

Learning from Health Care Experience in Cuba: Knowledge & Progress

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Health Provision in Cuba

‘ARTICLE 50.

Everyone has the right to health protection and care. That right; is guaranteed by the state;

- by providing free medical and hospital care by means of the rural medical service network, polyclinics, hospitals, and preventative and specialized treatment centres;
- by providing free dental care;
- by promoting publicity campaigns, health education, regular medical examinations, vaccinations and measures to prevent disease, with public cooperation in these activities and plans through social and mass organizations.’

Constitution of the Republic of Cuba, 1992, author’s translation.

On the eve of the Revolutionary victory of January 1st 1959, Eric Williams (1983: 479/480) gives a graphic description of the destitution, poverty and disadvantage of the essentially, rural majority of the Cuban population. However, by Latin American standards at that time, Cuba was relatively developed.

Public health was effectively an urban, largely private, enterprise: ‘...a business to which the poorest of the population had no access, and if they did, the services were of the worst quality’ (MacDonald 1995: 101). The public health budget was low, and plundered by corrupt politicians and government administrators. Doctors were concentrated in Havana, which, comprising 20% of the population accounted for 64% of hospital beds in Cuba, although access to hospital treatment, even in Havana, could only be secured by bribing politicians and health officials. ‘Clearly hospitalization, whatever the need was not an option lightly entered into and would not have been available to any but the relatively wealthy.’ (MacDonald 1995: 101). In rural areas health services were virtually non-existent. There was no collection of health statistics.

Yet within 15 years, ‘...a remarkable network of medical services ... [had been created that] reaches every Cuban man, woman and child with comprehensive, preventative and curative medical care, equal in quality and free of charge.’ (MacDonald 1995: 28). While the *strategy* of the Revolution – comprehensive health care for all on demand – has remained steadfast for over 50 years, health *policy* has continually evolved, sometimes being modified two or three times a year, to accommodate to the rapidly changing situation of a revolutionary society.

After the Revolution Fidel Castro appointed Dr Julio Martín Paéz to take charge of health provision – establishing care priorities, the provision of clinics and hospitals, and the training of medical and para-medical personnel (including replacing half of the qualitative doctors, some 3,000, who left Cuba to continue private practice in the United States after January 1959). In 1961

the construction of 156 rural hospitals and 118 dispensaries began, and by 1976 the one school of medicine at Havana University was joined by 3 more, in Santiago, Oriente and Santa Clara, (graduating 1000 general practitioners required to work their first year after graduation in rural areas, later extended to two years, and 300 medical specialists, every year).

Health achievement

In pre-revolutionary times the main cause of childhood sickness and death had been poverty, manifested as: parasitic infestation, malnutrition and enteric infections (diarrhoea). Perhaps predictably, given the political priorities pre-1959, none of these conditions had even been addressed in medical training, in what was a world class medical school at Havana University.

The dearth and paucity of health services pre-Revolution was part and parcel of an essentially feudal, exploitative social order, characterized by illiteracy and unemployment, a way of life dominated by the “*tiempo muerte*” [dead time] of unemployment between sugar harvests.

The post-revolutionary experience of health care, in which the incidence of infectious, parasitic and other diseases has either been eliminated or radically curtailed, extending longevity, has been part of the *social* process of increased well-being, including: sanitation services, provision of potable water, improved nutrition, ending of homelessness, universal literacy, high quality education, full employment, social services, economic equality, social and political inclusion, economic growth, etc...

The achievement of post-Revolutionary improved health indicators is an aspect of an essentially equitable, socialist, social order based on the satisfaction of human need.

‘In the past, Cuba had achieved some medical development in comparison with other Caribbean countries, but it was the profound socioeconomic changes which began to take place in 1959 that made it possible to create a comprehensive health-care system unparalleled among non-industrialized countries ... [that] allowed Cuban medicine to turn its attention to pathologies characteristic of developed countries.’

Bravo 1998: 189.

Beginning in 1962, when 56 doctors were sent for fourteen months to the newly independent Algeria, thousands of medical teachers, doctors, nurses and technicians have served in dozens of countries. For instance in 2006, Cuba maintained Internationalist Medical Missions in 68 countries, with twenty-five thousand medical personnel assisting the victims of the 2004 Asian Tsunami and the 2005 Pakistan earthquake. In 1999 the Latin American School of Medicine was inaugurated, and in 2007 there were over 4000 students on its campus near Havana, with more than 10,000 distributed in other institutions throughout the island. The project has drawn students from 28 countries, all of whom study free of charge, and has graduated 3,204 doctors (see *Granma International*, March 25 2007). The October 28th edition of *Granma International* reported that 10,000 Nicaraguans have had their sight restored in an ophthalmic centre run by Cuban specialists, and ‘...close to one million patients from 31 Third World countries have had their vision

restored thanks to the labor of Cuban doctors as part of the Operation Miracle program.’ (*Granma International* December 2nd 2007).

By 1996 Cuba had the highest number of doctors per capita of any nation: 60,129; 56.8 physicians per 10,000 inhabitants, or, one doctor for every 175 people (see, Pastors for Peace n.d.). More than 28,000 of these physicians were family doctors, living and working in communities of about 120-150 families.

‘If there are more than 120 families living in a high-rise apartment building, then there is a doctor in that building. In an urban area or a smaller town, there’s a doctor just a few blocks away, no matter what neighbourhood you’re in. (There are also doctors in day-care centers, schools, workplaces, bus stations, etc...). Family doctors and nurses have residence apartments where offices are located; they rotate duty, so someone is always on call.’

Pastors for Peace n.d.: 3

The family doctor and nurse process

The core of the network is the “family doctor-and-nurse” [FDN] system, instituted in 1984. The catalyst for the emergence of FDN practice, which evolved out of the knowledge process which is the culture of socialist Cuba (see below), was Dr Julio Martín Paéz. In a uniquely, de-centralized, family health care structure, a local team of a family doctor, a nurse and a social worker are assigned to care for around 120 families.

It is a system which accommodates to the social well-being of people, so that, in times of medical need... ‘... social workers ... fan out over the rural area, visiting sick people in their homes, arranging for transportation to the hospital. When a mother needs to be treated, they arrange for the children to be housed by other families or at a day-care center. When any prolonged treatment is called for, the social worker helps settle the home problems that might arise: providing a guaranteed salary from the Ministry of Work, school arrangements, child care, a job for another member of the family, special care for older members of the family.’ Cannon 1983, quoted MacDonald 1995: 29.

Each FDN team cares for the health of between 120 and 150 families.

Medical care is taken into the community by doctors and nurses residing in the community: the surgery is literally “just round the corner”.

Crucially, through the FDN process:

- Public health provision is integrated with clinical practice. Health in the community is assessed in epidemiological terms, the basis of preventative care in the community, while taking into consideration individuals’ clinical histories to effectively tailor treatment to each person.
- The Continuous Assessment and Risk Evaluation [CARE], the process of *dispensarización*, defines the “at risk” members of the patient population – each expectant mother, each diabetic, etc... – all of whom, continuously, receive prioritized treatment. The CARE process also follows up patients treated at other levels of the health system, for instance providing specialist care once members of the community are discharged from hospital.
- Health care needs are assessed in a family and community context, taking

into account individuals' social obligations and opportunities, promoting active involvement in each-others' well-being.

– People are (medically) treated not merely as patients, but as “social-individuals” (see the section on “knowledge” below), creating a *consciousness*, a social psychology of human existence. Sick or disabled people are not “patients” to be treated, but members of the community to be cared for.

– All medical services, processes and institutions, are both horizontally and vertically integrated. Each medical worker (doctor, nurse, social worker) is a member, both of the local community, and of an extended health care community, which includes, paediatricians, gynaecologists, psychologists, medical professors, etc..., who together can review individual patient care; ‘... paying special attention to troublesome diagnoses, difficult social cases, and the demands of rehabilitation’ (Reed 2000). And at the hub of this extended network is the community polyclinic (see, Reed 2000).

Just a few years after the instigation of the family medical programme, in 1991, Cuba had to accommodate to the collapse of the Soviet Union: ‘When the Soviet Union still existed ... we had solid bulwarks on which to depend and on which we have depended for the past 30 years. Now these bulwarks no longer exist. We are our own bulwark.’ (Castro 1991: 33).

Between 1991-1993, due to the collapse of socialist, European trading partners, imports declined by around 80%, creating shortages which were exacerbated by the tightening noose of the United States' economic embargo (see, Azicri 2000). Transportation ground to a halt, power blackouts at times

lasted for 16 hours a day, and hospitals lacked everything from antibiotics to aspirins.

Throughout the worst years, until recovery began around 1996, the FDN primary health care system is credited with the near miraculous feat of maintaining the basic health care indicators of Cuba stable. In some cases, for instance infant mortality rate, the indicators actually improved.

And in 2007, Cuban achievements in the realm of health care continue to baffle policy makers in so-called “developed” societies.

‘According to the World Health Organisation a Cuban man can expect to live to 75 and a woman to 79. The probability of a child dying aged under five is five per 1,000 live births. That is better than the US and on a par with the UK.

Yet these world-class results are delivered by a shoestring annual per capita health expenditure of \$260 (£130) - less than a 10th of Britain's \$3,065 and a fraction of America's \$6,543.’

The Guardian, September 12th 2007, “First world results on a third world budget”.

Cuba has distinct health policy priorities, which reflect a particular knowledge and understanding of human needs. Satisfying such needs is normally presented as an objective question above the political fray, addressing common demands of individuals’ idiosyncratic human experience. But the exigencies of social life and the normative priorities of health policy reflect a belief in the essential *political* concerns of society and (ontological)

convictions about human nature: ‘...how can we say how society *ought* to be organized unless we claim to know what human beings are really like?’ (Levins and Lewontin 1985: 254, emphasis in original).

However, what *is* human nature is the wrong question.

Human existence is extraordinarily diverse, both in individuals’ personal *experience* and in people’s social *existence*. Attempts to understand such diversity by identifying some ideal uniformity in behaviour called “human nature”, manifested in the miscellany of social life ignores the conundrum of *causation*.

Knowledge of human life

‘...sensory raw material [of experience], the only source of our knowledge ... may lead us to belief and expectation but not to knowledge [itself] and still less to understanding...’

Einstein 1982: 22.

For Albert Einstein human experience is the source of knowledge of human life: but people’s lives are more than individuals’ experience and knowledge must include the panoply of obligations and expectations associated with the social relations of existence; and any understanding of life must further address the evolving context of individuals’ behaviour as the social relations of existence adapt to the emerging opportunities and frustrations of human life and individuals’ developing potentials.

Humans are thinking beings who subjectively choose how to behave (albeit within objective social parameters). It is not obvious that: individuals’

preferences and personal experience determines the social parameters of existence; neither that the requisites of social life moulds individuals' experience. That is, it is not apparent whether or not experience is the independent variable in human life (i.e. determines existence), or is the dependent variable (is determined *by* existence).

A consideration of personal experience.

If it is (ontologically) assumed that human beings' choices create their social existence, then the implication is that individuals' preferences reflect their innate human nature; ultimately, social existence is biologically determined. And social (health) policy should be orientated towards the encouragement of people to use their skills and talents to meet social needs by offering personal incentives.

This is the logic of the competitive, market organization of society that has been in vogue since the late 1960s (see Cole 1999: Chapters 2 and 3) – though not in Cuba.

Within such an *individualist*, ontological approach, health care, like a can of beans, is a commodity. There is a “demand” and a “supply” which are equated in the market place by the appropriate price. There is a *reductionist* orientation to medical practice and research, addressing *individuals'* health needs and isolating the *particular* causes of disease/disability and treating them. The focus is upon the consumer and sick people only become patients if they can back up their demand for health care with money to pay for it (what economists call “effective demand”).

An appreciation of social existence.

Alternatively it can coherently be argued those individuals' choices (and experience) are constrained by the social parameters of existence: objective parameters which offer opportunities for, or frustrate, individuals' subjective preferences. Individual experience is now considered to be ultimately socially determined. There is a social *functionality* to human behaviour, a logic to existence which is above and beyond personal volition. And, essentially, this logic reflects the social exigencies of the technical division of labour in the production of social life.

The emphasis is on *social* producers not *individual* consumers.

This is the logic of the managed, structuralist, organization of society that was intellectually and politically dominant from the 2nd World War up until the late 1960s (see Cole 1999: Chapters 2 and 4) – though not in Cuba after the Revolution of 1959.

Within this *social* ontology, health care is organized to ensure the medical integrity of social existence, as in the early years of the National Health Service in the UK, or the current strategy of the World Health Organization: '...global public health security is defined as the activities required, both proactive and reactive, to minimize vulnerability to acute public health events *that endanger the collective health of populations living across geographical regions and international boundaries.*' (WHO 2007, emphasis added).

Rather than a reductionist emphasis on identifying the specific causes of disease and disability, the intellectual priority is an *holistic* concern with the

social morphology of health. The focus is on the social “whole” rather than the individual “component”.

Human knowledge.

An individualist, experiential approach to knowledge and a social, existential focus, ask different questions of the same (human) life process.

However,

‘The properties of individual human beings do not exist in isolation but arise as a consequence of social life, yet that social life is a consequence of our being human.’

Rose, Kamin and Lewontin 1984:11

A comprehension of human life depends upon the reconciliation of the knowledges of experience *and* existence: coherent knowledge of experience depends upon an appreciation of the social parameters of existence, and vice versa. However, these knowledges are *qualitatively distinct*; respectively: empirical and conceptual.

Knowledge of individual experience is *empirical* – describing actual behaviour: knowledge of social existence is *conceptual* – the relations of existence are the (abstract) spaces between people, spaces shaped by individuals’ (subjective) intentions.

Empirical knowledge of experience can be proved to be accurate through the theoretical tenets of positivist science (see Popper 2002). Conceptual knowledge of existence can be shown to be coherent through the conjectural principles of scientific paradigms (see Kuhn 1996).

These scientific knowledges are not right or wrong in any absolute sense: they are ontologically distinct, asking different questions of the *same life process*. And each ontological approach has a particular definition, and principles of, objective analysis: essentially a particular (ontological) interpretation on the nature of human life.

‘...a “fact” is not a “fact” until it is interpreted in the light of theory.’

Root-Bernstein 1993: xiv

Positivist, scientific, reductionism, assumes the primacy of individual experience, and *deduces* analytical conclusions from empirical evidence of human activity: whereas the holistic emphasis of paradigmatic, scientific conceptions, assumes the primacy of social experience, and *induces* theoretical conclusions from data of the *same life process*.

Objective conclusions reflect a *subjective* assessment of the relevant questions to be asked of human life.

Myths of human existence

A comprehension of human *life* is dependent on reconciling these ontologically discrete, *qualitatively distinct*, knowledges of experience and existence.

Historically, understandings of the dynamics and purposes of *human life* have been based upon myths. Beliefs in supernatural, biological or social forces and processes, beyond individuals’ control, which constrain human beings’ ambitions and intentions within elemental parameters.

For instance, the meaning of social life for people in Palaeolithic times (20,000-8,000 B.C.), in which human survival was a process of hunting and gathering, was conceptualized through legends, parables, symbols and rituals. 'Mythology was as essential to ... survival as the hunting weapons and skills that ... evolved in order to kill their prey and [people subjectively achieved] *a degree of control over their environment.*' (Armstrong 2005:13, emphasis added). And as people looked up into the sky and observed other active dimensions in existence, '...thunderbolts, eclipses, storms, sunsets, rainbows and meteors [etc...]....' (Armstrong 2005:19), and only through the worship of an imagined deity, could people subjectively assuage imminent catastrophe in such enigmatic dimensions of existence.

The social process of human life was understood mythically, and this obscure reality assumed a "sacred" importance. The spiritual dimension of individuals' existence was an essential category of *objective* existence. Humans are sensuous beings; individuals' lives reflect personal feelings which are structured by *social* experience.

Psychic, spiritual comfort, takes precedence over logic in human existence.

By means of beliefs about social existence, people create a sensation of security, a feeling that they mysteriously understand the future, and life has a degree of predictability. And when that feeling is a conviction of hallowed inviolability, then religion and ritual dominates human survival.

Myths draw upon experience, to make an otherwise unintelligible life, meaningful. Such collective knowledge permits the social organization of individuals' experience, for instance, through religious ritual. And the myths of

existence evolve with the social basis of human experience. In Neolithic times (8,000-4,000 B.C), when existence had become less hazardous with the emergence of farming and cultivation, agriculture assumed a sacred importance. The earth, the “womb” of life, was the basis for plant, animal and human existence. ‘The crop was an epiphany, a revelation of divine energy.’ (Armstrong 2005:44). And people asked of the gods, by means of ritual, that the contingency of existence be ameliorated. And “mother earth” became... ‘...a symbol of female heroism, in myths that ... [spoke] ultimately of balance and restored harmony.’ (Armstrong 2005:50).

Subsequently, with the emergence of cities, manufacturing and the built environment, technical ingenuity supplanted divine intervention. Supplication to a panoply of gods believed to be in the control of human existence was superseded by the conviction that the celestial superintendence of life was the resolve of one God. And the moderation of life by means of particular rituals was replaced by universal myths intended to address all humanity, as recorded in the Islamic Koran, the Christian Bible and the Jewish Torah.

The meaning of life remained an article of faith, manifested in a mystical and emotional appreciation of existence. With the emergence of the capitalist mode of production in Europe from the fifteenth century, effective power over social existence that had, in feudal times, been the prerogative of kings, nobles and cardinals, was assumed by merchants, industrialists and financiers. Human survival became subject to the exigencies of competitive commodity exchange, and well-being was associated with private investment, open markets, and the “enterprise” of capitalists. And the competitive dynamic

of social existence dissolved the myth of social permanence of feudal life (for instance, the “divine right of kings”) into the rivalries of personal ambition.

Human survival became contingent upon rational calculation rather than ritual supplication. Progress, development and human well-being were associated with idiosyncratic human qualities of talented individuals. And ‘...myths ... [became] narrowly racial, ethnic, denominational and egoistic ... [in] an attempt to exalt the *self* by demonising the other.’ (Armstrong 2005:142, emphasis added). Religion still plays a role in rationalizing why particular individuals have the good fortune (or bad luck) to be privileged (or disadvantaged), but the emphasis remains on *individuals*’ industry and prudence.

Contemporary myths of experience and legends of existence

‘In this majestic unfolding of life, all living organisms continually ... [respond] to environmental influences ... their interactions with one another and with the non-living environment ... [are] cognitive interactions. As their structures ... [of interaction increase] in complexity, so ... [do] their cognitive processes, eventually bringing forth conscious awareness, language and conceptual thought.’

Capra 2003:58

In contemporary times, within a reductionist, individualist, ontology of knowledge addressing individual experience, it is (mythically) assumed that personal choices and people’s’ behaviour *determines* social existence.

And within an holistic, social, ontology of knowledge addressing social existence, the legend is that the social parameters of existence limit individuals' preferences within functional limits.

So while positivist and paradigmatic scientific approaches *are* objective *within* certain ontological parameters (limiting the construction of human knowledge, respectively, to the spheres of *individual* experience and *social* existence), neither of these perspectives can objectively address *human* life.

To think beyond scientifically *describing* experience (positivism), or *explaining* existence (paradigms), to *understand* life, it is necessary to address the “cognitive processes” by which “living organisms continually respond to environmental influences”, highlighted by Fritjof Capra above.

We have to address humans as *sensuous beings*, who choose how to behave. And individuals, instinctively, intuitively, and constantly, reflect on (empirical) experience to explain (conceptual) existence, so as to understand an evolving life process and decide how to comport themselves.

But, scientifically, reductionist, empirical knowledge is qualitatively distinct from, holistic, conceptual knowledge: they are incommensurable. It is like adding together “seventeen academics” and “intelligence”: it can't be done. Empirical knowledge of experience and conceptual knowledge of existence can only be reconciled through *thought*. And the link is the *human mind*.

The mind is more than the brain: it is the *person*.

As sensuous beings, the content of thought is a process which reflects human experience as perceived by the senses: sight, hearing, touch, taste and smell.

And although the brain is a distinct human organ, neither the brain nor the body function independently: interdependently they *are* human existence. 'I must, being within myself, see myself through myself.' (José Martí, quoted Cardoso 1997:170).

'...mind and memory are not solely "in the brain" but are profoundly dependent on body states [sensations] ... mind and body cannot be separated.'

Rose 2003:7

But not only can the human mind and body not be separated, neither can individuals' experience from social existence.

To accommodate individual choice to social existence, human beings adopt beliefs about the nature of the abstract, social dimension of their existence. These intuitions about human nature plausibly explain existence, and allow people to choose their social activity. Historically these beliefs have been mythical. Individuals' conceptions about their social existence, through social interaction and the cultural institutions of society (education, media, the arts, etc...), coalesce into a "collective memory". And people are emotionally, even spiritually, integrated into social existence.

Collective memory is the integral, social connection, between a remembered past, an actual present, and an anticipated future. Remembered experience is not passed on genetically, and because self-conscious human beings have a memory, progress and development proceed more rapidly than biological evolution. Individuals learn from experience better ways to socially integrate

themselves into existence, building on the past to enhance and realize emergent human potentials, in the future.

People do not have to interminably “reinvent the wheel”. Learnt activity is culturally transmitted to succeeding generations. When novel human behaviour emerges in response to particular idiosyncratic experience or social frustrations, this behaviour can be intellectually (theoretically) articulated and shared. Memory and learnt behaviour essentially are consequences of *human consciousness* about the nature of social existence.

‘What ... distinguish[es] ... human from non-human memory is our social existence, and the technological facility which has created a world in which memories are transcribed onto papyrus, wax tablets, paper or electronic screens; that is a world of artificial memory. It is artificial memory which means that whereas all living species have a past, only humans have a *history*. Although the biological mechanisms of each humans’ individual memory may be the same as that of our fellow vertebrates, artificial memory is profoundly liberatory, transforming both what we need to and what we are able to remember.’

Rose 2003:387, emphasis added.

It is possible to anticipate the future not only because we know the past, but also because we have expectations and conceptions about individuals’ motivation in particular and of human nature in general. We have a social *consciousness*. Through reflecting on the experience of existence and with social organization, individuals’ anticipation assumes a social, creative

process, through which people build the social parameters of future experience.

But memory is more than a factual history of the events of social existence, '...a crucial determinant of what is remembered in real life ... *is the emotional content of an experience.*' (Rose 2003:330, emphasis added).

The praxis of existence

The emotional dimension of reality is the intuitive link which dialectically renders knowledges of individual experience and social existence commensurable. The dialectic is a property of the human mind, which '... explains nothing, proves nothing, predicts nothing, and causes nothing to happen.' (Ollman 1993:10), but makes life intelligible.

The emotional, creative process, in which the personal and social universes of individuals' lives are dialectically united into an understanding of human existence is *praxis*.

'Only men *are* praxis – the praxis which, as the reflection and action which truly transforms reality, is the source of knowledge and creation. Animal activity, which occurs without praxis, is not creative; man's transforming activity is.'

Freire 1972:73, emphasis in original.

When the essentially, human process of praxis, is articulated as collective memory, as a shared understanding of life, then people can begin to purposively create social relations of existence which presage a future in which individuals might be able to realize their emergent, human potentials.

In the realm of health provision:

– An individualist, ontological approach to health care emphasises the needs of patients, as expressed through the (market) demand for health provision.

This is not the case in Cuba.

– A social, ontological approach to health care emphasises the judgement and decisions of health professionals and politicians, as to the social environment people need to be healthy. This is not the case in Cuba.

– A human, ontological approach to health care includes people in the *process* of defining their own, social, priorities to lead a healthy life. This characterizes the Cuban approach.

The Cuban approach to the Human Immunodeficiency Virus [HIV]/ Acquired Immune Deficiency Syndrome [AIDS] pandemic.

An instance of policy to address *human* well-being is the reaction in Cuba to the (supposed) pandemic of HIV/AIDS.

Since the late 1960s the cultural emphasis in much of the world has been upon the primacy of individuals' experience. Politically, Conservative intellectual currents have supplanted post-Second World War Social Democratic priorities, and scientific reductionism has taken precedence over holistic concerns of social existence. And policy initiatives to HIV/AIDS have similarly reflected conservative intellectual currents. HIV/AIDS has been conceived as a "disease", not contingent on social parameters. There is not space here to address this issue, but, on the effect of such an approach see, Dr. Robert Root-Bernstein (1993), Dr Root-Bernstein is Professor of Physiology at Michigan Sate University, and asks: '...how could so many

scientists be so wrong? How could the vast amount of information concerning non-HIV immunosuppressive agents have been overlooked for so many years?' (Root-Bernstein 1993: 350).

In this individualist intellectual milieu, HIV prevention has been identified as the primary strategy to address AIDS, and has been closely associated with a concern for *individual* human rights. *Social*, public health measures, of quarantining infected individuals to protect the society at large, measures which have normally been applied when the transmission route of infectious medical conditions are unknown – for instance, in the Ebola fever outbreak in Zaire in 1976, the SARS gas attacks in South-east Asia in 2003, and the treatment of TB New York – have been eschewed.

'In the US, the rights of the individual are foremost, but in Cuba the individual is expected to do what is necessary to protect the collective society.' (Dr Byron Barksdale, quoted Fawthrop 2003). Cuba has based HIV prevention policy upon mass screening, contact tracing, medical surveillance, education, and the isolation of infected people. However, as knowledge of HIV transmission and the understanding of the onset of AIDS have improved, policy has evolved.

As far back as 1983, three years before the first reported incidence of HIV infection in Cuba, a National Commission was established to educate the Cuban population on the anticipated global pandemic.

Initially: all infected individuals were indefinitely quarantined in a sanatorium; sexual partners were traced and tested; all volunteer troops that had fought for the liberation of Angola were compulsorily tested, as were pregnant

women and blood donors; and anonymous testing was made available to the general public (and by 2002 there had been over 1 million such tests out of a population of 11 million).

Life in sanatoria for people diagnosed as HIV+, was/is very comfortable: patients, many of whom are poor or lack family support to live well, ‘...have a house, air conditioner, color TV, 100% of their salary and a diet very high in calories and rich in protein. No one else has so much.’ (Dr, Jorge Perez, head of the national HIV program and director of the Pedro Kouri Institute of Tropical Health, quoted d’Adesky 2003).

In 1989 the quarantine regulations were relaxed, although, for instance, in 2003, 48% of HIV+ people originally referred to a sanatorium preferred to remain there. In 1993 a system of ambulatory (out-patient) care was instituted [Sistema de Atención Ambulatoria]. The (17) sanatoria were integrated into a nationwide network of care centres, in which once diagnosed, patients spend at least three months for treatment and instruction on how to live with HIV, linked to an educational programme emphasizing that HIV is a medical condition for which the individual bears social responsibility. In the U.S.A. ‘... they may get about 5 minutes of education.’ (Dr Byron Barksdale, quoted Fawthrop 2003). And once the staff at the sanatorium are convinced that individuals are (sexually) socially responsible they are free to leave if they want to.

Both internationally and within Cuba there has been criticism of the quarantine strategy, as either being: contrary to (an individualist conception of) human rights; or some patients complain of being pressured to enter a sanatorium,

even being threatened with arrest by the police, and that there is ‘...a lack of privacy or consent for Cubans living with HIV ... [and] “You are seen as a threat to society by the authorities”...’ (d’Adesky 2003).

There is an ethical issue here. Is HIV/AIDS: a health problem with a human rights dimension; or, a social responsibility problem with health implications. Is the concern about “Individual Health or Population Health” as the January 2008 issue of *Student BMJ* summarizes the debate, or is it a political issue of “private versus public” health provision (see, *Student BMJ* 2008).

Essentially it is an ontological issue of the (intellectual and political) understanding of human life, and, what are the appropriate questions to ask of individuals’ social existence? Is the emphasis on individual freedom, or social responsibility?

And there are alternative ways of interpreting the evidence.

In 2005, 0.07% of the population of Cuba were reported as being HIV+, compared to 2.3% in the Caribbean region (and 6.1% in neighbouring Haiti) , and 9% in Sub-Saharan Africa (see, Krales 2005).

But do these statistics imply that...

‘Cuba is a shining example of the power of public health to transform the health of an entire country by a commitment to prevention and by careful management of its medical resources.’

Essif M, 2001.

or, that...

‘...life ... [in a sanatorium] ... is very controlled. It is all about illness.

People may get quality medical care, but they remain isolated ... There

is a lack of freedom here in Cuba, and when you have HIV it is that much harder.'

Cheo, an HIV patient, quoted d'Adesky 2003.

Knowledge & Progress

Cuban public health care is not merely the result of *policy* decisions which created a health *system*: neither are the medical achievements in people's well-being simply a product of a cultural *process* consequent on a health *strategy*.

"Policy" and "strategy", and, "system" and "process", are words which, respectively, *describe* and *explain* the intuitive dialectic of individuals', emotional, reconciliation of their personal experience (policy and system) to social existence (strategy and process): the dichotomy of human choice addressed in the discussion on "knowledge", above.

The dialectic of the human mind is an appreciation of *human life*: the reality of which is encapsulated in individuals' consciousness. A spiritual dimension which gives meaning to people's experience of existence: the intellectual parameters to human reality; the subjective expression of objective authenticity, and the (individual) appearance of the (social) essence of humanity.

There is no "policy", or model, of Cuban health care to be copied: just as there is no cultural "process" to be replicated. Both of these options offer a partial, one-sided, interpretation of human well-being.

But there is a *faith* in human beings from which we can learn.

In Céspedes Park in Santiago de Cuba, in the early hours of January 2nd 1959, just 24 hours after the victory of the military forces of the 26th July Movement, Fidel Castro addressed the people of Santiago de Cuba. Fidel's comprehensive account of the Revolutionary victory (Castro 1959) included, almost at the conclusion, the following passage:

'I have the greatest satisfaction in the knowledge that I *believed* so deeply in the people of Cuba, and having inspired my *compañeros* with this same *faith*. This faith is more than faith – it is *total confidence* in our people. This same faith that we have in you is the faith we hope that you will always have in us.'

Castro 1959: 131, emphasis added.

And after nearly 50 years of the Revolution, Fidel's intellectual resolve is resolute.

'We believe in man, in the human being, in the capacity to acquire an ethical understanding and a consciousness, and in the individual capacity to make great sacrifices...'

Castro 2006: 678, author's translation.

The building of such a capacity is a *political* task.

'I would like now to try to define the individual, the actor in this strange and moving drama of the building of socialism, in a dual existence as a unique being and as a member of society ... [The Revolution] is a matter of making the individual feel more complete, with more inner wealth and much more responsibility ... The revolution *is made through human beings*, but individuals must forge their revolutionary

spirit day by day.’

Guevara 1965: 216, 225 and 227, emphasis added.

Socialist development requires and generates in individuals a completely different type of social consciousness. Fundamentally the revolution is in the *human mind*: a revolutionary consciousness emerges as people intuitively understand their existence. Social consciousness is not *learnt*. Such an awareness is *acquired*, through individuals’ reflection on the experience and existence of human life. In this process education is the catalyst for the praxis of the human mind

And the role of political leadership is to create the ‘...necessary *subjective conditions* to carry out [socialist change]...’ (Guevara 1963: 172, emphasis added).

‘And if someone says we are just romantics, inveterate idealists, thinking the impossible, that the masses cannot be turned into almost perfect human beings, we will have to answer a thousand and one times: Yes, it can be done; we are right. The people as a whole can advance.

Guevara 1961, quoted Keeble 2001.

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