

Cuban Medical Internationalism and Globalization

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My current research focuses on the inequality of health care services in the Global South. Specifically, I am interested in finding ways of overcoming the condition of lagging health care services in rural and marginalized areas while wealthy urban pockets enjoy a plethora of resources. The main question is how we can get around the problem of having patients without doctors and doctors without patients, sick people without hospitals, and hospitals without sick people. As a geographer, I see these challenges as products of spatial constraints, but also of the conditions of place, where globalization has influenced the relationship between societies and nature as well as who gets access to health care services where, when, and from whom. As I see it, imbalance is not natural or inevitable; it is produced by too much inequity and too little understanding. The health care challenge in Latin America is well beyond spatial inaccessibility; it is about ethical accountability.

Neo-liberal economics insists that there is no alternative to centralization and privatization of health care services. According to such logic the private sector must find more innovative ways to deliver services to patients or "clients," and a healthy economy, through structural adjustments, will make for healthier people. Globalization not only displaces medical resources away from vulnerable communities, but human resources as well. For structural adjustments to take form we must ask what is the point of achieving a healthy currency without achieving healthy people?

John Ralston Saul reminds us that the logic of a rising tide raising all boats is a near-sighted argument. Tides, he says, do not raise all boats; they smash them into the rocks, break their lines, and send them adrift. It takes a well-trained crew for the boat to survive a rising tide. And we have seen this throughout the hemisphere. Structural adjustments, from the point of view of the economy do well to quell inflation and encourage spending, but from the point of view of the poor they close hospitals, remove doctors, and strip social services, which often leads to the spread of cholera, typhoid, HIV/AIDS, and other public health calamities. This is why Saul reminds us that we can not accept the neo-liberal creed as gospel. In fact, we must question the forces that try to make us think that economic inequity is inevitable for the Global South.

At times, though, and especially when considering global health, inequity seems like it is nothing less than inevitable. So much material and human resources are perennially taken from the South and given to the North. Pipelines of human resources from the South to the North, and overpriced treatments from the North to the South are not natural, nor are they neutral. Inequity is constructed, and we have to realize that every child in Freetown has the right to life as do children in Palm Springs, a mother in Lusaka has the same right to safely deliver her child as the mother in Paris, and a person in Lilongwe has just as much right to see a physician as someone living in Geneva.

In this spirit, my research focuses on finding ways to go against the inevitable. I have focused my doctoral work on Cuban medical internationalism. Sometimes labeled a paradox for such a poor nation to have such incredible health indicators, Cuba is a country that also plays a major role in combating global health care inequity. It has managed to achieve a level of comprehensive health

care that outdoes any other health care system in the world, and it commits thousands of its own doctors, nurses, and health care technicians to serve communities around the world. Cuba has sent doctors to, or received students from, 113 countries since 1960. While poor in material resources, the country is strong in human capital, an asset it shares with other countries, who like Cuba, are attempting to overcome the challenges of underdevelopment.

Specifically, I look at the Latin American School of Medicine (ELAM), the world's largest medical school. With a current student body of over 8,000 students, and having graduated over 4,500 students since 2005, ELAM consists of students from twenty-nine different countries, most of who come from marginalized communities in the developing South. The students receive a six-year medical education paid for by Cuba's ministry of health (MINSAP), which includes tuition, accommodation, clothes, books, food, and other expenses. The only cost is a moral commitment for every student to return to their home communities to apply their skills where they are needed the most.

Having explored this unique human resource capacity building project, which is one of the latest steps in Cuba's innovative foreign policy strategy, I see it as possible to train doctors from the developing South who, thanks to the paradigm of traditional medical education, would not otherwise become doctors. I see it as possible to bring health care services to people who, thanks to economic hardship, would not be able to receive quality primary care. I see it as possible to approach health care in the Global South not as a business, not as a charity, not even as a science, per se, but as a service — as a human right that can not be denied to anyone for any reason. This is how ELAM operates; above and beyond training students in core clinical competency, it fosters an institutional ethic of health care as a service, because health is a right.

The Cuban approach to globalization is one that involves reaching out to the world's forgotten communities. Their approach shows us that it is possible to empower individuals to impact communities and that it is possible to train physicians for the service of the poor. It is also possible to develop foreign policy in this age of management and technocracy that has an altruistic core — one that aims to improve the lives of tens of thousands. Cuba, since 1959, changed its own approach to health care to be universal, preventative, efficient, and effective. Today it teaches us that health is not dependent upon wealth, and that other possibilities exist. Health indicators are on par with Taiwan, Canada, and the United States, but economic performance on par with Indonesia, Lesotho, and Bosnia.

From my research, I see ELAM as an extremely important health care capacity building project that does well to give the right kind of people the right kind of toolkit to become the right kind of doctor. To bring thousands of students together across cultures, nations, languages, and continents in order to receive a free medical education that is meant to serve the poor, gives a stridently different sense to globalization. The challenge lies in these individuals going up against neo-liberal health care systems. The health care systems they return to are as hollow as gourds, as I have found out in Ecuador. Bare material resources and little chance of long-term employment for physicians is the diagnosis given to Ecuadorian doctors. It is a challenge that has yet to be realized, and I hope that this can be one of those stories where individuals can find ways to embolden health in their communities to demonstrate that an ethics of service and human rights in medicine can overcome an ethics of business in the delivery of care. While globalization has furthered the need for improved health care services, here is a country with an idea to fill in the void by using minimal resources and enormous effort.

Pressing Questions Related to Globalization

The biggest challenge as researchers today is going up against the feeling of inevitability. The discourse of inevitability is strong in any discussion of globalization. It is a moving train, some say, and it is one that cannot be stopped. But you can not be neutral on a moving train, as Howard Zinn put it, and to simply accept the condition of inevitability is to give in to broader structures and to cease innovation in making another possible world. Why is it inevitable that the rural health care landscape of Cuba will become that of Ecuador? Why is it impossible for the Ecuadorian rural health care landscape to become that of Cuba? What are the structures that make us believe something to be inevitable or impossible? As academics, we need to not only question forces of inevitability but the forces that make us believe that something is inevitable.

To be neutral and not to question such claims keeps us on the train. Charging patients for medical services, subsisting in rural landscapes without primary care, training doctors as leaders in research in London rather than community caregivers in Suharto, are all social constructs that can be questioned. Globalization in its fast and dizzying pace of events has somehow carried the message that it is an inevitable process. In line with Rawlsian cosmopolitanism, it is deemed ethical for South African physicians to migrate to Canada in order to seek out better pay, status, and working conditions. But what if those conditions could be remedied in South Africa? What if a body of doctors is actively replacing each and every South African doctor that leaves the country? If it is possible for physicians to want to practice in the very places those other physicians flee, then we must question the inevitability of the ethics of global physician migration from the South to the North.

Wider collaboration: Inevitability and health

Community-level health care desperately needs dialogue from the Global South and in particular with Cuban outreach: an outreach that actually reaches hundreds of thousands of people every year. The very same goals are being sought in both the North and the South: improving accessibility to care with reduced cost and greater participation. In the North, our policy makers and most academics have yet to break out of the inevitable neo-liberal paradigm. This is tragic, as it cripples our innovation; it limits our geographies of imagination. In the North the call to improve health care seems to equate with more money for more things. Bigger technology, more pharmaceuticals, and advanced testing. When health care costs increase because of too much focus on costly retroactive treatment, everyone pays. In the South it is well known that improving the health of communities rests in basic strategies of prevention, and promotion has tremendous social and economic benefits downstream. It is a lesson that the North needs to embrace. Collaboration for a human-resource approach to public health is badly needed, and in that dialogue maybe we can seek room to broaden our imagination. But what will we imagine? How to connect our differences, or to see our similarities? That globalization has not just divided rich countries from poor countries, but it has divided the rich and poor of all countries.

Globalization: The Canadian Perspective

Globalization from the Canadian point of view is often a *mélange* of discourses. Mostly it is discussed in economic terms. More planes, cars, and cheap things become available to the consumer: Australian wine in Vancouver, and Alberta beef in China. Uniformity and ever-quickenening transportation seem to be common threads. Fast food, fast life; before you know it, it is all over.

Some policy analysts, economists, and technocrats continue to write daily diatribes in national newspapers about supposed benefits of globalization and privatization. They sell it as if it were something new, and something that will benefit the entire society if not the entire global collectivity.

More options, more things to buy, more channels to watch. The right to consume is sold as humanity's ultimate obligation. But really, what we are missing is that globalization is little more than finding ways and reasons to move things, and sometimes people, incredibly far distances with transportation means that do a great deal to ruin the planet. Here we are functioning as Appadurai's "objects in motion." Cheap vacations to the Caribbean ruin the environment with jet fuel and unbalance social cohesion through resort tourism. Cheap soccer balls stitched in Malaysia arrive in Los Angeles shopping malls faster than David Beckham can kick one, and the little hands, the hands of children that stitched them, are all but forgotten. Coal, wheat, and other bounties of Canada head to China, and in exchange cheap candles and t-shirts wind up at suburban shopping centres.

The people who break their hands stitching soccer balls or their break their backs dismantling old ships are, as we are told, empowered because they have a job. There is no way to quantify a life of organic subsistence farming in Ecuador, or providing free health care services in vulnerable places. But it is possible to measure a life in dollars and cents if the person is selling gum or cutting flowers for a few cents at a time.

The debates of globalization in Canada hardly, if ever, get to that level, to the basics: moving things too far for no good reason, and finding ways to justify poverty by quantifying the lives of the poor. The proponents remind us that all will benefit. A tired song they sing, but it is all that is on the radio. Such audacious claims that the broiling misery of poverty can be overcome by continuing to move things long distances is so over the top that activists who see through it are often compelled to critique the inaccuracy of details.

The Challenges of Researchers

A thorough academic study will show that infant mortality will increase by 2.5 percent with a structural adjustment policy, or at-risk populations may increase by 5 percent, or caloric intake may be reduced by 10 percent. Academics have become art critiques, picking over the details of the brush strokes of globalization, while, in fact the entire gallery is a fraud. Why is it that academics have moved towards a technocracy of criticism rather than envisioning new strategies to overcome the widening inequity that globalization has afforded us? Is this just the condition of post-modernity, or is something else at play?

Cross-national Research Collaboration

Cross-cultural research can only work to improve the situation. Globalization has failed to bring a multitude of voices, ideas, and imaginings together. Instead it has given us broader access to a narrower set of ideas and norms. So much understanding has yet to be unlocked through collaborative projects, but it requires massive transitions on the part of academics and their funding bodies. For which audience will this research be received? Will it be filed away in archives in the university? Will it be aimed at the poorest 80 percent of the planet? If it is, how will it get there? How many people actually have access to the Internet, let alone regular electricity and clean water? In the slums of São Paulo, who can afford a book?

Research Ethics?

Appadurai's argument has a lot of potential for a place like Canada, and I can see the value of it from spending time in Cuba. When approaching questions of research ethics we have to ask ourselves why we are doing it. The simple pursuit of knowledge is not good enough. It keeps us on the moving train. With health care, research is done to further science, assist business, and then serve society. It

embraces an ethics of science before service. In Cuba research is done to improve accessibility, then to further scientific knowledge, and lastly to find lucrative ventures. It is service before science. Cross-cultural collaboration could serve to remind researchers in the North that the cost of health care does not have to be untamed. With a different approach to ethics, say in prevention before reaction, human resources before material ones, service before science, it could be possible to develop a new approach to global health that is governed by innovation and ideas rather than by bottom lines and short-term agendas.

This is a pre-print version of **Cuban Medical Internationalism and Globalization** by **Robert Huish** generated from the *Globalization and Autonomy Online Compendium*. The electronic original is available at http://www.globalautonomy.ca/global1/position.jsp?index=SN_Huish_Cuba.xml.