínez, 1996b). Its sole geriatric facility was a small private mutualist operation for mainly affluent patients (Bertera, 2003; Dotres Martínez, 1996b).

In principle, Cuba's doctrine of social equity was carried into the health and social welfare arenas in the immediate post-revolutionary era (Bertera, 2003; Garfield & Santana, 1997). Although health, economic, and social safety net programs were available to the older population, they generally were incorporated into the broader welfare structure; explicit public health spending on aging during the 1960s was limited to preserving some 20 church-operated nursing homes (Bertera, 2003; Dotres Martínez, 1996b; Garfield & Santana, 1997; Justiz Gonzáles et al., 1999; Schade, 1986). The changing age structure and epidemiologic transition of the later 20th Century, however, brought the distinctive issues and needs of older Cubans to the fore (Díaz-Briquets, 2002; Donate-Armada, 2001; Duran Gondar & Chávez Negrin, 2000; Garfield & Santana, 1997; MacDonald, 1999; María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Perdoma Victoria et al., 1999).¹

This chapter offers secondary source findings on the development of Cuba's long-term elder care response. The first section presents a run-up to the 1990s with regard to the nation's changing age structure, epidemiologic transition, social programs that affect older persons, the influence of the dispensarization health approach on latter day elder care practices, and antecedents of the 1992 national response to population aging—the National Comprehensive Care Program for Older Adults. The next section takes up the fifth developmental sequence of Cuba's health system, in which the national policy's institutionalization became the foundation of the long-term elder care services system. The policy's initial outcomes and potential impact on perceived health equity and health inequity will be discussed in the final section.

Changing Age Structure and Epidemiologic Transition

Cuban population aging is commensurate with the global aging phenomenon (Caballero, Naranjo Arroyo, & Fong González, 2002; Díaz-Briquets, 2002). The marked expansion in both

the number and proportion of older persons with extended life expectancies is projected through 2050 (Donate-Armada, 2001; Martínez Almanza et al., 1999). This trend follows steadily declining crude mortality rates and increasing life expectancy throughout the 20th Century, in addition to rapidly decreasing fertility and infant-maternal mortality rates after the 1960s.

The aging phenomenon in Cuba, however, is more approximate to the developed nations than the lesser developed world (Caballero et al., 2002; Díaz-Briquets, 2002). With the exception of Argentina and Uruguay, change in its age structure preceded that in other developing countries (Díaz-Briquets, 2002). The premature shift in Cuba's age structure was largely consequent of the great health campaigns, universal health care, and the international emigration of younger Cubans following the 1959 Revolution (Díaz-Briquets, 2002; Donate-Armada, 2001; Hernandez, 1992; Martínez Almanza et al., 1999).

Population aging entails the proportional upsurge in individuals age 60 years or older relative to the population as-a-whole and principally to those age 14 years or younger (Duran Gondar & Chávez Negrin, 2000). Table 8.1 offers a snapshot of Cuba's changing age structure from 1950 to 2050. Note the concomitant increase in the 15-to-59 age group and declivitous trend in the youngest age group from the late 1970s through the 1980s.

Growth among Cuba's older population increased the number of individuals age 60 years or older from 72,000 in 1899 to over 1.5 million in 1998 (Duran Gondar & Chávez Negrin, 2000; Prieto Ramos, 2000). Likewise, the percentage of older Cubans increased incrementally at the same time crude death rates declined throughout the 20th Century. For example, life expectancy at birth more than doubled from 33.2 years in 1900 to 76.8 years in 2000 (Martínez Almanza et al., 1999; World Health Organization, 2002c). Although figures are available for the later half of the 20th Century only, the United Nations (2002c) calculated a 34.5 percent decrease in Cuba's crude death rate per 1,000 persons (constant fertility variant).

By the turn of the millennium, about 14 percent of the total population was age 60 years or older, which was about twice the proportion in such lesser developed nations as Costa Rica and Mexico, and already equal to the 2025 world estimate (Prieto Ramos, 2000; United Nations, 2002b). The projections, though, indicate that one-fourth of all Cubans will be age 60 years or older by 2025, when 55 percent of all adults in this age range will be female (Martínez Almanza et al., 1999). By 2050, more than a third of the total population is projected to be age 60 years or older, while it is estimated that 29 percent of all Cubans in this demographic range will be age 80

years or older (United Nations, 2002b).

Cuban gerontologists cite declining fertility rates, which have been below the internationally recognized replacement level for three decades, as another major contributor to the changing age structure (Duran Gondar & Chávez Negrin, 2000).² For example, the rate for women age 15-49 declined 43 percent between 1985 and 1996 (Pan American Health Organization, 1998b). Between 1993 and 2003, the total fertility rate of 1.6 births per woman fell to 1.55 (Pan American Health Organization, 1998a). In contrast, the US had a rate of 2.1 births per female throughout the last decade of the millennium, while Costa Rica's rate declined from 3.12 to 2.77 between 1993 and 2003 (Pan American Health Organization, 1998a).

Table 8.1. Proportional Population Distribution for Select Years by Age Groups 0-14, 15-59, 60 or Older

Year	Age Group		
	0-14	15-59	60+
1950	35.8	56.9	7.3
1970	36.9	54.0	9.1
1975	37.3	52.8	9.9
1981	30.3	58.8	10.9
1991	22.4	65.5	12.1
2000	21.2	65.1	13.7
2025	16.0	58.9	25.1
2050	15.4	50.6	34.0

Adapted from "Las Personas de Edad en Cuba: Principales, Tendencias, Demográficos y Morbimortalidad," by L. Martínez Almanza, J. Menendez Jimenez, E. Caceres Manso, M. Baly Baly, E. Vega Garcia, E., and O. Prieto Ramos, 1999, *Resumed*, 12(2), 77-79; "World Population Ageing 1950-2050: Cuba," by United Nations, 2002.

Cuba's great health campaigns, the extension of universal health and social services, and modern medical advances, produced an epidemiologic transition after the 1970s, in which declining morbidity and mortality rates corresponded to increasing life expectancy (Bertera, 2003; Castillo Guzmán & Arocha Mariño, 2000; Dotres Martínez, 1996b; Perdoma Victoria et

al., 1999). Tables 6.1 and 6.2 underscore the transition, in which such non-transmittable diseases as cancer and heart and cerebrovascular disease replaced such communicable and parasitic illnesses as poliomyelitis, tuberculosis, malaria, and gastroenteritis as the leading causes of sickness and death. Consequent of the epidemiologic shift, life expectancy at birth, which was 33.2 years in 1900, increased from 58.8 years to 76.8 years in the four decades following the 1959 Revolution (Duran Gondar & Chávez Negrin, 2000). The proportion of newborns expected to reach age 60 years is projected to increase from the current figure of 75 percent to 87 percent by 2010 (Valencia, 2003).

Furthermore, whereas the number of expected years of life after age 60 was 15.5 in 1950, the figure had reached 20.5 years by the mid-1980s (Dotres Martínez, 1996b). Today, Cuban women who reach age 60 are projected to live another 21.1 years, while Cuban males are projected to live another 19.5 years (Martínez Almanza et al., 1999). For all Cubans who reach age 80, the current life expectancy is 87.6 years (Dotres Martínez, 1996b; Martínez Almanza et al., 1999).

Because chronic illnesses are more prevalent among older individuals than younger population groups, it became apparent by the late 1970s that major age-related expenditures would be required (Dotres Martínez, 1996b; Martínez Almanza et al., 1999). Thus, Cuban scholars joined the global debate over whether the aging phenomenon was a positive or problematic event (Duran Gondar & Chávez Negrin, 2000; María del Rosario Abreu Vázquez & Muñoz Peláez, 2001; Pan American Health Organization, 1990). For some Cuban gerontologists, population aging was viewed as a “medical and social problem” (Fernández Larrea, Clua Calderin, Baez Duenas, Ramirez Rodriguez, & Prieto Diaz, 2000, p. 1). For others, it was a symbol of the nation’s health achievements that could stimulate the economy in terms of potential demand for new age-related goods and services (Duran Gondar & Chávez Negrin, 2000). The general consensus, however, was that Cuba’s changing demographic and epidemiologic profile would place additional strains on health, social, agricultural, labor, and family resources (Martínez Almanza et al., 1999). However, the leadership’s initial age-related policy responses evolved piecemeal within the socialist framework for egalitarian welfare.

Social Safety Net

Cuba’s social welfare structure is composed of a far-reaching safety net of public

benefits, services, and subsidies. Since 1991, Social Security pensions, education, and health care have been the three largest expenditure areas (see Table 8.2). Health care, education, pensions, food assistance, and subsidized housing are safety net benefits that are available to the entire population (Alonso et al., 1994). Although egalitarian in design, the following paragraphs detail social welfare features that most affect older citizens.

Table 8.2. Main National Expenditures, 1986-1996

Expenditure Type	Year				
	1986	1989	1991	1994	1996 ^a
Social Security ^b	896.5	1,093.9	1,225.7	1,532.4	1,630.0
Education	1,640.2	1,650.6	1,504.0	1,334.4	1,430.0
Health	769.7	904.5	924.9	1,061.1	1,180.0
Defense	1,268.2	1,259.4	882.2	651.2	602.0
Housing & Community Services	443.7	406.4	280.2	316.1	470.0
Administration	530.2	489.9	400.2	354.2	357.0
Welfare ^c	83.3	101.1	88.4	93.7	150.0

Note. In millions of pesos. ^a1996 planned expenditures. ^bPension, disability and survivor benefits. ^cSubsidized food ration and other social assistance programs.

Adapted from "Cuban Health Care in the Nineties," by G. Reed and M. Frank, 1997, For World Health, Washington, DC.

Social Security

A decade before the US passed the Social Security Act of 1935, Cuba had instituted a pension schema, which, by 1958, covered certain urban labor groups through an ungainly association of 52 self-directed programs (Derthick, 1990; Pérez, 1998). During the 1960s and 1970s, legislative actions rallied extant programs and enlarged pensioner coverage (Pérez, 1998). Munificent coverage that was peripheral to the general pension schema, however, was granted to internal security and military personnel under separate laws (Donate-Armada, 1994).

In 1979, a major component of the safety net was formalized in Law 24 and a regulatory Social Security framework (Donate-Armada, 1994). This Social Security arrangement featured two benefit structures: 1) a regime that afforded a spectrum of benefits to all insured individuals and their beneficiaries; and 2) Ayuda Económica (Economic Aid or Social Assistance), which

provided benefits to all uninsured persons (Bertera, 2003; Donate-Armada, 1994; Pérez, 1998). The intent of both regimes was to equitably distribute benefits to all citizens in the form of free medical and dental care and in-patient medicines, pensions for retirees, disabled citizens, and surviving spouses and children of insured persons, financial assistance to unemployed workers, the sick and injured, and women on maternity leave (Donate-Armada, 1994; Pérez, 1998).

As the economic crisis pushed Cuba into its special period, pension and health-related benefits accounted for 98 percent of the total Social Security outlay (Donate-Armada, 1994). Although the statistics are extremely divergent, the pension regime alone comprised between 54 percent and 81 percent of all 1989 Social Security expenditures (Donate-Armada, 1994; Pérez, 1998; Reed & Frank, 1997).³ Even so, Social Security may be the Revolution's most important age-related bequest, because older Cubans are recipients of the greatest share of all health pension, and disability resources (Donate-Armada, 1994; Martínez Almanza et al., 1999).

Retirement Structure

Generally, the male retirement age is 60 years and 55 years for Cuban women with 25-year service records (Donate-Armada, 1994; Pérez, 1998). Male workers may retire at age 55 and female employees at age 50, however, upon completion of 11-years of service in a dangerous job (Donate-Armada, 1994; Pérez, 1998). Taken collectively, Cuba's retirement age and increased life expectancies produce a more lengthy pension period than in most Latin American countries and many nations of the Americas (Pérez, 1998).

The pension income for retirees equals half of the average salary, which is based on the 5 highest annual income levels of the last 10 years of work, in addition to 1 percent of the average annual salary per service year beyond 25 years of work (Donate-Armada, 1994; Pérez, 1998). The computation also includes a higher wage-earner cap, which reduces by half any annual average income level that exceeds \$3,000 pesos (Donate-Armada, 1994; Pérez, 1998). Furthermore, the schema promotes the continued employment of older workers; extraordinary increases of between 1.5 and 4 percent are awarded to persons who delay workforce departures beyond the general pension age stipulation (Bertera, 2003; Donate-Armada, 1994; Pérez, 1998).

Food Security

As with all citizens, older Cubans receive a free monthly food ration (Benjamin &

Collins, 1985). The allowance provides between 20 and 50 percent an individual's monthly nutritional needs (Alonso et al., 1994; Olshan, 1998). Additional purchases represent an out-of-pocket expense that can be made at state-run farmer's markets, dollar stores, and from private farmers (Schwar, 2002).⁴

The state-distributed ration book (*libreta*) contains 22 items, including the following: rice, beans, and sugar (8lbs. each per month); bread; condensed milk; eggs (4 per week); a 14-day supply of meat (2.5 kilos per month); coffee; bath soap and detergent; alcohol; and tobacco (Alonso et al., 1994; Schwar, 2001; Veeken, 1995).⁵ Ration stores, which are located in every urban center and scattered throughout rural Cuba, distribute monthly food allowances (Schwar, 2001). However, the state supplies ration stores with stocks that are commensurate with a community's specific level of need (Schwar, 2001). This information is received via lay volunteers, who conduct local food need surveillance activities (Bertera, 2003; Schwar, 2001).

Following the cessation of Soviet food imports, an emergency program that was established in 1989, but abandoned in 1992, provided extra rations to older persons, particularly those living alone and designated by their family doctor as special social cases (Garfield & Santana, 1997). Social cases refer to economically and/or medically disadvantaged persons with limited family support. Emergency rations and pensions notwithstanding, about 12 percent of all urban families headed by retirees could not afford to meet basic food needs during the economic crisis, particularly during the worst years of the special period between 1991 and 1994 (Delgado, 1995; Martínez Almanza et al., 1999).

Through the late 1980s, the government generally adhered to the equitable distribution of social assistance benefits (Bertera, 2003; Garfield & Santana, 1997). The same egalitarianism was embedded in health service provision. The next section, however, explores the evolution of a health practice that today stands out for its visceral gerontological focus.

Dispensarization

Modeled on the Soviet dispensary concept, Cuban dispensarization was initially used to identify population groups according to health status and risk for such chronic diseases as asthma, diabetes mellitus, and hypertension (Batista Moliner, 1997; Batista Moliner, Sansó Soberats, Feal Cañizares, Lorenzo, & Corratgé Delgado, 2001; Feinsilver, 1993; Gilpin, 1989; Justiz Gonzáles et al., 1999; María del Rosario Abreu Vázquez & Muñoz Peláez, 2001). In the

1970s, local polyclinic staffs were assigned to assess such vulnerable groups as infants through two years of age, pregnant women, older individuals, and marginalized persons (Batista Moliner, 1997). Later, the typology was modified to include care protocols for these four health groups (see Table 8.3). The four classifications were: asymptomatic persons; those at risk; people who

Table 8.3. Dispensarization Typology and Care Protocols

Group	Health Classification	Care Protocol
I	Apparently healthy	Annual or bi-annual examination
II	At Risk	Bi-annual examination
III	Manifest illness/disease	Bi-annual examination
IV	Deficiency, incapacity, complication	Tri-annual examination

Adapted from "La Atención Primaria en Cuba: El Equipo del Médico de la Familia y el Policlínico," by G. Eisen, 1996, *Revista Cubana de Salud Pública*, 2; "La Dispensarización: Entre lo Normado y lo Posible," by F. J. Sansó Soberats, A. Fernandez Pérez, and M. Larrinaga Hierrezuelo, 1999, *Revista Cubana de Medicina General Integral*, 15(6), 605-612; "La Dispensarización: Una Vía para la Evaluación del Proceso Salud-Enfermedad," by R. Batista Moliner, F. J. Sansó Soberats, P. Feal Cañizares, A. Lorenzo, and H. Corratgé Delgado, 2001, *Revista Cubana de Medicina General Integral*, 17(2), 109-120.

were symptomatic; and individuals who exhibited some health-related deficiency, suffered partial or total impairment, or had a morbidity-related complication (Batista Moliner et al., 2001; Eisen, 1996). In the mid-1980s, MINSAP applied dispensarization to all integral health care and promotion functions, ordered family doctors to conduct the evaluations, and established 1998 as the target date for the total population to be covered under the model (Delgado García, 1998; Sansó Soberats, Fernandez Pérez, & Larrinaga Hierrezuelo, 1999).

Family Doctors and Dispensarization

The family doctor model improved access to preventive-primary care services for the entire population. Dispensarization, however, enabled the neighborhood physician to pay greater attention to vulnerable sub-populations (Garfield & Santana, 1997; Justiz Gonzáles et al., 1999; Reed, 2000a). Because the risk for and prevalence of chronic diseases presented most in the older population, the dispensarization model provided the family doctor a method, in which to

target older persons with specific and protracted care regimes (Feinsilver, 1993; Gilpin, 1989; MacDonald, 1999).

Dispensarization-CARE Process

Under the dispensarization model of the 1980s, the family doctor-nurse team was mandated to complete an initial bio-psycho-social examination before referring the older patient to the local polyclinic, where a complete clinical history and necessary laboratory tests were performed (Eisen, 1996; Reed, 2000a). The comprehensive health synopsis was used to design individual treatment regimes based on the appropriate clinical protocol (Eisen, 1996; Reed, 2000a). Depending on the patient's classification, the care protocol (see Table 8.3) was carried out via family doctor referrals to medical personnel at the various health services levels. Therefore, the purpose of dispensarization, which is now called Continuous Assessment and Risk Evaluation (CARE), was to identify at-risk persons, diagnose emergent health problems, and manage existing conditions longitudinally (Reed, 2000a). Once again, lay volunteers were used to ensure that local residents actively participated in the CARE process (Bertera, 2003).

Despite MINSAP's universal coverage mandate, one study (Pérez Caballero, Cordiéz Jackson, & Vásquez Vigoa, 1998) found that only 10 percent of all adults had been diagnosed and categorized via the CARE model. A human resource assessment (Sansó Soberats et al., 1999) inferred that the vast duties MINSAP had placed on the family doctor contributed to the shortfall. Hence, it was suggested that some family doctor obligations be shifted to the polyclinic and that the typology be revamped to improve diagnosis and treatment processes (Sansó Soberats et al., 1999).⁶

CARE is just one facet Cuba's health safety net. An essential byproduct of the technique, however, was to identify older individuals in need of specialized attention. This precise form of risk assessment and treatment, in addition to a number of internationally supported health initiatives, were fundamental to gerontological research findings, upon which the Castro government based its initial responses and the contemporary approach to population aging.

Precursors of the National Response to Aging

A 1985 PAHO-assisted study in Cuba that was part of a regional action plan assessed chronic disease risk factors and other age-relevant issues to support the formulation of

population-based, non-communicable disease prevention campaigns (Martínez Almanza et al., 1999; MEDICC Review, 2000; Pan American Health Organization, 1990).⁷ Two major findings were that almost 69 percent of all older Cubans were hypertensive and that over half of all diagnosed and newly reported older hypertensives had sedentary life styles (Martínez Almanza et al., 1999).⁸ Additionally, about 60 percent of the older population was found to have some degree of vision impairment, 30 percent reported hearing difficulties, and more than a third smoked tobacco (Duran Gondar & Chávez Negrin, 1997; Martínez Almanza et al., 1999). Although Cuba lacked a vigorous aging research agenda at the time, the 1985 analysis defined a myriad of study questions for future investigations (Prieto Ramos, 1999a; Schade, 1986).⁹

Chronic Disease Control Efforts

In 1974, MINSAP representatives took part in the 13-nation WHO Community-based Program for the Control of Hypertension (MEDICC Review, 2000). Building on this program and the 1985 PAHO study findings, the Cuban health agency developed the so-called 1995 Global Cienfuegos Project for the purpose of managing and decreasing non-communicable chronic diseases through behavior modification (MEDICC Review, 2000; Pérez Caballero et al., 1998). The project was credited with reducing high blood pressure from 43.9 percent to 38.5 percent among participants over a four-year period (Alvarez-Li, Espinosa Brito, Ordunez Garcia, & Silva Aycaquer, 1999; MEDICC Review, 2000; Ordunez Garcia, Espinosa Brito, Cooper, Kaufman, & Nieto, 1998). Covering 51 municipalities by 1996, MINSAP expanded the project island-wide in 1997 as the National Program for Hypertension (Pérez Caballero et al., 1998).

With over 98 percent of the population under family doctor care by early 1998, MINSAP again revised its hypertension control efforts. The neighborhood care team was ordered to mold prevention activities around local epidemiologic profiles, and rely more heavily on community participation and consciousness-building (MEDICC Review, 2000). The agency also ordered the family doctor to follow diagnosed hypertensives more closely and provide more regular examinations and counseling to achieve desired behavioral change (MEDICC Review, 2000).

A hypertension program evaluation in late 1998 concluded that the effort's family doctor focus had increased the number of diagnosed and treated patients by 25 percent (MEDICC Review, 2000; Pérez Caballero et al., 1998). A second evaluation, meanwhile, revealed that the program had begun equalizing rural-urban disparities. For example,

hypertension was controlled in almost half of the entire urban and rural adult population in Matanzas Province (Pérez Caballero et al., 1998).

Re-emergent Transmittable Diseases

Epidemiologic research after the mid-1980s underscored the need to reorient health and educational approaches on aging to combat preventable non-communicable diseases (Feinsilver, 1993; Martínez Almanza et al., 1999). Unquestionably, research data pointed to traditional Cuban culture as a major contributor to risk behaviors associated with such chronic conditions as hypertension (Feinsilver, 1993). However, the notable reappearance of communicable diseases, particularly after 1989 and the onset of the economic crisis, represented yet another issue leading up to Cuba's national gerontological policy announcement in 1992 and its implementation after 1997 (Martínez Almanza et al., 1999; Reed, 2000a). For example, the crude death rate from acute respiratory illnesses rose from 228.9 to 283.8 per 100,000 persons in the period 1995-1996 alone (Martínez Almanza et al., 1999).¹⁰

Psycho-Social Aging Research

With an aging research agenda beginning to take shape, several psycho-social studies (Antonio Aja Díaz, 2000; Duran Gondar & Chávez Negrin, 2000) were produced during the early 1990s, the most salient of which (Duran Gondar & Chávez Negrin, 1997) correlated elder health risk factors with deficient socio-economic resources. It found that the rising cost-of-living during the economic crisis had deflated retiree pensions to the point that incomes covered only minimal needs and were wholly inadequate to meet other basic necessities. Although family doctor care was found to be acceptable, respondents at the time were most dissatisfied with medicine, food, eyewear, and hearing aid shortages.

Building on the 1985 PAHO study findings, which associated elevated hypertension rates with sedentarism among elders, psycho-social research during the early 1990s linked sedentarism with high rates of social isolation (Duran Gondar & Chávez Negrin, 1997). The majority of the older subjects had not enrolled in the two primary social organizations for older persons, namely senior citizens' clubs (Grandparents' Clubs) and retiree trade union groups, nor had they participated in religious activities. At issue was the lack of formal community organizations that were attentive to their interests and could employ their life experiences in some useful and

beneficial manner. Daily leisure time was confined to watching television, listening to the radio, and resting. More than 30 percent had not maintained relationships with old friends and the same proportion reported they had no friends. Meaningful family contact, however, was cited as the chief source of loneliness.

Cuba has a rich cultural tradition of inter-generational reciprocity. In addition to housing constraints, this tradition has contributed to multi-generational living arrangements, in which 91 percent of all older persons live with family members or kin, more than a third of all families have at least one member over age 60, and 16 percent of all families care for a disabled older neighbor (Dotres Martínez, 1996c; Duran Gondar & Chávez Negrin, 1997; Valencia, 2003). In contrast, 7.5 percent of all older Costa Ricans lived alone in the mid-1980s; the statistic was as high as 17 percent among rural residents age 80 years or older (Pan American Health Organization, 1990).

The Cuban state considers the family to be the “fundamental source of support for most elderly [*sic*]...not simply *one* of the players in the elderly’s [*sic*] social support system” (Duran Gondar & Chávez Negrin, 2000, p. 7). As a result of urbanization, job opportunity, and the immigration and emigration of younger persons, however, Cuba experienced a social shift after the 1970s, in which traditional inter-generational support weakened (Antonio Aja Díaz, 2000; Dotres Martínez, 1996b; Duran Gondar & Chávez Negrin, 2000; Valencia, 2003). Increasingly, many families were unable to help older members without government assistance (Dotres Martínez, 1996b; Valencia, 2003). This trend was evident in the psycho-social research of the early 1990s (Duran Gondar & Chávez Negrin, 1997), in which a majority of the older subjects reported that young people were disrespectful, overlooked their needs, and provided no assistance.

More alarming for researchers, however, were findings that more than half of all older adults considered their lives to be empty and that more than 30 percent exhibited depressive symptoms (Duran Gondar & Chávez Negrin, 1997). The older subjects had not reported feeling useless or fearful of life circumstances. However, they expressed that they felt bored, sad, and on the verge of crying. Only 20 percent felt hopeful about the future. The major source of meaningful social engagement, though, was solving personal health issues.

By the early 1990s, Cuba faced a labyrinth of age-related challenges. The re-emergence of communicable illnesses compounded the chronic disease profile of a rapidly aging population. Despite pensions and social assistance, more than 40,000 older adults needed additional

sustenance (Dotres Martínez, 1996b). Moreover, the erosion of traditional inter-generational support exacerbated the longer-term challenges of providing for the majority of older persons living with their families, as well as the 9 percent living alone; 13 percent of all older persons reported that family conflict disrupted traditional filial assistance (Acosta, 1998; Dotres Martínez, 1996b; Pan American Health Organization, 1990). Two antecedents of the 1992 national policy on aging, however, represent the first formal attempts to address the specific needs of older Cubans integrally.

Circuitos and Casas

The creation of Grandparents' Clubs (*circulos de abuelos*) in the late 1970s represents the leadership's effort to assist families with older members, combat social isolation, and tackle such chronic disease risk factors as sedentarism through an integrated service framework (Feinsilver, 1993; Gilpin, 1989; MacDonald, 1999; Morales & Acosta Lastra, 1991; H. Waitzkin & Britt, 1989). One key addition to the model after 1985 was for the family doctor to organize morning exercises for older neighborhood residents, which were led by a trained exercise specialist (Feinsilver, 1993; Gilpin, 1989; MacDonald, 1999). Later, MINSAP ordered a newly educated cadre of gerontological-geriatric specialists to support club health promotion activities (Greene, 2003).

In addition to social engagement opportunities, the clubs helped participants resolve problems via mutual assistance and self-help programs (Prieto Ramos, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003). As with the Committees for the Defense of the Revolution (CDR) and the Cuban Women's Federation (FMC), club members assisted in health campaigns, provided child day-care, and performed other community work (Greene, 2003). Though most community work was based on Guevara's moral incentive philosophy, some projects provided club members supplemental income (Greene, 2003). For example, club participants networked with artisan groups to provide paid public performances (Greene, 2003; Hernández Cabeza, Martínez Pérez, Rodríguez Brito, & Hernández Font, 1999).

By the late 1980s, the number of clubs had grown to 3,000 with a membership of 120,000 persons (Greene, 2003). Consequently, the clubs became an important lobbying entity. With Poder Popular as a direct conduit to local political representatives, club members were positioned to recommend and direct state responses to the local needs of older citizens (Santana,

1987).

A 1991 study (Morales & Acosta Lastra, 1991) assessed the bio-psycho-social effectiveness of the Grandparents' Club concept. It found that the health promotion and exercise components reduced smoking, obesity, and sedentarism. Accordingly, participants were found to have lowered their blood pressure, improved physical fitness test results, increased mobility functions, experienced less respiratory distress, and reduced medicine intake. Community work, meanwhile, was found to have improved the members' sense of well-being and self-esteem through a more active social life, community recognition, and supplemental income (Greene, 2003; MacDonald, 1999; Morales & Acosta Lastra, 1991).

Based on these successes, MINSAP created an institutional version of the Grandparents' Clubs (Valencia, 2003). Under the direction of medical specialist-nurse teams and with the aid of community volunteers, Casas de Abuelos (Grandparents' Homes) were established. The Grandparents' Home was designed as an adult day-care facility that incorporated most Grandparents' Club activities, but added rehabilitation and recreational functions to the model (Schwar, 2002; Valencia, 2003; H. Waitzkin & Britt, 1989).

International Precursors of the National Policy on Aging

Meaningful discourse on global aging first occurred at the 1948 UN General Assembly (María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Martínez Almanza et al., 1999). With the aging phenomenon still largely unaddressed, the UN in the late 1960s called for a world conclave on the subject (María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Martínez Almanza et al., 1999). The 124 member-states attending the World Assembly on Aging in 1982 developed an action plan that urged international entities and individual nations to make fundamental organizational changes within the contexts of the life course, human development, human rights, employment, education, health, housing, families, disability, and the advancement of women (Antonio Aja Díaz, 2000; Bertera, 2003; María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Martínez Almanza et al., 1999; United Nations General Assembly, 1983).

One Cuban offshoot of the 1982 National Assembly on Aging was the creation of the Geriatric and Gerontology Society. The society's original membership of eight internal medicine and family doctor specialists was rooted in the bio-medical geriatric tradition (Sociedad Cubana de Geriatría y Gerontología, 2002). By 1987, the organization's members, many of

whom Castro later appointed to the Central Latin American Institute for the Third Age (CITED), the nation's main aging policy and research institute, established gerontological-geriatric medicine as a new medical specialty and spearheaded the formulation of the 1992 National Comprehensive Care Program for Older Adults—the national policy on aging—and implementation of the long-term elder care services system after 1997 (Sociedad Cubana de Geriátría y Gerontología, 2002).¹¹

Concomitant with growing international interest in population aging was the WHO Health for All by the Year 2000 project, in addition to its Healthy Communities initiative. The latter initiative stemmed from the First International Conference on Health Promotion (Better Health Channel, 2003; World Health Organization, 1986). While centered mainly on the industrialized countries, conferees responded to increasing prospects for a new worldwide and regional public health movement (Greene, 2003; World Health Organization, 1986).

The 38 countries in attendance, including MINSAP representatives, identified critical policy actions to achieve Health for All project objectives through such promotional strategies as supportive environments, alliance building, and reducing the health equity gap (Better Health Channel, 2003; World Health Organization, 1986). A critical charter provision supported WHO positions on health as a national resource and the use of multi-dimensional promotion policies to maximize population health potentials (Greene, 2003; Justiz González et al., 1999; MacDonald, 1999; World Health Organization, 1986). Equally important, was an emphasis on the combined efforts of governmental policy, populations, communities, and individuals to enable “people to increase control over, and to improve, their health” (World Health Organization, 1986, p. 1). Thus, a direction that Cuba helped pioneer centered on the notion that public health programs could be improved by affecting individual responsibility in health maintenance, lifestyle change, and community mobilization (Greene, 2003; Justiz González et al., 1999).

1978 Cuban Aging Program

Anticipating the 1982 World Assembly on Aging conference, the Castro government instituted the National Program for Elders in 1978 (Valencia, 2003). Its aim was to provide a dignified life for the growing number of residents in Old Persons' Homes, or so-called hogares de ancianos (Valencia, 2003). As such, the policy dealt exclusively with the institutional side of the long-term care equation.

Recall that the notion of long-term in Cuba in the late 1970's was patterned on the Western concept. The Western long-term care idea generally focuses on such institutional residential services as nursing homes, such non-institutional settings as the home and adult-day care operations, and public-private financing vehicles (Holstein & Mitzen, 2001; Scharlach & Kaye, 1997; Schwar, 1998). By the 1990s, the concept of long-term elder care in Cuba had evolved into the idea of the holistic and longitudinal provision of all health, medical, institutional, non-institutional, social, and economic resources to older persons (Schwar, 2001, 2002).

PAHO-supported elder health research was underway in such Latin American nations as Argentina, Chile, Costa Rica, and Cuba by the mid-1980s (Justiz Gonzáles et al., 1999; Martinez Calvo, 2001; Pan American Health Organization, 1990). Its Cuban contribution was the 1985 National Survey of People over 60 (Martínez Almanza et al., 1999). The study's most important finding was that almost 70 percent of all older persons had at least one chronic disease (Martínez Almanza et al., 1999).

The 1978 Cuban National Program for Elders, internationally supported aging studies, and the other developments conferred thus far highlight the mounting effects of population aging on Cuban policy-making. Through the late 1980s, the state re-adjusted population-based social welfare services incrementally and met emerging age-related challenges through uneven program experimentation, enlargement, and recapitulation. As in the past, a phase of integration and further expansion followed these initial gerontological responses.

Cuba embraced the onset of the post-Cold War Era in 1989 with a substantive, albeit, imperfect system that had begun targeting the unique needs of older citizens. The Social Security regimes provided subsistence pensions, food rations, limited medicine coverage, and most important, cost-free health care to the older population. Via the family doctor, CARE, international assistance, and a growing body of aging research, a more ample services framework had been created to identify, holistically treat, and follow-up on long-term elder care needs.

As the economic crisis of the special period worsened, however, Castro ordered a large-scale study in October 1990 to chart national development through the end of the decade (Escuela Nacional de Salud Pública, 2001). The leadership unenthusiastically adopted the study recommendations to introduce market-like instruments in such key sectors as tourism (Delgado, 1995). However, Castro's insistence that social achievements be maintained and citizen demand

for safety net protections be satisfied were accompanied by directives to embark on a gerontological revolution within the Revolution (Delgado, 1995).

Fifth Developmental Sequence, 1992-Present

As part of the overarching 1990 national development study, Castro ordered MINSAP to assess and make recommendations about the future of the health system (Dotres Martínez, 1996b). The agency assembled 51 experts and 19 collaborators to survey sectoral health care providers throughout the nation, including representatives of the Society for Gerontology and Geriatrics (Escuela Nacional de Salud Pública, 2001). The group produced a 333-page document, which identified a total of 183 problems within ten issue areas (Dotres Martínez, 1996b; Escuela Nacional de Salud Pública, 2001; Pérez Hoz et al., 2001).

Table 8.4 presents the results of the sectoral analysis. Inadequate services for older adults and shortages in synthetic and natural pharmaceuticals were among the top-rated difficulties facing local health providers. The National School of Public Health, in the meantime, reported four additional problems: 1) patients were dissatisfied that family doctor consultorios were frequently left unattended; 2) family doctor-nurse teams were unmotivated; 3) family doctor consultorios and polyclinics were under-utilized; and 4) hospitals had failed to institute service capacity rationalization plans (Escuela Nacional de Salud Pública, 2001).

From this priority matrix, health administrators created a political, theoretical, conceptual, and operational framework to address six broad objectives, three of which were directly related the nation's aging citizens:

- expand health care services for the older population;
- increase this population's level of satisfaction with health care; and
- develop and use natural and traditional medicines and techniques in the treatment of chronic conditions (Escuela Nacional de Salud Pública, 2001; Jiménez Cangas et al., 1996; Pérez Hoz et al., 2001).

The MINSAP action plan also called for an expansion of in-home care services, de-bureaucratization of family doctor administrative duties, improvements to care-provider competency and professional fulfillment, and reformation of the transmittable and chronic disease programs (Escuela Nacional de Salud Pública, 2001).

Instead of simply acting on these recommendations, however, Castro saw the need for an

entirely new approach (Dotres Martínez, 1996b; Escuela Nacional de Salud Pública, 2001; Pérez Hoz et al., 2001). In May 1992, the Cuban president founded the Central Latin American Institute for the Third Age (CITED), staffed it with leading gerontological-geriatric specialists, ordered the group to operationalize MINSAP's age-related proposals, unify the disjointed sub-system of elder care programs, services, and organizations with the nation's cultural, sports, and

Table 8.4. 1990 Sectoral Health Priorities and Problems by Rank Order

Sectoral Issue	Ranking	Number of Identified Problems
Non-transmittable Diseases	1	37
Transmittable Diseases	2	30
Primary Health Care	3	23
Care for Older Adults	4	21
Medications and Natural Medicines	4	21
Hospital Care	5	12
School of Public Health	6	9
Maternal-Infant Care	7	8
Dental Care	8	7
Technological and Institutional Care		
Entry Points	8	7
Optical Care Services	9	5
Ambulance and Health Transportation Services	<u>10</u>	<u>3</u>
Total Number of Identified Problems		183

Adapted from "Programa MEDICC: Estancia: La Salud Pública en Cuba," by Escuela Nacional de Salud Pública, 2001, La Habana, Cuba.

recreational institutions, and bring all of these functions under a single, overarching, coordinative policy (Delgado García, 1996b, 1998; Dotres Martínez, 1996b; Martínez Almanza et al., 1999; Prieto Ramos, 1999b, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003; Schwar, 2001, 2002).¹² During the 10th anniversary meeting of the World Assembly on Aging in 1992, Castro announced Cuba's new policy on aging—The National Comprehensive Care Program for Older Adults (Dotres Martínez, 1996b). Formal implementation of the program began five years

later in 1997 (Prieto Ramos, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003).

Long-Term Elder Care Services System

The 1992 long-term elder care policy, which remains in place today, has a number of key characteristics. Foremost, individuals must be age 60 years or older to participate (Prieto Ramos, 1999a, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003). Second, it embraces the bio-medical, psychological, and social concepts of the holistic health approach (Prieto Ramos, 1999a, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003).

The new policy incorporates three sub-programs into the 1985 Comprehensive General Medicine Program, the local guide for practicing family doctor-nurse teams and polyclinics (Prieto Ramos, 2000). Thus, these inter-locking sub-programs, or so-called levels of attention, are superimposed onto the four-tiered health care services structure illustrated in Figure 7.1. The three sub-programs are the community, institutional, and hospital levels of attention (Programa de Atención al Adulto Mayor en Cuba, 2003). The Social Security regimes for health, pension, and social assistance, organizations for older adults, and other socio-political structures are integrated at the community and institutional levels (Prieto Ramos, 2000). Hospital-based geriatric services comprise the third sub-program (Programa de Atención al Adulto Mayor en Cuba, 2003). The hospital level of attention includes other institutional services that are not part of the second level, such as national bio-medical research laboratories. Hospital-level services expressly support community and institutional care providers.

To better understand the contemporary long-term elder care services system, one must recognize Cuba's all-encompassing arrangement. This, however, may make the demarcation between elder care services difficult. Assuming a hypothetical scenario, in which the patient's worsening condition progresses linearly, a clock-wise flow chart (see Figure 8.1) can be used to untangle the integrated, non-linear continuum of community-to-hospital-level service options.

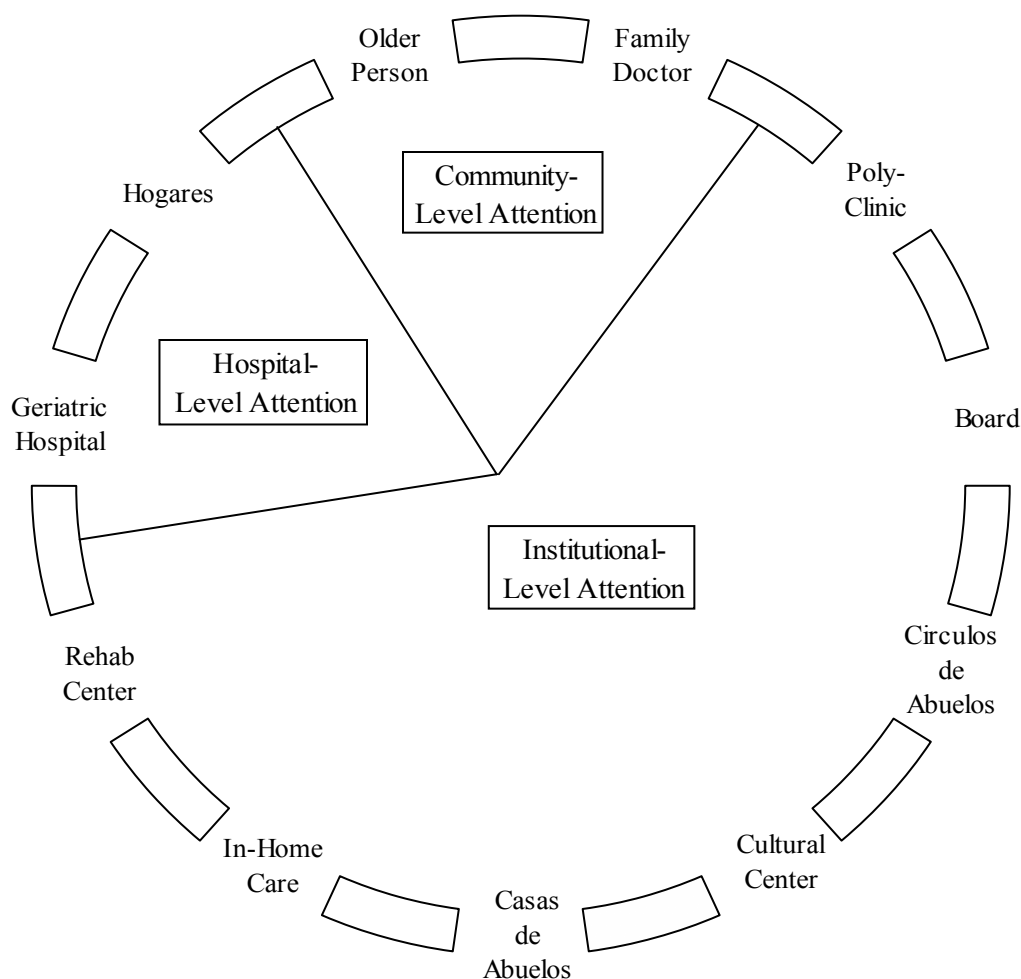
Community Attention

The community sub-program provides the first level of services. As gate-keeper and the older person's main access point to the entire elder care services system, the family doctor-nurse team is the centerpiece of the community level of attention. Accentuating primary care, disease prevention, and health promotion, the team relies on the CARE framework embedded in the

1985 Comprehensive Family Medicine Program (Prieto Ramos, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003).

Under the sub-program's requirements and the CARE regime, each older resident in the team's catchment receives multiple annual, holistic assessments, along with an individually tailored routine of regular check-ups and follow-up examinations for specified conditions either

Figure 8.1. Elder Care Services at the Community, Institutional, and Hospital Attention Levels



Adapted from "Datos Estadísticos de la Atención al Anciano: Programa de Adulto Mayor," by Sociedad Cubana de Gerontología y Geriátría, 2002, Retrieved October 20, 2002, from <http://www.sld.cu/instituciones/gericuba/socgg/index.htm>; "Political Structure and Perceptions of Cuba's Elder Care Continuum," by J. L. Schwar, 2002, Paper presented at the 98th Association of American Geographers Annual Meeting, Los Angeles, CA.

at home or in the consultorio (Prieto Ramos, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003). Specific conditions that might require additional scrutiny are hypertension, such acute episodic illnesses as influenza, family-related stress, or post-hospitalization complications (Feinsilver, 1993; MacDonald, 1999; Schwar, 2002). As part of its health promotion mandate, the team might counsel the older patient on sedentarism, smoking, or social isolation (Bertera, 2003; H. Waitzkin et al., 1997).

Institutional Attention

Institutional care is the second sub-program in the continuum. The family doctor refers the patient to this second level of attention if the condition warrants complex case management or acute study, is irresolvable at the community attention level, or is beyond the scope of family doctor resources (Prieto Ramos, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003). A survey of the institutional-level care options depicted in Figure 8.1 follows a brief explanation of the role of the gerontology-geriatric specialist and the Gerontology Board.

Gerontology-Geriatric Specialists and Gerontology Boards

In the early 1990s, Cuba's medical school curriculum (see Table 7.1) was modified to include clinical rotations in age-related environments. Today, the rotations provide every family doctor a fundamental understanding of elder care needs. Training programs also are formulated to support other health personnel in their work with older individuals (Batista Moliner et al., 2001; Bertera, 2003). Equally important, gerontological-geriatric medicine has been elevated as one the basic specialties (Sociedad Cubana de Geriatria y Gerontología, 2002). Consequently, family medicine and other medical specialists additionally licensed as geriatric-gerontological specialists form the core of the polyclinic-based Multidisciplinary Geriatric Team—the Gerontology Board (Branch, Borrayo, Sykes, & Vega Garcia, 2004).

As part of the CARE protocol, an elder patient assessment called the Functional Geriatric Evaluation was added to the family doctor's annual examination regime after 1992 (Infomed Red Telemática de Salud en Cuba, 2001). The geriatric evaluation calls for a polyclinic-based geriatric specialist to perform a more comprehensive evaluation than required of the family doctor (Infomed Red Telemática de Salud en Cuba, 2001). The geriatric evaluation is designed to further clarify the needs of identified frail and vulnerable older individuals, those who have

grave social problems, in addition to physically or cognitively impaired persons (Infomed Red Telemática de Salud en Cuba, 2001; Prieto Ramos, 1999b, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003)

Upon completion of the two examinations, the case is referred to the polyclinic-based Gerontology Board (Prieto Ramos, 2000). The board is a multi-disciplinary team that includes the patient and family, the family doctor-nurse team, a licensed geriatric and family medicine specialist, and a psychologist and social worker who have additional elder care training (Prieto Ramos, 2000). The panel reviews the family doctor's annual examination records, the Functional Geriatric Evaluation, and re-assesses the patient's current status. The group then constructs a long-term care plan from this review process. Returning now to the hypothetical scenario, the board would recommend and negotiate the individual's placement in the various institutional service options as an outcome of the review process and long-term care plan.

Circulos de Abuelos

The circulo de abuelo, or Grandparents' Club, is the first institutional-level service alternative. It provides individuals socialization, daily exercise, supplemental income, and self-help and mutual-assistance opportunities (Bertera, 2003; Feinsilver, 1993; Fernández Larrea, Clua Calderin et al., 2000; MacDonald, 1999; Morales & Acosta Lastra, 1991; Prieto Ramos, 2000; Schwar, 2002). The option serves those who are physically and cognitively functional.

Cultural Centers

The cultural center is a relatively new addition to institutional sub-program alternatives. Much like a US senior citizen center, the Cuban meeting place is established with the aid of local health councils and elder organizations (Prieto Ramos, 2000). Expanding on the Grandparents' Club concept, in which a trained specialist conducts daily exercises, the cultural center also draws on trained professionals from cultural and recreational institutions to help design and lead social and cultural activities (Prieto Ramos, 2000). Retraining programs also are offered to those retired persons who wish to re-enter the labor force (Prieto Ramos, 2000).

Casas de Abuelos

If the Gerontology Board deems the older person frail, suffering a minor impairment, or

no longer able to function at home, the next institutional option would be the Casa de Abuelo, or adult day-care center. Offering social and cultural activities similar to the Grandparents' Club and cultural center, a trained on-site medical staff is available to administer basic health and nutritional services to as many as 40 individuals (Bertera, 2003; Prieto Ramos, 2000; Schwar, 2002). Furthermore, visiting polyclinic specialists attend to the extraordinary care needs of the adult day care center resident (Schwar, 2002). Should a person's health condition exceed the minimum degree of competency required to participate in adult day-care, in-home care would be recommended as the next institutional option (Prieto Ramos, 2000).

Ayuda Domiciliaria

Ayuda domiciliaria, or home help, supports aging-in-place for the home-bound elderly person, whose care needs surpass the other institutional-level resources mentioned so far (Bertera, 2003). The person with an acute chronic disability, for example, would be seen at home by the family doctor-nurse team and/or polyclinic-based specialists on a weekly and sometimes daily basis (K. A. Swanson et al., 1995). Here too, the Gerontology Board's social worker and family doctor play a critical role in securing and monitoring such services as house-keeping, laundry, and food preparation (Bertera, 2003). Similarly, the family and other informal support network members would be called upon to provide additional in-home necessities (Prieto Ramos, 2000).

Centros de Rehabilitación Diurnos

The Centro de Rehabilitación Diurno, or Adult Day-Time Medical Facility, provides a fifth institutional-level option for the person with a moderate physical or cognitive disability. The individual also would be placed in the facility if comprehensive post-hospitalization health and rehabilitation services were deemed necessary (Infomed Red Telemática de Salud en Cuba, 2001; Prieto Ramos, 2000). The chief goals of skilled day-time attention are to maintain or recover the person's functional aptitude (Prieto Ramos, 2000).

The Polyclinic, Poder Popular, and Green Medicine

It might be valuable at this juncture to reconsider the Cuban polyclinic and Poder Popular, while introducing the use of natural and traditional medicine in the institutional services

mix. As mentioned above, the local polyclinic and its counterpart, the geriatric specialty polyclinic, provide a base for the geriatric specialist and Gerontology Board. The 1992 national policy on aging provided for the construction of new geriatric specialty polyclinics and the conversion of older ambulatory care centers to house the newly-trained cohort of gerontological-geriatric specialists (K. C. E. Macintyre & Hadad Hadad, 2002). The specialists and Gerontology Boards work out of the traditional local polyclinic in areas where construction or conversion efforts have not yet occurred (Schwar, 2002). Polyclinic specialists, staffs, and testing laboratories provide an institutional recourse for the family doctor, who cannot resolve a patient issue at the community level of attention. In addition to providing visiting services to the adult day care center, the geriatric specialist makes calls to in-home service recipients, the family doctor consultorio, and homes for elders provide the family doctor consultation on difficult cases (Demers et al., 1993; Programa de Atención al Adulto Mayor en Cuba, 2003; Schwar, 2002).

Poder Popular and Elder Care

The 1992 national policy integrated socio-political structures into both the community and institutional sub-programs. Consequently, local assembly representatives work with family doctor-nurse teams and institutional-level actors to prevent and resolve social and environmental conditions that contribute to elder health problems (Prieto Ramos, 2000). For example, the family doctor team and municipal delegates might jointly establish more Grandparents' Clubs if surveillance assessments found social isolation among older residents to be a major local issue (Prieto Ramos, 2000). Such collaborations have resulted in the development of special meal, exercise physiology, travel, and cultural programs for older residents in such alternative settings as work-places and schools (Feinsilver, 1993; Garfield & Santana, 1997; Morales & Acosta Lastra, 1991; H. Waitzkin et al., 1997).

Local assembly-persons and older citizen lobby organizations also collaborate to affect national policy. MINSAP officials, for instance, were persuaded to fund a national media campaign and a community, family, and elementary school program that promoted inter-generational values (Bertera, 2003). Similar alliances have resulted in the formulation of instructional programs to re-orient older citizens to retirement and to teach families and lay-persons how to care for dependent older persons (Bertera, 2003; Caballero et al., 2002).

Green Medicine

Traditional and natural medicines figures prominently in the community- and institutional-level strategy for disease prevention, treatment, and rehabilitation (Greene, 2003; K. C. E. Macintyre & Hadad Hadad, 2002; Padron, 2003; Planas Borrero, González, Pérez Richard, & Coello Morales, 2000). Building on traditional medicine practices, the sub-field was awarded medical specialty status and a national program was created in the 1980s to integrate older treatment forms with new approaches: acupuncture, herbal medicines and derivatives, massage, thermalism, cupping or suction, hypnosis, and music and floral therapies (Bosch Valdéz, 1999; Escuela Nacional de Salud Pública, 2001; Foreign Policy Association, 1935; Garfield & Santana, 1997; Kayne & Guajardo-Bernal, 2000; López Espinosa, 1999; K. C. E. Macintyre & Hadad Hadad, 2002; Oremas Díaz & Rodríguez Luis, 1999; Padron, 2003; Reyes Vaillant & Lena Lobaina Feria, 2002; Schwar, 2002; K. A. Swanson et al., 1995; H. Waitzkin et al., 1997). For example, common plant dilutions, teas, thermalism (heat treatment), and homeopathic anesthesia are employed as anti-bacterial agents, to treat coughs, fever, indigestion, and chronic rheumatologic disorders, and in dentistry (Kayne & Guajardo-Bernal, 2000; K. A. Swanson et al., 1995; H. Waitzkin et al., 1997).

Hospital Attention

The sub-program for hospital attention offers the last three service streams in the long-term elder care continuum. Should all institutional options be exhausted, or if the Gerontology Board decides that a more assertive treatment regime is needed, the older person would be cared for at this third level of attention. The hospital sub-program features specialized elder care services in facilities that most resemble traditional bio-medical institutions. Its two primary options are hospital-based geriatric services and hogares de ancianos, or homes for elders (Prieto Ramos, 2000).

Hospital-Based Geriatric Attention

Hospital-based geriatric services represent the first care option at the third sub-program level. As one might expect, hospital-based geriatric specialists offer the patient a range of established bio-medical and high-technology services. MINSAP has reserved more than 400 hospital beds nationwide specifically for older patients (Bertera, 2003).

Hogares de Ancianos

Hogares de ancianos, or homes for elders, are the second hospital-level option. Reminiscent of a small nursing facility in the US, the home is a semi-permanent residence for the discharged hospital patient requiring around-the-clock supervision. The home also is a permanent residence for the older person with more complex medical problems, or who is classified as a grave social case (Osmara Delgado Sanchez, personal communication, July 13, 2001). Nearly 15,000 beds were available in 124 homes for elders in the mid-1990s (Bertera, 2003; Dotres Martínez, 1996b).

MINSAP has established two important regulations for the homes. First, they must meet the same standards applied to the nation's hospitals (Dotres Martínez, 1996b). Second, a periodic review process ensures that benchmarks are met and, equally important, revises and incorporates the latest scientific research into their designs (Prieto Ramos, 2000).

Care Program and Homes for the Impaired

Based on a 1982 study on disabilities (Dotres Martínez, 1996a) and subsequent mental health, dementia, and Alzheimer's Disease research (Cruz Rolando, 1988; de J. Llibre Rodríguez, García Capote, & Guerra Hernández, 1999; Holtz, 1997; Murray & Lopez, 1997; Polo Robaina, Hemse Mikol, & Frank, 1987; Prince et al., 2003; World Health Organization, 2004), all national mental health efforts were incorporated into the sub-program for institutional attention. One outcome of this merger was the creation of a parallel system of 26 homes for severely disabled persons (Programa de Atención al Adulto Mayor en Cuba, 2003). Thus, a distinct residential system and specially trained providers are available to physically and/or cognitively impaired persons. Upon the discharge of an older adult from any of the three hospital-level alternatives—hospital-based services, homes for elders, or homes for disabled persons—the Gerontology Board and family doctor re-assume full control over the case and arrange any necessary institutional- or community-level services that assist in the patient's recovery and transition back into the home (Prieto Ramos, 2000).

Impact of the Care Program for Older Adults

The 1992 national policy on aging established a series of indicators to assess the preliminary impact of the long-term elder care system. Although services were not implemented

meaningfully until 1997, the policy established a number of structural targets to be met by 1999, including raising Grandparents' Club participation rates by 30 percent, expanding the number of municipal adult day care centers by 60 percent, and increasing the number of in-home care recipients living alone by 30 percent (Prieto Ramos, 1999b, 2000; Programa de Atención al Adulto Mayor en Cuba, 2003). The following outcomes were reported as part of the preliminary impact analysis:

- circulos participation rates have been increased by 34 percent by 1999 with a 37.6 percent rate recorded in 2000 (María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Programa de Atención al Adulto Mayor en Cuba, 2003);
- each province had at least one casa in 1999; the 93 homes in operations in 2000 covered 54 percent of all municipalities (María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Programa de Atención al Adulto Mayor en Cuba, 2003; Valencia, 2003); and
- a more than 100 percent increase in number of in-home care recipients living alone was recorded for the period 1997-1999; in La Habana, 38 percent of all eligible older adults were covered in 2001 (Programa de Atención al Adulto Mayor, 2001; Programa de Atención al Adulto Mayor en Cuba, 2003).

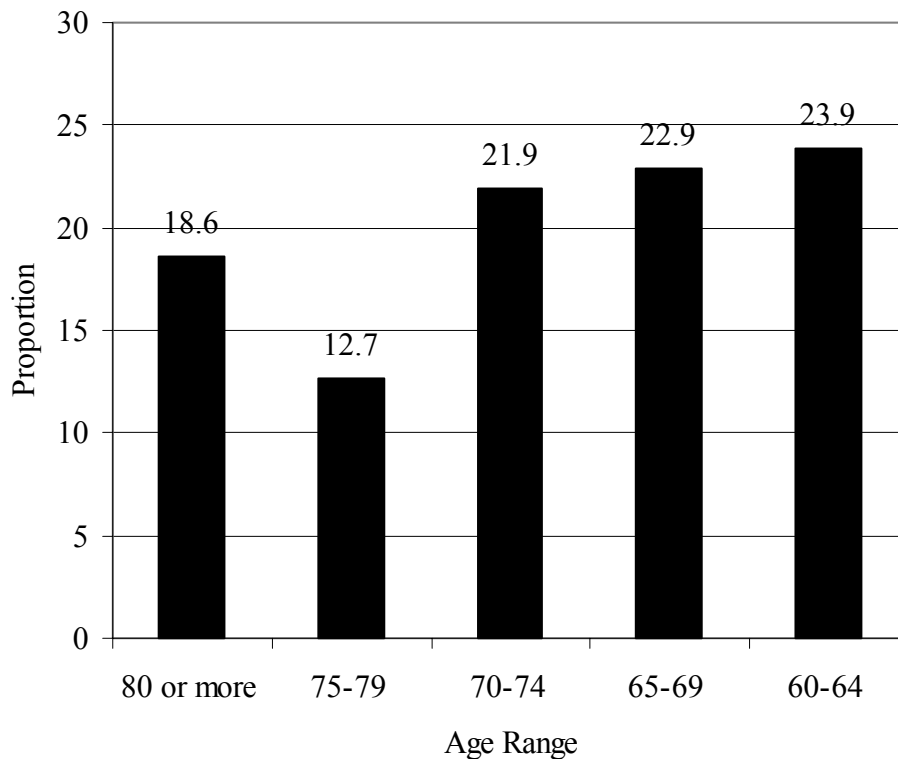
There were a total of 127 licensed gerontology-geriatric specialists in 1999 (Programa de Atención al Adulto Mayor en Cuba, 2003). These licensed specialists are mandated to qualify the Gerontology Boards and provide additional training, continuing education, and workshops for other health professionals (Bertera, 2003). The 1,208 active Gerontology Boards in 1999 signifies an almost 250 percent increase since the program's implementation in 1997 (Programa de Atención al Adulto Mayor en Cuba, 2003). Nationally, however, only 35 percent of all boards were qualified in 1999; around 75 percent of La Habana's panels were qualified by 2001 (Programa de Atención al Adulto Mayor, 2001; Programa de Atención al Adulto Mayor en Cuba, 2003).

Community Level Service Use

The results of a 2000 study (Fernández Larrea, Ibarra Salas et al., 2000) presented in Figure 8.2 show that the proportion of elders seeking family doctor care was nearly equal for all

older age brackets except the 75-to-79 grouping. The mean age of older patients seeking family doctor care was 71.35 years and the median was 70 years. The proportion of visits made by women to the family doctor was three times greater than visits made by men, and over four percent of all patients were determined to be healthy under the CARE, Group I, asymptomatic classification.

Figure 8.2. Proportional Age Distribution of Older Cubans Seeking Family Doctor Care Services



Adapted from "Use of Primary Care Services by the Elderly," by N. Fernández Larrea, A. M. Ibarra Salas, M. Bonet Gorbea, P. A. Murla Alonso, M. Canizares Pérez, & V. I. Prieto Díaz, 2000, MEDICC Review, 2(1). Retrieved October 21, 2002, from http://www.medicc.org/Medicc%20Review/1999/autum/html/use_of_primary_care_.html.

The following health issues accounted for about three-quarters of all family doctor visits in 2000: hypertension (37 percent), psychiatric issues (6.1 percent), diabetes mellitus (5.3 percent), and digestive disorders (4.1 percent). Nearly a third of all services rendered involved the control of and follow-ups to previously diagnosed chronic diseases. In that more than 30

percent of the family doctor's work time was found to be dedicated to seeing older patients, the study recommended more primary elder care services be added to the sub-program for institutional attention. Specifically, it was suggested that local polyclinic physicians be used to truncate the family doctor's elder care duties. Another recommendation was that new community-level programs be established and designed to assure the participation of older males in consultorio-based preventive-primary and follow-up care services.

Institutional Level Outcomes

As noted earlier, Grandparents' Club activities were shown to have reduced risk behaviors and improved such health conditions as hypertension and respiratory distress (Morales & Acosta Lastra, 1991). Despite availability, screening, placement processes, and increased Grandparents' Club participation levels, a recent study (Fernández Larrea, Clua Calderin et al., 2000) noted that fewer than 25 percent of all older adults participated in Grandparents' Club exercise programs. For about two-thirds of the study's older subjects, social engagement was limited to participation in the CDR and FMC, while half of the participants reported that most of their time was spent alone at home watching TV, reading, or listening to the radio. Although nearly a quarter of the subjects perceived their health situation as positive, more than 73 percent reported at least one chronic condition; vision difficulty was most-mentioned, followed by hypertension, diabetes, and ischemic heart disease. Nearly 66 percent perceived their life situation as unsatisfactory.

In-Home Care

Institutional-level in-home care was expanded after 1997. By 2000, however, deficiencies in the provision of laundry, housecleaning, and food preparation services were discovered (María del Rosario Abreu Vázquez & Muñiz Peláez, 2001). More disturbing, though, was that 2.5 percent of all in-home service recipients living alone were found to have died as a result of inadequate care, 70 percent of all in-home care receivers were malnourished, nearly one quarter of the beneficiaries (mostly males) were undernourished, and additional food purchases represented the greatest out-of-pocket expense for all in-home care program participants (Márquez Morales, Jiménez Cangas, & Torrez Díaz, 1998; P. Rodríguez, Macias Matos, Pérez, Serrano Sintés, & Rebozo Pérez, 1999). A related study (de la C. Santana Soto, Ricardo Acuña,

Castillo Hechaverría, & Von Smith Smith, 2002), meanwhile, concluded that more than one third of all in-home care providers lacked adequate knowledge and special training in such practices.

Medicine and Health Education

The national policy's gerontological research agenda, combined with crisis-related pharmaceutical shortages, spurred a number of aging studies on medicine use after 1997 (Lluís Ramos, González Cabeza, Loy Acosta, & Cubero Menéndez, 2002; María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Ramos Cedeño, Milián Vázquez, Fonseca León, & Quirós Enríquez, 2000; Santana Vasallo, Bembibre Taboada, García Nuñez, & González Avalos, 1998). Multiple morbidities, for instance, were found to be the primary contributor to over-medication, particularly among females ages 70-to-74; self-medication levels were as high as 60 percent among older males. Although educational interventions were found to have decreased over-medication, the outcomes were deemed substandard.

The following statistics also were gleaned from research conducted following implementation of the long-term elder care services system approach in 1997 (Lluís Ramos et al., 2002; María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Ramos Cedeño et al., 2000; Santana Vasallo et al., 1998): more than 60 percent of all older patients were found to have taken more than one medication with an intake average of 3.11 drugs per person; more than 11 percent of all women took 4 or more medications and almost 7 percent of all males took 5 or more drugs at one time; overdoses from professionally-administered multiple-medications occurred in nearly 18 percent of all cases surveyed and overdoses occurred in almost 17 percent of all self-medicating cases; adverse reactions were seen in 7 percent; and about 18 percent used non-prescribed drugs. Psychotropic drugs were found to be the leading group of medicines used by older Cubans, which corresponds to the number one cause of global disability—uni-polar major depression (Ramos Cedeño et al., 2000; World Health Organization, 2004).

Green Medicine

Although no benchmarks were set for traditional and natural medicine under the 1992 national policy on aging, the topic received considerable attention as a result of the economic crisis and synthetic medicine shortages. On such study (Kayne & Guajardo-Bernal, 2000) found that 55 polyclinics offered some form of homeopathic treatment by 1998. Homeopathic

therapies also were found to have accounted for improvements in 65 percent of all non-acute chronic disease cases with no apparent secondary effects, that the most significant outcomes occurred among diagnosed hypertensives, and that older females were more likely males to receive homeopathic treatment (Kayne & Guajardo-Bernal, 2000; Riverón Garrote, Campistrou, & Cruz, 1997). Hospital-level research (Reyes Vaillant & Lena Lobaina Feria, 2002) among residents institutionalized in homes for elders, meanwhile, found that homeopathy was mainly used to treat inflammatory pneumonia, influenza, and diarrhea.

Cost-benefit outcomes, particularly at the community and institutional levels, were discovered to have supported the continued practice of homeopathy among the older population following the 1997 implementation of the long-term elder care services structure (Kayne & Guajardo-Bernal, 2000; Reyes Vaillant & Lena Lobaina Feria, 2002; Riverón Garrote et al., 1997). The therapies were found to be most effective at preventing unnecessary hospitalization (Reyes Vaillant & Lena Lobaina Feria, 2002). However, it was observed that health providers were applying homeopathic techniques without a basic framework of uniform standards (Kayne & Guajardo-Bernal, 2000).

Death and Dying

With the epidemiologic transition and such degenerative chronic conditions as cancer and heart disease becoming the primary causes of institutionalization and mortality, the elder care program of the 1990s attempted to shift treatment foci from curative to primary palliative care approaches (Hernández Cabrera, Gonzáles García, Fernández Machín, & Infante Pereia, 2000; Perdoma Victoria et al., 1999). Thus, providers were expected to adopt a new orientation to death and dying. However, Cuban researchers (Hernández Cabrera et al., 2000) concluded that physicians had not fully embraced this change.

Although doctors were found to have perceived and accepted death as a natural life event, avoidance and fear, mostly in ambiguous situations, were found to be pervasive, especially among community-level physicians (Hernández Cabrera et al., 2000). In that inadequate training left family doctors unprepared to deal with protracted chronic illness developments, one study (Hernández Cabrera et al., 2000) inferred the possibility that medical decisions might preclude the use of such low-technology and humanistic care approaches as palliative relief.

Perceptions of Health Equity and Health Inequality Revisited

The renewal of socio-economic disparities associated with the momentous events of the later 20th Century is perhaps the greatest threat to community solidarity and the health and welfare of older Cubans (Nayeri, 1995). Despite the social safety net, special protections, and a more supportive system of long-term elder care services, older Cubans are unable to meet basic needs (American Association for World Health, 1997; Donate-Armada, 2001; Duran Gondar & Chávez Negrin, 1997; Garfield & Santana, 1997; Keck, 1993; Kirkpatrick, 1996; Pérez, 1998; Tucker & Hedges, 1993). The dollar economy and health resource constraints have placed additional burdens on older individuals, who are requiring greater levels of care at a time when they are incurring more out-of-pocket expenses, but have limited access to supplemental income sources than other population groups (Donate-Armada, 2001; Garfield & Santana, 1997; Mesa-Lago, 1998; Nayeri, 1995; U. S. International Trade Commission, 2001; Veeken, 1995).

The verisimilous data presented thus far suggest that though older Cubans are displeased with the current level of government assistance and somewhat dissatisfied with the health system, these types of supportive services continue to offer a sense of security and well-being. Similarly, while older patients are disgruntled that consultorios frequently are left unattended and that the neighborhood-based family doctor-nurse teams seem unmotivated, the family doctor generally is viewed positively. These inconsistencies may be manifestations of increasing social differentiation couched in the older person's awareness that she/he relies on this first level of community attention for most health and social welfare needs.

Although Figure 8.1 might indicate otherwise, the success of the national policy on aging and the long-term elder care services system rests largely with the family doctor, because of the physician's close association with the older patient at almost every care level. Despite efforts to lessen workloads and redress training deficiencies, the added care responsibilities of an aging population can be expected to fuel family doctor apathy and discontent (Grogg, 2003). If this already is occurring, then, a perceptive shift among older persons concerning family doctor care also can be expected. To explore these possibilities, the dissertation now moves to the principal and secondary subject findings.

Chapter Nine

Principal and Secondary Subject Findings

This chapter presents results from an analysis of principal and secondary subject data. The opening segment features two personal accounts that encapsulate the overall findings with regard to perceptions of health equity and health inequity among the principal subjects. The second section offers two family doctor case studies that amplify the overall findings. The results of a focus group interview in the third section illustrate linkages between community participation and the older person's understanding of the Cuban health care milieu. The final segment reports supplementary results that may well affect the future perceptions and expectations of older Cubans concerning the long-term elder care services system, the government, and the leadership.

Perceptions from Below

The analysis of principal subject data produced two overall results. Positive perceptions of health equity were found to correspond most with two geographic factors: the older person's residential proximity to their family doctor's consultorio, and the patient's nearly unbounded access to and the availability of their neighborhood physician. Conversely, perceptions of health inequity corresponded most frequently with the older person's experience of pharmaceutical shortages and the rationing of certain health and health-related resources.

The narratives that follow expand upon these two overall findings. Luis's story resonates with those older individuals, who registered perceptions of health equity. Although Pedro's health condition is atypical of the medical status of other principal subjects, the observations of he and his spouse are representative of the group of older Cubans, who conveyed responses about the inequity of health and health-related resources.

Luis's Chronicle

Luis is a 63 year-old retired farm laborer. He was age 21 at the time of the Revolution. Illiterate through his mid-twenties, he learned to read and write as part of the national literacy campaign in the 1960s.

The older Cuban and his 63 year-old spouse, Angelina, reside with their son, daughter-in-law, and two grandchildren. They live in a neighborhood on the outskirts of a community with

30,000 inhabitants in a mainly rural agricultural province. The family residence is sited within a few minutes walking distance of their family doctor's consultorio and a state-run food ration store. Their home also is approximately one mile from a polyclinic and an adjacent pharmacy, and a ten-minute drive from a municipal hospital in the community's central business core.

Resembling most other residential dwellings in the neighborhood, the family's small three-bedroom apartment is located on the second floor of a quadraplex. Although the cement exterior of the apartment complex appears somewhat worn, the interior of the family home is clean and tidy. The domicile has all municipal utility services, a fully functional lavatory and bath, and is modestly furnished. Family photographs adorn almost every wall of the home.

As with most of the study's other older respondents, my initial conversation with Luis began with exchanges of generalities and family ancestry. He is proud of the fact that his father was of Spanish decent and, as such, says he and the state consider his family's ethnic background to be white. Much of our first conversation also was spent discussing the birth- and burial-places and occupations of our deceased and surviving blood relations. Luis's first uneasy disclosure, however, centered on his hope that travel restrictions would be lifted so he once again could see family members, who had left Cuba for the US shortly after the Revolution.

Luis had worked in the surrounding corn and tobacco fields since he was a teenager. Although his son now helps with family finances, he and his wife's Social Security pensions are the couple's primary income source. If not for an unexpected medical condition, he says he would have continued working beyond his retirement in 1998 at age 60.

Luis's medical record coincides with the founding of his doctor's sectoral practice in 1990. The physician's initial entry noted the examination date, his age, employment status, household composition, and that he had the psycho-socio-economic "support of other family members." The doctor's first medical observations also included the following: Luis is a non-smoker; a life-long moderate coffee drinker; and a Group I dispensarization patient, because of his apparently asymptomatic physical and mental state.

Self-reporting his medical history, the older Cuban tells me that he has never been sick "a day in his life." However, my further prompting reveals that he was diagnosed with an enlarged prostate in 1993. Confirmed in his medical record, Luis says recurrent treatment and medication (partially subsidized) corrected the health problem and permitted him to continue working until his 1998 retirement.

During a subsequent chat, Luis admits to me that his family physician discovered that he had a hernia just before his 60th birthday. The doctor immediately referred him to the provincial hospital and “visited me several times before and after my surgery.” Discharged and temporarily side-lined from work during his post-operative recovery, Luis says his family doctor helped him win special social case status, which granted the family additional food rations and other forms of social relief. Despite a full recovery, the doctor advised him not to return to his former strenuous work life, which led to his decision to retire in late 1998.

These disclosures were followed by Luis’s confidence that he was diagnosed with onset hypertension in early 2001. However, he and his doctor “worked together” to stabilize the condition through medication, counseling, altered eating habits, and exercise with the neighborhood Grandparents’ Club. When I ask about his medications, he claims that the out-of-pocket costs place no significant burden on the family, because his son has a “good job” and he now receives remittances from family members in the US.

During one of our conversations, Luis observes that “older Cubans never complain about the health care system.” Later, however, he faults the municipal hospital and local polyclinic for having “no good doctors.” He asserts that he feels “safer” with his family doctor, because he can reach her from “home in minutes any time of the day.” He also believes that she is more concerned with his welfare than other Cuban physicians he has seen, because she “gave me everything I needed after the surgery, including clothes, milk, food, and constant medical attention.”

Luis credits his country and President Castro for his family’s life circumstances. Recalling life before 1959, Luis tells me that “we had nothing...little food, no electricity, support, or public works...I had no radio, bathroom, telephone, or television in my home.” Although he insists that he is not political, he adds that:

I have all these things in my home now. El último put doctors and new hospitals all over the province. Now I receive prompt, rapid responses to my health needs. Before, I was lucky to get them at all. Before the Revolution under the [Batista] dictatorship, we were always worried. Today, I’m not worried. Before the Revolution, most people were too poor to pay for hospital care and the five pesos to pay for a doctor visit. Today it’s my right to receive free food, dental, and medical services.^{1 2}

Pedro and Isabel's Story

Pedro and his spouse, Isabel, are retirees in their early 70s. They reside in an urban center in a predominantly rural central province. The community's municipal hospital catchment includes nearly 100,000 older residents. No other family members or non-kin live in the couple's home.

Pedro has abdominal cancer. He was diagnosed in 1992. Hospitalized off and on since specialists offered the initial medical opinion, Pedro recently had been permanently discharged into his family doctor's care. Hospital physicians told he and his wife that they based the discharge decision on his advanced condition—they no longer felt that non-invasive, chemotherapy treatment “was working” and that “surgery was too expensive” an option. Although her husband's prognosis was said to be terminal, Isabel says that the hospital physicians will not “tell us how much longer he might live.”

Isabel is most angry that Pedro has been “denied” additional in-patient palliative care. As a result of the discharge and out-patient classification, she says that her husband is now “ineligible” to receive “any more pain medicine” that he received previously from the hospital at no cost. Isabel claims that the local hospital doctors have informed her that “shortages” are forcing them to reserve medicines in short supply for patients, whose prognoses are more favorable. Instead, Pedro says that hospital physicians insist that he must now receive a prescription from his family doctor.

Isabel also is vexed that the couple's numerous petitions to the local Gerontology Board for special social case status have been rejected. She argues that they are “entitled to help with the [out-patient co-pay prescription] costs.”³ The family physician has written Pedro a pain medication prescription, but Isabel says they cannot afford to fill it at the pharmacy. Furthermore, Pedro's family in Miami, Florida is “too poor to send them money.” Isabel concedes that they are now “begging” from foreign tourists in order to pay for the prescription; tour operators regularly park their buses in front of the family home that is located directly across the street from a popular state-run tourist restaurant.⁴

Despite these hardships, Pedro and Isabel balance their disparagements of the state of the elder care system and health resources with a family doctor commendation. Although the physician is unable to acquire Pedro's certification as a special social case, Isabel tells me that she believes that their family doctor is “doing her best.” Despite my prompting, however, Isabel

and Pedro, decline to name or hold specific political leaders or health professionals responsible for their situation.

Family Doctor Case Studies

The two preceding narratives illustrate the sway that family doctors have on the perceptions of their older patients, even when the most unsettling factors present. To better understand this dynamic, we turn now to the findings from direct observations of family physicians at work. The two case studies that follow, which exemplify findings among other Cuban physicians that I observed in the field, contrast the common daily activities of a rural and urban family doctor. The case studies also feature relevant information gathered from the physicians' older patients and other secondary subjects.

Family Doctoring in Rural Cuba

Dr. María is a family medicine specialist. In late 1990, MINSAP assigned her to begin her solo practice/medical residency in a neighborhood located on the outskirts of a relatively small municipality in rural Piñar del Rio Province. The main community and surrounding localities have a total population of about 30,000 inhabitants. Horse drawn carts compete with tourist buses, taxis, and automobiles for space on a main highway that borders one side of the physician's catchment.

The doctor and her husband, a carpenter, tell me that they decided to remain in the neighborhood following the physician's medical residency and specialty licensure. Having no children, the 38 year-old physician admits to me that the demands of medical school and her career take priority over having a family. Serving almost 600 patients, 14 percent of the doctor's total patient load is age 60 years or older; older individuals comprise about 12 percent of the total provincial population. Her immediate health team consists of one assigned, full-time, Cuban-trained nurse and two visiting nurse interns, one from France and the other from Germany.

The doctor's medical office/residence is a two-story cement structure that was built by local volunteers shortly before she received her neighborhood assignment. The couple resides in the small, three-room upstairs apartment. Their rent is fully subsidized by the state.

The first floor of the consultorio features a waiting room that seats up to ten patients, a private consultation office, an examination room, lavatory, and several storage areas. The family

doctor-nurse team relies on the Ministry of Health's monthly distribution of supplies, including a limited stock of pharmaceuticals, primarily vaccines. The consultorio examination room is equipped with an examination table and light, an oxygen supply unit, a weight and height scale, several stethoscopes, an ophthalmoscope, and three mercury sphygmomanometers.⁵

In almost every one of my conversations with Dr. María's older patients, they refer to the physician as their "neighbor." When I ask about this recurring theme, the physician says that she maintains a small degree of authority as part of the professional doctor-patient relationship. However, she adds that the shared similarities of housing, community belonging, and the level of intimacy that accompany her physician-as-a-neighbor role diminish the "appearance" of social divisions between her and her patients, especially among older residents who can recall life before the Revolution.

Dr. María avails herself 24 hours-a-day, 7 days-a-week, with the exception of a state-mandated month-long vacation period in August, during which the local polyclinic gerontology-geriatric specialist attends to her older patients. Each older person in the catchment receives a minimum of four annual comprehensive examinations. The doctor schedules the four annual appointments at various times in her office or in the patient's home. The health team purposefully includes at least one informal annual home visit in its assessment protocol to determine social, economic, and psychological needs that might arise in her older patients' family environments; the majority of the neighborhood's older residents live in multi-generational households.

Although the doctor and her older patients acknowledge that any resident, even someone from another neighborhood, is permitted to schedule an office or home visit, the close proximity of her patients' residences to the medical office lends itself to informality. Most of the consultorio-based care-giving events I observe are unscheduled. The doctor, however, seems unaffected by the spontaneous interruptions of her older walk-ins and always greets them with a warm embrace in the office waiting room.

On each of these occasions, Dr. María's older patients arrive on foot. A 79-year-old woman, for example, comments that there is no point in taking public or private transportation, because she and all her friends live "just up the street." One can slowly traverse the doctor's catchment in six minutes. Furthermore, a common belief expressed to me by more than one older person in the neighborhood is that they feel they are healthier than are older persons in

other poor countries, because they can reach their family doctor at any time and in minutes in an emergency, or if they simply require reassurance about a minor problem.⁶

One patient visit to the consultorio demonstrates the influences that proximity, access, and availability have on the older individual's perceptions. Jaime is a 70 year-old Type II diabetic, who arrives at the medical office at 8:30am on foot to receive a weekly oral hypoglycemic prescription. The retired carpenter lives two blocks from the office with his 69 year-old spouse. Although the couple has four children, no family or non-kin members reside with them. After learning from the nurse that the doctor is out consulting on another case at the polyclinic, which is about a five-minute walk from the consultorio, Jaime shrugs his shoulders, smiles, and says he will return after lunch. In addition to enjoying a morning stroll, the older patient adds that "she is always there for me when I really need help."

During the 2½ hours following the doctor's 9 o'clock arrival that same morning, 16 unscheduled patients, mostly older walk-ins, keep the waiting room filled. Un-phased by the waiting period, the patients spill out onto the consultorio porch and chat with their neighbors. While the ambiance of the office setting bordering on chaos, the chief nurse performs triage on the waiting patients. The doctor, however, walks out to the waiting room, calls on each patient in order of the seriousness of the condition, exchanges greetings, embraces them, then gives each person her complete attention once she escorts them to the consultation office.

On average, the morning's examinations take about eight minutes each. The shortest consultation that is four minutes involves 76 year-old, Juanita. The older woman explains to the physician that she is losing feeling in her fingers from an incised cut on her hand that she fears might become infected. After examining Juanita's fingers, applying pressure to different points in the woman's hand and arm, and asking the patient to describe the sensations she feels, the physician leans closer and whispers that she has "no free medicine" available to treat the wound. Instead, Dr. María redresses the cut, and recommends the patient return home and apply a cold compress to entire hand. Juanita later tells me that she is satisfied with the recommendation, because she knows that she can return if her condition worsens. She also jokes that the free office visit would have cost "five pesos before the Revolution."

The longest examination with 74 year-old Esteban and his 80 year-old spouse, Carmelita, lasts 30-minutes. Although Esteban informs the nurse upon their arrival that his wife has been feverish for a few days, no temperature reading is taken.⁷ The nurse does perform a blood

pressure check, which returns normal readings. Following the brief consultation with the nurse, the doctor examines Carmelita's heart and respiratory functions and is informed that the older patient has had no occurrences of diarrhea in the previous days. The physician then writes out a prescription for an anti-biotic, schedules two future appointments, details how to administer the medication, and explains the process and co-pay required to fill the prescription at the local polyclinic pharmacy. The doctor informs Carmelita that she will have to undergo a "respiratory specialist's examination" at the polyclinic and have the specialist sign off on the prescription before the polyclinic pharmacy will fill it for free.

The doctor next examines Esteban. A sphygmomanometer reading shows his blood pressure to be normal. Other than suffering from minor head and lung congestion, the physician detects no other complications. The next step in Dr. María's examination process takes me by surprise. She hands Esteban and Carmelita specimen bottles and asks them to provide urine and lung expectorant samples. The doctor requests that the samples be returned to the office, after which she explains that she will take the samples to the polyclinic laboratory for testing; she tells the couple that she will follow-up on their tests and provide the results "the next time I see you." The doctor later informs me that she will order the lab to conduct "precautionary tuberculosis" analyses on the samples as part of her "normal" communicable disease surveillance duties.

In another conversation, I ask the doctor why she has written an anti-biotic prescription for Carmelita's respiratory problem, but has not pursued an anti-biotic treatment for Juanita. The physician tells me that she feels Juanita's cut is neither serious nor infected and, therefore, she cannot, in good judgment, refer the patient for further examination. As for Carmelita, the doctor explains that she believes the respiratory condition poses a potential threat to both Carmelita and Esteban, as well as other more vulnerable residents, especially if it involves a communicable virus or germ, such as tuberculosis. The doctor adds that her "training and instincts" compel her to contain the potential problem before the infection might spread throughout the neighborhood. However, the physician adds that she believes it is "unnecessary" to prescribe antibiotics to Esteban.

With regard to prescription-writing, I inform Dr. María that a polyclinic physician in a neighboring province explained to me during my February 2001 field visit that nationwide paper shortages had resulted in MINSAP's inability to provide the ambulatory facility and polyclinics elsewhere with formal prescription pads for almost six months.⁸ Dr. María tells me that she too

was without official pads and was unable to write prescriptions herself for several months earlier in the year. All of the consultorios in Dr María's community, though, had been re-supplied in spring 2001.

The physician divulges that she surreptitiously arranged to refer her patients in need of medications to specialists at the local polyclinic during the prescription pad shortage. The reason is that she knew that polyclinic physicians ordered medication directly from the in-house pharmacy in lieu of the required paperwork. Admitting that the unorthodox referral process was "time consuming and costly," Dr. María says she had to consult with the polyclinic specialists on each of these cases, while the specialists were required to perform separate examinations before they would fill her patients' prescriptions.

The brevity of her office exams and record-keeping practices are two other issues we discuss in follow-up conversations. The doctor explains that she conducts more lengthy evaluations as part of her annual examination protocol. She emphasizes that the annual process allows her to detect most health issues before they become a serious problem, reduces the amount of time required to spend with her patients during other office visits, and permits her to "listen" to more commonplace patient issues. She also believes that the repetitiveness of the shorter consultations allow her to "stay on top" of health issues. Indeed, my field observations reveal that many of the neighborhood's older residents return to the consultorio an average of three times each week and some more than once a day, a pattern I repeatedly see in numerous other localities in both urban and rural Cuba.

A provincial health administrator offers another perspective on the impact the examination protocol has on community health and, indirectly, on family doctor time management. The model is based on the "hypothesis that 20 percent of all vital [early] problem resolution resolved 80 percent of the community's [long-term] problems of well-being" (Teovaldo Triana Torres, personal communication, July 23, 2001). Hence, the official argues that most physician service time involves prevention, maintenance, and follow-up activities.

Despite the high frequency of patient visits to the consultorio, Dr. María rarely makes notations to the medical records of her older patients during the shorter, follow-up consultations. I see Dr. María make only one such entry to Esteban and Carmelita's medical record during the entire observation period. When I ask her about record-keeping, she says she makes it a "habit" of recording only significant changes in a patient's condition during the shorter office visits, but

makes the most detailed notations during the four comprehensive annual examinations.

At first, I suspect that Dr. María's behavior might be an outcome of rational choice, in which the physician believes that her patient service commitment outweighs the need to satisfy MINSAP's record-keeping stipulations. I also consider the possibility that the physician's behavior might be an act of defiance against the agency's administrative mandates. However, Dr. María and other family doctors tell me that they are lenient with their patient medical records, because they see their patients frequently, are aware of their patients' health conditions intimately, and know what public health statistics are necessary to accurately and effectively depict the epidemiologic profiles and status of the patients and neighborhoods they serve.

Family Doctoring in La Habana

Dr. Evaristo is a 34 year-old generalist family doctor. Assigned to one of La Habana's poorer neighborhoods in the late 1990s, he is nearing completion of his solo practice/medical residency. Unmarried, the physician lives in a small, rent-free (fully subsidized), upstairs apartment in the same building where his medical office is located.

Although the exterior of the structure is newly renovated, the consultorio's interior appears in a poorer condition than the majority of other rural and urban family doctor offices I observe; its floors are worn, the walls lack a fresh coat of paint, some of the office's ceilings are cracked, and discarded medical supply packages litter the floor of the dimly lit patient examination room. The medical office, however, is stocked with much of the same clinical equipment I find in other consultorios in rural and urban settings throughout the country.

Since beginning his practice, the physician says the number of patients in the catchment has ranged from about 700 to 900 individuals. Dr. Evaristo now serves 120 families; 180 persons out of the current total patient load of 799 individuals are age 60 years or older. Although his current total patient load and the percentage of older patients (22.5%) are higher than most other rural and urban catchments, he complains that MINSAP has assigned his practice only one nurse. In contrast, older adults comprise 14 percent of Dr. María's current total panel of patients, which is approximately the same proportion I find in other neighborhood catchments throughout the country. However, no other family doctor consultorio I observe has more than one assigned Cuban-trained nurse; Dr. María's practice is the only one I find to have visiting nurse interns from foreign countries assisting the consultorio's assigned nurse.

Mirroring the epidemiologic profile of Dr. María's catchment and the majority of other neighborhood consultorios, chronic diseases are the chief care problems that the La Habana physician encounters among his older patients. Showing me the catchment's recent monthly surveillance report, Dr. Evaristo's older patients suffer mostly from six chronic conditions: hypertension, diabetes, ischemic heart disease, high cholesterol levels, asthma, and cerebrovascular disease. On the other hand, the main chronic conditions among Dr. María's older patients are hypertension, arthrosis, asthma, ischemic heart disease, diabetes, and ulcers.

Dr. Evaristo's urban consultorio is open for scheduled and walk-in patients weekdays from 9am to 5pm and one Sunday each month. As with all other family doctor operations, the La Habana physician always is available for emergency cases. Noting the fluidity of his patient scheduling regime, he has "no problem with missed appointments...I'm very flexible."

The doctor schedules three formal annual examinations for most of his patients. A fourth examination, however, is given to all older adults in the catchment. The formal examination schedule for older residents includes two office and two home visits annually. As a solo practitioner/medical resident, the doctor adds that he regularly invites specialists from the nearby polyclinic to consult, especially on home visits to older patients. I find that Dr. Evaristo's office hours and elder care examination regime are unvarying from those of other family doctors.

Dr. Evaristo's professional demeanor, however, is markedly different from that of Dr. María, most other female family physicians, and even some other male family doctors. The most striking difference to me is that Dr. Evaristo does not meet his older patients in the consultorio waiting room nor does he escort them to his private office. Instead, he routinely sits at his desk, calls patients from the waiting room into his office, and verbally greets them with a simple "buenos días [good day]." Admittedly trained in a more "formal style" of doctor-patient relations, Dr. Evaristo and several other male family doctors I observe limit their physical contact with older patients strictly to the medical procedure itself. He explains that "touching them" in a reassuring manner is "just not my method."

Another distinction from Dr. María is that the La Habana physician has no training in an elder care "bed-side manner." Dr. María, however, says her continuing education classes taught her to be "more sensitive" to the expressed and non-verbal needs of her older patients, because many might have a "heightened sense of vulnerability." She says a geriatric-gerontology specialist also instructed her to speak more slowly, pronounce her words more carefully, repeat

her statements more often, and ask more questions to confirm that her older patients understand her explanations. Dr. María's special elder care training is exceptional; few other family doctors I meet receive such continuing education.

His more formal examination style notwithstanding, Dr. Evaristo's older patients also use such terms as "amigo (friend)" and "compañero" (partner or colleague) to describe their relationship with him. Dr. Evaristo attributes the "sense of closeness" he shares with all his patients to a familiarity with "their lives...[and] their family life." He adds that the high degree of awareness he must have of his patients is a critical part of the health surveillance training that is "stressed" in medical school.

The doctor then produces MINSAP's family health history form that he and all other Cuban family physicians use to document their patients' family home life.⁹ The front page includes three sections. One section includes spaces for the family's assigned health record number, home address, each family member's name, gender, birth date, educational level, profession or occupation, the actual work the individual performs, their dispensarization category, and each person's assessed risk factors and/or illnesses. Dr. Evaristo says he uses the second section of the form to note the hygienic characteristics of the family dwelling and family socio-economic factors. For example, hygienic characteristics include the following: the family's sleeping arrangements; the home's accident risk level; the residence's environmental state; family pets; and the dwelling's structural status.¹⁰ The socio-economic section, meanwhile, relates the family's social and economic status to its overall sanitary habits, psycho-social characteristics, and satisfaction of the basic necessities of individual family members.

Family doctors choose from one of three performance levels to gauge family socio-economic factors: good, regular, and poor. Sanitary customs relate to how well family members accept medical guidance, their awareness of community health promotion issues and practices, and the level of personal and collective hygiene practiced in the home. Similar performance levels assess such life issues as the family's psycho-social characteristics and all members of working age who work and those of school age who are engaged in study. The socio-economic section also includes a basic necessities space, in which the physician rates three levels of family satisfaction concerning nourishment, recreation, education, and other means that contribute to personal and environmental hygiene (Cuban Ministry of Public Health, 2004; Valdivia Onega & Zacca Peña, 1999). However, two aspects of this section that strike me as overly-invasive center

on physician assessments of whether the family maintains harmonious relations with their neighbors and if the family regularly participates in mass organization activities and projects.

Doctors use the opposite side of the health history form to document the family unit's general characteristics and functionality. Here, Dr. Evaristo notes the family type, its stage of development, and crises unrelated to the family's developmental stage.¹¹ The four possible levels of crisis are disorganization, dismemberment, familial transitions, and demoralization/corruption. Family disorganization refers to such difficulties as a teen pregnancy, sickness and other harmful health-related events, or the deterioration of family relations. Dismemberment pertains to an unexpected or abrupt separation, such as the death of a family member. A transitional crisis, meanwhile, includes the unexpected or abrupt return of an absent family member, family reunions in emergency situations, or the adoption of a child or orphan.

What seems odd to me is that the chief academic resource (Valdivia Onega & Zacca Peña, 1999) that all Cuban family doctors use to define and complete the various categories of the family health history form omits an explanation of the family crisis subsection on demoralization/corruption. A Ministry of Health publication, however, states that the demoralization/corruption category denotes a "crisis characterized by complaints about value [worth, merit, or efficacy] and the family's principal moral ethics" (Cuban Ministry of Public Health, 2004, p. 150). The Ministry document cites anti-social behavior, incarceration, and such community scandals as disturbance of the peace as examples of demoralization/corruption that are unrelated to the family's normal vital cycle. Once again, the demoralization/corruption portions of the health history form strike me as overly intrusive, because of my heightened sense of privacy invasion as a Unitedstatesian.

Other Cuban studies (González Benítez, 2000; Herrera Santí & González Benítez, 2002; Louro Bernal, 2003; Ortiz Gómez, 1999), however, expound on the topic of demoralizing family crises. In these articles, such events are reported to consist of unexpected episodes that destabilize family dynamics and may require psychiatric and/or psychological intervention. Forms of destabilizing events include alcoholism, drug dependency, delinquency, domestic violence, suicide, or dishonorable acts. Nevertheless, these clarifications fail to describe the exact behavioral characteristics that might constitute a dishonorable act.

The final section of the form's back page offers a space to construct a simple graphic

representation (histogram) of the family's life history. Five pages of the MINSAP publication regarding the health history form provide all Cuban family doctors a comprehensive symbology for completing family histograms (Cuban Ministry of Public Health, 2004). For instance, Dr. Evaristo notes the gender and age of male family members as a square with the numeric age of the individual placed at its center. On another form, he places a circle with an x in its center, notes the numeric age, and records the date to symbolize the death of a female family member. A third histogram illustrates the onset of a grandparent's incompatibility with other family members with a twisted line drawn next to the individual's name and the date that the physician first observed the dynamic.

Dr. Evaristo claims that health (bio-psycho-social well-being) and epidemiologic surveillance are the ultimate purposes of the health history document and the five other patient-related forms that he and his colleagues are required to maintain. For example, the doctor explains that he forwards a composite "report each month" to the municipal public health office for review and analysis, upon which local health appropriations are based. Furthermore, he submits a health planning form that details his strategies to address conditions that he feels pose a present and/or future danger to the health and well-being of residents in his catchment. As is the case throughout Cuba, local polyclinics generate independent surveillance reports, which MINSAP statisticians compare with individual family doctor reports in order to detect potential oversights that might warrant additional expenditures or overstatements that family doctors might use to garner uncalled-for appropriations.

Dr. Evaristo is exceptionally candid about the problems facing the family doctor program and the current state of Cuba's elder care services system. One of his chief complaints is that he lacks the time he needs to complete by hand the voluminous documents and reports that MINSAP requires of all family doctors. Citing the poor economy and the US embargo on imported Western technology, he laments that his job would be much easier if the "Ministry of Health gave me a computer."

A statistician with MINSAP's health surveillance unit confirms that the nation's family doctors and most polyclinics lack computerized record-keeping systems (Theresa Froletas, personal communication, June 28, 2001). A La Habana scientist, whose national research laboratory was outfitted with laptop computers in 1997, adds that MINSAP's slow adoption of computer technology is the result of the Helms-Burton Bill, which bans global distributors with

ties to US manufacturers from selling computer hardware and software to Cuba.

According to another scientist, however, the health agency itself resisted efforts to modernize the health system's computerized capabilities in an effort to control researcher access to potential anti-government information available on the global internet. Instead, MINSAP first created *Infomed*, the state-controlled electronic medical research and health statistics database, which carries predominantly Cuban scientific publications and MINSAP documents and reports. However, once MINSAP officials realized that computerization had begun improving systemic efficiency, the key informant tells me that he and his colleagues were granted partial access to the global internet. My visits to the National School of Public Health and several medical school campuses reveal that they now have computers and their faculty and students have full access to internet resources.¹² In light of MINSAP's cautiousness about potential anti-Cuban materials on the internet, I find it ironic that most Cuban students I observe at computer laboratory stations spend much of their on-line time in chat-room conversations.

Revisiting family doctor duties with Dr. Evaristo, the physician balks at my questions about whether administrative obligations are preventing him from meeting his patient care responsibilities. Subsequently, however, he criticizes the national home care model for older adults, expressing concern that the program now makes it "very difficult for family doctors and polyclinic physicians to keep up with current patient loads." He adds the caveat that, without additional support, the growing number of older non-ambulatory residents in his service area will undermine his ability to care for them in their homes.

Another criticism relates to emergency transportation and transportation funding issues. Dr. Evaristo says that it is the responsibility all family doctors to arrange ambulance transport for their patients through the local polyclinic assigned to serve the neighborhood practices. The majority of these transfers involve older patient "transports to the polyclinic, municipal hospital, and provincial" medical facilities. However, Dr. Evaristo claims it is now "very difficult for family doctors to make those arrangements, because of fuel shortages [and scarce] spare parts" required to keep the ambulances running.

A specialist at a rural geriatric polyclinic elaborates on the health transportation problem. He claims his facility now uses two ambulances that are based out of a nearby community hospital, because the polyclinic's two emergency vehicles are no longer running. When the polyclinic's vehicles are in use, however, physicians have to rely on "one Red Cross vehicle."

Fuel and funding shortages also are undermining Dr. Evaristo's mandate as patient advocate. Although MINSAP provides all family doctors funds to engage in intra-provincial consultations with specialists at other nearby care facilities, Dr. Evaristo says he has "no budget" to travel outside La Habana Province. The doctor cites a recent case, in which he was forced to cancel a "critical visit" to an older patient hospitalized in a nearby rural province for lack of gasoline money for his personal vehicle. He adds that he would have been forced to close his consultorio for more than a day had he used the public transportation system to visit his patient.

Focus Group Interview

The rural municipality of Piñar del Rio was one of this study's intended principal research sites. Key community informants, however, maintained that some older residents might feel uncomfortable speaking with an unfamiliar US investigator. Hence, a group encounter was organized for the purpose of introducing my research project and me. I sense, though, that the meeting is political and an attempt to assess my views on Cuba, Castro, and US-Cuban relations. However, the preparatory meeting rapidly evolved into an unexpected focus group interview, from which a valuable finding emerged—the older individuals' participation in local health activities gives them a sophisticated understanding of and insight into their community, and neighbors, and the local elder care structure. The following passages detail the results of the interview session.

The group and I meet in a family doctor's consultorio waiting room on a weekday morning. Once the doctor presents me to the group, and I outline my academic background, the purpose of the meeting, and the study objectives, the physician withdraws for the remainder of the two-hour encounter. Seven older individuals attend: 3 females and 4 males that range in age from 63-to-90 years.

One woman, who later states that she is a local Federation of Cuban Women (FMC) representative, initially is the most vocal female participant. During a subsequent discussion, I learn that the family doctor previously had approached the FMC about my research project. As a result of that meeting, FMC members suggested to the family physician that an introductory gathering was appropriate, and asked the older woman mentioned above to volunteer, organize a group of older neighbors, and ensure they attended our meeting.

The most vocal male participant is a 90 year-old retiree, who is unabashedly forthcoming

about his health condition. Without my prompting, the man stands up within minutes of the doctor's departure and proudly displays to the entire group a red spot on his neck that he says, and the family doctor later confirms, is a blemish from a carcinoma lesion. He goes on to praise both municipal hospital physicians for keeping him alive through the radiation treatment, and commends his family doctor for providing follow-up care after his hospitalization.

Another older male, who wears military-style sunglasses, sits quietly in the corner of the room with several chairs separating him from the rest of the group. Even when I attempt to include him in our discussion, he refuses to utter a single word. Instead, the individual closely observes the group and listens attentively to the responses of each active participant.

With the exception of the two most vocal members, the other interviewees sit in silence during the early part of the session, many with their arms crossed. However, a breakthrough occurs approximately 15 minutes into the discussion, when the FMC representative expresses her curiosity regarding my family. My response seems to place the group at ease and stirs more spontaneous interactions for the remainder of the session, during which the participants freely talk about their neighborhood, family life, and local health characteristics.

My general opening questions regarding the members' current life status and former occupations are met with a litany of former and current work activities:

- I was a panadero (male baker) until I retired.
- I still work part-time as a carpenter.
- I am a cocinera (female cook) and worked in a restaurant in town until just a few years ago.
- I also was a carpenter and still do other plumbing and electricity jobs.

A female participant adds that "most of us have kids who work and have grandchildren to care for during the day." The oldest group member, the verbose 90 year-old male, then quips that "I'm retired...I don't have to work...now my work is going to the video salon."¹³

The participants also offer differing replies, when I ask them about the most important things in their lives. All of the female respondents and one male answer that "family...children...and grandchildren" are the most important things in life. Another woman giggles and injects that "yes, I agree...I cherish my family most...all 104 of them." One man, however, chides the group for not mentioning "dinero y amor (money and love)." This disclosure prompts another man to note that the group has forgotten to mention "our health."

Jokingly, the garrulous 90 year-old states that “to me, the most important thing in life is to avoid death.” Closing this line of questioning on a more somber topic, however, another man says that visiting his family in the US the previous year is the most cherished thing in his life.

A critical result from the exchange is the keen awareness the members have of their neighborhood’s socio-demographic composition, the health status of their older neighbors, and the structure and operation of the local elder care services apparatus. For example, the participants agree that 586 individuals live in the neighborhood, of which 82 are age 60 years or older. Of the 151 local families, they concur that only one person lives alone.

After a somewhat contentious exchange, the respondents settle on the following additional characteristics: more than half of the households are composed of two-generation families; almost a third have three or more generations living in the same home; and “19 families” have one or more non-kin members living under the same roof. The group also demonstrates a remarkable understanding of the functional capacity of their neighbors. One respondent knows that “all but three” of her doctor’s 82 older patients are fully independent and require no special familial or community support. Another person says that only two neighbors need additional family support, but that no one is unable to function in their homes. A third individual states that one “impaired” neighbor is a likely candidate for institutional placement in a home for elders, because she has “no family,” lives alone, and needs “lots of support.” Yet another member observes that “about 60 percent of all Category II or III patients” (dispensarization-CARE typology for at-risk for illness or manifest disease/illness) under the care of the local family doctor are “over [age] 65.”

When I ask about local health conditions, the participants begin identifying and ranking the neighborhood’s main problems. They agree that hypertension, arthrosis, asthma, heart disease, and diabetes are the primary non-communicable diseases that appear in their neighborhood.¹⁴ One respondent, however, interrupts, and exclaims that they have forgotten to mention tuberculosis. A brief row ensues, during which the members debate whether the communicable disease is indeed a neighborhood problem. Referring to a community health meeting, the group decides that although tuberculosis has re-appeared in some parts of the island, no cases have been reported in their neighborhood and, therefore, they should not mention it as a local health concern.

The family doctor confirms many of the group’s citations in a follow-up conversation.

The physician explains that she regularly presents these types of statistics at health education gatherings and before local governing council (Consejo Popular) meetings. She adds that printed reports also are given to such local groups as the FMC and CDR.

With regard to the focus group member's understanding of the elder care structure, how older individuals navigate the system, and what particular health conditions motivate older people to seek out specialized services, the interviewees offer the following remarks. They establish that their family doctor is available almost all the time, even if they require emergency care in the "middle of the night." They confirm that their doctor never refuses to see them on a walk-in basis. However, the "best practice" is to schedule an appointment in non-emergency situations, because the doctor's additional responsibilities include visiting older residents at home and consulting at the polyclinic. Moreover, the group agrees that older patients can always visit the polyclinic, see another neighborhood doctor, or seek out one of the local school- or workplace-based teams if their family doctor is temporarily unavailable. Not one person, however, mentions the local hospital emergency room as an urgent care option.

The group members maintain that they have the opportunity to seek treatment for specific health conditions from specialists assigned to "their [local] polyclinic." For example, they all seem to know that a gerontology-geriatric specialist is on staff and available during the day. Still, they prefer to "walk to the consultorio" to see the specialists, who regularly visit their family doctor's office. Responding to my questions about how they know when a specialist will make a consultorio visit, and what type of specialist will visit, they point to a flyer pinned to the consultorio waiting room bulletin board and explain that their doctor posts a new schedule each month. Statistics regarding the catchment's epidemiologic profile and various health education and promotion materials also are posted on the bulletin board.

With the exception of the one silent member, all of the participants claim they most visit the polyclinic for dental care. They also use its laboratory services and pharmacy upon a referral from their family doctor. Conversely, the group members tell me that immunizations, blood pressure checks, diabetes testing and injections, regular examinations, and follow-up care for such conditions as asthma are the chief reasons they recently have visited their family doctor. When I quiz them about hospital visits, the respondents explain that they "hardly ever" go without a referral from their family physician. One man calls hospital care his family's "last resort."

Supplementary Findings

This final section presents results from an extended analysis of data from the study's secondary subjects. The analysis reveals three emerging and convergent dynamics—the movement toward deinstitutionalized care at a time of escalating social isolation and increasing cognitive disorders among older Cubans. Unlike the two overall findings, however, the yet discernable influences of these three dynamics on perceptions of health equity and health inequity have staid future implications.

Social Isolation

Cuba's "biggest social change" in recent years has been the upsurge in two-or-more working family members (Ivonne Plana, personal communication, June 27, 2001). Consequent of national family planning initiatives and enforcement of constitutional social equality provisions after the mid-1970s, and the poor economy after 1989, large numbers of mostly female family members are now in the labor force voluntarily or out of necessity. Because families and community volunteers have "less time to care for older relatives and neighbors", care-providers expect that isolation among older adults will become one of the country's "most significant social and public health problems" (Ivonne Plana, personal communication, June 27, 2001).

The FMC's lobbying efforts following the enactment of family legislation in the mid-1970s purportedly resulted in an adequate level of child day care services by the mid-1980s (Ivonne Plana, personal communication, June 27, 2001). However, economic conditions since 1989 have hindered government efforts to meet community demands for more day care centers for older family members and neighbors (Ivonne Plana, personal communication, June 27, 2001). Even if MINSAP is able to provide ample services, though, one health official doubts that most families with older members can afford the monthly 25-peso co-pay that the health agency recently has attached to state-subsidized adult day care services. The co-pay represents approximately six percent of a health care or agricultural worker's average monthly income.

A gerontology-geriatric specialist notes that rapid economic deterioration during the special period of the 1990s brought the problem of social isolation among older adults to the fore much sooner than anyone had imagined. The director of a La Habana home for elders, or hogar de ancianos (a small, skilled, long-term, residential elder care facility), concurs that growing

“physical and psychological isolation” beginning in the early 1990s are the chief reasons that working couples are choosing to admit older family members to the province’s 20 existing homes for elders (Osmara Delgado Sanchez, personal communication, July 13, 2001). However, a social worker, who first mentions to me that she had observed a similar family pattern after the mid-1990s, later describes the trend as “families using the government [homes for elders] program as a dumping ground” for older relatives they no longer wish to support.

An 85 year-old resident of one home for elders personifies the family abandonment issue. She produces her son’s business card for me and says she carries it with her to remember him. She becomes tearful upon recalling that he has not “visited me once since he put me in here almost ten years ago.” The staff confirms that they admitted the woman and several other clients on the basis of family neglect soon after the onset of the post-1989 economic crisis.

Isolation and Rural Tradition

In contrast to Cuba’s urban centers, I do not find isolation and abandonment to be major social and health issues in the nation’s rural areas. A number of rural family doctors tell me that very few of their older patients are at-risk for family nonattendance. They attribute this actuality to the elder care model, which mandates recurrent physician interactions with their older patients and physician intervention remedies.

A number of older subjects, however, cite Cuban tradition as the reason that social isolation is uncommon in rural communities. One retiree, for instance, maintains that the dearth of rural health services before 1959, in addition to incessant poverty and housing constraints ever since, obliges multi-generational living arrangements and a strong sense of “community interdependency.” Despite the flight of many young people to the cities, particularly after 1989, another individual observes that rural Cubans maintain their customs, wherein “we [older individuals] seldom live or are left alone.” Similarly, a 70 year-old woman praises the village’s younger residents for transporting her and her contemporaries any time they need to run errands—“we are always taking care of each other.”

Isolation and Mental Health

The Cuban medical community has long avowed that persistent social isolation can manifest as “old age depression” (Teovaldo Triana Torres, personal communication, July 23,

2001). Health professionals further recognize the “relationship between old age depression and suicide” (Teovaldo Triana Torres, personal communication, July 23, 2001). Hence, mental health experts speculated in the mid-1980s that projected increases in isolation due to changing social dynamics would produce a corresponding expansion in depression and suicide rates among the older population (Teovaldo Triana Torres, personal communication, July 23, 2001).

A physician specialist assigned to an urban adult day care center confirms that depression in his patients rose dramatically from almost nil to as high as 20 percent between 1989 and the late 1990s. The physician adds that 11 of the day care center’s 72 older clients currently are diagnosed with depression by reason of “exposure to long periods of physical and psychological isolation.” He points to a sharp rise in alcoholism and alcohol abuse during the 1990s as other symbols of the isolation-depression nexus.

A national health surveillance official, meanwhile, reports that surges in the harmful effects of increased social isolation began almost immediately following the strengthening of the US embargo in 1992 and again in 1996 (Theresa Froletas, personal communication, June 28, 2001). However, the director of a mental health clinic notices that persons in his service area are beginning to grasp that structural changes among importunately destitute families “long before the 1990s” also are responsible for isolation and such “insidious outcomes...[as] family dysfunction and suicide.” His clinic is located in a poor neighborhood, where the province’s highest occurrence of suicide is almost exclusive to its older population. Both the director and an area adult day care administrator credit major declines in isolation, depression, and suicide to new social, cultural, and recreational interventions after the mid-1990s. However, the clinic director believes that future socio-demographic, political, and economic tendencies will continue to make isolation a “long-term, high risk [elder care] issue.”

Although most key informants go out of their way to tell me how racial/ethnic biases no longer exist in Cuba, my conversations about social isolation with residents in this poor barrio (neighborhood) surprise me. The director of the adult day care facility, who is white (Spanish decent), tells me the area became a high crime area during the special period, because of the “high concentration of blacks [Afro-Cubans].” He credits Consejo Popular (neighborhood Poder Popular) representatives with a local anti-crime initiative that “took back the barrio.” He says the initiative has the added effect of making older residents “feel safer” about walking to the neighborhood facility, which he credits for increasing participation rates and a corresponding

decrease in elder isolation and its associated problems.

A Santeria priest, however, rejects the director's characterization as racially biased and incomplete. Instead, he attributes increasing attendance to both the anti-crime initiative and program adjustments after the mid-1990s, in which the "spiritual and social needs [of the neighborhood's older black residents] were finally offered." More than two-thirds of the day care center's members are black, the majority of whom confirm that they are Santeria.

The Dementia and Alzheimer's Conundrum

MINSAP directs scarce resources to problems that local health professionals recognize as a priority (Teovaldo Triana Torres, personal communication, July 23, 2001). Because Cuba had "more cases of suicides than dementia" throughout the 1990s, most health officials consider it the greater public health threat (Teovaldo Triana Torres, personal communication, July 23, 2001). Consequently, the Ministry developed and implemented a suicide prevention program nationally beginning in the early 1990s (Pérez Barerro, 1999). All the same, adolescent suicide remains the dominant theme in the Cuban academic literature on suicide and continues to be the major thrust of the national health initiative (Pérez Barerro, 1999). Thus, one official views MINSAP's response to suicide among older adults as simplistic; the agency "simply" asks that more Grandparents' Clubs be created, that older people participate more in club activities, and that local officials add such social engagement functions as arts and crafts and cultural outings to the clubs' activity programs.

For many health professionals with whom I speak, the agency's stance on cognitive health promotes an atmosphere of seeming denial about the scope and ramifications of such maladies as Alzheimer's Disease and other forms of dementia.¹⁵ One family doctor's remarks about the occurrence of dementias typify those of many other rural elder care professionals. Fourteen percent of the physician's patients are older adults, 60 percent of whom are age 75 years or older. However, the rural doctor maintains that she has seen "no patients with dementia or Alzheimer's Disease" in her five-years of practicing in the catchment. The physician is convinced that this trend stems from the daily contact her older patients have with their families, and an integral care regime of exercise and community socialization, regular geriatric and psychiatric specialist examinations, and orthodox and alternative medical care, all of which permit the physician to "catch and reverse" diminishing mentation at the "earliest stage."¹⁶

While no urban physician could offer me specific case figures, the city doctors generally are more forthright about the occurrence of dementias among their older patients than their rural counterparts are. A polyclinic specialist in one of La Habana's most affluent neighborhoods estimates that about one-to-two percent of his older patients suffer from dementia, a proportion a family physician in another major city also cites. A mental health clinic director, however, disputes these claims and asserts that dementia and Alzheimer's Disease affect "less than one percent" of Cuba's older population.¹⁷

Cuba's health surveillance mechanism allows professionals at all levels of the care system, as well as ordinary citizens, to recite actual figures concerning a range of issues, such as life expectancy and local epidemiologic characteristics. Yet, health officials and care-givers seem unable to provide little more than superficial statistics with regard to senile dementia, Alzheimer's Disease above all. When I ask various health informants to explain, the justifications they offer me about this inconsistency generally center on social norms regarding such cognitive disorders as dementias, professional uncertainty about their mental health care-giving responsibilities, and educational shortcomings, in which they do not receive proper training.

A social worker claims that "dementia and Alzheimer's Disease" are a "secret family problem" in Cuba. She confides that people are frightened to admit that a family member is impaired, because mental health issues carry with them a power social stigma. The director of a mental health clinic further explains that this apprehension among older persons stems from their memories of conditions before the 1959 Revolution, and the confinement of mental health patients as "prisoners in horrible institutional settings." Although mental health facility conditions improved considerably after 1959, MINSAP continued to pursue a policy of institutionalization through the late 1980s. According to one mental health expert, the placement of cognitively impaired persons in sanatoria (sanitariums) was routine. Since 1987, however, a community-based initiative that emphasizes out-patient care rather than institutionalization and segregation reflects the Ministry's "softened" mental health approach.¹⁸ Another Cuban care-giver, however, attributes the circumspection of older adults about mental health issues to machismo among older Cuban males and "older women too."

Expressing an uncertainty about appropriate treatment, the director of a home for elders tells me that dementia is not a major concern for the staffs of facilities such as hers, because

other institutions are designated to care for the unique needs of cognitively impaired persons. The director claims that because patients are immediately transferred to a home for mentally disabled persons within ten days of a diagnosis, they have “no handicapped” residents for whom to care and, consequently, have no need to learn about dementia nor institute an appropriate treatment protocol. A national health official, though, says that he is aware of at least one La Habana home for elders, whose staff is “well-trained to care for demented individuals and patients with Alzheimer’s.”

MINSAP officials tell me the agency has a small number of skilled, long-term, residential care institutions (homes for elders) in operation that specifically serve persons with physical and mental impairments. The so-called hogares de impedidos físicos y mentales (homes for physically and mentally impaired persons), however, should not be confused with the system of homes for elders (hogares de ancianos). In theory, homes for elders provide skilled, long-term, residential care only to physically and cognitively functional older individuals, whereas the homes for physically and mentally impaired persons are for persons of all ages, who suffer from physical and cognitive disorders. These discrete institutional variations notwithstanding, my observations of older individuals in homes for elders throughout the nation, as well as numerous adult day care centers and Grandparents’ Clubs, suggest that the cognitive functions of older persons in these elder care settings range from minor-to-more serious levels of impairment.

The comments of some Cuban elder care-givers infer that they believe particular treatment regimes have the capacity to reverse the progressively degenerative course of Alzheimer’s Disease. My conversation with a polyclinic gerontology-geriatric specialist about this topic, however, provoked an angry retort. The doctor attributes the inability of some of his colleagues to understand, properly diagnose, report, and treat demented patients largely to the “textbook problem” and inadequate continuing education for health professionals.

According to the rural physician, three factors are contributing to a nationwide shortage of contemporary texts on aging. First, the leadership prohibits Cuban medical faculty to teach from books or journals published in the US. Second, the poor economy and currency shortage continues to hinder MINSAP’s ability to produce new medical textbooks domestically and/or to purchase allowable new texts from external sources. Third, “Helms-Burton” makes international publishers with US corporate ties reluctant to sell relevant texts, journals, and instructional materials to Cuba for fear of the law’s prosecutorial stipulations.¹⁹

The doctor affirms that these circumstances have forced him to learn about such dementias as Alzheimer's Disease from experience and from dated medical books, research papers, and materials that are "in English and smuggled" to him by foreign colleagues and friends who visit the island. The specialist admits that his poor English makes it "very difficult [to interpret the information]." Consequently, the doctor says that while he receives no formal continuing education on the subject, his informal studies involve "lots of wasted time."

A polyclinic specialist notes a different environment in La Habana. He and his colleagues receive a few brief lectures on cognitive disorders, though they are given very little published information on the "diagnosis and treatment of dementia and Alzheimer's Disease." All the same, the physician's supervisors have ordered him to direct "all of his most important programs and activities toward the occurrence and retardation of Alzheimer's."

While social norms, administrative ambiguities, and educational defects have contributed to a general misunderstanding of such dementias as Alzheimer's Disease among some Cuban health professionals, a bio-medical researcher offers a political rationale. The scientist explains that if MINSAP has not created a program to address a specific problem, the agency rarely provides information about the issue to health professionals unless they demand it. More critical, however, is that if an existing program has not begun to reverse a specific health or social problem for which the government can take credit, then, "it [the problem] did not exist."

Responsiveness and Innovation

Let us briefly return to the topic of social isolation. More than a few urban elder care providers express their concerns that the scarcity of homes for elders may be contributing to the isolation problem almost as much as changing social dynamics. The director of a central La Habana day care center, who notes that there is no such home for elders in her poor barrio, argues that the relocation of older persons in need of institutional care to homes for elders in other parts of the city exacerbate their sense of "separation from the people and things they have been around all their lives." A mental health clinic administrator relays similar worries. Because many of his facility's poorest clients cannot afford to purchase enough food on their small pensions, he sees a marked deterioration in their cognitive functionality. Consequent of their worsening mental health states and no locally available home for elders, he has no option other than to refer his "patients for placement [in homes for elders] in other parts of the city....far

from their families, friends, and homes.”

In defense of MINSAP’s actions, one elder care administrator notes the “many ways” the agency responds to increasing demand for additional resources. She cites MINSAP efforts in the early 2000s to increase the number of Grandparents’ Clubs as one example. Similarly, the agency’s newest project in response to family concerns about social isolation involves the conversion of vacant spaces into adult day care centers. It also is now assigning other resources to existing day care operations in the capital to create and pilot hybrid medical facilities for ambulatory older patients.

The director of one such hybrid facility, which is located in La Habana’s second most affluent suburb, claims that the pilot project is largely the result of demands from families with older members, community organizations, and family doctors for more “centralized” elder care services (Ivonne Plana, personal communication, June 27, 2001). Constructed in 1926, the colonial mansion was commissioned as a senior citizen center in the early 1980s and as an adult day care center later that decade. With a small medical clinic, a day bed ward, a kitchen, a large congregational area, patios filled with rocking chairs, a garden, and landscaping with medicinal herbs, 10 percent of the center’s 70 clients have “minor [cognitive] handicaps.”

Initially designed to combat social isolation among the neighborhood’s older residents, the day care program operates weekdays from 8am-to-6pm. In recent years, however, more comprehensive medical services have been added to the day care track. Unlike the hogares de ancianos (homes for elders) transfer procedures mentioned above, the hybrid facility’s medical services track allows older clients with cognitive impairments to participate in the program, with the stipulation that the family and community volunteers are capable of attending to the person’s nighttime and weekend home-care needs.

With a full-time, on-site staff, the facility’s older clients are cared for by the director, who is a gerontology-geriatric specialist, a family doctor-nurse team with three assisting nurses, a social worker, and a trained recreational/physical therapy technician. Complementing the facility’s full-time staff, are visiting polyclinic specialists, a dentist, a psychologist, psychiatrist, and three health auxiliary volunteers. Thus, the director says that families arrive with their older relatives in the “morning and pick them up after work...[as if we were] a small hospital or geriatric polyclinic with medical elder care services and adult day care.”

Much in the same way, a home for elders in another affluent La Habana neighborhood

was founded in 1991 as an adult day care facility. Later, it was adapted to include skilled care on an out-patient basis and a residential track for skilled, long-term, in-patient care (Osmara Delgado Sanchez, personal communication, July 13, 2001). Hence, the facility blends adult day care services that are patterned after the adult day care prototype, a skilled out-patient program that resembles the adult day medical care example, and a skilled, long-term, residential service track for cognitively functional persons that is based on the *elder home* model.

Residents of a poor central La Habana barrio assert that they too are developing innovative approaches to combat local age-associated problems. The neighborhood's geo-political boundary encompasses an area of .81² kilometers and includes almost 36,000 residents, 20 percent of whom are age 60 years or older. Due to large numbers of working families, a single adult day care center, and no home for elders, the president of the Consejo Popular tells me that that 8-to-12 percent of her older constituents are "isolation cases."

As a result of the growing isolation problem, local families and health professionals demanded that council representatives obtain additional elder support services from the government. Although the council petitioned government authorities and won new funding and resources, MINSAP's appropriation is conditional on the following terms: the barrio's existing adult day care center is to be the sole recipient of all new funding; local political representatives must pledge to organize family doctors, polyclinic physicians, social workers, health educators, and mass organization members for a new in-home elder care outreach program; family members and their neighbors must consent to participate in the new program; and residents must agree to permit MINSAP instructors to train community volunteers, who, in turn, will teach families and neighbors "special [elder] home care techniques and coping skills."

The director of Cuba's National Health Promotion and Education Program adds that gerontologists at the Latin American Center for the Third Age (Centro Iberoamericano para la Tercera Edad) are assigned to outreach projects similar to the one mentioned above in order to locate specific at-risk families with older family members, assist local adult day care centers and community groups, and enhance the delivery of elder health education (Rafael Borroto Chao, personal communication, July 2, 2001). Cuba's most effective health education tool, according to the director, is multi-generational education, whereby children share "what [health-related issues] they have seen or heard" or have been taught with older relatives; in addition to in-home family training, organizers are given access to television, radio, billboards, video salons, and

movie theaters, which present “situational dramatizations of specific [elder and family] health issues.”

The elder health education outreach program, however, faces “big money problems, because of the economy” (Rafael Borroto Chao, personal communication, July 2, 2001). As a non-entitlement, it is financed through MINSAP’s annual budget. The director notes that additional funding is contingent on increased general revenues, which are reliant on increased tourism revenues.

In the face of such escalating problems as social isolation and dementia, however, the director observes that the “biggest gerontological issue now is [to increase] life expectancy.” The administrator claims that “10 or 20 years ago health officials did not recognize the demographic dimensions of health education...that a good health care promotion and education program could raise life expectancy.” Consequently, his staff has been working to develop and implement a health education-communication strategy on the topic.

Mixed Messages and Deinstitutionalization

Protracted increases in such dementias as Alzheimer’s Disease, in tandem with the loss of informal support systems, are expected to compel the leadership to provide for sizeable numbers of older Cubans in the coming decades requiring skilled, long-term, residential care. So far, the government’s chief responses include the enhancement of Grandparents’ Club program activities, adaptation of existing out-patient care operations mostly in La Habana, and elder home care training for most urban families. The 1992 national policy on aging, however, promises a collateral increase in services at the institutional level of attention, namely the system-wide expansion of homes for elders. Nevertheless, many health providers tell me with certainty that Castro already had decided on a policy of broad deinstitutionalization, whereby elder care will become more of a family and community custodial and economic responsibility.

According to a national health official, Cuban leaders cite two streams of public support to justify a long-term elder care policy of deinstitutionalized, community-based services. First, there are those families and care-providers, who express thankfulness for state-sponsored programs that have begun to relieve “anxieties regarding unattended older relatives and neighbors” that have been at a high point since the mid-1980s. Another source of public support comes from older Cubans themselves. Many “independent-minded” persons continue to voice

indirect support for deinstitutionalized services, because they view hospitals and homes for elders as “symbols of decreasing self-reliance linked with aging itself.”

A director of a home for elders, meanwhile, describes the political economy of deinstitutionalization in the early 1990s, when the number of social case admissions began mushrooming. Because Social Security provides full subsidies to indigent residents of homes for elders, and because MINSAP had such a “small” in-home care services budget at the time, political leaders feared that the entire system of homes for elders might be bankrupted just as the leadership was about to announce the 1992 national policy on aging. Consequently, a MINSAP dictate instructed staffs at homes for elders to triage all special social cases and admit only the “worst cases.”

Within this post-1989 political and economic environment, according to a physician-researcher, the agency instituted homes for elders fees for all non-social case and non-worst social case residents. The director of one such facility is proud of the relatively small monthly 40-peso co-pay, which provides “all food, clothing, and all other needs” to the resident. A staff member, however, insists that the co-pay drastically curbs demand for such services, because the cost is “ten percent of the [average monthly] family’s income.” A social worker, meanwhile, claims the intent of triaging social cases and the fee schedule is to “limit demand” until the economy improves.

Working his entire life in Cuba’s coffee fields, I listen to a retired laborer reflect on both his current situation and the future. He first expresses his appreciation for “free housing, health care, and my food ration.”²⁰ The 82 year-old then tells me that, in spite of his government allowances, his retirement income is not “enough to balance my living expenses.” He confesses that he does not know how he or his family will “get along” if he is unable to stay at home and has to be placed “into a hogar [home for elders]”.

Care providers, meanwhile, offer differing opinions about the future of the system of homes for elders and co-payment structure. Sneering, one nurse recalls the official promise of “no proposed or future increases in patient rates.” A few weeks later, MINSAP reported it would increase fees for residents of homes for elders “if necessary.” Another staff member points out that the monthly fee “can hardly pay the cost of [resident] breakfasts.”

In contrast, a director of another home for elders is convinced that the agency “will never ask patients to pay more” and predicts it will “reduce or altogether scrap the fees if the money is

there.” Citing agency actions during the most economically “difficult time” of the special period, the administrator tells me that agency officials “refused to raise fees” or cut her facility’s special nutrition program. She goes on to cite Castro’s “promise” for more programs that teach “families and community volunteers to assist older relatives in how to live alone” and his ongoing effort to “eradicate” the need for a system of homes for elders. The current strategy, therefore, is to conserve limited resources and “redirect them into [skilled, long-term, residential] care for those who need it most.” One employee of a home for elders places the situation and her prospects into perspective: “our future is in day care...family and community support in the home...not long-term [skilled, in-patient, residential] care.”

Summary

This chapter has related the older Cuban’s perceptions of health equity and health inequity, and offered the opinions and expectations of principal and secondary subjects regarding the long-term elder care services system. It also has conveyed findings from my direct observation of care-provider activities in numerous elder care settings, most notably the rural and urban family doctor consultorio. The next and final chapter synthesizes these findings and their implications, presents the study’s limitations, and concludes with suggestions for future research.

Chapter Ten

Synthesis and Conclusion

This dissertation has examined perceptions of health equity and health inequity among members of the revolutionary cohort in post-Cold War Cuba. Its specific aim was to explore dynamics from the global-to-sub-local levels that have most influenced the older individual's viewpoints regarding health and health-related resources. In discovering the commensal dimensions of macro-level activities and micro-level perspectives, this research also has provided a better understanding of the older person's daily care-seeking experiences and expectations during a period of rapid and dramatic change in global and domestic socio-political-economic conditions and paradigms.

Two overall findings emerged from the narrative, focus group, secondary subject, and secondary source data. First, the Family Doctor Program, the epicenter of Cuba's domestic health welfare policy, was identified as the overriding influence on perceptions of health equity among the study's older participants. The narratives and secondary sources, in particular, revealed five fundamental aspects of the program that had a great effect on the older individual's perceptions: affordability, availability, accessibility, accommodation, and acceptability.

Perceived inequity involving medicine shortages and health resource rationing was the second overall finding that was conveyed through the narratives. Secondary sources, meanwhile, established that censorious perceptions expressed by the older subjects were influenced most by five macro-level dynamics. Two international changes were among these five dynamics: attenuated trade alliances and a more restrictive US embargo. The three remaining dynamics involved domestic circumstances from the national to the sub-local levels: the consequences of economic failure, inadequate pharmaceutical production, and health and social welfare policy reform. Moreover, the narrative and focus group findings called attention to life course influences as seminal to both the positive and critical perceptions of the older participants.

This chapter opens with a synthesis and rigorous interpretation of the findings that integrates the extant literature. The study's implications and limitations then will be addressed, and a concluding segment will offer potential directions for future research.

Domestic Policy and Perceptions of Health Equity

The positive effects that the universal Comprehensive General Medicine Program and

family doctor model have had on the older person's perceptions of health equity was one clearly identifiable association revealed in the findings. The framework for comprehensive, neighborhood-based, preventive-primary family physician services was first integrated into the Cuban health care system in 1985, four years before the onset of the post-Cold War Era. However, its far-reaching effects were not felt until the 1990s, when the amassed deployment of family doctor-nurse teams throughout the island was completed (Feinsilver, 1993; MacDonald, 1999). Certain facets of the domestic health policy and related attributes have strongly affected perceptions of health equity among the study's older participants. These facets and attributes include affordability, availability, accessibility, accommodation, and acceptability.

Access-Related Attributes and Positive Perceptions

The individual's ability to "access the health structures and processes of care" (S. M. Campbell, Roland, & Buetow, 2000, p. 1614) is a critical dimension of a quality health care policy, a health care system, and associated services and benefits. The literature indicates that one's perceptions of and satisfaction with this health care framework are shaped a number of access-related characteristics that are explicitly or implicitly stipulated in every health policy—affordability, availability, accessibility, accommodation, and acceptability (Gribben, 1993; Humphreys, Mathews-Cowey, & Weinand, 1997; Mechanic & Rochefort, 1996; Penchansky & Thomas, 1981; The College of Family Physicians of Canada, 2000). With regard to Cuba's family doctor model, these characteristics have their own inter-connected and, at times, overlapping sub-functions or considerations.

Affordability takes into account total health care costs and the older Cuban's ability to pay for health services. Availability refers to the quantity of family physicians and consultorios. Accessibility indicates geographical associations between family physicians, consultorios, and patients. Accommodation describes the consultorio's organizational structure used to accept older patients. Acceptability pertains to the temporal, social, and inter-personal dimensions of continuity, or the older person's ability to visit the same consultorio on a long-term basis, in addition to longitudinality, which concerns the long-term relationship between the family physician and older patient.

Economic considerations, or affordability, are particularly important to access. Two factors—physician and transportation costs—are noteworthy as positive influences on the

individual's "perception of worth relative to the total cost" (Penchansky & Thomas, 1981, p. 128) of physician and health-related transportation services. The prohibitive cost of physician care for the majority of Cuba's citizens was a central concern for the revolutionary leadership in 1959. Consequently, cost-free physician care was guaranteed as part of a far-reaching socialized health agenda. The sway of the constitutional mandate for universal physician services on the perceptions of members of the revolutionary cohort, particularly care services now provided at the neighborhood-level by family doctors, can be found in Luis's narrative. The elder prided himself on his constitutional "right" as a Cuban citizen to receive such care for free. In truth, the now 40 year-old proviso has made the concept of fee-for-physician-services laughable for many older Cubans. Juanita, for example, quipped that her free family doctor visit would have cost "five pesos before the Revolution."

I am intrigued by the seeming ability of the older participants to separate their attitudes about the equitability of universal physician care from the denial of cost-free services that were obtainable before the post-1989 economic crisis. For example, although Dr. María informed Juanita that she was unable to offer her patient a "free" prescription, Juanita based her affirmative perception of the services she received on the expectation that she could return to the consultorio and see her doctor at any time for free if her injury worsened. Pedro's case was more revealing in his spouse's expressed understanding of their family doctor. Despite the physician's inability to secure additional services and the support needed to ensure the quality of Pedro's life and well-being at life's end, Isabel believed that the family's doctor was "doing her best."

Another issue related to the perceived impact of physician costs involves black marketeering. Although a secondary subject admitted to bribing her dentist in return for additional services, and despite one allegation of corruption among medical doctors, no principal subject reported such an occurrence with their family doctor. As with Cuba's elderly pensioners, most physicians have no access to tourism dollars and must subsist on meager state-dictated incomes. If Cuba's economic situation continues or worsens, one might expect physician black marketeering to become more widespread, which most likely would shift positive perceptions of physician affordability among older people toward the negative.

Akin to physician costs, available transportation is a second economic consideration relevant to one's perceptions of a health policy, care system, and related services. The narratives and secondary sources indicated that the nation's health-related transportation arrangements had

a positive influence on the older person's perceptions. The cost of transportation was a non-issue for most ambulatory older patients, because they preferred to walk to their family doctor's consultorio. Direct observations and secondary sources, meanwhile, revealed that transportation costs also were immaterial for non-ambulatory homebound elders, because their family doctors and other specialists provided regular home visits and in-home care services.

When older patients required public, private, and or emergency transportation to reach more distant health services, such transport was provided cost-free or was made affordable; public, horse-drawn taxis were observed transferring older patients to hospital, polyclinic, and physician appointments free of charge in the remotest areas of the country and no older subject voiced disapproval about the cost of state-subsidized public bus transportation in Cuba's urban centers. A 70 year-old subject further noted that such long-standing rural care traditions as providing private transportation to older neighbors in need had been transmitted to younger Cubans. Similarly, secondary sources identified the communal provision of private transportation to older patients in both urban and rural settings as a routine volunteer function of such mass organizations as Committees for the Defense of the Revolution, Federation of Cuban Women, and Union of Young Communists.

Positive Perceptions and Geographic Considerations

While cost-free family doctor care and free or affordable health-related transportation services have affected perceived health equity, at least three narrative responses point to other persuasive influences. Consider Juanita's contention that that she could return to see her doctor at any time, Jaime's imperviousness to his doctor's absence from the consultorio, and the 79 year-old woman who commented about walking to the doctor's office, because it was "just up the street." In each of these examples, one can distinguish geographical considerations included in the neighborhood-based family doctor model that have shaped elder perceptions.

Family and general practitioners in Australia, Canada, France, Finland, New Zealand, United Kingdom, and Cuba are most often the patient's first point of contact with the health system (Holroyd, Rowe, & Sinclair, 2004; Humphreys et al., 1997; The College of Family Physicians of Canada, 2000). As such, assertions are made in the literature that perceptions of health equity and health inequity largely are shaped by one's experience of the geographical aspects of the care system and services (Gribben, 1993; Humphreys et al., 1997; Mechanic &

Rochefort, 1996; Penchansky & Thomas, 1981; The College of Family Physicians of Canada, 2000). Geographical sub-functions include such availability and accessibility attributes as the number of physicians and facilities, the placement of care-givers and facilities relative to patient location, and distances and times required to reach and acquire health services. Other geographical considerations comprise such accommodative attributes as the physician's capacity to accept, organize, and provide an interface between patients and services via office hours of operation, appointment methods, and consultation length (Buetow, 1995).

The coverage capacity of a health care services system is reliant upon the volume and placement of physicians and facilities, whether the coverage area entails a small catchment or an entire nation. For example, Canada's universal care system features some 30,000 family doctors—94 family doctors per 100,000 population, or a doctor-patient ratio of 1:1,064 (The College of Family Physicians of Canada, 2000; Wood, 2001). However, Canada lacks an adequate quantity of family doctors to fully cover the entire population, because their numbers and office locations are poorly distributed (The College of Family Physicians of Canada, 2000). These shortcomings stem from doctor preferences for “locational factors...reputation...[and] patients with particular demographic and socioeconomic characteristics or types of problems” (Buetow, 1995, p. 215).

The Cuban findings, however, indicated the rectification of coverage issues and physician inclinations through its socialized, command income, and physician community service approaches to health and social welfare. Secondary sources and direct observations revealed that because of the hyper-localized consultorio model and the training of some 26,000 family doctors, the country had more than a sufficient quantity of family physicians and local facilities to care for every person in every neighborhood and rural community throughout the country with a doctor-patient ratio about half that of Canada's—1:600-to-900. Furthermore, the relative equalization of socio-economic and health disparities among the citizenry, the state's modest doctor wage structure, lifetime guarantee of fully subsidized physician housing, the physician's public service oath, and MINSAP's discretionary authority over doctor relocation requests act in concert to discourage physicians to seek more lucrative practice settings and patient bases.

Despite an unbroken series of explicit references in Castro's public discourse, a universal education system that has produced a high-level of health awareness among ordinary citizens, and the public's active involvement in health surveillance, none of the study's older respondents

referred directly to the adequacy of physician and facility coverage. Even so, the indirect influences of these geographical considerations were unmistakable. Every older respondent indicated that she or he was actively cared for by a family physician in the neighborhood in which the individual resided.

Perceived health status, particularly when compared to other persons of the same age, also contributes to one's perceptions of a health care framework (Penchansky & Thomas, 1981). Although the principal subjects failed to indicate a direct association between perceived health equity and such geographic sub-functions as physician coverage, a more subtle linkage is expressed between geographic considerations and the attitudinal response of perceived health status. Numerous older subjects reported that they felt they were healthier than were older persons in other poor countries, because they could more easily reach their family doctor at any time and quickly. This commonly expressed association underscores the influence of temporal geographic sub-functions, as well as spatial considerations, on the elder's perceptions regarding the equitability of the family doctor model.

Positive correlations between geographic proximity and patient perceptions are contingent upon such accessibility factors as the distance between the location of health resources and the location of patients, and the time required to travel between the individual's residence and care services—whether or not a physician is nearby and easy to get to from the person's home (Humphreys et al., 1997; Penchansky & Thomas, 1981). Numerous subjects claimed that they could reach a centrally located consultorio from their homes in minutes, and direct observations confirmed that, indeed, the average family doctor catchment could be crossed entirely in about six minutes at very slow pace. Furthermore, secondary sources reported that family doctors and local polyclinic specialists could reach homebound patients with similar ease. The physical proximity of the older person's home to the neighborhood consultorio, in addition to the time required to reach or receive family physician services, therefore, have had an affirmative influence on the older person's perceptions.

While the distance between the patient's residence and the physician's medical office and the time needed to reach physician services are influential accessibility factors, the organizational framework required to accept the patient is an important accommodative attribute. This type of geographical sub-function is predominantly temporal, and encompasses such characteristics as prescribed hours of medical office operation, waiting period, and the length of

physician-patient consultations (Buetow, 1995; Humphreys et al., 1997; Penchansky & Thomas, 1981). Regarding formal hours of operation, it has been shown that perceptions among British patients were positively influenced by morning office hours and weekend appointments, and evening sessions for working individuals (Buetow, 1995).

Direct observation and secondary sources verified MINSAP's standardized schedule, whereby formal family doctor sessions were predominantly held Monday through Friday in the morning hours. Doctors also accepted patients one Sunday morning each month. The study's older participants and secondary sources also agreed that family doctors were on call on a 24 hour-a-day, 7 day-a-week basis with the exception of an annual vacation; on numerous occasions, older individuals reported that their physicians were available at any time of the day and week. One person's comments, in particular, conveyed the strong influence and sense of security this accommodative attribute has imparted to older Cubans; Jaime pointed out that his doctor was "always there for me when I really need help."

The focus group results concerning family doctor operating hours demonstrated the elevated role of health education, promotion, and awareness among older individuals. Of note is that group participants believed that *unwarranted* patient visits outside regularly scheduled hours of operation overburdened the family care-giver. Instead, they agreed that most people should visit their family doctors on such occasions only in a medical emergency.

The older patient's awareness of the physician's off-hour needs was related to at least three factors. First, Castro's national addresses have communicated the expectation that citizens not abuse the accommodative attributes of the family doctor model. Second, although the older subjects had high expectations of the quality of family doctor care, the model's affordability and geographic considerations appeared to contribute to lower expectations for the instantaneous fulfillment of non-acute health needs. For example, upon learning that his doctor was temporarily away from the office, Jaime smiled, remarked that he had enjoyed the morning stroll to the physician's office, and calmly added that he would return later in the day, because "she is always there for me when I really need help."

The deep social and inter-personal doctor-patient connection, as suggested by the respect the subjects had for their physician's time, characterizes a third factor contributing to the older person's empathy toward their neighborhood doctor. Almost every one of the study's older participants remarked that their physician also was a friend and neighbor. The acceptability

attributes of the family doctor model, in addition to the social and inter-personal dimensions of the physician-patient relationship, will be examined in further detail later in the discussion.

Geographical considerations comprise such accommodative attributes as the physician's capacity to accept patients. The literature posits that unaccommodating physician office structures, such as appointment systems, extended waiting times, and curt physician-patient sessions, are among the chief sources of patient dissatisfaction and negative perceptions of a health policy, a system, and services (Gribben, 1993). The perceptions of individuals lacking social support and those in need of immediate physician care, above all, have been shown to be most influenced by such unaccommodating features as appointment scheduling systems (Buetow, 1995).

The narratives and direct observation revealed that the study's principal subjects exhibited a generally relaxed attitude about the organizational framework of family doctor consultorios. During one observation period, for example, Dr. María's waiting room was filled to capacity and some patients were forced to stand outside the consultorio and wait their turn to be seen. Having scheduled only a few patient appointments that day, the majority of the physician's older visitors were walk-ins. Opting for a triage approach, rather than a first-come, first-serve model, the physician examined the patients according to the seriousness of their health condition. None of these patients, however, expressed dissatisfaction or exhibited frustration with the relatively informal organizational structure. Another accommodative factor that contributed to the older patient's seemingly tranquil demeanor was that Cuban family physicians, such as Dr. Evaristo, were extremely flexible and had "no problem with missed appointments" and unscheduled patient visits. Physician flexibility and the triage scheduling form were observed to be fairly uniform throughout Cuba's consultorio system.

Clearly, the triage approach provides a counterbalance to the predominantly open access format. In combination, the two accommodative characteristics have had a positive influence in terms of the physician's ability to offer services immediately to those with the greatest need. However, a number of other compensatory factors also may be at work.

Although family doctors gave the neediest patients first priority, it can be argued that the consultorio walk-in arrangement produced lengthier waiting times for other patients. Direct observation, for example, revealed that the average consultorio waiting time was eight minutes. The non-Cuban literature suggests that the nominal waiting period before patient attitudes begin

to shift toward the negative is between six and ten minutes (Bower, Roland, Campbell, & Mead, 2003; Fallon, Hamilton, Bhopal, Gilmour, & Bhopal, 1990). However, the social aspects of visiting the consultorio, rather than waiting times, may offer alternative explanations of why elderly Cuban patients appeared unaffected by the waiting times they experienced.

US ambulatory care patients visit their physicians about three times each year (Woodwell, 1997). For British and Canadian patients, the estimated rate is slightly higher at 3.5 annual consultations (Fleming, 1989; Watson et al., 2004). The Cuban findings, however, indicated that the study's older subjects generally visited their family doctors several times each week. These visits were made in addition to the doctor's annual examination regime and follow-up protocol.

Older Cubans appear to have much higher frequencies of family doctor visits than in such nations as the US, Canada, and Britain. The frequency of visits and an acute understanding of the social, economic, and health nuances of neighborhood residents, as evidenced by the focus group members, suggest the principal subjects had a greater familiarity with the other patients who also waited at the family doctor's office. Therefore, enhanced social interaction from Cuban consultorio visits may impart benefits to older patients that are not found within other health care services systems.

Admittedly, Cuba's older, retired patients may be more accepting of accommodative inconsistencies, because they have a greater amount of free time than employed individuals do. Nonetheless, older patients still incurred the opportunity costs of travel time and consultorio waiting time. However, the family doctor model appears to have created a more relaxed atmosphere and produced a more indulgent patient, due to the close proximity of the consultorio to the individual's residence, uncalled for motorized transportation, and because cost-free physician services placed no additional financial hardship on the patient. The social benefits of the model's more intimate service provisions, therefore, might also be offsetting the opportunity costs of consultorio waiting times and walking to and from the medical office.

Short physician consultations, as well as cumbersome appointment systems and lengthy waiting times, have been linked to negative patient perceptions of Britain's health framework (Bower et al., 2003; Buetow, 1995; Howie, Porter, Heaney, & Hopton, 1991). Conversely, the literature reports that longer doctor-patient consultations generate patient satisfaction in US and Britain (Andersson, Ferry, & Mattsson, 1993; Buetow, 1995; Howie et al., 1991; Wilson, 1989;

Wilson, McDonald, Hayes, & Cooney, 1992). Patient satisfaction was attributed to extended sessions with the doctor-patient that allowed additional time for more psycho-social and screening service provision, health education and promotion activity, and greater attention to the patient's longer-term care needs, particularly a greater attentiveness to the long-term needs of older individuals. Direct observation of Cuba's consultorios revealed that family doctors, on average, spent about eight minutes with each older patient. This consultation time compared to an average five minutes for a short visit, six-to-nine minutes for a medium visit, and a long visit of ten minutes among British general practitioners (Fallon et al., 1990). None of this study's older participants, however, registered dissatisfaction with the time spent engaged in consultation with the family doctor.

One might conclude that the medium-range consultation time alone was sufficient enough to have positively influenced the attitudes of older Cuban patients. However, the findings indicated two other contributing factors. The accommodative attribute of the family doctor assessment protocol was first and foremost. As Drs. María and Evaristo confirmed, every older Cuban received a minimum of four annual comprehensive examinations, including at least one annual home consultation. The extended assessment formula precludes the need for longer, regular office consultations, which provided family physicians more time to "stay on top" of long-term health issues, "listen" to more commonplace patient concerns, and to discharge their health education and health promotion responsibilities. In Luis's case, for example, the assessment protocol gave Dr. María more regular consultation time to offer such health education and promotion services as nutritional and exercise counseling.

The second contributing factor concerns the regular eight-minute consultation, which may have been perceived positively because of patient recidivism and the accommodative attribute of the physician accepting older patients as often as needed. Direct observations confirmed that family doctors received the study's older patients several times each week and, on occasion, more than once a day. However, facility continuity and long-term doctor-patient relationships may be the superseding characteristics that have most influenced the older person's perceptions of health equity.

The findings regarding patient recidivism and accommodation may appear to contradict some of the literature, which claims that "there is no evidence of overuse, attributable in part to the fact that Cuba's system does not include unnecessary treatments (Branch et al., 2004, p. 26).

This statement, however, was made in response to US concerns. These concerns focused on the premise that the adoption of a Cuban-like health care approach that featured universal access to and total subsidization of all care costs would undermine the cost efficiency of the current US model, erode health resource supplies, and result in rationing in order to limit service availability. While my direct observation of such repetitious visits revealed that older Cubans did not always receive a specific health treatment in the strictest sense, and while it can be argued that patient recidivism does overtax family doctor time and energy, the concept of treatment overuse must be considered within the revolutionary philosophy and symbolism that Cuban health care traditionally has been much more than just time and money.

Acceptability and Positive Perceptions

The literature surmises that the temporal aspects of facility continuity and the longitudinal, or social and inter-personal dimensions of the long-term physician-patient relationship, play a governing role in shaping one's perceptions of a health policy, care system, and health-related services (Bower et al., 2003; Buetow, 1995; S. M. Campbell et al., 2000; Penchansky & Thomas, 1981). This most likely is due to lofty patient "expectations of continuity of care" (Bower et al., 2003, p. 1250) at the same treatment facility and the desire to establish "a longer relationship with the physician" (Penchansky & Thomas, 1981, p. 137). One study (E. D. Morgan, Pasquarella, & Homlan, 2004), for example, concluded that visiting the same health facility and seeing the same doctor in the longer term determined 78 percent of patient satisfaction. For older persons, in particular, the ability to see the same physician during each visit to the same facility was essential, because of the trust, respect, and more personalized attention that longer-term doctor-patient relationships offered (Humphreys et al., 1997; Mainous, Baker, Love, Gray, & Gill, 2001; O'Malley, Sheppard, Schwartz, & Mandelblatt, 2004; Parchman & Burge, 2004). Further illustrating the importance of continuity and longitudinality, on-going and strong relationships between treating physicians and individuals with HIV/AIDS were found to have contributed to patient survival (Mirken, 1998).

Much more than a temporal phenomenon, the provision of longitudinal care also symbolizes the doctor's enduring fidelity to the individual and the patient's family (McWhinney, 1975). Hypothetically, the physician's working style and such personal characteristics as age, gender, race/ethnicity, and sexual orientation would be expected to

influence patient attitudes and values (Andersson & Mattsson, 1994). However, it is the ongoing personal relationship and prospect of obtaining a greater knowledge of the individual patient within biological, psychological, social, and environmental milieus that may have a greater influence on perceived health equity (McWhinney, 1975; Parchman & Burge, 2004; Penchansky & Thomas, 1981; H. Waitzkin & Britt, 1989).

Continuity, Longitudinality, and the Family Doctor Model

The findings verified the incorporation of facility continuity in Cuba's model for neighborhood-based family doctor services. The study's older participants were observed to have made multiple weekly visits to the same consultorio. None of the older subjects reported that facility discontinuity had forced or prompted a visit to an alternative consultorio. One explanation might be MINSAP's mandate that local polyclinic gerontology-geriatric specialists attend to a family doctor's older patients during the family physician's annual vacation or when the doctor is unavailable to attend to a patient emergency.

With regard to longitudinality, most of the study's participating family doctors, who were among the first Comprehensive General Medicine Program graduates, had exceeded the policy stipulation that newly trained physicians make a minimum five-year public service commitment to the community where they were assigned to complete their solo practice/medical residencies. Dr. María, for example, had decided to remain in the same rural community and continue caring for the neighborhood panel of patients she was first assigned in the early 1990s. Additional contributors to long-term physician-patient relationships in Cuba were the state-command income schedule, lifetime doctor subsidization provisions, and the consultorio concept, all of which have diffused physician relocation preferences. Similar dynamics have moderated socio-economic conditions that might have fostered a more unequal social relationship between the medical professional and patients (H. Waitzkin & Britt, 1989). For example, evidence that the doctor-as-a-neighbor role has created a sense of social equality can be found in almost every older person's expressed belief that the family physician was both a friend and neighbor.

Although none of the study's older subjects offered a response that directly associated perceived health equity with the longitudinal quality of the family doctor model, its influence was inferred in the narratives. For instance, Dr. María had been Luis's physician since her practice was first opened. A compatibility established during their decade-long relationship, in

which Luis and his doctor had “worked together” on his health issues, gave the elder comfort and faith in his doctor’s skills. He not only believed that she was more concerned with his welfare than other care-providers, he also “felt safer” in her care.

The degree of trust that longitudinal doctor-patient relationships cultivate has been shown to be a powerful stimulus for other aspects of a health policy, care system, and associated services. Viewing the physician more as an equal, the trusting doctor-patient relationship generates a more reciprocal and meaningful inter-personal discourse (H. Waitzkin & Britt, 1989). The willingness of a patient to engage and work with the physician, in turn, has been shown to be “especially important as a potential determinant of use of medical services” (O'Malley et al., 2004, p. 778). Consequently, the older patient’s trust in their physician to act as patient advocate may “contribute to the effectiveness of medical care” (Mainous et al., 2001, p. 22), due to the individual’s “adherence” (Parchman & Burge, 2004, p. 22) to their physician’s counsel and increased probability to use medical services. Conceding that longitudinality provides few short-term economic benefits, some secondary sources asserted that the family doctor approach would bring about more effectual medical services, generate systemic efficiency, and in the long-run, make Cuba’s health policy more cost-effective.

Assuming physician expertise, there is common agreement that the doctor-patient relationship is an essential feature of quality care provision. This relationship is chiefly an outcome of patient trust in the physician (S. M. Campbell et al., 2000; Mainous et al., 2001). The physician’s working style and such personal characteristics as age, gender, and race/ethnicity also play a role in the patient’s trust in the physician (Andersson & Mattsson, 1994).

The majority of the Cuban family physicians I interviewed were relatively young; most were in their 30s. Many also lacked personal and social life experiences that one could argue are required to foster trust and produce the more superior doctor-patient relationship described in the literature. Dr. Evaristo’s “formal” demeanor and orthodoxical bedside approach, for example, seemed to contradict the degree of social informality and level of verbal and non-verbal inter-personal communications needed to encourage a more egalitarian doctor-patient bond.

Quite unexpectedly, though, I discovered that none of Dr. Evaristo’s patients, nor any other older participant, voiced dissatisfaction with their doctor-patient relationships. This outcome appears to support prior literature, which attributes patient trust less to professional

demeanor and personal characteristics, and more to higher facility continuity, the greater length of the relationship, longer consultations, and the physician's comprehensive knowledge of the individual (Mainous et al., 2001; O'Malley et al., 2004; Parchman & Burge, 2004).

To summarize the discussion thus far, the five access-related attributes incorporated into Cuba's policy model for neighborhood-based family medicine have had a potent influence on the older individual's perceptions of health and health-related resources. Perceived health equity closely corresponded with the ability of every older participant to easily and quickly reach and receive cost-free care at the same neighborhood consultorio over an extended time period from a family doctor, who the older person had come to trust as a medical professional, a friend, and neighbor. The next section, though, discusses international change and domestic policy shifts after 1989 that have impinged on health resources and generated perceptions of health inequity among older Cubans.

Global Change, Domestic Influences, and Perceived Health Inequity

Fidel Castro has secured Cuba's station within the global health community through a willingness to model his nation's care approaches on the exalted health ideals of the World Health Organization (WHO) and United Nations (UN). A recent example involved a 1992 UN General Assembly proclamation that urged individual nation-states to begin planning for population aging and consider developing long-term elder care policies (United Nations, 1992). Castro stunned the assembly by unveiling Cuba's new comprehensive national policy on aging. As part of the UN's International Year of Older Persons activities seven years later, both the WHO and the UN lauded Castro and the Cuban people for undertaking the elder care initiative, particularly during the special period of undue national hardship (Martínez Almanza et al., 1999; World Health Organization, 1998a).

Castro's unforeseen policy action symbolized the leader's ongoing effort to offer Cuba's socialized health approaches as alternatives to commodified health care in the capitalist world. The revelation also mirrored Castro's long-held position that the health of the Cuban people would remain a topmost priority, even when faced with mounting external opposition and grave domestic socio-political-economic concerns. However, against the backdrop of post-Cold War transformation—the Soviet Union's disbandment, the near total dissipation of Cuba's trade partnerships, amplification of the US embargo, Cuba's increased isolation from world markets,

international pressure on the leadership to accept a US-like capitalist-democratic paradigm, and the cascading effects of the socio-economic crisis—major policy reforms were inescapable.

The special economic period after 1989 obliged new fiscal controls and policy change not only to address the most urgent problems confronting the population, but to also preserve the Revolution's social and health gains, shelter the leadership from potential social unrest, and to ensure the "regime's survival" (Feinsilver, 1994, p. 167). Measured, market-oriented reforms liberalized specific economic sectors, and the nation's benevolent health and social welfare policy was restructured. At the same time the medical and bio-technology sectors were prioritized for continued investment, health cost reductions and welfare benefit limitations were instituted to conserve rapidly dwindling health and social resources.

The study's second overall result was that perceptions of health inequity among members of the revolutionary cohort were influenced most by health resource shortages and rationing. Medicines were found to be the most common health resource in short supply. Health resource rationing, meanwhile, ranged from constraints placed on the most expensive high technology care services and pharmaceuticals to routine medical supplies. The following passages synthesize the global and domestic circumstances that contributed to these consequences and profoundly affected the daily lives, health experiences, and perceptions of older Cubans.

International Change

The study's principal and secondary subjects, in addition to direct observation, provided demonstrative evidence that cost-free and/or subsidized health resources previously available to all older persons, either were rationed, were no longer available, or had become unaffordable for certain older individuals after 1989. Resources under duress included such care services as chemotherapy and palliative treatment, such health-related resources as special social case awards, and a large number of pharmaceuticals; anti-biotic, pain relief, and respiratory medications were most often mentioned. Secondary sources, meanwhile, provided verification that the loss of and/or constraints on these services and resources were direct outcomes of macro-level socio-political-economic change following the end of the Cold War.

The Cuban Trade Problem and the US Embargo

The consequences of shifting global circumstances, Cuba's international trade debacle,

and domestic turmoil after 1989 are visible even today. A La Habana pediatrician complained that his hospital still experienced acute shortages in critical medicines. A heart specialist further noted that such medications as anti-acids remained unobtainable in Cuba, even though they were “commonly available in other poor countries.”

Other key health informants pointed to the disruption of Cuba’s Cold War trade arrangements, new trade restrictions imposed in 1992 and 1996 under the US embargo, and the leadership’s defiance of the emerging global economic order as contributors to domestic pharmaceutical and health resource shortages. A rural Cuban health official, for instance, observed that the Eastern and Central European independence movements, the rise of national sovereignty among the former Soviet satellites, and the demobilization of the Council for Mutual Economic Assistance resulted in the nearly complete loss of Cuban trade with its Soviet partners on the council by the early 1990s. Almost overnight, Cuba “no longer had sugar export revenues” (Teovaldo Triana Torres, personal communication, July, 23, 2001) to purchase medicine, raw pharmaceutical materials, and medical equipment, nor did it have the ability to make “direct exchanges of sugar” (Teovaldo Triana Torres, personal communication, July, 23, 2001) for health-related goods from its former Soviet allies.

The realignment of many European pharmaceutical corporations with US-affiliated transnational businesses in the 1980s had an equally chilling effect on Cuba’s trade dilemma. As was the case in the former Yugoslavia, scarce medicines and other health-related shortages were largely the outcome of these resources being “available only on foreign markets at prices dictated by Western corporations” (Albert, Bennett, & Bojar, 1992, p. 2462). Furthermore, Western and Eastern European manufacturers, as they had with the new Czech Republic, demanded Cuba’s health-related purchases be paid in convertible hard currency (\$US), because of its deepening national economic crisis, the inability to service its outstanding international debt, and Castro’s incessant denunciations of the world powers that have “never given up the idea of destroying the revolution and its achievements” (Castro, 1996, p. 152).

Even with the necessary convertible currency to purchase health resources, new penalties incorporated into the US embargo in both 1992 and 1996, generated reluctance among some international exporters with US ties to engage the Castro government. A provincial health official also noted that the embargo’s new provisions “had an impact in the form of more expensive medicine, supplies, equipment, and technologies that Cuba must import from third

country exporters” that were willing to risk US penalties for exporting products that might aid Cuba’s bio-technology enterprise. A medical research scientist, however, argued that even if the US embargo were lifted, Cuba’s command model for health economics and more authoritarian policy actions during the special period had produced a “crumbling superstructure that cannot be corrected.”

Shifting Domestic Policy

Health equality is one of the main precepts of Cuba’s domestic health policy. Charged with ensuring equal access to health resources, the Cuban Ministry of Health (MINSAP) was given centralized authority over all provincial-level funding. Although local health departments are responsible for the municipal health structure, provincial health authorities, who answer administratively to MINSAP, have authority over all municipal-level funding. Since the special period, however, a Cuban health educator argued that MINSAP’s recomposition of a more dictatorial health economics model posed the greatest “organizational and administrative” threat to the goal health equality for both patients and care providers by undermining local-level autonomy.

A Cuban medical school faculty stated that MINSAP’s control over provincial funding was more flexible during less austere times. Therefore, local health officials had a greater voice in funding decisions that addressed the specific health needs of one local area that might have required more resources than another locality. However, the chief difficulty with the command model after 1989, according to another educator, was that extreme “funding and equipment limitations” provided MINSAP grounds to reassert its centralized authority under the health equality mandate. Consequently, decisions to equalize and/or reduce lower-level health funding streams produced local resource inequities, particularly in service areas that required additional funds and resources for such services as “medicine administration and expensive, specialized treatments.” As will be discussed below, the domestic policy shift toward health resource rationing has had a somber effect on local care-provider decisions and the health and perceptions of older patients.

In keeping with the themes of health equality, the command economy, and resource shortages, the literature notes that Cuba’s economic policy, which directed the entire economy toward “uncompetitive [subsidized and protected] production” (Feinsilver, 1994, p. 183), had

created an inefficient economic system long before the economic crisis of the 1990s. As a top Cuban science advisor observed, “Castro’s attempt to distance Cuba from the West made it [Cuba] over-reliant on the Soviet Union.” He added that now that Cuba was “alone, the socialist system is not productive enough...cannot produce enough revenue and products internally...[and] cannot maintain itself without outside funding.” The nation’s domestic bio-technology venture provides a case in point.

Bio-technology Policy, Domestic Pharmaceutical Production, and Inequality

Designated along with medicine as a national policy priority by the Communist Party Congress in October 1991, Cuban bio-technology has benefited from UN and Pan American Health Organization funding, in addition a reported US\$ one billion infusion of public expenditures since 1992 (Cuban Pugwash Group, 2001b; Feinsilver, 1994; Pérez-López, 1994a; Vásquez, 2004). Under MINSAP’s authority, the Cuban Academy of Sciences was awarded control over all bio-technology funding, research and development, and production activities, including the industry’s critical role in medical tourism. The literature points out that although medicine exports and health tourism sales purportedly have made the bio-tech enterprise self-financing, data supporting this claim were unavailable (Cuban Pugwash Group, 2001b; Feinsilver, 1994).

Such recognized scientific journals as *The Lancet* have quoted Cuban officials, who reported that the bio-technology venture generated US\$51.3 million in pharmaceutical sales 2002; US\$1 million in 2001 alone came from its meningitis B vaccine exports (Siringi, 2001; Vásquez, 2004). Cuba’s Economic Minister, meanwhile, recently stated that the bio-technology enterprise provided for more than two-thirds of the total population’s basic pharmaceutical needs (Vásquez, 2004). Excluding traditional and natural medicines, a secondary source further observed that because of the policy’s import substitution component, the country “enjoyed access to more than 400 [domestically produced] medicines” in 2001. A decade earlier, 1,297 predominantly imported medicines were available to Cuban physicians (American Association for World Health, 1997).

The globalization of the pharmaceutical industry and monopolization of health “technology, information and services” (Robinson, 1995, p. 650) by such advanced nations as the US, Canada, France, and Germany have limited Cuba’s ability to compete in the global

market place and meet domestic demand for medicine. Similarly, the US embargo, until just recently, has impeded the effectiveness of the bio-technology strategy by prohibiting all Cuban medicine technology imports into the US market (A. Pollack, 2004). Bio-technology and medicine production also were limited by Cuba's health economics model. However, the findings and literature suggests that the pharmaceutical enterprise is generating more medicine for domestic consumption and the export revenues needed to purchase supplementary drugs, raw materials, and health resources on the open market.

It also would appear from official statements that the bio-technology strategy of pharmaceutical self-sufficiency is succeeding. Given the uncorroborated figures and MINSAP's policy shifts after 1989, though, the disparity between the *official success story* and the numerous accounts of persistent medicine scarcity experienced by the study participants raises my concerns about the accuracy of government reports. These circumstances also raise my concerns about the fairness of the bio-technology policy and pharmaceutical financing priorities.

Initially funded to "provide medicinal products for her own population" (Tancer, 1995, p. 791), the worsening economic crisis, the need to "earn hard currency through exports" (Tancer, 1995, p. 791), and the economic allure of health tourism may have shifted MINSAP's emphasis from the domestic production program to the international functions incorporated into its bio-technology policy. Recall the literature presented earlier in the dissertation that established the leadership's fixation on cultivating political capital and hard revenue from Cuba's world-class bio-technology apparatus. This obsession heightened even more following the elimination of the foreign military assistance program in the late 1980s (Feinsilver, 1992, 1994; Kuntz, 1994; North American Congress on Latin America, 2002).

Beyond pure economics, key Cuban government sources hypothesized that the politics of the special period that allowed MINSAP to re-assert its authority over local health activities also may have influenced its emphasis on the international component of the bio-technology policy after 1991. One assertion was that it was politically expedient for the national health agency to provide sanctuary to revenue-producing pharmaceutical export activities. However, it was not advantageous to protect the revenue-consuming domestic medicine production and pharmaceutical import programs from fiscal retrenchment.

The 2001 Cuban legislative debate illustrates the tug of war over the two bio-technology tracks. Driven by the politics of economic rationalism, liberals within MINSAP endorsed

privatizing the policy's revenue-friendly track (Jorge Hadad Hadad, personal communication, June 29, 2001). Under this proposal, the revenue-consuming medicine substitution and importation programs were to remain public; imported pharmaceuticals, for example, represented more than half of all Cuban public health expenditures around the turn-of-the-millennium (Cuban Pugwash Group, 2001b). In the end, however, MINSAP traditionalists convinced Castro that privatization would drain revenue from the economy and endanger the recovery.

Although unthinkable for the leadership's staunchest supporters, the Cuban government's anti-US agenda also must be taken into account. Castro's detractors might argue that MINSAP de-prioritized the national medicine production and import programs, and used the pharmaceutical scarcity issue to demonstrate to world leaders US immoderation toward Cuba and the embargo's unjustness. At least one secondary source remarked that for decades, the leadership blamed the embargo for Cuba's economic shortcomings to obscure the truth that the "socialist system is not productive enough."

Such hypotheses notwithstanding, cases have been made for the positive effects of Cuba's bio-technology policy and medicine shortages. Physicians, for example, now offer "counseling...to adopt healthy lifestyles" (Branch et al., 2004, p. 25) as an alternative to medicating patients. A La Habana surgeon, however, criticized such alternatives as health education and traditional medicine as an inappropriate "low technology solution to [synthetic] medicine shortages." Rationing scarce medicines and other health resources, another option that almost certainly has influenced individual-level perceptions of health inequity more than any other macro-level factor, will be covered in the next segment.

Rationing and Perceived Health Inequity

On Cuba's domestic front, the findings identified six macro-level patterns that have shaped the older individual's perceptions of health inequity since 1989: 1) refusal of costly hospital services; 2) denial of cost-free prescriptions for in-patients and out-patients; 3) institutionalization of co-payments for subsidized medicine and the attachment of fees on certain long-term elder care programs; 4) increased rejection of social case awards; 5) rising numbers of non-subsidized pharmaceuticals; and 6) expansion restraints placed on new long-term elder care facilities and programs. These six patterns reflect the leadership's modification of the universal health care edict and tighter control of health resource allocations. Rationing has been the chief

vehicle for stretching resources, decreasing patient and care-giver demands for services, and lowering citizen and provider expectations (Pastor & Zimbalist, 1995).

Health resource rationing assumes three general forms: explicit rationing, implicit rationing, and cost-sharing (Mechanic & Rochefort, 1996). Centralized determinations regarding the “geographic availability” (Mechanic & Rochefort, 1996, p. 263) and accessibility of health providers and care settings are two main features of explicit rationing, the first rationing form. The second form, implicit rationing, typically involves the prioritization of patient health conditions based on severity decisions, regimented allocation determinations, and on resource costs and supply levels. Cost-sharing, or the attachment of any out-of-pocket fee or co-payment to health services, is the third rationing form. Normally used in combination, each of the three rationing types can be located in the six macro-level patterns of domestic activity cited above.

Take, for example, rationing restrictions placed on facility and program expansion under the 1992 national aging initiative. As prior literature has documented, such grand experiments as Comprehensive General Medicine and the family doctor model in the 1970s and 1980s were piloted in La Habana’s poorest neighborhoods, which had the greatest need (Alemañy Perez et al., 2002b; Cuban Ministry of Health, 1976; Danielson, 1981, 1985; Fernández, 1994; Martínez Calvo, 1997; Medina García et al., 2001; Ordóñez, 1976). The mental health and day care administrators, whose observations were included in Chapter Nine, however, inferred a shift in this precedent after 1989. By the late 1990s, MINSAP had begun targeting more affluent La Habana barrios to pilot the new hybrid facilities and programs associated with the 1992 national policy on aging.

Considering the elder care policy mandate, resource scarcity, and the need to develop and pilot such projects, it can be argued that rationing decisions to limit and locate these service types in the city’s more prosperous neighborhoods was a rational choice response to the need for cost-efficiency. Families and older individuals in higher-income neighborhoods would be in a more advantageous position to absorb the out-of-pocket costs that have been affixed to homes for elders and adult day care services. Poorer barrios, however, would require additional fiscal and material resources to support the expected higher numbers of older residents requiring special social cases awards.

Clearly, each rationing form places additional socio-economic and health burdens on service users, particularly older pensioners with limited supplemental income opportunities.

Still, explicit rationing is considered more just than the regressive aspects of cost-sharing, and less susceptible to the social, political, and/or individual predilections of decision-makers and care-givers inherent in implicit rationing choices (Gertler et al., 1989; Gonzáles Block et al., 2001). However, policy decisions to incorporate a mixture of rationing forms, which most frequently occur during times of extreme resource scarcity, compound the hardships of the poorest individuals, as well as placing added stress on health care providers (Mechanic & Rochefort, 1996)..

Direct observation and secondary sources confirmed prior literature, which detailed the impact of MINSAP's explicit rationing directives on care-givers. Physicians have been ordered to account for "every pill and drop of medicine" (Kuntz, 1994, p. 175) and recycle health resources in short supply, such as syringes (American Association for World Health, 1997; Branch et al., 2004; Díaz Beltran, 2001). Just as scarcities in spare parts and fuel shortages have disrupted emergency transportation services, a bio-medical researcher noted that similar scarcities had rendered unusable such hospital equipment as "magnetic resonance devices, and gamma cameras for cancer and cardiology" testing. Secondary sources also reported how patterns of scarcity and rationing forced accommodative changes, in which hospital emergency rooms adopted more excessive patient appointment systems and waiting periods.

Implicit rationing, the second rationing form, involves the care-giver's prioritization of different health conditions and health resources based on the severity of the patient's condition, resource costs, and resource availability. Normally the result of centralized decisions, in which care-providers are explicitly directed by an oversight agency such as MINSAP to safeguard particular resources, implicit rationing choices are the most visible to patients and their families. Pedro's experience, for example, illustrates the ripple effect of centralized rationing decisions on the implicit rationing choices of his hospital physicians. Dr. María's decision not to prescribe an anti-biotic for Juanita's injury, but prescribe the same medicine to treat Carmelita's respiratory ailment is another example of implicit rationing. The family doctor exercised what she believed was "good judgment" about her patients' conditions, the personal expense of the prescription copayment that each patient would incur, and the availability of local anti-biotic medicine reserves.

Given a defined patient population, Dr. María, Dr. Evaristo, and other Cuban family doctors are gate-keepers and advocates, who are responsible for all their patients regardless of the health tier, types, and quantity of services required. As Pedro's case demonstrates, however,

family doctor jurisdiction is limited. MINSAP restricts family doctor authority in hospital milieus to that of advisor and consultant, and prohibits family practitioners from writing hospital orders. Therefore, hospital specialists and treating physicians, as do their counterparts in the Canadian and British health systems, have exclusive authority to withdraw in-patient treatment or to place candidates with lower priority health conditions on waiting lists in order to conserve such services as high-technology diagnostic tests and operations, which almost always are provided in Cuba's higher tier service settings (Demers et al., 1993; Meadowcroft, 2003; *The Economist* (US), 1999b).

Likewise, Cuban family doctors have a voice in implicit Gerontology Board rationing choices concerning patient prioritization. However, Board resources are dictated by MINSAP's centralized explicit rationing decisions regarding special social care expenditure levels. The Boards' pluralistic characteristics further constrain family physician autonomy over decisions involving their older patients.

Gerontology Board determinations regarding special social case awards in favor of Luis and against Pedro exemplify how explicit national rationing choices affect local health-related allocations and influence arbitrary decisions based on the value preferences of local decision-makers. The same decision process has created meso-level health inequalities. For example, a study (Astrain, Pria, & Ramos, 1998) conducted in the province where Pedro and Isabel reside cited MINSAP's failure to balance its explicit rationing decisions evenly. The research concluded that unequal monetary, personnel, and health resource allowances had produced a range of inter- and intra-provincial inequities, including fewer prostate cancer examinations, inferior hospital bed ratios, and, presumably, fewer social case awards.

Widely regarded as the most unjust form, cost-sharing, or the addition of out-of-pocket fees and patient co-payments to health services, is the third type of rationing. For the study's older pensioners, many of whom lacked alternative income sources, the inability to purchase domestically-produced medicines to which co-payments had been attached was the macro-level dynamic that most influenced perceived health inequity. The leadership's rationing decision to pass the full cost of imported medicine directly onto older consumers had a similar influence.

The underlying rationale for cost-sharing is that the individual is mindful of the associative cost of the health service. The consumer's rational choice to purchase the service is an outcome of the service's perceived value and available personal resources. Hence,

consumption levels, or demand, are governed by the individual's capacity to pay out-of-pocket the fee placed on a valued health service, such as prescription drugs.

Much like explicit rationing, cost-sharing fee adjustments are largely the outcome of centralized decisions. Cost-sharing has proven to effectively reduce demand for health services that are under a patient's control, such as over-the-counter drugs (Mechanic & Rochefort, 1996). However, the procurement of health services outside the individual's control, such as non-subsidized, imported medicine, depends on one's personal resources and/or the availability of social welfare services (Mechanic & Rochefort, 1996). In a poor, socialist nation such as Cuba, the social structure has made most older citizens on fixed pensions with no supplemental income sources dependent upon such social benefits as fully subsidized medicine and special social case awards to compensate for insufficient personal resources needed to cover associative out-of-pocket expenses (Mechanic & Rochefort, 1996).

Luis's social case award following his surgery, along with the provision of radiation treatment to the 90 year-old focus group participant, signify the control that the implicit rationing form gives health and social welfare decision-makers. Centralized explicit rationing and cost-sharing decisions made at the highest administrative levels, however, remove this type of local decision-making authority and often produce ambiguous outcomes. MINSAP's reform of the National Medicines Program provides such an example.

In the 1990s, the health agency banned the direct dispensation of pharmaceuticals from hospitals and polyclinics (Cuban Pugwash Group, 2001b). Forbidding physicians from directly handing out medicine to hospital, urgent care, and polyclinic patients, individual doctors were assigned to a specific pharmacy and required to write an official prescription before the pharmacy was permitted to fill it. The explicit rationing decision saved millions of pesos by reigning in the liberal and unregulated distribution of fully subsidized, domestically produced medicines and costly imported drugs. It also prevented physician abuses, such as Dr. María's informal arrangement to secure free medicine for her consultorio patients from the local polyclinic without having to use MINSAP's formal prescription pads.

However, the unanticipated outcome of MINSAP's medicine protocol, to which the study's older participants have attested, was for hospital and polyclinic physicians to deny patients cost-free medicine outright or refuse to write prescriptions. As Pedro and several other subjects reported, they instead were referred to their family physician for a prescription. The

injustice of this explicit rationing decision lies in MINSAP regulations, which stipulate that only hospital and polyclinic physicians may allocate cost-free medicine and only then through the official prescription-writing process. Medicine received through a family doctor's prescription carries a patient co-payment if it is a subsidized, domestically produced pharmaceutical, or, if it is an imported, the full cost of the medicine in \$US at the going market price.

This section of the chapter has discussed associations between perceived health inequity among older Cubans, global socio-political-economic change, and domestic policy shifts that placed three forms of rationing on medicine, health, and health-related services. In contrast, perceptions of health equity, which were discussed in the chapter's opening segment, were coupled with the five access-related qualities of the family doctor model. A third linkage that warrants discussion is the impact of life course dynamics on the older individual's perceptions of health equity and health inequality, and expectations of the care system and health resources.

Perceptions and Life Course Influences

The procession of events from birth onward that comprise one's lifetime—the life course—reflect inimitable experiences that shape the individual's understanding of the world. One essential premise in the study of the life course, though, is that socio-historic-institutional dynamics, such as social structures and cultural forces, influence the life experiences of the collective, as well as the individual (Elder, 2002). The life course literature submits that while some life experiences are common-place and singular to the individual, the life trajectories of the collective are influenced by broader life-shaping patterns or shared occurrences (Dannefer & Uhlenberg, 1999; Elder, 2002; O'Rand, 1988; Riley, 1986b). Pre-revolutionary health and social conditions, the socialized health ethos that evolved between 1959 and 1989, and, now, rationing and the gradual trend toward fee-for-service medicine represent some of the shared patterns that have influenced the life trajectories, perceptions, and expectations of Cuba's revolutionary cohort regarding health policy, the care system, and associated services. Understanding these cultural forces and socio-historical structures, therefore, is elemental to understanding the life course of older Cubans.

Such social prescriptions as health roles that are communicated through a society's institutions and culture shape the perceptions, expectations, and behaviors of the individual and the collective (Giddens, 1987; Marshall, 1999). For more than four decades, Cuba's socio-

cultural forces, namely Castro, the leadership, the state-controlled media, and the nation's mass organizations, again and again have impressed upon members of the revolutionary cohort that individual sacrifice, collective unity, and social equality were the core developmental goals of the Revolution (Kahl, 1981). In direct opposition to the capitalist world, individual and collective sacrifice in socialist Cuba represented the "common good in response to moral rather than material incentives" (Stein & Susser, 1972, p. 552). Thus, Cuba's health gains and educational progress after 1959 epitomized the "satisfaction of a collective interest" (Azicri, 1981, p. 286) for the Cuban people to remain forever disconnected from a colonial and capitalist past that has been dominated by Spain and the US. However, dramatic shifts in international and domestic socio-cultural structures since 1989 have begun undermining these long-standing social prescriptions.

The influence of shifting societal patterns on the life trajectories of older Cubans can be seen in a number of responses, in which the subjects' perceptions of health and health-related resources were framed as 'before' and 'now' statements in reference to life prior to and after 1959. Juanita, for example, contrasted the pre- and post-revolutionary health care systems and conditions, in which a cost-free family doctor visit in 2001 would have cost "five pesos before the Revolution." Luis's persuasive account, meanwhile, offers an example of the feeling of security that the provision of health facilities and social welfare services instilled in members of the revolutionary cohort after 1959: "Before the Revolution under the [Batista] dictatorship, we were always worried. Today, I'm not worried."

These two examples illustrate the interconnectivity of significant life course influences in shaping one's retrospective and current perceptions. However, life course dynamics also produce a similar inter-relatedness between one's past and present interpretations of the world and prospective expectations. Luis's comments, for example, implied the security that health and social gains had come to symbolize for him would continue for an interminable period of time, because the Revolution had constitutionally guaranteed his inalterable "right" to such cost-free services. Luis was aware that post-1989 health reforms had diluted this entitlement via the attachment of a medicine co-payment. However, the fact that the added fee had not presented a financial hardship that threatened his family's well-being reinforced the elder's retrospective trust in Castro and the socialist system, which, in turn, allowed him to remain faithful to the Revolution's goals, and sustained his expectations about the future equitability of the care system

and his right to the uninterrupted provision of free health and social services.

The 82 year-old field laborer provided a more explicit example of how important life course dynamics influence one's retrospective, current, and prospective attitudes. Looking back on social life before and after 1959, the pensioner expressed an admiration for the support the Revolution had provided him, such as subsidized housing, food, and cost-free health care. However, the deteriorating economy after 1989 had deflated his retirement pay and magnified the cost of living such that he no longer could meet his "living expenses." Consequently, these critical life-shaping patterns undermined his beliefs and expectations that the socialist system that had supported him for most of his life could adequately care for him in the future; considering the fees MINSAP had attached to new long-term elder care services, the man expressed an uncertainty and fearfulness about how he and his family "would get along" if failing health required his institutionalization.

Although prescribed health roles communicated through a society's structures shape the perceptions, expectations, and behaviors of the individual and collective, they also influence the capacity for independent thought and action that successively reshape the social system—the complementarity of human agency and social construction (Giddens, 1987). For example, Isabel's remarks that Pedro's family doctor was doing "her best" implied a certain acquiescence and resignation that the socialist system was no longer able to meet her spouse's current and future health and social needs. This submission might appear to support the literature, which asserts that the Cuban health care model has imparted a health role that has rendered older patients dependent upon it (Werner, 1983). However, shifting socio-economic patterns after 1989, in addition to Pedro's new health trajectory, spurred the couple to independent action. As had several other older participants, Pedro and Isabel had begun engaging in beggary, which, according to Cuban law and the leadership, is an illegal, private income-seeking, capitalist activity (Castro, 1992; Moreno, 1994).

Comprehensive social welfare coverage for Cuba's elders has been declared one of the state's "top health care goals" (Jorge Hadad Hadad, personal communication, June 29, 2001). Unable to completely satisfy elder health needs through internal systemic efficiency modifications, however, state reforms to parcel out scarce health resources were focused outward on the older population in the form of rationing and non-subsidized medicine (Kuntz, 1994). Forced to sensitize older citizens and their families to the detrimental policy shift, Castro

acknowledged that although the development of compassionate elder care services remained one of the nation's highest goals, fiscally responsible solutions were now required (Prieto Ramos, 2000). The differing perceptions and expectations voiced by the retired field worker, Luis, Pedro, Isabel, and other older subjects point to a growing confusion and disunity regarding the inconsistency of the leadership's stated allegiance to universal health care and its simultaneous efforts to quickly create a society of health consumers (Solman, 2001).

Social Change, Altered Perceptions, and Summation

The perceptions, expectations, and behaviors of older Cubans have been influenced in large part by their experience of the health and social situation in pre-revolutionary Cuba, and, until 1989, four decades of socialized health care, universal services, remarkable health and social progress, and Castro's repeated assurances that these achievements would continue unabated. The recent opening of this once closed society, the institution of market-oriented economic techniques, and reformation of the welfare structure, however, have forced a new reality upon the Cuban people. The new reality is that health in Cuba no longer is a human right for which the state is fully responsible; it now is a national aspiration as it was during the rebellion and the early years of the Revolution. This actuality is especially true for members of the revolutionary cohort, who were most habituated to the state's total provision of their health and social needs.

In the rapidly globalizing world, where the mobility of capital has no regard for geopolitical borders or allegiances, the Cuban state's ability to satisfy the needs of the older population is being undermined. More important, a greater share of the health resources that older Cubans require are now in the hands of such foreign entities as pharmaceutical multinationals, which operate on the market principles of commodification, competition, and profit (Robinson, 1995; Solman, 2001). As the small, poor, atrophied nation was further cut off from the global economy after 1989, Castro attempted to insulate the health and social goals of the Revolution at the same time he assented to the new world order.

Consequent of the loss of the Soviet community, the US embargo, and an inefficient domestic economic model, Cuba's autocratic leader used two time-honored arguments to justify rationing as the means to protect national health and social progress. The first argument was that rationing guaranteed the fair allocation of scarce resources (Benjamin & Collins, 1985). Second,

rationing was designed to stabilize inflationary health costs in order to maintain the extant health and social welfare system in the long-term (Eddy, 1994).

Expectations and demand for equal access to health care quickly escalate in a very poor society that undergoes a successful socialist revolt (Kahl, 1981). Intensified exigencies derive from socialist morality, which bestows the universal right to participate equally in the consumption of such cost-free social resources as physician care, pharmaceuticals, high technology treatments, and long-term elder care services. For example, a poor Cuban, such as Luis, who was denied “access to such care [before the Revolution] is delighted with the [socialized] system at first, then...gets used to the idea that full care is his by right” (Kahl, 1981, p. 335). However, as Pedro, Isabel, and other older participants alluded, economizing universal services via such techniques as rationing is viewed as a betrayal of the individual’s perceived right to full care. The feeling of infidelity is particularly distended, when entitlements are guaranteed legally, and especially when the individual’s contemporaries are perceived as having differential access to the means needed to acquire rationed essential services that once were available collectively.

Prior to 1989, Castro swiftly responded to rising expectations and citizen discontent with the health care services system (Santana, 1987). Such a response, however, was precluded by the international and domestic environment after 1989. As this dissertation research has suggested, such resource efficiency measures as rationing have tested the older person’s understanding of the goal of social equality and the equitability of “the actual benefits” (Kahl, 1981, p. 353) provided by the socialized welfare model.

Dramatic change in the post-Cold War period has begun to splinter the health perceptions and expectations of older Cubans. For many of the study’s older participants, health and health-related resources were still perceived as equitable, because their lives had not yet been severely affected by the erosion of family economic support and health and social welfare benefits. For other elders, perceptions of health equity have shifted toward the negative for the following reasons: they no longer could afford certain health and social services, such as medicine co-payments, un-subsidized imported medicine, and fees for adult day care and institutional long-term care services; they were denied the costliest medical treatments; and/or they failed to meet eligibility thresholds for special supplementary social services.

As a medical school instructor conveyed, free medicine, cost-free physician services, and

special supplementary welfare considerations are powerful symbols of the Revolution's health and social gains. However, institutionalized rationing and non-subsidized medicine, according to the educator, are emblematic of Cuba's "slow and gradual evolution toward a fee-for-medicine system." A legitimate question, therefore, is whether the apparent evisceration of the nation's social justice proviso has begun to influence citizen perceptions regarding Castro, the leadership, and Cuban socialism, as it has elder perceptions of health equity.

The literature bears out that health and social resource rationing generates confrontations between decision-makers and "groups whose needs have been excluded by particular decisions" (Mechanic & Rochefort, 1996, p. 265). In times of hardship, the injudicious institution of such efficiency measures as cost-sharing and the withdraw of life-saving treatments may elicit "high levels of political conflict" (Mechanic & Rochefort, 1996, p. 265). The intensity of political discord and level of confrontation are a function of the degree to which decision-makers have applied one or more of the rationing forms to one or more of the access-related attributes of a health policy, care system, and related services. One imperative concept is that perceived health inequity not only mirrors the level of antipathy for decision-makers, but also is a measure of the level of enmity for the socio-political-economic order that decision-makers represent (Donelan, Blendon, Schoen, Davis, & Binns, 1999; Popay et al., 1998). This dynamic is especially valid in a society where citizen satisfaction with health and social benefits is so closely entwined with the legitimacy and authority of the leadership and the state.

The influence of socialized health and social services across the life course, along with the more recent interlacing of neighborhood-based family physicians in the daily lives of older Cubans, reinforced perceptions among some of the study's older participants that health and health-related resources were equitable. However, the amalgamation of scarce pharmaceuticals, health resource rationing, and economic hardship have shifted the opinions other older subjects, who now perceived health and health-related resources to be inequitable. The movement of the economy toward limited market socialism, though, has provided some socio-economic relief. Economic improvements, in combination with an unwavering support for neighborhood-based family medicine, have enabled Castro to offer older citizens and their families his continued assurance that long-term elder care services will be protected in a benevolent, but fiscally accountable way.

Such fiscal efficiency measures as rationing have generated perceptions of health

inequity among such older Cubans as Pedro and Isabel. However, Castro has promised that the state is *doing its best* to uphold the gains of the Revolution in an adverse world environment, in which Cuba stands alone against “these imperialist theories...neoliberalism...[and] capitalism”. This argument appears to have muted widespread citizen aversion and subdued a major political confrontation with the leadership over the Cuban socialist system itself. On the whole, the positive perceptions of those elders, whose observations resonated with Luis’s account, outweighed perceptions of health inequity voiced by the older subjects, whose viewpoints were aligned with the statements of Pedro and Isabel.

The perceptions of older Cubans regarding the equitability of health and health-related resources represent one measure of the citizenry’s modern-day disposition. Therefore, the dissertation findings suggest that the political health and survivability of Castro, the leadership, and Cuban socialism within the increasingly global and Neo-liberal capitalist milieus of the post-Cold War Era may not be as ephemeral as some literature has asserted (Dilla, 1999; Gonzalez & Szayna, 1998; Linden, 1993; Mesa-Lago & Fabian, 1993; Ritter, 1994). For this reason, the dissertation research has global, domestic, and theoretical repercussions.

Implications

Roberts et al. (1999) made a case that post-Cold War change had precipitated the need to assess the modern-day temperament of the Cuba people. My study appraised the impact of such macro-level influences as global change, domestic policy, and life course dynamics on micro-level perceptions of health equity and health inequity among older Cubans. These older subjects joined the Revolution early and represent some of the most devoted supporters of Castro, the leadership, and Cuban socialism.

Despite the nation’s precarious economy and a recovery strategy pinned on tourism, one key foreign policy implication that has emerged from the dissertation research centers on the global aspects of the US embargo. Furthermore, the dissertation research might also aid decision-makers and health practitioners in Cuba and elsewhere. The findings suggest a model that can be used to assuage escalating demand and expectations for more sophisticated elder health and social services in an environment of global aging, globalized social relations, globalized capital, and Neo-liberalism. The study’s theoretical implications, meanwhile, may possibly contribute to the further development of new International Political Economy.

Foreign and US-Cuban Policy Implications

Even with the collapse of Cuba's Soviet trade partnerships and more taxing accompaniments to the US embargo, the US policy on Cuba has failed to meet its goals. The purpose of the foreign policy was to oust Castro and the communist leadership, institute the democratic-capitalist model, and compensate Cuban exiles in the US for private assets nationalized after 1959. However, Cuba's gradual economic recovery underscores the policy's inability to blockade the island economy and prevent Castro from securing new trading partners and investment.

Still, enhancements to the US policy in the 1990s may have contributed to Castro's decisions to slightly modify the command economy model, accept minor democratic change, and, to some extent, reform the socialized health and social welfare system. However, the dissertation research illustrates that the main contribution of the US policy after 1992 was to inflict added hardship on ordinary citizens. Older Cubans on fixed incomes with few economic alternatives were among those hurt most by food, medicine, and health resource shortages, along with the mechanisms instituted to manage those scarce resources.

The embargo's unilateral design, in addition to the non-aligned characteristics of transnational corporations, also have hurt US business interests by creating an unfair trade advantage for non-US investment in Cuba. Because it has been easier under the embargo for the US government to intimidate and prosecute US-based firms than overseas corporations, non-US traders based in such nations as the Netherlands, Canada, Russia, Spain, and China have circumvented the US policy and engaged the Castro government. Thus, non-US investors have been able to secure an advanced foothold in the emerging island economy (U. S. Department of State, 2004).

Two other factors have weakened the embargo's effectiveness. First, while US authorities have threatened to prosecute other nations, foreign investors, and US-based firms for trading with this *enemy* of the US, the US leadership simultaneously has engaged such former and current US enemies as communist China, Vietnam, and North Korea for the purpose of establishing new trade relationships (Downs, 1996). Second, the US government recently licensed a US pharmaceutical company to distribute Cuban cancer medicines in the US. The license was granted on the basis that the drugs represent life-saving technologies. However, the transaction undermines the embargo's central philosophy to prohibit all US trade with Cuba. It

also establishes a dangerous precedent of corporate favoritism; only months before the award, US government lawyers successfully prosecuted a California firm for exporting infant vaccines to Cuba through the company's European subsidiary (A. Pollack, 2004; Vásquez, 2004).

One important foreign policy inference has emerged from the dissertation research. Short of preemptive military action, multi-national sanctions, and another destructive socio-economic crisis, the relative stability of Cuban society and seeming permanence of the leadership suggest the US embargo will remain incapable of satisfying the Cuban émigré lobby in the US and exacting the level of misfortune on ordinary Cuban citizens needed to spark a peaceful revolt that replaces the current regime. Therefore, US decision-makers may be required to acknowledge the embargo's impotence, enter negotiations to normalize US-Cuban relations, and embrace the tiny, poor, island country as a legitimate member of the world of nations.

Domestic Policy Implications

If the current policy trend continues, the Castro government can be expected to retain the most successful and politically expedient aspects of the socialized health system, namely universal, preventive-primary, family doctor care. Additionally, the continued provision of cost-free family doctor services will be accompanied by the corresponding application of rationing and limited market-oriented techniques on other social, health, and health-related services. For example, non-subsidized imported pharmaceuticals, domestically-produced drug co-payments, and cost-sharing fees for such elder services as adult day care and long-term institutional care most likely will be maintained, or perhaps increased with corresponding service demands. In lieu of increasing Social Security pensions, however, an important domestic policy implication is that a growing indigence among the older population will require the state to secure and appropriate extra funding for special social case awards. Furthermore, the need for MINSAP to grant family doctors authority that is more discretionary over Gerontology Board decisions and target awards to their older patients with the greatest need also would be necessary for the policy action to succeed.

While it appears that Castro has straddled two economic worlds, the framework now guiding Cuba's long term elder care services system is neither socialist, nor is it capitalist. Castro has developed a unique economic model that attempts to create a health consumer society, yet, retains key facets of socialized welfare. However, older Cubans who have been

acclimated the longest to the state's absolute provision of social and health services, have little understanding of where elder care resources originate, and the real costs of and restraints on those services and financing mechanisms (Meadowcroft, 2003; Solman, 2001). A second domestic policy implication is the need to educate older patients and their families about the new realities of Cuba's novel health economics model.

The obligation to alter public demand, perceptions, expectations, and behavior about such issues as health rationing and coverage restrictions traditionally has fallen on policy-makers and health administrators. Because the state's legitimacy and public satisfaction with the health system are so closely associated, Castro may be forced to develop alternative means of communicating new health norms to avoid a political backlash, particularly over reforms that appear to violate Cuba's landmark social justice proviso—constitutionally mandated universal health care. Whereas care-provider determinations regarding the use of health resources always have been influenced by patient demands and expectations, “to a great extent, those expectations are shaped by physicians” (Eddy, 1994, p. 823). Consequent of the high level of patient trust in the local practitioner, Cuba's family doctors might be leadership's most powerful ally in any effort to promote the new health economics approach among older individuals and their families.

Obviously, this type of patient education campaign would depend on MINSAP's ability to provide adequate family physician retraining, which the findings have shown to be inconsistent and ungenerous. Still, older patients are in a strong position to participate meaningfully in such a campaign. Older Cubans, more than any other age group, have been exposed the longest to health education, health promotion, community participation, and local health surveillance efforts, all of which have elevated their understanding of complicated health matters, as well as the need for individual and collective sacrifice to achieve health goals.

The trustfulness that older Cubans voiced in their family physicians was based on geographic accessibility, the longitudinality of the doctor-patient relationship, and a high degree of psychological and social intimacy with their physician. However, the very foundation of trust that grants family practitioners privileged access to their older patients' lives also creates an environment of vulnerability, in which the person may be harmed, especially for the individual who has a multi-faceted disease or is gravely ill (Mechanic & Meyer, 2000; O'Malley et al., 2004; Yeo & Longhurst, 1996). The non-Cuban literature indicates that recent violations of the provider-patient relationship have centered on economic conflicts of interest and the financial

reorganization of medical care within the Neo-liberal framework for systemic efficiency, particularly when careful physician management of resources was mandated (Door Goold, 1998; M. A. Hall, Dugan, Zheng, & Mishra, 2001; Mechanic, 1998a, 1998b; Mechanic & Meyer, 2000; Mechanic & Schlesinger, 1996). In such violate surroundings, older patients become overly concerned with the physician's advocacy role. They begin to question whether the doctor "will fight to get them what they need and how much control the physician has over their pattern of care" (Mechanic & Meyer, 2000, p. 666). Older Cuban patients, however, face the additional concern of health surveillance.

Ultra-centralized, state monopolized health and social welfare structures, such as those in Cuba and the former Czechoslovakia, mandate that primary care physicians be the gatekeepers for patient entry into the higher medical service tiers (Albert et al., 1992). Consequently, highly trained physicians frequently waste "potential treatment time performing administrative duties" (Albert et al., 1992, p. 2463). This dissertation research has revealed that administrative overload is one of the major challenges facing Cuba's family doctors. The addition of a new health economics education function, therefore, may further exacerbate physician disenchantment with current managerial obligations, such as those expressed by Dr. Evaristo.

Cuba's family doctors may become more beholden to the state for administrative and economic relief, particularly if they are asked to take on additional health education duties, are forced to make more implicit rationing decisions, and experience the same fixed income deflation as their older patients. This gratitude, however, may come at the expense of the doctor's patient advocacy mandate. More disturbing, though, is the potential repression of older citizens similar to the state campaign against dissident factions after 1989 (J. I. Domínguez, 1994). If so ordered, indebted family physicians might be asked to more carefully scrutinize and report those individuals, who have expressed dissatisfaction with the leadership over health reforms. Recall that it is the family doctor, who is responsible for assessing anti-social, demoralizing, and dishonorable family member actions via the annual in-home examination regime (Cuban Ministry of Public Health, 2004).

Theoretical Integration

Emboldened by the collapse of the Soviet economies, Neo-liberal political economists capriciously defined the market-dominated model as the only authentic form, against which all

other approaches were to be critiqued and appraised. At the same time the socialist approaches were demonized, and increasing social inequities consequent of the free market logic were unashamedly justified, Neo-liberal capitalism was assumed to be “common to all societies regardless of their historical context” (Williams & Taylor, 2000, p. 22). Consequently, differences have been constructed between the domestic and the international realms, and the advanced and lesser developed nations; entire regions and countries have been excluded from analysis (Gamble et al., 1996; Walker & Wong, 1996).

New International Political Economy (IPE) is much more than a pragmatic response to the recent analytical emphasis on Neo-liberal capitalism. IPE also establishes a set of global and national problems that defy comprehension and analysis through the traditional 19th Century lenses of politics or economics (Veseth, 2004). It assumes that understanding the complexity of the new world order, and the origins and results of the global expansion of market structures on such social activities as politics, culture, tourism, and gender relations require new constructs. These new IPE constructs would integrate orthodox political economy and the modern approaches, methods, and analytical advances of all the social sciences (Gamble et al., 1996). One hopeful direction in IPE is the development of integral approaches to explore the complementarity of macro-level social-historic-institutional structures and the micro-level activities of individuals (Gamble et al., 1996).

Four theoretical implications have emerged from this dissertation research. First, IPE and crystallization proved to be a perfect supportive union in the process of informing the selection of multiple methods and strategies for collecting, analyzing, and reporting data from a range of appropriate disciplines. The second implication involves the adoption of an integrated, qualitative approach of one-on-one interviews, the focus group format, direct observation, and secondary source consultations to assess the interactive influences global change, domestic policy reform, and life course dynamics at the macro-level on the micro-level perceptions of individual older persons. This framework appears to satisfy appeals for multi-level IPE designs that guide analyses of comparative and international political economy, structuration, and public choice (Gamble et al., 1996). Equally important to the appropriateness of a multi-level, qualitative construct is the third implication—this research suggests an apposite role for gerontological analysis in IPE research.

The fourth and final theoretical implication goes the heart of the premise that

advancement toward the Neo-liberal model is inevitable, particularly for such transitional nations as Cuba. This study has illustrated that Cuba's distinctive form of market socialism has not institutionally separated society into the private and public spheres as Neo-liberal political economy demands, nor has the role of the public sphere been degraded (Williams & Taylor, 2000). Furthermore, economic motivation, which the Neo-liberal hypothesis claims is the overriding force in all human behavior, has not completely succumbed to the moral imperative exhibited by the majority of the study's older participants.

Limitations

The generalizability of support for Castro, the leadership, and Cuban socialism from the older subjects' perceptions of health equity and health inequity is the dissertation's chief limitation. This issue arises from Cuba's history of state authoritarianism and citizen apprehension to voice dissenting opinions freely for fear of reprisal. For example, one of the study's secondary sources claimed that local members of such mass organizations as Committees for the Defense of the Revolution commonly applied "psychological pressure...ostracizing" fellow citizens overheard making anti-Castro, anti-socialist, or anti-government statements. Cuban dissidents also have reported the defacing of homes and abusive phone calls as part of a recent harassment campaign organized by local residents and national security personnel (Stone, 2004). This research, however, corroborated the results of studies made during the height of the special period, in which Cubans were found to have had "few inhibitions about complaining openly" (Kuntz, 1994, p. 176) about food shortages and scarce goods and services.

Admittedly, residual effects from the life course dynamics of state surveillance and threatened oppression can be found in the older participants' behaviors. There was a ubiquitous circumspection at the outset of each interview, even when conversations occurred in the privacy of the family home or behind closed doors. Take Luis's remarks, for example. His statement that older Cubans "never complain about the health care system" during an initial home interview session illustrates his reluctance to criticize conditions. However, he freely offered his disapproval of the health care situation in a series of follow-up interviews once he felt more comfortable speaking with me.

Pedro and Isabel's actions were reminiscent of other older subjects, who voiced their dissatisfaction with the current health care situation without reserve, but stopped short of openly

criticizing by name such authority figures as hospital physicians and other health care decision-makers. The most transparent behavior, however, was a pervasive disinclination among the older subjects to censure the government, the leadership, Cuban socialism, and, specifically, the primary architect of Cuba's health policy—Fidel Castro. Most family doctors, health administrators, and other participating health and government informants exhibited the same discretion.

A 62 year-old artisan explained that the reluctance of ordinary Cubans to speak freely to foreigners in public, particularly Unitedstatesians, stemmed from an implicit state directive that talking to tourists was “vedado [forbidden].” However, the elder added that “we feel more comfortable expressing sentiments about the difficulties” of daily life in private. He asserted that Cubans of all ages desired friendship with foreigners and quickly formed bonds in what he described as a “hidden system of relationship building.”

In reality, individual perceptions of health and health-related services are an accepted proxy for the degree of opposition or support for policy-makers and the socio-political-economic order they represent. Furthermore, the theoretical sampling technique provided a mechanism to ensure the accuracy of the data. The responses of the older subjects met the technique's theoretical saturation criterion, whereby the general themes of perceived health equity and health inequity appeared and reappeared time and time again as new subjects were incorporated into the opportunity sample. Moreover, the research protocol for protecting the subjects, becoming familiar with the participants before soliciting formal responses, and asking the most sensitive questions only in private enhanced the quality of the data and its generalizability.

Future Research Directions

This dissertation proposes five future research paths. First, future studies might contrast and compare perceptions of health equity and health inequity among dissimilar population segments. Such a study also might benefit from an analysis of the influence of disparate life course occurrences on the perceptions of individuals of differing ages and genders.

The impact of food shortages and such health-related inadequacies as diagnostic tests and appropriate pharmacological treatments on chronic disease pathways may not be detectable for years and, perhaps, decades. Thus, a second future examination might be conducted to gauge the longitudinal health effects of the events of the immediate post-Cold War Era on Cuba's older

citizens and the general population. Furthermore, the results of this study could be incorporated into a broader comparative analysis of the effects of socio-political-economic change in other transitional countries, particularly among the nations of the former Soviet bloc.

A third potential study centers on the 1992 national policy on aging. The undergirding design of the policy is to offer older Cubans a seamless care continuum of familial, community, and institution-based services. New research might analyze the potential interruption of seamless care provisioning as a consequence of resource rationing, co-pay structures, and the proposed deinstitutionalization of long-term elder care services.

Secondary sources noted an increase in social isolation and rising elder suicide rates, both of which were linked to increases in depression among older individuals. However, the dissertation research found Cuba's medical professionals to be irresolute about the incidence and prevalence of such dementias as Alzheimer's Disease. A fourth future research direction might try ascertain the tangible occurrence of dementias, then, examine their possible correlations with current mental health trends and the social stigma attached cognitive impairments.

Finally, it also might be useful for future studies to build on the theoretical findings from this qualitative inquiry. If impediments to conducting quantitative outsider studies in Cuba can be overcome, a fifth future research project would devise a quantitative analysis for hypothesis testing. A follow-up qualitative study that queries the results of this new quantitative piece could then be undertaken and, as proposed by new International Political Economy, further bridge the methodological rift by advancing a truly integrative qualitative-quantitative construct.

Appendixes

Appendix A
Questionnaire

Sexo: F M

Gender: M F

¿Cuál es su profesión?

What is your occupation?

¿Cuál era su profesión, si está jubilado(a) ahora? [Ama de casa, gerente, profesional, obrero, trabajar por cuenta propia, técnico, no trabaja (desempleado), trabajador en servicios, agricultor, administrador, fallecido, no sabe, otra]?

What was your occupation if you are now retired [Homemaker, management, professional, laborer, self-employed, technician, unemployed, services, agricultural worker, administrator, don't know, other]?

¿Cuál es su estado civil [casado(a), unido(a), soltero(a), divorciado(a), viudo(a)]?

What is your civil state (married, united (common law), single, divorced, widowed)?

¿Cuántas personas (incluyendo a Ud.) viven en la casa?

How many people (including yourself) live in your home?

¿Con quién(es) vive [parientes, miembros de la familia, no miembros de la familia (amigos de la familia), ambos]?

With whom do you live (close family members, relatives, non-kin, both)?

¿Cuántos años tiene?

How old are you?

¿Nivel de enseñanza (primaria, secundaria básica, preuniversitaria, tecnológica, universitaria, otra, no estudia)?

Education or level of schooling (primary, basic secondary, pre-university, technical, university, other, no education)?

¿Cuánto recibe Ud. de ingresos de pesos cada mes?

What is your total monthly income in pesos?

¿Total de ingresos en su casa cada mes?

Total household income per month?

¿Qué tipo(s) de servicios gratis o subsidios del gobierno [alimento (leche, huevos, arroz, frijoles, carne, pollo, pescado), alojamiento, la ropa, transportes públicos, vitaminas, medicina]?

What type(s) of free government services or subsidies do you receive [food (milk, eggs, rice, beans, meat, chicken, fish), housing, clothes, public transportation, vitamins, medicine]?

¿Cómo me describiría Ud. su salud actual?

How would you describe your health now?

¿Ha tenido Ud. algunos problemas de salud graves en el pasado?

Have you had any major health problems in the past?

¿Tiene Ud. algunos problemas de salud crónicos (diabetes, hipertensión, problemas de corazón, respiratorios, artritis)?

Do you have any chronic health problems (diabetes, hypertension, heart condition, respiratory, arthritis)?

¿Para qué condiciones ha utilizado usted o su familia los servicios del consultorio médico de la familia (reconsulta, accidente, chequeo médico regular, inmunizaciones, enfermedad, otros)?

For what types of conditions have you or your family used your family doctor's services (return medical consultation, regular medical check-up, immunizations, illness, other)?

¿A qué distancia está el consultorio de su médico de familia de su casa (número de cuadros)?
How far is your family doctor's office from your home (number of blocks)?

¿Cómo llega Ud. al consultorio de su médico de familia (a pie, en coche, otro)?
How do you get to your family doctor's office (on foot, car, other)?

¿A qué distancia de su casa se encuentra la policlínica?
How far is your home from the polyclinic?

¿Cómo llega usted a la policlínica?
How do you get to the polyclinic?

¿Cuántas veces visita Ud. a su médico de familia (diario, semanalmente, mensualmente, anualmente)?
How many times do you visit your family doctor (each daily, weekly, monthly, annually)?

¿Cuántas veces le visita a Ud. su médico de familia en casa (diario, semanalmente, mensualmente, anualmente)?
How often does your family doctor visit you at home?

¿A veces es difícil ver a su médico de familia en el consultorio?
Is it ever difficult to see your family doctor at their office?
¿A veces es difícil ver a su médico de familia en la policlínica?
Is it ever difficult to see your family doctor at the polyclinic?

¿Paga Ud. alguna vez los servicios de médico o salud de atención de sus ingresos (medicina, procedimientos clínicos, análisis laboratorios, equipo médico)?
Do you ever pay for any medical or health care services from your income (medicine, clinical procedures, laboratory tests, medical equipment)?

¿Cuánto cuestan estos servicios?

How much do these services cost?

Describame la relación que Ud. tiene con su médico de familia, por favor.

Please describe your relationship with your family doctor.

Appendix B

Glossary of Abbreviations

CANF	Cuban-American National Foundation
CARE	Continuous Assessment and Risk Evaluation

CDR	Committees for the Defense of the Revolution
CIA	Central Intelligence Agency
CITED	Central Latin American Institute for the Third Age
CMEA	Council for Mutual Economic Assistance
C-OPC	Community-Oriented Primary Care
FMC	Cuban Women's Federation
GDP	Gross Domestic Product
IRB	Institutional Review Board
MEDICC	Medical Education in Cooperation with Cuba
MGB	Basic General Physicians
MGI	Comprehensive General Medicine
MINSAP	Cuban Ministry of Public Health
NGOs	Non-Governmental Organizations
PAHO	Pan American Health Organization
PCC	Cuban Communist Party
UN	United Nations
UNESCO	United Nations Economic, Social and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
US	United States
WHO	World Health Organization

Appendix C

Personal Communications

Rafael Borroto Chao, Director, National Center for Health Promotion and Education. La Habana, Cuba, July, 2, 2001.

Osmara Delgado Sanchez. Director, Santa Fe Home for Elders. La Habana, Cuba, July 13, 2001.

Theresa Froletas. Professor, School of Public Health. Representative, Ministry of Public Health, Unit of Analysis and Tendencies. La Habana, Cuba, June 28, 2001.

Jorge Hadad Hadad. Principal of Medical Technology, Cuban School of Public Health. La Habana, Cuba, June 29, 2001.

Fred Harris. Faculty, Political Science Department faculty, University of New Mexico. San Jose, Costa Rica, June 21, 1996.

Ivonne Plana. Director of Services, Adult Daycare Center and Adult Day Medical Care Facility. La Habana, Cuba, June 27, 2001.

Teovaldo Triana Torres. Director, Piñar del Rio Province Health Department. Faculty, Ché Guevara Medical School. Piñar del Rio, Cuba, July, 23, 2001.

Fe Bosch Valdez. Director, Bauta Community Center for Natural and Traditional Medicine. La Habana, Cuba, July 16, 2001.

Notes

Chapter Two

1. Scheper-Hughes (1995) also argues that globalization and social inequities consequent of Neo-liberalism underscore the scientific need for the human rights perspective. The human rights perspective asserts that it is a researcher's duty to contribute to society as-a-whole through

political and social activism when confronted by oppression and fundamental human rights violations in the field. Also see Moran (2002) for a detailed discussion of the caveats of investigator activism, subjectivity, and biases.

2. An extensive search of the literature for peer-reviewed IPE research publications was conducted to determine if the field of gerontology has informed IPE. Only one article (Mutari, 2001) was returned. Mutari's (2001) historical treatment of IPE feminist critique, however, deals peripherally with the importance of age and other analytical categories in integrated class and gender research.

3. Pearson first details the impact of globalization and the Cuban response of market-oriented structural reforms, in which the author argues that women have disproportionately absorbed via new job constraints, reduced social welfare services, and delayed implementation of the national domestic equality policy. Then, based on an unstated number of interviews with professional and educated household members, the author extracts several quotes that embody the study's main argument. One woman was quoted as stating that although "My mother taught me how to cook economically—he [spouse] does not know....He can't do the washing, we are so short of soap" (Pearson, 1998, p. 248). A retired farmer residing with his family added, however, that "In 90% of Cuban households the men help, which has alleviated women's domestic work....I am the main cook—the women clean the house but father will clean the house if necessary but as there are women in the house" (Pearson, 1998, p. 248).

Chapter Three

1. References to the *Revolution* transcend the events of 1959, when Castro, his brother, Raúl, Ché Guevara, and their followers ousted Cuba's US-supported president, Fulgencio Batista (H. Thomas, 1998). The term connotes the ongoing process and unfinished business of Cuba's

socialist Revolution—social and income equalization, state provision of such basic human needs as health care, education, housing, food, and income security, human capital development, and the formulation of its own “appropriate forms of participatory democracy” (Pearson, 1998, Note 7, pp. 257-258).

2. See Jennissen and Lundy (2001) and Pearson (1998) for recent Cuban gender analyses that build on the work of Azicri (1981) and Bengelsdorf (1988).

3. One recent Cuban research publication is conspicuous for its disclosure of the investigator’s value preferences. In the opening paragraph of Pearson’s The Political Economy of Social Reproduction: The Case of Cuba in the 1990s (1998), the author states that “we engaged with fellow socialists in what was termed the ‘domestic debate’ in the 1970s” (p. 241).

4. Strictly defined, the Spanish term *caudillo* refers to a military leader during wartime. El Caudillo, for example, was the historic title given to Spain’s Franco (Blasco et al., 2002). In references to Castro, however, caudillo refers to a strong personalistic ruler or boss (Gonzalez & Ronfeldt, 1994).

5. The *Infomed* home page can be found at <http://www.sld.cu/>. Also see <http://bvs.sld.cu/indice.php> for a complete listing of electronically accessible Cuban medical and health journals. In October 2003, Pathfinder Press began offering subscriptions to two important Cuban periodicals: *Granma Internacional* and *Cuba Socialista*. *Granma Internacional* is the weekly international edition of *Granma*, the daily newspaper published by the Central Committee of the Communist Party of Cuba. Regular features include Castro’s speeches, official government releases, and news articles about domestic and global political-economic developments. *Cuba Socialista* is a quarterly Cuban Communist Party periodical published in Spanish. It carries theoretical and analytical articles on global political and economic debates by liberal factions.

6. See <http://www.medicc.org/pages/mr.html> for MEDICC Review, including an entire volume dedicated to aging in Cuba (2000, Vol. 2(1)).

7. Also see Mesa-Lago (2000) for a comprehensive mainstream review of political-economic reforms launched during the 1980s and Meur (1992) for a mainstream account of agricultural reform in the 1980s, including reforms that permitted free market agricultural operations, called agro-mercados (agri-markets).

8. The Cuban archipelago consists of the main island of Cuba, the Isle de Piños (Island of Pines), a special municipality that lies off the southwestern coast of the main island, and more than 4,000 smaller keys and islets. Much of the Isle de Piños is covered by pine forests and numerous mineral springs. Although the isle has marble deposits and other minerals, its primary economy is based on fishing and agriculture, primarily citrus fruits, some vegetables.

Colón first sighted the isle in 1499, after which, it was used as a penal colony, a secreted refuge for buccaneers, and vacation retreat for Spanish military. Following the Spanish-American War in 1898, the US Supreme Court ruled the US claim to the isle invalid and confirmed it as Cuban. Private US property owners remained there, however, until the enactment of the US embargo in 1960.

During the first Machado presidency, Cuba's model prison, la Cabaña, was built on the isle near the capital of Nueva Gerona. It was used mainly to house political prisoners, and where Castro himself was incarcerated by Batista in 1953. Castro renamed the tiny island *Isla de la Juventud* (Isle of the Youth) in 1966, on which an agricultural experimental center for permanent volunteers was established. Today, it again has become a tourist destination. It also is the site for Cuba's foreign educational assistance campus, where, in 1980, over 20,000 students from more than 80 countries received medical, health, engineering, and technical training (Central Intelligence Agency, 2003; Cockroft, 1996; Eckstein, 1988; Garvin, 2003; Inter-American Commission on Human Rights, 1983).

9. US-supported military dictator, Fulgencio Batista, had directly or, through indirect political back channels, headed Cuba's government since 1934. He was reported to have fled the country with most of the national treasury in the early morning hours of January 1, 1959, a week before Castro's rebel forces entered La Habana and three days after Batista's family had left Cuba for the US. Batista, however, took refuge in the Dominican Republic. Although Castro claims that

Batista escaped with as much as \$US400 million, Batista aids later stated the dictator had siphoned off and placed \$US300 million in New York, Mexican, and Switzerland bank accounts. Unlike events following the Spanish-American War, the Eisenhower Administration failed to create a provisional government that bated the revolutionary leadership in the weeks following Batista's exit from the island (Cockroft, 1996; H. Thomas, 1998).

10. Cuban president Gerardo Machado took office in 1925. A state of semi-civil war existed by 1932, however, largely due to the murderous actions of the administration's security forces. By the early 1930s, Machado's efforts to establish a dictatorship were confronted by his "most vociferous and dangerous opponents" (H. Thomas, 1998, p. 591), a rebellious cohort of students, ex-students, and professors from the University of Habana—Cuba's most influential and activist left wing. This student cohort later teamed with a second generation of students to oppose Batista in the early 1950s. Fidel Castro was a second generation University of La Habana student, where he had connections with at least two revolutionary campus groups after 1945, and from which he received a law degree (H. Thomas, 1998).

11. During a visit to Cuba in 2001, I spoke with a woman in her 90s in a La Habana nursing home, who had been recognized by Castro as the island's last Nambe Tribal member.

12. See 2002 Report of Jehovah's Witnesses Worldwide; World Jewish Congress, 1998.

Chapter Four

1. Cubans refer to US citizens as *Norte Americanos* (North Americans) or Yanquis (Yankees). The seldom-used term Unitedstatesians, however, is considered more geo-politically relative and culturally sensitive than such commonly used terms as Americans, Norte Americanos, or

Yanquis that are used to describe residents of the US (Fred Harris, personal communication, June 21, 1996).

2. In response to the Bush Administration's tightening of the US embargo in May 2003, Castro announced a ban on transactions using US dollars in Cuban stores and businesses effective November 8, 2004 (BBC News World Edition, 2004; CBC News, 2004). The policy also levies a 10 percent commission on every dollar exchanged for the convertible peso; the convertible peso is a domestic currency that has no value internationally.

3. The impossibility of sustaining the military program and other national projects after 1989 has been underscored by Alzulgaray (1995), who cites a report by Cuba's National Institute of Economic Research that 1992 modifications to the US embargo alone cost the nation \$US 40 billion dollars.

4. The majority of the research concerning geriatric exhaustion centers on behavioral change related to cardiac infarction among older persons. While two studies (Leger et al., 2000; Schmidt, Hill, & Guthrie, 1977) appear remotely connected to the psychological state referred to by Tamayo (2000), there is little scientific evidence that supports the hypothesis of geriatric overexertion, let alone geriatric exhaustion among Communist or revolutionary world leaders.

5. As this investigator watched the June 23rd speech on Cuban national television, it appeared that Castro did indeed become pale and experienced momentary weakness in his lower extremities, which the medical literature defines as part of a fainting episode (Venes & Thomas, 2001). However, the leader did not fall to the ground. Castro returned to the podium moments later and apologized to the crowd for having to delay the speech until later in the day when cooler temperatures prevailed. Edited Cuban television rebroadcasts of the speech removed the health episode from the video footage.

Chapter Five

1. The theoretical construct that guides, or drives the research does not place a value on either the qualitative or quantitative approaches used in the study, nor does it refer to the time and energy invested in answering every methodological question (Morse, 1991).

2. In early 2003, I submitted the appropriate US and Cuban documentation to return to Cuba and conduct additional quantitative research. The research application included a letter of support from a US scholar, who is the sole US consultant to Cuba's national aging initiative, and a hand-delivered letter of support from the director of Cuba's national elder care program. The requests for a Cuban educational visa and project approval, which are being considered as a single case, require authorizations from a number of actors within the Ministry of the Interior's Department of Bilateral Collaboration, MINSAP's International Relations Office, and the National School of Public Health.

Despite external and internal support, two previous research visits, and bi-monthly correspondences, Cuban officials have yet to reply. Although entirely unsubstantiated, I suspect that the deterioration of US-Cuban relations since the September 2001 attack on the US, the Bush Administration's crackdown on US citizen travel to Cuba in early 2003, heightened tensions from the most recent US-Iraqi war, the US Administration's linkage of the Castro government with global terrorism, and increased human rights violations in Cuba all have contributed to the delay. For these reasons, the intention to incorporate an advanced quantitative research component into this project so far has been unsuccessful.

3. The phrase *post-revolutionary era* refers to the period after Cuba's 1959 Revolution. For the majority of Cubans with whom I spoke, however, the Revolution is an ongoing process that was merely initiated by the 1959 revolt. All references to the post-revolutionary era used in the dissertation recognize this distinction.

4. The University of Kentucky College of Architecture holds a US institutional travel license, under which university-affiliated faculty and students may engage in educational activities in Cuba that are authorized by the Cuban government. I obtained permission from the Dean of the College of Architecture and the requisite travel document to conduct additional research on this project during a proposed third visit to Cuba in 2003. As mentioned above, Cuban authorities have yet to respond to the submitted application.

5. The Cuban government mandates that foreign researchers traveling in Cuba under educational visas provide and strictly adhere to pre-authorized agendas. For example, these schedules are required to access official sites and professionals, hospital and polyclinic personnel and family doctors. Official chaperones are required to accompany foreign researchers on all officially scheduled site visits and be present during professional interactions.

Throughout this project's two field visits, assigned chaperones graciously answered my general research questions, provided logistical information and transportation, and arranged special permission to visit (accompanied by the chaperone) official sites and speak with personnel not included in the pre-approved agendas. Frequently, my chaperones assuaged professionals, who were wary, protective and, in some instances, uncooperative. Nevertheless, I suspected that chaperones also were assigned to dissuade informants from offering personal observations that might have been critical of the leadership, government policy and programs, health and social resources and, perhaps, to report suspect subject responses to government authorities (Schweimler, 2001). Curiously, once working relationships were established with many of these individuals during the pre-authorized visits, I was invited to return unaccompanied and was provided full and unsupervised access to health facility staffs and clients.

The pre-authorized schedules and chaperone requirements do not apply to meetings and conversations with ordinary Cuban citizens. One outside researcher (Kuntz, 1994), for example, reported that ordinary citizens complained openly about crisis-era shortages. Still national security and law enforcement officers, particularly in La Habana's heavily frequented tourist areas, regularly interrupt exchanges between foreigners and citizens; on several occasions, law officers cut short my public interactions with citizens, after which the Cubans were pulled aside, ordered to produce identification documents, and questioned about the conversations. The official state argument for these types of security actions is to protect tourists and deter illegal and black market activities, such as prostitution and the private sale of state-manufactured cigars.

6. Previously validated questions from Schur and Franco's (1999) US health study were used, because they explored both the attitudes and opinions of vulnerable persons, particularly among rural populations. Furthermore, the general socio-economic conditions and health states of the study's rural participants were similar to those of older Cubans.

Chapter Six

1. Castro referred to this type of activity in speech in the late 1960s (Castro, 1969). Also see Thomas (1998) for other accounts of physician improbity in pre-revolutionary Cuba.

2. See DeVries and Sparks (1989) for comparisons with other Latin American countries and Danielson (1975; 1981) for a more extensive examination of the Czechoslovakian polyclinic model.

3. See Batista Moliner (1997) for a comprehensive survey of the development, organization, administration, and functions of MINSAP's national health surveillance system.

4. In 1990, PAHO set the goal of reducing reduce the infant mortality rate to 50 per 1,000 live births in all nations of the Americas by the year 2000 (Pan American Health Organization, 1998a). As Table 6.1 indicates, Cuba already had achieved that goal by 1970. By 1997, Cuba's Health Minister reported that the nation's infant mortality rate of 7.6 per 1,000 live births was the lowest in its history and commensurate with the industrialized nations (Radio Habana, 1997). Canada's infant mortality rate was 7 per 1,000 live births for the period 1990-1995 (Pan American Health Organization, 1998a). The US rate for the same period was 8 per 1,000 live births (Pan American Health Organization, 1998a). Between 1990 and 1995, Costa Rica had an infant mortality rate of 14 per 1,000 live births (Pan American Health Organization, 1998a).

In October 2002, Castro announced that the infant mortality rate was 6.2 per 1,000 live births (Castro, 2002a). He noted that the figure "signifies a 90% reduction" since 1959 (Castro, 2002a). By year's end, however, the rate had increased slightly to 6.3 per 1,000 live births (de la Osa, 2003). The top five 2002 rankings for infant mortality under age 5 for the nations of the Americas were as follows: Canada, Cuba, US , Costa Rica, and Chile (UNICEF, 2004).

Furthermore, of the 19 Latin American nations with 2.5 million populations or more in 2002, Cuba was ranked second only to Chile (22.7/10,000) in maternal mortality with a rate of 33.9 per 10,000 population (Pan American Health Organization, 2003). Argentina and Costa Rica were ranked third and fourth with maternal mortality rates of around 35/10,000 in 2002 (Pan American Health Organization, 2003). Cuba's maternal mortality rate of 42 deaths per 100,000 live births in 1990 increased dramatically during the critical years of the special period to a high of 57 deaths per 100,000 live births in 1994 (Pan American Health Organization, 1998a).

5. Over the years, the political importance of Cuba's mass organizations has eroded (J. I. Domínguez, 1994). By 1991, for example, leaders of mass organizations, including the FMC and CDR, had lost their posts in the Community Party's Political Bureau (J. I. Domínguez, 1994).

6. Despite FMC political influence and involvement in family-oriented health and social issues during the first and second developmental sequences, only three percent of all parliamentary seats went to Cubanas in the 1976 national ballot (Garfield, 1981). Although more Cuban women have been elected to national office since this first ballot, they have not yet achieved parity with their male counterparts (Garfield, 1981). In 1985, Cubanas held 25 percent of all National Parliament seats (Cockroft, 1996).

In contrast, women held 13.6 percent of the 535 seats in the 108th US Congress of 2003 (Center for American Women in Politics, 2002). Cubanas held 36 percent of all seats in the National Parliament in 2003, ranking the island nation 7th among 139 nations polled (Inter-Parliamentary Union, 2003). The United States tied Andorra for 59th place (Inter-Parliamentary Union, 2003). Costa Rica was ranked 9th, with 35.1 percent of all seats in its single house held by women (Inter-Parliamentary Union, 2003).

7. The Marianao suburb currently is home for some of the nation's preeminent bio-medical and technological universities, in addition to Freedom City, a Batista Era military quarter that was transformed into the country's most famous children's school (IslaGrande, 2003). The municipal health service area was later named the *Seat of the Revolution* for its pioneering work in the development of the prototype polyclinic for community medicine (Soberats et al., 1999).

8. The adoption of the idiom *policlínica* (polyclinic) refers to Cuba's integral ambulatory care delivery approach, while the use of the term *community medicine* in Cuba, is devoid of the class connotations associated with community medicine in the capitalists nations (Danielson, 1975, 1985). Danielson (1975) noted that the term polyclinic originated in Czechoslovakia. Czechoslovakian polyclinics, however, were designed to provide all ambulatory clinical medical services rather than integral care (Albert et al., 1992; Danielson, 1975; Potucek, 1991). Doctor Julio Martinez Paez, who is credited with developing Cuba's public health system in 1959,

viewed the polyclinic (the rural health center and urban clinic as they were called at the time) as the health system's linchpin, in which it would eventually provide all preventive-primary care services: vaccinations, ante-neo-natal-maternal services, and health care in the schools (MacDonald, 1999).

9. Citizens and health professionals continued to express a litany of complaints about the 1976 Community Medicine in the polyclinic model, including the following: 1) despite the presence of specialists in the polyclinics, patients still believed that hospital-based specialists could resolve medical problems expediently and more rapidly than polyclinic staffs; 2) the linkage between in-patient facilities and the polyclinics was deficient; 3) polyclinics lacked adequate resources; 4) the perceived inferiority of the polyclinics and excessive patient loads convinced residents to seek treatment in hospital emergency rooms; 5) holdups in polyclinic laboratory test and x-ray results increased patient flows to hospital urgent care units; 6) specialist physicians continued to address morbidity as a strictly bio-medical phenomenon; and 7) specialists resisted taking the pro-active approaches of conducting comprehensive evaluations and searching for the possible bio-psycho-social associations that might have more fully explained the patient's health problem(s) (Diaz Novas & Fernandez Sacasas, 2001).

Chapter Seven

1. In the US, students must have earned a Bachelors degree and passed the Medical College Admissions Test before applying to medical school. Medical school is a four-year process. The

first two years focus on classroom and laboratory studies. Although courses vary from institution to institution, almost every medical school requires students to take core classes in the first two years that include the following: gross anatomy, biochemistry, pathology, behavioral science, pharmacology, physiology, microbiology, physical diagnosis, microanatomy/histology, and medical ethics (American Association of Pre-medical Students, 2003; E. P. Wilkinson, 2002).

The final two years are spent predominantly in hospital rotations that are blocked in five basic specialty areas: surgery, internal medicine, psychiatry, pediatrics, and obstetrics-gynecology. Rotations are designed to support the selection of a specialty practice. Other rotations that may be required are family medicine, neurology, and orthopedics (American Association of Pre-medical Students, 2003; E. P. Wilkinson, 2002).

Every US medical student must pass the Medical Licensing Examination (national boards) to be licensed in virtually every state. The first part of the national boards is taken after the second year of medical school, completion of the basic sciences curriculum, and passage of the National Board of Medical Examiners' Basic Science Comprehensive Examination. Passage of Part I of the national boards is required in order for the student to begin clinical rotations.

Part II of the national boards is taken in the fourth year of medical school following completion of clinical rotations. Passage of the first two parts of the national boards and the Clinical Skills Assessment exam are required to gain acceptance into residency training. The skills exam is taken after the student passes the first part of the national boards. Part III of the national boards, the final requirement before licensing, is generally taken at the conclusion of residency training (American Association of Pre-medical Students, 2003; E. P. Wilkinson, 2002).

Residency training is designed to expose the US physician to the specialties. Its duration generally is two to three years (American Association of Pre-medical Students, 2003; E. P. Wilkinson, 2002). The first year is spent in numerous clinical settings that permit a sampling of the various specialty and sub-specialty fields. Medical residents are expected to have decided what specialty to pursue at the conclusion of residency training (American Association of Pre-medical Students, 2003; E. P. Wilkinson, 2002). Passage of Specialty Board Examination, which consists of a two-day written and oral exam, is required before the licensed physician may practice in a specialty area.

2. Consultorio construction paralleled a national housing and health facility building program that began in the 1980s (Santana, 1987; Warman, 2001). To this day, local residents decide where to locate the family doctor's residence/office (Gilpin, 1989). Consultorio construction brigades are composed of volunteer laborers, many of whom are retirees (Gilpin, 1989; Iatridis, 1990; Santana, 1987; Warman, 2001). Participants are awarded a new apartment in exchange for their unpaid work (Warman, 2001).

This arrangement underscores social change after the 1960s, in which material incentives replaced Guevara's moral incentives concept for the *New Man*. Guevara's moral structure, however, did not altogether disappear. By the 1990s, initial partnerships between family doctor-nurse teams and voluntary consultorio construction brigades were transitioned into joint efforts to encourage greater community participation in reducing health, social, and environmental risks at the neighborhood level (Hernández Cabeza et al., 1999).

3. Mirroring changes in the culture of machismo, almost half of all doctors in the early 1990s and more than two-thirds of all family doctors in 1997 were women (Fernández Rius, 2001; Froines, 1993; Iatridis, 1990; Jennissen & Lundy, 2001; Pérez Hoz et al., 2001; H. Waitzkin et al., 1997). Furthermore, revocation of the 1962 female nurse mandate and the erosion of traditional gender roles beginning in the mid-1970s increased the number of male nurses (Santana, 1987). Due to differential grade point averages (GPA) between women and men, however, MINSAP instituted a medical school quota system in the late 1980s (Gilpin, 1989). Males with a GPA of 90.0 were guaranteed acceptance into medical school. The GPA cut-off was set at 94.5 for female applicants, whose grades were found to be consistently higher than male candidates (Gilpin, 1989).

4. See Pérez Cardenas (2002) and Zayas Vinent & Rodríguez Jústiz (1997) on the persistent difficulties of teaching the concepts of community and community participation to Cuban health professionals.

5. It can be argued that physician resistance (human agency) to MINSAP's onerous directives during the fourth developmental sequence contributed to the lack of dedication in the arenas of epidemiologic surveillance and community partnering.

6. Waitzkin and Britt (1989) argued that US physicians began to address the Western-oriented model for medical discourse after the 1960s. They sought to reduce patient perceptions of the medical professional's dominance and improve doctor-patient communications through such direct, short-term, micro-strategies as leveling medical language barriers. The behavioral shift among health professionals also has been attributed to the US civil rights and consumer movements, in which the judicial system supported patient and family demands for greater involvement in medical decision-making, particularly for older individuals at life's end (Haug & Lavin, 1983; Schwar, 1997). Together, these changes brought the issues of medical competence and the sovereignty of the health professional to the fore and, generally, made doctor-patient relationship in the US more egalitarian (Haug & Lavin, 1983).

7. A later study (Medina Lorente et al., 1998) confirmed that patient satisfaction levels after the economic crisis eased in the mid-1990s remained consistent with the 1991 research findings.

Chapter Eight

1. In Cuba, the heterogeneous population sub-group of all persons age 60 years or older is referred to as los ancianos (elders) or los abuelos (grandparents) (María del Rosario Abreu

Vázquez & Muñiz Peláez, 2001; Perdoma Victoria et al., 1999). Cuban gerontologists also use the expression the *Third Age* to classify older adults in this demographic range (Centro Iberoamericano para la Tercera Edad, 2003; Delgado García, 1996b; María del Rosario Abreu Vázquez & Muñiz Peláez, 2001; Morales & Acosta Lastra, 1991; Schwar, 2002).

2. PAHO (1998a) calculates that a total fertility rate of 2.1 births per female produces static population growth with the total number of new births equaling the total number of deaths. If the rate is less than the 2.1 replacement statistic for a lengthy period of time, a population decrease will occur. Conversely, fertility rates that remain above the 2.1 figure for an extended period will result in population growth.

3. Statistical discrepancies in Social Security expenditures follow the general pattern of researcher value preferences. For example, the higher statistics presented in Table 8.2 are based on Reed and Frank's (1997) sources within the Cuban Ministry of Finance and Prices. Donate-Armada's Social Security study (1994), meanwhile, offered no reference for the much lower 1989 figure cited. Reed, a US-born, Cuban-based journalist, is International Director of Medical Education in Cooperation with Cuba, a non-profit organization composed of Cuban and US medical educators and practicing physicians that offers medical electives in Cuba to medical residents and medical and health sciences students (MEDICC, 2004). Donate-Armada, a recognized Cuban-educated economist who emigrated to the US after the Revolution, is a consultant with the American Association for the Study of the Cuban Economy, a non-profit research group that promotes Cuba's Neo-liberal transition (Association for the Study of the Cuban Economy, 2004; Tamayo, 1998).

4. Legalization of the \$US in 1993 permitted consumers to purchase with \$US currency only basic foodstuffs in dollar stores at non-subsidized prices (Schwar, 2001). The dollarization of the economy also encouraged a black market for all types of commodities, including foodstuffs, that generally are sold (\$US) below state prices if widely available (Cuba In Evolution, 1998).

5. As part of the government's anti-smoking campaign begun in 1971, the tobacco ration was reduced and restricted to individuals over 16 years of age (Feinsilver, 1993). In 1985, Castro stopped smoking cigars in public. He announced that he had given up smoking the following

year and made himself a public symbol of the anti-smoking initiative (Feinsilver, 1993; Shanken, 2003). A ban on smoking in the nation's health facilities, sports arenas, classrooms, business meeting centers, and on public transportation and domestic airlines flights was instituted in 1986 (Feinsilver, 1993). The campaign later banned smoking by government officials in public and mandated only positive media portrayals of the behavior (Feinsilver, 1993).

Between 1985 and 1995, the campaign was credited for halting the increasing trend in tobacco use and reducing the number of users by six percent (Feinsilver, 1993; Pan American Health Organization, 1999). Ironically, tobacco was one of the few products to escape emergency rationing during the special period, perhaps, because the state realized significant domestic revenues from non-rationed cigarette sales (Feinsilver, 1993; Schwar, 2001).

6. The human resource assessment (Sansó Soberats et al., 1999) concluded that almost 79 percent of total family doctor time was allocated to patient care, with a daily average of 9.4 consultorio and 8 in-home visits. This represents a 9 percent primary work time increase over MacDonald's (MacDonald, 1999) finding. The Cuban researchers (Sansó Soberats et al., 1999) inferred that the remaining 21 percent of family doctor work devoted to other activities was inconsistent with the time necessary to fulfill the CARE directive. The assessment also found that about 16 percent of all patients in its study area had not been classified (Sansó Soberats et al., 1999).

Thus, two critical changes were recommended (Sansó Soberats et al., 1999). The first was to modify the extant dispensarization typology and care protocols detailed in Table 8.3 to include the following: a second elevated risk classification for Group II patients; split the former Group III category into separate groups of low- and high-risk probability patients; create a fifth Group classification of patients with manifest health problems and consequences; and make correspondent adjustments to increase clinical examination protocols (see Table 8.5). A second proposal was to modify the family doctor-nurse model, revisit MINSAP's polyclinic nurse ratio regulation, and increase the number of polyclinic nurses involved in the CARE process. The later recommendation follows a longstanding argument by independent observers that Cuba's health system is over-reliant on the family doctor, has squandered its nursing work force, and could realize additional cost savings by relying more heavily on nurses and medical auxiliaries (Alonso et al., 1994).

Table 8.5. Proposed Dispensarization Typology and Care Protocol Changes

Group	Health Classification	Care Protocol
I	Apparently healthy	Annual or bi-annual examination
II		
A	At Risk	Bi-annual examination
B	Elevated risk for illness/disease	Tri-annual examination
III	Manifest illness/disease with low probability of complications and/or incapacitation	Annual or bi-annual examination
IV	Manifest illness/disease with high probability of consequences and/or incapacitation	Tri-annual examination
V	Manifest illness/disease with consequences	Quad-annual examination

Adapted from "La Dispensarización: Entre lo Normado y lo Posible," by F. J. Sansó Soberats, A. Fernández Pérez, and M. Larrinaga Hierrezuelo, 1999, *Revista Cubana de Medicina General Integral*, 15(6), 605-612; *La atención primaria en Cuba: El equipo del médico de la familia y el Policlínico*," by G. Eisen, 1996, *Revista Cubana de Salud Pública*, 2

7. See [A Profile of the Elderly in Costa Rica](#) (Pan American Health Organization, 1990) for the Costa Rican contribution to PAHO research in the Caribbean and Latin America region during the 1980s.

8. In the US and other developed nations, maximum normal arterial blood pressure for a healthy, resting, young adult is defined as 120mm Hg (Kapit, Macey, & Meisami, 2000). Maximum pressure occurs at midpoint in the systole cycle. Minimum pressure, which occurs at the end of diastole cycle, is 80mm Hg (Kapit et al., 2000). The accepted definition for hypertension is a systole/diastole pressure of 140/90mm Hg or more (Kapit et al., 2000). In 1974, MINSAP classified hypertensives as those persons with a systole/diastole pressure of 160/95mm Hg (MEDICC Review, 2000). The agency's adoption of the more widely recognized definition of 140/90mm Hg in the late 1970s, however, had the effect of doubling hypertension prevalence among the population age 15 years or older (MEDICC Review, 2000).

A later study (Ordunez Garcia et al., 1998) confirmed that a third of all adults in Cuba were hypertensive. It also determined that high blood pressure was a critical risk factor in the development of atherosclerosis (Zayas-Somoza & Guanche-Garcell, 1998). Therefore, as one of the most serious age-related pathologies and a leading cause of death in older Cubans, hypertension control was made a national priority for the danger it posed to the older population and potential drain on health resources (Pan American Health Organization, 1999; Reed, 2000b; Zayas-Somoza, Garcia-Iraola, & Raola-Sanchez Ma, 1999)

A retrospective study (Pan American Health Organization, 1999) showed a 12 percent increase in new hypertensives among urban adults in the period 1976-1995 and a prevalence level of 30.6 percent in 1995. In 1998, the WHO reported (1998c) a hypertension prevalence of 30.8 percent, which suggests a dramatic slowing in new hypertensives after 1995 as a result of the government's hypertension control efforts.

9. Several follow-up studies (Duran Gondar & Chávez Negrin, 1997; Martínez Almanza et al., 1999) to the 1985 research discovered that most older Cubans could attend to personal care and hygiene needs. However, the investigators noted that findings on medication management, laundry activities, meal preparation, climbing stairs, walking to the doctor's office, running errands, and negotiating public transportation were disconcerting. Accidents and falls also were reported to be sources for concern, particularly fall-related hip fractures. The mortality rate among older persons from accidents jumped from 193.1 to 197.4 per 100,000 persons between 1995 and 1996 (Martínez Almanza et al., 1999). Although the rate dropped back to the levels of the early 1990s after 1996, the steady increase in accidents since 1989 parallels the proportional increase in the older population (Martínez Almanza et al., 1999). A 1995 study (González Sánchez, Fernández Terrente, Rodríguez Sánchez, & Romero Guardes, 1998), meanwhile, related its findings on accidents, falls, and hip fractures to a single chronic disease; 65 percent of all older Cubans were found to have osteoporosis.

10. Re-emergent communicable diseases were believed to have contributed to Cuba's crude death rate of 7.20 per 1,000 population during the final half of the 1990s (Martínez Almanza et al., 1999). Although higher than the 6.50 rate in Latin America and the Caribbean, it still was lower than the figures for the lesser developed nations, the developed countries, and the world,

which were 8.50, 10.20, and 8.80 respectively (Martínez Almanza et al., 1999). Again, the Cuban statistic calls attention to health improvements made as a result of the great campaigns and universal health care after the 1960s.

11. The earliest efforts of society members were devoted to descriptive analyses designed to educate the leadership, health professionals, and the general population about the aging phenomenon. For example, Prieto Ramos' (1999a) abbreviated historic survey of the Western gerontological tradition parallels Cole's (1992) work. Another example is Duran, Gondar, and Chavez Negrin's (2000) seriation of the myths of individual and population aging and the cultural sources of age stereotyping in Cuba. By early 2002, the society was expanded to include other scientific affiliates in the capital and three other provinces (Sociedad Cubana de Geriatria y Gerontología, 2002).

12. Castro named CITED the nation's primary policy resource and research center for developing and applying new gerontological-geriatric methods and technologies (Centro Iberoamericano para la Tercera Edad, 2003; Dotres Martínez, 1996b; Escuela Nacional de Salud Pública, 2001). The institution was to acquire the educational resources necessary to prepare public health post-graduates and family doctors to care for older individuals and conduct multi-disciplinary aging research at the national and international levels (Centro Iberoamericano para la Tercera Edad, 2003; Dotres Martínez, 1996b). CITED drew upon the expertise of existing international and domestic institutions, as well as creating new advisory partnerships with such entities as the WHO and PAHO, MINSAP's National Statistics Division and Division for Social Assistance and Aging, Cuba's National Statistics Office, the National Medical Library, and the library's electronic linkages to such worldwide databases as *MEDLINE* and *LILAC* (Bertera, 2003; Martínez Almanza et al., 1999). One of its major objectives was to seek out new ways to correct the social biases and risks that led to isolation and poor nutrition, to control re-emergent transmittable diseases, and to reduce and manage such non-transmittable conditions as osteoporosis, dementias, encephalic vascular disease, and accidents (Escuela Nacional de Salud Pública, 2001; Justiz Gonzáles et al., 1999).

Chapter Nine

1. The strict Spanish-to-English translation of *el último* is “the last”, “the final”, or “the ultimate” (Blasco et al., 2002). In the Cuban vernacular, *el último* is a term that citizens use

when referring to Fidel Castro. However, I rarely heard Castro's name uttered aloud in public or in private.

2. The observations of two secondary subjects about dental care are noteworthy in light of Luis' remark. A researcher with a national health institute comments that many Cuban dentists, who engaged in black market bartering as early as the 1970s, render services not attainable for free or in a timely fashion in exchange for goods that are "difficult to get" legitimately.

Correspondingly, a Cubana in her late fifties divulges that she pays her dentist "extra money for special dental work." However, she adds that her husband, who has a prestigious position in the health care system, receives "good dental care" from his employer-based dentist.

Similarly, a Cuban physician tells me that a number of his colleagues began engaging in "illegal activities in the 1980s." Patients would bring "turkeys, chickens, fruit, or vegetables to exchange" for additional services. The doctor further claims that the lowest-paid physicians "went from [demanding] goods to cash" for additional care services in the 1990s.

3. After surveying a number of hospital administrators and local pharmacists, I learn that Cuba has three general cost structures for medicine. Drugs prescribed in hospitals to in-patients, including emergency room admissions, and such specific medicines as anti-influenza and other vaccines available through family doctors and polyclinics, are fully subsidized by the state. Certain medicines prescribed by family doctors and polyclinic physicians that can be purchased at local polyclinic and community pharmacies, meanwhile, are partly subsidized, and carry different co-pay schedules that depend on the particular drug. However, certain domestically-produced medicines in short supply and imported drugs are non-subsidized; most hard-to-find domestic medicines can be purchased in pesos at prices set by the state; imported medicines are sold at the going international market price at a one-to-one Cuban peso-to-\$US rate.

A senior hospital pediatrician, meanwhile, reports that his facility has been in short supply of such critical medicines as antibiotics for years, because transnational corporations with US ties that honor the US embargo refuse to sell Cuba medicine or raw materials for domestic production that the nation once received from its Soviet trading partners. The doctor adds that after the US embargo was tightened in 1992, Cuba's economic crisis left it without the hard currency (\$US) needed to import medicine and raw materials from willing third country

suppliers. Moreover, the physician argues that the spike in imported medicine prices after 1989 is the result of transnational pharmaceutical companies “artificially pushing up costs, because “Cuba is now alone” and without the support of its former trade partners.

4. A 72 year-old retired librarian relates circumstances similar to those of Pedro and Isabel. With a bandage on her hand and third degree burns partially visible on her forearm, the woman tells me that she was burned at home following a gas stove accident. She sought emergency care at a municipal hospital. However, an electricity brownout occurred shortly after her wounds were dressed, upon which the attending physician “would not give me any [pain or anti-biotic] medicine.” He “told me I had to get them [prescriptions] from my [family] doctor.” Although she explained to her family doctor that her monthly pension recently had been cut by seven pesos and that she could not afford to fill his prescriptions, “he told me I was not a social case.” She adds that she has been “asking tourists for money all afternoon” to help pay for the prescriptions.

Numerous informants report that asthma drugs and inhalers also are among the most rationed medicines. A recent Cuban émigré to the Bahamas, for example, says that when she was living in Cuba in the late 1990s she sought a free inhaler from a hospital emergency room. She tells me that she went to the hospital urgent care unit, because she was unable to pay the out-of-pocket cost for her family doctor’s prescription. Hospital physicians, who said they were “reserving” limited supplies of asthma medication and inhalers for patients with the most “serious” respiratory conditions, referred the woman to another facility in a nearby community.

Traveling via free public transportation to the second hospital that same day, the woman describes how scheduling rules forced her to wait another seven hours to see an emergency room physician. She was informed that all non-emergency patients from outside the facility’s service catchment had to wait until all proximate residents were treated. Once examined, however, the physician determined her respiratory condition to be non-acute and again refused to provide “a free prescription or an inhaler.” She claims that the almost 14-hour ordeal “left me right where I started.”

A cardiologist notes shortages in other common medicines. Suffering from acid reflex disease for years, the doctor explains to me that he recently experienced an acute month-long episode that prevented him “from sleeping.” The physician says that despite his “position and

[surgical] responsibilities” at the hospital, he still cannot obtain anti-acid medication, because it is “no longer in stock.”

5. The two pieces of medical equipment used to determine arterial blood pressure are mercury and aneroid sphygmomanometers. An ophthalmoscope or funduscope, meanwhile, is a device used to examine the fundus of the eye.

6. I find that in the country’s remote areas, where older patients do not live within easy walking distance of their family doctor’s consultorio, horse-drawn taxis commonly provide door-to-door transportation services at no cost. Even so, the majority of these older villagers express a similar affinity for their family physicians that is based predominantly on the characteristics of proximity, access, and availability.

7. I find it curious that neither the nurse nor the doctor take temperature readings from any of the older patients they see that day at the consultorio. Neither do I observe the procedure commonly being performed in other consultorios or such other health settings as polyclinics. A gerontology-geriatric specialist insists that it is a customary procedure, but adds that it depends on “the specific case, the type of examination, and condition of the patient.” Care-providers in all the health settings that I observe, however, perform blood pressure checks on every older patient they examine.

8. A National School of Public Health instructor says the Cuban Ministry of Health requires that all doctors use, and pharmacies only accept, its official prescription pads as a quality assurance mechanism to track supplies and consumption patterns. The interviews with Dr. María occurred throughout the summer of 2001. The rural polyclinic physician commented on the prescription pad shortage in February 2001.

9. Altogether, MINSAP requires that family doctors and polyclinic physicians use eight assorted forms to record the clinical, general health, psychological, and socio-economic information on each family unit and patient they serve, all health-related services and activities they render, and

proposed action plans to address identified community health problems (Cuban Ministry of Public Health, 2004; Valdivia Onega & Zacca Peña, 1999).

10. The *hacinamiento*, or stacking index, is a part of the health history form the family physician uses to track the composition and density of family living arrangements. It gauges the physical living space and separation of family members from one another to determine if adolescents and adults (unmarried) of both genders have separate sleeping quarters. The following formula is used to calculate the index:

$$\text{Stacking Index} = \frac{\text{Number of persons sleeping in the home}}{\text{Number of sleeping locations}}$$

Environmental agents, meanwhile, include extreme heat, humidity, noise, vibrations, dust, and soot. Similarly, family pets and animals that pose a hygienic problem are recorded. The structural status of the family residence considers such issues as the stress integrity of the physical edifice, ventilation, illumination, and how the family maintains the structure (Cuban Ministry of Public Health, 2004; Valdivia Onega & Zacca Peña, 1999). Dr. Evaristo stresses that while environmental factors are key to the health and well-being of all families in his catchment, he and all other family doctors pay particular attention to environmental conditions in homes where older family members, infants, and other vulnerable individuals are present.

11. Cuban studies (Delgado Cruz, Naranjo Ferregut, Camejo Macías, & Forcelledo Llano, 2002; García-Viniegras, 2003; Guerra Morales, Molerio Pérez, & Ahmed Al Gunedi, 2000; Pérez Cárdenas, 1999, 2001; Pérez Cárdenas, Rodríguez Quintana, & de Jesús Aguiar Pastor, 2000; Valdivia Onega & Zacca Peña, 1999) recognize four family types and three family developmental stages, or vital cycles, when considering the family as the unit of analysis. The family description and functionality sections of the family health history form reflect this framework. The four family types are:

- the single person household;
- the nuclear family, in which two generations live together;
- the extended family, in which three or more generations live in the same home;

- the enlarged family, in which various generations, including non-kin, live together under the same roof.

The vital family cycle is composed of the following three stages:

- the formative stage from the point of marriage until the birth of the first child;
- the extended stage from the birth of the first child until one of the children becomes independent of the family unit, whether it is the firstborn child or another offspring;
- the stage of contraction or dissolution, which includes the period from the independence of the firstborn child until the death of both spouses.

12. See note 19.

13. A 77 year-old La Habana retiree explains that most pensioners his age lack the money to pay for movie theater tickets, let alone personal “video-tape players.” Thus, the government provides equipment and public spaces in even the smallest communities called salons de video (video salons). Local residents gather in these small community centers to watch movies, for free, which are sanctioned and provided by state recreational authorities. Most of these movies also are shown in larger movie theaters to the public-at-large; a ticket costs a few cents.

14. Arthrosclerosis is the medical term that refers to the hardening or stiffening of the joints, particularly among older individuals (Venes & Thomas, 2001). The term artrosis (arthrosis in English) in Cuba refers to a similar condition, in which the older person’s joints and bones fuse.

15. Albeit the most dominant form, Alzheimer’s Disease is commonly accepted in most international health circles to be one of many types of senile dementia (Kawas, Gray, Brookmeyer, Fozard, & Zonderman, 2000). Most Cuban health professionals, however, seem to view Alzheimer’s Disease as a distinct cognitive disorder and, therefore, not part of the family of dementias. Hence, key informant comments about dementia and Alzheimer’s Disease in this final section of the chapter frequently mirror this peculiarity.

16. The use of so-called alternative, traditional, natural, or green medicine to treat a range of

minor-to-moderate health conditions gained prominence among Cuban family medicine and preventive-primary care providers at the community level of attention in the early 1990s (Fe Bosch Valdez, personal communication, July 16, 2001). The application of moxibustión (no English translation), for example, is one of the most common techniques that I observe in polyclinics and adult day care centers to reduce minor infections and inflammation. The technique involves a number of different herbs, including tobacco, which are rolled up into a cigar-shaped tube and lighted at one end. According to a nurse, the heat and medicinal qualities released from the burning herbs as the object is passed over specific parts of the body lifts “up the anti-bodies” and stimulates “the immune system.”

As medicine shortages worsened during the 1990s, more institutional level entities embraced alternative treatment forms (Fe Bosch Valdez, personal communication, July 16, 2001). For example, Cuba’s national palliative care clinic in La Habana, which serves 19,000 persons annually, relies almost exclusively on acupuncture, electric acupuncture, laser heat, floral and music therapy, and moxibustión in an effort to “stay away from” costly pharmacological treatments and synthetic medicines (Fe Bosch Valdez, personal communication, July 16, 2001). One clinic staff member informs me that the facility treats “only 1 out-of-every 100 patients” pharmacologically, mostly in the clinic’s oncology unit.

According to the clinic director, floral therapy is the most effective elder care treatment for early stage Alzheimer’s Disease, as well as minor-to-moderate depression. The administrator tells me the “positive response...[of] one patient with Alzheimer’s Disease” undergoing alternative floral treatment means that there is no need to introduce “synthetic drugs” (Fe Bosch Valdez, personal communication, July 16, 2001). A floral therapist explains that the extractions of “30 Cuban flowers used in some 38,000” combinant emulsions, some of which “correct human physical and psychological conditions” that correspond to certain cognitive impairments, can be inhaled and/or ingested.

A public health official, who is my site visit chaperon that day, recently experienced an acute asthma attack and volunteered to be the subject of a demonstration of floral therapy. The clinic and many other care-providers regularly use floral therapy to treat a host of respiratory ailments, including asthma. The therapist turns the man’s arm over to expose his wrist, places her other hand on the back of his neck, and taps his wrist with her three middle fingers. During the procedure, the therapist asks the chaperone to describe his health problem as related to him

by his doctor.

He explains that his family doctor's official diagnosis is "chronic asthma" and that the physician prescribes inhalers, or gives him injections during acute episodes. He adds that because he has never smoked and has not experienced the condition until recently, his family physician believes the asthma is the cumulative result of La Habana's "pollution" problem; despite the trade winds, temperature inversions and emissions from the heavy use of public transportation and personal vehicles, along with a nearby oil refinery, produce a copper-tinted cloud over the city almost daily. The therapist produces a bottle that she says contains a blend of three flower extractions, places three drops of the solution on the back of the man's tongue, and instructs him to repeat the process twice daily in morning and evening until the bottle is emptied. She then leans over and whispers in his ear.

Later, the chaperone, who has a doctorate in biology and statistics, confides to me that the therapist "believes that my asthmatic condition is psychological" and consequent of "extreme guilt." His guilt, according the therapist, is manifesting "physically as asthma." Following the therapist's departure, the public health official turns, smirks, and utters, "this is [expletive]... You would never find this [type of diagnosis and form of care] in a hospital."

17. A recent US study (Kawas et al., 2000) infers that 12.5 percent of the total US population age 55 years or older has some form of dementia. Furthermore, 74 percent of the study subjects diagnosed with dementia are believed to have Alzheimer's Disease (Kawas et al., 2000). However, Cuban researchers (Bedevia, 2003; Gómez Viera, Bonnin Rodríguez, Gómez de Molina Iglesias, Yáñez Fernández, & González Zaldívar, 2003) only recently have begun documenting such cognitive disorders aggressively. For instance, 9.4 percent of the Cuban subjects (N=286; age 65 years or older) in one La Habana study (Gómez Viera et al., 2003) have some level of cognitive deterioration, while a separate report (Bedevia, 2003) the same year cites a national dementia rate of 9.3 cases per 100 adults age 65 years or older. Although neither account offers projected Alzheimer's Disease figures, the later report (Bedevia, 2003) does mention the "presence of Alzheimer's Disease" (p. 1) in Cuba.

18. I find it interesting that MINSAP's HIV/AIDS policy came under attack about the same time the agency began easing its institutional mental health approach. As part of a nationwide

program, in which the entire sexually active adult population was tested, the agency exerted undue pressure on those who had tested HIV positive, but who refused to voluntarily quarantine themselves to facilities specifically established to care for those with the virus and disease (Avila, Torres, Fiol, Abreu, & Rodriguez, 1996; Feinsilver, 1993; Holtz, 1997). One study (Holtz, 1997) notes that the civil rights of these institutionalized patients were violated in that they were prohibited from leaving the sanatoria without state-selected chaperones. Consequent of international vilification and a greater scientific awareness among Cuban medical professionals and the leadership, the health agency began articulating a policy of de-institutionalized care for those with HIV/AIDS in 1990. However, there have been conflicting accounts about whether the outpatient care model is being acted upon (Avila et al., 1996; Feinsilver, 1993).

19. I find the availability of new and relevant publications on aging in Cuba to be inconsistent, and dependent on one's location or accessibility to computers. The Ché Guevara Medical School on the outskirts of rural Piñar del Rio provides a case in point. The medical school library has 12 gerontology-geriatric medical textbooks on its shelves, 10 of which are in English, and all of which were published before 1985. Medical students, however, tell me that they use the library's computers to retrieve most of their class and research information from MINSAP's electronic database, *Infomed*, and more recently, from such internet resources as *MEDLINE* and *PubMed*. Cuba's family doctors and most polyclinic-based physicians have very limited access to computerized electronic resources, and, thus, fewer opportunities to retrieve current gerontological information efficiently. Also see Stusser, Kriel, Dickey, and Krach (2003).

20. The older subject's reference to free housing is not completely accurate. Family members tell me that although he lives in the family home for free, the family unit incurs monthly rental co-pays as part of the Social Security subsidized housing program. The family acknowledges that out-of-pocket costs for additional food and their father's medicine regularly drain their monthly resources.

As part of a random sampling, I examine three different family food ration books to find that 6 kilos of sugar, 6 kilos of rice, and laundry soap are the only fully subsidized items that the families receive over a three-month period between November 2000 and January 2001. The

clerk, who manages the ration store where I inspect the documents, tells me that they are the only “free” supplies in stock at that time. Defensively, the clerk adds that she can sell any partially subsidized item that is in stock in Cuban pesos and that “families can go to the dollar stores” and purchase “almost any other item” at non-subsidized prices (in \$US only at the one-to-one peso-to-\$US rate). Additionally, older residents can purchase any partially- or fully-subsidized monthly ration that another individual or family has not redeemed. Older individuals also may exchange their fully subsidized monthly sugar ration for additional milk and meat if their family doctor has diagnosed them as diabetic or if they have special dietary needs. A rural resident, however, states that she has to arrive at the local ration store in the early morning of the first day of each month, because essential supplies quickly disappear and are rarely restocked until the following month. A La Habana resident, meanwhile, confides that she regularly travels outside the city to purchase vegetables and fruit grown by local black market farmers, because the items are “less expensive” than in the ration stores, state-run agro-mercados (cooperative farmer’s markets), and dollar stores.

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Curriculum Vita

James L. Schwar

December 9, 1953

Easton, Pennsylvania, United States of America

Education

University of New Mexico, Albuquerque, NM

Certificate in Gerontology Administration, May 1997

University of New Mexico, Albuquerque, NM

Master of Public Administration, December 1996

Chair: T. Zane Reeves, PhD

University of New Mexico, Albuquerque, NM

Bachelor of Arts, History, December 1994, magna cum laude

Professional Positions Held

College of Public Health, University of Kentucky, Lexington, KY, Graduate Research Assistant,
2001-2002.

Center for Health Services Management and Research, University of Kentucky, Lexington, KY,
Graduate Research Assistant, 2000-2001.

Montana Gerontology Society, Billings, MT, Board of Directors, Treasurer, 1997-1999.

Missoula Aging Services, Department of Elder Services, Senior HelpLine and Resource Center,
Missoula, MT, Resource Specialist, 1997-1999.

Missoula Demonstration Project, Missoula, MT, Staff Assistant, 1997.

Americans for Indian Opportunity, Bernalillo, NM, Intern, 1996.

New Mexico Advocates for Children & Families, Albuquerque, NM, Intern, 1994-1995.

Broadcaster, Colorado, Kansas, Michigan, New Jersey, New Mexico, Oklahoma and
Pennsylvania, 1970-1996.

Scholastic and Professional Honors

Phi Beta Kappa, Sigma Phi Omega, Pi Alpha Alpha, Phi Alpha Theta

James E. & Geneva Montgomery Student Gerontology Award-First Place Winner, 2003

Fellowship, Globalization Research Center, 2003

Dissertation Enrichment Award, University of Kentucky, Graduate School, 2003

Student Support Award, University of Kentucky, Graduate School, 2001-2003

Invited Delegate, People to People Ambassador Programs, Public Administration Delegation to Cuba, 2001

Fellowship, Research Challenge Trust Fund, University of Kentucky, Graduate School, 2001-2004

Gerontology Development Award, University of Montana, Gerontology Education Committee, 1998

Certificate of Accomplishment, University of New Mexico, School of Public Administration, 1997

Recipient, University of New Mexico, Summer in Costa Rica Program for Political Science Studies Abroad, 1996

Carol Burnett / University of Hawaii / Association for Education in Journalism and Mass Communications First Place Journalism Ethics Prize, 1994

Scholarship, University of New Mexico, Germany Today Program for Studies Abroad, 1994

Scholarship, New Mexico Broadcasters Association, 1994, 1992, 1991

New Mexico Associated Press Broadcast Journalism Award, 1988, 1986

Professional Publications

Schwar, J. L. (2004). Bridging the macro-micro-level rift: International political economy and gerontological research in Cuba. Manuscript submitted for publication.

Schwar, J. L. (Ed.). (2004). *Mentoring: Structure, design and implementation: The 15th annual student mentoring conference on gerontology and geriatrics: Keynote, symposia and posters* (Technical Report No. UGAGC-04-001). Athens, GA: University of Georgia Gerontology Center.

Schwar, J. L. (2003). Access and proximity: Influences on perceptions of health equity among older individuals in Castro's Cuba. *The Gerontologist*, 43(Special Issue 1), 214.

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