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Bulletin of Latin American Research, 2009 DOI:10.1111/j.1470-9856.2009.00314.x

Cuba's Medical Internationalism: Development and Rationale

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Since 1960, Cuba has been involved in providing medical support to the developing world, and at present has some 40,000 personnel in 74 countries – more than all of the G-8 countries combined. This article traces the evolution from its first (1960) mission to the current stage. The article also analyses various explanations for this extraordinary mixture of diplomacy and humanitarianism.

Keywords: Cuban medical internationalism, medical diplomacy.

In 2005, when Hurricane Katrina devastated New Orleans, the international media mentioned an unusual development – tiny Cuba (population 11.2 million) had offered 1586 medical staff and 36 tons of medical supplies to provide humanitarian relief services to that beleaguered city. Sadly, the administration of George W. Bush rejected the offer out of hand, and four years later the Cuban offer has largely been forgotten. This is unfortunate because it represents an important example of a tradition of Cuban medical internationalism that has been evolving for almost five decades – as well as an extraordinary humanitarian contribution from which we could all learn.

The numbers are staggering. Since 1961, over 130,000 Cuban health professionals have worked in 102 countries, and at present there are 36,770 medical staff working in 73 countries or overseas territories, looking after 70 million patients abroad (Gorry, 2008: 44). In fact, Cuba has more medical personnel working abroad than all of the G-8 (Group of 8) countries together, and it is astonishing that the Western media have widely ignored its contribution, since its medical internationalism programme is multifaceted, complex and constantly evolving – and has saved millions of lives.

However, not only does Cuba provide hands-on medical services throughout the developing world, it also provides medical training in Cuba (at no cost) to 24,538 students from 89 countries in Africa, Latin America and Asia, according to figures from the Cuban Foreign Ministry (MINREX) (MINREX Forum, 2007), most notably at the Escuela Latinoamericana de Medicina (ELAM), where for the past nine years an annual entry class of some 1,600 students from poor socio-economic backgrounds have started a six-year programme to become doctors. In addition, there is a medical school in Santiago de Cuba for several hundred Francophone students from Haiti and Africa. Moreover, medical schools with Cuban cooperation have been established in Yemen, Guyana, Ethiopia, Uganda, Ghana, Gambia, Equatorial Guinea, Haiti,

Guinea Bissau and East Timor. In his 2005 speech to the 'Henry Reeve Medical Contingent', Fidel Castro outlined the most ambitious goal of all – to restore the sight of 6 million people in Latin America and the Caribbean, and to train for the underdeveloped and developing world, at no cost to the students, 200,000 healthcare professionals in ten years (Castro Ruz, 2005). Cuban medical educators have recently completed a second ELAM in Venezuela, and in 2006 introduced in both countries a new 'hands-on' innovative medical training approach, involving family doctors supervising small groups of medical students. In addition, Cuba has embarked on a programme of ophthalmic surgery (again, at no cost to patients) that, since July 2004, has resulted in 51 specialised eye clinics being opened in thirteen countries, and has restored sight to 1.5 million people in 33 countries, mainly in Latin America and the Caribbean (Cuba Coopera, 2008). Moreover, following the Chernobyl reactor disaster, since 1990, Cuba has treated without charge some 24,000 children from the affected area. Finally, the Cuban government has also formed a medical emergency response team (the Henry Reeve Medical Brigade of some 10,000 personnel), which has provided medical support to several countries in the wake of natural disasters.

Any one of these medical feats would be extraordinary for a country of this size – particularly if one bears in mind that approximately one-half of Cuba's 6,000 doctors (and all but seventeen of the teachers at the only medical school) left the island in the early years of the revolutionary process. Also important is the fact that, following the demise of the Soviet Union, Cuba spent much of the 1990s struggling to survive its own massive economic difficulties, when some 80 per cent of trade with the Soviet Union and socialist bloc disappeared in a few months and GDP fell by 30 per cent. Together, however, these examples of medical cooperation illustrate an enormous emphasis placed on instituting sustainable health practices throughout the developing world. This article seeks to shed some light on the evolution of this remarkable medical strategy, from its origins in the early 1960s – with emergency relief in Chile following a devastating earthquake and a small medical mission to Algeria – to the present, with its many thousands of medical personnel serving abroad. A secondary objective is to provide an analysis of the motives and philosophy behind this ambitious approach.

Early Stages of Cuban Medical Internationalism

At the risk of being overly schematic, there appear to be three basic periods in Cuban internationalism. The first revolves around the initial years of the revolutionary process, once the government believed that its power had been consolidated. This can be termed a period of spontaneous medical response to emergencies abroad, and appears to have been developed without much thought of cost or benefit. The process can be seen clearly in the medical missions that were dispatched to Chile in 1960 after a major earthquake and to Algeria in 1963 in the wake of a massive exodus of medical staff there. The second period parallels the 1970s process of institutionalisation of the revolution, with guaranteed Soviet trade commitments and the benefits of membership in the COMECON common market of socialist countries, the Council for Mutual Economic Assistance (CMEA). The best example of this international solidarity can be seen in Cuba's response to the situation in Angola in the late 1970s, in the wake of the Portuguese evacuation of their former colony. The final period can be

traced back to the winter of 1998, when Hurricane Mitch wreaked havoc in Central America. In the decade since then, Cuba has professionalised its response to natural disasters, while also using these as a rationale for a greatly developed policy of medical internationalism.

The Cuban leadership has always stressed the need for preventive medicine – an approach that has resulted in the best medical profile in the developing world and one that in some ways is better than in many industrialised countries (Cuba, for instance, has a better infant mortality rate than the United States). However, it has also responded well to natural tragedies abroad, as can be seen in its response to earthquakes, hurricanes and the like. It is important to point out that this emergency aid has occurred regardless of the ideology of the government where the disaster occurred. As already pointed out, the very first example of this type of medical assistance came as early as March 1960 (just over a year after the Batista regime had been overthrown), when Cuba sent a group of doctors to Chile to assist the population following an earthquake there, despite that country's right-wing government.

One of the fundamental principles of the Cuban revolution – the need for international solidarity – is illustrated both in the emergency response to the Chilean emergency and in the sending of the medical mission to Algeria. Several massive earthquakes rocked Chile in May of 1960, killing an estimated 2,000 people, and injuring 3,000. The new revolutionary government of Cuba (with an exodus of Cuban medical personnel to Florida already underway) was one of the first countries to send medical aid. However, in terms of a planned medical programme (as opposed to the response to a natural emergency), the revolutionary government's first experience of medical aid was in Algeria, to which Havana sent a contingent of 56 public health workers in 1963.

In late 1961, the Castro government had offered military and medical support to the Algerian rebels, fighting for their independence from France. In the following year, independence was achieved and Ahmed Ben Bella assumed power, visiting Cuba in October 1962. Following the visit, Fidel Castro urged Cuban medical staff to volunteer their services in Algeria, reminding them of the parallels between revolutionary Cuba and Algeria (from which most of the French doctors in the former colony were already leaving). The Cuban Minister of Health at the time, Dr José Ramón Machado Ventura, illustrated well the context: 'Era como un mendigo ofreciendo ayuda, pero sabíamos que el pueblo argelino la necesitaba incluso más que nosotros, y que la merecía' ('It was like a beggar offering help, although we knew that the Algerian people needed it even more that we did – and deserved it') (Gleijeses, 2002: 28). It is worth noting that Dr. Machado Ventura himself was the first director of Cuba's first medical mission to Algeria. At present he is the first Vice-President of the Council of State, and remains a strong supporter of medical internationalism. It is important to understand the context in which this occurred. In many ways this initial medical mission was a politically dangerous move for Cuba, because Cuba's support of the Front de Libération Nationale (FLN) guerrilla movement had risked the wrath of President de Gaulle of France, who until that time had maintained normal relations with Havana. In addition, Cuba was in a parlous economic state, with most of the bourgeoisie already having left (taking with them badly needed management skills), with tension with the United States having already exploded (Washington broke off relations with Havana in January 1961) and with the October 1962 Missile Crisis having resulted in Cuba being treated as an international pariah. This was clearly not a time for an adventurous foreign policy by Havana, much less one taking away badly needed human resources.

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The early 1960s in the political history of Cuba were a time of idealism, of revolutionary romanticism with lofty goals to assist other nations also suffering under tyranny. The declaration of the socialist nature of the revolution in 1961, the massive social polarisation, sweeping nationalisation of the economy and unbridled nationalism against US hostility all helped to forge the essence of the Cuban revolutionary cultural identity. Humanitarian ties with the peoples of other exploited nations – from Vietnam to Nicaragua, from the Congo to the Dominican Republic – were the order of the day. One key facet of that policy of solidarity with those fighting to throw off the shackles of colonialism and imperialism was support for their struggle, both with arms and with medicine.

The need to provide medical support as well as military aid can be seen clearly in 1966, in the Congo. At that time and since, the mission led by Che Guevara (subsequently abandoned) has always been emphasised as a military one, yet it also contained a small, but effective, medical contingent. It is important to remember that only nine doctors remained in the former colony to serve almost 900,000 people. Polio was rampant in the country at the time, and as a result the small group of Cuban doctors requested medical assistance from both Havana and Moscow. The Soviet Union sent 61,000 doses of vaccine, and these were administered to children in June 1961 – the first mass vaccination in the history of Africa. It also fell to the Cuban doctors subsequently to organise the national health service there and provide elementary training for local nurses. Medical assistance soon followed to Guinea, Tanzania, Mali and Somalia.

Cuban Medical Internationalism in the 1970s

A quantitative jump in Cuban medical participation took place in the mid-1970s, when Cuba sent its first doctors to Angola. Most academic attention has understandably been focused on the military aspects of the mission, yet a crucially important facet of the Cuban presence was the medical contribution. It is significant that most of the staff from the earlier Congo expedition participated in the new mission, bringing invaluable experience. By the time that Cuba had withdrawn its troops from the country, a thorough study of the medical challenges facing Angola had been carried out by Cuban staff, the national public health system had been organised and Cuban doctors were active in 80 municipalities of the country.

Again, it is instructive to bear in mind the domestic context in Cuba. The failure of the 1970 '10-million ton' sugar harvest resulted in a major national soul-searching. The failure of Che Guevara's guerrilla war in Bolivia and his execution in 1967 also illustrated the need for a significant change in direction for the revolutionary process. The Soviet Union developed closer political ties with Cuba, whose economy became increasingly interconnected with that of the Soviet Union and the European socialist community. Cuba maintained an independent foreign policy, however, and, with a more solid economic base, decided to send both military supplies and medical support to popular forces in Angola and Nicaragua.

Piero Gleijeses has explained well the situation of Angola at the time of the arrival of the Cubans (Gleijeses, 2007: 14–15). By November 1975, fully 90 per cent of the Portuguese who lived in Angola at the time had left, leaving the country with extremely limited technical, managerial, and medical support. In the same month, within days of the arrival of Cuban military, the medical staff arrived. When the doctors reached

Huambo, Angola's second largest city, there was only one Angolan doctor and a Red Cross mission (which left three months later). Indeed, in the entire country there were only fourteen doctors at one point – soon to be bolstered by 200, thanks to Cuba. Following the Cuban involvement in Angola, Cuban civilian aid programmes expanded throughout the 1980s, with tens of thousands of Cubans subsequently working in Mozambique, Cape Verde, Guinea, Guinea-Bissau, Angola, Ethiopia, Sao Tomé and Principe, Tanzania, Congo, Zambia, Botswana, Burundi, Burkina Faso, Ghana, the Seychelles, Mali and Benin. Meanwhile, thousands of African students – some 18,000 in 1988 – came to further their education in Cuba, provided at no cost by the revolutionary government. In addition, Havana decided to help establish medical schools in a variety of countries in Africa: Yemen (1976), Ethiopia (1984), Uganda (1986), Ghana (1991), Gambia (2000), Equatorial Guinea (2000) and Guinea Bissau (2004).

In sum, the Cuban military presence in Africa from the late 1970s on was supported by large numbers of civilians. Indeed at one point in Angola there were over 7000 Cuban civilians working in education, healthcare, construction and agriculture – all provided at no cost. In 1991, in his visit to Havana, Nelson Mandela summarised Cuban involvement in Africa:

> Venimos aquí con el sentimiento de la gran deuda que hemos contraído con el pueblo de Cuba … ? '¿Qué otro país tiene una historia de mayor altruismo que la que Cuba puso de manifiesto en sus relaciones con Africa?' (We come here with a feeling of great indebtedness to the Cuban people … Which other country has a history of greater altruism than Cuba has shown in its relations with Africa?). (Gleijeses, 2002: 458)

Post-1998 Developments

To a large extent, the massive increase of the Cuban medical role in the past decade can be traced back to October and November of 1998, when Hurricane Mitch wreaked havoc in Central America. It came just a few months after the Dominican Republic, Belize and in particular Haiti had been devastated by Hurricane George. The death toll from Mitch was very high (approximately 30,000) and in November of that year Central American leaders made an emotional international appeal for assistance. By the end of December 1998, some 424 members of Cuban medical brigades had arrived, and eventually this increased to some 2,000, before settling back to the current complement of some 900. It is worth noting that at the time Cuba had poor diplomatic relations with several countries of the region, and these had consistently supported US actions against Havana.

Instead of concentrating on just sending medical assistance, however, Cuba soon decided to adopt a new tack in dealing with the massive problems faced by this region – in essence to train Central American and Haitian doctors to deal with their own health problems. The idea thus evolved to train Central Americans in Cuba to become doctors, and, in November 1999, the Escuela Latinoamericana de Ciencias Médicas (later changed to the Escuela Latinoamericana de Medicina, or ELAM) was inaugurated, with hundreds of Central Americans registering. Significantly, the students selected came from poor backgrounds, about one-half were women, and all had to make a commitment to return to work in impoverished communities in their home countries. The costs of their education and living expenses were to be borne by the

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Cuban government. In many ways this was an imaginative application of the basic principle of preventive (as opposed to curative) medicine that is a strong component of the public health policy of Cuba.

Cuba thus developed a two-pronged approach to providing medical care for those affected by these catastrophic natural disasters in the region. On the one hand, it provided emergency medical assistance as an interim measure. On the other, looking at long-term solutions, Cuba decided to train (at no charge) thousands of doctors from those affected regions, with the expectation that they would return to their country of origin after their six-year medical programme in Cuba, replacing the Cuban medical staff. The end result has been extremely positive, with millions of medical consultations carried out, and a noticeable drop in infant and maternal mortality rates. In Guatemala, for example, the infant mortality rate where Cuban doctors are serving has dropped from 45.0 to 16.8 deaths per 1000 live births.[1] At first, Cuba accepted students just from the countries affected. Soon afterwards the decision was taken to broaden the student intake from throughout the hemisphere, and indeed from some African countries. More recent developments have included scholarships being given to hundreds of students from East Timor and Pakistan, where major natural disasters have also occurred in recent years. Currently, ELAM has students from 28 countries (including 105 from the United States) – all told 8,234 – of whom 51 per cent are women.[2] This percentage is not surprising in a North American context, but it is in a continent where *machismo* is deeply rooted. So far some 7,400 students have graduated (Gorry, 2008: 46). It is the largest medical faculty in the world, and offers a full six-year medical programme (with the opportunity to do further specialised training) at no cost.

Mention was made at the beginning of the article of the emergency response medical contingent that was formed at the time of Hurricane Katrina. While the Bush administration might have scorned Cuban offers of help, other countries have since been delighted to receive free medical assistance. Among these, the most important contributions were to Pakistan following a major earthquake in 2005 (2,564 Cubans, of whom 1,463 were doctors), Guatemala (in the wake of Hurricane Stan in October 2005 some 688 Cubans, including 600 doctors went there), Bolivia (602 personnel, including 601 doctors, following massive flooding in February 2006), Indonesia in May 2006 after a major earthquake (135, including 78 doctors), Peru in August 2007 after an earthquake (76, including 43 doctors) and Mexico after flooding in November 2007 (54, including 39 doctors). (CubaCoopera, 2008). The results of this emergency medical relief, according to the same sources, are worth noting: some 3.8 million medical consultations and 18,898 operations were carried out; 36 fully equipped field hospitals were set up – 32 in Pakistan, and two each in Indonesia and Peru – and subsequently donated to those countries; and an estimated 4,619 lives were saved.

It is often claimed that a nation's humanity can be measured by the way in which it takes care of those who cannot do so for themselves. By extension, it is worth noting how Cuba has provided humanitarian assistance to arguably the poorest country in the Americas, Haiti, where the infant mortality rate was about fifteen times that of Cuba

1 See MEDICC (2006) for data. For a broad discussion of ELAM, see Huish and Kirk (2007).

2 There are presently 105 US students enrolled at ELAM, and a further seventeen have already graduated. All are from visible minority backgrounds in the United States, and all have agreed to work in underserviced areas after graduation (Gorry, 2008: 45).

when the Cubans sent a large medical brigade there. Despite strained political relations with Haiti, the Cuban government responded quickly after Hurricane George hit Haiti in September 1998. Some 200 doctors were dispatched immediately, and there are currently some 500 medical staff (including 332 doctors) there, providing healthcare to 80 per cent of the population throughout the country.

It is worth noting the benefits of this widespread medical coverage – since the infant mortality rate in the areas where the Cubans are working has been reduced from 80 per 1,000 live births to 28, and the mortality rate of children under five has been reduced from 159 to 39. The fundamental objective, however, has been to provide a sustainable healthcare model. Accordingly, by 2004, there were 247 Haitian students at a local medical school established by the Cubans, with an additional 372 studying medicine in Cuba. The following year this had increased to 600 Haitians in the medical faculty in Santiago. In 2005, the first cohort of Haitian doctors returned to practise medicine in their homeland, a process that has been repeated each year. Between 1998 and 2006, Cuban doctors carried out some 8 million consultations with Haitian patients, and carried out 100,000 operations (Kovac, 2006).

Also important in recent years has been Cuba's ongoing medical support to many underdeveloped countries in Africa. In South Africa, for example, there were already some 400 doctors by 1998, with a further 1,200 working on the continent by 2004. Cuba has also offered to send 4,000 medical staff to work in sub-Saharan Africa to resolve the HIV/AIDS crisis, but has requested that the industrialised countries also cooperate by providing financial support and medication to help treat the disease. So far the silence is deafening.

A relatively new phenomenon is the delivery to Venezuela of medical and educational services provided by approximately 30,000 Cubans (including approximately 23,000 medical personnel). This is a complex series of bilateral arrangements that is often incorrectly presented as a straightforward swap of oil for doctors. The reality is far more complex. The extremely close ties between Venezuela and Cuba have resulted in an increase in bilateral trade (from US$912 million in 2000 to $2.7 billion in 2007) and a broad range of cooperation agreements (increasing from 31 projects worth $28.5 million in 2000 to 355 worth $1.5 billion in 2007).

In terms of Cuban medical cooperation there are several key initiatives: over 566,000 Venezuelans have had their sight restored (either in Cuba or their home country) through free eye surgery performed by Cubans; some 20,000 Venezuelans are being trained as doctors by Cubans in Venezuela, with a further 2,400 educated on the island; the approximate 30,000 Cuban medical personnel in Venezuela have provided over 223 million medical consultations, and have saved some 85,000 lives since they have been involved in the Chávez government's slum regeneration programme (Barrio Adentro I program); there are now altogether about 800 local clinics, each mainly staffed by a team consisting of a Cuban doctor and a Venezuelan nurse; finally, Cuba has established 307 Centres for General Diagnosis (clinics), 406 rehabilitation rooms (complete with high-quality technology) and eleven ophthalmic clinics – with many more to come.

Perhaps the most innovative aspect of Cuban–Venezuelan cooperation in terms of public health is a radically new paradigm of medical training for doctors, designed to supplement the more traditional form of medical instruction, according to which students attend university classes and labs. The objective is eventually to train 40,000 doctors in Venezuela, by having each Cuban doctor in the clinics supervise two Venezuelan students working half-days at the clinic, and spending the rest of the time

in classrooms with a group of 25 students. In addition, 10,000 nurses are being trained with the help of Cuban medical teachers (Gorry, 2008: 46).

What is common to all these various initiatives is the determination by Cuba to use its medical expertise in providing assistance to patients and to regions that had been medically under-serviced for many years. There is no doubt that the Venezuelan context, complete with tremendous wealth based upon oil revenue and with the strong ties between the government of Hugo Chávez and his Cuban counterpart, is unusual. That said, the same humanitarian commitment has been provided by Cuban medical personnel wherever they serve, as can be seen from the recent Cuban missions to places as disparate as East Timor and Pakistan, Bolivia and Haiti. Indeed, this approach applies, regardless of whether the service is provided to one of the 37 poorer countries that pay a nominal sum for Cuban assistance through the Programa Integral de Salud (PIS; Comprehensive Health Programme), to those receiving emergency support from the Henry Reeve contingent, or to those in oil-rich Venezuela.

Rationale for Cuban Medical Internationalism

On one level, it is easy to rationalise Cuban medical internationalism as a means of intelligent diplomatic tactics to win support for crucial UN votes. This is particularly necessary given traditional US hostility (and extensive influence) in international fora. After all, goes the argument, in those circumstances, it behoves Havana to make diplomatic and commercial alliances wherever it can. Building upon her groundbreaking work, Julie Feinsilver has explained well the value of this successful strategic pursuit of what she terms 'symbolic capital' (Feinsilver, 1993, 2006).

While it is unclear if medical internationalism is just a cold analytical move to win 'symbolic capital' and political support for Cuba, what is indisputable is the success that Cuba has enjoyed in international fora. Cuba currently is the elected leader of the 118-nation Non-Aligned Movement. It was elected to the new UN Human Rights Council with the support of 135 nations. In November 2008, Cuba's annual motion condemning the US embargo was supported by 185 with only three (the United States, Israel and Palau (population 21,000)) voting against. Clearly Cuba is highly regarded in the developing world – and certainly the extensive medical cooperation programme will be helpful.

A second argument put forward by Feinsilver to explain Cuba's development of this internationalism is the commercial value of medical diplomacy. Cuba now produces about 80 per cent of its own medicine, and at a fraction of a cost charged by multinational drug corporations. With over 30,000 medical staff abroad, runs the argument, this offers Cuba an excellent opportunity to sell its pharmaceutical wares by means of those doctors. Certainly Cuba's extraordinary scientific research capacity at the Polo Científico in Havana offers enormous potential, and the number of joint venture operations in biotechnology, particularly in Asia, can only help Havana to take advantage of this unusually favourable context (In fact, however, governments that contract Cuban services are expected to provide pharmaceutical products, so at present relatively few Cuban medical products are used).

In addition, Cuba charges some countries for medical services provided and, although these are far below the market cost charged by medical staff in industrialised countries, the export of these services is extremely beneficial to the Cuban economy. The earnings from non-tourism services have increased dramatically in recent years, leading the

Economist Intelligence Unit to comment that 'agreements with Venezuela involving the employment of Cuban professionals, not only to treat Venezuelans but also for projects serving other countries in Latin America and the Caribbean lift Cuba's earnings from non-tourism services by as much as US $3 billion, outstripping earnings from tourism' (Economist Intelligence Unit, 2008: 42).

Less credible explanations of this ambitious medical internationalism come from US sources. Christopher Marquis of the *Miami Herald* summarised Cuban aid in simplistic terms: 'After relying for decades on guerrillas and guns to export his Marxist model, Cuban president Fidel Castro has found another tool: "doctor diplomacy"' (Marquis, 2000). The journalist presented the Cuban programme as a calculated tactic to obtain 'a needed burst of goodwill from his Latin and Caribbean neighbors', who a few months earlier had criticised Cuba's human rights record at the Ibero-American summit held in Havana, but after a visit to ELAM 'were dazzled by the school and clamored for more spaces for their students'. Eight years later, two other *Miami Herald* journalists took up the same theme, criticising the tactics of Cuba in sending its medical personnel 'to help spread ideology and earn income for their cash-starved homeland' (Robles and Woods, 2008).

Adopting a more personal attack in *US News and World Report*, and likening the Cuban president to H. G. Wells's mad scientist, Dr Moreau, Linda Robinson(1997), claims that:

> Cuba's attempt to leapfrog the natural chain of technological advancement reflects both its long isolation from outside investment and Castro's ego: His avid interest in medicine – and his belief that Cuba can play in the big leagues of science – has led him to personally direct many of the ventures.

In his weekly *Firmas Press* column of 12 September 2005, Cuban exile Alberto Montaner (2005) was particularly bitter in his denunciation of Havana's policy. He refers to Cuban doctors as:

> the *comandante's* favorite slaves: He rents them out, sells them, gives them away, lends them, exchanges them for oil or uses them as an alibi to justify his dictatorship . . . Sometimes he uses them to foment political dependence, as in his wealthy Venezuelan colony; others, to promote propaganda or exert diplomatic pressure on the country that receives his poisoned present.

These interpretations seem somewhat shallow and fail to take into account a number of essential factors outlined below.

A more balanced analysis than that of Montaner (who titles his 2005 article 'Slaves in White Coats') would reveal alternative explanations for the Cuban approach. The question of providing medical assistance for diplomatic support is a case in point. There is no doubt at all that, while it is obviously impossible to quantify how medical internationalism to a given country has translated into diplomatic support, assistance of this kind has indeed helped to win over erstwhile opponents. The case of Guatemala (which in 1998 reopened diplomatic relations with Cuba shortly after Cuba had sent hundreds of medical staff to assist in the wake of a devastating hurricane) is illustrative of this point – just one example of several that underline the success of this approach. Likewise, Honduran president Carlos Flores re-established diplomatic relations with Havana in 2002 shortly before leaving office, and was undoubtedly influenced in this

decision by the medical contribution of Cuban doctors (many of whom remain working in that country).

As noted below, however, revolutionary Cuba has been sending medical teams abroad for decades – and to countries such as Alessandri's Chile in 1960 and Somoza's Nicaragua in 1972, where there was absolutely no hope that the leader would change his views on the Cuban revolution. (It is worth noting that Cuban exiles set off for the Bay of Pigs invasion in April 1961 from Nicaragua, and it is impossible to think of more mutually antagonistic leaders than Anastasio Somoza and Fidel Castro.) Moreover, in 1986, Cuba immediately sent 22 tons of emergency medical supplies to assist Salvadoran relief efforts in the wake of the 1986 earthquake, despite an enduring hostility from that country's government. Cuba again sent specialised medical personnel there after an outbreak of dengue fever in 2000.

Likewise, Cuban doctors went to Iran in 1990 following a major earthquake, despite strong ties at the time with Iran's foe, Iraq. In the case of Uruguay, Havana donated 1.2 million doses of meningitis vaccine – despite diplomatic relations being broken off (temporarily) by Montevideo shortly before. In sum, the provision of medical assistance has been a fundamental principle of the Cuban revolution from the very beginning, regardless of the ideology of the government to which emergency aid was sent. Speaking to a foreign relations parliamentary committee in June of 2007, former Foreign Minister Felipe Pérez Roque synthesised Cuban medical cooperation well:

> no damos lo que nos sobra, sino que compartimos lo que tenemos.
> (We do not give our left-overs; rather, we share what we have.)
> (Mexidor, 2007).

The case of whether Cuba is developing medical internationalism as a commercial enterprise – that is as a prime export product – is more complex. There is clear evidence that the importance of biotechnology in Cuba as an export industry is moving very rapidly. Since 2006, the export of Cuban medical products has been second only to nickel in terms of income generated, and surgical supplies, dialysis equipment and diagnostic kits are now exported throughout the world. There have also been successful clinical trials on a number of drugs and vaccines, again sold internationally.

In short, there is no doubt that Cuba is obtaining substantial much-needed payment for its medical services abroad, and that this is a lucrative enterprise. In terms of the export of medical services, however, there is the need for some clarification, since in essence there are two groups of countries receiving Cuban medical cooperation. One group receives the PIS, paying a token amount for the services provided (approximately $US100 per month for the Cuban doctors in the case of Haiti or Belize). The other is a patchwork quilt of payments from dozens of countries with differing capacity to pay, which provides housing and transportation, and a reduced salary to the Cuban staff. The case of Venezuela is perhaps the most lucrative for Cuba, because it receives an estimated 98,000 barrels of oil per day at favourable rates. Havana has sent an estimated 30,000 medical staff to that country, and is being paid for their services by the Chávez government – but again the Venezuelan government is obtaining these services at a similarly reduced cost.

In a May 2007 interview with the author, Deputy Minister of Foreign Relations (and doctor) Jiménez (2007), the person in charge of Cuba's medical internationalism programme, explained the 'big picture' of these two major arguments about the reasons behind the export of Cuban medical services:

> Even taking the most cynical view, namely that Cuba is sending doctors abroad to poor countries in order to win votes at the UN, why doesn't the industrialised world do something similar? Surely the most important thing is to save lives. That is precisely what our policy is doing.

In terms of the second point – that Cuba is reaping large rewards for the export of its medical services – she was similarly blunt:

> We believe in fair trade. If that means that we export a product that we have a surplus of – in this case medical and educational goods and services – to a friend at a reduced price, and they export to us at favourable conditions something that they have in abundance – petroleum – what is wrong with that?

It is also important to bear in mind that Cuban medical internationalism has been in effect for 49 years – long before Cuba was seeking to convert its medical capital into diplomatic influence or to gain any commercial value. As a result, the ideological and philosophical aspects of Cuban medical internationalism have to be considered more seriously than has traditionally been the case. This is not to take away from the enormous symbolic capital generated by Cuba in recent years, much less the commercial value resulting from Cuba's capacity to export Cuban medical goods and services. There are, however, profound historical and ideological roots to Cuba's medical internationalism that have to be taken into account. Indeed medical internationalism is one of the guiding principles of the national healthcare system, an integral component of the national medical ethos.

A useful starting point to understanding these philosophical roots is the Cuban Constitution, which notes the commitment to 'el internacionalismo proletario, en la amistad fraternal, la ayuda, la cooperación y la solidaridad de los pueblos del mundo, especialmente los de América Latina y del Caribe' ('proletarian internationalism, fraternal friendship, aid, cooperation and solidarity with the peoples of the world, especially those of Latin America and the Caribbean') (Republic of Cuba, 1992).

In addition, one can refer to the very roots of internationalism in Cuban history, with volunteers and military leaders from around the Americas who helped win independence from Spain in 1898. Moreover, it was with the support of the Soviet Union and the socialist countries of Europe that the Cuban revolution managed to survive after Washington imposed an embargo of Cuban products, broke off diplomatic relations and supported Cuban exiles in terrorist activities against revolutionary Cuba. More recently, the underlying philosophical principles of ALBA (Bolivarian Alternative for the Americas), promoted so vigorously by Hugo Chávez, are also pertinent – because the basic concept of the various member nations exchanging their natural talents and producing for each other (in direct opposition to the Bush plan for a Free Trade Area of the Americas) also applies. One can also refer to the enormous influence of Che Guevara, who was a doctor, in promoting the moral values of truly revolutionary physicians – values that have been inculcated into Cuban society since 1959. Indeed, medical training in Cuba contains a fairly heavy dose of ideology, socialising medical staff to regard public health as a major human right.

Medicine is not seen as a business in Cuba, but rather as a right of the citizens, and a duty for physicians, regardless of the ability of the patient to pay. In April 2007, former vice-president Lage, himself a pediatric cardiologist, explained to graduating medical students in Venezuela the essence of revolutionary medicine:

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> Un médico revolucionario es aquel para el cual un enfermo no es un cliente, sino un paciente. Un enfermo no es su modo de vivir, sino su razón de vivir. Un médico revolucionario no gana dinero, gana vidas.
> (A revolutionary doctor is one for whom a sick person is a patient and not a client. A sick person is not a means by which s/he earns a living, but rather represents the physician's reason for living. Truly revolutionary doctors do not earn money – they save lives.)

Some data are particularly instructive. For nearly five decades in domestic policy this major thrust of the revolutionary government has been extremely successful. Infant mortality rate is just over 5 per 100,000 live births, life expectancy (78 years) is approximately the same as that of the richest developed nations, Cuba has one of the lowest rates of HIV/AIDS infection in the world, immunisation rates consistently lead international figures – as does the ratio of physicians to patients (5.91 per 1,000 population), and undoubtedly Cuba leads the world in terms of equitable distribution of physicians throughout the country. For further information, the websites of the World Health Organization (2009) and UNICEF are worth consulting.

This pride in Cuba's medical prowess undoubtedly has a nation-building component, as has the revolutionary government's ambition to become an international medical powerhouse, a desire articulated with some frequency by Fidel Castro since the 1980s. This status allows the leadership to remind the Cuban people both of the notable successes achieved in terms of public health, and their privileged international role, providing an inordinate amount of medical aid throughout the developing world. As a result, had the Bush administration accepted the offer of Cuban medical assistance after Hurricane Katrina, an enormous moral victory for the revolutionary government would have resulted. More importantly, scores of lives would undoubtedly have been saved.

It is also true that many of the Cuban medical personnel serving abroad receive privileges and benefits that they would not obtain at home. Their salaries are significantly higher than the approximately $US25 that they would receive monthly in Cuba – and even in poorer countries they receive at least four times that amount. The government thus provides an opportunity for physicians to escape from the inverted social pyramid that has prevailed in Cuba since the demise of the Soviet Union.

That said, from the evidence of interviews with many medical *internacionalistas* and government functionaries involved in this process, it is clear that the commitment to provide medical service is not seen primarily as a means of making a profit or winning UN votes. Both of these by-products are immensely helpful to the Cuban government, which is delighted to take advantage of them. This of course is enormously helpful to the sense of nation-building, and of national pride, but far more important is what is perceived as the basic duty to provide medical care, wherever it is needed. In this regard, the emphasis on public health by the revolutionary leadership from the very beginning of the revolutionary process has indeed paid off. It has also been extremely important for the doctors themselves, many of whom have returned professionally enriched. In many cases they have now treated diseases eradicated decades earlier in Cuba, are often more appreciative of the socio-economic gains made in Cuba and on a personal level are more mature, more useful to their patients on a humanitarian level. However, underlying their mission, both at the level of individual medical staff and at that of the senior bureaucrats, is a humanitarian commitment to assist those badly in need of their services.

Conclusion

Cuba's medical internationalism has been a major success, by any stretch of the imagination. It has won the support of many nations, some of whom had traditionally harboured little sympathy for the revolutionary government. It is a major source of income, now generating more than the tourism industry. It has contributed to an aura of international respectability because of the humanitarian zeal, and professionalism, shown by Cuban doctors. Indeed, many industrialised nations have taken heed of the primary healthcare model of Cuba, with its emphasis on preventive medicine, its demystification of high-tech medicine, and its doctors trained to work and live in the communities they serve. On a personal level, it has provided Cuban medical personnel the opportunity to obtain material benefits that they would have not been able to receive if they had stayed in Cuba. Perhaps most important of all, it has saved millions of lives.

Sadly, this success has led to the opposition in Latin America of some professional associations, jealous of the (free) medical training received by working-class students in Cuba, resentful of their very different approach to medicine, and fearful that they will lose their patients. There are also claims that the graduates of ELAM have been poorly trained, although this is mainly viewed as a smokescreen for professional jealousy. The Bush administration has taken this even further, seeking to foment a medical 'brain drain' of Cuban doctors serving abroad, and offering preferential treatment if they chose to defect. Most reports indicate that between 200 and 300 Cuban medical personnel – or about 2 per cent of those serving abroad – have done so. As a useful comparison, approximately 9 per cent of Canadian medical school graduates leave annually for the United States.

One point that needs to be mentioned is the impact that having almost one-quarter of Cuba's doctors living abroad has on patients back home. There have undoubtedly been complaints, as patients find their doctor has gone abroad on internationalist duty. In addition, Cuba initially transported large numbers of patients from throughout the region to Havana for eye surgery (provided at no cost) – particularly under the auspices of 'Operación Milagro'. For many years, patients in Cuba have been accustomed to a degree of medical assistance that would be impossible in many developed countries, and are used to not needing to queue for treatment and seeing their own family doctor whenever they wish.

In order to deal with these complaints, in mid-2008, the Cuban government reorganised the local medical structure, concentrating family doctors in larger units so as to better deal with local patients. Moreover, in many ways the Cuban system – even with one-quarter of medical staff abroad – still possesses a favourable ratio of patients to doctor (200 to 1), evenly distributed throughout the island. Indeed, despite the absence of many family doctors, the ratio is still better than that of most developed nations. Medical internationalism has undoubtedly caused significant inconvenience for Cubans. Many would argue, however, that in addition to being a duty to pay back the debt to the international community, the payment that accrues to the Cuban government (mainly from Venezuela) as a result of the export of medical goods and services also helps to subsidise the Cuban health system, from which all benefit.

This article is intended as a general explanation of the wide-ranging, multifaceted medical internationalism programme of Cuba. In many ways, what Cuba is providing the developing world in terms of medical support and, more significantly, as an example of alternative models, may well prove destabilising to the global medical establishment. Feinsilver (2006), has put it well:

> And now, with help from his friend, Hugo Chávez, who is awash in oil wealth, Fidel is threatening to provide massive amounts of medical aid to improve the health of poor Latin Americans. Rather than a fifth column promoting socialist ideology, these doctors provide a serious threat to the status quo by their example of serving the poor in areas in which no local doctor would work, by making house calls a routine part of their medical practice and by being available free of charge 24/7, thus changing the nature of doctor–patient relations. As a result, they have forced the re-examination of societal values and the structure and functioning of the health systems and the medical profession within the countries to which they were sent and where they continue to practice. This is the current Cuban threat.

It is clear that the Cuban model of public health has been extremely successful, both in Cuba itself and in its application abroad. Much has been said about the successes in the domestic public healthcare system, and the plaudits received are thoroughly deserved. Yet little is said about this extraordinary record abroad, one that has done more to help the underdeveloped and developing nations than the entire industrialised world – and has done so for fully five decades. In the last analysis, it comes down to Cuba embodying the threat of a good example – perhaps a concept that others in the industrialised and 'developed' world would one day do well to emulate.

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