Why Does Cuba ‘Care’ So Much? Understanding the Epistemology of Solidarity in Global Health Outreach

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Cuba currently has more than 38,000 health workers providing emergency relief, long-term community-based care and medical education to some of the most vulnerable communities in the world. This current outreach to 76 countries positions Cuba as a leader in global health outreach. This has been well documented and praised by many scholars and policy makers alike. While many acknowledge the importance and impact of the Cuba’s global effort, there is very little understanding as to why Cuba makes such a large global health commitment in the first place. I argue that solidarity is in fact a mixture of national pride, self-interest and humanistic outreach. Ultimately, it is a calculated effort to overcome current structures of inequity and exploitation on a global scale by expanding new opportunities for health professionals dedicated to providing care in marginalized communities.

Introduction

Cuba has more health-care workers providing care in foreign countries than all Group of Eight (G8) nations directly employ in overseas medical outreach (Kirk and Erisman, 2009). While many doctors from G8 nations do travel abroad to provide health care, only a small handful do so through direct employment from the state. The Cuban government, however, employs its physicians to serve other populations. Over 38,000 Cuban health workers were working in 76 countries as of 2013 (Huish, 2013). In 2014 the total number increased to approximately 50,000 in 65 countries including 11,400 Cuban health-care workers serving Brazil’s rural areas (Siegelbaum, 2014). This is a larger workforce than the Red Cross, Medicines sans Frontières and UNICEF, combined.\(^1\)

Cuba is a resource-poor country with paltry economic growth and limited direct foreign investment. It has faced decades of economic turmoil from a combination of internal factors such as stagnant industrial production and feeble agricultural output. More notably, Cuba has been economically isolated from the world’s largest trading market (the USA) as a result of an interminable 50-year embargo. While many countries in the global South struggle to meet their own development objectives, Cuba stands out as a notable example of a country that has invested enormous resources, notably human resources, to promoting health equity for its own population and also for advancing health-care services in other countries around the world. During the 2014 Ebola crisis in West Africa, Cuba offered 465 primary care workers to the affected region, when many countries were closing their borders to countries with Ebola (Siegelbaum, 2014).

In response to such medical assistance from Cuba, some wealthier nations, such as Brazil, South Africa and several Gulf Nations, pay impressive sums to Cuba for the provision of health-care services and medical training. Bloomberg reports that Cuba is expected to take in close to $8.2 billion USD as remuneration from sending its medical teams abroad (Sabo, 2014). However, in other cases, notably Haiti and The Gambia, the host country offers the Cuban government minimal compensation for receipt of health services (De Vos et al., 2007).

Many scholars recognize the value and impact of Cuban medical internationalism around the world.\(^2\) Spiegel and Huish (2009) call it an outstanding example of foreign relations through medical outreach. Kirk and Erisman (2009) praise Cuban medical internationalism as having deep humanitarian impacts around the world in opening up important diplomatic, economic and humanitarian relations. Brouwer (2011) claims that Cuba’s
cooperation with Venezuela provided never before offered care to the poor of that country, and subsequently created a new expectation of health care as a right—even for the poor. Huish (2013) argues that Cuba makes one of the most significant impacts in the global health landscape. While the impacts of Cuba’s efforts are widely acknowledged, there remains a tension within the literature as to the moral purpose of Cuban medical internationalism. Specifically, two questions continue to perplex scholars as to the rationale and determination of Cuba’s outreach. First, why does Cuba commit so much effort to global health? And second, why does an economically challenged nation send its medical professionals so far afield to meet the needs of citizens of other countries? What is the ethical foundation that grounds this practice?

Several simplistic responses to these questions exist in the literature, and with them come notable contradictions. A realist response may claim that economic motivation drives Cuban medical internationalism, as the Cuban government receives generous remuneration for its efforts (Agence France-Press, 2013). This may be true in the case of cooperation with a wealthier partner like South Africa or Saudi Arabia—countries that pay generously for Cuban medical professionals—but it fails to explain the efforts of Cuban outreach in Haiti, or to many other resource-poor nations that offer minimal compensation in return for medical cooperation (Kirk and Kirk, 2010). A realpolitik response suggests that Cuba offers foreign medical assistance to secure political advantage in world forums (Erisman and Kirk, 2006). This helps to explain the relationship between Cuba and Venezuela, where close to 20,000 Cuban health workers have served since 2003 as part of a broader cooperation framework involving substantial economic compensation through discounted oil imports. However, it does not explain why Cuba offers medical scholarships or humanitarian assistance to politically hostile nations such as Peru or the USA (Gorry, 2012). A critical response may suggest that the motivations of medical internationalism are tied to conceptions of antiquated socialist values whereby health workers are pressed into obligatory foreign-service contracts (Brotherton, 2012). This position is near sighted as it falsely renders medical internationalism as an indentured service, rather than as something that is desired by practitioners. As well critics tend to focus exclusively on the narratives of a small minority of Cuban health professionals who have abandoned their duties abroad due to tough working conditions and comparatively small wages. While low wages and difficult working conditions are part and parcel of Cuban medical internationalism, these conditions in themselves do not necessarily equate to forced service or discontent on part of the health professionals. The critical response does not take into account the experiences of the 97% of Cuban health workers who fulfill their service contracts (Kirk and Erisman, 2009).

The dilemma in understanding Cuba’s global health commitment is that such justifications of Cuban medical internationalism do not deliver a complete picture of the broader normative ethics or its social complexity that influences this unique foreign policy. This article suggests that the normative ethics of Cuban medical internationalism are deeply grounded in a conceptualization of ‘solidarity’ rather than frameworks of ‘aid’. As a result, the failure of policy makers and scholars to appreciate the dynamics of solidarity brings about misunderstanding as to Cuba’s normative practice in the global health landscape, and its potential impacts. This article shows how Cuban international solidarity is a unique, and important, normative approach to global health that avoids the shortcomings of charity, responsibility or altruistic frameworks for global health. Through the solidarity approach, Cuba demonstrates an advantage to strengthen international health systems, approach health care through health promotion and disease prevention, all the while furthering its own development goals.

I argue that the reason for a lack of depth in understanding the values of Cuban medical internationalism is not necessarily due to an insufficient response to the question of ‘why does Cuba commit so much to global health’, but that the question itself is grounded in assumptions that international health outreach can only be understood as purely altruistic or entirely self-interested. The dominant assumption is that if a nation offers something as precious as health care to a foreign country, it could be taken as only a rational action of emergency philanthropic charity, or, if the donor nation seeks to increase political or economic interest in the host country. As Moyo argues, aid has been routinely used as a gateway to gain access to the resources of other countries (Moyo, 2009). In sum, there is a broad tendency to approach actions of outreach as either purely charitable gestures of kindness, or intentional acts aimed at sequestering deeper influence and control within other nations. Rather than dismiss the Cuban experience as a nebulous phenomenon outside of these two pillars, it is worthwhile to gain a deeper understanding of the solidarity approach as an important third way forward for global health.

Medical internationalism approaches the provision of international health care as an integral right through the investment of ‘solidarity’ (Mawdsley, 2012).
The dominant view of aid approaches health-care provision as a reactive, albeit provisional, exercise rather than as an investment in overcoming deeper structural inequities (Calvert et al., 2012). Moreover, conceptions of foreign outreach assume a particular set of realist notions that aid must be of greater strategic benefit to the economic and political desires of the donor nation, even if as a supposedly apolitical function of charity (Azam and Laffont, 2003). Philanthropy, humanitarianism and aid all aim to produce altruistic outcomes, but they do nothing to question, let alone dismantle, hegemonic processes that systematically limit the accessibility and availability of sustainable health-care provision. In this way solidarity works to produce development processes that are of mutual benefit of both the donor and recipient nation. This is shown through a brief discussion framing the concept of solidarity followed by an overview of Cuba’s medical internationalism and then a critical discussion of the realist development approach, taking note of Canada’s international development trajectory. I take note of Canadian policy in particular, as it is an example of consciously compacting international development into a foreign affairs portfolio that is primarily concerned with employing military operations and economic diplomacy, before that of humanitarian commitment. Lastly, the article reflects on the current opposition to Cuban medical internationalism by the Brazilian medical association as an example of resistance to the solidarity approach, and why it is so threatening to traditional power structures. In sum, the value of approaching Cuban medical internationalism through the lens of solidarity opens global health discussions to a deeper appreciation of Cuba’s normative ethics that challenge hegemonic power structures by embracing health care as an integral right for all.

Approaching Solidarity

Solidarity at the international level is an intentional act of cooperation between two nations in order to produce benefits for both. International solidarity is not altruism, nor is it imperialism. As (Featherstone, 2012) sees it, solidarity dates back to the 19th century when unions and labor movements employed outreach to politicize working class struggles on a global scale. Solidarity can be viewed as relations ‘forged through political struggle which... challenges forms of oppression’ (Featherstone, 2012: 13). It is a common mistake to view solidarity as international actions based solely on similarities of culture, language or location. For example, in the 19th century cotton workers in Northern England took actions for support of emancipation in the USA, even though the dearth of imported cotton during the US civil war created widespread unemployment in the British cotton industry (Featherstone, 2012). Tobacco rollers in Florida aligned with Cuban peasants in the war of independence in 1895, even though there was little economic reason to join the fight. In the 20th century student movements on university campuses across the world rose up in protest against the war in Vietnam. Often the call for peace was combined with anti-capitalist and anti-establishmentarian undertones. Solidarity can involve a seemingly distant, albeit disconnected, group in one part of the world employing tactics to challenge structures of power that impact the lives of others.

Gramsci viewed such action as a means of generating ‘good sense’, as a sense of acknowledging broader systems of hegemonic power. For Gramsci (1995), a certain degree of complacency among a nation’s citizenry toward social inequities must go unabated for structures of power to dominate. When groups in one part of the world organize actions to support the cause of others in another part of the world it is, to Cox (1983), a means of generating emancipatory activities through civil society. For Katz (2006), counter-hegemonic solidarity is in a transitional phase, where civil society groups are using the tools of globalization to seek emancipatory development against neoliberal globalization. The tools of rapid global transportation, global communication and interconnectivity through economic and social networks can all serve to benefit counter-hegemonic processes to challenge current power structures.

International solidarity is not just constructed between civil society groups, it can occur through bilateral relations between nation states. Cuba has a long-standing tradition of engaging in tactics of solidarity with other countries that are working to overcome subdevelopment (McCloskey, 2011). This has involved a wide range of tactics ranging from direct military intervention (in Angola in the 1970s and the 1980s) to sending literacy teams to teach adult education (New Zealand and Canada in the 2000s). This international cooperation began in the 1960s as an action of political transformation to challenge broader structures of inequity among other developing nations (McCloskey, 2011). By providing education opportunities for foreigners, and by adding strength to the health-care systems of
foreign deeper structures of marginalization (Huish, 2008). The small sacrifice of the cost of offering scholarships for marginalized students from other parts of the world is an action of building capacity within an otherwise inequitable global system—one that rarely provides such opportunity for the marginalized. Beyond symbolic capital, building capacity is a form of resistance against hegemonic global structures that assertively restrict education for the poor. Rather than subscribe to the modernization approach to development that typically calls for a generation to work for meager wages in industrial factories in order to make enough money for the benefit of the next generation (Sachs, 2005), Cuba’s scholarships are aimed directly at the marginalized of today, not the would-be marginalized of the next generation. Moreover, building capacity for health is an action of local transformation within other nations that directly challenges the norms of inequity. Solidarity relies on ‘forces from below’ and person-to-person organization. Sending doctors to, and training doctors from, marginalized communities in the global South who willingly serve the destitute creates a voice of opposition to inequity and social injustice. This does not mean that Cuban doctors actively campaign to vociferously challenge political structures within a host nation, but that their very presence in providing health care to the poor, when others refuse to do it, is a political statement within itself. In marginalized communities within Honduras in 1999, Venezuela in 2001, and Brazil in 2013, Cuban doctors provided health care for the first time to persons from poor and vulnerable communities. By simply providing care to those who were denied care by traditional hegemonic structures, Cuban and Cuban-trained doctors create an experiential alternative to systems that maintain inequity through the denial of care. The result is a new political landscape of counter-hegemonic resistance. However, lead-by-example politicization does not guarantee progressive social transformation. As is the case with Venezuela, and now in Brazil, the offering of affordable and accessible medical services by Cuban professionals created a ferocious lash back by the national medical association (Watts, 2013).

Why Medical Internationalism is Solidarity

It is valuable to demonstrate exactly how Cuban medical internationalism can be defined as solidarity. As mentioned above, solidarity can be interpreted through several contexts, with policy makers viewing the term in values of ‘obligations’, ‘rights’ and ‘claims’ through contractual frameworks. Marxist scholars approach solidarity as the binding of people who ‘occupy the same place in the capitalist mode of production’ (Prainsack and Buyx, 2011). In these ways solidarity is a state of existence, based on conditional circumstance that then justifies conduct of individuals. However, in bioethics, as Prainsack and Buyx (2011) suggest, solidarity can be approached as a practice that requires action, rather than as a sentiment built on circumstance. In this way solidarity can be understood as the ‘shared practices reflecting a collective commitment to carry “costs” (financial, social, emotional or otherwise) to assist others’ (Prainsack and Buyx, 2011: xiv). This understanding implies a level of agency to participate in solidarity and also that the participant can receive benefit. The sort of benefit is not clearly defined in a solidarity approach, meaning that remunerations or rewards are not preconditions for solidarity, rather it is the value of willingly carrying costs that underscores the concept (Prainsack and Buyx, 2011: 46). As well, solidarity is less transactional in terms of cost vs. benefit, or donor vs. recipient. Instead, solidarity implies a collective participation in the practice itself.

Sharing costs through the solidarity approach differs greatly from three common notions that can be confused for solidarity and that are common in aid frameworks: responsibility, charity and altruism. Responsibility is expressed as moral behavior and ‘the expectations of such behavior’ is considered normative. Failing to act responsibly can bring about negative consequences, and hence a strong moral incentive to act responsibly is to avoid negative consequences. Failing to commit to solidarity does not result in direct penalization for acting immorally as it does when actors fail to act responsibly.

Charity is an act of the privileged voluntarily offering support to those in need without the recipients ‘having any political or legal claims to it’ (Prainsack and Buyx, 2011). Charity expects nothing directly in return beyond moral self-fulfillment, and it implies a sense of service to the marginalized rather than a direct collaboration with them. Charity is typically a top-down action of those with power and privilege extending their services, in a manner that they see appropriate, to the marginalized. Solidarity departs from the idea of charity in two ways. First, solidarity does not impose offers, but instead encourages collaboration. Second, participants in a solidarity approach recognize the vulnerability of their neighbor as potential vulnerability of their own, because
both participants are subjected to similar structural forces (Prainsack and Buyx, 2011). Unlike charity, solidarity does not require monetary affluence before taking action.

Altruism is mostly confused to solidarity as it ‘signifies the opposition to selfishness’, and it implies a concern for the well-being of others (Prainsack and Buyx, 2011). Altruism implies that practices are carried out to benefit others without being obliged due to a legal regulation or without receiving anything in return. Here solidarity departs from this definition, even though solidarity is grounded in having deep concern for the needs of others. Solidarity practices are open to mutual benefit and receipt of actions in return for service. Solidarity can also be grounded in legal regulation through bilateral agreements between nations. The receipt of reciprocal actions is not required, nor is it always expected, but it is always welcome, whereas altruism fosters one-directional actions out of compassion. Compassion is shared with solidarity, but within a normative structure that allows for give-and-take exchanges and shared benefits against broader social or economic structures.

Considering these points, Cuba’s medical internationalism operates outside of the parameters of charity, altruism or responsibility, and instead deeply within the solidarity framework. Cuban health workers abroad are not penalized for not participating in responsible actions for others. No direct consequences for a lack of responsibility come to foreign students who come to Cuba to study medicine. This is to say that there are no direct consequences for not participating in responsible actions for others. No direct consequences for a lack of responsibility come to foreign students who come to Cuba to study medicine. This is to say that there are no direct consequences for not participating in responsible actions for others. No direct consequences for a lack of responsibility come to foreign students who come to Cuba to study medicine. This is to say that there are no direct consequences for not participating in responsible actions for others. 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Cuban Medical Internationalism

Cuba’s approach to counter-hegemonic solidarity dates back some 50 years. Since 1960, over 101,000 Cuban health workers have provided care in 110 countries (Kirk and Erisman, 2009). This extensive outreach deeply impacts the nature of Cuban medical training, the expectations of continued foreign outreach and the ethics of medical service in the country. After the 1960 Valdivia earthquake, the most powerful ever recorded, killing between 3000 and 5000 people, Cuba sent a medical team to assist with the recovery in Chile. This was at a time when Cuba had only 6000 medical personnel within the country and faced enormous health disparities. By 1965, in the height of the cold war tensions, over half of Cuba’s physician workforce was depleted as a result of massive out migration. Only 12 teaching faculty remained at the University of Havana by 1963, which formerly had over 250 (Huish, 2013). Still, that year Cuba sent a medical team of several dozen physicians to Algeria to assist with revolutionary pursuits in that country. This opened a new era of cooperation through medical outreach, as the Cuban government justified the contribution as a deeper commitment to international solidarity against imperial domination affecting all poor nations (Castro et al., 2008). Cuba assisted in several military theatres since 1960, notably Angola, El Salvador, Ethiopia and the Democratic Republic of the Congo. Cuban physicians were deployed in all of these campaigns and they provided care for civilian populations alongside military casualties. However, medical assistance was not exclusively tied to revolutionary struggle or military intervention. There is a long history of Cuban medical outreach to politically hostile nations, such as Nicaragua during the Somoza dictatorship, and to Peru in the 1970s—two nations that vehemently opposed the Castro regime. Although offered on humanitarian grounds, the medical interventions are
noted for producing valuable symbolic capital among victims and populations who were rarely served by their own country’s medical personnel (Feinsilver, 1993). Cuba seized the opportunity of medical outreach as a way to develop soft power among nations in the global South by opening opportunities for enhanced diplomatic cooperation that facilitated economic partnerships and deeper bilateral cooperation (Nye, 2004). Mawdsley (2012) argues that such cooperation is approached not as philanthropic aid, but as conscious development investment in the pursuit of mutual benefit between emerging nations. In the 20th century socialist-oriented countries like Cuba and Vietnam viewed medical, technical and education cooperation as a modern face of solidarity in a globalizing world (Mawdsley, 2012: 78).

The international dimension of socially oriented values aligned with Cuba’s own priorities for increased health-care capacity, domestically. With half of its medical personnel emigrating between 1960 and 1965, Cuba changed its approach to medical education in order to facilitate training on a massive scale. In 1965 Cuba had 1 physician for every 1200 people, which was about the same ratio as China or Venezuela at the time (Gapminder.org, 2013). By 1975 Cuba’s ratio shrank to 1 physician to every 1000 people, about that of Japan or the United Kingdom that same year. By 1985, the ratio was 1 physician to every 500 people, a number that many Organization for Economic Co-operation and Development (OECD) countries do not achieve (Gapminder, 2013). In 2005, Cuba boasted 1 physician for every 167 people—a number unparalleled anywhere in the world. The increase in health capacity came through two important steps. First, Cuba invested in the geographical equity of health resources, meaning that hospitals and teaching schools were constructed across the entire island, rather than concentrating them only in the major cities. This opened opportunities for local vacancies for medical education and human resource retention nation wide. Second, Cuba constructed medical spaces as teaching spaces so that practicing physicians would be expected to teach new physicians as part of their program of work. Unlike most countries where teaching medicine and the practice of medicine are tersely divided, Cuba streamlined the two worlds so that most practicing physicians would take on teaching duties (Pernas et al., 2012). As the numbers of medical professionals increased in Cuba, this model diminished, although a generously large space for medical education capacity remains. With greatly improved structural and human resource accommodation put in place, Cuba did not reduce capacity but maintained the level for training its own physicians to serve abroad and offered available medical school space to students from other Southern countries under the moral agreement that they would return to their home countries to provide care. Unlike many Northern medical schools that restrict large-scale enrolment through fierce competition, restrictive tuition, or consensus by medical associations that there are ‘too many physicians’, Cuba transformed its domestic capacity at minimal cost into strategic foreign outreach to build capacity by receiving medical students from abroad alongside its own domestic lot. The goal of this process was not to retain exclusive control of health-care services by a small cadre of physicians, but to open medical practice and education as widely as possible in order to address massive health inequity in Cuba. By including foreigners in this capacity building process, Cuba built on its domestic strength to meet the needs of citizens of other countries with little added strain to its development plans. Including citizens of other countries within Cuba’s enormous medical education capacity, falls into the solidarity framework as it is a sharing of costs within the nation’s capacity. In sum, it was a minimal burden for Cuba to receive foreign medical students among its own ranks.

In 1992 the collapse of the Soviet Union brought about unprecedented economic hardship to Cuba. The country lost 35% of its Gross Domestic Product (GDP) and 88% of its exports in under a year (Huish and Kirk, 2007). Resources were stretched to the point of interminable blackouts from a lack of fuel to shortages of foodstuffs. Despite the economic catastrophe, Cuba did not close a single hospital or university, and actually increased medical school spaces for its own citizens as well as for citizens of other countries. This was done in order to improve local access to care by putting more Cuban doctors into the domestic service, but to also build on well-established strengths of medical education to facilitate new opportunities of collaboration and solidarity with other nations, albeit on a relatively small scale during the 1990s.

In 1999 hurricane Mitch devastated Central America and Haiti, leaving tens of thousands of persons homeless. Cuban medical brigades responded to the aftermath in Honduras, El Salvador and Guatemala. Many other countries answered the call for assistance as well. After 6 weeks, when many other national brigades pulled out of the area, Cuba approached the Central American countries about staying on for a long-term basis as a form of solidarity cooperation. Despite protests from their own national medical associations, all countries accepted the Cuban offer for providing medical care to areas that
were most severely impacted by the hurricane. Realizing that continual outreach would not be sufficient for meeting the domestic health needs of these countries, Cuba offered scholarships to Central American students on a scale never seen before. The agreement required that the students would return home after graduation, preferably to the affected regions, to take over from the work of Cuban professionals. While the Central American governments were paying the Cuban delegations for their services, the scholarships were covered entirely by the Cuban government (Huish, 2013). Cuba’s Ministry of Health established a dedicated campus for the scholarship recipients at a former naval academy outside of Havana, calling it ELAM—La Escuela Latinoamericana de Medicina. In 2001 the scholarship offer was expanded beyond the hurricane-affected regions to all students of Latin America, Africa and the USA, bringing in students from some 29 countries by 2002. The scholarship was later extended to students from 36 countries by 2008. As of 2014 over 23,000 students from 83 countries have graduated the ELAM campus since 2005, and some 19,500 are currently enrolled in the program (MEDICC REVIEW, 2014).

Wendy Perez, a student at ELAM in 2005 said, ‘More than anything, we have learned to be students of science and conscience, to become doctors that are both scientists and conscientious. We are learning to serve people, as it should be, to treat people because of who they are—not because of what they have. We are being trained in the principles of solidarity’ (MEDICC, 2005). Luther Castillo, a graduate from ELAM told the US organization, Medical Education Cooperation with Cuba (MEDICC), ‘When I went back [to Honduras] on vacation, someone told me, “I’m 75 years old, and I had never been treated by a doctor without showing disgust for me.” They use this term, “disgust” to refer to a kind of rejection, you understand? And he said, “No one had ever examined me with such delicacy, sitting by my side, holding my hand”’ (MEDICC, 2005).

The evolution of Cuba’s extensive health-care capacity building is one that is grounded in a national commitment to meet its own immediate domestic needs by overcoming structures of inaccessibility. This approach is inherent to the Cuban medical system. As one graduate of ELAM said, ‘Cubans put emphasis on primary health care in all areas . . . it actually attacks the problem before it becomes bigger for them to handle’ (MEDICC, 2005; Huish, 2013). In working to expand infrastructure and human resources for health, Cuba strategically linked its capacity building to meet the needs of foreign nations who could provide hard currency and other resources to the cash-strapped country. Herein lies the divergence between the realist approach of conceptualizing health outreach and aid to that of solidarity. While the realist approach understands outreach as a reasonable donation of one’s domestic wealth to relieve the immediate suffering of a lesser fortunate nation, the investment in solidarity approaches subdevelopment as a mutually shared consequence of global hegemony that is not limited to any one region or restricted within one’s own borders. In order to overcome conditions of subdevelopment, solidarity requires deep transformations of inequities that restrict nations from the autonomy to meet their own national development priorities. It is ultimately about investing in a pathway of self-dependence of the host nation so as to be able to participate in interdependent cooperation with donor nations to resist hegemonic power. As such, Cuba’s investment in health care is not solely a humanitarian exercise of relieving suffering among the poor, rather it is tightly associated to its own national interests in forming alternative networks of collaboration, exchange and, most importantly, what is perceived in Cuba as resistance to dominant processes of inequity from global capitalism. While this approach seeks benefits for Cuba’s own domestic interests, it does not do so by subverting the partner nation with enormous debt or intentional control over its resources.6

The very nature of Cuban outreach is grounded in cooperation rather than direct aid. Cuban medical internationalism works through bilateral cooperation with the host nation, and as a result, cooperation agreements vary widely with each particular nation, although they tend to fit into three distinct categories. The first category is solidarity remuneration. This occurs when countries directly pay the Cuban government and its health workers in cash for services. Gulf nations like Qatar and Saudi Arabia use this model to receive Cuban health workers in their hospitals and medical schools in exchange for direct cash payments to Cuba (Hammond, 2013; Rasooldeen, 2013). Countries like Brazil, South Africa and China also contribute large sums of hard currency to Cuba for the receipt, and exchange, of medical personnel. To the host country there is benefit in expanded human resources for health capacity, and to Cuba the benefit comes from the acceptance of desperately needed foreign currency for its own balance of payments. The second category is solidarity bartering. In this model, Cuban medical internationalism operates under agreements to receive preferred trading privileges for particular commodities. The notable case here is Venezuela, which offers oil to Cuba at preferred credit rates that beat the world market price (Feinsilver, 2008). More modest bartering occurs with
other nations as well. As a result of medical cooperation, Bolivia allows Cuba to purchase goods in the Sucre rather than the US dollar. Guatemala exports commodities to Cuba at preferential rates, and as a result stocks the shelves of subsidized government stores across the country from time to time. The Gambia has offered to include Cuba as a preferential partner for its peanut exports (Embajada de Cuba en Gambia, 2013). The third category can be understood as long-term solidarity investment. This brings in countries like Haiti, which are economically devastated and offer no formal remuneration or bartering to Cuba, but still receive thousands of Cuban health workers on an annual basis. Here Cuban outreach is covered directly by the Cuban government, and some costs are offset through trilateral cooperation with countries like Norway, that provided medical equipment to 700 Cuban doctors in Haiti and Taiwan, that provided supplies and funding for Cuban medical teachers in the Gambia (NORAD, 2014; Statehouse.gm, 2004). None of these models fit well into the responsibility, charity or altruism frameworks. In all cases costs are being shared, and there is some effort to compensate if not reciprocate Cuba for its outreach. Even for aid to Haiti, third parties offer some level of assistance to Cuba. The sharing of costs and the nonstandardization of cooperation models in all three approaches suggest that medical internationalism operates well within the solidarity approach.

The Normative Ethics of International Outreach

The value of understanding the foundations of Cuban medical internationalism is that the normative ethics of the programs are not placed into a framework of charitable aid. The outreach is not done out of pity, nor is it done out of pure opportunism. It is constructed on a case-by-case basis that aligns the needs of the host nation to the capacities of the Cuban government. If a nation is in a position to pay generously, Cuba expects that they will. If the country has nothing, the solidarity ethos does not wane, but it is assumed that the symbolic capital will one day facilitate important cooperation. The sense that outreach is an investment directly challenges the assumptions of the realist view that medical outreach is limited to temporary actions of relief.

The realist view on medical outreach positions the receipt of care as a condition of broader frameworks of aid that are loaded with strategic interests (Alesina and Dollar, 2000). In post-disaster scenarios, such as in the Philippines in 2013, many nations responded with medical staff and supplies. Often the number of security personnel provided by governments far outweighs the number of medical staff. In 2013 Canada offered only a dozen doctors to the Philippines, but over 300 soldiers accompanied the brigade on security detail (Wingrove, 2013). In 2005, when an earthquake crushed Pakistan, Canada sent only six physicians to that country for a 3-week period within a security detail of 60 military personnel (Spiegel and Huish, 2009). Cuba, on the other hand, offered Pakistan 1285 health workers for a 13-month period (Spiegel and Huish, 2009). The often paltry and short-term medical relief by affluent nations such as Canada, although precious and valuable to relieve immediate suffering, does little to foster the long-term development strategies so that recipient nations can develop sustainable health-care resources of their own.

Three main issues explain why many resource-flush donors enact health aid in short-term and minimalist interventions. First, official development assistance in the global North is grounded in the belief that population health improvements through reactionary care rather than guaranteeing public health investment through long-term structural and human-resource commitments. After a natural disaster many fund-raising efforts get underway for food aid, vaccines and other medical supplies. Money is raised, grains and cereals are secured and then shipped to the recipient nation. The provision of food aid, which accounts for a substantial amount of all international donor assistance, is often viewed as politically neutral. Providing grains and technical assistance is considered arm’s length to directly intervening in a recipient nation’s political affairs (Barrett and Heisey, 2002). In this sense, food aid is by far one of the most popular avenues of international assistance, as it portrays a moral sense of empathy in giving, and it also appears to ensure autonomy by not meddling with the long-term infrastructural development of other countries. Finally, there is domestic benefit in supporting one’s own economy by purchasing and shipping out agricultural exports.

The second issue stems from the more overt practice of structuring aid to meet the donor nation’s vested interests in gaining access to resources abroad. Referred to as ‘tied aid’ where a donor nation imposes conditions on official development assistance so that the recipient must purchase equipment or material directly from the donor, or agrees to a vested package of trade agreements that benefit the donor’s domestic economy (Alesina and Dollar, 2000). China overtly engages in tied aid in Africa by agreeing to construct roads, hospitals and electrical projects in exchange for uninhibited...
access to resources and agricultural land (Moyo, 2009). In recent years Canada has positioned a great deal of its official development assistance to coincide with the operations of Canadian mining projects overseas (Clark, 2009). In 2013 the Canadian government dissolved the Canadian International Development Association, and folded all development assistance into the Department of Foreign Affairs and International trade (Huish and Spiegel, 2012). The move symbolizes a de-prioritizing of aid to that of political and trade interests abroad, notably mining interests. Before Canadian International Development Agency (CIDA) closed its doors the former minister for International Development, Julian Fantino, called for a freeze of all aid to Haiti, as he suggested that the results of years of assistance were far below expectations (Clark, 2013). Even though Haiti has an overwhelming need for support, notably in terms of improved housing and access to clean water, the Canadian government entertained the idea of halting all new projects to the country, and significantly reduced support for the impoverished country.

The third point stems from a belief that sharing medical resources is not to the benefit of national interests in the global North. Direct medical interventions abroad are not within the mandates of many donor nations’ official development assistance operations. For example, the idea of sending doctors abroad when tens of thousands of Canadians do not have a family doctor, or when millions of Americans have inadequate health insurance would be rendered as weakening already imperfect systems rather than strengthening them. Physicians from affluent nations do, however, travel abroad on overseas medical interventions. This is usually coordinated through charitable or religious nongovernmental organizations. It is morally acceptable that a team of medical specialists may travel to a country like Nepal to provide clinical care for 2 weeks a year, have their costs covered and then return to their normal practice. It is seen as a sacrificial act of charity and unabated kindness. It is not considered a responsibility, nor is it assumed that Canadian or American doctors head to Nepal and never return to serve their own populations. There is a clear normative assumption in the global North that physicians matter for the nation, and that society needs them to meet domestic health needs. If a country struggles to provide quality health-care services in its own marginalized communities, how could a government open up opportunities for physicians to travel abroad to meet the needs of citizens of other countries?

Pogge (2002) speaks to this by suggesting that there is an enormous moral bias in accepting that health services should benefit fellow citizens, but the needs of citizens of other countries is seen as preferential, if not secondary to national immediate needs. It suggests that health care is rigidly defined along national borders and through citizenship. Even if a country is inadvertently contributing to poor health in another country, say by exporting harmful substances like asbestos, Pogge (2002) suggests that moral loopholes exist with the normative behavior of affluent nations to feel that the immediate need for health care is not so great as to warrant direct intervention. The underlying tenet is that in the global North there is a deep affinity to a sort of nationalism that prioritizes access to quality health care among compatriots rather than to the marginalized abroad. This is to say that there is an expectation among Canadians, for example, that compatriots in Vancouver should have the same entitlement to health-care services as those in rural Québec even though there is very little in common between the two locations, economically, culturally or socially. Yet, when pressing health needs arise in Haiti (a 3-h flight from Montreal, compared with a 5-h flight to Vancouver from Montreal) there is less willingness to act with the same level of urgency or assurance of quality.

By rigidly dividing the needs of compatriots into a separate moral category to that of the needs of citizens of other countries, affluent nations remove themselves from any obligation to act toward alleviating the structures that prohibit access to quality care. In this sense the solidarity approach is compromised between affluent and impoverished nations. More subtly, the unwillingness for the global North to commit health-care service to the global South on a large scale entails dilemmas of compensation for physicians. Physicians practice as entrepreneurs, and there is a normative expectation of generous remuneration for their services. Although some physicians choose to volunteer their services abroad for a couple of weeks a year, it is not expected as a responsibility of service that they will succumb to financial hardship or self-sacrifice in the process. The normative ethics of medical service to the destitute is embedded in a sense that such actions are, temporary, charitable, sacrificial and exceptional, rather than an action of responsibility.

Taken together, lofty nationalism and the expectation of generous compensation, the normative ethics of health-care outreach in the global North has not been embraced as a value of responsibility, and instead is positioned as an act of exceptional charity. It is why medical outreach in the global North is largely relegated to the efforts of civil society groups and religious organizations, and not in any way seen as a direct strategic initiative by governments, or even by professional
associations. As a result, the solidarity model has not taken hold, and little effort is demonstrated by nations in the global North to provide the means for physicians to serve the marginalized, or even to offer medical education to the marginalized from abroad, as doing so would be viewed as creating competition for precisely few medical school seats that are meant to build capacity for national rather than foreign interest. In sum, in the global North human resources for health are involved in international health outreach, but not through solidarity, as the normative ethics create a dichotomy that give priority to the service of fellow citizens before the ‘destitute sick’ abroad (Farmer, 2005).

The Normative Ethics of Solidarity

Cuba’s contrasting approach of large-scale medical solidarity, to that of the minimalist efforts of the global North are still done with national self-interest in mind. The main difference is that the solidarity approach seeks transformative change through alter-globalization by expanding the abilities and the choices for medical personnel to engage in service to the destitute sick. The ethics of international outreach in the global North are too deeply influenced by lofty nationalism as well as by the charity approach to provide any substantive outreach that would challenge structures of power abroad. The solidarity approach provides avenues for transformative change for both the health-care workers venturing abroad and for the communities that they serve. Cuban health workers working abroad receive better remuneration than their domestic counterparts, and communities receive much-needed health resources (Huish and Spiegel, 2008). On a global scale, there is an enormous effort taken by medical systems the world over to recruit, attract and retain physicians in some of the wealthiest and affluent centers in the world. But efforts often fall short to recruit, attract and retain human resources for health in the world’s poorest communities. It is an enormous double standard to offer the sort of choice to serve the affluent that comes with a comfortable lifestyle, generous remuneration and upward career mobility, while serving the poor is only done through the auspices of short-term charity relief. Cuban solidarity challenges this double standard by providing Cuban and Cuban-trained physicians with a choice to serve the destitute that brings about shared benefits for the individual health workers and for Cuba’s national interests.

John Rawls understood the equality of opportunity principle to mean that a talented individual in a poor part of the world should not be denied the same rights, quality of life and choices as an equally talented person in an affluent part of the world (Rawls, 1999). The equality of opportunity principle has been used to justify the outbound migration of human resources for health for decades (Eckhert, 2002). Why should a talented physician in South Africa be denied the advantages of working in Canada? Why should a Filipino nurse have any less access to remuneration than her Californian counterpart? For Rawls, the ability to choose where one wants to work in order to fulfill their chosen lifestyle is essential to the equality of opportunity principle, and taken this way it aptly justifies the migration of human resources for health from poor health systems to affluent ones.

However, what if it is the choice of an individual to serve the poor, to work in marginalized communities, and to build a career that aims to address the structural limitations of health equity? What if it is the desire of a physician to serve the destitute? Is the choice to work in marginalized communities accompanied with job security, safety precautions, upward career mobility and generous remuneration? More often than not, these conditions—the very tenets of the equality of opportunity principle—are denied to those who choose to serve the destitute, but that are almost always guaranteed for service to the affluent. If physicians want to serve the destitute sick, they do so through a choice of self-sacrifice for long-term interventions or through the auspices of charity for the short term. In the global North there is little choice to serve the poor that is on the same moral level, and that includes the same life benefits, as serving the affluent. Nor are there many opportunities for persons from marginalized communities in the global South to acquire a medical education in the global North and then commit to serving the destitute.

By offering medical scholarships to students from marginalized communities with the expectation that they will return to those communities, Cuban solidarity opens up choice that did not previously exist for many in the global South. The prohibitive cost of medical education typically drives graduates into urban centers where well-paying specialization and private practices offset medical school debts. With a free medical education, Cuba positions foreign students in a better place to take on public service postings in their marginalized communities. There is no guarantee that students will return to those communities, nor is there any guarantee that their national health systems will accommodate them with jobs. In fact, many ELAM graduates have struggled to find public health postings within their home countries (Huish, 2013). But if a student makes
the conscious choice to serve the poor, ELAM enables them to pursue this choice.

Rawls’ equity of opportunity principle actually applies well for Cuban doctors who serve on medical brigades abroad; three tenets exist that fulfill the equality of opportunity principle. First, if a Cuban physician chooses foreign brigade service in another country it comes with added financial support from both the Cuban government and the host government so that equipment, medicines, accommodation, transportation and incidentals are all covered (Huish, 2013). While the working conditions are difficult, the physicians are not cut off from national-level support and coordination from Cuba—something that many nongovernmental organizations struggle with in the field.

Second, unlike most doctors who serve the marginalized and take a pay cut, in going abroad on a medical brigade, Cuban doctors get a pay raise. The level of remuneration is far less from physicians’ salaries in the global North, however by Cuban standards international brigadistas are in a position to gain considerable remuneration. They are paid their regular salary by the Cuban government, and then an additional salary by the host government. This varies greatly by country, as the salary in The Gambia is far less than in South Africa. Broadly speaking, in South America Cuban doctors receive between $200 and $500 a month from their host governments. What’s more the Cuban government directly deposits $150 each month into the physician’s bank account in Cuba. This can be accessed upon completion of the brigade contract, which is often 2 years, or family members in Cuba can access it while the physician serves abroad. A Cuban doctor working in country makes roughly $35 USD a month; however, the physician who chooses international service can gain exponentially more. It is a rare case where it pays, and pays well, to serve some of the most vulnerable populations in the world. Admittedly, this does not compare with the sort of money that can be made in the global North or in the private sectors in the South, but it is still a noticeable benefit to individual physicians who seek to serve the vulnerable. As of September 2014, the Cuban government was in the process of matching domestic service physician salaries to their international counterparts.

Third, Cuba’s ministry of health ensures long-term career advancement for Cuban doctors working on international brigades. There is considerable room for upward mobility and promotion, and many positions abroad come with teaching roles that can be transferable to university positions in Cuba. The Cuban medical system offers generous job security for its physicians, and there is little risk of career regression by choosing to serve the poor abroad. Notably, many brigadistas gain more prestigious teaching roles and policy roles upon their return to Cuba (Huish, 2013).

In sum, the design of Cuban medical internationalism to offer structured support, significant remuneration and long-term career advancement is a unique approach to international health outreach that fulfills the equality of opportunity principle by enhancing real choice to serve the poor on the same moral level, if not more so, than serving one’s compatriots. It is a tactful approach of encouraging sustained attention to the needs of the vulnerable abroad, through a solidarity framework that generates remuneration and barter for the benefits of home.

A Threatening Example

Considering that the world requires 4.3 million health workers in order to achieve global health equity, there is no underestimating the immediate need that populations around the world have for health-care services. Yet, so many populations remain unserved and underserved even when physicians within their countries are physically available, but not necessarily morally compelled, to do so. A case in point is the recent deployment of 11,400 Cuban physicians to Brazil as part of the Mais Medicos program. Dilma Rousseff’s government created the program to add 15,000 doctors to rural and underserved areas of Brazil in the coming years. Brazil sent out a call through the Pan-American Health Organization for foreign governments to assist in the program, and in return Brazil would offer financial remuneration to that government through a solidarity approach. Only Cuba came forward to offer a large-scale intervention. Cuban doctors had practiced on medical brigades in Brazil since 1998, but only in small numbers. Mais Medicos scales up the Cuban intervention to a level that will bring medical professionals to some of Brazil’s most marginalized communities, and ensures that the services are provided at minimal to no cost for anyone who seeks them out. The Cuban doctors will be paid as per the usual solidarity remuneration scheme, where Brazil will pay a monthly salary directly to the physicians ($400 per month), and the Cuban government will top up their bank accounts at home ($600 per month; Lissardy, 2014). A small difference with Mais Medicos to other Cuban solidarity schemes is that Pan American Health Organization (PAHO) is regulating the financial exchange between Brazil and Cuba, rather than payment occurring directly through bilateral exchange. Not all participants are content with the terms though. One Cuban physician, Ramona Matos Rodriguez, left her
post with Mais Medicos, and took to the US embassy in Brasilia seeking entrance to the USA. Matos Rodriguez felt that Cuban doctors should be paid that of other foreign physicians (Lyons and Cowley, 2014). Similar desertions have taken place on other medical missions, but the overall number is incredibly small, with about three percent of physicians leaving their brigades (Millman, 2011; Huish, 2013).

The influx of Cuban physicians into the Brazilian health system stands to reshape Brazil’s health-care landscape by offering publically accessible, and affordable, services in areas that had been traditionally denied quality care. A patient in one small village called the introduction of Cuban doctors a ‘gift from God’ (Boadle, 2013). Dania Alvero, a Cuban physician working in the Amazon, was quoted as saying that ‘there are illnesses here that I had only read about in books, like leprosy, which no longer exists in Cuba’ (Boadle, 2013).

From the point of view of the marginalized and the destitute sick, this program has the potential to increase access to much-needed health-care services. For the Cuban physicians Mais Medicos provides the three tenets of the equality of opportunity principle. However, for the Brazilian physician’s association, Mais Medicos is an enormous threat.

Many Brazilian physicians did not view the influx of Cuban physicians as a positive move toward building strength and capacity of national health services (Watts, 2013). Instead, Brazilian doctors took to the streets wearing clown noses in protest of the Cuban doctors. In Fortaleza, a crush of local physicians greeted the Cuban doctors at the airport chanting ‘slave’ and ‘incompetent’ (Watts, 2013). The Brazilian medical association publicized a wide range of critiques against the Cuban doctors (Laboissiere, 2014). They claimed that they were under-qualified, and that they were not real physicians. They also claimed that it was wrong to pay Cuban physicians so little for their services when physicians working in the private sector are able to garner so much more (Israel, 2013). Ultimately, the argument made by the Brazilian doctors against the presence of the Cubans came down to Brazil having enough doctors, and that Mais Medicos will take away work from qualified Brazilian doctors. It is a threat to physician’s control of the labor market, access to medical education and community-health provision. Medical associations in Venezuela, Honduras and Bolivia launched the very same critiques (BBC NEWS, 2006; HAVANA TIMES, 2013). The debate about the discrepancy in pay for physicians working in rural service versus that of the private sector is an important, albeit classic, debate and speaks to broader ethical challenges of the role of the physician as a healer of the sick or a maker of money.

The critique from the Brazilian medical association is grounded in professional self-protectionism rather than in broader ethics of cosmopolitanism or solidarity for the poor. Mais Medicos facilitates greater access to care and greater opportunity for physicians to serve the poor, and it directly addresses structures of power that have maintained inequity. The Brazilian medical association’s critiques against Mais Medico fail to appreciate the ethics of solidarity, and the association’s activism is grounded in syndicate tactics to maintain an exclusive cadre of power on health care within the country. Such protest against the Cuban doctors speaks to a deeper commitment to maintain health-care frameworks outside of the solidarity approach, rather than to find ways to dismantle hegemonic structures of power.

Conclusion

This article set out to address two questions. Why does Cuba commit so much to global health equity? Why does an economically hobbled nation feel it best to meet the health needs of compatriots alongside citizens of other countries? While simplistic responses exist for both of these questions, Cuban medical internationalism operates within the ethics of solidarity, which challenges the auspices of aid and humanitarian relief. By understanding Cuba’s global health outreach as a practice of solidarity, Cuba commits to global health in order to meet its own national interests through cooperation frameworks. Second, despite its own economic and social challenges, committing human resources for health for the needs of citizens of other countries works to address deeper structures of inequity found within health-care provision on a global scale. The effectiveness of this approach can be seen through Cuba’s continued ability to foster bilateral relations with other countries in the global South, and how other countries in the global South continuously seek out Cuban support. It can also be seen through the vehement reaction of professional medical associations who recognize how the solidarity model creates serious threats to existing hegemonic structures of power.

The solidarity model opens an important ethical dimension for health-care provision for the global poor. While it may intimidate existing national medical professions, it opens up greater opportunities for physicians to serve the poor in a way that fulfills personal ambitions, and offers choice to do so on a moral platform of autonomy for self-improvement rather than charitable
obligation. The pressing need for human resources for health on a global scale is so great, that global health equity cannot be achieved through piecemeal charity responses or short-term commitment. Real change toward global health equity will only come through broad national, and international, efforts to scale up human resources for health to a scale the world has never seen before. Although some medical professional associations pursue actions to maintain their own power, authority and control of medical care, Cuba presents a compelling case that not only is it possible to offer opportunity to for physicians to serve the global marginalized on the same moral level as serving compatriots, but that there are in fact thousands of individuals who are seeking the chance to provide such care to such places. It demonstrates that solidarity can be an important framework for addressing global health inequity.

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Notes

1. Medecins sans frontiers has 22,000 working in the field in 60 countries. The International Committee for the Red Cross (ICRC) employs hundreds of medical doctors in the field for emergency relief and training services. UNICEF employs about 10,000 people, but only a small percent are physicians working in the field, and their roles are mostly for technical assistance for local physicians dealing with HIV and public health.

2. Cuban medical internationalism is understood as a unique mix between foreign policy and medical outreach. It is understood as a foreign policy scheme that achieves broader economic and political goals through notable health transformations on the ground. The term is meant to capture a broader dynamic of Cuba’s outreach that does not necessarily fit into the auspices of ‘aid’ or ‘humanitarian outreach’.

3. After Hurricane Katrina in 2005, Cuba offered to send 188 health-care workers to the affected area. The US government refused the offer. Also, Cuba has offered hundreds of scholarships to US students for medical education, as well as to students from Peru. There is no direct support or assistance offered to the Cuban-trained scholars for reintegration into the US medical system, and in Peru the medical association refuses to acknowledge the value of the degrees.

4. ‘Destitute sick’ is a term used by Paul Farmer to describe marginalized populations in the global South who will needlessly succumb to additional suffering and poor health not from any biological predisposition, but from social, economic and environmental structures in which they live. The term is meant to draw attention to the social determinants of health that rigidly impact the lives of the poor.

5. This is taken from an interview between Fidel Castro and Ignacio Romanet. Castro alluded to the idea that the Algerian intervention was the foundation of employing medical outreach as a process of anti-imperial resistance and as a means of generating formal links of solidarity with other poor nations.

6. An enormous proportion of aid to governments in the global South comes in the form of development loans that require repayment, with interest, to the donor nation. Even in post-earthquake Haiti a large portion of dollars entering the country came through World Bank and International Financial Corporation loans for the creation of new manufacturing enterprises and export-oriented agricultural development. It is then up to the government to repay such debts with interest. Often, the economic forecasts do not pan out, and the recipient nation struggles to repay debt to donor nations. The solidarity approach avoids strapping the partner nation with debt of this nature.

7. The Cuban Medical Parole Program is a US State Department initiative designed to recruit overseas Cuban medical workers to US embassies to immigrate to the USA. The program runs on a $10 million budget and specifically targets health workers in rural and outlying areas. Once Cuban physicians enter the USA through this program, there is no guarantee that their qualifications will be recognized. Many of the 1800 or so physicians who have entered the USA through this program have worked as medical assistants rather than as practicing physicians.

8. The balance between profit and care dates back to antiquity as Plato said, ‘Is it not also true that no physician, in so far as he is a physician, considers or enjoins what is for the physician’s interest, but that all seek the good of their patients? For we have agreed that a physician strictly so-called, is a healer of the sick, and not a maker of money, have we not?’
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