Confronting Colonial Legacies and Neoliberal Hegemony in Global Health and Development: Creative Cuban Social Medicine Adaptions from Venezuela to Timor-Leste

By
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A Thesis Submitted to Saint Mary's University, Halifax, Nova Scotia
in Partial Fulfillment of the Requirements for
the Degree of Doctorate of Global Development Studies.

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Land Acknowledgement

Saint Mary's University is built on the ancestral and unceded territory of the Mi'kmaq People. This territory is covered by the "Treaties of Peace and Friendship" which Mi'kmaq, Wolastoqiyik (Maliseet), and Passamaquoddy (Peskotomuhkati) Peoples first signed with the British crown in 1725. The treaties did not deal with surrender of lands and resources but in fact recognized Mi'kmaq, Wolastoqiyik, and Passamaquoddy titles as well as established the rules for what was to be an ongoing relationship between nations. Thus, we are all treaty people. More information regarding the treaty can be found online as well as at the Nova Scotia Archives in Halifax. <https://archives.novascotia.ca/mikmaq/results/?Search=AR5&SearchList1=all&TABLE2=on> *Importantly, research for this dissertation beyond Nova Scotia took place in areas of significant colonial legacies which is also important to acknowledge including the: lands of the Kaska Dena Kayeh, Dënéndeh, Sahtu Dene, Métis, Dehcho Dene, Shita Got'ine peoples (around Yellowknife); the Secwepemcúl'ecw (Secwépemc), ʔamakʔis (Ktunaxa), sngaytskstx tum-xula7xw (Sinixt), Syilx tmix^{w} peoples (throughout the interior region of British Colombia); the Taino and Guanahatabey peoples (in Cuba); the Taino, Carib peoples (throughout central and western Venezuela); and the Tetum, Mambi, Kemak Tukudede, Galoli and Baikeno peoples (throughout Timor-Leste). Note that this list is not exhaustive.*

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Abstract

Despite recent and significant declines in health outcomes and health services in Cuba as well as a retreat of Cuba's medical internationalist program, this dissertation argues that there is a potential wealth of lessons to be learned from Cuba's successes and challenges in both Timor-Leste and Venezuela, particularly throughout the 2003-2020 era. Cuba provides particularly important considerations, especially in its assistance to developing Venezuela's *Misión Barrio Adentro* (*MBA*) primary public health programme, that could help overcome fragmented Global North healthcare systems which struggle with the hospitalization of primary care to reimagine a truly patient-centred, team-based, proactive/preventive primary care and education system. Cuban efforts in Timor-Leste also have significant potential internationally in development efforts which could capacitate, through their creative medical education programmes, those in the Global South to meet their own health needs in an effort to buttress against future pandemics and global health challenges. In both examples, Cuba accomplished these feats with comparatively far less material and financial resources than Global North development efforts. However, Cuba's subaltern healthcare example has often been dismissed by many, either explicitly as part of a larger neoliberal geo-political project, or unconsciously, assumed by many to be too poor or undeveloped a country to learn from. As such, with the help of a political economy framework, this dissertation will evidence how health outcomes cannot be separated from power and inequality, nor can subaltern / oppressed voices reach those who would benefit from their knowledge in the current neoliberal hegemony.

November 2024

This dissertation is dedicated to my parents, Pat and Paul Walker. Without their support, this degree would not have been possible.

This dissertation is also in memory of my grandfather, Dr. William H. Walker, as well as the renowned academic, activist, and friend, Dr. Helen Hill. Both are dearly missed.

Importantly, this dissertation would not have been completed without the help and support of many colleagues, research contacts/participants, and friends from Canada, Cuba, Venezuela, Timor-Leste, and beyond who shared their journeys and were the inspiration for this project. You all have my deepest appreciation. Of particular note are Dr. John Kirk and Dr. Gavin Fridell for their supervision, guidance, patience, and sense of humor throughout it all.

List of Abbreviations Used

AIDS	Acquired Immunodeficiency Syndrome
ALBA	*Alianza Bolivariana para los Pueblos de Nuestra América*/Bolivarian Alliance for the Peoples of Our America
CAT	*Centros de Alta Tecnología* / High Technology Centres
CAWG	Canada Asian Working Group
CDI	*Centro de Diagnóstico Integral* / Integrated Diagnostic Centre
CENESEX	*Centro Nacional de Educación Sexual* / National Center for Sex Education
CIA	Central Intelligence Agency
CITGO	Citgo Petroleum Corporation
CMPP	Cuban Medical Professional Parole
CNIC	*Centro Nacional de Investigação Científica* / National Centre for Scientific Investigation
COPC	Community-Oriented Primary Care
COVID-19	Coronavirus Disease
CP	*Consultorios Médicos Populares* / House Clinics
CT scans	Computed Tomography Scanners
ELAM	*Escuela Latinoamericana de Medicina* / Latin American School of Medicine
ETAN	East Timor and Indonesia Action Network
EU	European Union
FEDECÁMARAS	*Federación de Cámaras y Asociaciones de Comercio y Producción de Venezuela* / Federation of Chambers of Commerce and Production of Venezuela
FRETILIN	*Frente Revolucionária de Timor-Leste Independente* / Revolutionary Front for an Independent East Timor
g7+	Group of Seven Plus / Group of Fragile State Countries
GAC	Global Affairs Canada
GDP	Gross Domestic Product
GDS	Global Development Studies
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
IDS	International Development Studies
ILO	International Labour Organization
IMF	International Monetary Fund
LASM	Latin American social medicine
MA	Master of Arts
MBA	*Misión Barrio Adentro*
MGI	*Medicina General Integral* / General Comprehensive Medicine
MGB	*Médico Geral Básico* / Basic General Doctors
MRI	Magnetic Resonance Imaging

NGO	Non-Governmental Organization
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PD	*Partido Democrático* / Democratic Party
PDVSA	*Petróleos de Venezuela, S.A.* / Petroleum of Venezuela
PKI	*Partai Komunis Indonesia* / Communist Party of Indonesia
PRADET	Psychosocial Recovery and Development in East Timor
PSD	*Partido Social Democrata* / Social Democratic Party
PSUV	*Partido Socialista Unido de Venezuela* / United Socialist Party of Venezuela
RACS	Royal Australasian College of Surgeons
SAP	Structural Adjustment Programme
SDOH	Social Determinants of Health
SRI	*Salas de Rehabilitación Integral* / Physiotherapy and Rehabilitation Centres
STBBI	Sexually Transmitted and Blood-Borne Infections
TB	Tuberculosis
TNI	*Tentara Nasional Indonesia* / Indonesian National Military
TPI	Transnational Pharmaceutical Industry
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Program
UNTAET	United Nations Transitional Administration in East Timor
UNTL	*Universidade Nacional Timor Lorosa'e* / National University of East Timor
US	United States
USAID	United States Agency for International Development
USD	United States Dollars
USSR	Union of Soviet Socialist Republics
WB	World Bank
WHO	World Health Organization
WTO	Word Trade Organization
WWII	World War Two

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Introduction: Charity or Dignity?

"Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution."
Rudolf Virchow (1821-1902) as quoted by Ashton in the Journal of Epidemiology and Community Health, 2006

"The International Conference on Primary Healthcare calls for urgent and effective national and international action to develop and implement primary healthcare throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order . . . The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary healthcare in accordance with the spirit and content of this Declaration."
Alma Ata Declaration, 1978

In 1978, the Alma Ata Declaration had the potential to initiate a new era to improve the global health landscape, especially for the most health equity-deserving populations and those affected by colonial legacies. The Declaration—which was supported by nearly all member states of the World Health Organization (WHO)—called for a united effort from governments, multinational agencies, and non-governmental organizations (NGOs) to make access to healthcare a priority, both domestically and internationally, as well as to narrow the disparity in health outcomes between nations and between populations within nations. Well before the rise of the social determinants of health (SDOH) in the early 2000s (R. Wilkinson & Marmot, 2003; Marmot, 2005; WHO, 2008a; Bryant et al., 2010),[1] the Declaration called for a broader

[1] The SDOH popularity expanded significantly in the early 2000s with Wilkinson and Marmot's 2003 book *The Social Determinants of Health*, as well as the 2008 Commission on the SDOH by the World Health Organization. As promoted by the Commission: "Traditionally, societies have looked to the health sector to deal with its concerns about health and disease." Although "maldistribution of healthcare" is "one of the social determinants of health," the greatest "burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age—conditions that together provide the freedom people need to live lives they value . . . Poor and unequal living conditions are, in their turn, the consequence of deeper structural conditions that together fashion the way societies are organized—poor social policies and programs, unfair economic arrangements, and bad politics. These 'structural drivers' operate within countries under the authority of governments, but also, increasingly

conception of healthcare, beyond conventional biomedical western approaches, and a greater focus on primary care (WHO, 1978).

However, the following decades, dominated by neoliberal approaches to healthcare and development, especially during the 'lost' decade of the 1980s, ensured that inequality in outcomes continued to grow (Bryant et al., 2010; C. Walker, 2015; Tavernise, 2016).[2] Moreover, the 7 million shortfall of healthcare workers predicted to happen by 2013 was projected by the WHO to increase to an estimated 18 million by 2030 (WHO, 2019). Not only are many countries in the Global North (many with long histories of colonialism and oppression of Indigenous populations) not training sufficient numbers of doctors for their domestic needs, but countries such as Canada, Australia, the United Kingdom (UK), and the United States (US) all benefit from the brain drain and active recruitment of health workers from the Global South[3]—

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over the last century and a half, between countries under the effects of globalization. This toxic combination of bad policies, economics, and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible. Daily living conditions, themselves the result of these structural drivers, together constitute the social determinants of health" (2008, p. 26).

[2] It is important to note the different typologies associated with neoliberalism as well as its ideological assumptions. These assumptions include: "the *Great Moderation*: the idea that the period beginning in 1985 was one of unparalleled macroeconomic stability; the *Efficient Markets Hypothesis*: the idea that the prices generated by financial markets represent the best possible estimate of the value of any investment; *Dynamic Stochastic General Equilibrium*: the idea that macroeconomic analysis should not concern itself with economic aggregates like trade balances or debt levels, but should be rigorously derived from microeconomic models of individual behavior; *Trickle-down economics*: the idea that policies that benefit the well-off will ultimately help everybody; and *Privatization*: the idea that any function now undertaken by government could be done better by private firms." When combined, these assumptions form a package under different typologies: "'Thatcherism' in the United Kingdom, 'Reaganism' in the United States, 'economic rationalism' in Australia, the 'Washington Consensus' in the developing world, and 'neoliberalism' in academic discussions"—which is the term that will be operationalized throughout this dissertation. While the majority of these are "pejorative, reflecting the fact that it is mostly critics of an ideological framework who feel the need to define it and analyze it," politically "dominant elites don't see themselves as acting ideologically and react with hostility when ideological labels are pinned on them. From the inside, ideology usually looks like common sense . . . If these ideas continue to influence policy, they will ensure a repetition of the" 2008 crisis. (Quiggin, 2010, p. 2-3)

[3] It is very important to note that "Global South" is not utilized in a geographically literal sense. This dissertation will utilize "Global South" in place of other terms such as "developing," "underdeveloped," "Lower Income Country (LIC)," and "Third World." Though all these terms have a number of issues, I felt this term—harkening to its attempt to wrestle with hegemonic geopolitical forces (including global capitalism and globalization) which often undermine the sovereignty and development of countries as well as grapple with other cultural and developmental considerations—was marginally better suited due to this dissertation's focus on the political economy of health and development as well as

contributing to poor health outcomes in the world's most vulnerable regions (Negin, 2008; Kelland, 2011; York, 2011; Huish, 2013; C. Walker, 2015).

Even before the 1978 Alma Ata Declaration and long before the SDOH, the concept of social medicine by Rudolf Virchow existed in the mid- to late 19th century (Porter, 2006; Brown & Birn, 2013).[4] This ideology advocated for biomedical practices aided by social science, where medicine 'has the obligation to point out problems and to attempt their theoretical solution,' with the help of the 'politician' and 'practical anthropologist,' who 'must find the means for their actual solution' (Ashton, 2006, p. 671). The ideological transfer of European social medicine from Virchow to his student Max Westenhöfer in the 1930s (who would become the director of the Department of Pathology at the University of Chile), and onto future Chilean president, Dr. Salvador Allende, assisted in establishing social medicine in the Latin American region in the 1930s (Castelló González et al., 2016, p. 4).[5] This helped initiate the ideological roots of Latin American social medicine (LASM) which began spreading throughout parts of Latin America in the 1950s and 1960s, attempting to fulfill the future goals outlined of Alma Ata long before the

subaltern knowledge production. Thus, as Sinah Theres Kloß notes: "The Global South is not an entity that exists per se but has to be understood as something that is created, imagined, invented, maintained, and recreated by the ever-changing and never fixed status positions of social actors and institutions. For the context of knowledge production in academic institutions, the idea of the Global South may be embraced as a process or practice through which new modes of knowledge production are created and learned and more balanced relationships in the global system of knowledge production are achieved" (2017, p. 1).

[4] As noted by David Low et al., the main suggestion by SDOH scholars that health goes beyond mere genetics and is measurably "influenced at a population level, social position and its attendant assets" (2005, p. 1136). Thus, it is an argument that has been evidenced for centuries (as per Louis-René Villermé, William Farr and others in the mid-1800s), if not millennia (as per Hippocrates in 460-377 BCE) (Routh, 1998; Brown & Birn, 2013).

[5] Réne Sand, a Professor of Social Medicine at Brussels University in 1945, was also pivotal in the expansion of social medicine on both sides of the Atlantic in the early 20th century. Believing in the sociopolitical aspect of healthcare, Sand assisted in the creation of social medicine departments and institutes in Peru and Brazil (Porter 2006).

official 1978 Declaration by the WHO was made (Tajer, 2003; Yamada, 2003; Briggs & Mantini-Briggs, 2009; Birn et al., 2017).[6]

After the disruption of left-leaning governments in Latin America by the US, particularly in the 1970s, few were left to comprehensively implement LASM.[7] The era of neoliberal development spearheaded by the World Bank (WB) and International Monetary Fund (IMF) (K. Sen & Koivusalo, 1998; Carrasco, 1999; C. Walker, 2015) increased privatization (Quiggin, 2010), expanded the influence of the Transnational Pharmaceutical Industry (TPI) (Tucker, 1996a; 1996c; 1997), prioritized curative-focused western conventional biomedical approaches to healthcare (Cooke et al., 2006), as well as contributing to the decline of social medicine approaches. Only one country in Latin America escaped the influence of neoliberal development, rampant privatization, and overwhelming US influence—Cuba.[8]

Employing significant political will to implement a 'health in all policies' approach (WHO, 2008b; Castell-Florit Serrate & Más-Bermejo, 2016),[9] Cuba had built a low-resourced

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[6] Anne-Emanuelle Birn et al. give a succinct general understanding of social medicine as a "realm of study, practice, and activism based on an understanding of health and disease as inherently rooted in social and political conditions" (2017, p. 818).

[7] The US approach to isolationism arguably began with the Monroe Doctrine in 1823. Without consent from Latin American nations, the US gave itself the right to intervene anywhere in the Western Hemisphere (Chomsky, 2003). Throughout the 20th century, the US enacted the Monroe Doctrine to dispose of many democratic or left-leaning leaders such as Chile's Salvador Allende and Guatemala's Jacobo Árbenz in place of often brutal and violent dictators such as Augusto Pinochet and Carlos Castillo Armas. In Cuba, the US backed the violent dictator Fulgencio Batista, who was responsible for the deaths of approximately 10,000 to 20,000 people, to be their puppet government whose sovereignty was conditional on Washington (Guzman, 2015).

[8] Since the geopolitical project against Cuba is primarily from the US, many healthcare comparisons, as well as evaluations of human rights and foreign policy objectives, will contrast Cuba with the US to highlight a number of contradictions and nuances. Additionally, in terms of the anti-imperialist tone of this dissertation, I will simply echo the reflections of fellow Canadian Thomas (Tommy) Douglas during the 1971 NDP National Convention in Ottawa, Ontario: "We [Canadians] are not anti-American. we do not dislike Americans though we abhor American imperialism in all its manifestations. But then, so do many Americans. Many of them have said that even more forthrightly than we have, and many of them have suffered more than any of us for their plain speaking" (April 21, 1971, NDP National Convention, Ottawa, Ontario).

[9] The "health in all policies approach" is based on the "recognition that population health can be improved through policies that are mainly controlled by sectors other than health" (WHO, 2008b, p. 64).

yet robust domestic healthcare system as well as a globally respected medical international program based upon LASM (J. Kirk, 2015). Cuba was able to do this by utilizing its limited resources to focus on primary healthcare, as well as apply broader 'biological-psychological-social' (bio-psycho-social) approaches to health delivery at all levels far more comprehensively than most Global North countries (C. Perez, 2008; C. Walker, 2015).[10] As such, Cuba not only met all the United Nations (UN) millennium development goals (MDGs) but was also one of the only countries in the world that was on target to meet all the sustainable development goals (SDGs) well before the 2030 deadline (E. Kirk & C. Walker, 2020). Thus, Cuba continued to effectively pursue the best practices of the WHO and Alma Ata, nationally and internationally, yet began 18 years before the 1978 Declaration. Hence, their bio-psycho-social LASM approach to comprehensive healthcare prioritized the SDOH long before they became a serious consideration in the Global North.

Additionally, while Cuba has effectively met most of the MDGs and SDGs domestically (E. Kirk & C. Walker, 2020), it also helps deliver healthcare internationally. Cuba’s medical internationalism involves nurses, medical assistants, doctors, surgeons, technicians, social workers, pharmacists as well as a host of other specialists and workers in the medical field. As of

[10] The bio-psycho-social spheres of health are an important aspect of this dissertation. They encompass many aspects of the SDOH long before those were established. The bio-psycho-social spheres of health form a key part of Cuba's LASM approach to healthcare from its revolutionary beginnings in the 1960s. Christina Perez explains that the biological, psychological and social role of the doctor entails "addressing multiple dimensions of human life. When doctors ask what has caused disease in a particular patient they evaluate the microscopic physical level. They also look at how individual behaviour may impact disease. Then, the Cubans examine how material conditions shape and/ or restrict particular decisions and actions. They also consider how culture impacts decision-making and how cultural practices emerge out of particular historical, political, and economic moments. Key also are mind/body connections, which are viewed as multiple and dialectical . . . Within the Cuban understanding of the bio-psycho-social paradigm, the materialist dimension is emphasized. Cuba's bio-psycho-social approach centres minds and bodies in particular social, economic, and physical environments. The bio-psycho-social paradigm is the key reason why Cuba has been able to transform the bodies of the population from bodies of deprivation to bodies of affluence even in the midst of extraordinary financial crisis and growing economic stratification" (2008, p. 269).

2021, more than 400,000 Cuban healthcare workers had "served in 164 countries" (Saney, 2021).[11] As of 2020, 28,000 Cuban personnel were providing healthcare in 59 countries (Augustin, 2020). Cuba had also trained approximately "30,878 doctors from 122 countries [in addition to] more than 250 young people from the United States" (Cuba's Representative Office Abroad, 2024)—primarily at *Escuela Latinoamericana de Medicina*/Latina American School of Medicine (*ELAM*)—throughout its 60 plus years of medical internationalism (Granma, 2018; 2024; Reed, 2020).[12] Yet, their significant example often remains confined to the 'subaltern' realm.[13]

Even during the COVID-19 pandemic, while Global North countries hoarded vaccines as well as enacted Word Trade Organization (WTO) Trade-Related Aspects of Intellectual Property Rights (TRIPS) patents on important healthcare resources and technology to the detriment of Global South countries, Cuba added approximately 4,000 healthcare workers to help in 40 countries (including Global North countries such as Spain and Andorra as well as offering to help Indigenous populations in Canada) (Durkin, 2020; Fridell & Higgins, 2020; Kimber, 2021; Saney, 2021; Wilkins, 2021). Moreover, Cuba had developed five COVID-19 vaccines at their

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[11] However, after the COVID-19 pandemic, a further tightening of the US embargo, and other domestic challenges, Cuba has had to reduce many of their medical internationalist missions as they lack resources despite the pressing medical needs of vulnerable populations in those countries. There are currently approximately 24,000 medical personnel working in 50 countries.

[12] Margaret Chan, the Director-General of the WHO from 2006-2017, explains one of the most significant aspects of *ELAM*: "I know of no other medical school that offers students so much, at no charge. I know of no other medical school with an admissions policy that gives first priority to candidates who come from poor communities and know, first-hand, what it means to live without access to essential medical care. For once, if you are poor, female, or from an indigenous population you have a distinct advantage. This is an institutional ethic that makes this medical school unique" (Chan, 2009).

[13] Antonio Gramsci utilizes 'subaltern' to refer to oppressed classes (Gramsci, 1971, p. 202-207).

publicly funded institution (BioCubaFarma) for global use, including two which entered stage three trials in April 2021 (Democracy Now!, 2021; Saney, 2021).

Despite recent and significant declines in health outcomes and health services in Cuba, as well as a retreat of Cuba's medical internationalist program, this dissertation argues that there is a potential wealth of lessons to be learned from Cuba's successes and challenges, particularly throughout the 2003-2020 era. Cuba provides particularly important considerations that could help overcome fragmented Global North healthcare systems which struggle with the hospitalization of primary care to reimagine a truly patient-centred, team-based, proactive/preventive primary care and education system. Their example also has significant potential internationally in development efforts which could capacitate those in the Global South to meet their own health needs in an effort to buttress against future pandemics and global health challenges. However, Cuba's subaltern healthcare example has often been dismissed by many, either explicitly as part of a larger neoliberal geo-political project, or unconsciously, assumed by many to be too poor or undeveloped a country to learn from.

The motivation for this dissertation comes from many different sources: the significance of Cuba's subaltern example; the poor, rural, and marginalized populations deserving of dignity not charity;[14] the determination of Canadian medical colleagues who have struggled to provide help for those in need while neoliberal systems and political will fail them and their patients

[14] I tend to agree with Paul Farmer's assessment of charity, development, and social justice. As he highlights, "[e]ach of these might have much to recommend it, but it is my belief that the first two approaches are deeply flawed. Those who believe that charity is the answer to the world's problems often have a tendency—sometimes striking, sometimes subtle, and surely lurking in all of us—to regard those needing charity as intrinsically inferior. This is different from regarding the poor as powerless or impoverished because of historical processes and events (slavery, say, or unjust economic policies propped up by powerful parties)" (Farmer, 2005, p. 153-154).

(especially relevant during the COVID-19 crises); as well as my passion for researching the political economy of healthcare.

Journey

Interest in this dissertation began with my upbringing in a family of rural healthcare workers. My mother is a retired registered nurse and my father is a retired family doctor. The significance of rural-urban healthcare disparities was an important challenge in the Kootenay area where I was raised. Though this disparity continues, I began to realize it was not as desperate as many other rural areas of Canada, some of which have limited to nearly no access to effective public healthcare services in their communities. Thus, interest in medical accessibility for Indigenous, marginalized, and impoverished communities developed over the following years as I worked in several Western Canadian communities.

My academic journey on this topic began with my honours thesis which looked at rural healthcare disparity and the 'Cuban paradox' (C. Walker, 2011). The thesis discussed how Cuba challenges the assumption of being an "underdeveloped" nation yet had a "developed nation's" health indicators for all populations, even those geographically remote. This Cuban paradox challenged the neoliberal development hypothesis, strongly promoted by neoliberal knowledge- and policy-producing institutions such as the WB and IMF, on the need for economic development *before* social development can be initiated.[15] Cuba's example strongly contests the

[15] It is important to situate the type of knowledge being produced by powerful institutions such as the WB and IMF. The ideology guiding their knowledge- and policy-production have dogmatically remained a representation of Western neoliberal economics favoring the perspective of "development economists" over other development professionals (Stone, 2003). By stating that they are neoliberal knowledge- and policy-producing institutions, the reader can hopefully

neoliberal hypothesis that healthcare funding should only be pursued after achieving high GDP growth.[16]

However, key questions arose after this thesis. Is the Cuban healthcare example '*sui generis*' (so unique that it is beyond replication)? Or is the Cuban example adaptable in other countries? Additionally, can a Cuban social model of healthcare take root in a 'democratic' country that still is in contestation with embedded elites in control of the media, commerce, land etc.?[17]

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disembed the assumption that the knowledge and influence of these institutions is apolitical. Thus, their narrow ideological allegiance to neoliberalism helps contextualize the narrow range of solutions these institutions conceptualize to very complex problems in international development and global health. In this way, the reader is able to identify the institutions as well as their ideological leanings since, as this dissertation evidences, their influence is largely to the benefit of some, often the most powerful and wealthy in the Global North, and to the detriment of others, often the rural and poor in the Global South (Stiglitz, 2003). These institutions produce economic knowledge which often biases US and Western European approaches to development (despite histories of colonialism, neocolonialism, and slavery) that is ahistorical and lacking deeper geopolitical power imbalances as well as political economy critiques (Komisar, 2000). Neoliberalism has always struggled with issues of agency. Problematically, neoclassical economics, "with its assumption of atomistic individuals exercising rational choice" also continues "as if this sphere is the only sphere. In reality the sphere in which this applies is quite circumscribed. Complexity is by far the more common condition, north and south" (Pieterse, 2010, p. 160). Therefore, solutions from neoliberal knowledge- and policy-producing institutions often overlook important issues of structural violence—including low health outcomes for the most rural, poor, and marginalized populations—who often lack agency the most.

[16] 2017 appears to be the first time a World Bank development report (*Governance and the Law*) admitted it was wrong to peruse its unproven hypothesis on the need to prioritize GDP growth in order to obtain development. Among other interesting shifts in this report was that it finally considered a development approach based upon more than mere economic ideology, now considering questions of power and culture. The inclusion of Max Weber and other scholars is considered a positive turn by development scholars who have long dismissed the WB's dogmatic neoliberal ideology. There is a possibility that the WB may also look at deeper considerations such as structural violence which may also have a profound impact on how it collects data as well as its approaches to future development initiatives. Though mainstream economics has long struggled with notions of agency, it appears that this academic nuance may help bring much needed legitimacy to the WB on the topic of international development after decades of disrepute.

[17] Cuba's distinct nature of political participation has been noted and debated by numerous philosophers, scholars, academics, and political writers with no concise consensus drawn from among them. The list of conclusions about the political participation of Cuba ranges from a "mobilizational authoritarianism" (see Domínguez, 1998; Pérez-Stable, 1999); to a "dictatorship" (see Horowitz, 2000); or "totalitarian state" (see Bolton, 2002; Thompson, 2002). Others believe Cuba to be a "revolutionary democracy" (see Fidel Castro's many speeches and publications as well as Patricia Olney's chapter in Mauricio Font's 'Cuba Today' titled *Cuba Through Mexico's Mirror*, 2004); or a "centralized democracy" (see the Cuban Communist Parties declaration of a centralized democracy immediately after the at 1959 revolution); or having aspects of a "grassroots democracy" (see Dilla Alfonso & González Núñes, 1997); or even elements of a "direct democracy" (see Greenwood & Lambie, 1999, as well as Hernández & Dilla, 1991). I am inclined to agree with Antoni Kapcia (2008) who states that any attempt to either justify or articulate Cuba's political system and political participation is highly problematic given its complex history and ability to defy almost any theoretical framework. Hence, a full

Venezuela's Medical Revolution: Can the Cuban Medical Model be Applied in Other Countries?

To explore these questions my MA research project (C. Walker, 2013) as well as its adaptation into a book, *Venezuela's Healthcare Revolution* (C. Walker, 2015), explored Cuba's healthcare assistance for Venezuela's public healthcare system. Called *Misión Barrio Adentro* (*MBA*)/Mission Inside the Neighbourhood (English translation), this public healthcare system initiated by the late Hugo Chávez in 2003 targeted the most rural, poor, and marginalized populations by training these populations to become their own healthcare providers. I chose Venezuela because it provided a unique opportunity to analyze the potential successes and challenges of implementing Cuban revolutionary medicine in a country that did not have the complete breakdown of its old social order that Cuba had.[18]

Venezuela had the largest medical cooperation agreement with Cuba. When the Cuban medical adaptation was broken down from its *sui generis* whole into its core elements and adapted to a Venezuelan context, it offered interesting findings that could potentially inform domestic healthcare, medical and educational institutions, as well as policies (especially those targeted at improving capacity in rural, poor, and marginalized areas). As of 2021, approximately 1,700,000 lives had been saved by *MBA*, and 30,000 community physicians (of whom more than

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discussion of Cuban governance is beyond the scope of this dissertation as it remains hard to place a label that encompasses the complex political nature and history of Cuba while weeding through the political agendas on both sides of these debates.

[18] The debate over the health of Venezuela's democracy is complex and deserving of a lot of scrutiny yet is also beyond the scope of this dissertation. The Chavistas hail the democratic processes in Venezuela as one of the best in the world while the opposition in Venezuela refer to the Maduro-led Chavista government as a dictatorship. Many cite the appointment by Maduro of Supreme Court judges as undemocratic (Vyas & Kurmanaev, 2015). Yet these appointments seem in line with partisan Supreme Court appointments in the US (The Economist, 2018) as well as (until recently) the history of partisan Senate appointments in Canada (Fine, 2017). All of which seem problematic due to their comparatively undemocratic nature.

14,000 graduates are specialists in comprehensive general medicine) had been trained through the Cuban-supported medical education program which was a part of Chávez's broader public education initiative called *Misión Sucre* (Ortega, 2021).

The original research for my MA thesis (as well as the following study for this doctoral dissertation) mainly took place in the capital, Caracas, as well as in the rural and relatively impoverished (compared to other Venezuelan regions) Torres health district with its main centre being town of Carora. Carora, located in the state of Lara, was a focus in Venezuela due to many similar rural and poor health challenges in Canada, especially rural, marginalized, impoverished, northern, and Indigenous communities. These include high rates of traffic accidents, diabetes, sexually transmitted and blood borne infections (STBBI), as well as limited access to healthy food and other issues of structural violence.[19] Once this research project was finished, however, other questions arose.

Since, during the time of my MA, Venezuela was still doing relatively well—due in large part to wealth garnered by high oil prices at the time—I was curious to analyze other nuances regarding the adaptability of Cuba's development approaches. The Cuban coordinated team-based approach (especially at first contact primary care centres) to decentralizing health services and education represented significant points of contrast from other conventional healthcare approaches. However, due to the limited presence of NGOs and western development/aid industry in both Cuba and Venezuela, I was unable to make important comparisons between

[19] Structural violence is a term most often attributed to Johan Galtung in his 1969 article *Violence, Peace and Peace Research*. Structural violence analyzes how certain social institutions or structures may cause a form of violence since they can become harmful if they prevent people from attaining their basic needs. This important concept will be featured, along with Paul Farmer's conceptualization of medical structural violence (Farmer, 2005; Farmer et al., 2006), throughout this dissertation and detailed extensively in the following chapter on the political economy of health and development.

Cuba's approach to healthcare cooperation based on dignity and the Global North's neoliberal development model based on charity.[20]

Thus, I became increasingly interested in whether or not Cuba's revolutionary social medicine could take root in a country with major limitations in resources, infrastructure, economic output, and social capital. Additionally, could it take root in a comparatively culturally different environment (since Cuba and Venezuela are quite similar due to a shared language, history of Spanish colonialism, geopolitical influence of the US/impact of the Monroe Doctrine, love of baseball etc.)? I also wanted to follow my 2013 MA research findings in Venezuela, where a period of change—initiated by the collapse of oil prices and Chávez's death—had started.

These significant changes continued to accelerate as I began my doctoral research during the new era of Chavista leadership by Chávez's successor, Nicolás Maduro. Sustained low oil prices on the oil-dependant nation, increased scarcity of goods, and rising inflation changed the research landscape and findings considerably when I returned in 2015-2016. The manifest opposition of the Trump administration to Venezuela also added enormous pressure to the governance structure. Another key research question I was eager to follow up on was the impact of brain drain on *Misión Barrio Adentro* and *Misión Sucre* medical graduates—both domestically from public care to private clinics as well as internationally from Venezuela to other countries.

[20] It should be noted that many in the development industry are doing their best with the best of intentions. Many in the development and aid industry do great work and provide important care and help to many in the Global South. However, as noted by the critiques of Mark Duffield, Arundhati Roy, Jan Nederveen Pieterse, Michael Woost, and others, the empathy of these workers is often captured by the industry in a way that feeds an ahistorical and apoilitical neoliberal narrative while also having limited success or effective long-term outcomes (Woost, 1997; Duffield, 2007; 2010; Pieterse, 2010; Roy, 2014). This 'empathic capture' will be discussed further in the following chapters, especially in the section on psychoanalysis.

Lastly, I was curious about how the Venezuelan agreement and outcomes contrast with Timor-Leste, given Cuba's key role in the public healthcare system there. Thus, the operationalization of Cuban healthcare cooperation being adaptable to different contexts, scales, geographies, and cultures became a central question which began to uncover the deeper geopolitical and for-profit pressures on such an endeavour. It was at this point in my academic journey that it became very clear: power, inequity and health outcomes cannot be separated.

After writing an article on Cuban cooperation in the South Pacific (C. Walker & J. Kirk, 2013), Timor-Leste became a natural next step in the process of addressing these questions since almost its entire public primary healthcare system was being constructed with the help of Cuba using Cuban LASM approaches to healthcare. Timor-Leste was one of the poorest countries in the Oceanic/Southeast Asian region at the time. It was clearly more culturally different from Cuba than Venezuela with different national languages (Tetum and Portuguese). It was colonized by Portugal, not Spain, and was not as directly impacted by US foreign policy/the Monroe Doctrine as Venezuela was.

Due to the high presence of NGOs and the development/aid industry, which had significantly less impact in Venezuela and Cuba, there was a wealth of interesting lessons for international development. Thus, the high degree of foreign aid as well as the UN state-building experiment that followed Timor-Leste's 25-year Indonesian genocide, also made for an important contrast between the role of western neoliberal development as charity and that of Cuban cooperation as dignity. This was the start of what would become my doctoral research project.

"But what possibly could a Canadian researcher learn about healthcare from such a poor country? Doesn't Canada have one of the best health systems in the world?"

These were questions I faced from many respondents and interested strangers when I would explain my research program. It was not only a challenge to explain the Canadian-specific health issues and significant medical disparities in outcomes and access between populations (Cameron et al., 2014; Khan et al., 2015; Martin et al., 2018; de Souza et al., 2018; Kimse, 2018), but also to highlight how there might be potential, low-cost yet effective, examples found in the Cuba's approaches to overcome these challenges.[21] The embedded assumption by many was that there is little that 'rich' Canada could learn from 'poor' Cuba. This led to an additional set of research questions embodied in this critical study. The attempt to dislodge this assumption in addition to a variety of challenges—untangling narratives (both conscious and unconscious) which oversimplify complex systems and international medical agreements; distilling and documenting the complexity, similarities, and differences of the Cuban subaltern example; offering a context-specific analysis that can add to debates on team-based, patient-centred, bio-psycho-social health; creating robust healthcare systems for health-equity deserving populations;

[21] In the article by Mushira Khan et al., they highlight that, though there are disparities between populations, the Canadian health system does a poor job of tracking these disparities ultimately concluding that there is a "major gap in health data and research on visible minorities in Canada" (2015, p. 2). Nick Kirmse (2018) summarizes a McMaster University research team's findings by lead author Russel de Souza which documented geographic disparities in Canada: "We believe that this information shows there are factors outside of a person's control that influence the individual's health, and these factors likely differ depending on where they live." A few key findings include: "Access to public transportation; The variety of fresh fruits and vegetables in stores; The prices of popular foods; The availability and prices of cigarettes and alcohol; Advertising, or lack thereof, of healthy foods in restaurants" (de Souza et al., 2018, p. 123). As co-contributor Sonia Anand notes, "[p]lace matters as our environment affects our health behaviours without our realizing it" (Kirmse, 2018). Cuba's example strongly contests the neoliberal hypothesis that people are solely responsible for their economic and health outcomes.

shifting development and healthcare as charity towards development and healthcare as dignity—have all motivated this research project.

"Ahhhh, so you are a communist!" Or: "You are just one of those Marxists who would make everyone poor." For a few interactions, these were some of the responses to my research project. Though fewer in number than other interactions, these debates eventually led to attempts to add context and complexity to oversimplified dichotomies. One prominent assumption was that the 'capitalist' US is a free market country with little government interference. However, beyond the bailout of many of its major banks with public tax dollars during the 2008 financial crisis (ProPublica, 2018), the US also uses public money to subsidize many of its industries and corporations, including Boeing, Intel, Alcoa, General Motors, and Ford Motor (Delpeuch et al., 2014; Chokshi, 2015; Sumner, 2016; Amadeo, 2018). It also provides other public services such as a basic right to healthcare and social security (Amadeo, 2018).[22]

Another important point to add is that inequality (a significantly greater factor when free-market capitalism is the dominant force of policy development) counter-intuitively increases the need for big government as can be seen in the provision of more prisons and police as well as increased social and health services. For the US, this problematic context means that "high levels of inequality create the problems" that public services struggle to grapple with, including some neoliberal governments that "spend more on prisons than on higher education" (R. Wilkinson &

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[22] With the significant amount of public tax dollars used to support the major banks that were complicit in the 2008 financial crash (Financial Crisis Inquiry Commission, 2010; Quiggin, 2010), the corporations which are unable to perform competitively on the global market, the arms manufacturers, and the oil industry, as well as tax dollars for foreign wars; the backlash by many in the US over Obamacare's use of tax dollars to increase public health access remains an interesting contrast. Thus, the hypothesis that healthcare outcomes and access is political, often responding to power instead of need, has opened other areas of consideration beyond the scope of this dissertation, many of them regarding ethical use of public tax dollars for public good.

Pickett, 2010, p. 294-295). Thus, as noted by R. Wilkinson and Pickett, "one of the best and most humane ways of achieving small government is by reducing inequality" (ibid., p. 295), despite the narrative of 'free-market' economics emerging from hegemonic neoliberal knowledge- and policy-producing centres like London, New York, and Washington (Peet, 2015).[23]

On the other side of this assumption was that 'communist' Cuba had no private enterprise. Yet, to some people's surprise, there had been a significant expansion of private business in healthcare (Font & Jancsics, 2015; Campbell, 2016). Most surprising for some people was finding out that even aspects of Cuba's healthcare system are private.[24] For most countries, every system has a mix of public and private healthcare.[25] To generalize, the US leans strongly on the privatized side of the health system spectrum and Cuba leans much closer to the public side. But, even given their two extremes, both systems have similarities.

Debunking these loaded, (often) emotive-based dichotomic terms led to possibly the most laborious conversations I encountered, especially in Venezuela where I was constantly asked: "Are you Chavista or opposition?" In a world of dichotomies—communist versus capitalist, left versus right, Republican versus Democrat, Chavista versus opposition etc.—the victim of these over-simplifications is frequently healthy debate, important nuance, beneficial knowledge

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[23] As Quiggin evidences: "Among the developed countries, the United States has the lowest social mobility on nearly all measures, and the European social democracies the highest" (2010, p. 160). Hence, as comedian George Carlin once observed, "The reason they call it the American Dream [regarding US social mobility,] is because you have to be asleep to believe it" (Carlin as cited by Urbisci, 2005).
[24] Medical tourism, for example, and the sale of sophisticated biotechnology and pharmaceutical products, help to support the public healthcare system. Additionally, the provision of international healthcare services is the major source of hard currency for the Cuban government, bringing in approximately twice the funds generated by tourism.
[25] This is mentioned by Phil Deans in Richard Stubbs' 2009 article as a "blurring of the public-private distinction" (p. 6) as well as in Pieterse's (2010) book where "the boundaries between political and non-political, public and private spheres have become increasingly fluid" (p. 199).

production based upon context-specific examples, as well as decreasing 'relational space'.[26] The era of social media 'echo chambers' (where debates between opposing views are commonly vetted prior to personal interaction) combined with a mainstream media more concerned with soundbites, differences, exacerbating conflict, and 'clickbait' rather than facts or giving space to important debates, has created a vacuum of healthy engagement with the Other almost as powerful as the era of Cold War propaganda.[27]

Conflict sells and the small differences of opinion that divide are given greatest focus while nuance, complexity and exploring similarities seems to be overlooked in many interactions and media representations.[28] "You are either with us or against us" of the Cold War and Bush era has transitioned into "You believe in these topics, or we can't talk or be associated with each

[26] For the use of this thesis relational space will be operationalized to denote a 'space' that overcomes exclusion, closing the distance with the 'Other'. It is space that people can meet and connect with the Other in a way that transcends socio-economic status, geographies, race, religion, age etc. This concept will be explored at length in the Theoretical Framework chapter.

[27] This is reflective of other such binaries or dichotomies such as "indigenous/foreign; dark/light; traditional/modernity . . . masculine/feminine . . . national independence/foreign intervention; world market/US market" and highlights the importance of interrogating these binary contrasts or what "Abdul R. JanMohamed has called the 'Manichean allegory'." As Sean Brotherton notes, "Manicheanism makes use of neatly bounded discursive oppositions that polarize conceptions, for example, 'colonized' versus 'colonizer' or, in the case of contemporary Cuba, the presumed oppositions implied by the demarcation of pre- and post-revolutionary eras or the existence of different forms of capital, whether centralized or dispersed. To uncritically apply such binary contrasts, JanMohamed (1985) suggests, elides nuanced understandings of the implicit complexities involved in these relations; it reduces their plural, multifaceted, and multivocal aspects to a unidirectional movement, expressed as a linear view of history, and, ultimately, to singularity" (Brotherton, 2008, p. 268).

[28] Even academia suffers from oversimplified binaries and erasures of complexity due to, in large part, significant logical fallacies such as slippery slope (or others such as the fallacy of composition and division/incomplete comparison/appeal to emotion/false cause fallacies). For example: public healthcare equals Marxism, which equals communism, which equals totalitarianism, which equals repression of rights etc. As noted by Brown and Birn in their 2014 response to one such critique of their 2013 book: "It is one thing for [Chris] Beyrer [professor of epidemiology at the Johns Hopkins Bloomberg School of Public Health] to disagree personally with the politics of the individuals included in this book; it is another entirely to disregard the clear and challenging contrast they present to dominant approaches to addressing health inequities between and within nations" (2014, p. 1262). Their book is not, as Beyrer states in his review (2014), an "attempt to delineate a tradition in US international health efforts as part of a Marxist tradition writ large" whereby the authors are "are apologists for Stalin, Mao, etc." (Brown & Birn, 2014, p. 1262). Despite this emotive Cold War logic and over-simplified fallacy, Brown and Birn's 2013 book is actually "a set of accounts of individuals who consider/considered themselves to be one variety or another of progressives or radicals or leftists (but not necessarily Marxist)" who often "raise questions about those regimes and note that some of the subjects of [their] book may have overlooked the horrors under those regimes" (ibid.).

other" of the social media cancel-culture era.[29] Relational distance between people based upon differences of opinion seems to be expanding under the era of social media, online echo chambers (where people only surround themselves with others that reflect their opinions), as well as the desire for mainstream media to draw people in with controversy—pinning one group of people against the other.[30] Though the Other is no longer confined to the political project of nation states and the Cold War to evoke the constant threat of 'barbarians at the border' in order to maintain power, the Other is constructed to invoke fear and division instead of curiosity and a compassionate exploration of shared experience as well as what connects each other.[31]

Though these conversations can be challenging at times, they continued to provide important reflection throughout my MA and into my doctoral research. I wanted to test the hypothesis that there might be aspects of the Cuban healthcare system, when broken down into its core elements, that could be creatively adapted in both Global North and Global South contexts. Not only could it potentially evidence an alternative to neoliberal assumptions, in a similar way that David McNally highlights in his 2006 book *Another World Is Possible*, but it

[29] This is well summarized by Obaid Omer's experience upon his return to Canada after an overseas stint as a translator: "I left a culture that was steeped in a sentiment that could be summed up as, 'I may disagree with what you say, but I will respect your right to say it.' I returned to a culture summarized by, 'I disagree with what you say, so shut up'" (2021).
[30] This echo-chambering has been exacerbated by social media algorithms set to divide people (also known as algorithmic amplification) (Del Vicario et al., 2016; NPR Staff, 2016; Sadagopan, 2019). One of the best contemporary cases regards Facebook (now Meta), where, even though there was internal discomfort by employees regarding the social media giant's use of algorithms that place people against each other, in an effort to mine divisiveness for profit, the executives of the company squashed the dissent (Sonnemaker, 2020). In a 2020 study by Matteo Cinelli et al., Twitter's (now X) algorithms were found to be similarly divisive as Facebook's.
[31] As explored in psychology literature on the rise of hostility towards people with moderate or complex views on a range of topics, especially notable during increasing activist activity by leftist groups and pressure to take sides or cancel people for their comments or actions, the lack of relational space for healthy debate and discussion is potentially assisted by an understanding of 'psychological splitting'. As noted by J. Reid Meloy regarding the "centrality of binary oppositions," psychological splitting as a defensive response in adults potentially resulting from a "psychopathological outcome of the normative infant and childhood need to separate objects and pleasure/displeasure feeling states . . . The predominance of splitting in adulthood is signaled by the tendency, if not conviction, to view the world in stark black and white terms, to simplify reality, to eliminate the gray zones, to perceive the self and others as part objects, and a gross failure to empathize with, or understand the inner lives of others—a failure to mentalize" (2018, p. 76).

may also help bring to light what Noam Chomsky considers the "threat of a good example" (1992, p. 22-24; 1995, p. 104; Birn & Muntaner, 2019, p. 825-827).

The threat of this potential Cuban example may help understand why a small country has had to face such obvious challenges posed by an oft-hostile Global North media as well as geopolitical and economic challenges from the US government. As noted by Mark Duffield's 'paradox of liberalism', these challenges frequently appear hypocritical given US (and other neocolonial powers such as the UK and France), as well as extractive industry neocolonial (including Canada and Australia) relations with other countries that have significant human rights abuses.[32] Canada's extractive industry is an incredibly problematic geopolitical actor in this regard as "50– 70% of Latin American mining activity involves Canadian companies, with significant health injustice consequences" (Birn et al., 2018, p. 786).[33] Additionally, many Global North counties cultivate close ties with other communist countries such as Vietnam as well as have communist China as their largest trading partner.[34]

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[32] "Paradox of liberalism" is a critique of neoliberalism by Duffield that highlights a country's "ability to invoke freedom and rights while at the same time accepting the necessity of despotism" (2007, p. 129).

[33] The disparaging results of Canadian mining are detailed in work by Anne-Emanuelle Birn et al. (2018, p. 787): "Canadian-owned Marlin Mine in Guatemala has been linked to various environmental damages, water scarcity (the mine uses 45,000 L of water per hour), forced dispossession, heavy metal poisoning, and increased poverty and food insecurity in nearby Mayan communities . . . Between 2006 and 2009, local communities received just 1.4% of the mine's total earnings (less than US$4.5 million, while Goldcorp pocketed $269.3 million in net earnings) . . . In Colombia, the activities of Canada's Pacific Coal Resources Ltd. contributed to water scarcity and respiratory disease, dizziness, and abdominal pain in community members . . . Additionally, many people have been forcibly displaced by environmental destruction and water and soil contamination."

[34] The reasoning for continued political pressures as well as the embargo against Cuba raises several challenging questions for the US (US Department of the Treasury, 2019). The unique hypocrisy behind the disproportionate attention give to Cuba by the US could include the following: Why is the US able to have close relations with communist Vietnam (Albert, 2018) shortly after the US lost the war? Or have communist China as its largest trading partner (Office of the United States Trade Representative, 2016), yet is unable to treat Cuba as a partner? Why do the US and the media continue to scorn Cuba for human rights abuses yet turn a blind eye to the active genocide of Houthi by its close ally, Saudi Arabia (Glazebrook, 2017; Shahtahmasebi, 2017). Or ignore the violence of Israel against Palestinians (Center for Constitutional Rights, 2016)? Why is the US concerned with comparatively minor Cuba's imprisonment of political prisoners (LeoGrande, 2015), yet ignore the murder of over 110 journalists in Mexico 110 since 2000 (Reuters Staff, 2017), as well as the death and imprisonment of activists as well as the murder of 25 journalists in Honduras (Human

Gary Olson (2013) as well as Robert Mizzi et al. (2016) have also noted that it is almost taboo to give serious consideration to Cuba's achievements in education and healthcare, both domestically and internationally, from those in policy and academic circles in the Global North, despite the overwhelming positive recognition from countries that have been in receipt of those services (J. Kirk, 2015). As Steve Brouwer suggests:

> The efforts of Cuba and Venezuela, and the [*Alianza Bolivariana para los Pueblos de Nuestra América*/Bolivarian Alliance for the Peoples of Our America] *ALBA* nations to meet the social needs, provide healthcare, and educate their populations are progressing, not without mistakes and miscalculations, but for the most part with results consistent with the socialist egalitarianism and humanistic solidarity they espouse. The United States has taken note of the contending philosophy developing in the south, but it is not interested in engaging in a 'battle of ideas' or intellectual debate with those whose concepts and values challenge the basic tenets of global capitalism. Instead, it employs a strategy that could be best described as a *war on ideas*, an intensive assault of disinformation meant to make sure that most people, not just in the United States but around the world, are never aware that there is an alternative to capitalistic values developing in the Western Hemisphere. (Brouwer, 2011, p. 201-202 emphasis added)

Rights Watch, 2018)? Additionally, why is there limited political will to tackle the genocide and displacement of Royingya people in Myanmar as well as the imprisonment of reporters there (B. Wilkinson, 2018; Domonoske, 2018)? This criticism against Cuba is also interesting to note when contrasted with the arbitrary detention of prisoners by the US in Guantanamo—the US military base on Cuban soil—where 779 prisoners were held with few rights since 2002 (of whom 9 have died) and 41 remain to be tried or convicted (Worthington, 2018); as well as the jailing of whistleblowers attempting to bring transparency to the media-military-industrial complex (Maass, 2016; Sterne, 2017; Government Accountability Project, 2018).

Therefore, this dissertation is not a simple consideration of the successes and failures of Cuban medical internationalism in Venezuela and Timor-Leste, but rather an additional political economy and psychoanalytical critique of why this potential alternative is frequently not given serious consideration.[35] Thus, as noted by Chomsky, Mizzi et al., Olson, and Brouwer, Cuban approaches are dismissed due to a "war on ideas" (Brouwer, 2011), perceived as a 'threat' by the Global North 'of a good', 'publicly-funded', 'example' (Chomsky, 1992, 1995; Birn & Muntaner, 2019, p. 825-827) in the neoliberal era.

Hence, in the case of Cuba, the voice of the 'subaltern' (Kapoor, 2002; 2005) is potentially both silenced via a political project of media and Global North governments as well as through the unconscious disavowal made by those in the Global North development/aid industry.[36] Many in the development and aid industry have often unquestioningly assumed that the 'NGO-ization' of development (as well as the notion of development as charity) is the most effective form of development (Pieterse, 2010; Roy, 2014). Cuba's publicly funded education and medical internationalism are seen as foreign, ineffective, and impossible to replicate by many in the Global North. In this sense, the geopolitical project to silence the voice of the

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[35] The psychoanalytical critique of development is strengthened by a political economy analysis which helps explain the explicit of development as a geopolitical project, including the nature of those who manipulate, through media and military, the outcomes of populations around the world for their power and profit. The explicit nature of media representation and attempts to destroy alternatives that might be considered a threat to the status quo by those in power are why Bouwer's statement that it is a "war on ideas" (2011) helps to frame the difficulties of learning from the subaltern example.

[36] The promotion of NGO-led healthcare as well as the resistance to state-led health development initiatives raises an interesting question for Global North countries. Why, in many cases, are tax dollars used to fund state-led military and policy 'security' development (Rosén, 2009; Blair, 2011; Beeton, 2017; Task Force 75 Commander, 2017; Ward & Cronan, 2017) unquestioned in this era of neoliberal development, yet state-led bilateral healthcare development not given serious consideration? Why has it historically been commonplace for the US to use public tax dollars to resource and train foreign military and police in places such as Pinochet's Chile, Somoza's Nicaragua and a host of other contemporary examples such as Afghanistan and Iraq yet are not used to help state-led healthcare in these countries. Why is the securitization of development, governmental, and why is healthcare development non-governmental?

subaltern Cuban example of development as dignity is, at times, aided by the disavowal of neoliberal development workers who assume that development is charity.

However, my interest in the voices and views of the subaltern were not merely at the geographic scale of the state. Beyond knowledge transfer from Global South to Global North it is also essential to ensure knowledge transfer from rural-to-urban, poor-to-elite, and marginalized-to-powerful. Thus, at the core of this dissertation is my main belief that, to turn from development as charity (both domestically and internationally) towards development as dignity, an effective approach to development must not only empower the poor, rural and marginalized, but also utilize their unique experiences, perspectives, and knowledge in order to build a better system due to their 'relational distance' to poverty and structural violence in a similar way that liberation theology advocates.[37]

Rather than assuming knowledge production as top-down from those most powerful, a subaltern system would seek the knowledge gained from the subaltern as well as position them as the core of the solution. With health outcomes closely related to poverty and vice versa, this dissertation posits that it is important to listen to those most impacted by—and relationally-close to—the situations that contribute to poor health outcomes and issues of structural violence.

[37] As noted by Farmer: "If you work in the service of the poor, what's happening to that particular class, whether in Harlem or in Haiti, always counts a great deal. In fact, it counts most. And from this vantage point—the one demanded by liberation theology—neither medicine nor development looks nearly so successful. In fact, the outcome gap between rich and poor has continued to grow" (2005, p. 157).

Outline

This dissertation consists of five chapters. The first begins with a literature review of some central elements applicable to the political economy of health and development. In this first chapter four key themes, as well as their corresponding debates, will be discussed. This chapter will draw primarily from Vincent Tucker's 'critical holism' (1996a; 1996b; 1997; 1999) to introduce issues of 'structural violence' (Galtung, 1969) and 'medical structural violence' (Farmer, 1996, 2004, 2005; Farmer et al., 2006). The next section will discuss neoliberalism's impact on healthcare and development, including the impact of the WB and IMF structural adjustment programs (SAPs) on the Global South—this section is a key point of contrast to Cuban healthcare and development approaches.

Chapter Two consists of the theoretical framework. Though the entire dissertation is primarily guided by political economy and critical holism, this dissertation will also incorporate several other analytical frameworks such as Ilan Kapoor's psychoanalytical work, Georg Simmel's work on 'critical sociology' and 'critical distance', Antoni Gramsci's work on 'hegemony' and 'counter hegemony', as well as Mark Duffield's 'biopolitical' work. The first section of this chapter will mainly utilize psychoanalysis and critical sociology to explore the explicit and unconscious aspects of development.

Section two will draw primarily from Gramsci's work on hegemony and the impact of culture. The final section will add Mark Duffield's biopolitical work—specifically the challenges of the development/aid industry, 'institutional fragmentation', 'contingent sovereignty', and 'non-insured populations'—to highlight core contemporary problems of the current neoliberal paradigm. Primarily drawing from Kapoor, the final section will end with a psychoanalytical

discussion of the significance of the subaltern and how challenges to international development and healthcare may be better positioned if flows of information were, at times, reversed—going from South to North, rural to urban, and poor to elite. Thus, Cuba's work in Venezuela and Timor-Leste may provide important information for both international development and bilateral agreements as well as domestic health improvements for rural, poor, and marginalized populations in the Global North.

Chapter Three will focus on Cuba. Beginning with a brief history of its revolutionary government and the geopolitical challenges facing it, the chapter then analyzes its domestic healthcare system as well as its medical internationalist program. It is important to discuss Cuba's domestic healthcare system since, in many ways, this system is the model upon which they base their international programs. A key aspect throughout the dissertation will be an analysis of aspects it has adapted into the programs of Venezuela and Timor-Leste in creative ways for local contexts. The adaptability of this unique, proactive, and preventive bio-psycho-social team-based health system is one small, yet important, aspect that this dissertation seeks to understand.

Chapter Four will begin to incorporate primary research findings by analyzing Venezuela. Starting with an overview of the pre- and post-Chávez era, this dissertation will also examine the findings of two separate research trips. The first trip occurred shortly after the death of Chávez in 2013 and was a time of significant changes and challenges for the country as it attempted to move forward without its charismatic leader of 14 years. The next trip occurred two years later in late 2015 and early 2016, when the acceleration of Venezuela's economic and social decline was starting to hit record levels. Both programs of research were incredibly

difficult to carry out in Venezuela for several reasons including insecurity, travel difficulties, as well as issues of 'socio-political polarization'. The findings from both trips were very important and require a significant amount of context. However, it should be noted that, though continuing declines in health outcomes and resources were not personally witnessed after 2016, I continued to conduct research over email as well as through secondary literature.

Chapter Five will then shift to one of the newest countries in the world, Timor-Leste. After a background of its geo-political history, discussing its emergence in 1999 from a 25-year genocide by Indonesia (backed by US weapons and training), it will then analyze the environment that led to this small nation in Southeast Asia/South Pacific to reach out to Cuba for help. Once the terms of the bilateral agreement are noted, the core of this chapter will then turn to the primary findings from a 2016 research trip. This chapter provides a detailed analysis of the development/aid industry. It examines the complexity of a Cuban program working alongside a western NGO/development approach to provide comprehensive care for this health-vulnerable nation.[38]

Finally, the Conclusion will review the main findings from the dissertation as well as discuss potential limitations and further question that were raised but are beyond the scope of this research program. The final core chapter will discuss how the previous chapters may have implications for both Canada and the study of international development. As Stephanie Nixon et al. note in their article *Canada's Global Health Role* (2018), this dissertation also posits that Canada has a responsibility to help, not hinder, global health equity in a similar fashion to Cuba.

[38] After the completion of the research program in 2018, I had to take a leave of absence from this dissertation for a number of years due to surgery, a near-fatal medical accident following a routine procedure in Canada, and the COVD-19 pandemic. This was followed by four years of unmanageable gout attacks which have finally been brought under control in 2024, allowing for an opportunity to return to the completion of this dissertation.

The challenges of engaging subaltern knowledge may not be as daunting with more acknowledgment of Cuban medical impact worldwide, but they remain significant.

The importance of the Cuban medical example domestically for Canada is best seen in the operationalization of the community *MBA* medical program in Venezuela, which operates alongside a conventional medical system (similar to those systems found Canada and the US). The significance of Cuba as an important contrast to the neoliberal international development/aid model was most significant in the Timorese example. While both examples are highly context-specific, as well as containing many important challenges and differences, certain themes and strengths have clear potential and should be considered for those countries attempting to address significant medical disparities for the most vulnerable, as well as for those countries who wish to turn development programs from charity to dignity. As such, this dissertation is an attempted act of subversion in an effort to challenge hegemonic views of what is—and is not—global or replicable. Evidencing Cuba as a global/comparative development and healthcare model (not just reserved for the Global North)—as well as documenting subaltern Cuban, Venezuelan, and Timor-Leste voices/approaches—has been a process of recognizing my own relational/ideological distance as well as necessarily imperfect attempts to surmount it.

Thus, this dissertation argues that there are lessons to be learned from Global South subaltern examples. However, it is not enough to simply explore these examples. Particular attention should be paid to the systems, assumptions, socio-political, geopolitical, and psychoanalytical considerations which overlook, dismiss, disavow, or undermine important knowledge production from nations such as Cuba, Venezuela, and Timor-Leste. This dissertation highlights that Cuban medical cooperation not only has a number of important considerations for

improving international development approaches, including approaches that are in line with the g7+ group of Fragile State countries "New Deal" (g7+, 2018), but also for potential domestic improvements in health policy and practice as well as health education in the Global North. By combining the political economy of health and development with psychoanalytical, critical sociological, and biopolitical critiques, the hope of this dissertation will be to highlight the shortcomings of a Global North health and development charity approach by the neoliberal development industry for the most health-vulnerable communities, as well as to evidence possible Global South subaltern social medicine alternatives focused on empowerment and dignity.

Chapter 1 Literature Review: The Political Economy of Health and Development

"Explanations exist; they have existed for all time; there is always a well-known solution to every human problem—neat, plausible, and wrong."
Henry Louis Mencken, 1921, p. 158—Prejudices: Second Series
"*My study documented that, in Upper Silesia and elsewhere, epidemic disease reflected social problems. Typhus appeared when people were crowded or hungry . . . I commented, 'the government has done nothing for Upper Silesia'. My only treatment plan was full and unlimited democracy for the region. This would include admission of Polish as the official language, separation of church and state, shifting of taxes from the poor to the rich, improvement of agriculture, building of roads, forming of farming cooperatives, reopening of homes for orphans, and local administration of relief funds.* ***My politics were those of prophylaxis, my opponents preferred those of palliation****. Of course the Berlin government fired me."*
Monologue paraphrasing Rudolf Virchow given by Ed Friedlander at a 2005 meeting of the Group for Research in Pathology Education, Hershey, Pennsylvania

Rudolf Virchow's social medicine approach as well as his understanding of the political economy of disease and proactive healthcare were often in conflict with the heads of government as well as those in wealthy and powerful positions. What his 19th century findings documented are that health outcomes and transmissible diseases are frequently complex problems which can often only be robustly addressed with comprehensive socio-political will—that remedy issues of representation, education, power imbalances, allocation of resources, and inequity—in coordination with biomedical interventions such as vaccines and access to medical services.

A political economy approach to healthcare and development will help this dissertation highlight often overlooked questions in mainstream global health and biomedical circles. This approach offers five main lessons: exploring structural violence and health disparities;

documenting the impacts of inequality and injustice; locating geopolitical power and profit; highlighting the limitations of biomedical and market-based healthcare; and critiquing neoliberalism. This sets the stage for exploring Cuba's implementation of Latin American social medicine (LASM).

The objective of this chapter will be to understand core political economy issues of healthcare and development. It will historicize curative biomedical approaches to conventional healthcare and medical education, as well as the Global North's neoliberal development/aid industry responses to Global South poverty.[39] The following four sections include: critical holism (highlighting the influence of the transnational pharmaceutical industry [TPI]); structural violence; and lastly, the impact of neoliberal approaches to development and healthcare (especially, to detail the era of structural adjustment programs [SAPs]).

These sections will establish important foundational political economy challenges to healthcare and development. The next Theoretical Framework chapter—exploring psychoanalytical, hegemonic, biopolitical, and critical sociological approaches—will then provide the lens that the rest of this dissertation will utilize to explore the potential of Cuba's subaltern counter-hegemonic approaches to the political economy challenges found in this Literature Review.

[39] The homogenous conception of development was destroyed in the 1960s (Pieterse, 2010). During this time, it was "no longer possible to talk of a mainstream of development economics" (Martin, 1991, p. 55). By the 1970s, an emerging Chicago School of Economics version of monetarism came to dominate the previously heterogenous and contested field of development. However, monetarism was not to be confused with neoclassical equilibrium theory (Pieterse, 2010) as it was little more that a re-emergence of 19th century "bankers' principles of 'sound money'—currency convertibility, stable parity, fiscal thrift, low wages and minimal government influence in business" (FitzGerald, 1991, p. 15).

Structural Violence

"There is an enormous difference between seeing people as the victims of innate shortcomings and seeing them as the victims of structural violence"
(Farmer, 2005, p. 153-154)

An important concept to understand the significance of many health issues facing the most impoverished and marginalized of the world's populations is the issue of structural violence. Structural violence is a term most often attributed to Johan Galtung in his 1969 article: "Violence, Peace and Peace Research." Structural violence is not an explicit act of physical violence, but rather constitutes a basic impediment to people meeting their fundamental human needs. Structural violence is also closely linked to a lack of social justice, which is both the attempt by a society to pursue justice among different social classes and a state of being. Solidarity and equity are often considered core values associated with social justice (Hörmansdörfer, 2009).[40]

James Gilligan adds to the understanding of structural violence in his book *Violence: Reflections on a National Epidemic*, stating that structural violence results in "increased rates of death and disability suffered by those who occupy the bottom rungs of society, as contrasted with the relatively lower death rates experienced by those who are above them" (1996, p. 192). He typifies these as 'non-natural' or 'excess deaths'. Examples of structural violence include institutionalized ageism, adultism, classism, ethnocentrism, elitism, heterosexism, nationalism, and sexism. Essential to this dissertation is the understanding that the concept of structural

[40] Galtung refers to social justice as such: "In order not to overwork the word violence we shall sometimes refer to the condition of structural violence as social injustice" (1969, p. 171).

violence is also used to illustrate a lack of access to efficient and effective healthcare, since this also causes 'excess' or 'non-natural' deaths.

Slavoj Žižek's 2008 book, *Violence*, expands on the structural violence conceptions of Galtung and Gilligan. In it he explores three different types of violence; subjective (such as crime and terrorism); the symbolic (which is violence embedded in language and discourse);[41] and, most applicable to this chapter, systemic. Systemic violence is important in that it identifies the kind of violence specifically perpetuated by capitalist economic and political systems. While Paul Farmer's conception of structural violence constitutes suffering that is 'structured' from "historically given (and often economically driven) processes and forces" which conspire to constrain agency, including "political violence and grinding poverty" (Farmer, 2005, p. 40), Žižek notes that capitalism exerts a particular type of violence, including obscuring issues of inequality to focus on poverty. This is a similar process to obscuring the potential need for robust political action, struggle, and even revolution, to instead focus on "tolerance" (Žižek, 2008, p. 140-177).[42]

Thus, there is a need for healthcare systems and the medical personnel in them—as well as the governments that support them—to comprehend the larger-scale societal issues such as inequality, racism, and classism (Farmer, 2005). Additionally, for those in healthcare, academia, and activism, there is also a need to challenge the barriers that limit and obscure the 'systemic violence' perpetuated by unjust capitalist economic and political systems as well as neoliberal development/aid approaches (Žižek, 2008; Duffield, 2007). However, conventional medicine

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[41] Žižek's "symbolic" aspect of violence will be discussed further in the following Theoretical Framework chapter.
[42] This analysis of "tolerance" connects to Mark Duffield's (2007) critique of liberal development's goal of "self-reliance" and "sustainable development" which is similarly focused on merely palliating the symptoms of poverty instead of addressing the root causes of mal-development and inequality.

(heavily influenced by the TPI) appears to be more inclined to maintain the status quo, choosing instead apolitical tolerance and palliation to manage the symptoms created by a system and ideology which prioritizes efficiency over equity (Farmer, 2005). This, in turn, leaves behind social justice and social determinants of health (SDOH) approaches to healthcare and governance (Hixon et al., 2013).[43]

With media, finance, law, and political systems more inclined to respond to wealth and power, the world's poor "are not only more likely to suffer," but also "less likely to have their suffering noticed" (Farmer, 2005, p. 50). Unfortunately, due to this lack of attention and increasing relational distance from accelerating inequality, the poor continue to be the main victims of structural violence while simultaneously being blamed for their lack of 'personal accountability' in removing themselves from systemic marginalization and injustice. This continues to defy the scrutiny of many in the development industry, academics, and government agencies concerned with understanding the "nature and distribution of extreme suffering" (ibid.).

Therefore, to assume that health disparities are apolitical and ahistorical—with clear differences in outcomes between Global South and Global North, poor and rich, marginalized

[43] North American SDOH approaches have a very difficult battle and face numerous barriers. Despite calls from Hixon et al. (2013) for a stronger emphasis upon social justice and health equity in medical schools, the tradition of conventional medicine struggles with an embedded apolitical culture, lacks robust preventive and proactive approaches (including the marginalization of social workers, who are on the front line of connecting the political with the bio-psycho-social aspects of health, yet remain largely ignored by politicians and the healthcare industry), underemphasizes broader team-based bio-psycho-social approaches (C. Walker, 2015), and relies on a curative biomedicalization/pharmaceuticalization approach to health (Biehl, 2007; Abraham, 2010; Livingston, 2012). Thus, while SDOH and health ethics courses may be taught to often urban and middle-to-affluent income populations in certain conventional medical education institutions, these courses are often electives, not taken seriously, or seen as a minor inconvenience on the path to comfortable incomes by those who consider the pursuit of healthcare as a comfortable lifestyle, not as the pursuit of social justice and health equity. This is the core importance of the subaltern Cuban approach to health equity and development. It attempts to train the most vulnerable and marginalized to become a part of the solution for their own health-vulnerable community, with team-based bio-psycho-social training that focuses on LASM and SDOH, a process which shifts the paradigm of charity and management of symptoms of poverty, towards health equity and the dignity of empowerment (C. Walker, 2015).

and powerful, rural and urban—is problematic. Indeed, healthcare—like media, finance, law, and development—has always been, and will continue to be, political. Despite the 1978 Alma Ata Declaration, the promotion of SDOH in the 2000s (R. Wilkinson & Marmot, 2003; WHO, 2008a, 2008b; Bryant et al., 2010), and international examples of social medicine (Tajer, 2003; Yamada, 2003; Porter, 2006; Briggs & Mantini-Briggs, 2009; Birn & Muntaner, 2019), conventional Global North approaches to healthcare and medical education (influenced by the TPI) tend to over-emphasize biotechnical, curative, and market-driven aspects to the benefit of the wealthy minority while being to the detriment of other less-wealth and less-powerful populations (Tucker, 1996c; Cooke et al., 2006; Farmer et al., 2006; Hixon et al., 2013; C. Walker, 2015).[44] Thus, health outcomes are rarely divorced from power, history, and ideology.

Yet the past 50 years of ideologically-narrow neoliberal development have left many areas of the world worse off (Simon, 1997; Tucker, 1999; Giroux, 2004; D. Harvey, 2016).[45] This ideology has failed to address issues of structural violence (Galtung, 1969) and systemic violence (Žižek, 2008),[46] as well as issues of expanding inequality and inequity (R. Wilkinson &

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[44] The biomedical influence of the TPI plays a significant role in this regard as a "powerful global cultural agent shaping and often distorting health thinking, healthcare practice and health economics." It maintains a "hegemonic role in health thinking and practice by its virtual monopoly over the production of medical knowledge" (Tucker, 1996c, p. 117).

[45] Though the concept of neoliberalism is delineated by John Quiggin (2010, p. 2-3) in the second footnote of the Introduction, and the implications of neoliberalism will be discussed at length later in this chapter, this footnote utilizes Paul Farmer's definition to provide a succinct reference point for the reader as it aptly applies to most themes of this chapter. Farmer uses the term neoliberal economics "to refer to the prevailing (at times contradictory) constellation of ideas about trade and development and governance that has been internalized by many in the affluent market societies . . . The dominance of a competition-driven market is said to be at the heart of this model, but in truth this ideology is indebted to and helps to replicate inequalities of power. It is an ideology that has little to say about the social and economic inequalities that distort real economies and instead, reveals yet another means by which these economies can be further exploited. Neoliberal thought is central to modern development efforts, the goal of which is less to repair poverty and social inequalities than to manage them" (2004, p. 312-313).

[46] This will be explored later but systemic violence is a specific indirect type of violence enacted by unequal capitalist political and economic arrangements.

Pickett, 2010).[47] With this in mind, it is important to explore broader and more encompassing transdisciplinary considerations such as Vincent Tucker's work on critical holism.

Critical Holism

> *"Groups of any size . . . operate within an evolving historical system and can only be understood if careful placed within that system, its pressures and constraints, its multiple actors and their actions, its possibilities and limits."*
> (Janet L. Abu-Lughod, 1999, p. 260)

This dissertation posits that a LASM approach to healthcare (Tajer, 2003; Porter, 2006; Briggs & Mantini-Briggs, 2009; Birn & Muntaner, 2019) and Tucker's critical holism approach to development (Tucker 1996a; 1996b; 1997; 1999; Pieterse, 2010) are helpful consideration for addressing issues of structural violence as well as medical structural violence (Farmer, 1996, 2004, 2005; Farmer et al., 2006). Without the ideological breadth of critical holism and LASM—which are more inclined to consider the interconnections of healthcare policy and medical science with social sciences—this dissertation argues that over-simplified and ideologically-narrow apolitical and ahistorical neoliberal solutions to complex problems, such as providing

[47] Richard Wilkinson and Kate Pickett (2010) note how developed countries, when post-industrial societies have less inequality with a lower disparity of income between poor and rich, tend to be generally healthier and happier in comparison with countries that have a larger disparity between the poor and rich in terms of wealth. R. Wilkinson summarizes their findings on inequality in a presentation following the release of their book: the "average well-being of our societies is not dependent any longer on national income and economic growth." It is now the "differences between us and where we are in relation to each other now matter very much" (R. Wilkinson, 2011).

more egalitarian healthcare and development outcomes, will continue to have limited success.[48] [49]

LASM and critical holism have many parallels and help us appreciate why Cuba can be considered an important 'counter hegemonic' model for subaltern knowledge production (Peet, 2015). LASM fosters broader political and biosocial considerations of healthcare in its efforts to demystify "processes of neoliberal health reform." Under a LASM approach, the state has an obligation to push for the defense of health as a "citizen's right" (Tajer, 2003, p. 2025).[50] Similar to LASM's emphasis on broader conceptions of healthcare, critical holism (which also borrows directly from Virchow's sociological considerations of medicine) is an approach to development that is similarly theoretically diverse.[51] Tucker's critical holism argues for a need to identify with the 'whole means' of development, whereby "development can no longer be simply geared to material aims and achievements but must include non-material dimensions" (Pieterse, 2010, p. 164). Thus, there is a need to go beyond traditional economic measures of development success,

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[48] Jan Nederveen Pieterse, a close academic friend of the late Vincent Tucker, outlines the ideological-diverse threads that Tucker employed in order to conceptualize critical holism (2010, p. 145-146). Tucker combined a "critical synthesis of holistic medicine, political economy, development theory, environmentalism and feminism . . . a theoretical synthesis of holistic theory, Marxist political economy and culture critique" (1996a, p. 3). Thus, critical holism encompasses "social, economic, political and environmental systems including world systems" (ibid., p. 41).

[49] Débora Tajer (2003, p. 2024) highlights that the "conceptual matrix of LASM." is revealed by the "incorporation of social sciences into the fields of collective health" as well as an early adoption of "dialectic materialism." Later, in the 1980s, LASM began to incorporate "several developments of the European social sciences such as those by Althusser, Bourdieu, Foucault, Giddens, Gramsci, Habermas, Heller, Laclau, and Rorty."

[50] Health system reform is one of the "central pillars of the academic work of the LASM movement," especially since the turn of the 21st century. This movement "has expanded its areas of action" to include issues that "must be addressed for full implementation of citizens' right to healthcare." These include: "violence, gender, human resources, public policy, decentralization, health system reform, globalization, epidemiology, environment, equity, bioethics, social participation, ethnicity, multiculturalism, and human rights" (Tajer, 2003, p. 2025), many of which connect to challenges of structural violence.

[51] Tucker, while borrowing from a diversity of theoretical strands and approaches, also leans on the early work of Virchow. Critical holism "derives from the more sociological approach of Engels and Virchow . . . It also derives from the public health tradition. It encompasses economic and political systems as well as biological and environmental systems and is based on the notion that health and illness are not simply biological phenomena but are socially produced. This more sociologically informed holism has been further developed by Marxist political economy and radical development theory" (1997, p. 42).

towards other more varied and nuanced sets of indicators that include health outcomes (measured by life expectancy, maternal mortality, and infant mortality, etc.).[52] [53]

In a similar manner, Tucker advocated a more 'holistic perspective' of health promotion (which merges preventive and proactive interventions with curative and biomedical interventions). This holistic approach may comprise "public health practices, environmental campaigns, political action, educational activities and complementary forms of medicine" (1997, p. 45). Importantly, a critical holism approach to healthcare will not only include "changes in personal lifestyle, but also collective action to challenge organizations and institutions . . . which act in ways detrimental to public health" (ibid.).

Tucker's critical analysis of the dominant western medical ideology provides the context to help understand certain conceptual issues when discussing public health—especially since the unique operationalizations of the Cuban healthcare approach in Venezuela and Timor-Leste expand upon a more holistic and socio-political approach to equitable healthcare. Tucker emphasizes that medical development is just as relevant and important a point of contestation and theoretical debate as economic and political development (1996a; 1996b; 1996c; 1997).

[52] The 'economics-first' mentality, where the market was considered the major driver of economic development, never produced the wide-ranging success it had promised. Instead, authors like Heidi Monk (2010) and Amartya Sen (1999, 2000) did much to reveal the lack of correlation between health and wealth. Monk discovered that there was solid empirical evidence which highlights that the challenge of achieving health is "not necessarily linked to economic growth." Instead, health can be "pursued at low levels of economic activity" whereby a "government's fiscal ability to finance health is not closely linked to economic growth." A government can "finance health even when its total expenditure ability is restricted without worsening its financial predicament" (Monk, 2010, p. 12). Thus, it was found that a nation's high level of health indicators was achievable, despite low levels of economic activity as seen in Monk's analysis of health systems in Kerala (India) and Cuba. These health systems had successfully addressed the issues of medical accessibility for impoverished segments of their population through efficient allocation of resources and human capital, as well as their unique medical education (A. Sen, 1999; 2000; Monk, 2010; C. Walker, 2015). The analysis by Monk as well as the work of Sen provide a conceptual evolution in healthcare thinking since it has shown that the macroeconomic relationship between health and wealth is more dynamic.

[53] Reliance on a limited number of indicators to measure development is clearly problematic. This dissertation does not advocate that the measure of development should only be health indicators, but rather that they are important, and can add significantly to what a given population could (and should) consider development successes.

Farmer et al. believe that one reason for the biomedical focus of modern medicine, away from other SDOH or social medicine approaches, is the fascination to find the 'holy grail' of a molecular basis of disease. Though the "practical yield of such circumscribed inquiry has been enormous, exclusive focus on molecular-level phenomena has contributed to the increasing 'desocialization' of scientific inquiry: a tendency to ask only biological questions about what are in fact biosocial phenomena" (2006, p. 1686).[54]

Tucker provides a nuanced view of medicine that goes beyond the limited, yet pervasive, mentality that "health = doctors + drugs" (1996a, p. 17). This 'pharmaceuticalization' of healthcare illustrates how the evolution of medical development is instead a significantly larger part of the development paradigm since it is linked to a number of other socio-political issues and geo-political power imbalances (Tucker, 1996c; Biehl, 2007).[55] Hence, medicine is not just the practice of doctors with medical degrees solving a singular health issue for one patient, but rather an ideologically expansive and contested field. Thus, numerous health issues—as well as issues of structural violence—may be tackled by different levels of education; utilizing different access to resources; with different methods; occupying different scales of organization (from team-based community-oriented primary care to state-led universal medical programs); and,

[54] Thomas McKeowan was a noted social medicine advocate who was critical of the curative prioritization of conventional medicine (1979; McKeown & Brown, 1955). He posited, in a view that is still relatively uncontested, that "curative medical measures played little role in mortality decline prior to the mid-20th century." Both McKeown and Ivan Illich "shared the view that the increasing emphasis in the second half of the 20th century on high-technology, curative medical efforts was a misguided diversion of resources away from more environmentally focused health programs" (Colgrove, 2002, p. 726).

[55] 'Pharmaceuticalization' is a term which aptly describes how "drug companies engage in research, development and marketing of drugs to deal with what might otherwise be social, personal or political problems"(Goodman, 2012). This "pill for every ill" (Tucker, 1997; Pym, 2014) approach to healthcare is a major concern (Tucker 1996a; 1996b; Abraham, 2010), since not only does it limit biopolitical and SDOH approaches, but also contributes to higher rates of iatrogenesis (Illich, 1976) and lower health outcomes.

ultimately, different conceptions of what healthcare should be including the ideologies that guide them (C. Walker, 2015).

Tucker also notes that the social construction of medicine as a business has, over time, actively replaced the value of serving those in need—for whom healthcare is a basic right. In this sense, western conventional medicine has, at times, limited health outcomes and contributed to a more inegalitarian approach to health access than neoliberal knowledge- and policy-producing institutions as well as conventional biomedical discourse have recognized. Pierre Chirac et al. argue that the discrepancy between the prevalence of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) treatment and outcomes between populations in the North and the South highlights a deeper and more complex problematic that goes beyond the capacity of apolitical conventional medical systems. They note that this discrepancy is a moral, social, political, and economic issue. Thus, the "question of AIDS treatment leads to a wider reflection of the balance between public and private interests, between patent rights and rights of patients" (2000, p. 502). Through this political economy analysis, it becomes clear that access to healthcare and to "medical progress as a human right is a challenge that AIDS poses to humanity" (ibid.).[56]

However, as Tucker notes, in many cases western conventional medicine considers itself as being separate from the economic and political processes and has, to a large extent, managed

[56] Other authors (see Gerth & Stolberg, 2000a, 2000b; Stolberg & Gerth, 2000a, 2000b; Chirac et al., 2000; Trouiller et al., 2001; von Schoen Angerer, 2001; etc.) have also written extensively on the negative influence of TPIs in the Global South. Farmer gives a detailed account of numerous debunked arguments (including how the cheap distribution of life-saving drugs would "compromise" funding for research and development) that the TPIs have used to validate their use of the patent system to suppress the widespread use of cheaper generically produced alternatives. The "patent rights versus patient rights" debate is most thoroughly expressed on note 11, pages 316–318 in Farmer's 2005 book *Pathologies of Power*.

to hide this connection. Tucker expands on why and how this has happened. As is the case with imperialism, colonialism, and modernization, modern medicine has long-held monopolistic ambitions. The 'healthcare industry', often referred to as the TPI, has emerged as one of the most powerful industries in the world (1996c, p. 111).[57] Its profits—estimated at $1.3 trillion in (Burke, 2020)—exceed those of most other industries, accomplished by utilizing a mix of persuasive and coercive strategies (Tucker, 1996c).[58] Additionally, pharmaceuticalization by the TPI, whose drugs are increasingly seen as a significant cause of concern and, as highlighted by the web of controversy over opioids and OxyContin (Glazek, 2017; Meier, 2018), are increasingly seen as the cause of 'iatrogenic illness'/death, much as Ivan Illich cautioned (1976).[59] Due to a lack of oversight in US (even less oversight than even the military-industrial

[57] Some of the largest corporate players include Roche, Pfizer, Sanofi, Johnson & Johnson, Merck & Co. etc. (Burke, 2020). The largest global pharmaceutical market share, over 48%, is in North America/primarily in the US (Mikulic, 2020), which makes the US one of the most significant power centres for promoting the TPIs hegemonic approach to healthcare.

[58] The TPIs exert a tremendous amount of power and influence, especially in the US (Braithwaite, 2013). There are approximately two lobbyists from this industry per member of Congress. In addition, 97% of US senators as well as 90% of the members of the House of Representatives have received campaign contributions from drug companies. Between 2007 and 2017 alone, Big Pharma spent about $2.5 billion to lobby and fund members of Congress and $152 million in 2016 to influence legislation. They can charge as high a price as they wish to federal government-run Medicaid and Medicare programs, thus cashing in on public tax dollars for some of the most expensively-priced drugs in the world—irrespective of potentially meagre production costs (McGreal, 2017). Thus, through donations, funding and lobbying, drug companies have ensured that almost every major politician in the US is somehow connected to, or financially backed by, Big Pharma. Therefore, from a political economy perspective, it should not be surprising that governments are potentially more inclined to respond to the dictates of the TPI over the health and well-being of their voters, especially if this relation continues to be obscured or ignored. As this dissertation highlights, Big Pharma's power and influence are not limited to the US as they often use their powers to block affordable, potentially lifesaving, generic drug production in other countries, including generic HIV/AIDS medication in India (Braithwaite, 2013; McGreal, 2017). Hence the international nature of Big Pharma and Tucker's important critique.

[59] As of 2017, the opioid 'crisis' had claimed approximately 200,000 lives in the US since the release of OxyContin in 1996 (Glazek, 2017). The addictiveness and dangers of OxyContin were overlooked and underregulated. The Sackler family made billions off the production and distribution of this drug, and the unfettered distribution and deaths of their drug. Farmer notes that in 2000, pharmaceutical giant Glaxo-Wellcome attempted to block the "sale of cheaper generic AIDS drugs in Ghana." This is just one example of many he highlights which outline the "high stakes and complicated legal battles surrounding patent rights versus patient rights in the developing world" (2005, p. 317). Though TPIs often positions themselves as the heroic face of healthcare, they lobby politicians harder than most other industries to bypass regulation of the industry (McGreal, 2017; Glazek, 2017), exercise their powers to increase profits by blocking the production of affordable generic drugs and strengthening patents (Farmer, 2005), ignore or supress findings that

complex/arms manufacturers) and power of their lobbyists, the TPIs are a particularly apt, albeit troubling, example of neoliberal governmentality whereby their pursuit of profit and influence has come at the cost of human lives.[60]

Thus, TPIs have established themselves as a dominant global influence able to shape health knowledge and practices, government health spending, doctor-patient relationships, diagnostic procedures, household budgets, development priorities, as well as, in some instances, industrial health policy. Its worldwide influence is so significant that in the mid-1970s Dr. Halfdan Mahler, who was then Director General of the World Health Organization (WHO), "aptly described the situation as one of 'drug colonialism'" (Tucker, 1996c, p. 111). The influence of the TPI now "far exceeds its economic power. Pharmaceutical drugs have come to be perceived as the most typical representation of medicine—indeed they have become the most central part of, and have given their name to, the entire enterprise: medicine" (ibid.).

Tucker demonstrates how this system, based on pharmaceutical drugs, has constructed itself as a "potent symbol of modernization and development and [was] promoted as offering yet another technical fix for the social, economic and political problems which were 'endemic' to the 'Third World'" (p. 116). Therefore, the TPIs "have shaped, in varying degrees, the belief system of virtually every society on the globe. Under their influence 'health for all' has virtually meant

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products may be addictive or harmful (Smith, 2005; Braithwaite, 2013; Meier, 2018), and emphasize the pharmaceuticalization of healthcare as a political project to subvert other important biological, psychological and social aspects of health (Abraham, 2010; Tucker, 1996a). A significant consideration behind a lack of enthusiasm for the Alma Ata Declaration as well as the SDOH in North America, despite the importance of such approaches, is the influence of the TPIs and the power they wield on the healthcare 'industry'.

[60] As noted by Trent Hamann (2009, p. 37), neoliberal governmentality involves the "strategic creation of social conditions that encourage and necessitate the production of Homo economicus, a historically specific form of subjectivity constituted as a free and autonomous 'atom' of self-interest. The neoliberal subject is an individual who is morally responsible for navigating the social realm using rational choice and cost-benefit calculations grounded on market-based principles to the exclusion of all other ethical values and social interests."

'drugs for all" (p. 112). He also highlights that this relationship began as early as the colonial era, when medicine was a huge part of the knowledge and technology system of development as well as had an immense impact on developing nations even then.[61]

Global Health Watch notes that "despite advances in science, technology and medicine, the largely market-driven system for allocating resources to pharmaceutical research and development ignores diseases that affect the poor, including several that constitute a significant portion of the global burden of disease" (2005, p. 102).[62] However, the TPI is instead primarily focused on investing in "new and expensive 'lifestyle' medicines such as Viagra, which claim to address the needs of the affluent minority of the world's population. Global and national strategies to correct this market failure are therefore necessary" (ibid.).

Therefore the "pipeline of drugs for neglected diseases has been virtually empty for decades" with only "16 of the 1393 new chemical entities (drugs or medicines) registered in the US and Europe in 1975-1999" for "'tropical diseases' that afflict people in developing countries"—five of which "emerged from veterinary research" (ibid.). The frustrating "result is a critical shortage of effective drugs for many diseases that mainly affect the poor, such as leishmaniasis, Chagas disease, trypanosomiasis (sleeping sickness), malaria and [tuberculosis]

[61] This criticism, as well as the direction of healthcare towards profit motives, links to an observation by Illich: "What was meant to constitute healthcare will turn into a specific form of health denial."(1976, p. 223). He continues by explaining that cheap and simple measures, including sanitation and public housing, have benefited populations more than expensive, complex, and modern measures which tend to be unsuccessful and detrimental. Unfortunately, a disproportionate amount of money and time is spent to further improve them, often by increasing the cost and intricacy. Over-treatment and over-medication—where the cozy relationship between doctors and pharmaceutical industry often places the patient at risk—have shown to also decrease health outcomes (Gibson & Singh, 2010; Kolata, 2010; Schroeder, 2011). Tucker recalls one TPI director who stated that the "incidence of disease cannot be manipulated and so increased sales volume must depend at least in part on the use of drugs unrelated to their real utility or need" (Tucker, 1996c, p. 117). In this way, as Illich notes: "Modern medicine" has become "a negation of health. It isn't organized to serve human health, but only itself, as an institution. It makes more people sick than it heals" (Sturmberg, 2018, p. 73).

[62] Additionally, most "advances in medical care have come from publicly funded research and from innovations developed in the public health sector. The contributions of for-profit pharmaceutical companies, though important, have been modest by comparison" (Quiggin, 2010, p. 147)

TB" (ibid.). As a "powerful political actor," the TPI utilizes its significant financial and political resources to shape health spending and policy as well as "supress challenges to its hegemony" (Tucker, 1996c, p. 117). US, German, and United Kingdom (UK) pharmaceutical companies went on the offensive when Sri Lankan and Bangladeshi governments attempted to "control the proliferation of drugs, tackle overpricing" and establish national drug industries for public benefit. The TPI rapidly "mobilized the political support of their governments, turning to suppress aid and to stop all further investment in the countries" (ibid.).[63]

An example of the TPI's global power even extends to United Nation (UN) agencies such as the WHO. The Pharmaceutical Manufacturers Association managed to use their influence in 1986 to stop the WHO's attempt to institute an ethical marketing code. Despite the support of all but three countries, the TPI utilized their influence—via pressure from the US and Japan—to withhold payments from the WHO, to shut down an attempt to implement ethical oversight of the drug manufacturing industry (Tucker, 1996c).

In 2013, the CEO of Bayer (a prominent drug producer headquartered in Berlin, Germany) went on record to say that his company did not develop cancer medications for the

[63] Though the TPI's influence via Global North governments put immense pressures on Bangladesh and Sri Lanka, both countries were able to withstand and develop what would become fairly successful national drug policies and drug production (Chowdhury, 1995; Balasubramanium, 2002). These countries remain as some of the few significant examples which managed to retain some semblance of drug sovereignty in the face of international pressure by the TPI's and their allied Global North governments. However, unlike Bangladesh or Sri Lanka, Chile's attempt—which was one of the first countries to implement a national drug policy in 1967—never fully realized its potential. When President Frei took over the government in 1964, Chile underwent a major political change and "took measures to rationalize drug supply and use" (Balasubramanium, 2002). The following general election in 1970 brought Dr. Salvador Allende to power who continued "rationalization of the pharmaceutical supply system." Unfortunately, the TPI struck back shortly after his electoral victory and, "in the three months following" Chile's call for the international tender of widely used drugs (including analgesics and antibiotics), the TPI cut their production to make them unavailable on the market. The TPI agreed to "replenish the market within one week only if the international tenders were called off. In 1972, the government was forced to succumb and called off the tenders." By 1973, the Allende government was overthrown with by a US-backed coup which put dictator Augusto Pinochet in power. The result was that the "first essential drug program that we know of introduced in 1967 was dead by 1973" (ibid.).

Indian market since it is only Global North patients who can pay for it. As the executive director of *Médecins Sans Frontières* explains, this admission suggests that drugs are only going to be sold to the wealthiest patients. Essentially the pharmaceutical industry is so focused on profit that they "aggressively push for patents and high drug prices," a process which limits medically and financially vulnerable populations from getting potentially life-saving drugs (Balasegaram, 2014). This is a problem since diseases that "don't promise a profit are neglected, and patients who can't afford to pay are cut out of the picture" (ibid.). Though pharmaceutical "companies claim to care about global health needs," their increasingly extensive "track record says otherwise" (ibid.).[64]

Fortunately, the turn toward human development by various scholars and policymakers helps position health indicators as a valid way to gauge the level of social development. This has also coincided with the rise of human rights-based approaches which, as noted in the Universal Declaration on Human Rights and Human Development Index, highlights that the state should have the political will to take an active role in providing a universal healthcare system (UNDP, 2010). This position was largely developed by Amartya Sen, who believes that development has been reconceptualized as an expansion of people's agency and human capacitation (1987; 1999).

In this model, much as LASM advocates, the state is biopolitically perceived as being contractually obliged to its citizens.[65] It must have the political will to provide: safe "drinking water and adequate sanitation;" safe food; adequate "nutrition and housing;" healthy "working

[64] The contrast between Cuba's state-led pharmaceutical approach and the TPI approach can be summed up like this: Bayer produces drugs for the market, and Cuba produces drugs for patients—including the most vulnerable populations in many other Global South countries. Thus, Cuba's drug industry is helping address the medical need for life-saving drugs that the TPI has ignored in favor of profits (C. Walker, 2015).

[65] The biopolitical work of Michel Foucault and Mark Duffield provides deeper analysis of the role of the state and will be explored in the following Theoretical Framework chapter.

and environmental conditions;" health-related "education and information" and, particularly relevant to this chapter, it is essential that all "services, goods and facilities must be available, accessible, acceptable and of good quality" to ensure that a functioning public health system and "health-care facilities, goods and services must be available in sufficient quantity within a State" (OHCHR, 2008, p. 3-4).[66]

The UN adoption of this framework highlights an attempt to institutionalize the turn towards human development and the acceptance of health indicators as a measure of development. Given this turn, critical holism, drawing upon a multitude of theoretical tools, is potentially more adept at addressing structural violence than neoliberal development approaches, just as this dissertation also posits that LASM is potentially more adept at addressing medical structural violence than conventional North American biomedical approaches.

However, due to the assumption that Global North countries, such as the US and UK, are the pinnacle of development (Berger, 2003; Quiggin, 2010),[67] the influence of their approaches

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[66] Ibekwe Perpetus Chudi highlights the significance of this approach and notes that a "great deal of the underlying causes of disease, injury and death in developing countries lie beyond the preview of the healthcare system." This is especially true for nations that adopt a narrow view of healthcare responsibility. Many countries remain disconnected from broader spheres of influence such as the economy, as well as "a range of physical factors (inadequate sanitation, water, drainage, waste disposal, housing and household energy) and behavioural factors (personal hygiene, sexual behaviour, driving habits, alcoholism and tobacco smoking)" (2010, p. 10). However, "policies in these sectors"—especially for these negative impacts—"are often not based on health criteria. The health sector itself tends to focus its interventions within the health-care delivery system, not necessarily in other sectors that are the sources of the problem." Therefore "the enormous health benefits possible through interventions outside the health sector are not being realised" (ibid.). Thus, if a government is truly to tackle many of the most pressing health issues it will have to adapt a 'health in all policy' approach which addresses structural violence since many of these environmental and occupation related health problems often "turn into public health problems when they become widespread," which is a "factor aggravated by inadequate public health infrastructure" (ibid.).

[67] Despite the narrative of the US being the apex of development, all but the "very richest groups of Americans do worse on most measures of social well-being than people with a comparable position in the income distribution in more equal countries." These comparatively poor outcomes occur even though the median income of "non-Americans in these groups is much lower than that of the corresponding Americans" (Quiggin, 2010, p. 167). Not only is the US medical system considered one of the least efficient, placing 50th out of a study of 55 countries (Du & Lu, 2016), but the "number of people without health insurance rose steadily over the period of market liberalism, both in absolute terms and as a proportion of the population, reaching a peak of 46 million, or 15 percent of the population" (Quiggin, 2010, p.

to healthcare, medical education, and development must be analyzed and critiqued to understand why it is possibly difficult for some, including those in the development industry and conventional western healthcare systems, to seriously consider subaltern Global South approaches.[68] As Julie Livingston highlights, global "public health has long been founded on an assumed developmental telos. The goal has been to mirror the epidemiological transition of Western Europe, Japan, the United States, and Canada" (2012, p. 34).[69] This literature review will proceed by examining the impacts of neocolonial and neoliberal policies, as well as their underlying ideologies.

Neoliberalism and Era of Structural Adjustment Programs (SAPs)

"Excessive government spending, taxing, and regulating—no matter how well intended—is a formula for disaster."
(US President Ronald Reagan's 1981 speech to the National Alliance of Business as quoted in Léa Pool's *Pink Ribbons Inc*: 6:06-6:40)

Since the 1970s, the state was increasingly viewed in many countries as the cause of poverty, and reducing the power of the state was the proposed solution.[70] As articulated in his

155). After an attempt to implement Obamacare, the number of non-insured people has dropped to 29.6 million people, accounting for approximately 9.2 percent of the population at the time of the study (Keisler-Starkey & Bunch, 2020). Thus, it is not surprising that "access to healthcare for poor households has become worse over time, as has the gap in health outcomes between the rich and the poor." Though emergency "healthcare remains generally accessible and has benefitted from technical progress, which has contributed to declining mortality" (Quiggin, 2010, p. 156), regular health access has become increasingly unaffordable for many in the US, resulting in a wide array of chronic conditions that go untreated (Wilper et al., 2008).

[68] This discussion on the implicit and explicit challenges of imagining an alternative subaltern approach to development and healthcare will be discussed in depth in the following chapter.

[69] This is problematic since the majority of public health activity in the Global South, especially Africa, have therefore been "animated by a range of competing interests" which have "developed within this epidemiological progress" an unfortunate "narrative that has rendered contemporary health" in simplified historical terms (Livingston, 2012, p. 34).

[70] A significant argument against the role of the state was the idea that many Global South countries were corrupt, squandering development funds and public tax dollars for their own means. Thus, it became "difficult to oppose" the

1962 book, *Capitalism and Freedom*, Milton Friedman proposed a list of policy changes aimed at market expansion as well as the removal of various government agencies to free the individual from the 'coercive and oppressive' state.[71] Privatization, trade liberalization, deregulation, and fiscal austerity were recommendations from Friedman's influential list that were adopted by many Global North governments as well as the World Bank (WB) and International Monetary Fund (IMF) which imposed conditions, known as structural adjustment programs (SAPs), attached to developing countries' loans.[72]

Arguably, after the untested neoliberal hypothesis was proposed by Friedman and the Chicago School of Economics, its governmental catalyst began in the UK with Prime Minister Margaret Thatcher, and in the US with President Ronald Reagan (as noted above in Reagan's 1981 speech to the National Alliance of Business). During the 1980s, this "new religion of neoliberalism" combined a "commitment to the extension of markets and logics of competitiveness with a profound antipathy to all kinds of Keynesian and/or collectivist strategies" (Peck & Tickell, 2002, p. 381).[73] Under this ideology, the structure and advancement of competitive forces became "married with aggressive forms of state downsizing, austerity

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generalized concept of privatization, since privatization was assumed to also "serve as a barrier against corrupt politicians. This however does not settle the problem of accountability; on the contrary, market forces are still less accountable than state bureaucracies. The question, then, is not one of state versus market but rather points towards democratization and reforms that make both the state and corporations more accountable" (Pieterse, 2010, p. 44).

[71] This list is found in the 2002 edition on pages 35-36.

[72] Prior to the 2010s, only Global South countries were typically forced into this program of repayment where the risk involved in the loan was deemed not to be the responsibility of the Bank. For more contemporary examples of austerity measures being imposed on countries (McKee et al., 2012) in a fairly recent version of the SAPs being forced onto 'developed' countries for the first time., see the examples of Greece and Spain from 2011 to 2015.

[73] In a 2016 interview, David Harvey notes the transition by the IMF and WB towards neoliberalism and the removal of employees with state-led or public sector ideological leanings. One of the key transitions towards the neoliberalization of these institutions was when they threw "out all the Keynesians" in 1982 which amounted to "a total clean-out of all the economic advisers who held Keynesian views. They were replaced by neoclassical supply-side theorists and the first thing they did was decide that from then on the IMF should follow a policy of structural adjustment whenever there's a crisis anywhere." (D. Harvey, 2016)

financing, and public service 'reform'" (ibid.). Many who backed this new neoliberal religion, while "rhetorically antistatist," have instead proven themselves to be very "adept at the (mis)use of state power in the pursuit of these goals" (ibid.).[74]

Significantly, the 'disease' of inequality spread rapidly during this era. Widening income discrepancies in the 1980s resulted from right-leaning political change in many English-speaking countries. Following the adoption of neoliberal policies, inequality initially widened most rapidly in the UK, US, New Zealand, and Australia, "accompanied in each case by a free-market ideology and by policies designed to create a more 'flexible' labour force" (R. Wilkinson & Pickett, 2010, p. 244).[75] Predictably this 'disease' also spread south as neoliberal influence expanded or was imposed due to geopolitical power imbalances and neocolonialism.

Neoliberal knowledge- and policy-producing institutions, such as the WB and IMF as well as the Chicago School of Economics, continued to ignore inequality and advanced the idea that economic growth was the first important building block of 'development' for the Global

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[74] State rollback and the expansion of privatization were the rallying cry of the new political economy ideology, which, in large part led to the institutionalization of the SAPs. Yet, even after the 2008 financial crisis (Financial Crisis Inquiry Commission, 2010), the conceptual hopes that privatization would "produce competitive markets in industries thought to be natural monopolies . . . have ultimately proved unfounded." Problematically, the neoliberal claim that "privatization always yields net social benefits and therefore that, other things being equal, the price for which a public asset can be sold will exceed its value in continued public ownership . . . has never had much empirical support." Instead, it was "taken on faith as a consequence of the Efficient Markets Hypothesis. With that hypothesis discredited, it is possible to consider how the public might lose from privatization" (Quiggin, 2010, p. 188). However, despite "evidence that privatization mostly makes governments worse off, it continues to be promoted as a solution to short-term financial difficulties" (p. 194).

[75] R. Wilkinson and Picket (2010) note a few interesting aspects about the rise in inequality. Public policy and political will played significant roles in countries such as Sweden, which utilize "redistributive taxes and benefits and a large welfare state"(p. 183). Importantly, "changes in institutions, norms and the use of political power" have played significant roles. However, most changes in income distribution for most countries are almost never "attributable simply to market forces influencing wage rates" (p. 243). Differences in rising "pre-tax earnings," less progressive tax rates, rollback of benefits, and law utilized to weaken trade union powers" all increase inequality (p. 243-244). Thus, due to a strong neoliberal approach, the US remains an outlier in studies on inequality. Despite being the "wealthiest country in the world and the most unequal of the rich countries," is does "poorly on a wide range of measures of social well-being, from life expectancy to serious crime, and even on such objective measures as average height" (Quiggin, 2010, p. 167). Only Portugal and England are close to the US in poor outcomes due to inequality (R. Wilkinson & Pickett, 2010).

South.[76] Under this evolution of hypothesis into policy it was assumed that the 'trickle-down' effect of social progress would occur once the country had stabilized its economy, after which economic growth (as measured through an increase in GDP) had begun. Once growth in GDP was initiated, a country could begin establishing other services for its population, such as healthcare and education.[77] Thus emerged the creation of a seemingly altruistic and harmless concept where "the main purpose of economic development" was "to permit the achievement of a decent level of living for all people, everywhere" (Inkeles and Smith, 2019, p. 70). It was then expected to help fortify the link to economic growth while subjugating the idea that health without wealth was possible (C. Walker, 2015).

Kasturi Sen and Meri Koivusalo note that, in the years following the 1978 Alma Ata Declaration, healthcare systems in some major capitalist countries were still in opposition to principles of development and re-distribution, with the healthcare sector in the Global South being "increasingly influenced by private interests and by the principle of 'willingness to pay'" (1998, p. 210). This has meant that healthcare "reforms have, in effect, encouraged the growth of private providers in healthcare and further legitimized private services for the affluent sections of

[76] The WB and IMF attempted to spur Global South economies to cut back social programs in order to focus on opening up market access. SAPs caused per capita public expenditures on healthcare to drop. The reduced investment in health meant that both the quantity and quality of subsidized public healthcare services decreased correspondingly. In many cases levels of utilization, especially at rural health facilities, fell. Outreach services often no longer functioned, drugs were often unavailable, and healthcare staff were "unsupervised and sometimes unpaid for long periods of time." Rural populations also "faced higher costs for healthcare in terms of transport and time to get to hospitals in larger towns, or by payments to private providers of treatment and medication." In this case "free" care had "come to mean unacceptably poor care" (Creese & Kutzin, 1995, p. 1).

[77] This was also affirmed in 1987 Brundtland Report released by The World Commission on the Environment and Development. It called for countries to focus on increasing economic growth to develop other sectors of their society (such as education and health) in both Global North and Global South countries. This was a landmark call for reforms that helped establish economic growth as the primary goal which, when achieved, would then assist meeting other objectives such as increasing public health and education (Brundtland, p. 1987).

the population while limiting public provision to selective, basic services for the poor" (ibid.).[78] Thus, even though Global South countries are burdened by 90% of the world's diseases, they are often only able to allocate less than 10% of their budgets to public healthcare (Chudi, 2010, p. 10).

Anne Mills notes that, on average, approximately "50% of healthcare financing in low-income countries comes from out-of-pocket payments, as compared with 30% in middle-income countries and 14% in high-income countries" (2014, p. 553). Thus, risks are shared in high-income countries while vulnerabilities created by a lack of public health access and insurance mean that patients in low-income countries are much more vulnerable to spikes in ill-health.[79] As a result, one of the most unfortunate realities for Global South countries—especially countries where patients' healthcare services are based upon the ability to pay—is the reflexive relationship between ill health and poverty: where "poverty begets ill health, and ill health begets poverty" (C. Walker, 2015, p. 29). As Global Health Watch outlines, the "challenge of improving global health is therefore inextricably linked to the challenge of addressing widespread and growing poverty" (2005, p. 3). And yet, this understanding appears to remain outside the purview of the TPI.

[78] Unfortunately, poor outcomes are consistently observed wherever "privatization has been extended to the core areas of the welfare state such as education, health, retirement income, and criminal justice" (Quiggin, 2010, p. 195). Thus, it is not just healthcare which has limited to absent positive correlations with privatization, but other areas that also include non-medical determinants of health such as education.

[79] Mills surmises that when payments from "general government expenditures, social (public) health insurance, and prepaid private insurance are combined, only 38% of healthcare financing in low-income countries is combined in funding pools, which allow the risks of healthcare costs to be shared across population groups, as compared with approximately 60% in middle-income countries and 80% in high-income countries" (Mills, 2014, p. 553). This heightened vulnerability means that the cycles of ill-health and poverty are more intimately connected in countries which lack robust public health services.

The relationship between poverty and disease is seen in the spread of tuberculosis (TB), malaria, HIV/AIDS, and dysentery since all four are effectively stymied by adequate healthcare as well as effective public policies targeting sanitation, housing, and access to healthy food.[80] The spread of treatable pathologies is especially troubling since medical personnel and policymakers often overlook SDOH which negatively impact access to effective healthcare. In a medical policy framework, structural violence is the result of ineffective and oversimplified social and policy structures. The positive change needed to address the roots of structural violence can only be produced by changing the processes in which structural violence is deeply embedded (Farmer et al., 2006). Thus, one of the issues facing conventional North American healthcare models—which tend to be clinically-based and curative-focused—is the simplistic construction of the praxis of healthcare.

This situates the locus of health primarily on the individual, while ignoring the larger structures and policies that create ill health. This, in turn, "can slide a whole family into poverty if the healthcare is inadequate, unaffordable or inaccessible" as members often have to leave income-generating employment to care for loved ones in the absence of publicly funded social safety nets (C. Walker, 2015). Evidence of marginalizing environments, which result in poor/unequal health outcomes, if known by government and those in power, constitute a biopolitical responsibility to address the root causes of their health issues. When governments

[80] Few other diseases provide better comparative analysis into the connection between poverty and illness than TB. TB is one of the most effective indicators of structural violence's influence on health. The consequences of structural violence—ill-ventilated housing, unbalanced diet low in fresh vegetables and lack of access to expensive drugs—increases the spread of TB. In both Russia and New York, within the past 40 years, economic policies, and social inequalities (including racism) combined to create epidemics of dangerous drug-resistant strains of tuberculosis. These situations constitute "a human rights violation, a fact ignored by many in the human rights community" (Farmer, 2005, p. 22).

have the ability and power to do so, but do not act towards the betterment of poor health outcomes for marginalized populations, this constitutes a form of 'necropolitics' (Mbembé & Meintjes, 2003). In this sense, the state knowingly has the power to biopolitically act, as well as the knowledge of the plight of these fatally health-impacted populations, yet consciously decides who dies due to, in this case, necropolitical inaction.

The issue of poverty is also cyclical in nature. Impoverished segments of the population are often the least informed regarding threats to their health, a situation which frequently makes them the most vulnerable to the risks of hazardous environments. Unfortunately, this mix of factors—poverty, education, and illiteracy—means that these populations have substantially increased vulnerability to poor conditions of ill health. This often increases inequality as many marginalized and impoverished members of the population spend their often-meagre resources on health services and products that may not result in an adequate solution due to the lack of accountability often found in market-based health systems (Kaseje, 2006; C. Walker, 2015).[81]

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[81] Trudy Harpham highlights Judy Baker and Nina Schuler's characteristics of urban poverty and identifies additional health implications of those characteristics in italics as follows:
- commoditization (reliance on the cash economy): *poorer nutritional status due to lack of food from subsistence farming, reduced care of infants and children due to distant work places;*
- overcrowded living conditions (slums): *infectious diseases, accidents;*
- environmental hazard (stemming from density and hazardous location of settlements, and exposure to multiple pollutants): *respiratory diseases, diarrhea;*
- social fragmentation (lack of community and inter-household mechanisms for social security, relative to those in rural areas): *mental ill health;*
- crime and violence: homicide, injuries, *mental ill health;*
- traffic accidents: *injuries and death;*
- natural disasters: *injuries and death.* (Harpham, 2009, p. 109)

Understandably, the oversimplified austerity and privatization measures imposed upon developing countries by the IMF and WB did little to mitigate many of these issues, and in many cases exacerbated them instead. The decimation of healthcare by the SAPs and the lack of Alma Ata's implementation has continued to burden many countries wishing to address these legacies (C. Walker, 2015). Harpham helps expand on the impact of poverty on health by outlining that most of these aspects "are particularly harmful for health can be characterized as negative health and social externalities" (Harpham, 2009, p. 109).

Thus, due to even greater levels of private expenditure in the Global South because of their poor quality public health systems and lack of universal coverage, for-profit medicine adds additional issues for the patient since the "value of health and education services is derived in large measure from the knowledge of the providers (doctors, nurses, teachers and others) and their skill in applying that knowledge to benefit patients and students" (Quiggin, 2010, p. 203). To put this in context, "the standard economic analysis of markets begins with the presumption that both parties are equally well informed about the nature of the good or service involved." However, this is not necessarily the case since the "asymmetry of information is intimately linked to the fact that the benefits of health and education services are hard to predict in advance, or even to verify in retrospect" (ibid.). Therefore, it can create "severe problems for financing through market mechanisms such as health insurance and student loans." In most cases, "substantial government involvement in the financing of health and education is unavoidable. Once governments are paying some or all of the bill, the most cost-effective solution is often direct public provision" (ibid.).

Thus, in a highly privatized healthcare model, whereby the healthcare worker responds to profit and pressures of business management personnel instead of the health needs of the patient, the health professional "holds all or most of the cards" when engaged in transactions for medical services and goods (C. Walker, 2015, p. 76). In this way, the 'patient-turned-client' may be unable to evaluate whether procedures, health products, drugs, or appointments are required for their health; or whether they are desired by the health professional to increase profit since the patient is subject to an unequal power dynamic "regarding the knowledge base of the transaction" (ibid.). The healthcare providers under this system also often 'advise' the patient

which products or drugs to buy—a process which may be linked to private kickbacks from the pharmaceutical industry or private medical suppliers. This often occurs at a time when the patient has limited options or the knowledge base to decide whether the quality or cost is reflective of their situation (ibid.).

The shift to private healthcare during the era of the SAPs meant that most companies focused on extensive use of high technology and curative healthcare approaches instead of low-cost primary preventive healthcare (Brunelli, 2007). The focus of private healthcare, often found in hospitals and clinics, were most often located in urban centres (K. Sen & Koivusalo, 1998). These private companies did not prioritize preventive community clinics which were needed to replace government clinics that had been forced to close due to the SAPs. The growth of the private medical sector after the "lost decade of development" caused, in part, by SAPs, paved the way for the 'Trojan Horse' of private health (Carrasco, 1999).[82] This meant that a reversal of privatized health measures was—and continue to be—difficult to dislodge, regardless of adverse effects.[83]

The IMF and WB also compromised food security due to trade liberalization as well as reduced levels of education due to cuts in social spending—both of which entailed additional

[82] Faranak Miraftab explains how the private sector acts as a Trojan Horse: "In the context of the third world's wide socioeconomic gaps and decentralizing states, where central governments often have neither the will nor the ability to intervene effectively, [Public-Private Partnerships known as] PPPs are free to operate as the 'Trojan Horses' of development. Private sector firms approach local governments and their impoverished communities with the message of power sharing, but once the process is in motion the interests of the community are often overwhelmed by those of the most powerful member of the partnership—the private sector firms" (2004, p. 89).
[83] As highlighted by Bianca Brunelli, reductions in healthcare expenditure can arguably be considered a form of "structural violence" (2007, p. 11). This is because such policies often isolated marginalized and rural populations, blocking them from obtaining quality primary healthcare due to a lack of money and resources. This two-tiered system for many Global South countries affected by the SAPs resulted in the middle–class and elite having improved private healthcare, while marginalized and impoverished populations were left with either inaccessible or inadequate primary care options (K. Sen & Koivusalo, 1998).

indirect impacts on population health.[84] The SAP era, which reduced the state's capacity to provide healthcare, concerned Annella Auer and Juan Eduardo Guerrero Espinel who note that though "many health determinants transcend a country's borders, the primary responsibility for the populations' health resides within the national sphere, most commonly with the State" (2011, p. 123).[85] In the most marginalized areas in the Global South there tends to be limited or poor-quality healthcare. In these areas, NGOs and informal market medical providers are often the only option for formal healthcare provision in the absence of government-run healthcare initiatives, even though history has shown that major communicable diseases were "brought under control through public health measures" (Kaseje, 2006, p. 8).[86]

As noted by Peter Evans and William Sewell, neoliberalism now functions as economic theory, political ideology, policy paradigm, and social imaginary (2013, p. 36). The neoliberal

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[84] In a 1995 review done by Tyrone Ferdnance of *The Impact of Structural Adjustment on the Population of Africa*, the details of the damage caused by the WB and IMF are revealed to be very extensive, and even exacerbated some of the economic issues they originally sought to remedy: "SAPs caused a decline in jobs, living standards, and healthcare delivery, and an increase in unemployment, absolute and relative poverty, income inequality, and food prices. Nii Kwaku Sowa finds that although Ghana achieved impressive rates of growth under the IMF structural adjustment program, both absolute and relative poverty levels increased. In Zaire, M. Lututala, M. Kintambu, and M. Mvudi reveal that malnutrition rose as the leading cause of death among children during the implementation of IMF structural adjustment policies. In many of the studies, the analysts find that not only did the structural adjustment programs cause social problems, but they also failed to correct the targeted economic ills (balance of payments and budget deficits, low and negative growth rates, and the lack of development). Most analysts conclude that IMF structural adjustment programs could not overcome external shocks, and they discover no strong association between structural adjustment policies and positive economic performance" (p. 506).

[85] Transmissible diseases, despite neoliberal focus on the scale of the individual as the agent of change and personal responsibility, operate at different geographical scales including international and community transmission. Infectious diseases also affect all socioeconomic classes regardless of relational distance (although, due to increased agency and freedom of movement as well as access to a wider array of health measures and working arrangements, rich populations tend to suffer less). This raises the question of resistance by some affluent people regarding taxes directed at public health measures. Though they may be relationally distant from the most rural, poor, and marginalized, it should be in the interest of the rich and powerful to contribute to broad public health initiatives which robustly address the health of all populations and limit the transmission of diseases which, like COVID-19, do not strictly respect socioeconomic class hierarchies (even though the poor and front line working class populations are far more burdened by infection with limited means to leave work if their health insurance is tied to employment, while rich populations are far more prone to increasing the international transmissibility of COVID-19 due to the income to travel).

[86] The reliance on NGO health initiative will be expanded upon in a later section of the literature review.

policy paradigm is described as "increasing the role of markets in regulating economic life;" privatizing public services and goods; reducing controls on the distribution of capital; expanding global free trade agreements coupled with the deregulation of labour and credit markets; utilizing IMF (and WB) aid conditions; as well as advancing intellectual property rights (p. 37).[87] While neoliberal social imaginary praises self-reliance and individualism; equates the "pursuit of self-interests and consumer satisfaction with human freedom; glorifies personal wealth; sees volunteerism, [charity, and NGOs] as the appropriate way to solve social problems; [while associating] government programs with inefficiency, corruption, and incompetence" (p. 38).[88]

Thus, contemporary international development approaches have joined with conventional high-technology biomedical and apolitical curative medical approaches. The neoliberal development/aid industry often shuns publicly funded approaches, imposing what Global North countries consider most pertinent for the Global South. Therefore, part of improving international development and global health is the acknowledgement that these neoliberal international institutions, agreements, and logics must also change.

Conclusion

With many in the Global South seeking to migrate to the Global North for numerous reasons, including the desire to gain access to welfare states/publicly funded services which have comparatively robust public health systems, the Global North attempts to instead manage the

[87] One contemporary problematic aspect of this is the example of the TRIPS agreement which holds back important medical resources and technology that would help, primarily Global South countries, battle COVID-19 (Fridell & Higgins, 2020).
[88] Notably, neoliberal ideology has become definitive to US national identity (Evans & Sewell, 2013, p. 49).

symptoms created by significant health and development disparities as well as contain the migration of vulnerable 'surplus' Global South populations (Duffield, 2007; 2008; 2010).[89] For the past thirty or more years, the Global North's attempts to manage these symptoms—which were often exacerbated by WB and IMF SAPs as well as other geopolitical power imbalances and neocolonial relations—are regularly left to the charity of the neoliberal development/aid industry and its, often, non-governmental approach. Yet the apolitical focus on managing poverty has obscured and depoliticised the shortcomings of this expanding neoliberal ideology despite a rising amount of evidence that inequality has substantial detrimental effects to healthcare systems and health outcomes (Quiggin, 2010; R. Wilkinson & Pickett, 2010).

Neoliberal knowledge- and policy-producing institutions such as the WB and IMF ignore (or even intentionally undermine) the whole means of development—focusing primarily on apolitical and ahistorical economic aspects. It also overlooks the belief of many that political and regulatory systems work towards the benefit of the public, choosing patient rights over patent rights or patient health over private and TPI profit. The work of Illich (1976), Tucker (1996a; 1997), Farmer (2005), John Braithwaite (2013) and Christopher Glazek (2017) highlight that blind faith in business, educational, research institutions, and regulatory bodies originally designed to protect the public, as well as the political will of politicians to prioritize their voters'

[89] As evidenced by the UN: approximately 85% of the world's refugees are hosted in developing countries: Turkey has 3.5 million, Pakistan has 1.4 million, Uganda has 1.4 million, Lebanon has 998.900, and Iran has 979,400 (UNHCR, 2018). As Deputy General Secretary of the g7+, Habib Rehman Mayar, notes: "Although I am not sure if empathy can be attributed to states but nothing else can explain better the trend that the world's less prosperous nations take greater responsibility in shouldering global challenge" (2018). This dissertation posits that it may be empathy, geography as well as the relational distance of Global South countries combined with the biopolitical strategy—aimed at containing the fallout from Global North geopolitical and resource interests (especially from mining and oil)—of western liberal development and its focus on containment.

health, are, at times, an illusion.[90] These bodies are not apolitical advocates. They are willing to prioritize, too often, corporate profits over public health and the for-profit privatization of public issues.

Thus, broader approaches to healthcare and development, rooted in critical holism, are important considerations for improving outcomes for poor, rural, and marginalized populations globally. Yet evidencing these approaches are challenging as few countries have escaped neoliberal globalization as well as the influence of the TPI. Due to these considerations, the example of Cuba is potentially significant as the impact of its medical internationalism emerged, not from an Organisation for Economic Co-operation and Development (OECD) country or a global superpower, but from a relatively 'poor' Global South country with stagnant GDP, limited resources, and marginal geopolitical power. As such, Cuba's significance is not simply relegated to the measurable outcomes produced by its approaches to development and healthcare (including both successes and challenges), but to evidence the geopolitical project against it and why few other countries are ideologically/politically willing or able to replicate its human capital-intensive approaches to global solidarity and healthcare as a human right.

[90] This is where Foucault's work on governmentality is pertinent. Bio- and necro-political critiques of the state provide a deeper analysis of the role of the state, including its absence in key aspects. Whereas Cuba's state-led approach attempts to secure biopolitical rights of its citizens, the absence of the state as well as evidence of the state responding to the dictates of the TPI, mean that the neoliberal governmentality of health and wellness is partially in control of private interests. The necropolitical potential of the TPI is highlighted in the OxyContin example. It is also highlighted in the Bayer's example in India, whereby the desire for profits is given greater concern than the health outcomes of the poor in India. In the absence of state regulation, the necro-political impact of TPIs and their focus on profit allow the heads of Big Pharma, such as Martin Shkreli (Mole, 2018), to buy patents and increase the prices of essential drugs, since profit motive is more important than patient rights under this neoliberal approach. Though Foucault's governmentality may have originated as a critique of the powers of the state, and its ability to decide the life and death of its citizens, Cuba, in contrast to impacts of TPIs and the reductionist biomedical approaches to Global North healthcare and education, may put forth a positive interpretation on governmentality.

Thus, Cuba's 'health in all policies' approach to healthcare and development remains a subaltern outlier. However, despite conventional healthcare systems as well as neoliberal knowledge- and policy-producing institutions dismissing or overlooking its 'counterhegemonic' example (Peet, 2015), important lessons on health equity can be studied from its domestic healthcare systems as well as adaptations in Venezuela and Timor-Leste. With robust preventive and proactive socio-political aspects of their health systems complemented by curative biomedical aspects, this state-led example ensures that healthcare and medical education no longer overlooks those with limited agency, limited wealth, or limited power; but rather, equitably focuses on their empowerment so that they can become healthcare providers for their own relationally close, yet medically vulnerable, communities. Thus, the poor, rural, and marginalized communities are no longer seen as populations whose well-being is marginally acknowledged by urban and affluent population charity nor Global North development workers/volunteers; but instead, these health-vulnerable populations are the focus of their own solution based upon dignity through capacitation.

Because rational evidence is not enough to draw attention to the significance of the Cuban model or overturn the dominant neoliberal paradigm, the following Theoretical Framework chapter will build upon this political economy Literature Review by drawing from critical sociology, psychoanalytical approaches, as well as biopolitical considerations to highlight psychological and political biases at play. This will help explore deeper implications of the explicit and unconscious/implicit of healthcare and development, including the biopolitical project of the neoliberal development/aid industry. Through these theoretical lenses, the political economy challenges outlined in this Literature Review will highlight additional ideological tools

which may help address complex global health and development issues, currently overlooked by the pervasive hegemonic neoliberal paradigm.

Chapter 2 Theoretical Framework: Identifying the Explicit and Implicit of Healthcare and Development

"*Neoliberal democracy . . . Instead of citizens, it produces consumers. Instead of communities, it produces shopping malls. The net result is an atomized society of disengaged individuals who feel demoralized and socially powerless. In sum, neoliberalism is the immediate and foremost enemy of genuine participatory democracy, not just in the United States but across the planet, and will be for the foreseeable future.*"
(Robert W. McChesney referencing the work of Noam Chomsky, 1998, p. 11)

"*If ignorance is the result of the ideological belief that science is and ought to be ideology free, then it is a hidden ideology that is the most serious barrier to enquiry.*"
(D. Harvey, 1974, p. 276)

This chapter will situate theoretical considerations for healthcare and international development from a transdisciplinary 'critical holism' approach. Because development is "not merely a science or analytics (development theory) but also a politics" (Pieterse, 2010, p. 161), the goal of this chapter will utilize a range of considerations (political economy, critical sociological, biopolitical, and psychoanalytical). These considerations will help differentiate between explicit /conscious geopolitical projects of those in positions of neoliberal power and wealth (as evidenced in the previous political economy chapter), in contrast to the implicit/unconscious social fantasies of many in the development/aid industry. Due to relational distance and ideological assumptions of the current neoliberal hegemony, many in the development/aid industry—often unknowingly—produce and maintain hegemonic systems of injustice, inequity, and inequality (frequently to the benefit of many of the most wealthy and powerful). Therefore, development and solidarity could benefit from an optimal "critical

distance" to "avoid being taken in by the group's definition of the situation but being near enough to understand the group's experience" (Andersen & Taylor, 2007, p. 11).

Critical distance involves being "able to detach from the situation at hand and view things with the critical mind," where, importantly, the optimal sociological perspective "requires a combination of nearness and distance" (ibid.). Critical distance arguably appears on a spectrum of relational proximity and distance whereby critical distance denotes the optimal 'relational distance' for a given context, be it healthcare, development or otherwise.[91] Thus, if a development worker from the Global North (many who are often drawn from urban and affluent populations) is too disconnected from the realities of the plight of the Global South poor, that person might be too 'relationally distant' to possibly be as effective as a person who is 'relationally closer'. As such, relational distance will simply be operationalized in this dissertation to signify 'distance' (or proximity) between two or more individuals, groups, and organizations (including institutions) as they are able to 'relate' to each others' experiences, ideologies, cultures, histories, and backgrounds.

This concept will be used to highlight how Global North solutions to complex development and healthcare challenges rarely involve (in practice) those who are relationally near or engaged with ideological shortcomings of the current neoliberal hegemony—including those from the World Bank (WB) and International Monetary Fund (IMF). As such, many

[91] Relational distance is a concept usually associated with a branch of sociology, called 'pure sociology', and the work of Donald Black (1976). In Black's work on legal sociology, he discusses relational and cultural distance as a form of social distance, which also includes cultural distance. The concept of relational distance is also used in leadership studies, where Laura Erskine (2012), who uses a "multidisciplinary lens" as well as including "findings from a larger number of disciplines," defines relational distance as a "multidimensional and interactive distance between individuals" (p. 97). The three dimensions of relational distance in her article include "structural distance" (including physical distance, channels of communication and frequency of interaction), "status distance" (including demographic distance and social distance), and "psychological distance" (including relationship quality and decision-making latitude) (ibid.).

proposed development solutions to geopolitical poverty and marginalization, advanced by these neoliberal policy- and knowledge-producing institutions located in hegemonic power centres (London, New York, Washington etc.) (Peet, 2015, p. 265), are often carried out and managed by populations who have little lived experiences of poverty and marginalization. This disconnect may be one of many reasons why numerous Global North international development projects meet limited long-term success in Global South poor and rural locations as they are often unable to 'relate' to the Other.

Additionally, while "development thinking has become more participatory and insider-oriented, . . . development practice has not been democratized, particularly when it comes to macroeconomic management, so there is a growing friction between development thinking and practice" (Pieterse, 2010, p. 162). Therefore, this theoretical framework will begin by situating what may potentially be limiting or blocking Cuba's subaltern 'counter-hegemonic' lessons—including democratized policies and practice based on bilateral (as well as emerging triangular) agreements—from being considered by both Global South and Global North countries. This connects to the dissertation's main question: Can Cuba's state-led medical internationalism achieve better and more long-term health outcomes as well as a scaling up of public healthcare systems/personnel (especially those drawn from rural, marginalized, and poor communities) in the Global South than current—'hegemonic'—neoliberal non-governmental development efforts based primarily on Global North charity?

An additional set of questions, drawn from Mark Duffield's 'biopolitical' work on the development/aid industry, will conclude this chapter. These questions include: Does Cuban cooperation produce 'insured' or 'non-insured' populations (Duffield, 2007; 2008)? Does Cuban

cooperation address challenges of 'institutional fragmentation' (Duffield, 2012)? And finally, does Cuban cooperation offer an alternative to neocolonial 'contingent sovereignty' and 'native administration' (Duffield, 2007; Duffield & Hewitt, 2009)?[92] These considerations are important in order to understand the significance of Cuba's healthcare model—including its operationalization in Venezuela and Timor-Leste—as well as to evaluate their ability to provide effective and efficient public healthcare and development lessons which address structural violence for other countries. As such, addressing the complex challenges of healthcare and development will utilize a range of theoretical considerations.

Critical Holism: An Attempt to 'Heal' Development Logics and Practice

"*While there is a mysticism of the human body, a theory and a practice (holistic medicine), there is no equivalent holism of the social field. This is the missing element. There are, so to speak, 'a thousand points of light', but they are scattered about . . . local alternatives, cultural and spiritual alternatives, rival theories, counterpoints and countercurrents, but there is no unifying, overarching paradigm as there is, up to a point, in relation to health.* ***The appeal of critical holism is that it places holistic theorizing and practice in relation to collective existence on the agenda and thus renders it imaginable****: at least steps can be taken in its general direction*."
(Pieterse, 2010, p. 157—emphasis in bold added)

In his work on critical holism, Vincent Tucker combined a "critical synthesis of holistic medicine, political economy, development theory, environmentalism and feminism" with a "theoretical synthesis of holistic theory, Marxist political economy and culture critique" (1996a, p. 3)—despite contestation between them and contradictions found in nearly all of them,

[92] These terms will be discussed in detail in the following sections.

including in this dissertation.[93] This is because, in International Development Studies(IDS)/Global Development Studies (GDS), one-sided disciplinary perspectives have gradually been in retreat as well as—importantly—"relegated to the status of partial knowledge" (Pieterse, 2010, p. 158). Though disciplinary knowledge is still seen as foundational in many departments and interdisciplinary research is "more widely applauded than it is practised," while a "multidisciplinary approach refers to a combination and an interdisciplinary approach to an interaction of disciplines," a holistic approach to development is a significant evolution. In this sense, holistic "means integrated from the outset, which implies a revisioning of each discipline (a new view of economics, etc.) and not just an adding up" (p. 159).

Understandably, critical holism is a fairly uncommon synthesis as they both "refer to different modes of cognition" (p. 146). However, in a "broad sense both criticism and holism then refer to modes of healing: from the point of view of completeness in a societal sense by way

[93] By drawing on a wide range of traditions, it is important to recognize their antinomies, where they disagree and, on this basis, what this dissertation takes from them as well as what this dissertation rejects. Thus, in terms of Karl Marx's work, the semi-ridged state-level scale of analysis and teleological development as replicating Global North industrial development has traditionally overlooked environmental, inter-personal, psychoanalytical considerations as well as the expanding influence of finance etc. His argument that socialism can only be accomplished through class conflict/proletarian revolution, not through democratic means (as the case of Venezuela or social-democratic examples such as Finland highlight) etc., is also potentially problematic. As noted by Sparby et al. (2019, p. 6) regarding Michel Foucault and others' view of (radical) subjectivity, the 'true self' is far more contingent on "biological, cultural or other environmental factors" including structural violence. Also, regarding Foucauldian traditions, despite his romanticism of liberal freedom and distain for governmental involvement, this dissertation has found the biopolitical work of Mark Duffield quite applicable to Timor-Leste's example as a strong critique of the [neo]liberal development/aid industry and how it undermines welfare state development in the Global South. Thus, the governmental state that concerned Foucault, according to the biopolitical work of Mark Duffield, has been internationalized in Global North neocolonial and [neo]liberal institutions that govern "non-insured" life in the Global South (Duffield, 2007). However, the postmodern/post-development criticism without solutions (endemic in Foucauldian traditions) means that, under these theoretical approaches, development is essentially stuck in, what Slavoj Žižek terms as, "ironic distance" which is a drive towards criticism without engaging in solutions (Žižek, n.d.). This is where psychoanalytical criticism is applied as a (potentially controversial) synthesis with Foucauldian biopolitical management of populations via [neo]liberal development, Gramscian (hegemonic versus counter-hegemonic analysis), and Marxian political economy traditions. It pushes into deeper, multiscale, multitemporal, complexities, while attempting to opening space for alternatives including subaltern knowledge production and counter-hegemonic examples such as Cuba, Venezuela, and Timor-Leste. It also advocates for, as Marx would, the advancement of social justice as well as the development and support of welfare states which advance public services for public good.

of emancipation and justice, and from the point of view of wholeness in a multidimensional sense" (p. 147).[94] As noted by Jan Nederveen Pieterse, "considering that development is applied modernity, all the contradictions of modernity are reproduced within development as dramatically unresolved tensions" (2010, p. 152).

As such, development theory (much like this dissertation's diverse theoretical considerations that draw from Marxian, Gramscian, Foucauldian, and Žižekian traditions), "is often being torn between paradigms—mainstream, alternative and post-development—or between internal and external critiques of development" (ibid.). In a critical holism approach, "development means acknowledging paradox as part of development realities: such as the antinomies between measurement and meaning, between intervention and autonomy, or the tension between the local and the global" (ibid., p. 161). Additionally, these "antinomies are part of the perplexities of the human condition" whereby "*development participates in these perplexities* and is not in some fashion outside or beyond them" (ibid. emphasis in italics added).

[94] Much like Pieterse, this dissertation finds that both criticism and holism form a 'welcome synthesis' in its attempt to challenge academic libidinal drives toward theoretical contestation and divisiveness between disciplines/theoretical approaches (possibly due to ego-attachment and defensiveness). Thus, without a 'critical edge', holism, like modernization theory and neoliberal development, "easily becomes totalizing, romantic, soggy; and without holism, criticism easily turns flat, sour" (Pieterse, 2010, p. 146)—much like the 'ironic distance' of post-development and Foucauldian tendencies towards critique without solution. However, if these critical and holistic sensibilities are re-coded, their "synthesis becomes easier. To 'criticism' there are several strands: it refers to the exercise of analytical faculties; it means a repudiation of 'faith' and dogmatism in the Enlightenment tradition; it entails a commitment to class struggle in Marxism; an emancipatory knowledge interest in critical theory; and equality and social justice in dependency theory. Key elements of criticism then are analysis, anti-dogmatism and social justice . . . If we take criticism in its affirmative sense it means acknowledging dimensions which have been left out. Through criticism an inclusive knowledge is to be achieved, which represents those elements which are outside or not acknowledged in the status quo [such as the neoliberal hegemony]. Accordingly, criticism is also an attempt at healing in the sense of restoring wholeness—by acknowledging and rendering visible that which has been ignored, left out" (p. 146-147)—including subaltern knowledge produced by counter-hegemonic examples such as Cuba. Interestingly, critical holism shares similar transdisciplinary considerations as Mi'Kmaw Elder Albert Marshall's notion of "Two-Eyed seeing" which attempts to bridge the gap between Western science and Indigenous knowledge.

Thus, critical holism attempts a delicate, complex, multiscale, multitemporal, dynamic and imperfect balancing act.[95]

Thus, while critical holism encompasses "social, economic, political and environmental systems including world systems" (Tucker, 1996a, p. 41), this dissertation will add how neoliberal and unconscious 'social fantasies' can problematically motivate conventional healthcare and development approaches. This will help identify how the Global North's hegemonic neoliberal development program is furthered by unconscious desires, 'libidinal drives', 'disavowals', and 'empathic capture' of many in development and healthcare industries.[96] This is because, as Žižek observes:

> The fundamental level of ideology is not of an illusion masking the real state of things but that of an (unconscious) fantasy structuring our social reality itself. And at this level,

[95] To Pieterse, this complex balancing act of critical holism "involves balance in a wider and more fundamental sense, across dimensions of collective existence, from the epistemological to the practical, which may take several forms: A multidimensional approach, or a balance between the horizontal and vertical dimensions of collective existence. . . A multifaceted approach . . . which reflects or shines light upon relations and dynamics across sectors (economy, politics, social, cultural) and levels (local, microregional, national, macroregional, global) and achieves a balance between them . . . A chiaroscuro social science which abandons the assumption of full transparency of society . . . This is a matter of modesty, a sense of the contingency of knowledge, or self-limiting . . . A distinction between and combination of objective and subjective dimensions of development. Development thinking is now increasingly anchored in people's subjectivities rather than merely in overarching institutions—the state or international institutions . . . A trend in local and increasingly also in large-scale development is towards partnerships across sectors, or synergies between different development actors – government, civic associations and firms . . . Since development is concerned with the measurement of desirable change over time, it is chronocentric. For a more complex awareness, what is needed is combining multiple time frames and a balance between 'slow knowledge' and the 'fast knowledge' of instant problem solving." (2010, p. 161-162)

[96] Disavowal, as Maureen Sioh notes, is both simultaneous acknowledgement and dismissal (2014). In this case, Global North healthcare and development approaches often acknowledge the poverty of their capitalist approaches to development and healthcare yet continue to be invested in maintaining a social fantasy of development/healthcare as charity, eroding welfare state development in the Global South. This drive for charity has also resulted in the dumping of aid and unused/obsolete medical equipment (Miesen, 2013), undermining local economies as well as increasing toxic waste (often dumped next to poor and racialized communities) (Waldron, 2018), while Global North countries continue their push for unequal terms of trade. Additionally, Global North extraction of Global South resources as well as "the race to the bottom" of international manufacturing are often accompanied by pressures to decrease environmental and labour standards as well as little economic returns for host countries (Klein, 2000; 2015; Hanieh, 2013). Thus, the Other's poverty is essential to Global North material enjoyment in addition to ideological enjoyment (such as charity) while some in the development/aid industry also further ineffective neoliberal development processes by their libidinal desire for virtue signalling/social media as well as policing/gentrifying discourse.

> we are of course far from being a post-ideological society. Cynical distance is just one way—one of many ways—to blind ourselves to the structuring power of ideological fantasy: even if we do not take things seriously, even if we keep an ironic distance, we are still doing them. (Žižek, n.d.)

Problematically, many well-intentioned people who are blind to structures/systems of power, social fantasies, and ideology (including myself), can undermine welfare state development and public healthcare in the Global South—despite the best of intentions—as well as silence potential alternative subaltern health- and development-equity approaches (Kapoor, 2020).

Therefore, while the political economy of capitalist marginalization occurs, the neoliberal development/aid industry continues its ideologically and relationally distant desire to palliate symptoms of a geopolitically unjust systems that are the foundation of capitalist globalization, profit, and charity. Thus, similar to many others in the conventional development/aid industry, "liberal economists such as Amartya Sen, Joseph Stiglitz, and Jeffrey Sachs, while primarily concerned about the problem of poverty, take for granted a capitalist political economy as the solution" (Kapoor, 2020, p. 271). Quoting David Blaney and Naeem Inayatullah, Ilan Kapoor notes how this narrow reading by those in [neo]liberal development circles, industries, and academia, much like Sachs, Sen, Stiglitz, and others ignore how "poverty might be intrinsic to wealth creation . . . additional wealth creation, rather than solving poverty, [which] only exacerbates the patholog[ies] of the wealth/poverty"/health nexus (ibid.).

As such, this chapter will next explore the explicit and unconscious elements of development. It will start with the explicit geopolitical capitalist development project spearheaded by Walt Rostow and the transition from 'modernization theory' to neoliberal

development. It will then highlight the example of Jeffrey Sachs as an apt example of neoliberal development from someone who (in his most popular 2006 book, *The End of Poverty*) exemplifies the emotionally charged and empathically driven, yet relationally distant and ideologically narrow, neoliberal approach to end 'global poverty'.

The Explicit and Unconscious of Development: From Rostow to Sachs and Celebrity Humanitarianism—A Case for Relational Distance

> *"a tendency . . . inaugurates the field of Development Studies . . . since cold war politics demanded the construction of a strong and irreproachable West, cleansed of any suggestion of complicity in Third World 'underdevelopment'. Thus, the discourse of modernisation (in its postwar and contemporary forms) can be seen as receiving back its own message to the Third World in inverted form: it is as if it is saying 'you need to be backward, irrational, poor, terroristic, weak, exotic, fundamentalist, passive, etc. since that is my way of reassuring myself that I am civilised, rational, scientific, rich, strong, secular, active, etc.'. What psychoanalysis adds to the postmodern understanding of binary construction is the dimension of the Real, which shows up here in the form of the blind spot—the element of selflimitation that one cannot really come to terms with, so one averts it by (unconsciously) projecting it onto the Other."*
> (Kapoor, 2014, p. 1127)

Since the end of World War II (WWII), many academics specializing in development theory, as well as politicians and practitioners, have promoted the idea of the need for economic growth as a main goal to achieve high health indicators.[97] It was after WWII that Harry Truman, then President of the US, made his landmark speech regarding the 'First World's' future relationship with the 'Third World'. Truman stated in his speech that there was a need to embark upon a "bold new program . . . for the development . . . of underdeveloped areas" (Truman,

[97] However, it must be highlighted that 'basic needs' theorists contested this notion in the 1960s. For more on the basic needs conceptualization of health and development see Gunnar Myrdal (1963) and Dudley Seers (1969).

1949). It was after this speech when modernization theory, in the field of international development, became the dominant theoretical paradigm upon which to form development plans for the Global South—especially during the 1950s and 1960s.

The focus of early modernization theory was centred on 'evolutionism', 'diffusionism', 'structural functionalism', and 'interactionism'. This approach echoed one of Karl Marx's beliefs that "the country that is more developed industrially only shows, to the less developed, the image of its own future" (Marx, 1990, p. 91).[98] Here, the foundation of a linear path in the development of a country is hypothesized in international development thinking. This hypothesis eventually expanded to the point where modernization toward Global North industrialization by the Global South became the dominant goal in an effort to increase economic growth.

Rostow's 'five stages of growth' remain an influential blueprint for modernization theory and mainstream development. His reason for writing *A Non-Communist Manifesto* (1959) was to explicitly counter the spread of communism following World War Two (Berger, 2003). As an influential United States (US) academic, political theorist, and economist, Rostow argued for a simple and attractive path to development where a country transitions from each stage: 1) 'traditional'; 2) 'the pre-conditions to take-off'; 3) 'take-off'; 4) 'the drive to maturity'; 5) 'the age of high mass consumption' (Rostow, 1959). He viewed development as economic growth and capitalism as the engine for that growth. His 1956 article, "The Take-Off to Self-Sustained Growth," focuses on the transition to the third stage.

[98] This is taken from a revised edition. The original quote is found in Karl Marx's initial 1867 German publication—*Das Kapital*.

Yet Rostow explicitly manipulated the discourse surrounding the concept of development through various organizations, universities, and committees.[99] In these environments, "modernisation theory privileged an evolutionary conception of political change and development grounded in a romanticised vision of the history of the United States of America" (Berger, 2003, p. 429).[100] One of the central efforts was explicitly to "marginalise the concept of the 'state'," so that its role was limited to assisting the market. Thus, "the discipline of political science" became "consolidated and professionalised around pluralism as both the basis of US politics and the norm by which political theory and practice elsewhere were to be measured" (p. 428).

As such, the state's role was also particular in the way it stems from his agenda to distance its capitalist role from that of communism's role as a redistributor of wealth (Berger, 2003).[101] Instead, the state's role was primarily needed for "capital-supply" to initiate an industrial revolution as well as to "mobilise supplies of finance and to undertake major entrepreneurial acts" (Rostow, 1956, p. 39-40).[102] Problematically the notion of class struggle, structural violence, inequality, and injustice are overlooked in his analysis. For Rostow,

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[99] One example is the Committee of Comparative Politics, which became an important "force behind modernization theory in the 1950s and early 1960s" (Berger, 2003, p. 427). Political scientists from this Committee "engaged in the production of a theoretical alternative to Marxism" for the purpose of forming a "non-Communist theory of change" and "provide a non-Marxian alternative for the developing nations" (p. 428).

[100] Berger argues that this perspective "was grounded implicitly, and often explicitly, in romanticised visions of the history of North America and Western Europe (especially the US and Great Britain)" (2003, p. 444).

[101] The larger role of the state by Rostow is a notable difference between Rostow's modernization theory and neoliberalism—which could be considered the current 'development' paradigm.

[102] As Berger notes: "Although modernisation theory was clearly anti-Communist in its political outlook, it rested on a deeper set of assumptions about progress and modernity that in fact overlapped with Marxism. In particular, industrialisation and urbanisation were central to both liberal and Marxist visions of modernity and national development" (2003, p. 429). In this way, the debate became framed about the differences of competing development discourses—Marxism and Modernization—despite some of the more striking similarities. The early versions of these theories also lacked notions of environmentalism, instead framing the use of the environment in terms of extractive capital.

modernization is something you *choose*, not something that a country or population is necessarily *blocked from* (emphasis added).[103] Thus, Rostow (like his contemporaries) would have ignored possible lessons that could be learned from 'traditional' and Indigenous cultures—or, in the case of this dissertation, lessons that may be learned from non-Western countries such as Cuba, Venezuela, and Timor-Leste.[104]

During the 1970s, due to a worldwide production crisis and impending economic collapse, modernization came under fire with 'dependency' theorist, Immanuel Wallerstein, declaring modernization theory 'dead' in 1974. It was then that, despite diverse critiques from the political left, the voices of dissent from the political right "questioned state-centred solutions to developmental problems and began to argue for global free trade as the engine of economic growth" (Parpart & Veltmeyer, 2011, p. 43).

This neoliberal counter-revolution began to dominate conventional Western development practice and thinking. Supported by 'neoconservative' ideology as well as its "associated political regimes," specifically Reaganism and Thatcherism, mainstream neoliberal development viewed the "world market as the engine of growth" (p. 45). Thus, the private sector became the drivers of the development "engine," and "freedom—the untrammelled freedom of individuals to pursue their self-interest, accumulate capital and profit from their investments"—became the "fuel and

[103] This is a particular critique of modernization theory often done by World Systems theorists (Wallerstein, 1974; Skocpol, 1977).

[104] Rostow would possibly fail to recognize the historically complex relationship between capitalism and 'traditional' cultures in a way that Eric Wolf thoroughly explains in his 1982 book, *Europe and the People Without History*. Rostow's simplification of traditional societies would also fail to distinguish between tributary and kin-ordered societies. Thus, Rostow overlooks the rich and complex history of how these societies organized as well as often interacted, mixed, and overlapped, with capitalism (Wolf, 1982, p. 12-13).

catalyst of the development process" away from welfare state publicly-funded proactive and preventive primary care approaches (ibid.).

As such, modernization-turned-neoliberalism became a discursive project of "neoliberal knowledge production" and the institutions associated with it (Springer et al., 2016). The WB, the IMF, and university centres such as the Chicago School of Economics, framed development as neoliberalism—to present neoliberalism in a positive light or, at least, distance neoliberalism from blame. The lens of neoliberal knowledge production is helpful for understanding how these institutions have shaped (and are actively shaping) neoliberalism as a political project of supranatural institutions which often promote a fundamentalist market epistemology (Peck & Tickell, 1994; Mirowski, 2011; D. Harvey, 2016). The authors of these neoliberal knowledge-producing institutions face pressures, both consciously and unconsciously, to write from this econocentric point of view—a view that, at times, has struggled to address issues of agency, structural violence, inequality, and marginalization (Fridell & Walker, 2019). Some authors from these neoliberal institutions write from this point of view to protect their positions of employment or to "identify with the aggressor" of these institutions (Frankel, 2002; 2004).[105]

For Richard Peet, a core concern about these neoliberal knowledge- and policy-producing institutions is the way in which power has become concentrated in "a few spaces that control a world of [relationally-]distant others" (2015, p. 265). This has happened in such a way as to avoid primarily 'functionalist' approaches while simultaneously recognizing the broader structural powers of both capital and state. Peet argues for "a critical institutional analysis

[105] The term "identifying with the aggressor" was used by Ana Freud (1992). It means that a person may identify with the cause of a threat (such as criticism or disappointment) from a person of authority, and then respond to that threat by adopting attributes of the threatening figure or by appropriating their aggression.

embedded within structural terms and categories," including attention to mapping the location of these institutions as they are associated with "power centers" (2015, p. 265).

A key distinction for Peet is that his conception of "institution" includes both "material" (such as an organization with a specific building, space, mission, backing, resources, conventions, norms, discourse, and rules) as well as an institution with a "community of experts" (of devoted and disciplined experts who take many of the same assumptions for granted and work to reproduce the same body of knowledge) (ibid., p. 266). Thus, Peet's framework is important to analyze how hegemonic power centres "filter and direct interpretations of experiences" by means of civil society institutions which have specific goals and missions (ibid., p. 271). These institutions are often maintained by "communities of experts who discipline knowledge" (Fridell & Walker, 2019, p. 5). The result is the "creation of collective consciousness with limits on what can be legitimately thought, even while they are perpetually contested, and then reinvented, by class, gender, ethnic, and regional differences" (ibid.).

David Featherstone also expands on the teleological historical narrative that has been explicitly constructed to favour neoliberalism over competing, plural, and subaltern discourses. In his book, *Solidarity: Hidden Histories and Geographies of Internationalism*, he challenges and complicates "accounts of international politics which position the latter half of the twentieth century as an unfettered march towards neoliberal globalization" (2012, p. 250). By contesting such simplified political narratives Featherstone highlights diverse 'political presents and futures'. This in turn traces "plural trajectories constituted through solidarities" which have "shaped a concern with the coeval possibilities shaped through internationalisms" (ibid.). This helps

highlight the "importance of solidarities that refused or challenged the spatial demarcations marked out through the Cold War" (ibid.).

Therefore, it is important for development academics and policymakers to position the "Cold War as not just about East-West conflicts", but instead to the process of "opening up conversations between post-colonial and post-socialist projects" (ibid.)—including Cuban, Venezuelan, and East Timorese counter-hegemonic approaches to healthcare and development. These alternative approaches help challenge "teleological constructions of the Cold War as an unbridled victory for neoliberalism and the political right and asserts the coexistence of different ways of shaping political alternatives" (p. 251).[106]

Berger maintains that the battle over the discourse of development was particularly fierce regarding the 'successful' development of East Asian countries such as Hong Kong, Singapore, South Korea, and Taiwan—known as the 'Asian Tiger Economies'.[107] Advocates for neoliberal economic approaches promoted their successful development as being due to free-market economics despite all countries being a large mix of economic approaches and state intervention. Thus, throughout the Cold War period, Rostow and his contemporaries utilized "selective readings of particular cases of nation-state formation, crisis and/or consolidation" to promote

[106] Jeffrey Leo and Uppinder Mehan note: "Neoliberalism has a varied history depending on its variant as well as its history. For some, neoliberalism begins with the work of Adam Smith and the classical political economists such as David Ricardo and James Steuart. For others (Foucault and Stuart Hall for example), neoliberalism proper starts in the 1970s or 80s. An important early link between the economic and the cultural is the nexus of free trade and peace. Nineteenth-century economists explicitly argued that the development of free trade could lead to the replacement of mercantilist relations that depended on war by capitalist relations of commerce that depended on peace. The same argument in favor of free trade has been consistently voiced with each episode of globalization and neoliberalism" (2014, p. 14-15)

[107] Ha-Joon Chang notes that there is a particular desire by neoliberal knowledge-producing institutions and disciplines to associate the economic success of Singapore with merely free-market approaches as promoted in neoclassical economics. He challenges this notion by highlighting that it is nearly impossible to reduce in this way the complex case of Singapore as a success, especially given the strong role of the state in housing and healthcare to being a product of neoclassical economics. He highlights that it may take as many or more than four of the nine mainstream approaches to economics to explain the particular case of Singapore (Chang, 2016).

their development discourse contrary to facts that would have led others to conclude differently (Berger, 2003, p. 444).

Despite being ideologically at odds with Gramscian and Marxian approaches, Foucault importantly highlights that the spread of liberalism morphed into neoliberalism, where the liberal paradigm does not just assert the freedom of the market, but also in its neoliberal form now extends market rationality into areas it previously did not occupy such as families, relationships, and bodies (Foucault et al., 2008, p. 243-246).[108] In this way, the "generalization of the economic form of the market beyond monetary exchanges functions in American neoliberalism as a principle of intelligibility and a principle of decipherment of social relationships and individual behaviour" (p. 243). This mentality is so pervasive that most people act, not just with 'common sense', but with a kind of common sense that values economic sense over other kinds. Foucault categorizes this shift of the individual under the neoliberal paradigm as becoming "homo economicus" (Leo & Mehan, 2014, p. 15).

Thus, despite the theoretical antinomies of Gramscian and Marxian approaches with Foucauldian, this observation highlights a particular synergy that brings them together and links with psychoanalytical approaches. In this way, under the guise of a lack of ideology via 'common sense', neoliberalism, as well as neoclassical economics, appear to most as the only natural approach to health, development, and other psycho-social interactions. It has become, as Antonio Gramsci's conceptual legacy advances, hegemonic.

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[108] This dissertation reflects on Foucault's definition of neoliberalism because it helps understand how deeply ingrained into the public psyche it is. This is particularly important to understand when it comes to comprehending the affective role of development and why there needs to be further engagement with psychoanalytical slippages and gaps behind assumptions made, and traditionally held. It also helps to understand why engaging in alternative ideas or directions of development are so difficult, given the pervasive and embedded nature of individualism and materialism found in neoliberal societies.

As such, the far-reaching effects of neoliberalism are culturally ingrained so strongly that they are self-replicating, whereby alternative conceptions of development (or the creation of an alternative system to global capitalism) are often readily dismissed, or rarely considered. Hegemony, the concept originally developed by Gramsci, helps understand how to locate power—as well as the construction of power—in societies. He outlines with clarity how social classes or groups gain supremacy. Significantly, Gramsci explains how the public is often conditioned into accepting various political systems through complex mechanisms of coerced consent. These forms of consent are created through the means of moral and intellectual production (Femia, 1981).

Gramsci argues that this 'consent'—which he considers 'social control'—operates on two levels: externally through material behaviours and actions, and internally by "moulding personal convictions into a replica of prevailing norms" (Femia, 1981, p. 24). This, in turn, subsumes behaviours and thought which then become self-replicating and commonplace by diffusing their basic ideas throughout society (ibid.). The dominance of this discourse becomes hegemonic, which Barbara Bush defines as being "the predominance obtained by consent rather than force, of one class or group over other classes . . . the spontaneous consent of masses to the general direction imposed on social life by the dominant . . . group" (Gramsci, 1971, as cited in Bush, 2014, p. 124).[109] These values, norms and culture then become internalized which, in turn, shape "cognitive and affective structures" (Femia, 1981, p. 24)—particularly regarding economic organization and, as this dissertation argues, approaches to healthcare and development.

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[109] This is different from the Foucauldian tradition which argues that predominant form of discipline and cultural control emanates from the governmentality of states, not necessarily elites from wealthy and powerful backgrounds who shape culture and pull the strings of finance, white-collar corruption and bribery/lobbying, governance, control as well as coercion.

This is important to note in order to understand the slippages and gaps of development as well as the formation of healthcare policy. As Jan Nederveen Pieterse highlights, "grand theories have typically been fashioned in the west and therefore articulate western political interests and western intellectual styles and priorities. Reading development theory then is also reading a history of hegemony and political and intellectual Eurocentrism" (2010, p. 9). In this sense, Gramsci's work on hegemony helps highlight concern for how society consents to capitalism despite the way in which capitalism often works against the interests of the majority. His work also helps highlight what a counter-hegemonic alternative, such as Cuba, might operate differently, both in terms of domestic and international policy (as noted in Figure 1).

Figure 1: Hegemony of the Explicit Neoliberal Project and Empathic Capture of those Unconsciously Replicating the Logics of Those in Power Versus the Counter-Hegemony of Cuban Medical Internationalism

Region / Who	Global North TPI, WB, IMF, Media-Military-Industrial Complex, Walt Rostow, Milton Friedman, Dick Cheney etc.	Global North Development / aid industry, NGOs, healthcare personnel, some WB and IMF personnel, Jeffrey Sachs, Kony 2012 activism etc.	Global South International Cuban medical workers / teachers	Global South Decentralized medical trainees of Cuban medical missions from rural, poor, and marginalized backgrounds
Hegemony	Explicit / conscious hegemonic	Implicit / unconscious hegemonic	Explicit / conscious counter-hegemonic	Implicit / explicit counter-hegemonic
Neoliberal Logic	Implied / actively advanced and pressured	Implied as the status quo / unchallenged	Confronted / explicitly discussed	Alternative / may be discussed or confronted
Sovereignty of host country	Dictated by the Global North through unequal power relations and multinational institution	Contingent upon the Global North	Seeks to reinforce the host countries' sovereignty	Seeks independence from neocolonial efforts of the Global North
Modus operandi	Priorities are set by the Global North based upon what they think is best		Bilateral agreement based upon the need of the host country and what Cuba can provide	

Logics / how they operate	Neocolonial, market-driven, expansion of private / for-profit services, ahistorical, expansion of inequality, power is centred in the Global North, transfers wealth from the Global South to the Global North	Sustainable development that seeks to reactively cure symptoms of globalization while maintaining the hegemonic status quo, circumvents the sovereignty of the host country, often overlooks importance of the state and public services with non-governmental approaches, ahistorical, can exacerbate institutional fragmentation with an array of different NGOs competing for purpose and funding while lacking coordination with each other and the host countries public services	Solidarity, egalitarian, stresses the importance of public services, equity-based approach to training, attempts to capacitate host country until threshold of independence reached, attempts to streamline public health services to overcome fragmentation with a vertically oriented system, proactive and preventive approach to development through the capacitation of public services	Focuses on the expansion of public services, especially to the poor, rural and marginalized
Distance to Global South Poor and Marginalized Populations	Relationally distant	Relationally distant	Critically distant (Georg Simmel, 1971)	Relationally close
Motivation	Profit and power	Human rights / desire to do good / travel experience / virtue signalling on social media etc.	Work experience / remittances / desire to do good / human rights etc.	Desire to help family and community that were previously underserved etc.
Connection to the poor, rural and marginalized "Other"	Absent or ideologically distant	Empathically captured by neoliberal logics and social fantasies	Empathically driven foreign policy based on solidarity	Empathy for their underserved community

Source: Author, 2021

Robert Cox also expands on Gramsci's analysis by explaining how hegemonic pressure by upper class populations (such as the '1%' which entered popular discourse after the 2008 financial crises) often pressure as well as control the direction and policies of the state, rather than the state representing the majority in order to expand the common good and advance welfare state services and protections (1996). Thus, governments instead often serve the interests of the elite, which is perhaps best exemplified by super-wealthy business tycoon and

philanthrocapitalist, Warren Buffet: "there's class war alright, but it's my class, the rich class, that's making war, and we're winning" (cited in Tsianos et al., 2012, p. 448).

This is because the "administrative, executive and coercive apparatus of government" is effectively "constrained by the hegemony of the leading class of a whole social formation" (Cox, 1996, p. 51). When this happens, it becomes "meaningless to limit the definition of the state to [only] those elements of government." Therefore, the development academic/thinker and health policymaker must always "relate global relations of power or international hegemony to intellectual patterns of hegemony (in line with the Gramscian approach to international relations)" (ibid.). This is because the "assumption in this schema" draws from the idea that "paradigms that are available in the intellectual market at the time shape the explanatory frameworks that inform development thinking" (Pieterse, 2010, p. 9).

Thus, development thinking and health policy could be understood as "a terrain of hegemony and counter-hegemony. In this contestation of interests there are many stakeholders and multiple centres of power and influence" (ibid., p. 9-10). Therefore, many people—including development academics and policymakers—are often unable to critically engage with the ideology their ideas and policies emerge from. This neoliberal ideology forms the basis of their interactions with the rest of the world regardless of limits, disavowals, and negative impacts hidden in it such as structural violence. In this sense, ineffective Global North development and healthcare solutions to Global South development and healthcare issues might additionally be due to a lack of 'critical distance' (as noted prior).

In this sense, Friedman's neoliberal influence on those in power—still in effect today—is potentially problematic. He occupies close relational distance to heads of state, playing golf with

and advising former-president Obama, as well as spending significant time with heads of various corporations. He is relationally distant, like many of the people he influences (including the heads of the WB and IMF), from the most poor and marginalized—especially those in the Global South. Thus, his books (frequently considered best-sellers which promote the hegemony of neoliberal globalization) as well as his problematic ideas and policy prescriptions are diffused throughout the world by those in power (Baban, 2013). This is simply another conceptual consideration to explain why WB, IMF, and Heads of State often introduce unsuccessful and detrimental policy prescriptions onto poor and marginalized populations—they are simply too relationally distant from the lived realities and structural violence of those vulnerable populations.[110] That, or they are simply too racist and/or classist to care.

Despite being relationally distant from the lived realities of the most impoverished and marginalized, Sachs (in a similar fashion as his celebrity humanitarian contemporaries such as Friedman, Bono, Madonna, Al Gore, Oprah Winfrey, Lawrence Summers, and Bill Gates among others) is an example of a person from the Global North who has had significant impact on populations in the Global South (as well as Poland and Russia) (Kapoor 2012; 2020; Fridell & Konings 2013; Wilson 2014a; 2014b; 2014c). Sachs' early views of international development emerge from a place of power and affluence. He has influenced—politically, economically, and

[110] An example of the detrimental policy effects of relational distance occurred in 1991 when the former head of the WB, Lawrence Summers, wrote a memo advocating that Africa would be a great place for the Global North to dump toxic waste since Africans rarely live long enough "to care about cancer" (Livingston 2012, p. 30). Due in part to his lack of understanding of both cancer and the challenges of development for those in the Global South, Summers "tapped into a long-standing image of African publics as biologically simple ones, an image undergirded by an assumption that infectious disease, fertility, and malnutrition are the problems that matter in African health" (ibid.). Without the proximity to those in the Global South affected by the detrimental policies from the WB, poor development policies continued to be produced by relationally distant people—often urban and affluent white men—in the Global North. As Julie Livingston points out: "Summers was not alone." Africans are still "envisioned or ignored by the global health and oncology industries" which highlights the need to shift scales of analysis and "consider a political economy of knowledge in Africa, particularly in southern Africa, in relationship to cancer" (2012, p. 31).

intellectually—the direction of international development. As one of the youngest tenured professors of economics in Harvard University's history, in addition to being the director of The Earth Institute at Columbia University and a US policy advisor, Sachs has helped reinforce the position of capitalism as development in more contemporary times—albeit a narrative that emerges from good intentions, yet relationally-distant, ignorance.

The Unconscious and Relational Distance of Neoliberal Development

> *"Disavowal . . . involves both simultaneous denial and acknowledgement . . . We see this in the insistence on the part of Western multinationals on docile labour forces as the price of investment, while the blame for human rights abuses falls mainly on the host country governments, a form of moral outsourcing, if you will . . . the disavowed price [is] seen as necessary for economic growth [and] becomes detached from its political context. Therein lies the paradox behind the choices for the economically disadvantaged; only success redeems one from having to face such Faustian choices but success requires making those choices. Cultural expectations that accompany the economy serve to reproduce and perpetuate relations of dominance, but the power of these expectations lies in their disavowal, so that those who enforce the rules escape censure."* (Maureen Sioh, 2014, p. 1164-1165)

When reflecting on the myriad ways Western neoliberal knowledge- and policy-producing centres associate economic growth with development, Sioh helps highlight the "power of disavowal in reproducing relations of dominance, narrating race, and managing Western anxiety" (Sioh as quoted by Fridell & Walker, 2019, p. 11). Moreover, "Western experts insist on the necessity of making sacrifices for economic growth, while simultaneously condemning non-Western actors for human and labour rights violations" (ibid.). Sachs, during the era of SAP 'shock doctrine', was one of many at the forefront of this particular disavowal. In his 2006 book, Sachs argued that we can end "poverty in our time" (2005, p. 1). In Chapter 2 of the book, "The Spread of Economic Prosperity," he argued, from his econocentric viewpoint, that the world is

on an uninterruptible path of economic growth from which poverty will be eliminated. Though he notes "highly uneven" economic growth as a problem (p. 30), his misunderstanding of inequality and structural violence is glaring since it overlooks structural limitations of unequal exchange that perpetuate poverty at individual and national levels.

It seems that Sachs—imbued with optimism, hope, and empathy—often reduced in simplistic fashion the impacts of history, unequal global trade, structural violence, and social class imbalances in a way that validated the role of capitalism in development, especially in his examples of Bolivia, Poland, and Russia. Thus, Sachs reinforced mainstream development as Rostow had—linear, urbanized, capitalist and modeled on the US and UK as well.[111] Moreover, he does so while being unaware of the "mortal flaws" of his ideology such as assuming that neoclassical economics and free-market approaches are the best route to poverty alleviation and development (Lewis, 2006, p. 166).[112] In contrast, Rostow was knowingly complicit in advancing capitalist ideology as a development tool in the context of the Cold War.

Sachs' desire to end poverty via capitalism can best be explained through both his lack of relational distance to Global South poor as well as through Japhy Wilson (2014b) and Kapoor's use of psychoanalysis. From a psychoanalytical lens, Sachs' inability to realize the implications behind biases of his 'inter-psychic life' leaves him unable to comprehend 'reality' due to the

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[111] Sachs' notion of linear development is mostly highlighted in Chapter 1 as well as throughout the rest of his book and is not explicitly highlighted in Chapter 2. His linear approach begins with the individual getting on the "bottom rung" of the development "ladder" by moving to urban centres and working at sweatshops to learn valuable skills. They then work up the "ladder of development" (Sachs, 2006, p. 14) to small business or higher-level jobs such as IT until (p. 15), one day, Sachs posits that the individual will inevitably emerge out of poverty.

[112] Stephen Lewis makes a key point regarding the short-sighted, yet well-intentioned, ideas of Sachs: "it would seem from his writings that [Sachs is] a profoundly misguided democratic capitalist" where his philosophical differences are "mortal flaws" (Lewis, 2006, p. 166). However, despite these intellectual flaws, Sachs remains "unswerving" in his "pursuit of the end of global poverty, and the amelioration of the human condition." Lewis believes that Sachs' "influence in the service of the most noble of causes are things that should be commended." Lewis explains that he will "be damned if [he'll] allow ideological dogma to get in the way" (p. 166-167).

seductive meanings and images that shape his 'Imaginary', as well as how he understands, acts, desires and interprets the 'Symbolic' regarding the relationship between poverty and capitalism (Kapoor, 2014, p. 1122).[113] Thus, like the collective social fantasy manifest in the neoliberal development/aid industry, the 'Real' for Sachs, is the gap between his desire to end the poverty of the "Other" and the reality of capitalism's inability to address the roots of poverty and inequality.[114] This is because Sachs, like the rest of us, is a linguistic being whose "symbolic order is lacking," making him "divided and alienated" from his world and biological instincts (ibid.).[115]

Kapoor continues by noting that: "development is a linguistic/discursive/institutional construction [which] is proof that it is replete with unconscious desires that 'speak'" (p. 1124). Thus, "the unconscious in this way helps underline the fact that trauma is not an 'inner' condition to development and its subjects but is externalized and materialised in development institutions" (ibid.). For Sachs, the "dimension of the Real" is in the "form of a blind spot," where there the "element of self-limitation" (regarding comprehension of his ideological drive) that he cannot "really come to terms with" is averted (unconsciously) by "projecting it onto the Other" (p. 1127)—in this case, the poor.[116]

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[113] As Kapoor explains: "Our symbolic world . . . is not some theoretical entity; in the way that Lacanians conceive it, we understand, desire, act, and interact only through it. No wonder that its gaps show up in everything we do, and hence that it is possible to say that the unconscious is present as much in family circles as in our work environments, shopping malls as much as universities, and discursive politics as much as development's institutional policies and programs" (2014, p. 1124).

[114] For Sachs, 'the Other' would mean the poor.

[115] In contrast, and given Berger's critique, this thesis argues that Rostow uses his influence and ideas to shape development discourse in the explicit favour of the US. Indeed, though he engages the idea of capitalism as poverty alleviation via his stages for take-off, his real desire is the promotion of an explicit ideological agenda to counter the development strategies and influence of the former USSR.

[116] Referencing Slavoj Žižek, Wilson highlights the difference between 'the Real' and reality (2015, p. 80). Through the "work of Jacques Lacan, Žižek argues that 'reality' is itself ideological, to the extent that it is symbolically structured by a

As such, Sachs' suggested development solutions are problematic since his unconscious desires and biases 'speak' as a reflection of the relational distance and culture of affluence and power from which his ideas emerge. Thus, in terms of the development and aid industry, it is often not that the plight of the poor "rarely enters the consciousness of the affluent" as Paul Farmer suggests (2005, p. 31)—but that Sachs believes himself to be crucially involved and concerned about providing solutions for the Global South poor. He assumes this despite his problematic ideological disavowal of agency, structural violence, and neoliberalism as well as an apparent absence of Global South subaltern knowledge production, including solutions that may emerge from those living in, or relationally closer to, poverty, inequality and racism etc.

This is troubling because people who often shape development discourse, and are relationally distant, often do not face their biases, logics and 'positionality'. They struggle to understand their privilege, or comprehend the systems, institutions, power relations, structures, and ideology that influence the most marginalized in a way that reinforce the poverty experienced by poor populations. As Farmer highlights: "the world's poor are the chief victims of structural violence—a violence that has thus far defied the analysis of many who seek to understand the nature and distribution of extreme suffering" (2005, p. 50). A core issue is that the "poor are not only more likely to suffer" (ibid.), but they are also less likely to have the ideological roots of their suffering noticed due to implicit neoliberal social fantasies that functions as a kind of common sense. Thus, neoliberal development initiatives, at times, seem

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web of social fantasies that protect us from 'the Real'. The Real is a traumatic and unrepresentable presence-absence that is excluded from our symbolically constituted reality, but which makes its existence felt in 'a series of effects, though always in a distorted, displaced way' . . . The task of ideology critique is to identify the symptoms of the Real that appear within a given symbolic universe 'in a coded, cyphered form' . . . in order to drag the Real into the realm of the Symbolic."

destined to fail due to the lack of relational distance and critical engagement with ideology/social fantasies that are commonplace in conventional development/healthcare policy, practice, and academia.

A non-conventional development alternative to these examples would be Cuba's medical internationalism based on solidarity. Cuba's difficult economic conditions, neocolonial/geopolitical pressure faced by Global North countries, and material poverty position them as relationally closer and more experienced to possibly deliver better health outcomes in low-resourced and low-technology Global South settings. This is potentially due to their population engaging in a different social project from capitalism since 1959, as well as having a more diverse population represented in government—such as people in key positions who are drawn from rural, poor, and marginalized populations who potentially have deeper understandings of structural violence as well as familiarity of low-resourced challenges (Kirk & Erisman, 2009). Cuba's relative social egalitarianism places them in a relational position to understand conditions of poverty facing their domestic populations.

Hence, workers in Cuba's formally vast medical internationalism programs are potentially more likely to understand the plight of the poor due to being socioeconomically and geographically closer to the average Global South person's living standards and geopolitical challenges. As Farmer notes "human rights abuses are best understood (that is, most accurately and comprehensively grasped) from the point of view of the poor" (2005, p. 17)—or, in this case, from a critical distance of those drawn from more egalitarian backgrounds that emphasizes human development and dignity over material wealth as well as public rights over individual and corporate rights. Though Cubans were partial strangers to the people they work with on medical

internationalist programs, they were much relationally closer than many Global North development organizations such as the WB and IMF.

Thus, in contrast to the Cuban approach, Sachs tends to overlook the complexity of capitalist systems (which reinforce the dominance of the US and UK), as well as their institutions, market-oriented policies, and unequal social classes which, in turn, perpetuate underdevelopment as well as reinforce the popular narrative or development 'myth' (Escobar, 1995).[117] Sachs' book provided readers with a snapshot argument that lacked historical depth, which in turn, mystified the real reasons behind inequality, structural violence, and unequal class structures. Sachs ignored other critically engaged academics—including Eric Wolf (1982), Arturo Escobar (1995), and Berger (2003) among others—who challenged these assumptions prior to his book. Hence, while Sachs admits that slavery and colonialism happened, he views these as singular events—or 'difficulties' (2006, p. 39)—that have no structural implications or historical legacy.

Despite Farmer's argument that any analysis must be both 'historically deep' and 'geographically broad' (2005, p. 42), Sachs instead makes an especially troubling claim that the

[117] For many countries from the Global South, it is problematic to follow a simplified version of development based upon a western development model, since their realities and challenges are radically different. Despite facing fewer risks from human-created climate change than vulnerable Global South countries, for example, Global North countries—especially Canada and the US—pollute at often much higher per capita rates. Global North countries also claim a disproportionate amount of global resources while benefitting from unequal terms of trade due to geopolitical and institutional power imbalances—be they through military advantage or in international World Trade Organization (WTO), UN, WB, and IMF forums or otherwise. Thus, predicating a western approach to development as the appropriate model to emulate—given this geopolitical scale of structural violence—is incredibly problematic. This is true, not only in the unattainability of their examples or the rigour to which they actively hold down countries in the Global South, but also in the outright destruction of the planet if the entire world polluted and consumed at the same levels of the average US citizen (Townsend & Burke, 2002; Dovers & C. Butler, 2015).

"colonial era is truly finished" (Sachs, 2006, p. 50).[118] In this way, Sachs engages in 'fetishistic disavowal' where Sachs' ideology is held back by a lack of relational distance. Referencing Slavoj Žižek, Kapoor notes: "most often, it is not a lack of knowledge that is the problem, but our unconscious commands and passions that bind us to ideology despite critical distance" (Kapoor, 2014, p. 1135).

In this sense, Sachs—in his glaring disavowal—simultaneously acknowledges geopolitical power imbalances as well as the importance of history while in the same breath dismissing their significance and ongoing impact.[119] Thus, even with the best of intentions, Sachs manipulates and "produces a pre-ideological enjoyment structured in fantasy" (Kapoor, 2014, p. 1135). In contrast, a healthcare student and practitioner from Timor-Leste or Venezuela—drawn from marginalized, poor, or rural communities—may have a better chance of grappling with the health needs of their own medically vulnerable communities because they are relationally closer and more familiar with those needs as well as being possibly more ideologically critical of the dominant neoliberal paradigm than Global North personnel.

For Kapoor, this is why he has "been arguing for the importance of psychoanalysis in development: to better identify and come to terms with our libidinal attachments and the lure of

[118] On page 39, Sachs (2006) refers to slavery, colonialism, and inequality by saying that, "despite these *difficulties*, the basic underlying forces that propelled the Industrial Revolution could be and were replicated, multiple sites of industrialization and economic growth took hold" (emphasis added in italics). To simplify slavery, colonialism, and inequality as merely "difficulties" that can be easily overcome constitutes one of the weakest points in his chapter.

[119] As noted by Kevin Watkins and Penny Fowler, as early as 2002, if sub-Saharan Africa were simply able to increase exports by 1%, this amount would be more than all the aid sent to Africa. Yet, when negotiating terms of trade at WTO meetings (most notably being the 2003 meeting in Cancun), most African countries are not able to give voice to their concerns regarding the fact that—though they are being told (or have been coerced by SAPs) to be free-markets societies—western powers consistently do not play by their own rules and instead subsidize their own industries and agriculture (Wild, 2004). This often happens to such an extent that the excesses of western overproduction and consumption get dumped onto the Global South in the form of 'charity' (including often-obsolete medical equipment) (Miesen, 2013)—a process which further undermines the Global South from expanding their own agricultural productions and industries or strengthening their own public institutions.

development's many sublime objects and fantasies" (Kapoor, 2014, p. 1135). Because of this, and despite the fact that many development academics "may be critical of or despondent about development," they "still 'buy' into such development fantasies as 'doing good' or 'free markets'" (ibid.).[120] Unfortunately, these often screen the "anxieties (about social injustice, inequality, or our own complicities as Westernised elites)" which, in turn, "set off our desires (e.g. to help, to save the Other, to donate money to charity, or to call for the privatisation of public services)"—as are commonplace in mainstream development and global capitalism (ibid.).

Kapoor notes that colonization, race, and history get erased by mainstream development discourse. However, though a post-colonialist himself, he is critical of Escobar's analysis that it is simply discourse that drives us.[121] Instead, Kapoor posits that discourses emerge from people's desires and are not produced spontaneously. For Kapoor, "desire (growing out of enjoyment)" which "fixes the subject (however precariously and contingently)," describes "how we both (mis)perceive power and become libidinally invested in it" (ibid., p. 1132). He continues by explaining that "desire/enjoyment is not discursively produced, as Foucault would have it, but . . . is an inherent excess or an extimate core (the Real) to any discourse; it is the result of the insubstantial loss that arises the moment we enter language" (ibid.). Thus, it is people that create, reproduce, and ultimately benefit from discourse—including development discourse (ibid., p. 1132-1133).

One of the key points of Kapoor's article, drawing from Žižek, is highlighting that everyone is ideological. Everyone could benefit from attempting to understand their own

[120] Or, in Sachs' case, the "diffusion of modern economic growth" (2006, p. 39-41).
[121] Escobar is a well-known development scholar from Colombia. He often draws upon the work of Foucault and Edward Said to critique mainstream development approaches as well as the discursive power of neoliberal knowledge production.

ideology as well as being critical of it in order to be conscious of their own desires, biases, and potential for misrepresentations—no matter how altruistic their beliefs.[122] In this sense, though Sachs as well as other Global North neoliberal policymakers and academics (such as the WB and IMF) believe they can provide the path to ending poverty, they are blinded by their own biases, and their contagious discourse emerges as a representation of mainstream development.

They are therefore unable to critically engage with the shortcomings of their ideas before they permeate mainstream development institutions and policy spheres. They reinforce the very system of capitalism and market liberalism by couching it in a simplified, jingoistic narrative, that is easy to grasp and extremely attractive (Wilson, 2014b). Much like others from Global North development knowledge- and policy-producing centres, Sachs thus provides both ideologically-thin and relationally-distant simplified solutions to complex Global South development and healthcare challenges.

This narrative is linear and easily blueprinted in much the same way as Rostow's 'stages of growth.' They subvert alternative arguments that may challenge the structures which perpetuate inequality by proposing a simple solution to the complex problem of poverty and structural violence. The structures and systems of inequality remain strengthened through its oversight, and development is again encapsulated in a capitalist mode that merely manages the poor. Thus, development is both an implicit and explicit act, as well as constructed, reproduced, and reinforced by people in a way that benefit some and marginalize others. Until international

[122] Kapoor notes that "Žižek's position on ideology differs from the Marxist one, which implies a privileged, neutral point from which one can distinguish between 'objective reality' and 'false consciousness'. For Žižek we are all ideologically produced, so there is no question of being outside ideology. Rather, what we can do in terms of ideology critique is to try and detect, in the manner of the psychoanalyst, the gaps in ideologically constructed reality, gaps which, as we have seen, show up as slips, blind spots, symptoms, irrationalities" (2014, p. 1133).

development engages with relational distance as well as the explicit and unconscious of its underlying ideology, it may continue to advance the interests of the wealthy few at the cost of the poor, as well as manage/palliate the symptoms of poverty and injustice rather than challenge their roots. By noting the importance of both Sigmund Freud and Jacques Lacan, Kapoor (2014; 2020), and Wilson (2014b; 2015) present the affective role of development as a form of critique as well as a research gap in contemporary development thinking—an important step when critically challenging the development and aid industry.

The Neoliberal Development/Aid Industry

> *"Biopolitics deals with the population, with the population as a political problem, as a problem that is at once scientific and political, as a biological problem and as power's problem."*
> (Foucault, 1978-1979, as cited in Foucault et al., 2008, p. 245)

For many, discussion of the United Nations' (UN) Development Goals inspire images of poor and marginalized communities in the Global South, receiving aid, loans, and non-governmental organization (NGO) support from the Global North despite one of the main issues of Global North development being its 'pretentiousness' and the "insurmountable arrogance of intervening in other people's lives." (Pieterse, 2010, p. 161). By contrast, the UN and the Global North are typically envisioned as industrialized, modernized, and largely responsible for assisting low-income nations to achieve development targets.

Yet can a country with limited resources from the Global South achieve universal healthcare, and do so without the support, aid, or influence of the Global North and the development/aid industry? The case of Cuba and its medical internationalism, based upon solidarity (Featherstone, 2012), may offer some insight into this as well as help other countries

address issues of non-insured populations, institutional fragmentation, and contingent sovereignty—which are biopolitical critiques of mainstream neoliberal international development by Duffield (2007; 2008; 2012; Duffield & Hewitt, 2009).

As noted previously, psychoanalysis adds to postmodernism's understanding of binary construction by noting the "dimension of the Real" which appears as an ideological blind spot that includes an element of "selflimitation that one cannot really come to terms with, so one averts it by (unconsciously) projecting it onto the Other" (Kapoor, 2014, p. 1127). While there is much debate between Foucauldian traditions and psychoanalysis, this dissertation will focus upon the way in which Cuba may potentially provide evidence how psychoanalytical 'subaltern flows of information' may be the key to finding solutions for other countries—especially those with limited access to resources and limited or declining external help. First, however, it is important to have a basic understanding upon the way in which development models from the Global North are 'biopolitically' foisted upon those in the Global South. This helps understand Global North hegemonic approaches as well as appreciate why the Cuban counter-hegemonic strategy is do different.

Adam Hanieh evidences, from a Gramscian perspective, the use of aid and debt as a Global North tool of control in his 2013 book, *Lineages of Revolt*. Hanieh highlights how—repeatedly—aid and debt have been used to control countries in the Middle East. For example, the dumping of aid undermined Global South industries (such as Egypt's textile industry and agriculture) which are important for tax generation and the maintenance of welfare state services. With little control over national resources and increasing debt, the implementation of SAPs further reverse state control over public services once the country finds itself unable to support

its welfare state.[123] If there is unrest, the UN and development industry then often has the job of cleaning up and establishing security in order to provide a bare minimum of now absent social services. Yet this insecurity, problematically, also increases relational distance for on-the-ground development workers who find themselves increasingly relationally-distant behind walls and wires, 'bunkerized', segregated, and alienated from the people most in need of their services and help (Duffield, 2010).[124]

As such, according to David Keen when reflecting on Duffield's work, "'permanent emergency' arising from the workings of capitalism itself and from increasing automation . . . points to a systematic devaluation of human interaction and human thought in the formulation of responses" (2020, p. 1146). Thus, aid and development workers are increasingly "physically sealed off from some of the risks associated with wars and emergencies" and, problematically, may "lose many of the opportunities for normal human interaction that have sometimes allowed

[123] With their industries in retreat, unable to compete with free Global North aid, the Global South country then begins to go into economic decline. Then, neoliberal institution such as the WB and IMF push in predatory fashion for loans to be made to the Global South in order to put those countries into debt (Perkins, 2004; 2016). Indebted countries further lose their sovereignty as these neoliberal institutions impose SAPs as a condition of their loans, which subsequently demand that countries privatize their public services and national resources. This, in turn, opens their resources and industries to Global North corporations which—in the search for cheap labour (easily obtainable with newly disenfranchised surplus populations), low taxation, reduced labour rights, and low environmental regulations—geopolitically shift wealth from the Global South to Global North (Perkins, 2004; 2016; Hanieh, 2013). If there are revolts against miserable conditions, the uprisings are then quashed by, at times brutal and violent, regimes who are subservient to the needs of Global North interests/foreign policy. If these regimes then seem to ignore the dictates of the Global North and try to nationalize their wealth, as the cases of Saddam Hussein in Iraq, Muammar Gaddafi in Libya, and Muhammad Hosni El Sayed Mubarak in Egypt highlight, the Global North (typically the US and allies) will then use 'hard power' to (often first) intercede through economic pressure (with sanctions and embargos), and then intervene using military power if cooperation with their aims is slow or absent (Hanieh, 2013).

[124] While analyzing literature on the production of space (Lefebvre, 1991) as well as research on the politicization of healthcare space (Walker & Kirk, 2017), it became clear that, increasingly, spaces became more homogenous and exclusive. Areas were increasingly associated with socio-economic class, race, age, and even political leanings. Fewer and fewer spaces created an environment to truly engage with the Other in a way that deconstructed social barriers. Thus, the notion of relational space—a space that transcends socio-economic, racial, age, and political ideologies—where people connect with the Other—are increasingly important.

aid workers to develop a good understanding of the societies with which they are dealing" (p. 1151).

By extending Global North biopolitical reach into the Global South to palliate symptoms of poverty and structural violence via their 'soft power' 'sustainable development' approach/focus on building 'resilience' (Duffield, 2007).[125] Along with NGOs, the neoliberal aid and development industry, in turn, cause 'institutional fragmentation' and 'native administration' of host country services (Duffield, 2007; 2021). This dependency ensures that Global South sovereignty is then 'contingent' on the Global North (Duffield 2007; Duffield & Hewitt, 2009).

This process simultaneously fills the dual purpose of making donors from the Global North feel good about their empathically-driven efforts to save the 'poor people in Africa or India' while being relationally and ideologically distanced from the Global South poor's complex geopolitical and neocolonial reality (Roy, 2014). As Arundhati Roy notes:

> NGOs have to present their work—whether it's in a country devastated by war, poverty, or an epidemic of disease—within a shallow framework more or less shorn of a political or historical context. At any rate, an inconvenient historical or political context. It's not for nothing that the 'NGO perspective' is becoming increasingly respected. Apolitical (and therefore extremely political) distress reports from poor countries and war zones eventually make the (dark) people of those (dark) countries seem like pathological

[125] In Joseph Nye's 1990 book, *Bound to Lead: The Changing Nature of American Power*, he outlines the differences between hard and soft power: There is a certain "power that comes from setting the agenda and determining the framework of a debate. The ability to establish preferences tends to be associated with intangible power resources such as culture, ideology, and institutions [including development and aid institutions]. This dimension can be thought of as soft power, in contrast to the hard command power usually associated with tangible resources like military and economic strength" (p. 32). Thus, soft power non-coercively co-opts and attracts to shape preferences while hard power imposes, dictates, and uses other obvious coercive forces (Nye, 2012). In this sense, as Paul Dukes notes, the US, as "a superpower must be able to conduct a global strategy including the possibility of destroying the world; to command vast economic potential and influence; and to present a universal ideology" (2002, p. 1) like neoliberalism.

> victims . . . in need of the white man's help. They unwittingly reinforce racist stereotypes and reaffirm the achievements, the comforts, and the compassion (the tough love) of Western civilization, minus the guilt of the history of genocide, colonialism, and slavery. They're the secular missionaries of the modern world. (2014)

Thus, the creation of the development and aid industry is associated with the expansion of NGO charity, assisted by the empathic capture of its workers and volunteers, while overlooking geopolitical and corporate intentions.

In the case of Africa and the decimation of public health brought on by WB and IMF SAPs, the 'pharmaceuticalization' of public health has spread throughout the continent (Livingston, 2012, p. 41). Pharmaceuticals, which are vitally important, were "offered in the absence of and as a replacement for hollowed out" African public health systems. Julie Livingston highlights this as a problematic "return to the magic bullet campaigns of the 1950s" (2012, p. 41). Thus, as João Biehl notes, "this market-based biopolitics" means that "pharmaceutical companies are themselves engaging in biopolitics, gaining legitimacy and presence in both state institutions and individual lives through drugs" (2007, p. 1093). Not only does this often-further atrophy public services of the host country, but it also fragments these services to such an extent that it is difficult to coordinate between services, and results in what Duffield terms 'institutionalized fragmentation' (2012).[126]

[126] Observations of the g7+ meeting were made in 2016 while doing research in Timor-Leste. Other themes regarding the lack of input that the g7+ nations were able to make when coordinating efforts with donor countries made it clear that much of Duffield's analysis of the development industry leaving host countries' populations 'non-insured' and sovereignty 'contingent' upon interests, with the help of 'native administration', of the Global North. It was a strong theme among almost every country at that particular set of meetings. The emergence of the New Deal by g7+ countries is a coordinated effort to address many of these shortcomings and to give a subaltern voice to resolve challenges of development from these fragile states.

This was a key issue raised at the g7+ conference for fragile states in Dili, Timor-Leste, in 2016. Fragile states, many emerging from post-conflict situations (where Global North military-industrial complexes profited immensely from), have already fragmented public services such as healthcare and education. Due to the NGO-ization of the development/aid industry, the influx of NGOs further fragments public services while at the same time they primarily respond to orders/directives from donors, directors and managers located in the Global North—regardless of the voice and needs of the Global South (see Woost, 1997; Pieterse, 2010; or Roy, 2014, for more details). In this way, the NGO-ization of the development industry is making the sovereignty of many countries in the Global South contingent upon projected notions of western development by those in the Global North—regardless of global power imbalances, history of colonialism, and complex situations faced by Global South countries (Duffield & Hewitt, 2009; Pieterse, 2010; Roy, 2014). In this way, not only is the sovereignty of countries in the Global South contingent upon the interests of the Global North, but also their populations remain, as Duffield terms it, 'non-insured', yet wanting of welfare state 'insured' services such as healthcare (2008).

As such, Global South countries are often unable to sustain or strengthen their own public services due to: having limited voice in their own public services (which are fragmented from post-conflict situations and continued NGO-ization of service provision); having aspects of their sovereignty contingent upon the direction of donors/actors from the Global North who may be relationally distant from on-the-ground realities/contexts; and facing neocolonial pressure to adopt neoliberal and free-market policies (despite evidence that the Global North is much more complex than the free-market policies they promote, often having huge public services including

protections over their own production of goods and services). As Duffield notes, the underdeveloped/non-insured populations in the Global South suffer vulnerabilities that the insured/developed in the Global North do not since this developed "life is sustained primarily through regimes of social insurance and bureaucratic protection historically associated with industrial capitalism and the growth of welfare states" (Duffield, 2008, p. 149).

Additionally, these non-insured populations are looked at as threats by insured populations in the Global North when they often migrate because of the idea that they will take advantage of the benefits of the Global North's public services and infrastructure created by their welfare states. This is a key aspect which makes the Global North 'insured' despite its promotion of free market and neoliberal policies in the Global South (Duffield, 2008). Therefore, a difficult question needs to be addressed: if Global South countries are looking to strengthen their government's public institutions and services to support their vulnerable populations, why do development/aid workers, volunteers, thinkers/academics, and policymakers from the Global North still often assume that the best way forward is through non-governmental organizations? As noted by Rosi Braidotti, it is a situation not without its own irony (2011).

Thus, with the Global North "cleansed of any suggestion of complicity in Third World 'underdevelopment,'" many development programs, often initiated by Global North NGOs to promote the Others' empowerment, are hinged crucially upon the western development industries' "complicity and desire" to regulate social and material reality (Kapoor, 2005, p. 1203; 2012, p. 8). Moreover, "because disavowing such complicity and desire is a technology of power," and since that complicity and desire are written into the process of development, the

very development industry often makes it prone to "exclusionary, Western-centric and inegalitarian politics" (2005, p. 1203).

In this sense, the complicity of many development personnel emerges, unlike Rostow yet more like Sachs, from often unconscious and relationally-distant desires to help. These development personnel are, at times, ideologically distant from actual embedded developmental constraints of the free-market neoliberal paradigm. As such, this type of philanthropy repairs "with the right hand" (via aid, donations, and charity) what is "ruined with the left hand" (expanding inequality and structural/systemic violence) (Žižek, 2010). This is reflective of what Nigerian-American novelist Teju Cole calls the "white savior industrial complex" (2012), and Indian novelist Arundhati Roy calls the "NGO-ization of resistance" (2014).

Thus, the development industry functions as an empathic capture of do-gooders from the Global North who, with possibly the best of intentions, try to improve the lives of those the Global South. While many accomplish positive results to varying degrees, many others remain unaware of the atrophy and fragmentation of public systems which leave host populations 'non-insured', and the sovereignty of underdeveloped nations 'contingent' upon the direction of the Global North (Duffield, 2007; 2008; Duffield & Hewitt, 2009).

As noted in the previous section, many development workers are also relationally distant from the people whom they wish to 'save'. The NGO population is largely drawn from upper-/middle-class members of the population with a high portion of these drawn from populations which comparatively far less in terms of racial, rural, systemic or socio-economic structural violence. Thus, there is a potential issue that many in the development industry are unable to

connect fully with the lived realities of those they are trying to 'save', and thus, may limit the overall effectiveness of their efforts due to a lack of relational distance.

Additionally, the heads of most liberal knowledge-producing institutions and development actors such as the WB, IMF, International Labour Organization (ILO), and others—whose primary goals are assumed to address global poverty from their neoliberal viewpoint—are drawn from primarily elite, white, urban, and affluent populations in the Global North who often lack robust personal/relational experience of structural and systemic violence. The discrepancy in relational distance appears quite troubling when you consider their approach to development (and the deterioration of public services), their history of often-poor results, and their ideologically dogmatic efforts to maintain this approach (Ferdnance, 1995; Perkins, 2004; 2016). It also begs the question: how can a rich, white, urban and affluent person in the Global North, be assumed to be the person considered most informed regarding the lived realities of the poorest, rural and most marginalized populations in the Global South? It is not totally surprising, then, that the current neoliberal development paradigm faces a high degree of scepticism.

Conclusion: The Subaltern

> *"Post-development's source of strength is a hermeneutics of suspicion, an anti-authoritarian sensibility, and hence a suspicion of alternative development as an 'alternative managerialism'. But since it fails to translate this sensibility into a constructive position, what remains is whistling in the dark. What is the point of declaring development a 'hoax' without proposing an alternative?"*
> (Pieterse, 2010, p. 123)

The Global North development/aid industry helps undermine/obscure/disavow (welfare state development, universal public healthcare approaches, equitable terms of trade, national resources, and taxation for nationalize public services) with the left hand, with what it attempts

to repair and palliate with the right hand (through charity and NGO-ization). This desire is often maintained/disavowed by an implicit neoliberal social fantasy/drive to solve social ills with charity. This is why a psychoanalytical critique is important.

If the development/aid industry were truly concerned with Global South development, it would shift its focus from palliating the symptoms of geopolitical poverty and Global North guilt (through acts of charity) towards proactive and preventive challenges to geopolitical inequality, inequity, and injustice. It would explicitly confront neoliberal ideology to target Global North foreign policy efforts that often destabilize Global South countries (especially oil-producing or social leaning nations), advocate for higher taxation regarding corporate extraction of Global South resources for public services etc., as well as demand stronger environmental and labour standards for Global North companies operating in the Global South.[127]

This is why the example of Cuba is intriguing. Not only for the impressive results of their public healthcare system, but also due to the global impact of their state-led development programs aimed at capacitation of the most vulnerable and marginalized. This is important because, as Kapoor notes, a "participatory organisation would ostensibly reverse the flows of authority and knowledge" (2005, p. 1217). In this way, the Cuban example might "make management more accountable to its putative beneficiaries" which could result in "South-to-North and subaltern-to-elite flows" in order to "wean" development "into better learning from, as opposed to patronising, Third World and subaltern communities" (ibid.).

[127] Possibly including the litigation of those companies in Global North countries as evidenced by a 2019-2020 landmark decision against Canadian mining companies (Findlay, 2019; Coop & Fogdestam-Agius, 2020).

Therefore, the leading question this dissertation posits: what can other Global South countries learn from Cuba to address their own public healthcare challenges? And, perhaps more importantly, what can the Global North learn in order to help write a subaltern history "from below" so it can help subvert "orientalist modes of representation" (Kapoor, 2002, p. 653, 648)? With limited help from donors and the development industry, Cuba has been forced to address large-scale public health system development and capacitation almost entirely alone.

Yet, with its state-led healthcare initiatives, Cuba had achieved more than most countries from the Global North in terms of international healthcare development—supporting populations with less resources, with less resultant fragmentation, with less inequality in access, and without undermining host country sovereignty. Indeed, even in the difficult post-COVID times, and despite the aggressive policies of the Trump and Biden administrations, Cuba continues with a healthcare policy—both in domestic and international contexts—that is lacking throughout the Global South, and indeed in many industrialized nations that continue to grapple with long wait times and crowded emergency rooms. Though the Cuban healthcare programs in Venezuela and Timor-Leste are not without their challenges, shortcomings, and limitations (which will be noted), the following chapters will describe in detail the possible lessons for both domestic public healthcare systems as well as international healthcare development by first starting with a background chapter on Cuban approaches to healthcare and development.

Chapter 3: The Critical Distance of Cuba's Counter-Hegemonic LASM Approach to Health and Development

"power centers formed by institutional complexes can be classified as hegemonic, meaning that they produce ideas and policies with enough theoretical depth and financial backing that they dominate thought over wide fields of power (New York, London, Frankfurt, etc.) . . . or counter-hegemonic, meaning centers, institutions, and movements founded on opposing political beliefs that contend against the conventional, exercise counter-power, and advocate policy alternatives (Havana, Caracas, etc.)." (Peet, 2015, p. 267-268)

Due to Cuba's state-led 'health in all policy' alternative approach, as well as the global influence of the market-prioritizing neoliberal 'hegemony', many Global North countries overlook the potential of Cuba's 'subaltern' example either implicitly or, in the case of United States (US) foreign policy, via explicit programs to dismiss, obscure, supress, and overthrow Cuba. Thus, Cuba remains a 'counter-hegemonic' (Peet, 2015) outlier to the neoliberal development paradigm that the Global North has often tried to 'domesticate' or 'ignore' (Tucker, 1999), at times, entailing an all-out 'war' on the examples and social-equity ideals it represents (Brouwer, 2011). Cuba's ability to achieve high health outcomes—by utilizing a significant amount of 'human capital' (as will be detailed this chapter)—is impressive given its economic and resource limitations as well as incredible geopolitical pressure by the United States (US) and allies reflective of the political economy literature review.[128]

[128] However, it is important to note that research for this chapter was largely completed prior to the COVID-19 pandemic and that important geo-political and healthcare changes have occurred in Cuba since then, such as a further tightening of the US embargo, as well as the exodus of a significant portion of the Cuban population, including medical practitioners. Another unfortunate turn of events is that, much to the detriment of Global Health and vulnerable populations around the world, Cuba's medical internationalism program, a significant feature of this dissertation, has been significantly reduced since 2020. As such, sections of this chapter are written in the past tense in an effort to more accurately portray research findings during the 2015-2020 era.

Cuba's counter-hegemonic approaches to public healthcare as well as bilateral (and, increasingly, 'triangular') international development are the foundation of this dissertation as well as provide an important starting point for the following chapters. The main goal of this section will be to evidence how a healthcare-obsessed Fidel Castro and his government—with their 'health in all policies' method of governance and approach to development (WHO, 2008b; Castell-Florit Serrate & Más-Bermejo, 2016)—prioritized a universal public healthcare system based on its Latin American social medicine (LASM) approach (Briggs & Mantini-Briggs, 2009; C. Walker, 2015; Birn et al., 2017).[129] In order to detail the political economy significance of Cuba's subaltern example, this chapter will include a brief history of Cuba's pre-revolutionary background. This will follow with a post-1959 comparison and explain the significance of the 'Cuban paradox'.[130]

Additionally, this chapter will document the obsessiveness of US hostile foreign policy directed at the small island nation located a mere 90 miles away from Florida—an important factor when considering the powerful knowledge- and policy-producing institutions located there or influenced by it. This context helps highlight the, at times, fierce battle to evidence Cuba's subaltern counter-hegemonic example. The chapter will then conclude by noting the expansion of Cuba's medical internationalism programs, loosely modeled from its domestic public care system, that strives for health equity to overcome issues of structural violence including health disparities for rural, poor, and marginalized communities. This foundation will help detail and

[129] See Nicolás Garófalo Fernández and Ana María Gómez Garcia 2011 book, *Pensamientos de Fidel Sobre la Salud Pública* (Fidel Castro's Thoughts on Public Health), for more details of Castro's public health obsession.
[130] For many the Cuban revolution is a process and is perpetually ongoing.

contrast the agreements in two different bilateral contexts: between Cuba and Venezuela as well as between Cuba and Timor-Leste.

Thus, Cuba's example provides important lessons for Global South countries, especially those facing substantial resource, financial, and human capital challenges (Pineo, 2019). Additionally, the significance of this chapter highlights the potential for subaltern flows of information, from Global South to Global North (Kapoor, 2002), which could help countries—such as Canada (especially for rural and Indigenous populations)—strengthen their increasingly privatized and curative domestic medical systems. Lastly, their example has the potential to improve the effectiveness of Global North international development approaches by the 'development/aid industry' (Duffield, 2007; 2010) which are often mired in, and disavowed by (Sioh, 2014), neoliberal hegemonic ideology despite the—often—best intentions and empathic drives of many hard-working development personnel. The following section, detailing pre-Castro Cuba, is a reminder of US influence on Cuba over the past 100 years.

Pre-Revolutionary Cuba and the Challenges of Neocolonial Governance by the US

Throughout the colonial period (from 1492 until 1898), Spain was mainly in control of Cuba and used the island, not just for its resources and labour, but as a key point from which they controlled much of Latin America. After many Global South countries had undergone processes of decolonization throughout the 1800s, the Cuban population was also eager for their own independence. After various struggles for independence (primarily beginning in 1868), Cuban poet and leader, José Martí, initiated what would become the final 'War of Independence' against Spain. Despite Martí's death during the War, Cuban revolutionary forces turned the tide

in 1897 and were positioned to finally win their hard-fought autonomy by 1898. However, "motivated primarily by the desire for Cuban markets," US President William McKinley's administration declared war on Spain when it was clear that the Cuban movement for independence was about to succeed (Cannon, 1983, p. 35).

Thus, Cuba's impending victory over Spanish colonial forces was "snatched from the Cuban liberating army at the moment of its success" by US interventionist forces (ibid.). Cuban independence was further set back through the ratification of The Treaty of Paris between Spain and the US on December 10th, 1898, "behind the backs of the islanders," which "transferred sovereignty of Cuba to the US" (Hatchwell & Calder, 1995, p. 11). After a brief Cuban occupation, the US withdrew its troops but continued to compromise Cuban sovereignty with the Platt Amendment (Thomas et al., 1984, p. 61; Pérez-Stable, 1999).

The Platt Amendment justified US neocolonial interventions in Cuba ranging from "landing marines on Cuban soil to sending special proconsuls to exert diplomatic pressure on Havana" (p. 61-62). Even though direct American military control ceased in 1902, the Platt Amendment was invoked on three occasions within fifteen years as the US military was mobilized to supress revolts and ensure Cuban "loyalty" (Cannon, 1983, p. 39). During the "1890s and 1930s, the US helped Cuban elites to defuse popular challenges" (Pérez-Stable, 1999, p. 36). This alienated the rest of the populace because the 'Cuban *politicos*' (elites) who came to power, did so to mainly acquire wealth for themselves and their friends with public funds from the Treasury.

The Platt Amendment signified an era of continued neocolonial dominance by the US on the Cuban economy as US influence covered nearly "every sphere of activity" (Hatchwell &

Calder, 1995, p. 12).[131] By 1959 US companies owned approximately "40 percent of the Cuban sugar lands . . . almost all the cattle ranches . . . 90 percent of the mines and mineral concessions . . . 80 percent of the utilities . . . practically all the oil industry . . . and supplied two-thirds of Cuba's imports" (Kennedy, 1960). As John F. Kennedy noted before he was US president, "our action too often gave the impression that [the US] was more interested in taking money from the Cuban people than in helping them build a strong and diversified economy of their own" (ibid.).

During the pre-revolutionary period indirect majority ownership by the US of Cuban resources and services was assured through the US puppet dictatorship of President Fulgencio Batista who ruled from 1940 to 1944 and again from 1952 to 1958. With US backing and military support, Batista implemented the harshest dictatorship the Cuban population had yet been subjected to. He "abolished the Constitution, dissolved Congress and crushed the opposition ruthlessly. Thousands died in the violence, but Washington supported him regardless" (Hatchwell & Calder, 1995, p. 13). Before Fidel Castro flew to Mexico to start the July 26 Movement, he wrote to select political leaders on July 7, 1955:

> I am leaving Cuba because all doors of peaceful struggle have been closed to me . . . As a follower of [José] Martí, I believe the hour has come to take the rights and not beg for them, to fight instead of pleading for them. (Cannon, 1983, p. 66)[132]

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[131] In 1925, American historians Scott Nearing and Joseph Freeman provided a summary of this period: "Theoretically, Cuba [was] a sovereign state. Practically, the economic and political life of the island [was] controlled by New York and Washington. This method of control avoids the expenses of colonisation, while leaving the field open to American interests. Cuba's property is almost entirely in the hands of the National City Bank. The bank directly controls the General Sugar Company. Its directors control the consolidated railroads and the huge sugar properties of the Cuban enterprise, as well as many other Cuban corporations . . . The political life of Cuba is directed by the representative of the State Department. The US dominance on the island is absolute (1973, p. 193).

[132] The influence of Martí permeates many things Cuban to this day. Martí, who was killed in the field of battle against the Spanish in 1895, led the struggle against Spain for Cuban independence in the late 19th Century. Before his death he foresaw United States intentions in Cuba and warned: "I have lived inside the monster and I know its entrails" (Cannon,

From his new outpost in Mexico, Fidel Castro planned his return to Cuba with an invasion force by gathering support, resources, and personnel—including LASM advocate and revolutionary, Dr. Ernesto 'Che' Guevara.

At the time that Guevara met Fidel Castro in Mexico, Guevara's memory of the 1954 US Central Intelligence Agency (CIA)-led overthrow of Guatemala's democratically elected socially progressive government (headed by President Jacobo Árbenz) by a brutal dictator (Carlos Castillo Armas) was still very fresh (J. L. Anderson, 2010). Seeing the geopolitical influence of US capital destroy a democratically-elected government—with a social and more egalitarian distribution of resources, services, land, food, healthcare, and water (all aspects of a LASM health in all policies approach)—left Guevara and others weary of how to develop a liberal social alternative approach in Latin America.

In January 1959, Batista resigned and fled to the Dominican Republic. Fidel Castro's 26 July Movement took over control of the government, and Fidel Castro (alongside Guevara and his brother, Raúl Castro) marched into Havana (Thomas et al., 1984). In addition to the *políticos*/elites close to the Batista regime (who were 'relationally distant' to poverty outside of Havana), approximately half of the physician population also fled to Miami when the revolution took place.[133] This decreased the total number of physicians (mostly located in Havana and working in private for-profit clinics leaving healthcare out of reach for much of the general

1983, p. 35). During the fight against US-backed dictator, Batista, Fidel Castro stated that "the intellectual author of this revolution is José Martí, the apostle of our independence" (Reid, 2008, p. 95).

[133] This population constituted a very wealthy segment of the Cuban population, mostly from Havana. Their affluent and powerful backgrounds as well as location in the wealthiest city in Latin America at the time, meant that many of them were relationally distant to the plight of Cuban poor and marginalized populations, most of who were located outside of Havana and had little access to public health or education. This particular wave of Cuban migrants continues to be very influential in US politics/foreign policy. This is especially true during US presidential elections given the nature of the US electoral college system and importance of Florida in winning the presidency.

public) in half, to 3,000, by the mid-1960s for the entire island and its over 7 million people (ONEI, 2019). It also left only 16 full professors at the one medical school (Gilpin, 1991, p. 87).

Kennedy (whose administration would ultimately become responsible for the 1961 Bay of Pigs invasion after it was set in motion by Dwight D. Eisenhower's administration) provides a succinct summary of how the pre-revolutionary social, political, and economic environment helped create the conditions for revolution.[134] In the run-up to his presidential election bid, he addressed people at a Democratic Dinner in Cincinnati, Ohio:

> First, we [the US] refused to help Cuba meet its desperate need for economic progress . . . instead of holding out a helping hand of friendship to the desperate people of Cuba, nearly all our aid was in the form of weapons assistance—assistance which merely strengthened the Batista dictatorship . . . Secondly . . . we used the influence of our Government to advance the interests of and increase the profits of the private American companies . . . which dominated the island . . . The third . . . was the decision to give stature and support to one of the most bloody and repressive dictatorships in the long history of Latin American repression. Fulgencio Batista murdered 20,000 Cubans in 7 years—a greater proportion of the Cuban population than the proportion of Americans who died in both World Wars . . . Finally, while we were allowing Batista to place us on

[134] The 1961 Bay of Pigs invasion was an attempt by the US to overthrow the Castro government. It involved the training (mostly in Guatemala with the support of US-backed dictator, General Miguel Ydígoras Fuentes) and arming of approximately 1,500 Cuban exiles, most of whom were close to the Batista dictatorship. The US- backed invasion force left on United Fruit Company ships from Nicaragua (with the blessings of another US-backed dictator, Luís Somoza) to land in Cuba. However, the invasion was, by most accounts, a complete disaster. Unlike successful and bloody overthrows of democratically elected leaders in other Latin American countries in an attempt to install a puppet government friendly to US corporate and foreign policy interests, the Bay of Pigs invasion is considered a large foreign policy blunder (L. Pérez, 1995; Quesada, 2009; T. Anderson, 2010a).

the side of tyranny, we did nothing to persuade the people of Cuba and Latin America that we wanted to be on the side of freedom. (1960)

Though this is an interesting and rather honest glimpse of US foreign policy from a US president, little would change during or after Kennedy's short tenure in office. Instead, the geopolitical pressure against revolutionary Cuba arguably gained significant momentum.

In the decades following the 1961 Bay of Pigs invasion by US-backed Cuban exiles, while no further direct invasions of Cuba would take place, several covert and economic attempts to destabilize the Revolutionary Government would occur—including an estimated 638 CIA-sponsored attempts on President Fidel Castro's life (Font, 2006). Ensuing Cold War hostilities, the embargo, the Trading with the Enemy Act, and other events would shape the relationship between the US and Cuba for decades to come (US Department of the Treasury, 2019; National Archives and Records Administration, 2018).

It is important to note that, because of the relative autonomy of Cuba from the US and its allies following the 1959 revolution (despite ensuing geopolitical pressure), Cuba did not fall victim to the same structural adjustment programs (SAPs) imposed on most other Latin American countries by neoliberal free-market knowledge- and policy-producing institutions such as the World Bank (WB) and International Monetary Fund (IMF). In contrast, rather than turning public services into market-driven/for-profit corporations, Cuban internationalist efforts—based upon the requests/needs of the host country—help capacitate public healthcare and public education in hopes that host governments will become independent of external help and, thereby, confronting conventional international development issues of 'institutional fragmentation', 'non-insured populations', 'native administration', and 'contingent sovereignty'. Thus, one of the main

reasons Cuba's achievements in healthcare, education, and international development have been so significant is due to Cuba remaining outside of the geopolitical project to neoliberalize formerly public services.[135] During the development of Cuba's revolutionary government, most other Latin American governments were privatizing healthcare services, financing, and other public goods.[136]

These SAPs (discussed in prior chapters as well as again in the following chapter) would weaken and even devastate many Global South countries' social programs—especially healthcare and education. Thus, some of the most remarkable results of Fidel Castro's 1959 revolution would be the creation of comprehensive public health and public education systems as well as the creation of its medical internationalist program that would spread its version of LASM to many countries, helping 'insure' vulnerable populations—the biggest of which is Venezuela (Muntaner et al., 2006; Briggs & Mantini-Briggs, 2009; C. Walker, 2015).[137]

However, even though Cuba would free itself from direct US control (including the New York-based Mafia), it would go on to face the longest embargo ever imposed on another country

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[135] Because of this, and as detailed further in the chapter, Cuba's achievements include areas of public education where Cuba has much higher outcomes than all other Latin American countries as well as higher literacy rates than the US. As evidenced by Frank Adamson from the Stanford Center for Opportunity Policy in Education, "a high-quality public investment system similar to those in Finland, Cuba, and Ontario, uses equity-based processes and focuses on teacher professionalization and is often accompanied by high educational outcomes" (2016, p. 9).

[136] As an example, both Brazil's and Mexico's "neoliberal healthcare reforms reduced access to healthcare services for poor and working-class people, burdened the public healthcare sector with higher-risk patients, and further compromised the quality of public services, while private insurance companies reported significant profits." Even though these neoliberal healthcare reforms were never "fully implemented in most Latin American countries, and despite the increasing evidence of the ill effects of these neoliberal reforms on health and well-being, all countries but Cuba have undergone, to some degree, these health sector changes" (Muntaner et al., 2006, p. 805). Thus Cuba, being outside of the influence of neoliberal knowledge- and policy-producing institutions such as the WB and IMF, managed to maintain its counter hegemonic state-led approach to government policy and public healthcare.

[137] It is argued by John Kirk and H. Michael Erisman that Cuba's medical internationalism program is one of the main reasons that, following the 1959 revolution, international support for Cuba increased (J. Kirk & Erisman, 2009; J. Kirk & C. Walker, 2012; J. Kirk, 2015). A recent indicator of this support for Cuba is evidenced in the UN vote against the US directed at Cuba. As of 2023, only two countries voted for a continuation of the embargo, the US and Israel. In contrast, 187 countries voted against the embargo (UN, 2024).

in the modern era as well as an all-out media war on the small island nation—a war that has continued to polarize discourse and subsume important lessons regarding Cuba. More than just a depoliticized narrative of development, as modeled after Global North capitalist approaches or a disavowal of Global South knowledge production, it has truly been, as Steve Brouwer notes: a deeply political and explicit 'war on ideas' (2011, p. 201-213).[138] In addition to the embargo, the US would continue to expand their military assistance to more violent dictators in Latin America in order to control/profit from resources as well as expand geopolitical influence, overthrowing many democratically elected governments—especially those governments which strove to provide for their people through social programs and public services funded by nationalized resources.[139]

Thus, because the US and their allies shunned Cuba politically and economically (especially from the 1970s to 1990s when Cuba was excluded from WB and IMF loans), Cuba was able to chart a different course—one that was more egalitarian and state-led—rather than

[138] One of the best examples of the explicit neoliberal development project by the US to stifle social and counter-hegemonic approaches is outlined by US efforts during George W. Bush's presidency. As detailed by Liliana Fernández (2021, p. 93): "On 5 December 2003, a 'Commission for Assistance to a Free Cuba' was created, which submitted its first report on 1 May 2004, known in Cuba as 'Plan Bush I.' The document recommended the privatization of education and healthcare and the dismantling of the social security system following the fall of socialism on the island. The most damaging measures were those implemented on 16 June 2004, by the Office of Foreign Assets Control (OFAC), as these affected family relations and tightened the constraints of the embargo."

[139] In 1960, Senator Kennedy summarizes the influence of the US well: "We have not only supported a dictatorship in Cuba—we have propped up dictators in Venezuela, Argentina, Colombia, Paraguay, and the Dominican Republic. We not only ignored poverty and distress in Cuba—we have failed in the past 8 years to relieve poverty and distress throughout the hemisphere. For despite the bleak poverty that grips nearly all of Latin America—with an average income of less than $285 a year—with an exploding population that threatens even this meager standard of living—yet our aid programs have continued to concentrate on wasteful military assistance until we made a sudden recognition of their needs for development capital practically at the point of Mr. Castro's gun." See other sources regarding US geopolitical fallout from interventions and backing dictators for more details: Pion-Berlin, 1985; Kirsch, 1990, p. 269, 395; Vasallo, 2002, p. 163; Gabino, 2008; Sanford, 2008; Malkin, 2011; Filho, 2012; El Mundo, 2013; Hone, 2017; BBC, 2018; T. Walker, 2019; or Zero Hedge 2017 (from the Global Research website which has an interactive map: https://www.globalresearch.ca/all-the-countries-america-has-invaded-in-one-map/5606068).

suffer through aggressive privatization reforms and austerity brought on by SAPs.[140] This is an important point and relates to the core areas of this dissertation: to document the spread of Cuban medical internationalism as a subaltern alternative to conventional neoliberal development/aid models; to document geopolitical pressure against Cuban approaches; as well as to document efforts to maintain Global North neoliberal development models despite (increasing) evidence against their ability to address structural/systemic violence, inequality, inequity, and injustice.

This will be key in order to understand how Cuba's alternative social medical model (based on LASM) can take root in different countries while not undermining host country's biopolitical sovereignty (with a focus on Timor-Leste and Venezuela). Though social medicine advocate Thomas McKeown once emphasized that "the importance of economic growth, rising living standards, and improved nutrition" were the "primary sources of most historical improvements in the health of developed nations" (McKeown as quoted in Szreter, 2002, p. 722), Robert Evans noted that Cuba stands in stark contrast to the assumption of economic growth (2008). This is known as the 'Cuban Paradox'.

[140] The US government has made it clear it would like multinational neoliberal financial institutions, such as the WB, to finance a "post-Castro" Cuba based upon neoliberal logics such "price liberalization, deregulation . . . privatization," including the "privatization of utilities" and increased "competition in services" (Commission for Assistance to a Free Cuba, 2004, p. 214, 255). In the 2004 report to the president, it states: "At this time, Cuba is not a member of and does not receive loans or credits from the World Bank, the Inter-American Development Bank or the Caribbean Development Bank. While mobilization of private investment, including from local capital markets, will most likely be the long-term financing source for Cuba's sustainable development, multilateral development banks can play a key role in helping to improve environmental governance, democratizing decision-making and making it more transparent, and creating a climate favorable for private investment. The US Government could help a post-Castro Cuba access the public international financial community (e.g., the [International Development Bank] IDB's Multilateral Investment Fund and the World Bank initiatives on infrastructure and municipal governance) in order to create sustainable finance systems for environmental protection and natural resources management" (ibid., p. 422). Thus, it is falsely premised that unregulated markets are to be the 'best managers of the environment and social services.

The Cuban Paradox (and the Geopolitical Project to Undermine its Significance)

"As reported by Wikileaks, in July 2006 Michael Parmly of the US Interest Section in Havana sent a cable requesting 'human interest stories and other news that shatters the myth of Cuban medical prowess.'"
(Olson, 2013, p. 2013)

Until the outbreak of the COVID-19 pandemic, Cubans enjoyed health outcomes that rival (and in some cases even exceed) many Global North 'developed' countries. It managed this despite being a Global South 'developing' country with limited resources and having a geopolitically constrained economy (Muntaner et al., 2006; C. Walker, 2015), yet, with significantly less debt as a per cent of GDP than Canada and the US (Fieser, 2021; Hanke, 2021; Patton, 2021; Trading Economics, 2021; World Population Review, 2021a).[141] The following table by the World Health Organization (WHO) highlights how assumptions can be formed about Global South countries—specifically how they can't achieve comparable health outcomes with Global North countries:

Table 1: Estimates of maternal mortality ratio (MMR; maternal deaths per 100 000 live births), number of maternal deaths, lifetime risk, and AIDS-related indirect maternal deaths by United Nations Millennium Development Goal (MDG) region, 2015.

MDG region	MMRa	Range of MMR uncertainty (80% UI)		Number of maternal deaths	Lifetime risk of maternal death, 1 in:	AIDS-related indirect MMR	Number of AIDS related indirect maternal deaths
		Lower estimate	Upper estimate				
World	216	207	249	303,000	180	3	4,700

[141] According to the World Population Review website (2021a), the debt to GDP ratio carried by Cuba is approximately 18.2%, whereas comparative figure for-Canada is 89.7%, and for the US is 107%. In pure numbers, during the last 2017 estimate, Cuba owed $17.8 billion USD (Fieser, 2021). Currently, however, that number is expected to be higher, potentially closer to $25 billion USD (Hanke, 2021). As of 2021, US debt currently exceeds $28 trillion (and is estimated to approach $89 trillion and a debt-to-GDP ration of 277%, surpassing Japan's 272%) (Patton, 2021). Canadian debt stands at $721.36 billion CAD (which is approximately $595.9 billion USD) in 2020 (up from $685.45 CAD million in 2019) (Trading Economics, 2021).

Developed Regions	12	11	14	1,000	4,900	1	87
Developing Regions	239	229	275	302,000	150	4	4,600
Northern Africa	70	56	92	3,100	450	0	10
Sub-Saharan Africa	546	511	652	201,000	36	11	4,000
Eastern Asia	27	23	33	4,800	2,300	0	43
Southern Asia	176	153	216	66,000	210	1	310
South-eastern Asia	110	95	142	13,000	380	1	150
Western Asia	91	73	125	4,700	360	0	5
Caucasus and Central Asia	33	27	45	610	1,100	0	8
Latin America	60	57	66	6,000	760	1	51
Caribbean	175	130	265	1,300	250	3	20
Oceania	187	95	381	500	150	1	30

Source: WHO, 2015.

While this table presents relevant data, for some, this table can also be used to highlight a common assumption by many in the development industry: that Global South countries are unable to achieve Global North health outcomes and are therefore in need of assistance from 'developed' countries. However, the idea of the Global North learning subaltern lessons from the Global South can be overlooked by this oversimplification. Data, when presented in this fashion, can lack context and an understanding of the history of colonialism and neocolonialism, while omitting political economy analyses of power, dismissing Global South agency and knowledge production, as well as affirming the assumption that the Global South is in need of charity—often through the aid of the neoliberal development industry.[142]

[142] It is becoming apparent that the Global North development and aid industry is also increasingly being utilized to destabilize, control, and target other countries (Hanieh, 2013; Currier, 2015). A 2004 report by the US Commission for Assistance to a Free Cuba highlights the use of NGOs by the US to overthrow the Cuban government: "Cuba presents itself internationally as a prime tourist destination, as a center for biotechnological innovation, and as a successful socialist state that has improved the standard of living of its people and that is a model for education, healthcare, and race relations for the world . . . We [the US] propose increased efforts to illuminate the reality of Castro's Cuba, with the objectives of encouraging international solidarity with the Cuban people and promoting democracy on the island, including through the funding of NGOs to facilitate the distribution of information on the condition of the Cuban people, the reality of the circumstances under which they struggle to survive, and the nature of the Castro regime, including its threat potential" (Commission for Assistance to a Free Cuba, 2004, p. 9-10).

The next three tables compare Cuba to Global North countries (Canada and the US), regional neighbours and Global South countries (Indonesia, Papua New Guinea, Mexico, Colombia, Jamaica, Honduras, and Haiti), as well as the countries that are the focus of this dissertation (which receive public health support from Cuba)—Venezuela and Timor-Leste.

Table 2: Comparison of Health Outcomes Between Cuba and Other Countries

Country	Life Expectancy at Birth (2021 est.)	Maternal Mortality (per 100,000 live births) (2017 est.)	Infant Mortality (probability of dying between birth and age 1, per 1,000 live births) (2021 est.)	Physician Density (per 1,000 population)	Hospital Beds (per 1,000 population)
Cuba	79.41 years	36	4.19	8.42 (2018)	5.3 (2017)
United States	80.43 years	19	5.22	2.61 (2017)	2.9 (2013) *
Canada	83.62 years	10	4.44	2.31 (2016)	2.5 (2017)
Mexico	76.94 years	33	11.64	2.38 (2017)	1.5 (2015)
Colombia	76.91 years	83	12.88	2.19 (2018)	2.19 (2018)
Jamaica	75.49 years	80	11.42	1.31 (2018)	1.31 (2017)
Haiti	65.61 years	480	41.29	0.23 (2018)	0.7 (2013)
Honduras	74.9 years	65	15.39	0.31 (2017)	0.6 (2017)
Venezuela	72.22 years	125	22.23	n/a	0.9 (2017)
Timor-Leste	69.62 years	142	34.47	0.72 (2017)	0.72 (2018)
Indonesia	72.82 years	177	20.16	0.43 (2018)	1 (2017)
Papua New Guinea	69.86 years	145	40.33	0.07 (2018)	n/a

* Data collected from CIA World Factbook in 2015 and is no longer currently available.
Source: CIA, 2021.

As seen in Table 2, Cuba often outperformed other Global South countries for health outcomes. What sets Cuba apart from many of its Global South neighbours is that some of their indicators not only come close to countries in the Global North, but even exceeded countries such as Canada and the US, particularly in areas such as infant mortality, under-5 mortality, and physician density (of which, on a per capita basis, Cuba has three times more doctors than Canada, and access to family doctors is guaranteed).

When contrasting outcomes directly between Cuba and the US, Nakul Bhardwaj and Daniel Skinner note:

> Cuba boasts a life expectancy of 79.0 years from birth, almost identical to that in the United States, and an infant mortality rate of 4.4 per 1000 live births in 2018, lower than the US rate of 5.7. Furthermore, thanks to its emphasis on prevention, Cuba boasts a vaccination rate that is highest in the world: a 99% vaccination rate in 19–35-month-old children (vs. 70% vaccination rates in the United States). Finally, Cuba has the lowest HIV rate in the Americas and 100% of its pregnant citizens have more than four prenatal visits per year (versus 97% in the US). (2019, p. 462)

Thus, Cuba achieved high health outcomes despite comparatively limited material and financial resources than its Global North neighbours (as seen in Table 3 below). And yet it did this despite Washington's prohibition of sales to Cuba of important medical devices and drugs.[143]

The success of Cuba has been attributed to a comprehensive web of government initiatives including a reduction of deaths from communicable diseases. Cuba's health in all policy approach has meant that its healthy living programs, addressing the roots of embedded poverty and structural violence, confronting inequality, ensuring that food distribution reaches those in need, the primary healthcare delivery system, and especially its immunization program, have all played a part (C. Perez, 2008).

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[143] As documented by Gary Olson, these include: "the inhalant agent sevoflurane, the best pharmaceutical for applying general anesthesia to children, and dexmedetomidine, especially effective for treating elderly patients needing extended surgical procedures. The US firm Abbot Labs produces both of these. And Erwinia l-asparaginase, known commercially as Elspar, is denied to Cuban children suffering from lymphoblastic leukemia. The US firm Merck and Co. refuses its sale to Cuba. And Washington denies visas to Cuban medical specialists seeking to attend conferences in the United States, thus denying their access to state-of-the-art knowledge" (2013, p. 2013).

Cuba's comprehensive immunization program is the product of the broader preventive health system. In pre-revolutionary Cuba, the poor health situation "was largely due to malnutrition, lack of medical care, and unequal distribution of medical services; in addition, there was a high incidence of vaccine-preventable infectious diseases which took a high toll on the lives of mainly children" (Más Lago, 1999, p. 681). Under Fidel Castro's leadership, the Ministry of Public Health initiated plans for wide-scale immunization programs to reduce or eliminate diseases on the island. Cuban medical research has progressed has been able to develop vaccines, including creating vaccines for pneumonia and meningitis (Más Lago, 1999; Arsenault, 2010).

Table 3 compares the same group of countries to contrast GDP, resources spent on healthcare, as well as per capita expenditure by the average person:

Table 3: Comparison of GDP, Inequality and Expenditures Between Cuba and Other Countries.

Country	Population (World Bank)	Population Below the Poverty Line (CIA)	GDP purchasing power parity (CIA)	GDP per capita (CIA)	Health Expenditure % of GDP (CIA)	Education Expenditure % of GDP (CIA)	Literacy —age 15 and over that can read and write
Cuba	11,333,483 (2019 est.)	n/a	$137 billion (2017 est.)	$12,300 (2016 est.)	11.2% (2018)	12.8% (2010)	99.8% *
United States	328,239,523 (2019 est.)	15.1% (2010 est.)	$20,524.9 trillion (2019 est.)	$62,530 (2019 est.)	16.9% (2018)	5% (2014)	86% # to 92-96% ^
Canada	37,593,384 (2019 est.)	9.4% (2008 est.)	$1.842.1 billion (2019 est.)	$49,031 (2019 est.)	10.8% (2018)	5.3% (2011)	99% #
Mexico	127,575,529 (2019 est.)	41.9% (2018 est.)	$2,525.5 billion (2019 est.)	$19,796 (2019 est.)	5.4% (2018)	4.5% (2017)	95.4% *
Colombia	50,339,443 (2019 est.)	37.4% (2019 est.)	$741.1 billion (2019 est.)	$14,722 (2019 est.)	7.6% (2018)	4.5% (2018)	95.1% *
Jamaica	2,948,279 (2019 est.)	17.1% (2016 est.)	$28.8 billion (2019 est.)	$9,762 (2019 est.)	6.1% (2018)	5.2% (2019)	88.7% *

Haiti	11,263,077 (201 est.)	58.5% (2012 est.)	$32.7 billion (2019 est.)	$2,905 (2019 est.)	7.7% (2018)	2.8% (2018)	61.7% *
Honduras	9,746,117 (2019 est.)	48.3% (2018)	$55.8 billion (2019 est.)	$5,728 (2019 est.)	7.1% (2018)	6.1% (2018)	67.2% *
Venezuela	28,515,829 (2019 est.)	33.1% (2015 est.)	$269.1 billion (2018 est.)	$7,704 (2018 est.)	3.6% (2018)	6.9% (2009) ~	97.1% *
Timor-Leste	1,293,119 (2019 est.)	41.8% (2014 est.)	$4.6 billion (2019 est.)	$3,553 (2019 est.)	4.3% (2018)	6.8% (2018)	68.07% -
Indonesia	270,625,568 (2019 est.)	9.4% (2019 est.)	$3,196.6 billion (2019 est.)	$11,812 (2019 est.)	2.9% (2018)	3.6% (2015)	95.7%*
Papua New Guinea	8,776,109 (2019 est.)	37% (2002 est.)	$38.2 billion (2019 est.)	$4,355 (2019 est.)	2.4% (2018)	1.9% (2018)	64.2%*

* Data collected from World Population Review, 2021b.
# Data collected from WorldAtlas, 2020.
^ Data collected from Mamedova & Pawlowsk, 2019.
- Data collected from Macrotrends, 2021.
~ Data collected from CIA World Factbook in 2015 and is no longer currently available.
Sources: Mamedova & Pawlowsk, 2019; WorldAtlas, 2020; CIA, 2021; Macrotrends, 2021; World Bank, 2021; World Population Review, 2021b.[144]

The previous two tables, when combined, evidence the Cuban Paradox. While the WB, IMF, as well as other neoliberal knowledge- and policy-producing institutions promote a neoclassical economic hypothesis to focus on GDP growth first, Cuba debunks the assumption that healthcare outcomes are necessarily positively related to GDP growth. The Paradox is solid evidence that even during times when GDP decreases or when economic growth stagnates, a country can still put the health of its population first (A. Sen, 1999; 2000; Monk, 2010).

It is important to understand that most of the increase in Cuba's healthcare outcomes came with the emergence of Fidel Castro's revolutionary government (including significant input from Guevara's LASM background). As Cuba moved on from the Batista era, the focus on public

[144] Data on literacy is notoriously hard to find for Global North countries. As such, United States literacy appears to range from 86% (WorldAtlas, 2020) to between 92% and 96% depending on the source (Cardoza, 2019; Mamedova & Pawlowsk, 2019).

healthcare, education and services, were made a top priority throughout the rest of the country (beyond Havana) to great effect. What makes this even more significant is that, as noted previously, Cuba achieved this despite being the focus of the most economic and human resource pressure that the US has ever placed on another country.

Table 4: Cuban Health Statistics from pre-Revolutionary Cuba in 1950 to Present.

Years	Total Population (ONEI)	Life Expectancy at Birth (World Bank)	Maternal mortality ratio (modeled estimate, per 100,000 live births) (World Bank)	Infant Mortality Rate, Infant (per 1,000 live births) (World Bank)	Physician Density (population per doctor) (ONEI)	Literacy rate among the population aged 15 years and older (UNESCO)
# 1950	5,876,052	59.2 *	137.8 (Rate for years 1950-1959) *	80.6 *	n/a	76.4% *
# 1955	n/a	n/a		n/a		n/a
+ 1960	7,077,190	63.834	96.7 (Rate for years 1960-1969) *	59.4 *	1,076 (1958) (6,286 total)	76.4% *
^ 1965	n/a	66.956		38.7	1,252 (6,238)	n/a
1970	8,603,165	69.809	n/a	31	1,393 (6,152)	
1975	n/a	72.138		24	996 (9,328)	
1980	9,693,907	73.794		18.3	641 (15,247)	97.85% (1981)
1985	n/a	74.511		14.1	439 (22,910)	n/a
- 1990	10,662,148	74.638	58	10.9	274 (38,690)	
- 1995	n/a	75.412	55	8.6	193 (56,836)	99.8% (2002)
- 2000	11,146,203	76.699	46	6.9	170 (65,997)	n/a
2005	n/a	77.688	41	5.7	159 (70,594)	99.8% (2006) *
2010	11,167,934	78.388	44	4.8	147 (76,506)	99.75% (2012)
2015	11,239,004	78.561	38	4.2	128 (87,982)	
2016-2019	11,333,483 (2019 est.) (World Bank, 2021)	78.802 (2019)	36 (2017)	3.8 (2019)	125 (90,161) (2016)	

Cuba under control of the US-supported Batista government.
+ Cuban Revolution occurred in 1959.
^ Universal public healthcare reforms begin to expand in Cuba under the Socialist Government.
- Special Period: USSR collapse in 1991 (was Cuba's biggest trading partner and ally) coupled with increasing US pressure.
* Statistics by C. Pérez (2008).
Sources: C. Perez, 2008; ONEI, 2019; UNESCO, 2019; World Bank, 2021.

This set of tables outlines statistically significant improvements in health outcomes in relation to Global North assumptions and conflated hypothesis regarding the relation of GDP to

health outcomes as well as other non-biological areas that affect the health outcomes such as literacy.[145] Additionally, Table 4 outlines the improvement of these outcomes and their correlation with Fidel Castro's revolutionary government through public policies and interventions. It was this era, with the help of Guevara's LASM approach to healthcare, that made this 'developing' country an outlier amongst other countries in the Global South. The health system is also quite resilient. It managed to do this throughout the 'Special Period' during the 1990s when massive subsidies from Cuba's former ally, the Union of Soviet Socialist Republics (USSR), ended, and economic pressure by the US increased (Chomsky, 1998).

The embargo—introduced in 1962 and considered the most comprehensive set of US sanctions on any country, including countries designated as being state sponsors of terrorism—was tightened under the Clinton Administration. In 1996 with the Helms-Burton Act in combination with the Trade Sanctions Reform and Export Enhancement Act in 2000, became additional foreign policy tools to tighten the embargo further.[146] These measures, according to

[145] With the relatively recent appreciation of the social determinants of health (SDOH) in the Global North (R. Wilkinson & Marmot, 2003; WHO, 2008a; Bryant et al., 2010), the importance of literacy and its relationship with health outcomes has taken on greater significance. Due to Cuba's LASM approach, the importance of literacy was an early focus of the revolution long before the SDOH. As the 1953 Cuban census highlighted (which was the last census taken in Cuba prior to the revolution), approximately 23.6% of Cubans were illiterate. Due to the attention given to Havana, often at the sacrifice of resources, education, and public services in the rural areas, there was a significant rural to urban disparity in literacy. Approximately 41.7% of the rural population was illiterate in contrast to only 11% of the urban population. In 1961, known as the 'Year of Education' in Cuba, the revolutionary government made the eradication of illiteracy one of its primary goals in addition to improving health outcomes for all populations. With the help of 105,664 student volunteers, known as the Conrado Benítez Brigades, "707,212 of the nation's 979,207 illiterates" attained a functional level of literacy within the year (55% of whom were women) (Herman, 2012, p. 97-98).

[146] It is also important to note that, when Cubans were suffering the most during the Special Period, under the Clinton Government, the US further tightened the economic embargo on Cuba. This included the Helms-Burton legislation signed in 1996. Despite being internationally condemned, including by many US allies which had normal trade relations with Cuba—such as the European Union, Argentina, Brazil, Britain, Canada, and Mexico—the Helms-Burton Act was ratified: international sanctions against the Cuban Government block Cuban membership to many multinational financial institutions as well as prohibiting them from working with Cuba. If they do not follow the US dictates, then any "loan or assistance provided by any of these institutions to the government of Cuba will result in the withholding of the same amount by the US Secretary of Treasury from payment to that institution" (Amnesty International, 2009, p. 10). In an effort to cut Cuba's economic trading and assistance relationships with other countries, the Act also added some

Amnesty International, constitute a violation of the human and economic rights of the Cuban population as well as being a violation of international law (based upon moral, political and economic grounds) (Amnesty International, 2009). In addition to Amnesty International, the embargo has also been condemned as a "violation of international law" due to the restrictions on medicine and food by the United Nations (UN) as well as by the Inter-American Commission of Human rights (Chomsky, 1998, p. 44).

A supplementary factor, often highlighted in US media, is the emigration of Cuban medical personnel, including doctors from Cuba's medical internationalism program.[147] While the media framed the issue of Canadian doctors migrating (at a rate of approximately 10-12%) to the US as simply seeking higher wages (OECD, 2015, p. 151), the common representation of Cuban doctors by mainstream media and American officials, are deemed to be leaving, not for 'better wages', but because they are fleeing the Cuban 'dictatorship' or Castro 'regime' (Kitchens, 2005; O'Grady, 2014; Fields, 2019). Additionally, many Global North media outlets often overlooked the 2006 Cuban Medical Professional Parole (CMPP) program or continued to fail to

extra-territorial measures such as legal action against any non-US company that economically deals with Cuba (including company leadership being barred entry to the US). Thus, international companies must choose between Cuba and the much larger market of the US. Title Three of the Act goes so far as to allow "US nationals to sue foreign companies deemed to have gained from investments in property" (ibid.). Company stockholders and senior officials as well as their families who do business on Cuban property that was once expropriated from American citizens can be excluded from the US. So far international executives from Canada, Israel, Italy, Mexico as well as the United Kingdom (UK) have been banned from entry into the US under this legislation. Thus, international condemnation of the embargo against Cuba, as noted at the UN General Assembly meeting in 2014, highlights that the extraterritorial effect of the embargo additionally affects the "sovereignty of other States" (UN, 2014).

[147] See Kitchens, 2005; O'Grady, 2014; Londoño, 2017, Pentón, 2018, or BBC, 2019 for examples news on Cuban personnel fleeing the 'Regime'. According to Teishan Latner, the main goal of the CMPP program was "designed to undermine Cuban medical cooperation through attrition and, especially, to bolster the argument that Cubans on the international missions were exploited" (2020, p. 334). Additionally, little comparative attention is paid to the high rates of medical migration from Canada, or from countries backed by, or have warm relations with, the UK and Canada such as Honduras, Guatemala, El Salvador, and Mexico. Salim Lamrani's book evidences the challenge of documenting the rich context of Cuba in his 2015 book *Cuba, the Media, and the Challenge of Impartiality*.

compare the rates at which medical personnel from other countries migrate—often at much higher rates than Cuba.

First and foremost, the CMPP program was an attempt by the US government to stifle the 'soft power' influence of Cuba's medical internationalist programs. Secondly, the brain drain of Cuban medical personnel would potentially help address the workforce shortage of the US healthcare system—which has a perpetual shortage of doctors, nurses, and other medical personnel, often relying on recruitment/brain drain of medical personal from other countries. The CMPP program, throughout its tenure until 2016 (when the Obama administration ended it), expedited the legal travel of 7,000 Cuban personnel and arranged their residency statuses etc. (Erisman, 2012; Burnett & Robles, 2015; LeoGrande, 2015; Brenner & Castro, 2017; US Citizenship and Immigration Services, 2017). As noted by William LeoGrande, the rich irony of this situation is that the US government was praising "Cuba's humanitarian health programs on the one hand while trying to subvert them on the other" (2015).

As Michael Erisman observes, Cuba's 2-3% defection rate did not "bode well for Washington, at least insofar as it might hope that the CMPP [was able to] exert a significant negative impact on Havana's ability to provide quality medical aid" (2012, p. 281). The reason that the CMPP was so ineffective in limiting Cuban medical internationalism is that Cuba anticipated the defection rate into their medical internationalist programs. In comparison to Global North international approaches to development, whereby short-term local disruptions can occur when "aid workers abandon their posts, the negative potential" of Cuban medical cooperation is "neutralised from a long-term macroperspective since replacements for the

defectors will always be readily available from the extra cadres who have been built into the personnel equation" (ibid., p. 281-282).[148]

Moreover, while Cuba employs hardly any foreign medical personnel, in contrast as the end of the "medical migration pipeline" for many, Australia, Canada, the UK, and the US recruit, employ as well as massively contribute to the brain drain of Global South health workers (Hallock et al., 2003; Aluttis et al., 2014; OECD, 2015; Bezner Kerr & Luginaah, 2016; Simpson, 2019). The most brain drain-dependent of Global North countries, by far, is Australia. Approximately half their doctors are foreign-born while New Zealand is only slightly less than half. They are followed by the UK as about one-third of its physician population are not drawn from their domestic population. Canada sits between a quarter and one-third of foreign doctors in its domestic care system (OECD, 2019; WHO, 2014). Significantly, nearly a quarter of all doctors practicing in the US are foreign medical graduates from other, mostly Global South, countries (Hallock et al., 2003; Simpson, 2019; OECD, 2019).

In contrast, Cuba's approach contributed to the financial well-being of host countries, garnered political support via trade relations based upon what they had to give (not what was left over in order to dump excess material etc. as a form of 'aid'), as well as met the needs of health vulnerable populations abroad (J. Kirk, 2015; Bezner Kerr & Luginaah, 2016). As noted in the Introduction, more than 400,000 Cuban healthcare workers had "served in 164 countries" (Saney, 2021) and 28,000 Cuban personnel had provided healthcare in 59 countries in 2020 alone

[148] The issue of aid workers leaving the Global South has accelerated significantly during the COVID-19 pandemic. While Cuba has increased its medical internationalist programs (including to Global North countries such as Italy and Andorra), Global North development workers often returned to their home countries to weather the pandemic and Global North aid has been significantly reduced (Development Initiatives, 2020; The New Humanitarian, 2020; Saney, 2021).

(Augustin, 2020). As noted previously, they had also trained approximately "30,878 doctors from 122 countries" (Cuba's Representative Office Abroad, 2024) (Granma, 2018; Reed, 2020)—drawn from Africa, Europe, the Middle East, Asia, and the Pacific, with the majority "based in Latin America and the Caribbean" (Baggott & Lambie, 2018, p. 166). And yet, it did all of this while maintaining a robust domestic health system that achieved high health outcomes.

While the Cuban Paradox highlights that a low-resourced and low-income country can attain high health and education outcomes comparable to wealthy Global North countries, it is important to analyze the core structure of its education as well as its health system based on LASM. Cuba's approach to healthcare and education for all via a health in all policies approach to governance, targeting the most vulnerable populations suffering structural violence, must be detailed. This foundation, beginning with the Constitution, will help contrast the differences and similarities to their medical programs: one that is paralleled alongside Venezuela's conventional medical system, as well as the program in Timor-Leste which became the main public primary care system there.

Cuban Constitution: Healthcare as a Human Right

Since the 1959 Cuban revolution, the once market-dominated, centralized/urban, and informal medical system in place under the US-backed Batista dictatorship, has been remade into a state-led public healthcare model with comprehensive government control, limited corporate influence, as well as significantly greater accessibility for rural and poor areas. Unlike other countries, the transnational pharmaceutical industry (TPI) was also unable to exert its influence,

control, and desire for profit over the health practices and priorities of the Cuban population.[149] The revolution's healthcare system managed to hold off the Global North TPI-influenced idea that "health = doctors + drugs," which often perpetuated overmedicalization and overtreatment (Tucker, 1996a, p. 17)—instead charting its own course towards comprehensive proactive and preventive public healthcare that utilizes human capital in place of expensive curative/biotechnical approaches (as found in Canadian and US systems).

The revolution itself was the basis upon which Cuba's socialist mentality was born. This mentality, based upon their medical training as well as the societal values inculcated since pre-school times, became integrated into the medical system by healthcare workers who viewed their roles as being imbued with *conciencia*—consciousness/a sense of duty, commitment, compassion as well as a true comprehensive awareness of their patients being—with fewer benefits resulting from status or income (as opposed to the benefits and status that might be found in other countries) (C. Walker, 2015; J. Kirk, 2017).[150] This will be a key point of distinction when understanding what made the Cuban system of that era unique in contrast with conventional Global North medical education systems. Global North health systems often produce significant health disparities. Their vulnerable populations are often cared for by Global

[149] See the literature review for a more in-depth analysis of TPI influence on health and education priorities of many countries, specifically the work of Vincent Tucker (1996a; 1996c; 1997) and others (Farmer, 2005; Farmer et al., 2006; Cooke et al., 2006; Abraham, 2010; Braithwaite, 2013; Hixon et al., 2013; C. Walker, 2015; McGreal, 2017; Hagopian, 2018; Sturmberg, 2018).

[150] In 2005, Fidel Castro outlined how *conciencia* is a key pillar of Cuba's medical system: "What is the secret of our system? It comes down to the basic fact that *human capital is worth far more than financial capital* [emphasis added]. Human capital is based not only upon knowledge but also—and of particular importance—*conciencia*, a sense of ethics, solidarity, truly human feelings, a spirit of sacrifice, heroism, and the ability to do a lot with scarce resources" (F. Castro as quoted in J. Kirk, 2017, p. 75). Thus, Cuba's holistic approach to patient-centred healthcare training and practice is manifest in *conciencia*'s "sense of commitment, compassion and empathy to treat patients as family", as well as "situating their patients in their entire biological, psychological and social spheres of health." This may be one of the most important aspects to understand Cuba's unique LASM approach to health (C. Walker, 2015, p. 34). As such, *conciencia*, appear to have certain parallels to Paulo Freire's 'conscientization' or 'consciousness raising' (Roberts, 1996).

North doctors, who *practice in* (as opposed to being *drawn from*) poor, rural, and marginalized areas (Furlong, 2004; S. Giles & A. Giles, p. 2008; emphasis added).

Thus, a unique aspect of the revolution's LASM healthcare system was its ability to reach as well as train the most rural, poor, and marginalized populations. This ensured that little medical disparity remained between different populations on the island while it achieved high health outcomes at relatively low cost as well as with limited access to resources, trade, and foreign assistance. All populations are represented in their medical schools across the country. Students are drawn from rural and racially diverse backgrounds to learn in a highly decentralized university system—they are not limited by income or other structural violence challenges as many aspiring Global North students from poor, rural and marginalized backgrounds are (Field, 2006; C. Walker, 2015).[151]

Since the Cuban revolution in the late 1950s, the public healthcare-obsessed Fidel Castro and the LASM activist doctor, Ernesto 'Che' Guevara, set out to establish a strong universal public healthcare system as a national priority. This national priority is embedded in the 2019 Cuban constitution:[152]

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[151] This provides and interesting contrast with the US where racial disparity has contributed to high rates of infant mortality. By 2013 the infant mortality rate for the non-Hispanic African American population was approximately 11.1 per 1000 live births. This is a glaring disparity when compared with the 5.1 mortality rate for the non-Hispanic white population. (Brown Speights et al., 2017, p. 775)

[152] In the 2019 version of the Cuban Constitution, the following responsibilities of the state were outlined in these three points found in Article 50: "Everyone has the right to have his health attended to and protected. The State guarantees this right;
- with the provision [*prestaci6n*] of free medical and hospital assistance, by means of the installations of the rural medical service network, *polyclinics*, hospitals and preventive and specialized treatment centres;
- with the provision of free dental care;
- with the development of the plans of sanitary dissemination and of health education, periodical medical examinations, general vaccinations and other preventive measures for disease. In these plans and activities all [of] the population cooperates through the social and mass organizations." (Government of Cuba, p. 15).

ARTÍCULO 72/ARTICLE 72:

- La salud pública es un derecho de todas las personas y es responsabilidad del Estado garantizar el acceso, la gratuidad y la calidad de los servicios de atención, protección y recuperación.

- Public health is a right of all people. It is the responsibility of the State to ensure free and quality [access to healthcare] services [involving] the attention, protection and recovery [of the citizen].

- El Estado, para hacer efectivo este derecho, instituye un sistema de salud a todos los niveles accesible a la población y desarrolla programas de prevención y educación, en los que contribuyen la sociedad y las familias.

- The State, in order to implement this right, institutes a health system at all levels in order to make it accessible to the entire population. The State develops [health] prevention as well as education programs, in which society and families contribute.

- La ley define el modo en que los servicios de salud se prestan.

- The law defines how health services are delivered.

(Government of Cuba, 2019)

The Cuban Constitution provides an important outline for the public healthcare system. Through the Constitution, the Cuban government created a contract with its citizens to prioritize their citizens' health, free of cost, using preventive, proactive and curative approaches, removed of geographic and structural violence barriers, as well as to involve all members of the Cuban population. This is important since it evidences how effective policy reforms and their unique LASM approach to health, which incorporates the aspects of the Alma Ata Declaration on

primary care as well as the social determinants of health (SDOH) before either came into popular Global North discourse and consideration, helped Cuba become a world power in healthcare.[153]

The Revolutionary Government and Universal Public Healthcare

As Julie Feinsilver notes, Cuban leadership championed free universal healthcare as a basic human right as well as the responsibility of the state to guarantee this right. Additionally, Cuba's revolutionary leaders believed that the health of the population is reflective of the health of the body politic.[154] This prioritization has established a "national health system that, over time and through trial and error, has evolved into a model lauded by international health experts, including the World Health Organization and the Pan American Health Organization" (2008, p. 2).

With half of the physician population gone by the mid-1960s, training of all medical personnel became a focus of the Fidel Castro government (Gilpin, 1991; J. Kirk, 2015; C.

[153] After then director-general of the WHO, Margaret Chan, visited Havana in 2014, she called on other nations to emulate Cuba's healthcare example. The WHO's ranking of countries with the "fairest mechanism for health-system finance", places "Cuba first among Latin American and Caribbean countries (and far ahead of the United States)" (Hamblin, 2016). In addition to Margaret Chan's assessment of the Cuban model, former Secretary-General of the UN, Ban Ki-moon also remarked on Cuba's global health impact during a 2014 speech in Havana: "Many health officials and Ministers I have met in developing countries were trained in Cuba—some many decades ago. This shows your country's long history of cooperation. Your doctors are with communities through thick and thin—before disasters strike . . . throughout crises . . . and long after storms have passed. They are often the first to arrive and the last to leave. For those students who cannot come to Cuba, you are also helping to establish medical schools from Bolivia to Eritrea to Timor-Leste. *ELAM* has trained tens of thousands of students—but Cuba can teach the entire world about healthcare. I want to join so many others in saluting Cuba's healthcare system rooted in primary healthcare which has yielded outstanding results—lower infant mortality, higher life expectancies, universal coverage. This is a model for many countries around the world. In countries like Haiti, the Cuban Medical Brigade have been life-savers" (Ki-moon, 2014).

[154] Arnold Harvey explains that the body politic is the "idea that there is an analogy between the social collective and the human body." He highlights that the origins of this analogy began "more than twenty-five centuries ago" (2007, p. 1). It was an analogy known to Plato as well as St. Paul and had been used in the Middle Ages by state functionaries. Thus, the Cuban interpretation is that the health of the Cuban population is reflective of the role of the State. When the Cuban population is healthy, that means that the State system is functioning well. Therefore, if the population is unhealthy then the State apparatus is unwell and in need of a 'repair' or a 'cure'.

Walker, 2015). Cuba's 6 nursing schools, 1 dental school, and 1 medical school in pre-revolutionary 1959 (when the population was approximately 7 million), were increased to 34 nursing schools, 4 dental schools, and 21 medical schools by 1991 (when the population was approximately 10.5 million)—all dispersed throughout the various health regions across the country "in accord with health, geographic and demographic conditions" (Gilpin, 1991, p. 87; ONEI, 2019).

The shift of primary healthcare delivery system from acute care in hospitals to geographically decentralized preventive community care clinics (known as *consultorios* and *policlínicos* in Cuba for the first two levels of primary care) occurred in the 1970s as it broke free from the pre-revolutionary health system. This model formed the blueprint for the primary healthcare delivery system and is a key aspect of this dissertation due to its success despite limited resources as well as in the face of geopolitical challenges. The Cuban healthcare system is controlled by the Ministry of Public Health and explicitly prioritizes "primary care and preventive activities" (Spiegel & Yassi, 2004, p. 97).

The government finances the public medical system to provide free pharmaceuticals (still often in short supply due to limited resources and the US embargo) for hospitalized patients, and free preventive diagnostic tests and medical care. In addition to these free services patients can "pay for drugs, hearing, dental, and orthopaedic prostheses, wheelchairs, crutches, and similar items but prices are low and subsidized by the state; and in the case of low-income patients, these items are offered free of charge" (ibid.).

Moreover, in pre-COVID times Cuba produced more than sixty per cent of its own pharmaceuticals (Romeu & Perez Cristiá, 2020, p. 165),[155] but "at a fraction of a cost charged by multinational drug corporations" from its publicly-funded *Polo Científico* medical research facilities in Havana—which has a number of beneficial joint venture agreements with other countries, especially in Asia (J. Kirk, 2009, p. 504).[156] In all, some 20,000 researchers and scientists worked in 30 facilities there. The high level of training by Cuban pharmacists is also important to contrast since, in Latin America, the majority of pharmaceuticals are "dispensed by non-pharmacists who, except in Cuba, are not required to have any pharmacological or medical training" (Homedes & Fugh-Berman, 2019, p. 190). Thus, out of all the Latin American countries, only "Cuba has a well-structured educational program for pharmacy clerks" (ibid.).

Significantly, Cuba has five state-funded products it is using to vaccinate the population against the coronavirus, the most frequent being Soberana 02 and Abdala. The goal was to have the entire population vaccinated by the end of August 2021 with plans to include the vaccines in their medical internationalist efforts to the benefit of global health (not corporate profit). Important to note is that Cuba is also the only Latin American country to produce its own vaccines (Yaffe, 2021). In contrast, while the Global North TPI test drugs on Global South populations—who take on the disproportionate risks of clinical trials for the global good to the disproportionate benefit of Global North populations (Lange, 2021)—the TPIs enforced waivers

[155] However, due to significant resource challenges, Cuban pharmaceutical production has been cut in half, producing approximately 30% of its own drugs as of 2023, due to COVID-19, the US embargo, and governmental mismanagement.
[156] During the brief thaw in relations between the US and Cuba under the Obama Administration, many US pharmaceutical companies were attempting to secure agreements with the Cuban government over the international sale of their products. Cuban drugs, such as Cimavax (a lung cancer vaccine) and Heberprot-P (for the treatment of patients with diabetes) are highly sought after by the TPI (Almendrala, 2016; HemOnc Today, 2017; Notman, 2018; Grillo, 2019).

and pressured governments to limit their use in the Global South. Additionally, TPIs ensured their already record profits in 2020 continued to balloon in 2021 and beyond while the virus continued to circulate and mutate (Wilkins, 2021).

As such, under a capitalist for-profit market approach to vaccine production, the TPIs profit from both the duration and the spread of COVID-19 (as it historically has with other pathologies) as well as the current endemic nature of coronavirus. Walter Bortz highlights the core issue of the current Global North neoliberal paradigm: "capitalism should serve our health needs, not, as is currently the case, the other way around" (2011, p. 84). Thus, even during the advanced stages of the COVID-19 pandemic, it became disparagingly clear that 'our health needs' are serving Global North capitalism and corporate interests as evidenced in the record profits of the TPIs (Lange, 2021; Wilkins, 2021; Yaffe, 2021).

Due to geopolitical pressure from the US and their allies as well as a lack of economic resources, Cuban human capital has often had to take the place of equipment, supplies and technology.[157] Proactive and preventive medicine are strong reasons why Cuba's approach had high health outcomes when most other Global South countries with their highly privatized and curative models have struggled. In 2018, Cuba spent approximately 11.187% of its GDP on health expenditures, which is comparable to Global North countries such as Canada, yet far less than the 16.885% GDP of the US which has some of the poorest health outcomes in the Organisation for Economic Co-operation and Development (OECD) despite comparatively spending the most on its highly privatized and curative healthcare system (World Bank, 2021; G. F. Anderson et al., 2019; Benham & Scullin, 2019; Pratt, 2019).

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[157] This approach will be outlined in further detail later in the chapter.

Table 5: Health Expenditure (% of GDP).

Country	2000	2005	2010	2015	2018
Cuba	6.582	8.755	10.688	12.814	11.187
United States	12.542	14.606	16.345	16.711	16.885
Canada	8.276	9.064	10.684	10.683	10.79
Mexico	4.449	5.836	5.975	5.797	5.371
Colombia	5.635	6.067	7.071	7.523	7.64
Jamaica	5.645	4.546	5.295	5.626	6.061
Haiti	6.879	5.509	8.146	8.629	7.695
Honduras	6.268	7.501	8.725	7.484	7.05
Venezuela	7.334	6.055	6.831	5.797	3.563
Timor-Leste	2.564 (2003)	1.345	1.427	3.954	4.326
Indonesia	1.909	2.584	2.961	2.991	2.671
Papua New Guinea	1.972	2.444	2.108	1.819	2.367

Source: World Bank, 2021.

Prohibitively high costs are what the Cuban model strived to avoid through their proactive and preventive focus based on its Community-Oriented Primary Care (COPC) model. The core of what made this model efficient and effective revolved around its use of human capital. They focus on educating patients and viewing patients as a part of a greater biological, psychological, and sociological (bio-psycho-social) environment.

The vertically integrated catchment system (see Figure 2 below) provides the framework for the health system. This system ensures:

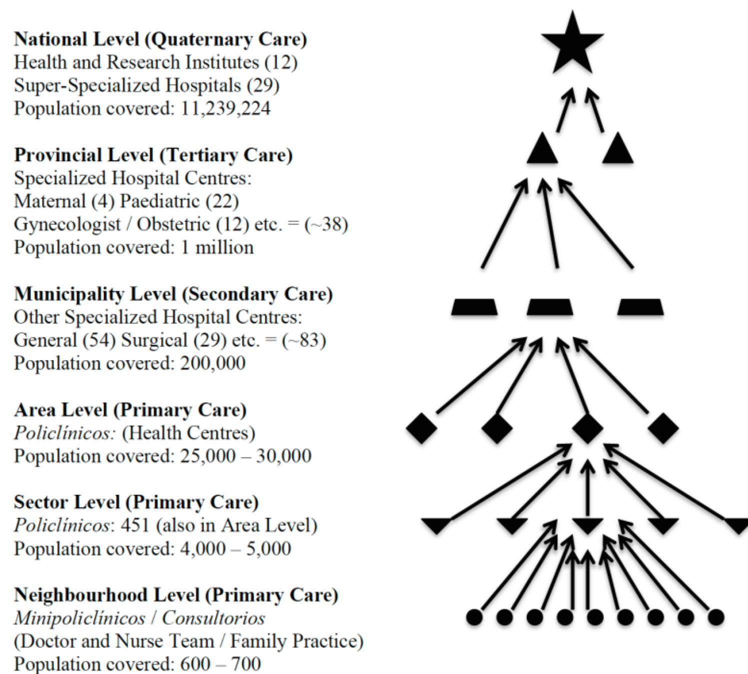
- limited fragmentation at the national level;

- functions with comparatively little institutional fragmentation than the aid industry when utilized internationally;

- operationalizes an expansive set of health indicators based upon LASM to tackle issues of structural violence (well before the adoption of SDOH in the Global North);

- employs a comprehensive health team approach where, at the *policlínico* health team level especially, doctors work alongside nurses, social workers, lab technicians, radiologists, physiotherapists, epidemiologists, gynaecologists, paediatric specialists etc.;[158]
- utilizes community involvement and mass organizations help distribute information, medicine, and vaccines (Feinsilver, 1993; Spiegel & Yassi, 2004; Dresang et al., 2005; C. Perez, 2008; Fitz, 2011, 2018; C. Walker, 2015; Thomas, 2016).

Figure 2: Cuba's Vertically Integrated Healthcare System as of 2016



Sources: Author, 2021, drawing data from Iatridis, 1990; C. Walker, 2015; ONEI, 2019.

[158] In the earliest years, when the *policlinicos* were first being developed, they began with a "general practice physician, nurse, pediatrician, OB/GYN, and social worker." Later, dentists and others were also "brought under the umbrella." Nurses and social workers began to make house calls and medical staff "extended services to workplaces, schools, and communities" (Fitz, 2018).

As noted in Figure 2 above, Cuba's COPC is integrated into six vertically interlocking levels of health services which are hierarchically organized to "correspond to the country's administrative and political divisions" (Iatridis, 1990, p. 31).

This vertically integrated catchment health system provides a high level of control and limited institutional fragmentation by delegating responsibility down to local community levels, including for the most remote areas. Utilizing their significant human capital advantage, proactive and preventive primary was often initiated at the neighbourhood/*consultorio* level by the family nurse-doctor team, whose strong community connection ensured continuity of care for their patients, and then works its way up through the next levels containing bigger and bigger catchments of patients before it finally reaches the secondary care level under the administration of the municipality, at the *policlínico*, serving local *consultorios*.[159] The province then looks after tertiary care at specialized provincial hospitals before a patient reaches quaternary care at the national level (Iatridis, 1990; Spiegel & Yassi, 2004; Dresang et al., 2005; Feinsilver, 1993; C. Perez, 2008; C. Walker 2015).

Doctors' responsibilities go beyond regular duties of many conventional Global North medical personnel. They are involved in proactive and preventive community education programs about general health issues, disease transmission, and environmental health. In an example of their significant human capital at work, doctor and nurse teams at the primary care/*consultorio* level are required (as per their undertaking as primary care providers) to make

[159] 'Continuity of care' is a significant challenge for many patients in the Global North, especially those patients struggling to find a family doctor. It is argued that systems with a high degree of continuity of care are less likely to suffer from the iatrogenic effects of fragmentation, whereby the duplicity and overlap in fragmented care between medical personnel, create an environment where medical mistakes, such as overmedicalization or assumptions of the work done by other medical personnel, occur at a high rate (Haggerty et al., 2003; Gray et al., 2018; Kao et al., 2019).

house calls to each of their patients several times a year, especially for patients under their care with mobility challenges. The *consultorio* team typically spend half their day at the clinic tending to patients and the other half is spent visiting patients at home (or even at work and other locations) in order to take "stock of their living styles, potential health concerns, and environmental influences" (J. Kirk, 2017, p. 73).

By having medical teams available 24 hours a day 7 days a week through house calls and the open door *consultorio* approach, health issues were readily addressed at the primary care level by a system that requires comparatively more doctors and nurses than Global North systems, but with less material resources, less reliance on technology, and less cost. This also ensured that medical issues get addressed in a low-cost environment, the *consultorio* or patient's home, and not at the hospital where there are higher risks of iatrogenic illness and hospital-acquired infections (Fitz, 2011).

At-risk patients with chronic or severe illnesses are seen at least once every three months (Keck & Reed, 2012). The primary care team works with "local schools, factories, and especially the mass organizations, to ensure that health concerns are addressed promptly, again following the emphasis on preventive medicine" (J. Kirk, 2017, p. 73). At the next rung on the vertically-integrated system of care, the team of specialists at the *policlínico* level supports approximately 20-40 doctor-and-nurse teams throughout their geographic catchments area of patients (Keck & Reed, 2012, p. 8-9). This basic *policlínico* work team helps to supervise and evaluate the *consultorio*/family medical offices at the neighbourhood level. The need for this type of low-

cost, low-technology, and low-resourced approach helps account for the necessity of their high human capital approach (Spiegel & Yassi, 2004; Keck & Reed, 2012; C. Walker, 2015).[160]

In contrast, a conventional Global North curative system has a much higher propensity for primary care issues to go unaddressed, especially in countries such as Canada, the UK, and the US, where first contact primary care is increasingly becoming hospitalized due to a lack of access to family/general practice doctors. Thus, this trend towards hospitalization of primary care requires an often-excessive use of resources as underutilized proactive and preventive measures are instead addressed by expensive biotechnology requiring and ever-increasing cadre of specialized medical professionals and medication. Additionally, hospitalization means that patients reside in an (at times crowded) environment that often perpetuates the spread of infectious illnesses (especially risky during challenges with airborne transmission as the case of COVID-19 has highlighted).[161]

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[160] As noted by John Kirk: "Communal relationships are a significant factor in the doctor-patient relationship. In terms of the working environment, it is important to note that physicians and nurses often live in the same neighbourhoods as their patients. Usually one doctor and one nurse, in a partnership, work in each of the thousands of small *consultorios* or family practices. Their children attend the same schools and play sports together, and they shop in the same stores, use the same local services, and socialize together. There is thus a constant interaction between physicians and patients. Doctors understand well the conditions in which their patients (and neighbours) live and work; they see them on a daily basis, rather than once or twice a year when patients visit the clinic because of a medical complaint" (2017, p. 73). Thus, this proximity closes the relational distance between patient and healthcare worker. The medical professionals themselves are often drawn from and live in the communities they serve, and they are much more familiar with the unique pathologies facing their patients, including pathologies arising from poverty or other issues of structural violence.
[161] The hospitalization of primary care is an increasing challenge of a few countries in the Global North (Ricketts et al., 2001; Rosano et al., 2012). Access to robust primary care facilities and clinics as well as lacking access to family doctors has increasingly meant that the first contact point in the health system for many people has become the hospital or emergency room. There are many concerns about this trend. First and foremost, it runs counter to Thomas Douglas's (often referred to as Tommy, is considered the 'father' of Canadian Medicare) 1984 speech titled "The Future of Medicare" outlining the importance of proactive and preventive medicine as well as primary care facilities: "Let's not forget that the ultimate goal of Medicare must be to keep people well rather than just patching them up when they get sick. That means clinics. That means making the hospitals available for active treatment cases only, getting chronic patients out into nursing homes, carrying on home nursing programs that are much more effective, making annual checkups and immunization available to everyone. It means expanding and improving Medicare by providing pharmacare and dentalcare programs. It means promoting physical fitness through sports and other activities. All these programs should be designed to keep people well–because in the long run it's cheaper than the current practice of only

Hospitalization as a primary care solution (instead of Cuba's approach using house calls and accessible *consultorios*) means that patients are often only seen during hospital or clinic hours, specialists are used more often than are needed as illnesses can become more complex with increasing duration (thus requiring more resources and human capital), and transmissible diseases are concentrated in one centralized location among other patients (Fitz, 2011). Thus, health issues are also dealt with further up the chain of specialization increasing cost as seen in Figure 3 below (C. Walker, 2015; Douglas, 2016).

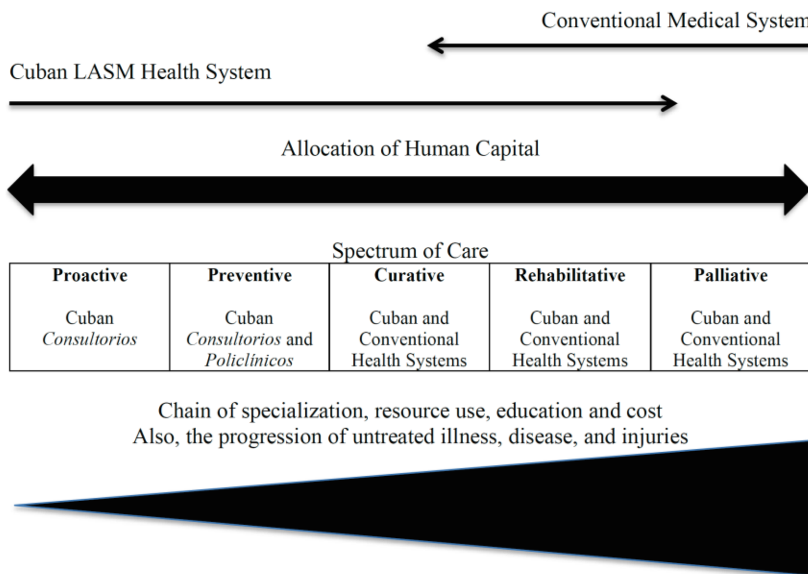
Even though the Canadian system has begun to consider a more comprehensive set of SDOH indicators, the Canadian medical approach is still primarily curative-focused as well as heavily reliant on technology and resources—despite the need for a more comprehensive and holistic approach to healthcare. This high-tech curative approach often requires x-rays, computed tomography scanners (CT scans), magnetic resonance imaging machines (MRIs), and other expensive equipment since the doctors do not have the same 90% primary care success for preventing illnesses and injuries (such as is the case in the Cuban model) which, instead, move up the chain of specialization (Landau, 2008).

The Cuban system expanded its set of indicators by turning rhetoric and concern for citizen well-being into tangible results through a comprehensive list of targeted indicators, a health in all policy approach, as well as its bio-psycho-social view of the patient. Any Global

treating them after they've become sick" (Douglas, 2016). Additionally, hospitalization, and mistakes at hospitals (iatrogenesis) (Illich, 1976), are the third leading cause of death in the US (Makary & Daniel, 2016, p. i2139; Daniel, 2016). Thus, the lack of robust primary care clinics and a lack of family doctors increase fragmentation of the system as well as reducing the continuity of care for a patient. Hospitals tend to increase disease transmission, especially of airborne illnesses. Populations from lower income tend to face iatrogenic effects of hospitalization at disproportionally higher levels than those in the upper social strata. This is known as "iatrogenic poverty" (Meessen et al., 2003; Xu et al., 2007; Kruk et al., 2009). As one Global North family doctor noted in 2017: "if you don't want to get sick, stay out of the hospital."

South country that wishes to make the most of the Cuban health model must factor in this comprehensive view of health as an interrelated set of indicators that go beyond mere illness and injury and into housing, work, social, environmental etc. (Romanow, 2002; Spiegel & Yassi, 2004; Dresang, 2005; Fitz, 2011).

Figure 3: Allocation of Human Capital Along the Spectrum of Care



Source: Author, 2021.

Thus, an expensive high-tech curative approach can be a challenge for Global South countries as they lack access to important resources and infrastructure as well as may be limited by international patent protections which prioritize corporate profit over human need (C. Walker, 2015). According to Don Fitz, Cuba demonstrated that:

> a quality health-care system does not have to be based on unending expansion of expensive medical technology. Removing profit from medical care lowers administrative costs, reduces over treatment, tempers the expansion of diagnoses, stops making people

sicker by denying them preventive treatment, controls exorbitant incomes of doctors, and helps focus research in needed areas. (2011)

In Cuba's COPC model, healthcare personnel are "held accountable for healthcare outcome measures of the community members they serve. In Cuba, a growing cadre of family physicians are being trained to provide health education and preventative service, offer comprehensive medical care, and conduct population based-research" (Dresang et al., 2005, p. 298).[162]

Each team cares for their catchment of patients in a system-oriented approach based on the principle of COPC (Spiegel & Yassi, 2004; Dresang et al., 2005; Feinsilver, 1993; C. Perez, 2008). This team-based proactive and preventive COPC approach, utilizing significant political will by the government, is reflective of the comprehensive bio-psycho-social patient-centred care advocated by LASM scholars and policymakers. It also ensures that the Cuban population remains, as Mark Duffield's analyses of the current system of neoliberal global governance, 'insured' (2007; 2008; 2010). In contrast, many other Global South countries, due to a lack of access to robust public health and education, remain 'non-insured'. Therefore—unlike the Cuban population who had similar levels of public services and supports as the Global North—these vulnerable Global South populations (lacking a welfare state), frequently migrate at high rates to Global North countries in order to access public healthcare and public services (Duffield, 2007).

[162] This unique community approach has been considered in Canada. In November 2002, Commissioner Roy J. Romanow released his final report, *Building on Values: The Future of Healthcare in Canada*. In the report on Canadian healthcare, he came to the conclusion that the health of the Canadian population was not just the matter of an isolated illness of a single individual patient, but should consider a much more comprehensive interrelation of factors to include access to water, nutrition, and increased physical activity in a broader scope of community and family health (Romanow, 2002). Though this comprehensive SDOH view took place in 2002—advocating for a health in all policy approach to tackle structural violence—it struggles to be implemented at both policy and medical education levels in a meaningful way. In contrast, Cuba's LASM medical model—involving significant political will—has scaled up the ideas found in the 2002 Romanow report since their 1959 revolution.

Thus, Cuba became a subaltern welfare state example of healthcare as a human right by utilizing a uniquely decentralized healthcare system to advance its micro-level community-centred approach. This approach guaranteed that community members had access to 24-hour medical services regardless of how impoverished or rural the area (C. Perez, 2008). The medical services and personnel are both located in, as well as trained from, the communities they serve. This also ensures that they are relationally close to the patients under their care as well as familiar with the unique pathologies and challenges in those communities.

The large number of physicians has meant that by "focusing on primary care and health promotion, the Cuban health system is designed to prevent 90% of health problems" before they move up the chain of specialization and cost in an effort to decrease hospitalization (Loewenberg, 2016, p. 327). Impressively, prior to COVID-19, Cuba had "more doctors abroad than the entire World Health Organization" (Landau, 2008, p. 42), as well as had far more doctors abroad than any other Global North/OECD country, which was a testament to the strength of its education system (J. Kirk, 2015).

To put this in perspective, in 2016 Cuba had 90,161 doctors for a population of 11,239,224 (ONEI, 2019), while Canada had 86,644 physicians in 2017 to serve its population of 36,545,295 (CIHI, 2020; World Bank, 2021). That is almost 4 thousand more doctors than Canada despite having less than one-third of the population. Approximately one in five Cuban physicians served internationally at any one time (Baggott & Lambie, 2018, p. 166). This international involvement is a valuable source of healthcare experience, combined in particular with 'critical distance' (that is socio-economically and geopolitically relationally closer than

Global North approaches), as well as increased income generation for the medical staff (and the state).

Due to a high proportion of Cuban medical personnel who served two-year rotations in other medically vulnerable countries around the world (J. Kirk, 2015), many of these doctors—this dissertation argues (based upon observations in Timor-Leste and Venezuela)—attained a certain optimal critical distance. Hence, when observing Cuban medical personnel internationally and in Cuba, their relational distance as well as their knowledge of the pathologies of Global South poverty and disease as well as how to mitigate them in low-resourced settings, is significantly closer to the communities they serve than their Global North counterparts. Yet, importantly, their training and international experience gave them added perspective to critically examine other challenges, especially difficult cultural challenges, which may be harder to confront in their own communities without that relational distance, perspective, and experience gained in other environments.

The decentralization of health services and medical education as well as bio-psycho-social approach to healthcare and the development of *conciencia*, are some of the most important aspects of the domestic medical education program as well as at the *Escuela Latinoamericana de Medicina*/Latina American School of Medicine (*ELAM*) program for foreign medical students. These training programs, based upon Cuba's unique LASM adaptation, are the next important aspect to highlight as it stands in contrast medical services which are directed at vulnerable Global North populations.

The Challenge of Health Services for Rural, Poor and Marginalized Populations

This section will begin by contrasting the motivations of Global North personnel who pursue work in foreign/rural locations alongside Cuban counterparts. Michael Tyrrell et al. note that there is complexity needed in the oversimplified '3 M'—'missionary', 'mercenary' and 'misfit'—categories of rural health and international development workers. The missionary, mercenary and misfit archetypes are often used to describe international development workers who travel at great lengths and effort to work in difficult conditions in foreign countries (Tyrrell et al., 2018; Stirrat, 2008). They suggest that "spiritual beliefs reflected 'missionary'-based motivations to a moderate extent; financial interests reflected 'mercenary'-based motivations to a moderate extent; and avoidance needs and belonging needs provided measures clearly relevant to 'misfit' (i.e., searching for better sense of fit) motivations" in their study of rural Australian medical personnel (Tyrrell et al., 2018, p. 326).

Regarding medical students who would be considered medical missionaries (Furlong, 2004), and who want to make a difference in the rural communities in which they work, they often also come from relationally distant backgrounds (middle- to upper-class families) and graduate from urban medical schools.[163] Noting the example of 'Che' Guevara and medical-anthropologist Paul Farmer, Gary Olson highlights how these missionaries could be known as

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[163] It should be noted that there are current initiatives in Canada to decentralize education and make becoming a doctor more accessible to rural populations. 'Distributive medical education' approaches are evidenced in the Northern Ontario School of Medicine (NOSM) located in Sudbury and Thunder Bay, University of British Columbia's (UBC) rural medical programs located in Kelowna, BC, as well as through the University of Northern British Colombia (UNBC) in Prince George, and in smaller initiatives such as Selkirk College in Castlegar, BC and Aurora College in Yellowknife, NWT. On a conceptual note, this dissertation prefers 'decentralized' over the term 'distributive' healthcare due to the conceptual association of distribution coming from a hierarchical source, which can often be seen as charity/dependence. As such, distribution appears more in line with conventional approaches to healthcare, while decentralization has a bit more conceptual space for capacitation/empowerment as well as counter-hegemonic logics.

'physician outliers' since they often comprehend the larger-scale societal issues of structural violence and have a high level of empathy for the most medically vulnerable (2013, p. 103).[164] However, these physician outliers or missionaries are few and are becoming less common as the "traditional ministry of medicine is shifting to the business of medicine" (2004, p. 46). The missionary to mercenary transition is increasing since "physician dedication and devotion now more than ever seems only to come for a price" (ibid.).

Thus, regarding the missionaries in particular, criticisms of their positionality alone as being inherently problematic is quite controversial (especially given the absence of alternatives for many communities). How healthcare and development workers use their positionality arguably matters more. Additionally, as noted in the Introduction, if healthcare and development workers attempt to surmount their own relational/ideological distance behind their development and healthcare approaches—in efforts to confront/disembed logics of neoliberalism and neocolonialism—they should be recognized and commended for their efforts.

However, with the neoliberal status quo being development and healthcare for the most vulnerable framed largely as charity from those whose positionality is comparatively urban and affluent, what might the solution be? Many journal articles debate policies on how to attract

[164] Olson explains how empathy inspired the contributions of Farmer and Guevara to medical debates as well as to the practice of social medicine. Paul Farmer, who is an international public health activist, infectious-disease specialist, contemporary medical anthropologist, as well as founder of Partners in Health, utilized a different approach than Guevara's even though his understanding of the "pathologies of power" is very similar. Farmer often commends Cuba's health programs in his own publications and draws parallels to their medical internationalism programs with his own extended work in Haiti. Guevara, he notes, turned away from being a doctor because medicine was limited to only treating the symptoms of poverty. For him, revolution became the expression of empathy and the only capable way to address the root cause of people's suffering. This required "melding the cognitive component of empathy with engagement, with resistance against asymmetrical power, always an inherently political act. Otherwise, empathy has no meaning" (Olson, 2013, p. 103). Both Guevara and Farmer were influenced early by the belief that "artificial epidemics have their origin in unjust socioeconomic structures, hence the need for social medicine, a 'politics as medicine on a grand scale'" in order to face the structural violence of the poor and marginalized. They truly represent "exceptional social outliers of engaged empathy and the interplay of affective, cognitive, and moral components" (ibid.).

medical graduates towards practice in health vulnerable communities. Return for service agreements, rural resident rotations (in hopes that they will return to practice in the underserved communities), and rural stipends are all attempts to solve this complex problem. However, for the most part, many have fallen short as few solutions ensure continuity of care, community connection, and an end to Global South brain drain since these doctors are increasingly at the forefront of rural medical practice, particularly in Canada.

In a review of secondary literature, throughout various research trips to Cuba, as well as a tour of Cuba's *ELAM* in 2014, a subaltern alternative became clear that there might be an answer for health vulnerable populations. During this period of research, specifically from 2014-2020, it became clear that rural, poor, and marginalized populations might no longer have to rely on relationally-distant charity of the urban and affluent Other, but instead capacitate their own health-vulnerable populations to become part of the solution—transitioning from healthcare and development as charity, to healthcare and development as dignity.

Latin American School of Medicine/*Escuela Latinoamericana de Medicina* (*ELAM*): From Brain Drain to Brain Gain

> *"Medical education does not exist to provide students with a way of making a living, but to ensure the health of the community."*
> - Rudolf Virchow

Cuba not only managed to produce enough doctors which supported one of the highest physician-to-population ratios in the world (approximately one physician per 122 people in 2017) (Latner, 2020), but also utilized its health education system to supply doctors around the world as a key element in its foreign development assistance program (J. Kirk, 2015; J. Kirk &

Erisman, 2009). While other Global North countries actively recruit and give immigration preferences to individuals from the Global South fortunate enough to obtain high levels of education required (especially medical personnel), depleting important human resources in healthcare and other fields, Cuba attempts to reverse this practice.

As noted previously, this dissertation argues that Cuba's 2014-2020 example should be emulated by Global North countries in order to remedy, not exacerbate, global health challenges and health workforce shortages. As noted previously, the US, UK, Canada and Australia, are countries most complicit in the brain drain from Global South countries (a process which has been exceptionally devastating during the COVID-19 pandemic). Cuba, in contrast, was the main global contributor to brain gain for many Global South countries as its *ELAM* program which, as noted previously, had graduated approximately "30,878 doctors from 122 countries [in addition to] more than 250 young people from the United States" (Cuba's Representative Office Abroad, 2024) (Gorry, 2018, p. 11; Granma, 2018; Reed, 2020).

Thus, no country had trained more medical personnel for the explicit purpose of global health equity, with a duty to serve the indigent, who were also drawn from medically-underserved communities in the Global South (including poor and marginalized neighbourhoods in the US). The students were selected not only for their intelligence and academic standing, but also for their commitment to the social good and overcoming structural violence for the most vulnerable (Huish, 2008; J. Kirk & Erisman, 2009; J. Kirk, 2015, C. Walker, 2015; Gorry, 2018).

ELAM was established amid the economic hardship of the Special Period in 1998 with the purpose of training fellow Latin American doctors from poor backgrounds—who are intelligent but simply unable to afford medical school or struggle to outcompete their urban and

affluent counterparts (who have less structural violence challenges) for finite entrance positions. This six-year training program was provided for free for countries such as Haiti (including food and accommodation), paid for by the Cuban government, to meet the health needs of impoverished, Indigenous, and rural populations (from which most students were drawn from). Students from wealthier countries, such as South Africa, Qatar, and Saudi Arabia paid a nominal fee based upon a sliding scale of tuition. Upon graduation all students were simply expected to work where they are most needed to replace 'brain drain' with 'brain gain' (J. Kirk & Erisman, 2009, p. 54).

The *ELAM* program expanded to include other countries and regions, even to the US (with the help of Pastors for Peace), graduating "30,878 doctors from 122 countries [in addition to] more than 250 young people from the United States" (Cuba's Representative Office Abroad, 2024). Throughout its 25 years, *ELAM* "has also been visited by 60 heads of state, 300 ministers of health, three Nobel Prize winners and more than 80,100 foreigners" (Granma, 2024). Taken from mainly low-income and African American communities, these American students get an additional year of practice in Cuba to help them-prepare for their US medical board exams.[165]

As noted earlier, *conciencia* (a sense of duty, empathy, and compassion) is considered essential to all aspects of medical training. The importance of the *ELAM* "project is the development of an institutional ethic that values success as a graduate's ability to serve the indigent" (Huish, 2008, p. 552-553). This project involves a broader re-focusing of healthcare in

[165] During a 2014 interview with the Director of *ELAM* in Havana, this was highlighted as a recent addition for their US students.

a way that addresses the roots of structural violence by those familiar with the pathologies of poverty due to their relational distance and unique approach to education.

Under this approach to training, the healthcare team's duty is rooted in LASM service towards the communal good. The need for a high physician-to-patient ratio is also linked to the manner in which doctors' responsibilities go beyond regular duties and are utilized in community education about general health issues and environmental health, an aspect which corresponds to the broad range of health indicators utilized by the healthcare team (Spiegel & Yassi, 2004; Feinsilver, 1993; C. Perez, 2008; Huish, 2008).

Rather than compartmentalize each health aspect, as is done in many medical education systems, the entire Cuban medical education system ensures that the diverse aspects of health are conceptualized as interrelated and taught in a participatory manner in much the same way that Vincent Tucker advocated (as referenced in Chapters One and Two).

Brouwer (2011, p. 121) highlights one of the main courses of the Cuban education system, called 'Morphophysiology', which is an "interdisciplinary combination of all basic sciences that are taught separately in the traditional [Global North] Flexnerian medical school." In addition to this comprehensive course, the first-year medical education system also adds a "Community Health and Medicine component (social-medical sciences and social science) that includes introduction to social sciences, introduction to primary healthcare, social communication, and civics" (ibid.).

The second year expands through the study of basic sciences in 'Human Morphophysiopathology', where the Medicine and Community Health aspect covers "public health, history of health, epidemiology and hygiene, medical research, community intervention

and health analysis" (ibid.). This model situates the patient as part of the wider and interlinked bio-psycho-social spheres of health, and away from the narrow view of the patient as having a singular ailment resulting from a singular diagnosis and treatable by a simple prescription (C. Perez, 2008). The sense of empathy and compassion, as well as the revolutionary socialist mentality ingrained in their medical education, lead the Cuban medical teams. Their preventive healthcare work and community-centred approach also helped forge strong community bonds.

Cuba's education system was able to train students from vulnerable populations to develop healthcare strategies and solutions for their own relationally-close and health-vulnerable communities in significant numbers. In contrast, North American healthcare systems continue to struggle in delivering quality preventive primary care. Thus, rural and marginalized populations have continued to struggle with complex issues of structural violence as well as a sense of dignity about their agency to improve their own lives. Robert Huish notes that "*ELAM* is unique in the sense that its students receive an education centred entirely towards an ethical commitment to serve the destitute" (2008, p. 553).

Thus, *ELAM* is an example of how global health equity can be realized. The *ELAM* program is an important example to illustrate the potential afforded by this model as most of the foreign medical students graduate from *ELAM* with the realization that they could never have afforded to go to medical schools in their own countries. As a result, they 'buy in' and are generally prepared to return to their own, or similar, impoverished communities (Huish & Kirk, 2007; C. Perez, 2008). Their students learn to use important lessons drawn from empowerment theory. *ELAM* also develops the ability of its students to make larger organizational adjustments to healthcare in the "locales in which they practice. It is hoped that when the graduates return to

the field, they will be able to practice in clinics and treat preventable health problems through community-orientated primary care" (ibid.).

Therefore, other medical systems may benefit from having a medical education system that recruits potential doctors from impoverished and rural areas if medical accessibility is to be comprehensively addressed—thus going to the root of the structural violence problematic. It is crucial that the medical education system be made available and affordable to the communities that are in greatest need of physician accessibility (that the Cuban model achieved). Distributive medical education programs, already underway in Canada, should also be expanded so that health vulnerable populations remain connected to their communities throughout the process of their medical education/capacitation.

As such, Cuba's 2014-2020 example evidenced five clear challenges to conventional Global North healthcare and development models. Confronting ideological hegemony is crucial. Without doing so amounts to trying to solve global crises in healthcare (including current and future pandemics), inequality, and the environment; with the same methods and ideology that perpetuate, obscure, disavow, and deny them. Cuba is a counter-hegemonic subaltern alternative to conventional neoliberal approaches with clearly demonstrated results in health outcomes.

Inequality needs to be confronted to improve health outcomes, both between populations as well as between countries (WHO, 1978; R. Wilkinson & Pickett, 2010). Equality and social programs/services (such as housing, sanitation, access to healthy food etc.) for the public good are essential to confront structural violence. Relationally closer (albeit potentially impoverished) Global South populations, when capacitated, can make a measurable difference in health outcomes and global equity. And, lastly, a political economy analysis of geopolitical power

matters. Without confronting neoliberal/neocolonial logics, policies, and politics; wealth and power accumulation by the richest will continue to come at the cost of health outcomes and livelihoods—especially for poor and middle-class populations.

In sum, despite the comment often made by the Trump administration that 'Cuban doctors are poorly trained' (echoing that of Brazil's Jair Bolsonaro), and despite the concerted geopolitical project against Cuban medical internationalism, the

> high health indicators that Cuban doctors have produced both abroad and at home, which have been lauded by the World Health Organization and the United Nations as offering a model for global healthcare, show that the credentials and efficacy of Cuban medical professionals are beyond reproach. If Cuba's 'on-island services barely meet the basic needs of Cuban citizens,' as USAID claims, then it is unclear how Cuba has achieved world-class health indicators despite material shortages . . . Many Cuban hospitals suffer under shortages of supplies, due in large part to the US embargo. Yet Cuba's medical wealth lies in what Fidel Castro referred to as its 'human capital,' which 'can achieve far more than financial capital.' By 2017, Cuba had one doctor for every 122 people, according to the WHO—the highest ratio in the world. The [former] Trump administration and other critics of Cuba's health system lose credibility when they ignore indisputable evidence of Cuba's public health successes. (Latner, 2020, p. 335)

Thus, as Rudolf Virchow advocates in his early conceptualization of social medicine, health outcomes can no longer be divorced from power or history. Rare is a Global South country able to completely free itself from neocolonial rule as well as free itself from the dictates of Global North corporate interests while depending on their own limited resources and services.

These broader themes will be explored, contrasted, and critiqued in the following chapters as, possibly the best example of the adoption of the Cuban medical system, is the rapid implementation of Venezuela's Cuban-sponsored *Misión Barrio Adentro* (*MBA*) program alongside Venezuela's conventional healthcare system. Unlike hierarchical top-down Global North approaches to development and aid (often reflecting neocolonial logics), Cuban efforts advance "*social justice-oriented health cooperation based on horizontal power relations* [emphasis added], shared political values, a commitment to social and economic redistribution, bona fide equity, and an understanding of the societal determination of health" (Birn & Muntaner, 2019, p. 817). While the conventional system is highly urban and curative, *MBA* and its associated *Misión Sucre* medical education system focuses on medical access and capacitation of relationally-nearer rural and marginalized populations. The culture of compassion, empathy and *conciencia* among Cuban and Venezuelan medical workers in *MBA* is a result of their unique educational background. This background is one of the key strengths that will be analyzed at length in the following chapter.

Chapter 4: The Explicit Geopolitical Neoliberal Project Against South-South Solidarity in Venezuela

"*The United States appear to be destined by Providence to plague America with misery in the name of liberty*."
(South American Liberator from Spanish colonial rule, Simón Bolívar, 1829 as quoted in Gerassi, 1963, p. 209)

"*It is a policy of the Venezuelan State to enlist public health as a tool for social transformation. From the beginning, Mission Barrio Adentro has captured the interest of public health professionals, social scientists, and journalists around the world. Barrio Adentro was created within the context of social transformation initiated in Venezuela in 1998, the new corporate structure of which is reflected in the Constitution of 1999. It includes a ban on the privatization of natural resources and public services in the areas of health and education, the development of Social Missions, equal access to learning, an endogenous development model, protection of the environment, food security, and agrarian reform*."
(Pan American Health Organization, 2006, p. 142)

Caracas maintains one of the closest relations with Havana despite geopolitical pressure from the United States (US) and allies, socio-political polarization, material shortages, hyperinflation, as well as cyclical and historic oil dependence issues (due to having one of the world's largest oil reserves).[166] While relations between Havana and Washington have fluctuated, relations between Caracas and Washington have been consistently at odds since the first election of Hugo Chávez in 1998, appearing to escalate with each US president: from George W. Bush, to Barack Obama, to Donald Trump, to Joe Biden. Despite this, Havana and Caracas have committed to advancing their 'counter-hegemonic' solidarity, through good times

[166] The majority of this dissertation chapter has been pre-published in various articles (C. Walker & J. Kirk, 2013; C. Walker & E. Kirk, 2017), books (C. Walker, 2015; Bain & C. Walker, 2021), and book chapters such as the latest, published 3 May 2021, titled 'Havana and Caracas: Counter-Hegemonic Cooperation and the Battle for Sovereignty'.

and bad, as well as continue to pursue social-egalitarian policy alternatives to neoliberalism and inequality.

As such, few countries have been as enmeshed politically, economically, and cooperatively as Cuba and Venezuela since 2003. This relationship has benefited both countries, mainly in economic terms for Cuba while Venezuela has benefitted from increasing 'human capital' as well as the expansion of its welfare state services and institutions aimed at addressing structural violence (especially to the benefit of previously poor and marginalized non-insured populations). Venezuela's former leader, Chávez, considered Fidel Castro his mentor and, upon Chávez's death, Fidel Castro lamented that Chávez was the 'best friend' the Cuban people have had in their history (Castro & Prensa Latina, 2013).

This chapter analyzes potential lessons from the collaboration between Cuba and Venezuela during the 2012-2020 period, particularly the application of some key aspects of the Cuban approach to public healthcare to Venezuela. Throughout the research process it became apparent that the lessons and challenges of Venezuela's subaltern example could potentially help Global North countries, such as Canada, as well as remedy health disparities and structural violence for rural and non-insured populations. The core findings are drawn from Venezuela's Cuban-supported Latin American social medicine (LASM) health program, *Misión Barrio Adentro* (*MBA*), the foundation of which was built on Cuba's medical model with additional lessons drawn from Cuba's early medical missions in Nicaragua in the 1980s (C. Anderson, 2020, p. 261). Additional analysis includes *MBA*'s corresponding LASM approach to equity-based post-secondary medical education program, known as *Misión Sucre*, which is focused on

capacitating vulnerable populations to meet their own (relationally near) community's health needs.

Additional political economy analysis will highlight the challenges of establishing these counter-hegemonic alternatives within the global neoliberal hegemony. As such, this chapter seeks to clarify how—while there are many similarities to Venezuela's cyclical oil-dependency crises/'Dutch disease'—the Chávez era (from 1999 to 2013) highlighted a particularly important period when nationalized wealth generated interesting publicly-funded ideas, policies, and outcomes that challenged the geopolitical status quo (including conventional curative-focused healthcare approaches), even if only temporarily.[167] Significantly, the ideas generated from this research have the potential to inform alternatives that may also mitigate the spread of global pandemics, internationally between countries and domestically among populations (as highlighted by the COVID-19 crisis).

Outline

"*In order to know Venezuela, you must know the history and what it means for [those of] us who have never seen ourselves as [having the potential to be] doctors or lawyers. Who have never seen ourselves as having dignity or being worthy of care*."

[167] Dutch disease is a well-documented issue for Venezuela since initial production began in the early 1900s (Nakatani & Herrera, 2008). The paradoxical "disease is caught whenever a commodity brings a sudden increase of income in one sector of the economy, which is not matched by increased income in other sectors of the economy. What happens is that this sudden sectoral increase causes severe problems in the other sectors. The increased sectoral income causes a distorted growth in services and other non-tradables, which cannot be imported, while discouraging the production of tradables, which are imported. The reason for this disparity is that the greater income rapidly raises the demand for imports, since domestic production cannot meet demand quickly enough, and also raises the demand for services, which the domestic market has to supply because services cannot be imported as easily as tradables can. The increased demand for imported goods and domestic services, in turn, causes an increase in prices, which ought to cause domestic production to increase, but doesn't because the flow of foreign exchange into the economy has caused a general inflation of wages and prices" (Wilpert, 2003). By the 1930s, oil dependence quickly became the major economic thrust of Venezuela, constituting approximately 90% of exports and could arguably be diagnosed by an "economic doctor" as having some "Dutch disease" (Schwartz, 2019).

(Chavista supporter in Carora, 2015, as translated by the author)

This chapter will begin by geographically and methodologically situating the research process. Of note will be a discussion of socio-political polarization, a unique experience not faced when researching other countries (Cuba, Timor-Leste, and Canada). The core of this chapter will then detail the political economy conditions in Venezuela which gave rise to Chávez's electoral victory on December 6, 1998 (he would assume office on February 2, 1999), as well as secondary source analysis of healthcare and inequality in the pre-Chávez era.

The Chávez era (from 1999 to 2013), with a focus on Cuban cooperation and implementation of *MBA* (including discussions of similarities and differences between *MBA* and the Cuban health system), is the most important section of this chapter for subaltern knowledge production. It will document the bilateral medical cooperation agreement between Caracas and Havana, the health in all policy approach to Venezuelan social missions aimed at addressing social determinants of health (SDOH), the team-based approach to primary care, viewing the patient as a complete biological, psychological and social (bio-psycho-social) being (beyond the conventional biomedical view of an individual patient in need of medication or treatment for a singular disease or injury), the structure and integration of *MBA*'s vertically-oriented catchment system, as well as the praxis that drives *Misión Sucre's* equity-focused decentralized medical education program.

These aspects constitute the core research foci (albeit influenced by important exogenous and geopolitical factors). After reviewing these key points, this chapter will then highlight the era of Chavista governance under Nicolás Maduro (starting in 2013), including the fall of oil prices, intensified US pressure, re-emergence of the Venezuelan right (especially among youth),

transition from inflation to hyperinflation, as well as increasing material shortages in order to situate its healthcare, cooperation, and medical migration/brain-drain.

This chapter will conclude with some thoughts on lessons learned, the applicability of the model to other contexts and geographies (including Canada), reflections on the successes and challenges of the Cuban-supported *MBA* program, as well as future considerations (given geopolitical uncertainty in the wake of COVID-19 and further US administrative changes). As was the case with the previous political economy analysis of Cuban healthcare and medical internationalism, *MBA's* counter-hegemonic example will also incorporate psychoanalytical and critical sociological considerations to underline the importance of subaltern knowledge production in re-imagining healthcare and development as dignity through the capacitation of the most health vulnerable to meet their own health needs.

The Chavista government's focus on decreasing inequality, addressing structural violence, and improving social services are significant reasons why—despite severe material, resource, and geopolitical challenges—the current Chavista government (led by Nicolás Maduro) still has significant support from various sectors, especially non-insured Venezuelans who had been historically disregarded, ignored, or repressed (C. Walker, 2015; Charles & Castrillo, 2016; Palast, 2019).[168] Additionally, information on Cuba and Venezuela has become compromised by search engines/big tech as well as increasingly less subtle and more overt media control by the US Central Intelligence Agency (CIA) as documented by Glenn Greenwald (2020) and Caitlin Johnstone (2020; 2021). When analyzing the power of tech giants like Twitter (now X) and

[168] Chavista government simply refers to the governmental legacy of Hugo Chávez who united many left-leaning political parties to establish and maintain power in Venezuela. As such, followers of Chávez as well as supporters of United Socialist Party of Venezuela/*Partido Socialista Unido de Venezuela* (PSUV) are often referred to as 'Chavistas'.

Facebook, Branko Marcetic (2018) and Alan MacLeod (2021) evidence how these companies, either voluntarily or under pressure by US agencies, repeatedly blocked subaltern information produced by Cuban and Venezuelan governments/officials (such as Maduro's Twitter account), as well as two of the better sources for Venezuelan information: Venezuelanalysis and TeleSUR.

Thus, attempting to scrutinize health outcomes and detail the *MBA* health system as separate from exogenous factors—geopolitical, economic, media, or otherwise—is problematic. These factors are even more challenging given Venezuela's polarization. Power, elites, political will, health in all policies approaches, globalization, and polarization have all shaped—not just the system, structure, policy, and health outcomes—but analyses, research, news, and discourse about Venezuela and—especially—Venezuela's cooperation with Cuba.

Polarization

"*So you are a communist [researcher] then? You do know that communists in China eat their babies . . . The communists here probably do the same.*" (Affluent opposition supporter in Caracas, 2016, as translated by the author and verified by a Caracas colleague. Of note is that this comment was the most extreme example of a strawman logical fallacy encountered during nearly all opposition interviews)

As highlighted in the Introduction, it must again be clearly outlined that any analysis of Venezuela is incredibly challenging due to the unique degree of socio-political polarization and role of the mainstream media. Two books (C. Walker, 2015; Bain & C. Walker, 2021), a Masters thesis (C. Walker, 2013), a publication (C. Walker & E. Kirk, 2017), as well as research trips to Venezuela in 2013 and 2015/2016, provided opportunities to explore the complex—politicized and polarized—case of Venezuela's *MBA*.

Chavistas have their own academics, media, and leaders while the opposition also have their own academics, media, and leaders. There is little middle ground and limited evidence of an effective centrist or third-party political movement observed during the 2012-2020 period of research.[169] This research found little relational space—socially, politically, as well as, increasingly, geographically. The lack of relational space appears to actively limit critical and dissenting voices of either side an opportunity to discuss challenges or opportunities for collaboration that may help depolarize difficult rifts or provide alternative options of community and political representation as often seen in other multi-party democracies.

Often attempting to investigate Venezuela's complexities, grey areas, and rich context can leave a person ignored or distrusted by both sides of the political spectrum. "Are you Chavista or opposition?" is a question that appears to be a staple of most interactions when conducting research as well as navigating everyday life in Venezuela. Requests for interviews as well as throughout the course of observing the quotidian experiences of Venezuelans, efforts to respond to this polarizing question—framed in any number of direct, creative, or subtle ways—often predetermined the course of the ensuing interaction. Thus, collecting data on Venezuela and its healthcare system, through 64 interviews (primarily conducted via snow-ball sampling), 7 focus

[169] The original election win by Chávez was a disruption to Venezuela's predominantly two-party system. After a brief multi-party period of democracy from 1945-1948, Venezuela entered a period of brutal rule by US-backed military dictator, Marcos Pérez Jiménez, from 1948-1958 (Wilkins, 2019). From 1958 until 1998, Venezuela was mainly governed by the two major parties, *Acción Democrática*/Democratic Action (*AD*) and the Catholic-based *Comite de Organizacion Electoral Independiente* (*COPEI*) (most popularly known as the Social Christian Party) (Karl, 1987). In 2002, many opposition parties joined a short-lived collective called *Coordinadora Democrática*/Democratic Coordinator (*CD*) in an effort to win power from Chávez's *Movimiento Quinta República*/Fifth Republic Movement (*MVR*) and its left-leaning allies. However, by 2004, *CD* fell apart. Chávez unified many left parties under *Partido Socialista Unido de Venezuela*/United Socialist Party of Venezuela (*PSUV*) in 2007, which was promptly followed by an alliance of opposition parties in 2008 to again create a stronger united opposition party, *Mesa de la Unidad Democrática*/Coalition for Democratic Unity (MUD), in another attempt to challenge the Chavista government. This marked a return to the two-party political system that had dominated the 1958-1998 era and continues to reinforce the political polarization found in the country (Janicke & Fuentes, 2008; AFP, 2017).

group discussions, and extended periods of observation of medical facilities (public and private, conventional and Cuban-supported), was challenging.

Research Undertaken for This Chapter

Most primary research took place in the rural Torres health region (located in the western state of Lara, the capital of which is Barquisimeto), as well as urban Caracas (located in *Distrito Capital*/Capital District) during both trips in 2013 and 2015/2016. Carora (little over 100,000 population), is the regional medical hub for the sparsely populated desert region of Torres of Lara State and provided some of the most important primary research findings during both research trips.

Research in the Torres health region included observations and interviews with the goal to assess the vertically integrated healthcare catchment system and complexities of Carora's parallel healthcare system as well as the role of *MBA*. Research in Caracas entailed further interviews and observations of *MBA, Misión Sucre*, and *Escuela Latinoamericana de Medicina* (*ELAM*) Salvador Allende (the Venezuelan sister university to Cuba's *ELAM*) located on the eastern outskirts of Caracas. During shorter trips other urban locations were researched including Barquisimeto (Capital of the Lara State) and Coro (Capital of the Falcón State).

Very rural locations such as Río Tocuyo (Lara State northeast of Carora), Arenales (Lara State east of Carora), Altagracia (Lara State north of Carora), Curimagua (Falcón State south of Coro), Santa Ana (Falcón State north of Coro), Tucacas (Falcón State east of Coro), Choroní (Aragua State west of Caracas), Chuao (Aragua State west of Caracas), and Gran Roque (a Caribbean island 165 km north of Caracas) were included in the research program. These areas

were important in order to assess the range, coordination, challenges, and integration of *MBA*'s vertical catchment system as well as the level of decentralization of *Misión Sucre's* medical education program.

Observations and interviews with *MBA* personnel and patients were often contrasted with observations and interviews of opposition academics, doctors, medical personnel, and patients from conventional and private healthcare systems—many within their clinics and offices. Some key *MBA* personnel were contacted via e-mail or phone to help situate the broader context of *MBA*'s implementation as well as potential future direction of the program. Due to the (often hostile) political climate in Venezuela, anonymity of all respondents has had to be strictly maintained for this research with all respondents having only minimal identifiers to ensure safety.[170]

The success of *MBA* has been noted in various publications including reports by the Pan American Health Organization (PAHO) (2006; 2012), as well as detailed in a 2011 book about *MBA* by Steven Brouwer, *Revolutionary Doctors,* among others (see for example: Trotzky Sirr, 2007; Briggs & Mantini-Briggs, 2009; Docksai, 2012; Robertson, 2013; C. Walker, 2015, 2021; Birn & Muntaner, 2019). The challenges and decline of Venezuela's healthcare system in recent years—especially from 2013 onwards—are also well-documented as rates of various transmissible diseases have been on the rise and some health indicators are on the decline. This decline is noted in the 2017 *Health in the Americas* report by PAHO as well as other reports

[170] However, it should be noted that in certain circumstances there was often an expression of bravado among respondents. An attitude of "let them kill me for what I am about to say" was sometimes emphatically stressed by various respondents. Additionally, due to the fierce socio-political battle of ideas and politics, finding respondents through snow-ball sampling in Venezuela—unlike any other place experienced—was far easier as many people (if not most) wanted to have their "side of the story" heard or to draw attention to "the lies" of the other side in a true 'battle of ideas'.

(PAHO, WHO, UNAIDS & *Gobierno Bolivariano de Venezuela*, 2018; Page et al., 2019; Mesones Rojo & Collins, 2020). Additional sources include neoliberal think tanks such as the Center for Strategic and International Studies (Rendon & Fernandez, 2020) and websites such as the Caracas Chronicles (2021).

Opposing views and relational distance between Chavista and opposition groups often over-simplify important and complex context. Being the target of geopolitical pressure by the US and its allies (in an attempt to wrestle for control of its vast oil reserves as well as stifle a social alternative emerging in the Western hemisphere) has meant that Venezuela's example—while having potentially beneficial subaltern knowledge to learn from—is not without controversy, heated debate, and incredible challenges. This example is perhaps best highlighted by repeated mainstream news cycles of empty store shelves and Venezuelan hardship. These mainstream reports often disavow or intentionally exclude mention of the economic embargo and sanctions (initiated in 2015)—which have been found in violation of international law—against the Chavista government.

These challenges are also extensively detailed in a report by the United Nation's (UN) Special Rapporteur on the Negative Impact of Unilateral Coercive Measures on the Enjoyment of Human Rights:

> In January 2019 . . . the United States imposed further sanctions against [*Petróleos de Venezuela, S.A.*/Petroleum of Venezuela] *PDVSA*, the Venezuelan Central Bank and key government officials, and it imposed a total economic embargo in August 2019. The United States also gave the self-proclaimed interim presidency [Juan Guaidó] the control of the Venezuelan Government's assets and property in US bank accounts, including

> money going to PDVSA from its US unit, Citgo. Other US sanctions in 2018 and 2019 targeted the gold and other mining, food, crypto-currency and banking sectors . . . Since 2020, the United States has tried to block Venezuela from getting fuel from Iran by listing captains of oil tankers, [and] prohibiting the use of Venezuelan air and sea ports . . . US officials are reported to have made unofficial threats to prevent transactions by third-state companies with Venezuela. (OHCHR, 2021)[171]

The diversion of assets of *Petróleos de Venezuela, S.A.*/Petroleum of Venezuela's (*PDVSA*) US subsidiary, Citgo Petroleum Corporation (CITGO), from the Maduro government to Juan Guaidó's US-backed opposition "has prevented transplants of liver and bone marrow to 53 Venezuelan children; such transplants were reportedly done in Italy and Argentina before 2016 at the expense of the state" (ibid.). Additionally, access to water treatment has also become compromised through the trade impediments noted above as "the use of chemical agents to treat and purify the water to make it potable has been reduced by 30%" (ibid.), affecting a significant factor in non-medical determinants of health: drinking water.

Thus, considering the significant geopolitical project against Venezuela's government—contributing to substantial declines in health outcomes—the research environment was rife with loaded and emotive terms (capitalism, communism, democracy, and human rights etc.), as well as deep polarization. As such, the history of Venezuela provides an important contrast between what has changed for rural, poor, and marginalized populations under a social-egalitarian counter-hegemonic approach to governance and healthcare, as well as what represents a continuation of past, seemingly embedded, challenges.

[171] The detailed findings in this report were released in 2021, at a presentation to the UN Human Rights Council.

Before Chávez's 1998 election, Venezuela was in turmoil and facing deep social inequities, further exacerbated by SAPs, which had spread into healthcare (Muntaner et al. 2006, p. 804-806). Prior to the Chavista government, response capacity of the healthcare network had become "critically insufficient" (PAHO, 2006, p. 11). Though all Venezuelans were supposed to be "ensured access to a basic list of drugs through the Venezuelan Social Security Institute," the reality was that availability was very limited due to the "lack of progressive public funding of the Institute itself" (p. 10). Thus, in pre-Chávez times, by 1999 poor Venezuelans comprised almost "three-quarters of the population, with a very limited access to healthcare services through a precarious public system" (Muntaner et al., 2006, p. 806).

As is the case with current material, resource, and healthcare challenges faced in Venezuela today (Page et al., 2019), these difficulties primarily affected only the bottom three-quarters of the population yet were ignored by a relationally-distant elite who pulled the strings of power. When reviewing the history of Venezuela and its struggle with single resource Dutch Disease, outside of a golden period in the 1950s, the rise and fall of government support and economic strength has been strongly associated with oil prices. As noted by Gregroy Wilpert, oil "has shaped practically every aspect of the country, its history, its economy, its politics, and its culture" (2003). Much like healthcare, Venezuelan oil has played a very significant role in its relations with Cuba.

The reduction of healthcare access at that time also exacerbated already high levels of poverty highlighting the health/wealth nexus (C. Walker, 2015, p. 29). Brouwer highlights that even Moses Naim, a strong critic of Chávez as well as Venezuela's Minister of Trade and Industry from 1989-1990, acknowledged the extent of poverty. He noted in 2001, that in the past

20 years, critical poverty had "increased threefold and poverty in general" as well as more than doubled. Even real wages "were 70 percent below what they were in 1980" (Naim as quoted in Brouwer, 2011, p. 76).

This is why, as one wealthy opposition academic noted in an interview: "if we had paid more attention to the poor *before* Chávez came to power, we never would have had to deal with the problem of Chávez *being in power*" (pers. comm, 2013, emphasis added in italics). Yet, as witnessed throughout the research process, the lack of relational proximity to the poor might be an additional consideration of why insured Venezuelan elite paid little 'attention to the [non-insured] poor before Chávez came to power'.[172] As such, Mark Duffield's (2011) biopolitical critique of the 'bunkerization' of development workers (interestingly inspired by gated communities) as well as Global North 'aid archipelagos' of bunkerized and relationally distant spaces was fascinating to reflect upon while conducting research in Venezuela and Timor-Leste.[173]

In Venezuela, much like many countries (especially those with the high rates of inequality) wealthy and powerful populations have similarly constructed bunkerized and

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[172] As noted by Arlene Eisen, racism may have also played a factor as it appeared as one of leading "engines and expressions of the current counter-revolution. In Venezuela, the revolutionary struggle to end white supremacy and for self-determination is slow, and complicated by white elites, backed by US imperialism, and by the denial of many that racism persists" (2014).

[173] Development workers tend to enjoy a securitized life (often living, shopping, and recreating in comparatively secured areas with comparatively better access to food, water, electricity, and other resources) in contrast to host populations. As Duffield explains: "In light of the bunker's military origins, the spatial propagation of the bunker is traced in the growing polarization between public and private urban space. Reflected in the gated communities, green zones, fortified aid compounds, shopping malls, and tourist enclaves of the global city, bunkers offer sites of elite refuge, private consumption, and a secure base from which power, in an uncertain and divided world, can be strategized without negotiation" (2011, p. 2). This arrangement increases relational distance, segregates insured development workers from non-insured host country populations, and reinforces neocolonial hierarchies. While Duffield's critique of the [neo]liberal development/aid industry was less applicable in the Venezuelan case (due to a lack of Global North NGOs etc.) as it is in the Timorese case, geographies/spaces of exclusion—including relationally distant insured archipelagos of affluence among Venezuelan populations—were interesting to witness during the research process.

relationally distant 'archipelagos of affluence and consumption' to traverse: from their mansions and gated communities, to exclusive shopping centres and resorts, to country clubs and golf courses etc. As found in the US, this arrangement ensures Wall Street's relational proximity to those in power in Washington while limiting interactions with 'expendable' sectors of the population. This is reflective of the increasing fragmentation among global cities and "elite regions [which] will continue to forge special arrangements, modes of privileged interconnection and private provision" (Duffield, 2011, p. 24).

While non-insured populations may work at these locations, many of them are designed to implicitly and/or explicitly exclude all but the most powerful and wealthy populations as was similarly witnessed in Venezuela. Importantly—in contrast to development and aid workers who may unconsciously not engage or attempt to surmount their own logics of neocolonialism and neoliberalism—many super wealthy/powerful populations, rather than attempt to surmount logics of neoliberalism and neocolonialism, explicitly defend or actively use their power to advance them.

Much like the US, members of the wealthy Venezuelan elite can traverse affluent, relationally distant, and ideologically insulating archipelagos designed, in part, to limit their contact with poor and marginalized non-insured or 'dangerous' surplus populations. Neighbourhoods such as La Lagunita and Chacao, shopping centres like Centro San Ignacio, as well as country clubs like Carora's Club Torres de Carora and the Caracas Club (where only US dollars were allowed as a form of exchange and, according to Ethan Bronner writing for Bloomberg News in 2019, 'where the 0.01% await socialism's collapse'). As such, the power of Venezuela's wealthy establishment is a factor that neither Cuba (whose wealthy and powerful,

tied to the Batista dictatorship, mainly fled to Miami, Florida) nor Timor-Leste (whose population was decimated by the US-supported Indonesian genocide) had to face to that magnitude.

In the 20 years prior to Chávez's 1998 election, protests occurred with deadly results. As noted by Jason Margolis, in 1989, "Caracas exploded into protests, riots and looting. Somewhere between an estimated few hundred to 3,000 people were killed, mostly at the hands of a brutal crackdown by government security forces" (2019). Additionally, from 1988 to 2002, "Venezuela experienced among the steepest declines in per capita income and largest increases in income inequality in Latin America" (Di John, 2005, p. 107-108). Thus, these issues—material and resource shortages, severe inequality, inflation, unemployment, insecurity, mainstream media, as well as the power and influence of the embedded super wealthy—were some of the most difficult challenges for Chávez when he was first elected through a liberal democratic process yet appear to be absent in the memories of opposition who often glorify pre-Chávez years. It meant that non-insured poor and marginalized populations—constituting a significant majority of the Venezuelan population at the time of his election—were ready for change by the time he took power.[174]

[174] It is particularly important to highlight this era to understand the contestation as well as socio-economic and generational differences between support for Chavistas and opposition. Many of the poorest, rural, and most marginalized, with a memory of pre-Chávez-era structural and political violence, still hold on to their support for the Maduro government despite serious economic, health and security challenges.

The Challenges of Honouring a Constitution for the Non-Insured: From the Vargas Tragedy to the 2002 Coup

> *"This is the story of Venezuela in black and white, the story not told in The New York Times or the rest of our establishment media. This year's so-called popular uprising is, at its heart, a furious backlash of the whiter (and wealthier) Venezuelans against their replacement by the larger Mestizo (mixed-race) poor . . . Four centuries of white supremacy in Venezuela by those who identify their ancestors as European came to an end with the 1998 election of Hugo Chavez, who won with the overwhelming support of the Mestizo majority."*
> (Palast, 2019)

During Chávez's inauguration in February 1999, Venezuela was mired in the "deepest economic crisis in more than a decade" with the poor representing "80 percent of the population" despite being the world's second largest petroleum exporter and the largest source of foreign oil to the US (Kovaleski, 1999). His inauguration ceremony included 16 heads of state and delegations from 45 nations while, significantly, the US sent Energy Secretary, Bill Richardson, as its representative (ibid.). As noted by former-president Donald Trump's previous National Security Advisor, John Bolton, the focus on Venezuelan oil for US interests would not fade in the years to follow (Rowell, 2019; Telesur, 2019; Wilkins, 2019).

When Chávez came to power one of the first—ambitious—changes he made was to the Constitution. This particular change cannot be understated since it outlines the government's commitment to provide healthcare to its population. As Eva Golinger notes, the "1999 Constitution was, in fact drafted—written—by the people of Venezuela in one of the most participatory examples of nation-building, and then was ratified through popular national referendum by 75 percent of Venezuelans" (Golinger as cited in Brouwer, 2011, p. 77).

Throughout Chávez's tenure, Venezuela was one of the most progressive countries in the world regarding human rights, largely because of its constitution. It ensured the rights to Indigenous lands, languages, living wages, workers' rights, women's rights, housing, education, access to food, healthcare, as well as a "whole host of other rights that few other countries recognize on a national level" including the "right to a dignified life" (ibid.). Thus, the LASM view of healthcare as a human right through a health in all policies approach (incorporating SDOH) is embedded in the Venezuelan Constitution.[175]

Articles 83-85 have the most important and direct implications for healthcare reform. As noted in Article 83, health became embedded as a fundamental human right that the state is obligated to guarantee. Article 84 stipulates that the state has the responsibility to develop and maintain a universal, integrated public health system that prioritizes health promotion and disease prevention while at the same time providing free services. And finally, in Article 85, the public healthcare system must also be publicly financed through social security, taxes and oil revenues, "with the state regulating both the public and private elements of the system and developing a human resource policy to train professionals for the new system" (Muntaner et al., 2006, p. 806). However, before Chávez was able to robustly institute important constitutional changes with the help of nationalized wealth as well as confront rampant inequality, tragedy struck in December—nearly an exact calendar year after his 1998 election victory.

[175] It must be noted that though health is identified in Articles 83-85, Articles 80-82 and 86 also contain important distinctions from other constitutions that often omit rights to senior citizens, the disabled, social security, as well as the right to adequate housing.

The 1999 Vargas Landslide and Request for International Help: Cuba Answers the Call

Between December 14th and 16th, 1999, Venezuela suffered one of its worst national disasters when mudslides, debris flows, and flash floods in Vargas State killed up to an estimated 30,000 people (only 1,000 bodies were recovered), displacing approximately 114,000 people and affecting, directly or indirectly, 600,000 people (USAID, 2000). Instead waiting for Global North aid, NGOs, or multinational development institutions for help, Cuban medical personnel were some of the first and most effective responders.

Reflecting on the work of Duffield (2007) and Adam Hanieh (2013), Chávez (like Fidel Castro) was weary of Global North biopolitical extension into their countries and began searching for alternatives to support the non-insured populations in the region.[176] The Vargas Tragedy became the spark where, as Max Azicri observed, "Socialist Cuba and Bolivarian Venezuela" first embarked on a "historic journey of hemispheric dimensions" (2009, p. 99). After the disaster, Cuba sent a team of 454 Cuban healthcare personnel who began providing medical care to many of the marginalized and poor living on the hillside peripheries. These *barrios* (neighbourhood in Spanish but slang for slum specifically in Venezuela) dwellers became the focus of Cuban medical teams as a part of Cuba's international solidarity program which would then become a major part of the development of Venezuela's parallel LASM system, *MBA* (Muntaner et al., 2006, p. 806).

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[176] As noted previously, through crisis, aid, and decimation of public services (largely by SAPs), the Global North development industry has often positioned itself as the arbiters over the expansion and containment of non-insured 'surplus life' in the Global South while simultaneously expanding free-market interests and profits (Duffield, 2007, p. 17-24; Hanieh, 2013, p. 14–73). This life is considered 'non-insured' because of the lack of access to welfare state services and supports (often devastated by SAPs) that many in the Global North take for granted such as public education, social services, worker insurance programs, respect for labor and environmental rights, and—particularly significant to the contexts of Venezuela and Cuba—universal public healthcare.

Many Venezuelan physicians from the conventional health system refused to work in poor areas and help the most-affected populations from the landslide, often citing a lack of infrastructure and security concerns. In contrast, Cuban medical personnel responded to the request for help, assisted these vulnerable populations, and—significantly in terms of critical distance—lived among them while doing so (ibid.). Thus, "under the collaborative and solidarity alliance between Havana and Caracas a complex web of bilateral trade and services . . . developed, including Venezuelan oil and Cuban medical expertise" (Azicri, 2009, p. 99).[177]

Thus, the government's creation of *MBA* following the Vargas tragedy was directed at fulfilling their sovereign constitutional guarantee of health as a "social right through a public healthcare system that spans all levels of care. It is a popular program based on the principles of equity, universality, accessibility, solidarity, multisectoral management, cultural sensitivity, participation, and social justice" (Muntaner et al., 2006, p. 806). Fidel Castro and Chávez's solidarity eventually formed the "bedrock of the alliance" and is based upon the "vision of a united Latin America free of Washington's control, turning Simón Bolívar's legacy into a new reality" (Azicri, 2009, p. 99). As such, Cuba, Venezuela, and their counter-hegemonic Bolivarian Alternative for the Americas/*Alianza Bolivariana para los Pueblos de Nuestra América* (*ALBA*) allies, involving other left-leaning nations in Latin America and the Caribbean, began to operate

[177] Cuba also supplied medical resources and pharmaceuticals where needed and increasingly, Venezuelan physicians have joined the ranks as well, many of whom are graduates of *Misión Sucre*. Importantly, as detailed later in the chapter, *Misión Milagro's* program in Venezuela has transitioned from primarily being run by Cuban personnel to Venezuelan personnel as more and more graduates have filled the ranks (J. Kirk, 2015, p. 112-117; C. Walker, 2015).

in direct "opposition to the Free Trade Area of the Americas, the Washington Consensus, and neoliberalism" (ibid.).[178]

While many Global South countries have lost aspects of their biopolitical sovereignty to the Global North through SAPs and the expanding reach and soft power of international development approaches by the aid industry (Duffield, 2007), Cuba and Venezuela remain counter-hegemonic outliers that attempted to chart a more social egalitarian welfare state approach to governance, policy, healthcare, and geopolitical solidarity. Yet hard power has also become a significant Global North tool. Thus, this section will next outline how the foreign relations between these countries drew the ire of the explicit neoliberal hegemony, as manifest in US and ally foreign policy efforts.

Hegemony Pushes Back: Hard Power, Soft Power, and the War on Ideas

> *"On April 13, [2002] early in the morning, and very spontaneously, Chavismo swept through my barrio. People looked for motorcycles and buses that would take them downtown, to Miraflores and the Fuerte Tiuna (military base). The people were determined to fight this (coup). This is something we felt collectively. Women in particular responded: 'If Chávez fought so much for us, why would we leave him alone now?' This was the first time in my life that I had seen workers, mechanics, caretakers, transgender people, students, lesbians, seamstresses, gays, everyone united without any prejudice, forming a network based in solidarity and support to look for President Chávez wherever he had been kidnapped.'"*
> (Katherine Castrillo, a member of the Sex and Gender Revolutionary Diversity Alliance, as interviewed by Jeanette Charles, 2016)

[178] After the retreat of left-leaning "Pink Tide" governments in Latin America, some by coup and others through electoral losses, Cuba and Venezuela lost significant counter-hegemonic allies. One of the more significant losses was in Ecuador. However, it appears that a left-leaning government is returning to Bolivia (Eulich, 2020).

During Chávez's speech at the 2005 World Social Forum, he stated: "We can't wait for a sustained economic growth of 10 years in order to start reducing poverty through the trickledown effect, as the neoliberal economic theories propose" (Sojo, 2005). Prior to that speech, in order to accelerate the process of reducing poverty, in November 2001 the Chavista government raised the royalty rate for Venezuelan oil "from 16.7 per cent to 30 per cent and decreed that all future foreign investment would have to be made in joint ventures, in which the state company [*Petróleos de Venezuela*, *SA* or *PDVSA*] would have a 51 per cent stake" (Gott, 2008, p. 482). However, almost immediately, his counter-hegemonic efforts elicited responses from the US and allies that might best be understood as a 'war on ideas' (Brouwer, 2011, p. 201-214). This 'war on ideas' involved—and continues to involve—the use of both 'soft power' (culture, media, neoliberal development, and aid) as well as 'hard power' (sanctions, embargos, asset freezes, blockades, coups, and military action) (Nye, 1990; 2012; Dukes, 2002).

This was noted in a 2002 US Central Intelligence Agency (CIA) document which had circulated a week before the Venezuelan coup (subsequently revealed in 2004). In the CIA briefing to various members of George W. Bush's administration the CIA wrote the following: "Conditions are ripening for a coup attempt. Dissident military factions, including some disgruntled senior officers are stepping up efforts to organise a coup against President Chávez, possibly as early as this month" (Hasan, 2015, citing the 2002 CIA document).[179] Blueprinted from other US-backed coups, dissenting military groups took Chávez hostage and instituted a media blackout of non-opposition outlets. Pro-opposition media outlets began their news cycle

[179] Mehdi Hasan read the 2002 CIA document during his 2015 interview with Otto Reich, who "was at the heart of US Latin American policy" at the time of the coup.

by "blaming him for the bloodshed, and claiming that he had resigned. In his place, the coup plotters anointed *Fedecámaras* president Pedro Carmona as the country's new president. Carmona immediately dissolved the National Assembly, the courts, and the new [1999] constitution" (Green Left, 2014).[180] However, the coup attempt was short lived and popular upheaval brough Chávez back to power, partially due to his efforts to advance promises made in the new Constitution, much of which was directed at advancing the well-being of the non-insured majority who had suffered through the era of SAPs prior to his election.

As PAHO documents, the 1999 ratification of the Constitution commenced the "collective construction of a new economic and social model. This model is guided, among other principles, by the affirmation that health is a fundamental social right guaranteed by the Venezuelan State" (PAHO, 2006, p. 21). This fundamental right includes the "co-responsibility on the part of all citizens" to guarantee participation by community organizations (ibid.). This would become the premise from which the *MBA* was constructed (along with its associated missions directed at SDOH). To ensure that healthcare as a human right would be firmly understood as a constitutional obligation, Chávez issued a presidential decree in 1999 "that prohibited the collection of fees in the country's public establishments" (ibid.).

Unfortunately for poor non-insured populations, fee collection by private/conventional healthcare personnel became another point of contestation, when Venezuela's Medical Federation, "supported by the Caracas Metropolitan City Administration (which served five metropolitan *municipios* and a total population of 2,762,759 in 2001), protested the reforms

[180] The Venezuelan Federation of Chambers of Commerce and Production/*Federación de Cámaras y Asociaciones de Comercio y Producción de Venezuela* (*Fedecámaras* or *FEDECÁMARAS*) is Venezuela's main business association whose primary goal is to advance free-market capitalism/'economic liberty' (Fedecámaras, 2021).

outlined in the constitution" (C. Walker, 2015, p. 24). The Venezuelan Medical Federation and its supporters then "called for a national work stoppage of the federation's members in connection with demands for wage-related benefits" (PAHO, 2006, p. 21). The protest halted the "majority of outpatient clinics and public hospitals in Venezuela, seriously affecting access to health care in the country, especially in the metropolitan area of Greater Caracas" (ibid.). Reflecting neoliberal for-profit logic over patient needs, 81 outpatient clinics were shut down by conventional/private medical personnel in the Caracas Metropolitan District, while "those that remained open did so for only a couple of times a week, providing service in return for a 'contribution.'" (ibid.).

This is especially important to note when discussing how Cuba came to be involved in the creation of a parallel public healthcare system. Cuban cooperation, which helped establish Venezuela's health reform "is founded on an international cooperation model that emphasizes 'South to South' solidarity, rather than the more typical channels of 'North to South' aid" and charity (Muntaner et al., 2006, p. 804). The solidarity established between Cuba and Venezuela is directed at fulfilling the obligations outlined in the 1999 Constitution that some conventional medical personnel were unwilling to accept and, at times, protested against.

Insured and Non-Insured Human Rights: Relational Distance and Protest Against Cuban Doctors

As happened in Haiti, Brazil, and Bolivia, when *MBA* began expanding, protests against Cuban doctors also took place throughout Venezuela (C. Walker & E. Kirk, 2017; C. Walker, 2021). The general pattern of protest against Cuban healthcare assistance is two-fold. The first

step is for the local medical federation(s), often including private medical personnel, to petition the government to reject Cuban medical personnel in their country. This step usually occurs when the host country and the Cuban government are in negotiation over the details of the cooperation, including the number of personnel needed, and the results of the negotiations become public.

The second step is for the medical federation(s) to protest through mainstream media outlets in order to spread the idea that Cuban personnel are poorly trained, taking healthcare jobs away from local healthcare personnel (BBC, 2006; Wills, 2013; Fitz, 2016), do not meet local levels of certification to practice domestically (Dominican Today, 2006; C. Walker, 2015; Fitz, 2016), and may even harm patients due to their lack of medical expertise. This often happens close to the arrival of the Cuban personnel and throughout the first years of Cuban personnel working in the most medically underserved areas (interviews in 2015/2016; C. Walker, 2015; C. Walker & E. Kirk, 2017).

Don Fitz (2016) calls this type of behaviour 'neglect projection'. As he explains, "Cuba's most persistent difficulty in developing international medical policy has been the intense hostility it faces from some other countries' medical associations and governments, including those in the United States" (ibid.).[181] In this sense, those Latin American medical associations which have "displayed intense hostility toward Cuban doctors, accusing them of taking jobs from the country's own doctors; coming to another country just to spread propaganda; lacking

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[181] Fitz uses the term 'neglect projection' to explain why some people attack Cuban humanitarianism. From a physiological point of view, the term 'projection' describes those "individuals who attribute their own unacceptable thoughts or impulses to another" (2016). In the case of 'political projection', a country attributes its "own reprehensible action to another government" (ibid.). In the Cuban context, anger against Cuba's medical solidarity programs could be considered "medical neglect projection" and can take a number of forms.

qualifications; and not providing sufficient follow-up care," are enacting their own "medical neglect projection" onto the Cuban personnel (Fitz, 2016).

Once Cuban personnel are established and conducting their work, many of the domestic medical personnel-turned-protesters from the conventional health system and private clinics, then rebrand themselves as human rights advocates *for* Cuban personnel; sometimes stating that the Cubans are "slaves" (as was particularly noted in Brazil, see J. Kirk et al., 2016), and that they work in poor communities under terrible conditions. Robert Huish noted how, in Venezuela, "private sector doctors swarmed the streets in protest against 19,000 Cuban healthcare workers offering free care in parts of the country where no Venezuelan doctor had ever worked before" (2013, p. 19).

Several protesters, "consumed by nationalist pride and free-market passion, went as far as to lob tear gas and concussion grenades at the Cuban embassy in Caracas in protest of the presence of medical workers" (ibid.). In interviews with some officials in charge of implementing *MBA*, open protests and street demonstrations against Cuban medical personnel lasted for about three years—though many opposition voters and doctors from the conventional health system still feel that Cuban doctors, as well as the Venezuelans that they have trained, are at a substandard level.

In this context, doctors from Venezuela's conventional and private healthcare systems, at times, believed their profession (alongside relationally nearer professions such as banking, law, and politics) entitles them to live in certain ideologically-insulating areas of affluence, privilege and consumption as well as traversing similar relationally-exclusive archipelagos of affluence. It becomes a human rights issue for this segment of conventional and/or private healthcare

personnel when doctors—in this case Cuban and *MBA* doctors—live in places that, traditionally, are occupied by non-insured unemployed, service industry personnel, labourers, informal workers, and marginalized people of limited income-generating backgrounds. The culture of neoliberal affluence thus has ideologically constructed geographic allocations for certain socioeconomic classes of people who constitute surplus segments of the population, at times providing clinical services *to* (some for profit), *but not relationally-integrate with* (emphasis added).

This means that, for them, relationally-distant poor and marginalized surplus populations are allowed to live, work, and die—often with significantly shorter life spans—in environments that are more dangerous, more insecure, and more health vulnerable than insured populations employed as doctors, lawyers, and politicians. This stands in stark contrast to the logic of *conciencia*: to treat patients as family. These same conventional doctors have almost never filled the streets to protest against the living conditions of their own poor, rural, and marginalized surplus populations (as is similar to their wealthy counterparts from legal, political, and Global North backgrounds)—for whom the Cubans are there to provide care, and live alongside (C. Walker & E. Kirk, 2017).

During interviews with officials in charge of implementing *MBA* (pers. comm., 2015, 2016), the protests and street demonstrations targeting Cuban healthcare personnel lasted for about three years—though many opposition voters and doctors from the conventional health system still feel that the Cuban doctors, as well as the Venezuelans that they have trained, are at a substandard level. Though these criticisms of the lack of pertinent training and an emphasis on

a curative approach may have had an element of truth during the early stages of the implementation of *MBA*, the same can hardly be said for the years following.

This is highlighted in a survey on patient satisfaction of *MBA*. The 2008 Household Survey was "conducted to determine people's level of satisfaction with the health services" (PAHO, 2013, p. 9). The following results demonstrated that "93.5% of users of the public–sector services provided by *Barrio Adentro* were satisfied with them: 75.4% were satisfied with outpatient services or public dispensaries and 71.2% were satisfied with the services provided in public hospitals" (ibid.). The few reasons "given for dissatisfaction related to a lack of specialized doctors and problems with medicines" (ibid).

During 2013 interviews, some arguments against *MBA* also included its significant focus on preventive medicine and the inability to address widespread trauma cases resulting in the high rate of gun and stab wounds as well as car accidents. Though, at the time, most complex medical emergencies were often not addressed at either of the main *MBA* centres—the local *CPs* and *CDIs*, both of which are mainly concerned with first contact primary care—and go directly to the hospital level. During follow-up research in 2015 it was clear that some *CDIs* were being adapted to help address complex emergencies to aid hospitals. Employing intensive care doctors and nurses at all times was made a priority for many *CDIs*. Thus, since its implementation, it was observed that the program has adjusted in an effort address this criticism in both Torres and Caracas *CDIs*.

There is also a very acute awareness by Cuban medical personnel of the criticisms against them. Because they live within the communities they serve, they are very conscious that segments of the population may dislike them or even feel that they are enemies. In addition to the

previous points of view of the opposition, some critics suggest that the primary healthcare focus on prevention has undermined the curative aspect of the health system by shifting the focus too far toward the preventive side of the medical spectrum.

Regarding criticisms against the Cuban medical mission, one Cuban respondent highlighted (pers. comm., 2013).

> the significance of MBA has been the establishment of an actual primary healthcare system that has an impact on many health indicators as well as its recognition by community members. The criticisms of the political opponents of the Chávez government about Cuban doctors add to the significance of what has been accomplished since Chávez came to power, and what is currently being done. The adversaries to *MBA* cannot understand the concept of free healthcare, because they have the resources to pay extremely high fees of private doctors. One cannot deny the quality of most of the private practitioners, but as a rule they consider patients as clients, and their main purpose is to obtain as much money as possible out of them. The Cuban approach is different and more humane—solidarity is the main motive.

Thus, after significant criticism of Cuban doctors and of their south-south collaboration in general, Chávez decided to confront those who thought Venezuela was being exploited by Cuba.

In 2010, stating that Cuba's contribution 'is priceless,' he hypothetically asked his critics what it would cost if Venezuela instead contracted the "services of 30,000 medics from the United States or Europe to work in the barrios and the poorest towns," live alongside the Indigenous populations, "build the medical facilities, bring the equipment for the medical laboratories and operating theaters, and provide" medicine? He continued: "How much would a

capitalist country charge us to bring that size of an army of doctors and that sea of medicines for our people, and be on call 24 hours a day?" (ABN, 2010).[182]

As such, conventional and private healthcare personnel were also, at times, criticized by the domestic population once Cuban personnel established care in neighbourhoods previously absent or lacking health services and personnel (as was evidenced during interviews with Chavista supporters and conventional healthcare workers during both research trips). Thus, it is very important to again highlight that—outside of Cuba—few health systems actually have sufficient human capital to meet their domestic health needs (while the Global North often take their best and brightest via the medical migration pipeline). Additionally, almost no other country produced a surplus of healthcare workers as Cuba did during the 2012-2020 research period. Furthermore, the lack of ability to train enough medical personnel to meet local demand means that many personnel chose to go into medicine as a calling to fill a need and were left with few domestic options or only private practice in certain cases—especially in examples such as Venezuela, where the public health system was devastated by SAPs.

As such, criticism by a select group of conventional healthcare personnel toward Chávez, Maduro, and other Chavistas (throughout the research process), was seen as overlooking this important aspect. Yet many other conventional healthcare workers never protested, complained, or withheld work and often felt content to receive support for an overburdened healthcare system

[182] However, it is important to again highlight that—outside of Cuba—few health systems actually have sufficient human capital to meet their domestic health needs. Additionally, almost no other country produces a *surplus* of healthcare workers as Cuba does. Furthermore, the lack of ability to train enough healthcare workers to meet local demand means that many personnel chose to go into medicine as a calling to fill a need and were left with few domestic options, or only private practice in certain cases. As such, the criticism faced by conventional healthcare personnel by Chávez, Maduro, and other Chavistas, were seen as overlooking this important aspect. Especially as not all conventional healthcare workers protested, complained, or withheld work, some were content to work alongside *MBA* personnel and *Misión Sucre* graduates.

that had been devastated by SAPs. Significantly, many conventionally-trained medical personnel were content to work alongside *MBA* personnel, Cubans, and *Misión Sucre* graduates—often contributing to the medical missions through teaching and residency programs. In some interviews (2013; 2015), opposition respondents stated that they were not opposed to some of the missions, even *MBA*. They often only highlighted issues that they had with the government and talked at length about inflation and material shortages.

When conducting interviews about geopolitics during both research trips, left-leaning Cubans and Venezuelans in particular noted examples in other countries where national/nationalized industries were decimated due to dumping of Global North aid. Awareness of this is highlighted by Chávez's 2006 speech before the UN General Assembly, where he praised Chomsky's 2003 book, *Hegemony or Survival: America's Quest for Global Dominance*, as well as when he gifted Eduardo Galeano's 1973 book, *Open Veins of Latin America*, to Barack Obama shortly after Obama's electoral victory in 2009. There appeared to be a cannon of counter-hegemonic literature actively circulating among Chavistas and, especially, the *Partido Socialista Unido de Venezuela*/United Socialist Party of Venezuela (*PSUV*) party supporters during both research trips (often followed by requests to bring them various books that were hard to obtain domestically during future research trips).

Thus, alongside a range of counter-hegemonic literature, the 2002 coup remains deeply ingrained in the memories of many Chavista government members and supporters while continued neoliberal hegemonic pressure continues. According to Dr. Francisco Domínguez (Head of the Latin American Studies Centre at Middlesex University) during a 2015 Al Jazeera interview with Mehdi Hasan:

> anybody who believes that US interventions and destabilisation plans in Latin America have come to an end . . . should go and get their brains examined, because it's as heavy as before, but it's different. It doesn't have the same format. The basic idea is to penetrate society from within through monies, NGOs, all of the bodies and so on the National Endowment for Democracy has channeled about $120m to opposition groups in Venezuela.[183] [184]

Venezuela, much like other countries who did not abide by Global North aid, debt, and the biopolitical reach of neoliberal development, often faced 'hard power' of US and ally sanctions, embargos, coups, and interventions. As such, knowledge of the overt and covert US pressures often had the effect of driving some segments of the population away from opposition support, despite the many shortcomings of the Chavista government. Put simply, many Venezuelans mentioned that they did not want to become 'another Afghanistan' or 'another Iraq' or even 'another Colombia' of US interventions and foreign policy endeavours.

Thus, US interventions and interests (in resources, not 'performatively' in people), as well as memories of the 2002 coup, ultimately had the effect of confirming to significant segments of

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[183] The National Endowment for Democracy (NED) is a fairly well-known US foundation with a reputation, especially in international development circles, for supporting right-wing and free-market civil society, NGO, and political groups. They explicitly advance neoliberal logics under the guise of supporting 'democracy'. As their website states: NED "is a private, nonprofit foundation dedicated to the growth and strengthening of democratic institutions around the world. Each year, NED makes more than 2,000 grants to support the projects of non-governmental groups abroad who are working for democratic goals in more than 100 countries" (2021).

[184] Despite the importance of the 2021 UN Report calling for an end to US and ally sanction, it comes to a fairly interesting conclusion: "The Special Rapporteur calls on the Venezuela Government, working with the UN Resident Coordinator and OHCHR in Venezuela, to finish drafting clear and non-discriminatory legislation *enabling and facilitating humanitarian work by international and national NGOs in Venezuela*, and to guarantee security and integrity of their personnel." At the same time, she refers to the obligation of humanitarian NGOs to abide by standards of purely "humanitarian activity" (OHCHR, 2021). As such, following biopolitical logics of the development and aid industry, it appears as though the UN is suggesting that Venezuela choose contingent sovereignty through Global North charity/NGO-ization rather than supporting (through resources and human capital) the foundations of Venezuela's already expansive welfare state/solidarity efforts with Cuba.

the Venezuelan public the lengths that opposition and US foreign policy efforts would take to control and profit from Venezuelan oil and resources. It also had the effect of drawing more of the Venezuelan population towards the Chavista movement and support for Cuban solidarity despite significant hardship.

Hence, the transition to revolutionary medicine, fueled by nationalized wealth, was sparked shortly after the 2002 coup. Richard Gott details how, after gaining control of *PDVSA* and surviving the 2002 coup,

> Chávez now had the income stream necessary to invest in social programs at home and support radical policies abroad. This important Venezuelan lesson was not lost on the Bolivian government of Evo Morales, which realised early after its election victory in December 2005, with the benefit of Venezuelan advice, that foreign companies investing in oil and gas (including Brazil's Petrobras, Spain's Repsol and Britain's BP) had been having an easy ride during the neoliberal era. They could be challenged and obliged to pay larger royalties. An oil law in Ecuador, introduced by Rafael Correa's government in October 2007, followed in the same direction, obliging the foreign companies operating in the country to pass on the profits from the price hike to the government. Venezuela's revitalised state oil industry, overflowing with profits as the international oil price has risen from roughly $10 a barrel at the end of the twentieth century to close to $140 a barrel ten years later, has enabled the Chávez government to spearhead efforts to secure energy integration across the continent, with some solid results. PetroSur, an 'oil alliance' between Venezuela, Brazil and Argentina, was established in May 2005, to be joined later by Uruguay and Bolivia. PetroCaribe, a Caribbean initiative, was launched the

following month, to provide subsidised oil from Venezuela to 17 countries in the Caribbean and Central America. (2008, p. 482-483)

Clearly, Venezuela (in addition to Cuba and allies) was beginning to constitute a very significant manifestation of what Chomsky conceptualized in his 1992 book, *What Uncle Sam Really Wants,* as the 'threat of a good [welfare state] example': a country using its nationalized wealth—not for the profit of the few—but for advancing the human rights of the masses. And it was catching on.

Principal Research Findings from Fieldwork in Venezuela

"MBA relieves the traditional medical network. It reactivates the object of what primary healthcare is because it serves people in the same place where the people reside. People not only go to health centres because they are sick, but [because] some health pathologies [need to be] followed up. [If people are unable to make it to health centres,] Barrio Adentro [not only] visits families at their home, [but] identifies risk factors for disease, attacking [those risks] immediately—with help from other missions if need be—to prevent people from getting sick. The culture of Venezuelans is that they will only go to a doctor when someone feels ill. However, many people do not seek medical help until the illness has gone very far and most do not go for routine check-ups enough to prevent many health issues before they start. But that is what was expected and it is the plan of the Ministry of Health to change the culture so that people go to health centres to keep track of their health . . . The key changes for the health system are going to be because of information gathered from the bottom that moves up to change policy."
(Manager of Dr. Pastor Oropeza Hospital in Carora, interviewed in 2013)

Under his leadership, Chávez significantly expanded relations with Cuba and became one of Fidel Castro's main allies in the counter-hegemonic vacuum left following the 1991 collapse of the Soviet Union (USSR) as noted in Paolo Spadoni's 2021 work (seen in Table 6 below):[185]

[185] Also see Mervyn Bain's 2021 chapter on Moscow-Havana relations for more details.

Table 6: Cuba's Largest Merchandise Trading Partners, 1990-2018 (Percentage of total bilateral trade)

Year	Venezuela	China	Spain	Canada	Mexico	Brazil	Russia
1990	0.5	4,7	2.1	1.3	1.5	1.6	67.9
1995	5.4	8.2	10.2	10.3	9.2	1.4	5.7
2000	14.1	8.1	13.8	9.1	5.2	2.3	6.7
2004	19.0	8.4	10.3	9.5	3.3	2.8	2.5
2008	27.3	12.1	8.0	7.9	2.1	3.6	1.8
2012	44.2	8.7	6.0	4.8	2.6	3.9	1.8
2014	40.6	9.1	6.5	5.2	2.6	3.6	1.1
2016	17.7	20.5	10.4	4.8	3.6	4.0	1.8
2018	22.4	14.4	10.0	6.3	3.9	3.4	3.3

Sources: Spadoni, 2021.

Before 1998, Venezuela was only Cuba's fourth largest trading partner. After Chávez's election, trade increased significantly, and Venezuela leaped past other countries to become Cuba's main economic collaborator by 2000. Under one of the first agreements signed by Chávez, Cuba would import approximately 53,000 barrels of oil a day which amounted to approximately 29% of Cuban needs (Mesa-Lago, 2003, p. 104). Thus, after the collapse of the Soviet Union and Eastern European countries, Cuba was forced to diversify their trading partners with Venezuela taking a significant proportion of the trade, from 8% in 1999 to 13.9% in 2000 (ibid.).

After the ink dried on their bilateral relationship and establishment of the Cuban-supported parallel healthcare system for poor and marginalized populations *MBA* in 2003, cooperation truly took off with the help of a newly nationalized oil industry. Spadoni (2021, p. 226) highlights that, driven by Cuba's special deals with Venezuela in the area of *MBA* medical assistance, "the share of Cuba's total exports of goods and services accounted for by services other than tourism almost tripled between 2004 and 2013 from 21.0% to 57.5% . . . and by 2018, it had reached 63.1%." Their bilateral solidarity involves a range of programs beyond oil for

doctors. While their cooperation has fluctuated significantly (as noted in Tables 6 above and 7 below by Spadoni), it has included "development aid, joint business ventures, large financial transactions, exchange of energy resources and information technology, and cooperation in the fields of intelligence service and military" (Corrales, 2005, p. 2).

Table 7: Cuba's Merchandise Trade with Venezuela, 1998-2018 (USD Million).

Year	Exports	Imports	Bilateral Trade
1998	2	386	388
2000	14	898	912
2002	19	725	744
2004	367	1,143	1,510
2006	409	2,232	2,641
2008	414	4,473	4,887
2010	1,717	4,302	6,019
2012	2,484	6,079	8,563
2014	2,069	5,189	7,258
2016	642	1,583	2,225
2018	462	2,642	3,104

Sources: Spadoni, 2021

One of the defining characteristics of their cooperation is that, instead of dumping leftover/obsolete materials and aid, or issuing loans tied to conditionalities, "both nations are exchanging assets among each other which are inexpensive for the sending country but of high significance for the receiving country" (ibid.).

Significantly, due to returns on high oil prices and Chávez's policies focusing on non-insured populations, Venezuela had become the most egalitarian country in terms of income distribution in the Andean regions by 2009. Though inequality had risen "substantially in the 1990s, with a Gini of 42.5 in 1989 increasing to 47.2 in 1998" by the time of Chávez's election, after a brief fluctuation in 2005, the Gini fell rapidly in 2006 (Gasparini et al., 2009, p. 6). Throughout the research process a clear correlation was beginning to emerge in the distribution of physicians in pre-Chávez Venezuela with per capita income as free-market capitalist

approaches to healthcare tend to allocate human and material resources of health to areas of higher income rather than area of higher medical need.

In 1998, 51 percent of physicians were "concentrated in the five states with the highest per capita income" (PAHO, 2006, p. 83). This is reflective of the work by Helen Hazen and Peter Anthamatten who document that highly-privatized neoliberal health systems "often leaves the poorest in society unable to afford much, if any healthcare" while healthcare resources also tend to concentrate in "urban areas where the largest number of people with the resources to afford healthcare reside" (2012, p. 155).

One rural Torres respondent reflected on similar difficulties of receiving healthcare under the pre-Chávez health system (pers. comm., 2013). The respondent's uncle had a severe stroke late one night and he rushed his uncle to a local private clinic since the hospital was overwhelmed with patients. Initially, at the private clinic, the stroke patient was denied medical care since he was unable to remember the PIN # on his credit card to pay for the care that he needed. The healthcare providers at the clinic refused to provide medical care until a payment was processed. They did not want to take the nephew's word that he would pay them back so the nephew pleaded with the physicians to take his car keys as insurance until he could contact family members to help pay for the fees the following day. Though a number of similar stories were mentioned on both trips, this remains as one of the clearest examples of the gaps in the pre-Chávez care system.

However, since the establishment of *MBA*, many respondents explained that these situations declined sharply between 2003 and 2013 since the healthcare system improved as

MBA's free services had ramped up.[186] As Rick Docksai noted, even as early as 2004-2005, *MBA* was completing comparatively more medical consultations than the conventional system. During this period, more than "150 million consultations—four times as many as did Venezuela's conventional outpatient services" (Docksai, 2012, p. 46). After Cuban medical cooperation was initiated, the Gini coefficient of physicians dropped from 0.23 in 1998 to 0.12 by 2005 with the vertically integrated *MBA* public healthcare network, based upon a population catchment system, managing to "cover 70 percent of the population previously excluded from medical care" (PAHO, 2006, p. 83).

By 2012, nearly 900 clinics were running and *MBA's* continued "expansion of health-care availability [became] nothing less than historic: Nearly 100% of the Venezuelan public now has access to health care" (Docksai, 2012, p. 46). This level of accessibility was truly impressive. For the first time economic, racial, and geographic barriers to healthcare access appeared to be overcome. Significantly, in order to build sustainability into the *MBA* program, Cuba and Venezuela launched their bilateral, equity-based, medical education program within Chávez's broader public education initiative, *Misión Sucre*, to empower and train the most vulnerable populations to become health providers for their relationally proximate underserved populations (Gorry, 2019, p. 91).

This substantial decrease in inequality (both in terms of economic and healthcare access), in addition to the *MBA* agreement and other social missions, contributed to significant increases in health outcomes. The health in all policy Bolivarian missions, which focus on addressing

[186] Since it began, all MBA services have been free of charge. Its services have also expanded beyond primary care to include "ophthalmologic services, high-tech diagnostics and laboratory analyses, comprehensive rehabilitation services, and a hospital staffing and modernization program" (Gorry, 2019, p. 91).

structural violence and inequality, are wide-ranging—with many targeting specific SDOH in a coordinated effort. Thus, the medical system's ability to inform government agencies of structural health inequalities illustrates how, in many cases, the government actually has the political will to make radical changes. In the Torres region and other areas observed, these changes made a significant difference for poor, rural, and marginalized populations—even though these populations are the ones most-often overlooked and under-represented in many developed countries' health systems.

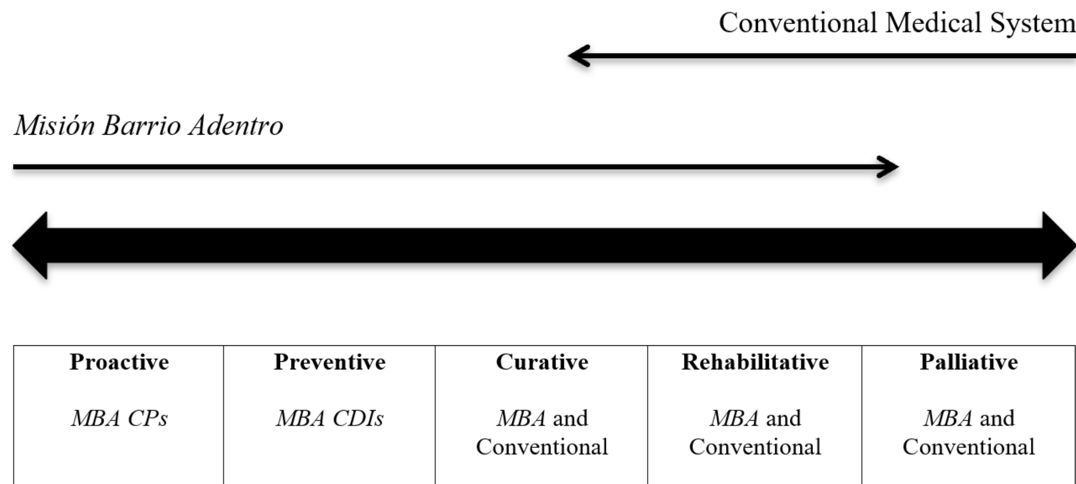
Attempting to Surmount Neoliberal and Neocolonial Logics through Subaltern Knowledge Production: *MBA* and *Misión Sucre's* Golden Era

> *"The most general meaning of justice is parity of participation. According to this radical-democratic interpretation of the principle of equal moral worth, justice requires social arrangements that permit all to participate as peers in social life. Overcoming injustice means dismantling institutionalized obstacles that prevent some people from participating on a par with others, as full partners in social interaction."*
> (Fraser, 2010, p. 16)

Though bilateral cooperation started small during the 1999 Vargas tragedy, with only a few hundred Cubans (as detailed earlier), it rapidly scaled up, reaching its peak in 2014 with approximately 30,000 Cuban medical workers—constituting "a whopping 60% of the Cuban health workers abroad at the time" (Hege, 2020). After Venezuelan graduates began taking over, leaving Cubans to assist other countries, there were "22,793 Cuban health professionals serving in Venezuela—of these, 6154 were physicians", by December 2018 (Gorry, 2019, p. 91). As noted in the 2006 PAHO report, and reflective of the Cuban system (highlighted by Figure 2 in the previous chapter), the goal of *MBA* and *Misión Sucre* was to address shortcomings in the

conventional healthcare system regarding access and approaches—specifically proactive and preventive public care for vulnerable communities as seen in Figure 4 below.

Figure 4: Diagram of Venezuela's Parallel Health System



Source: Author, 2015.

The structure and praxis of Venezuela's Cuban-supported *MBA* parallel public healthcare system during its pre-hyperinflation era (2003-2013), based on a LASM approach, is a particularly important period of analysis and constitutes a significant era of declining poverty and inequality coupled with an improvement of health outcomes as noted in Table 8.

Table 8: Venezuelan Health Statistics from 1980s pre-Chávez Venezuela to Present

Years	Total Population	Life Expectancy at Birth	Maternal mortality ratio (modeled estimate, per 100,000 live births)	Infant Mortality Rate, Infant (per 1,000 live births)	Literacy rate among the population aged 15 years and older
1980	15,182,611	68.542	n/a	35.2	84.732 (1981)
1985	17,319,520	69.715		29.6	n/a
1990	19,632,665	70.658		24.7	89.825
1995	21,931,084	71.321		22.1	n/a
# 2000	24,192,446	72.112	119	18.4	92.98 (2001)
# * 2005	26,432,447	72.852	113	15.8	95.155 (2007)
# * 2010	28,439,940	73.134	117	14.7	95.512 (2009)
^ * 2015	30,081,829	72.584	115	16.4	96.605

^ * **2016-2019**	28,515,829 (2019)	72.064 (2019)	125 (2017)	21 (2019)	97.127 (2016)

* Cuban support for the Venezuelan health and education systems.
\# Venezuela led by Hugo Chávez: 1999-2013.
^ Venezuela led by Nicolás Maduro: 2013-present.
Source: World Bank, 2021.

An analysis of this era has the potential to help inform other countries struggling with hospitalization of primary care, mitigation of hospital-acquired infections, fragmentation of services, limited continuity of patient care, as well as weak proactive and preventive primary care approaches. Carora remained an intriguing location to conduct research since the Torres health region remains one of the more remote areas and health-challenged in Venezuela. The Torres region continues to struggle with some of the highest rates of diabetes, sexually transmitted and blood borne infections (STBBI), traffic accidents, and obesity in Venezuela.

Carora

Carora was the primary research focus in 2013 while 2015/2016 research updated important findings—especially the question of brain drain (from *MBA* to private for-profit care as well as *MBA* to other countries), continuity of care, fragmentation of services, and emerging challenges. In 2015/2016, Caracas was the primary focus of my research, specifically *ELAM* Salvador Allende as well as various policy personnel involved in *MBA* and Bolivarian Missions.

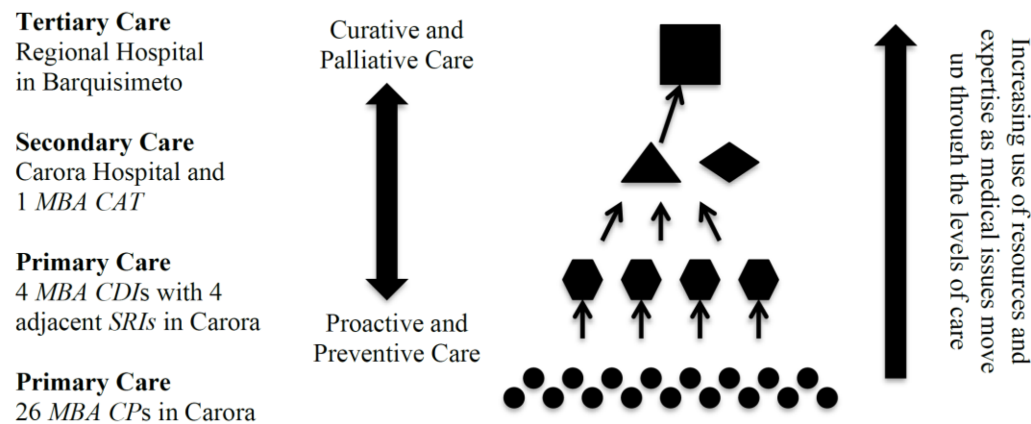
During both trips, research in the Torres health region included observations and interviews of the conventional health system at private/for-profit clinics, two *ambulatorio* clinics (some of which rely on two-year residency agreements of recent medical graduates to staff

locations that struggle to retain continuity of care) and three private pharmacies.[187] *MBA*-specific research took place at six primary care clinics involving a doctor and nurse team called *consultorios médicos populares* (*CPs*), four team-based mini hospitals open 24 hours known as integrated diagnostic centres/*centros de diagnósticos integrales* (*CDIs*) as well as adjacent physiotherapy and rehabilitation centres/*salas de rehabilitación integral* (*SRIs*), the high technology diagnostic centre/*centro médico diagnósticos de alta tecnología* (*CAT*), and the regional hospital Dr. Pastor Oropeza (staffed by a mix of *MBA* and conventional healthcare staff).

Observations of several medical facilities were accompanied by interviews with various patients and healthcare workers (clinic managers, nurses, doctors, accountants, surgeons, physiotherapists, epidemiologists, hospital, and social workers, as well as other medical personnel). The goal of this research was to assess *MBA's* vertically integrated healthcare catchment system (as seen in Figure 5), as well as explore the complexities of Venezuela's unique parallel healthcare systems and the coordination between them.

[187] However, as noted in six separate interviews in the Torres health region—two with conventionally-trained *Misión Sucre* instructors in 2013, six with community members and health workers at Río Tocuyo in 2013, three with elderly patients in Arenales and Altagracia in 2013, as well as eight interviews with various medical personnel (including six conventionally-trained personnel, four of which worked in *MBA,* and two who worked in both the privates system and *MBA*)*,* as well as four *Misión Sucre* graduates in Carora in 2015—many students from the conventional residency program often did not show up for their rural residency requirement at the *ambulatorios* or left early. Thus, not only was continuity of care limited in these situations, but access to important primary care services were also lacking or often absent in many rural regions of Venezuela.

Figure 5: Torres Region Vertically Integrated MBA Health Catchment System as of 2015



Source: Author, 2015, based on interview with the Head of Nursing for the Torres health region.

The vertical integration of Carora's parallel health system is similar to the Cuban model as seen in Figure 2 of the previous chapter. However, instead of a top-down implementation taking ten years per level (as was the case of Cuba), Venezuela integrated *MBA* from the ground up proactive/preventive primary care level (beginning with the *CPs*), taking approximately two years for each ascending level: *MBA* one (primary and preventive care at clinics and *CPs*), *MBA* two (comprehensive health services through *CDI*s, *SRI*s, and *Centros de Alta Tecnología*/High Technology Centres [*CAT*s]), *MBA* three (focused on the care of chronic diseases and surgical interventions), and *MBA* four (specialized care centres such as the Dr. Gilberto Rodríguez Ochoa Latin American Cardiology Children Hospital/*Hospital Cardiológico Infantil Latinoamericano*) (Ortega, 2021). Important to highlight are that the Venezuelan primary care equivalent of Cuban *consultorios*/*minipoliclínicos* and *policlínicos* are known as *consultorios médicos populares* (*CPs*) and *centros de diagnósticos integrales* (*CDIs*) respectively.

Along with the Coordinator of Social Missions, 25 interviews (16 in 2013, 9 in 2015) with conventional, Cuban, and Venezuelan *MBA* medical personnel also discussed the rejection of *Misión Sucre*-trained doctors as well as doctors working in *MBA* by staff and physicians in the

conventional system. At times, medical personnel from the conventional medical system refused to recognize the diagnosis of *MBA* personnel, either demanding or encouraging a second medical opinion form the conventional system (this particular dynamic was highlighted by both sides of the political and medical spectrum yet did not necessarily mean that all diagnoses were dismissed—just that there were select examples where they had been). As such, four conventional and private healthcare respondents still deemed the quality of training at both *Misión Sucre* and *ELAM* inadequate during follow-up interviews in 2015.

Public healthcare supplies and pharmaceuticals, in addition to other government subsidized resources, that were being trafficked to Colombia appeared to increase as most respondents noted during 2015 interviews (some suggest that they were even being exchanged for weapons or as a part of ongoing Colombian drug wars). During 2015 research, the Venezuelan government closed the land border with Colombia in an effort to halt this trend. While originally being condemned by many in both countries, the closure of the border seemed to reduce violence and other challenges for border towns on both sides. Anticipating otherwise, many border communities began to change their opinions about the closure, welcoming the newfound, albeit temporary, peace at that time.

Interestingly, based on conversations in 2016 with two Cuban managers (one from the Torres health region and one who managed the Cuban side of *MBA* in the state of Anzoátegui, Venezuela), the Cuban government was looking at taking lessons learned from their experience of *MBA* and adapting them to their domestic vertical catchment system. Further interviews and

observations were conducted at *Misión Sucre* education facilities where two classes (including teachers) were interviewed in a campus next to the colonial district near Carora's downtown.[188]

Additional observations and interviews noted the focus on accessibility for the elderly to use transit systems for free (or for a reduced price). As highlighted previously, many, if not most, Chavista respondents highlighted *Misión Mercal* and subsidized health food for those in need (although there was a devastating decrease observed from 2013 to 2016 in both the quality and quantity of food in all stores, a trend that continued after primary research was finished). Free housing for people from the *barrios* was noted in 2013, yet Maduro announced that people would begin to pay rent or be encouraged to use the subsidized housing program *Misión Hábitat y Vivienda*. The need to 'change the culture' tended to come up often with medical respondents on both trips, especially regarding diet, proactive sanitation and public health measures (such as removing standing water to limit mosquito-born pathogens), as well as encouraging proactive contact with healthcare personnel.

Due to their proactive and preventive medical training, Cuban and *MBA* healthcare personnel (especially in contrast to private medical personnel) highlighted how dietary habits are one of the main issues (especially in the Torres region where everyday staples: *arepas*, *cachapas*, and *empanadas*—all effectively fried corn with meat and/or cheese). When combined with the region's inclination for beer and high-fructose corn syrup sweetened soda, the correlation between the Torres diet and the region's disproportionately high rate of diabetes became clear. As noted in the 2013 research trip, it was not until *MBA* that Cuban medical personnel became

[188] The 2015 National Assembly election appeared to throw many things into uncertainty. Many respondents were unable to make interviews and shortly after the loss of the election to the opposition, government employees were often restricted from talking to foreign media or academics. As such, research during this period became very difficult.

aware of the issue of widespread diabetes and radically created changes to the public health and education systems to address it proactively.

Prior to *MBA*, patients with swollen legs from type-2 diabetes often traveled to the state capital, Barquisimeto, to get amputations at the suggestions of conventional medical clinics and overburdened public hospital personnel. Dietary advice and appropriate early detection have been advanced since Carora established a centre for diabetes directed at providing regional education measures as well as medical detection and treatment. However, despite increasing knowledge of dietary impacts on health, the beloved 'Torres diet' did not appear to be going away anytime soon even though some, albeit minor, inroads were being made (specifically in areas of reduced beer consumption and increased exercise).

Services were structured in a manner that was very similar to the Cuban medical system with a focus on first contact patient-centred primary care in order to deliver a high degree of proactive and preventive healthcare at the *CP* level. While Cubans were often housed in residences attached to local *CDIs*, many also lived in houses provided by local citizens. Primary contact *CPs* were often in houses of locals who would set aside a room for Cuban doctors to stay, as well as an adjacent room for medical examinations. These were strategically placed in areas accessible to populations that had previously-limited healthcare access prior to *MBA*. Importantly, this arrangement was witnessed in even some of the most remote locations observed such as Río Tocuyo, Arenales, Altagracia, Curimagua, and Santa Ana in 2013/2015, as well as Chuao and Choroní in 2016.

The proactive nature and easy access helped ensure that even the most trivial health questions from locals were treated with great sensitivity from 7 am to 4 pm. The doctors working

in the *CPs* often did house calls as well as rotations in *CDIs* as well. If concerns were raised at any of these drop-in health examinations, the patient would be forwarded to the corresponding location most able to deal with the health needs including the corresponding *CDI*, public hospital, or *centro de alta tecnología*/high-technology centre (*CAT*).

This particular scale of care was key for continuity of patient care as well as for doctors to truly understand the bio-psycho-social environments—due to their relational proximity—that impacted their patients' health. Witnessing interactions between patients and *MBA* personnel was observing *conciencia* in action. The level of familiarity and relational warmth appeared often much like an interaction between family members or close friends. If the *CP* was closed or if medical issue had advanced beyond first contact primary care levels, then the patient would be transferred to more comprehensive 24-hour care at a nearest *CDI*. If more complex care was still needed, then the patient would enter the regional hospital level.

Interestingly, the *Barrio Nuevo CDI* is located in one of Carora's most dangerous and impoverished neighbourhoods. As such, this was in contrast to many private health clinics observed which tended to locate their services near higher-income communities, potentially in order accrue higher profit with less geographically proximate 'risk' by surplus populations who, due to a variety of reasons such as structural violence, could potentially default on payment (as one private care doctor suggested, 2015). This particular *CDI* also had an obstetrician and a gynaecologist (particularly important given the high rate of teen pregnancy in the area).

The regional hospital itself has been expanded since, before *MBA*, the hospital often only had two full-time doctors working there regularly, even when the demand for medical care was overwhelming. All accounts from both the opposition and Chávez supporters mention that in pre-

MBA times the public hospital was regularly well beyond capacity, understaffed, and lacking in essential resources and medications needed to serve the regional population of Torres. With only two full-time doctors to rely on at the hospital, many doctors had either given up, due to the stress of the environment and/or desire to improve their lifestyle and wages via private practice.

As one regional director for the health system highlighted, before *MBA*, medical accessibility had been very limited. In particular, low-income families and those with weak social safety nets disproportionately suffered. Private medical care was predominant, and the government supported public hospitals poorly. Many doctors working at public hospitals were involved in private practice and, unfortunately, tended to spend as little time as possible in the poorly funded and run-down public health system.

Regrettably, the situation in public hospitals on the curative side of the health system, that was still lacking terribly pre-Chávez, was still marginally lacking in 2013, quite lacking in 2015, and according to 2020 correspondence, was again terribly lacking. One reason highlighted was because time dedicated toward public medical care facilities by specialists from the conventional system remained low. It appeared that it also proceeded to get worse each year after 2015 as more emigrated to other countries as sanctions and hardship took over.[189] Thus, it should be

[189] In 2013 the regional hospital was a major source of political division and controversy. The state of Lara was governed by the opposition and at the time was being investigated by the federal government for having withheld supplies to the Carora hospital—located in the pro-Chávez region of Torres. As noted then by one anonymous respondent, the Ministry of Health has its presence and network at all level states. The budget for its operation to pay staff and all employees means that 90% of those funds basically comes from the central government level and is administered in some states by the state government because of the decentralization process. The state of Lara has a partial decentralization and the resources that comes from the central level are administered by the state. For example, if the central hospital is going to make a request for a repair, or to buy some medications or any surgical medical equipment and requests an estimate, the state government provides the freedom to ask the price, but the control and final payment are made by the state government through *Fundasalud*. That is to say, the hospital in Carora does not have direct control of the resources and only has the power to suggest what to buy. Often the hospital receives some medications which it had not requested. Thus, while funds and resources at the central government level have been allocated to develop and

alarming to the Chavista government that "around 50 per cent of medical doctors and 37 per cent of nurses emigrated to other countries of the region, mainly due to their low wages and the lack of conditions to provide adequate health services" (OHCHR, 2018, p. 40).

High rates of teen pregnancy (especially in Carora) and traumatic health cases from gunshots (especially in Caracas), stab wounds, and car accidents were also noted by respondents on both sides of the political spectrum. Cuban healthcare personnel often stated in interviews (including Cuban personnel in Timor-Leste who had previously worked in Venezuela as interviewed in 2016) that these were *the most significant differences* from working in Cuba (considered one of the safest countries in Latin America with some of the lowest rates of gun violence).

In Cuba surgery is not carried out in *polyclinics* but in hospitals "as a rule" (pers. comm. with former Cuban head of Anzoátegui state, 2013). However, in Venezuela some *CDIs* have surgery facilities, instruments and equipment for general surgery and traumatology due to the high demand in Venezuela resulting from frequent injuries including traffic accidents, shootings, and stabbings, etc. Traffic accidents were especially prevalent in the Torres region as it was a hub where two major highways intersected: East to West and North to South. This challenge seemed almost endemic as little difference was noted in interviews during the course of research between the two trips (including efforts to curb drinking and driving).

improve hospital operation, the Carora hospital has remained stagnant. Badly needed repairs, and an increase in human resources to improve their performance, were unmet. Essentially the Carora hospital, which is a type III hospital, only operated as a type II in the classification of the ministry. Often the hospital at Carora had to refer patients to other type III hospitals, such as Antonio Maria Pineda, when the hospital should have been able to meet 90% of Carorans' needs. Additionally, as observed in 2015, shortages and other issues appeared to be returning to pre-Chávez levels. Follow-up correspondence over email confirmed that in the years to follow, this was very much the case (2017-2020).

The high-technology centre houses the most complex diagnostic equipment for difficult medical cases. *MBA's* vertical integration is similar to the Cuban model which helps overcome issues resulting from fragmentation, while at the same time ensuring a high degree of first contact primary care success with the possibility of early detection of a pathology in an effort to reduce the hospitalization of care. If cases become too complex to be treated at lower levels, the vertically integrated health system then moves the patient up the chain of expertise. Major trauma cases like car accidents as well as gun and stab wounds were still being treated at the *CDI* level (specifically at a *CDI* such as Andrés Sierralta de Santiago in Carora) but are more often treated at the central hospital level in Carora.

During interviews, disproportionately highlighted by Chavista supporters, it was noted that public medical supplies were being sold for profit in private medical clinics. This issue appeared to be growing in 2015, especially as increasingly more doctors were working in both *MBA* as well as the conventional system. When asked about what role private healthcare can have in increasing medical accessibility for rural and marginalized non-insured populations, nearly all respondents on both trips stated that it offered very little. Even among private doctors, only one out of eight lauded its ability to do so, stating: "private clinics had done a fine enough job for the poor and rural inhabitants before Chávez" (pers. comm., 2013).

Another private doctor, who split his time between *MBA* and conventional clinics, simply remarked: "private medicine for the poor is a contradiction in terms, private medicine never serves the poor and never will" (pers. comm., 2013). When asked about the role of private medicine in Venezuela, many public doctors also highlighted that in almost all cases, it would

never be able to address issues of structural violence, and at worst, a dependency on only private medicine would make the issue of healthcare accessibility and structural violence dire.

However, it should also be stressed that many doctors did not think private healthcare should be completely removed. Twelve of sixteen respondents highlighted that, in the absence or ineffectiveness of public medicine as well as desire for non-essential and cosmetic/lifestyle medicine, private clinics would still be necessary. Thus, private medical care can inform the shortcomings of the public system regarding medical accessibility as well as highlight possible additions or changes that should be made to improve public access. As one retired conventional doctor from Carora, who is also a staunch opposition member (pers. comm., 2013), stated: "If *Barrio Adentro* worked as well as it should, there would be no one going to private clinics." This might eventually become a reality given the announcement by Maduro that same year outlining that *MBA* would be expanded to include more services.

However, while much had been accomplished in a short time (especially between 2003 and 2013), much clearly remained to be done before achieving that degree of accessibility. Additionally, acceptance of *MBA* from all socio-economic and political sectors might never come given the degree of polarization (as will be explored later in this chapter). Interestingly, six public sector doctors (four in 2013 and two in 2015), who were conventionally trained and working in *MBA*, stated that if the wealthy were willing to pay taxes in support of an efficient and effective public health system, the option of reasonably taxed hotel-style hospitals and exceptional healthcare/cosmetic care centres should still be something made available for those who could afford it.

However, when interviewing fourteen rural, poor and marginalized patients of *MBA* about the level of training and professionalism of the Cuban and Venezuelan *Barrio Adentro* program, the responses were almost unanimously the same on both trips. These patients highlighted that, for many of them, this was the first time they were able to consistently access medical services near them for free. They were not turned away for not having enough funds and challenges of geographic accessibility were far less.

However, unlike interviews in 2013, in interviews held in 2015/2016, especially during follow-up correspondence from 2016 to 2020, some patients were increasingly finding that some services were progressively limited and deteriorating due to medical migration, physician burnout, and especially lack of supplies/medicine (among other reasons). By contrast, 2013 interviews highlighted that most respondents were clearly pleased with the medical services to which they now had access—many for the first time—while ensuing research (both primary and secondary) documented unfortunate declines as reflective of the UN report (OHCHR, 2021).

At the time of 2013 and 2015 interviews, it was outlined that the only doctors to migrate to other countries were from conventional and private medical systems. However, follow-up interviews via email (from 2016 to 2020), as well as publications by the UN Office of the High Commissioner for Human Rights (OHCHR) (2018) and Kathleen Page et al. (2019), highlight how the escalating crisis has increased conventional medical migration, and now also includes *MBA* personnel and *Misión Sucre*-trained doctors.

In 2015 research throughout the Torres health region noted that, in significant contrast to the findings of 2013, more *MBA* medical personnel were taking on additional jobs (including non-medical work) to augment declining income generation relative to inflation. Furthermore, at

the time of research in Carora in the Fall of 2015, many medical teachers and personnel had not received their pay in a month (as was the case in a few sectors due to the rising economic crisis). Though this appeared to be resolved before the end of the research trip, further correspondence over email in following years confirmed findings from the 2021 UN report which noted that this appeared to be a fairly cyclical issue.

Vaccines and the Fight Against Transmissible Diseases

Starting with vaccinations against tuberculosis, poliomyelitis, diphtheria, tetanus, pertussis, measles, rubella, parotitis, yellow fever, and tetanus toxoid, the Chavista government added treatment against hepatitis B, meningitis, and pneumonia due to haemophilus influenzae type B, rotavirus diarrhea, and influenza. Impressively, by 2008, Venezuela would go on to achieve "universal vaccination for the first time, affirmed Mirta Rosas, director of the Pan-American Health Organization (PAHO), during a visit to Caracas" (Docksai, 2012, p. 46).

Not content with that level of success the program continued to expand. At the time of the first research trip in 2013:

> The rotavirus, seasonal influenza, and 23-valent pneumococcal polysaccharide vaccines were introduced into the national system, for a total of 10 vaccines that protect against 14 diseases. Likewise, 1,732 establishments joined the National Vaccination program, bringing to 5,916 the total number of vaccination sites open in 2010. In 2010 transmission of measles and rubella remained interrupted and polio remained eradicated . . . Universal access to antiretroviral therapy for people living with HIV/AIDS continued. In 2010 a total of 35,893 people had undergone treatment . . . The supply of special

> medications made it possible for mortality among patients with cystic fibrosis to drop to 0%. (PAHO, 2013, p. 3)

The program's ability to counter the threat of different pathologies spreading into highly populated areas was one of the key strategies of the vaccination and prevention programs.

During interviews with the head of vaccinations for the Torres health region, it was outlined how the main vectors of dengue, malaria, and yellow fever (among others) reached Venezuela. Knowing where these pathologies started, a mix of proactive health education measures and vaccinations were then integrated into an approach which targeted the main routes that these diseases took before they could reach densely populated centres of Maracaibo, Barquisimeto, Valencia, Caracas, and others. Aided by the Cuban state-led pharmaceutical industry, additional medications were flown into the country to counter the spread of these often-deadly pathologies, as well as other health challenges.

The head of the Torres immunization program also noted in 2013 that communicable diseases are everyone's problem. Although they often disproportionately affect the poor, they still impact the rich. Malaria, yellow fever, dengue, and COVID-19 do not care which socioeconomic level a person belongs to. In contrast, a curative, clinical-based, and highly privatized medical system, which often only adequately cares for rich and urban populations, can inhibit the health of those same populations by ignoring the health of the non-insured. Thus, given the contagious nature of communicable diseases it means that the plight of the non-insured should also in the best interests of the insured rich and powerful who should help contribute to health solutions (even if it means through measures such as progressive taxation for public health

and decreasing inequality). Yet, as noted previously, relational distance and archipelagos of affluence may contribute to this challenge.

Despite being "almost entirely dependent upon medicine imported from abroad" (OHCHR, 2021), Cuban officials documented that:

> between 2003 and 2015 [*MBA*] cared for more than 53 million patients, treating 1.7 million life-threatening emergencies amidst a quadrupling of health care facilities. Since its inception, [*MBA*] has been integrated with other social programs targeting nutrition, medications, poverty reduction, employment, and health education among other areas, enabling referrals and coordination across sectors . . . Together, these efforts contributed to infant mortality declines from 21 deaths/1000 live births to 14; malnutrition reductions from 21% to 14% of the population (and accelerated child growth rates), and an increase in access to clean water from 80% to 94% of the population. (Birn & Muntaner, 2019, p. 826)

Not surprisingly, the most significant increases during the 2003-2013 era were felt among the poor, rural, and marginalized non-insured majority.[190]

While at the time of research there appeared to be sustained success behind the Chavista vaccination program in the Torres region, secondary research highlighted that, since 2016 especially, much of the previous success has been reversed as transmissible and vaccine-preventable diseases were on the rise (Page et al. 2019; OHCHR, 2021):

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[190] Yet, in the current crisis, vaccines have also been affected by geopolitical pressure. Thus, the "majority of public medical services were provided by the state free of charge before 2016. Impediments to healthcare include a lack or severe insufficiency of medicines and . . . [facing] severe shortages of vaccines against measles, yellow fever, and malaria in 2017–2018. The lack of tests and treatment for HIV in 2017–2018 reportedly resulted in the severe rise of the death rate" (OHCHR, 2021).

> Ongoing outbreaks of diphtheria began in 2016 and measles in 2017. Since the beginning of the diphtheria outbreak in July 2016, to January 2019, there were 2,512 suspected cases (1,559 confirmed cases) and 270 deaths; the [case fatality ratio] CFR among confirmed cases was 18% in 2016, 13% in 2017, and 20% in 2018 . . . Malaria rates have been increasing in Venezuela since 2012 and have soared in the past several years. From 2016 to 2017, Venezuela had the largest rate of increase of malaria in the world (69%) with 414,527 cases in 2017 alone . . . The HIV mortality rate was 38% higher in 2015 (8·03 per 100,000) than it was a decade earlier (5·80 per 100,000 in 2006) . . . Between 2014 and 2017, tuberculosis cases increased by almost 68% (6,063 cases vs 10,185) and cases of multidrug resistant (MDR) tuberculosis doubled (39 vs 79 cases). (Page et al. 2019, p. 1256-1257)

Thus, while the comprehensive health in all policy approach and vaccination program, the *MBA* agreement, along with the other social missions, all contributed to the significant increase in health outcomes during the 2003-2013 era (assisted by high oil prices)—geopolitical pressure (both overt and covert), mismanagement, economic decline, and other reductions in SDOH have reversed many of the initially-promising gains.

Caracas

Caracas was the focus of 2015/2016 research in an effort to update interviews from 2013 as well as conduct new interviews with a range of policy personnel.[191] Importantly, this included

[191] A fairly ambitious research plan was revised due to challenges accessing money, insecurity, as well as the logistics and uncertainty of travel and conducting research in unfamiliar/increasingly insecure locations. Despite a fairly simply to

observations and interviews at facilities such as *ELAM* Salvador Allende (discussed in detail later in the chapter). *MBA* research in Caracas entailed further interviews and observations primarily at three *CDI*s (*CDI* Salvador Allende south of downtown, *CDI* Montalban in western Caracas, and *CDI* Amelia Blanco just north of downtown) as well as at two *CP*s.

A significant part of the 2015/2016 research program included a tour of various medical facilities (a *CP* and *CDI*) with the former Minister of Health/Director of the international cardiac care hospital for children. Based upon an agreement between Chávez and Castro in 2006 and instituted as a part of *MBA* IV, the tour by the Director focused on the work being done at the Dr. Gilberto Rodríguez Ochoa Latin American Cardiology Children Hospital/*Hospital Cardiológico Infantil Latinoamericano* where highly specialized care is conducted free of charge for Latin American children up to 15 years in age. This hospital specializes in a range of child cardiac diseases such as atrial septal defect, septal, tetralogy of fallot, patent ductus arteriosus, pulmonary stenosis, and aortic stenosis etc. and almost exclusively had Venezuelan doctors as staff (yet coordinated with Cubans found throughout the rest of the *MBA* system).[192]

Additional research of the parallel health system included the University of Caracas hospital/*Hospital Universitario de Caracas* as well as at another hospital called Dr. Jesús Mata de Gregorio and two pharmacies/clinics in the Sábana Grande area of Caracas. Throughout interviews in Caracas, the transformative nature of *MBA* appeared to be quite impressive. Venezuelans with health insurance, yet who occasionally used *MBA*, were surprised at the

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organize flight into Caracas in the Fall of 2015, flights domestically and internationally quickly became increasingly difficult to find as many airlines pulled out of conducting business in Venezuela, primarily due to inflation.

[192] Unfortunately, this hospital has suffered immensely from geopolitical challenges as the it now faces a "5 times decrease of the number of surgeries (from an average of 1,000 interventions annually in the period 2010–2014 to 162 in 2020)" (OHCHR, 2021).

quality, effectiveness, and efficiency of the program. For some, *MBA* had been a last resort when their comprehensive health insurance plans were unable to provide care in the area they were visiting or had simply run out. As an alternative, at the suggestion of people in their community, they went to seek treatment at the local *CDIs*.

One moderate respondent was surprised at the speed of care for her broken arm. Within 20 minutes she had been x-rayed and attendants were already at work preparing a cast. Her medical treatment was finished within 40 minutes from when she first entered the door of the *CDI* (pers. comm., 2013). Yet, many Venezuelans, especially among the opposition, tended to view *MBA* as a sub-standard system for poor populations and often refused to seek treatment there. As such, they often chose to utilize, at times costly, health insurance plans paid for personally or by their companies.

After interviews with five opposition patients (three in 2013 and two in 2016) who eventually went to *CDI*s for medical care (as they or their families were unable to afford private medical alternatives), it was clear that *MBA* had shaped opinions about Cubans and Cuban cooperation. On two occasions, elderly opposition patients were brought to *CDI* faculties by their moderate or Chavista family members. Both respondents were fiercely against Cuban involvement and opposed to seeking treatment by Cuban doctors at the time.

However, after other options were exhausted, specifically given expenses incurred due to the frequency of their treatment, these respondents reluctantly visited *CDI*s (2013, 2016). In one case the relational experience elicited a 180-degree change of opinion and the elderly respondent stated that, after getting treatment by the Cuban doctors, she realized that many of Venezuelan doctors from the conventional system seemed cold and uncaring. After observing the interactions

of these two respondents with their Cuban healthcare personnel, it became clear how *conciencia* was initiated from the very first interaction.

The Cuban doctors, trained to see their patients as family members and empathize with their bio-psycho-social spheres of health (especially in the *Morphophysiology* and *Morphophysiopathology* courses listed in the following *Misión Sucre* section), greeted both respondents as a member of their family with a warm embrace and '*Hola abuela'* (hello grandmother) for the one respondent (2013) and a '*Hola tío'* (hello uncle) for the other (2013). It was not a relationally distant appointment between doctor and 'client', whereby the doctor stayed on one side of the desk running through the list of symptoms and asking questions to find a quick diagnosis, write a prescription, and then bill for their services. Rather, it was an interaction that began with a hug and the doctor holding the hand of the grandmother, asking her how she and her family have been. The level of empathy and connection in almost all observations at *MBA* facilities (from Venezuela to Timor-Leste), including these examples, were fairly consistent.

As seven Cuban doctors have noted (four in 2013, three in 2015), though a patient might show up for treatment of a biological illness, mind-body health connections must always be considered and explored. These physicians regularly noted that patients heal better in an environment of friends and family. If that environment can be recreated at *MBA* health centres, then the challenge of healing is often off to a far better start. As one Cuban doctor in Carora noted:

> we receive patients as a family and not as a source of income. In this way we have sometimes found that the greatest need for a patient's well-being is social and emotional. Some patients just need someone to talk to. As a doctor we should never push the patient

> away and say 'that it is not our job'. Building a relationship is building a community, and often the mental health of a patient is more important than simply medicating a patient. (pers. comm., 2013)

This may be one of the most important points witnessed during these interactions between *MBA* personnel at *CDI*s and *CP*s. When profit is taken out of medical appointments and services (as found in systems where the approach seems to be 'time is money'), then medical personnel can truly get to the root of the health challenge, instead of merely medicating the issue and moving on to the next client. This particular element is arguably what makes the LASM approach to *Misión Sucre's* healthcare education so significant and successful.

As such, the parallel *MBA* health system has made significant improvements in the lives of many, even despite significant challenges. As of April 10, 2021, *MBA* had completed the following since it started in 2003:

- 1,468,553,750 medical consultations (including dental surgery) had been carried out.
- More than 168,000,000 physiotherapy and rehabilitation treatments had taken place in *SRIs* (168,318,257 and applied treatments 1,491,157,025).
- More than 761,000,000 diagnostic examinations (706,156,979 had taken place in *CDI*s, 54,661,342 in *CAT*s, and 478,623 in cardiology centres).
- 66,626,688 eye consultations and 73,252,089 dental consultations had been conducted.
- More than 3,700,000 surgeries had taken place of which 2,553,328 were performed in *CDI*s, 47,347 were performed in Venezuelan institutions/hospitals, and approximately 1,101,387 eye surgeries (many for cataracts) took place as a part of *Misión Milagro*.

- More than 158,000 deliveries were carried out (1,369 in clinics, 24,163 in *CDI*s, and 132,822 in Venezuelan institutions/hospitals).
- Saved more than 1,700,000 lives (305,078 in *CP*s and 1,484,472 in *CDI*s) (Ortega, 2021 as translated by the author).

Additional lessons from this research program focus on *Misión Sucre's Plan Cada Hogar Una Escuela*/'Every Home A School Plan' approach to equity-based education as well as Caracas' *ELAM* Salvador Allende's efforts to reverse the brain drain, or exodus of trained doctors for better paying positions abroad. This decentralized education system (throughout 21 different national programs) helps capacitate rural, poor, and marginalized populations in a range of disciplines, graduating 600,000 post-secondary students by 2021 (Gobierno Bolivariano de Venezuela, 2021). Using Cuban curriculum primarily taught by Cuban and—increasingly—local medical professors, its decentralized healthcare-specific program (known as distributive medicine in Canada) capacitates non-insured populations to become healthcare providers in their previously under-served communities (Gorry, 2019, p. 91).

In 2019, Maduro made a bold announcement about increasing the original goal of the *Misión Sucre's* medical education program from 60,000 doctors to over 100,000 by the end of his 2023 presidential term, including 50,000 who would become medical specialists (Cubadebate, 2019). To put this in context, Canada, with approximately 10 million more than Venezuela's 29 million population, had approximately 91,375 physicians in 2019 (CIHI, 2021). Unfortunately, there is little evidence of Canada or the US employing a rapid scale-up of medical personnel, or that it had any inclination to reverse its current approach to Global South brain drain of healthcare human capital, limiting Global South ability to mitigate the impacts of COVID-19 and

future pandemics. As such, one of the most important considerations would be the opportunity to reform medical education similar to *Misión Sucre's* approach.

The Curricular Justice of Misión Sucre's *Medical Education*

> "*Educational encounter is always multiple, in terms of the numbers and diversity of people involved and the number of structures shaping educational relationships: not only class structures, but also gender structures, ethnic and race relations, connections with region and land, generational relations and more. Trust and citizenship cannot be limited, cannot be made a privilege of specific groups. Education is inherently socially inclusive; any failure of inclusion signals the presence of power. An exclusive education is a corrupted education.*"
> (Connell, 2013, p. 105)

Raewyn Connell's 'curricular justice' is especially significant in terms of this dissertation. Connell emphasizes that curricular justice is not about creating isolated curriculum 'ghettoes', but rather about reconstructing education to prioritize the interests of equity-deserving populations. In healthcare curricula, this means designing education to address the specific needs of underserved communities as well as to ensure that medical professionals are well-prepared to serve diverse populations without stigma or structural violence. Thus, *Misión Sucre*'s LASM equity-based training process, which empowers non-insured populations to help their own community's medical services, challenges Global North hegemonic medical curricula by incorporating subaltern knowledges as well as by promote equitable access to quality healthcare and education.

As noted in a PAHO article analyzing the medical education program and role of *CDI*s, the "network of services in comprehensive community health areas also uses a comprehensive and intersectoral model of a continuum of free, universal health care for families and communities" (PAHO, 2013, p. 11). *MBA* has also established an "innovative human resource

health education strategy into the comprehensive community health areas" where the "academic standards are high and participants are socially committed" (ibid.).

The first *Misión Sucre* medical class graduated in February 2012 when over 8,000 doctors completed the 6-year Cuban-led curriculum (AVN, 2011; pers. comm. with Head of Nursing in Torres, 2013). The significant increase in the physician-to-patient ratio—from 18 doctors per 10,000 inhabitants in 1998 to 58 doctors per 10,000 inhabitants by 2012 (Robertson, 2013)—was a very strong signal of the Chávez government's commitment to the 1999 constitution and healthcare as a human right.

Since then, it has continued to graduate medical students in impressive numbers, with "2130 new physicians and 4251 family medicine specialists in 2018" alone as well as an additional 38,045 Venezuelan students throughout various stages of the program (Gorry, 2019, p. 91). In contrast to highly centralized and urban university medical programs in the Global North, which have consistently been unable to meet domestic healthcare needs (as a process of Global South brain drain instead of the capacitation of non-insured populations appears to continue to be the dominant policy tool), *Misión Sucre* trains community physicians at the municipal level who, in turn, are more likely to go on to be the future doctors at "their place of origin, in an exercise based on solidarity and humanism" (PAHO, 2013, p. 11).

This high level of local training is undertaken in primary healthcare centres (*MBA* I and II) through the "guidance of professionals from the Cuban Medical Mission in Venezuela, and in hospitals through clinical internships in various specialties (medicine, surgery, pediatrics, gynecology, and obstetrics, etc.) under the supervision of Venezuelan physicians" (ibid.). Very significantly, during interviews with 17 students, it was made clear that for the first time in

Venezuela's history, people from non-insured backgrounds, including mothers, family caretakers, and part-time workers, were able to obtain medical degrees because of flexible hours available in the medical education program, as well as increasing geographic proximity of educational centres.

Thus, the *Misión Sucre* program was specifically structured in such a way as to advance curricular justice by ensuring that part-time education was possible for the most vulnerable and financially disadvantaged sectors of the population as well as for those who were incapable of making full-time commitments to a medical degree (such as having other work commitments or being a caretaker). As noted by one teacher at *Misión Sucre*, there was a gap in medical training provided by traditional universities prior to Chávez. Before 1998, the government reduced the number of doctors by limiting the enrolment for people who needed it most by demanding higher grades and tuition fees (pers. comm., 2013).

This system overlooked challenges faced by non-insured populations as many did not have enough money to move to expensive urban centres or sufficiently high grades to out-compete wealthier counterparts for finite spaces in medical programs (often because they came from under-resourced schools, had less supports, or faced other difficulties and time constraints resulting from structural violence). As such, medical education prior to Chávez's *Misión Sucre* was quite exclusive and thus, as noted previously by Connell, the failure of inclusion—similarly found throughout Global North universities—not only 'signaled the presence of power', but also a 'corrupted education'.

One innovative feature (and with particular relevance for Canada) is that Venezuela's Ministry for Indigenous Affairs, established in 2007 by Chávez's Presidential Decree No. 5103, helped launch two projects:

> the first aims to provide prompt medical care and a continuum of care for the most vulnerable indigenous populations and the second strengthens social participation and empowers indigenous communities. In 2008 the Comprehensive Plan for the Defense, Development, and Strengthening of Border Municipalities in the State of Zulia was approved and the Caura Plan was created to serve the indigenous communities affected by mining in the State of Bolívar. By 2010, a total of 2,886 indigenous communities were registered and 1,186 indigenous leaders were enrolled in the Comprehensive Community Medicine degree program. (PAHO, 2013, p. 6)

These students would go on to complete their studies in 2012 and "become community physicians in health facilities in indigenous communities" (ibid.). Significantly, capacity was expanded in 2010 through the construction of 28 facilities which were specifically directed at delivering healthcare and mental health services for Indigenous populations in the following regions: "Amazonas (1 facility), Anzoátegui (4), Apure (2), Aragua (1), Barinas (2), Bolívar (6), Capital District (2), Delta Amacuro (1), Monagas (2), Sucre (2), and Zulia (5)" (ibid.).

Though the use of resources and human capital have been outlined, the shift in ideology incorporated into the free medical education program in *Misión Sucre* must also be noted due to its impact in changing the culture, values, and norms of the healthcare providers as well as patient-physician interactions. The unconventional non-insured backgrounds of students in *Misión Sucre's* decentralized program helps ensure that medical professionals from *MBA* see

their positionality—not as a source of entitlement or incredible wealth—but rather, as a profession grounded in compassion and empathy with community health at its heart. This is an important distinction from other developing countries that often suffer from low patient accessibility for non-insured populations, and where this sense of community and continuity of care are often limited.

As such, this sense of community helps to establish *conciencia*—a sense of commitment, compassion and empathy to treat patients as family—as well as situating their patients in their entire bio-psycho-social spheres of health (not simply as individuals to be treated as a result of a singular biological issue). These spheres of health are the bedrock of the human medical system since, as detailed in the previous chapter by Christina Perez (2008), the bio-psycho-social role of the doctor allows for a much broader focus on many aspects of human life. *Conciencia* is integrated into the medical education program through courses including Citizen's Conscience, Latin American History, Community and Family Health, as well as others. The bio-psycho-social spheres of health are directly taught in *Morphophysiology* as well as *Morphophysiopathology*. The list of *Misión Sucre* courses in Venezuela is noted in Figure 6 below:

Figure 6: Comprehensive Community Medicine Courses in Misión Sucre

First Year:	**Fourth Year:**
- Morphophysiology I, II and III - Citizen's Conscience - Introduction to Primary Healthcare - Basic Procedures - Primary Health	- Paediatrics I and II (Comprehensive Care) - Gynaecology and Obstetrics I (Comprehensive Care) - Health Situation Analysis - Comprehensive Healthcare - Comprehensive Healthcare in specific environments (Including: School, Labour, Recreational, and Health Institution Environments) - Elective Courses

Second Year: - Morphophysiology IV - Human Morphophysiopathology I and II - The Psyche in the Health-Disease Process - Community and Family Health I and II - Medical Informatics I and II - Latin American and Caribbean Thought (The Health Situation in Latin America and the Caribbean) - Elective Courses	**Fifth Year:** - Clinical Surgery - General Surgery - Dermatology - Gynaecology and Obstetrics I (Hospital Care) - Paediatrics III (Hospital Care) - Physical and Rehabilitative Medicine - Natural and Traditional Medicine - Tropical Medicine - Legal and Toxicology Medicine - Health Intervention - Elective Courses
Third Year: - Clinical Medicine I and II (Semiology y Propaedeutics) - Clinical Medicine III and IV (Internal Medicine I and II) - Pharmacology I (General Pharmacology) - Pharmacology II (Clinical Pharmacology) - Psychology of Health - Community and Family Health III and IV - Elective Courses	**Sixth Year:** - Comprehensive Adult Care - Comprehensive Child and Adolescent Care - Comprehensive Care for Women and Pregnancy - Comprehensive Family and Community Care - Thesis - Final Accrediting Evaluation

Source: Slides provided by medical professors of *Misión Sucre* translated by the author, 2013.

In Paul Farmer's 2005 book, *Pathologies of Power,* he advocated for doctors to go beyond their basic duties (of simply curing or palliating the symptoms of poverty/various ailments with prescription drugs), and instead becoming politically motivated activists healing the sources of structural violence—a basic concept which is very similar to the development of *conciencia* in *MBA* and *Misión Sucre*. In his book, he believes that doctors should make this a conscious part of their practice when they undertake the decision to become a physician.

Thus, it is worth noting that in courses taught at *Misión Sucre* (noted above) activism in social and community affairs is institutionalized in their medical education process in an effort to end structural violence and advance curricular justice. Thus, it is not implied but is instead made explicit in the development of *conciencia*. This highlights how the medical education program also creates healthcare advocates who proactively help challenge the roots of inequality and

injustice, instead of merely being members of a profession that reactively provides prescriptions (for profit, in much the same way Vincent Tucker criticized).

This is not only institutionalized in the education program but is also structurally integrated into the medical system. Comprehensive community health areas allow for interaction between the health services system that consist of *MBA* I and II as well as "social networks and other services . . . [which serve] as the base from which the primary health care services network links with social networks in the community and other social initiatives" (PAHO, 2013, p. 11). This was very much the case for the community health region of Torres.

Additionally, Cuban teachers along with their Venezuelan colleagues at *Misión Sucre* also analyze and make an effort to reinforce human and professional values while working with the next generation of Venezuelan medical professionals at the clinical level. Besides the two courses directly related to the bio-psycho-social spheres of health spheres of health—*Morphophysiology* and *Morphophysiopathology*—a Cuban medical manager highlighted there are several courses directly related to the bio-psycho-social spheres of health (Psychology and Health Psychology) as well as all courses associated with comprehensive community medicine (Community and Family Health, Community Health Diagnosis, Health Education and Promotion, Community Intervention Research etc.).

In the final year, students in small groups write a community intervention health research plan, in which they work together with formal and non-formal community leaders to address structural violence and improve SDOH. Most of the health research plans include an educational intervention to enhance the knowledge of community members of a disease or a group of diseases that have a high prevalence in the neighbourhood and try to modify non-healthy habits.

Without the bio-psycho-social approach to health "a person cannot successfully develop that kind of research" (pers. comm. with the Cuban manager, 2013).

Though often lacking in many traditional biomedical and curative-focused models, many people interviewed highlighted that the focus on proactive and preventive health was almost absent in Venezuela prior to *MBA*. However, things changed drastically. One Cuban respondent who helped implement *MBA* noted that from the very beginning during the *premédico* (a course before being fully admitted into the program), students spend most of the time in first-contact primary care facilities. Each student belongs to a local medical office and becomes part of the health schedule under the supervision of the family doctor. The main work of those doctors is prevention of diseases, and the promotion of health, mainly through health education. Students learn very early how to perform health situation analysis (or diagnosis) and to develop an action plan in order to *modify the health status of the community* (not simply the individual) (pers. comm. with Cuban health manager, 2013).

Cuban medical professors all seemed to generally agree that *Misión Sucre's* medical education is at a comparable level to Cuba's, but that it contains several adjustments needed to tackle the unique pathologies and health issues in Venezuela. This is perhaps one of the more interesting aspects of the implementation of *MBA*. This approach is in a constant state of evaluation, adaptation, and evolution. In many cases it can recognize shortcomings, unique regional pathologies (such as STBBI and diabetes in Torres), as well as other challenges, then adjust to those contexts as well as make additions to the program on short notice. This is a unique example of how the entire medical agreement between Cuba and Venezuela appears to recognize that the health of the body politic (the analogy that situates the health of the human

body as the social collective) is linked to the outcomes of effective policies that address structural violence.

However, few responses were more clearly and deeply polarized than the role and contribution of Cuban medical personnel. Most criticisms against Cuban involvement appeared to be remarkably uninformed regarding the specific details of *MBA* as well as the training by Cuban doctors. An overwhelming percentage of opposition respondents' fear was directed at the idea that the Chávez government would head towards 'communism.' Complaints range from Cuban doctors infiltrating Venezuela as 'soldiers in white coats,' to being grossly under-qualified for the job. A common criticism was raised about Cuban medical personnel not understanding the unique health issues of Venezuelans (including the high incidence of trauma cases from car accidents, as well as gun and stab wounds from increased violence).

The critiques and accusations against Cuban involvement are also well known to the Cuban personnel serving the Venezuelan populations. As one of the Cuban state-level managers of *MBA* highlighted in interviews in 2013, many opponents to Cuban involvement continue to offer similar arguments:

> Cubans are not really professionals, that in the medical faculties many students are admitted without a high enough level of education for a university program, that many of them have attitude problems, that the students graduate from *Misión Sucre* with a poor level of knowledge and skills, and that they are promoted because of political criteria instead of educational excellence. They often hate the Cuban government due to many years of propaganda against Cuba, and the fear to change may explain their view of Cubans. Of course, whatever mistakes are committed by a Cuban professional, or a

> medical student of the community medicine program, they are used to denigrate the obvious achievements. There are things that should be emphasized . . . errors and mistakes are the exception and not the rule.

Though the involvement of the Cuban doctors appeared controversial, the fact that Cuban medical schools, including Cuba's *ELAM*, are recognized in the US seemed baffling to members of the opposition and often caused a pause for reflection during discussions.

In fact, *ELAM* is "officially recognized by the Educational Commission for Foreign Medical Graduates and the World Health Organization. It is fully accredited by the Medical Board of California, which has the strictest standards in the United States" (Hege, 2020). Essentially, the medical education program in Venezuela appears to be at the same level as other Cuban medical schools as well as Cuba's *ELAM*. Additionally, as evidenced in the previous chapter, 172 students from the US have already graduated from *ELAM* and returned home to practice medicine (Gorry, 2018, p. 11).

This is significant since the medical education component of *Misión Sucre* is, in many cases, intended to ensure that Cuban-trained medical personnel, utilizing bio-psycho-social approaches (aligned with SDOH and in contestation with neoliberalism), are very knowledgeable about the living conditions of the populations they work with (especially the non-insured sector) through relationally-proximate contact. To ensure *MBA* sustainability, Cuban doctors have been training successive generations of Venezuelan medical personnel under a Cuban conception of LASM which directly re-visits most primary healthcare principles found in the Alma-Ata philosophy. Carles Muntaner et al. highlight how early on, given the "continued (though decreasing) reluctance of Venezuela's medical establishment to participate in the program, the

government launched a massive training effort to replace, over time, the thousands of Cuban health workers with Venezuelans" (2006, p. 807).

It also became clear through a series of interviews and observations that the education program was not training less qualified doctors and medical personnel, but rather that the medical education program is now more widely available to a greater range of social sectors who were traditionally excluded from pursuing a medical degree due to cost, status, distance to school, time, or structural violence. This is significant. To solve structural violence in terms of a lack of accessibility to public health for non-insured populations, a country must have the political will to make available all the services and train representatives from those very sectors of the population who were traditionally excluded from healthcare in a true reflection of curricular justice.

If the plight of the (relationally-distant) poor rarely enters the consciousness of the affluent as Farmer posits (2005, p. 31), then a concerted effort must be made to empower those who do comprehensively understand—through their relational proximity—the plight of the poor. Hence the need to educate the poor to become doctors and medical personnel, since they already have relationally-closer knowledge of the pathologies of poverty and structural violence. This may seem revolutionary to some, but in Cuba and Venezuela it appears to be common sense.

In addition to the increased staffing of intensive and emergency personnel, a government announcement was made in 2013—that specialized medicine would now be included free of cost in the *Misión Sucre* medical education program. As a regional Cuban medical manager noted, in January 2014 *Misión Sucre* took a new step toward building on the foundations of *MBA's* primary care system in Venezuela. The postgraduate program will train more than 6,000

specialists in General Comprehensive Medicine (*Medicina General Integral—MGI*). Residents of this program were mainly drawn from graduates of the first cohort of *médicos integrales comunitarios*.

One Chavista respondent, a doctor who graduated from the traditional system prior to Chávez (and has helped in the regional implementation of *MBA* as well as teaching at *Misión Sucre*), highlighted some of the issues that led to this decision. He explained the there was a problem with previous graduates from the conventional system who had taken advantage of the public health system to develop their private medical practices. These doctors emphasized private healthcare and profit to such an extent that when the *MBA* community doctor program arrived, instead of helping them consciously and voluntarily in their preparation to serve the community, they instead rejected them (pers. comm. in Carora, 2013, 2015).

He further explained that doctors from the conventional system who graduate from what are generally seen as 'distinguished universities,' have a sense of professional zeal, and they say that doctors graduating from *Misión Sucre* are ill-prepared. These doctors often criticize without knowing much about the education of the community doctors at all. So instead of helping integrate those doctors from the community medical program in a way that links with conventional medical specialists, many decided instead to dismiss them as being sub-standard and choose to work only with their peers in conventional and/or private systems.

However, since a medical system relies on efficient coordination and transitions between medical care levels, the comprehensive community medical program in *Misión Sucre* was modified. Starting in 2020/2021 it is hoped that these doctors will eventually become specialists accountable for the health of the entire country *including* the poor as many are drawn from those

populations and areas (pers. comm. with *MBA* manager in Torres, 2013, 2015). Thus, some fragmentation issues between the preventive-focused *MBA* and conventional curative system may, in time, become a non-issue through the expansion of the education program.

As such, the significance of a future of a healthcare system for non-insured populations is noted by a *Misión Sucre* physician graduate from Río Tocuyo (pers. comm. 2013). She stated that her inspiration for entering medicine was due to the early and untimely death of her beloved grandfather. At the time, only two doctors were working full-time at the central hospital in nearby Carora (approximately 40 to 50-minute drive away). These two doctors were often very over-worked and were unable to adequately maintain the health of the populations that could not afford to go to private healthcare clinics—which, to highlight previous pre-Chávez poverty rates, represented approximately 70-80% of the population. As such, her grandfather died in the hospital hall after waiting hours for treatment that never came.

As noted previously, this was because treatment would often be denied based on ability to pay at private clinics and hospitals. Additionally, wealthier people would often skip lines with well-calculated bribes which, in turn, meant that in a system compounded by service fragmentation and shortages, poor populations often spent hours and even days in lines to seek treatment. As such, due to stories such as this one, it not only became clearer why rural and impoverished segments of the population suffered disproportionately, but also why so many of them were inspired to get medical degrees *in service of* their families, friends, and communities.

In addition to this example, one medical professor from the local nursing school noted that one of the most beneficial aspects of expanding the healthcare system in Venezuela is that patients can be treated closer to home and often in their communities surrounded by families and

friends (pers. comm. in Carora, 2013). Teaching staff recognized that being around family, as well as with the support of their community, helps patients recover much better. This has a double effect since families no longer have to travel great distances—often at great expense given the need to find accommodation as well due to the previously-centralized nature of the pre-Chávez health system—in order to visit and help with the recovery process.

This aspect should be emphasized since even one person's fall into ill health can slide a whole family into poverty if healthcare is inadequate, unaffordable, or inaccessible. Families would often have to take time off from income-generating work to wait in line-ups with health-compromised family members, travel long distances to visit, and/or provide care if there was not room in the medical system. Thus—understandably—those populations who were traditionally excluded from comprehensive health have become strong advocates for *Misión Sucre* and *MBA*'s continued integration into the healthcare system. Significantly, this education program shares a similar approach—with comparable 'buy-in' or acceptance from similar non-insured (albeit international) populations—to *ELAM* Salvador Allende medical school in Caracas.

ELAM Salvador Allende

> "*Education either functions as an instrument which is used to facilitate integration of the younger generation into the logic of the present system and bring about conformity or it becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world.*"
> (Freire, 2012, p. 34)

In late 2015, two visits were made to *ELAM* Salvador Allende (inaugurated in 2007) to interview 14 students (6 from Palestine, 4 from Colombia, 2 from Bolivia, and 1 from Peru, and 1 from Egypt), 3 teachers, and 2 members of the university administration. During the process of

initiating and conducting interviews, *ELAM* Salvador Allende was in a state of flux as there was a new university director and many of the staff had been replaced. At *ELAM*, and at the time of the interviews, some 800 students from 37 different nationalities (with nearly 100 from Palestine alone) were taking classes at the university free of charge.

Students were selected for *ELAM* Salvador Allende by *Fundayacucho*, a Venezuelan organization that works with host governments to ensure that the best and brightest from health-equity deserving communities are trained—as well as imbued with *conciencia* and a duty to serve the indigent—to return to their own relationally proximate communities with a newfound critical distance in order to ensure brain gain and continuity of care. During late 2015 interviews, two cohorts had graduated—approximately 600 international students with the third graduation set to take place in January 2016. An additional 2,000 students were undertaking clinical rotations throughout the country as a part of their studies.

Increasingly there was an apparent delegation of geographies between sister universities, with Venezuela taking on more responsibility to train those from South America and the Middle East while Cuba's *ELAM* was beginning to focus on other regions around the world such as the US, Central America, Caribbean, Africa, and South Pacific. It should be noted that, at the time of research, students from countries such as Paraguay, Palestine, and Colombia had their medical degrees from *ELAM* recognized immediately. However, various other countries' medical federations did not immediately recognize their training or simply required further training/certification before being incorporated into their health system.

For students who are not from a Spanish-speaking country, both *ELAMs* added one year of Spanish language training to the 5 years of core medical courses. While the courses/course

structures were nearly identical (other than up to 10% of the content for certain contexts, mainly found in premedical class), the Cuban *ELAM* students worked towards their degree in *medicina integral*/doctor of comprehensive medicine while Venezuelan *ELAM* students worked towards their degree in *medicina comunitaria*/doctor of community medicine.[193] Empathy/*conciencia* is a significant part of their training, especially after they finish their first year of course work and conduct clinical rotations at *MBA CPs* and *CDIs* throughout Caracas and Venezuela's other states (including Zulia and Amazonia).

Palestinian students, most of whom were in the second year of the program as a part of the Yasser Arafat Scholarship program (which aims to train 1000 doctors), stated that, of the approximately 500 who applied in the latest round of admissions, 100 were selected by the Palestinian Ministry of Education who evaluated a range of factors such as high school grades and family situation (whether they were orphaned and/or had fewer psycho-social supports than others). If they eventually wished to continue their education by specializing, Palestinian students had to work at least a year in general medicine before being considered. All medical training done in Cuba and Venezuela is recognised in Palestine.

Of note is that the university does not accept older/'mature students', instead focussing only on younger populations in hopes that they will be able to utilize their education further into the future for the benefit of their patients/communities. Everything is free at the school, including food and accommodation. While most of the curriculum is based on the Cuban model, there is space for approximately 10% of the curriculum to be changed to accommodate conditions of

[193] Thus, these designations—'doctor of community medicine' and 'doctor of comprehensive medicine'—share similarities with Canada's family doctors/general practitioners (GPs)

local contexts. However, as 9 students noted, the 10% curriculum for Venezuelan context (primarily found in the premedical course) was to situate, politically and historically, anti-imperialist, anti-neocolonial, and anti-neoliberal Chavista stances.

While 4 students were blasé about it, 2 thought it was important to note the geopolitical significance of the program, while 3 other students thought it went a bit far and was unrelated to medical studies, some amounting it to a *panfletario* (propagandist) nature of education. The new Director was a doctor trained from the conventional medical system and the Principal Director decided the direction of the school. At the time, the only teachers were Cuban but, as per the agreement, the hope is that one day all teachers and doctors will be Venezuelan and Cuban doctors/teachers then work in other health-equity deserving countries as needed.

The university itself is located on the outskirts of East Caracas past Venezuela's (and one of the world's) largest slums, Petare. However, due to *ELAM*'s proximity to a very dangerous neighbourhood (along El Roble), insecurity was a significant issue. In November, 5 students were robbed at gunpoint the day before the second round of interviews while they were walking to the gondola en route to Caracas (as the bus that would have typically run from the university to the gondola station had broken down).

Of note is that the southern section of the Petare slum (known as the San Blas barrio) is where approximately 207,686 Colombians settled between 1980 and 1999 when fleeing civil strife (Campos, 2019). This is unsurprising as Venezuela has historically accepted immigrants from around the world, "first from Europe (mainly Spain, Italy, Portugal, and Germany), and later from elsewhere in Latin America: Colombia, Peru, Ecuador, Argentina, Chile, the

Dominican Republic, and Haiti" (Ruiz, 2020, citing information from the Migration Policy Institute).

An interesting contrast is that Colombian refugees in Venezuela, as with other migrants, were able to rapidly access Chavista social missions including free healthcare, housing, and education (including Colombians who are not migrants, but are disproportionately represented at *ELAM* in contrast to other nationalities). As noted in a 2015 interview with the Coordinator for Social Missions in Caracas, it was made clear that Colombian migrants could train at *Misión Sucre* as well as work at *MBA* if they chose, whether their intention was to migrate back to Colombia at some point or not.

In 2019, Greg Palast posited that in "Venezuela, as in the USA, poverty and race are locked together" (2019). Given the history and analysis of *MBA* and *Misión Sucre*, it should not be so surprising why so many non-insured poor and *Mestizo* Venezuelans loved Chávez and were a significant part of his support prior to his death. Even the CIA's Fact Book reflects why this might be the case: "Social investment in Venezuela during the Chavez administration reduced poverty from nearly 50% in 1999 to about 27% in 2011, increased school enrollment, substantially decreased infant and child mortality, and improved access to potable water and sanitation through social investment" (ibid. citing the CIA). However, following the 2015 National Assembly election (when the opposition won their first significant election in sixteen years), it became clear that—despite former divisions between Chavistas and the opposition generally along race and socio-economic lines—there was an emerging generational divide forming among Chavistas.

Maduro Takes the Reigns of Falling Oil Prices, Uncertainty, and Increasing Challenges: The Transition from Soft back to Hard Geopolitical Pressure

"Hey, look [at us], look at me and my [black/Mestizo] friends, it isn't just rich white people voting for the opposition anymore. We know things improved [under Chávez], but even some [of us from lesbian and gay communities] are tired and want change."
(Approximately thirty-year-old centre-opposition supporter in 2016 after the National Assembly election)

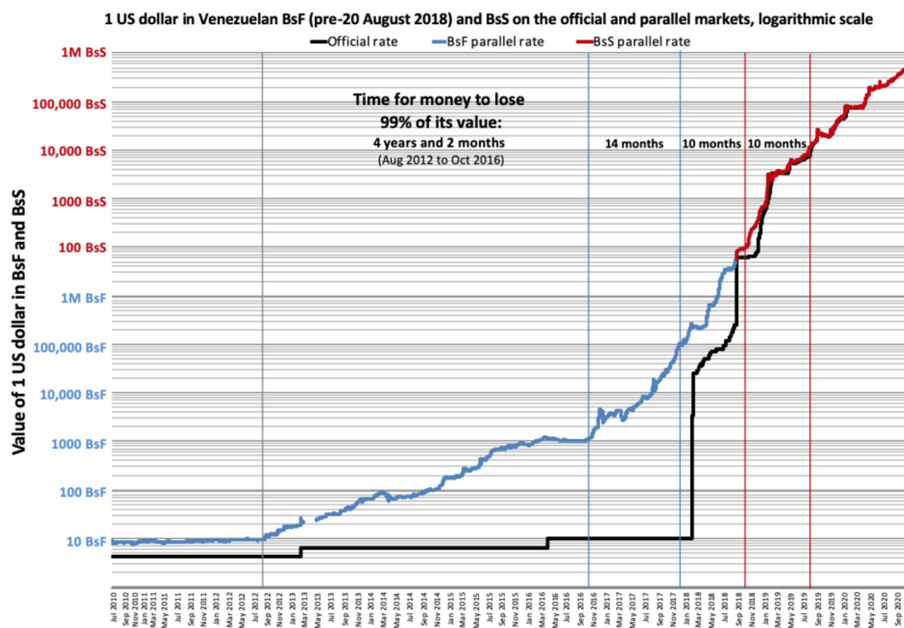
As documented throughout this chapter, the first research trip to Venezuela in 2013 was quite different from the second 2015-2016 trip. Both research trips were marked by very significant events that changed the course of Venezuela. In 2013, planning and purchase of plane tickets for the research trip happened while Chávez was alive. At that time, oil prices were still relatively high. However, by the time primary research took place, Chávez had died, Maduro was elected by a narrow 1-2 percent margin over Capriles, and oil would be on an increasingly steady decline beginning June, 2014 (as will be detailed further on).[194] Ensuing economic hardship was noted by a decrease in bilateral trade between Cuba and Venezuela from the 2012 peak of 8.563 billion United States dollars (USD) to 3.104 billion USD in 2018 (in a return to 2006-2008 levels) as seen in Table 7 prior. The country went from having a majority Chavista government, to a near 50/50 division between Chavista supporters and the opposition in 2013.

During the 2013 trip, there was an active exchange of USD for Venezuelan Bolivars. At the beginning of the 2013 trip the official exchange was approximately one for six while the

[194] During the second research trip two Chavista party insiders posited Chávez's rationale for choosing Maduro as his successor over other, more recognizable and much more powerful, choices. As one respondent remarked in January 2016: "Up until his last moments Chávez didn't believe he would die. When that moment of recognition finally happened, he had to act quick. He recognized that some of the main party leaders were eager for the reins of power and worried that it was simply power for power's sake. He ultimately decided to put his support behind Maduro, not because of his leadership abilities or influence within the party, but because from the very start Maduro always believed in the social-egalitarian process and never showed a desire to secure power for himself throughout his time by Chávez's side."

black-market exchange was approximately one for twenty. Within three months, that jumped to about one for 29 in mid-2013. By the end of the following year, it was one for 100. Upon returning for research in 2015, the very active exchange had exploded to one for 900 and then to 1000 in very short order. 2015 Christmas in Caracas among friends included gifts wrapped in newly-discontinued two, five, and ten Bolívar Fuerte notes. The biggest bill, the 100 Bolívar Fuerte, at the time of both research trips, was discontinued the following December 2016. As noted in Figure 7 (from the black-market currency estimation website, DolarToday (2020), the ensuing four years of hyperinflation starting in 2016 "resulted in the total devaluation of the national currency (1 USD = 1.8–1.9 million bolivars) . . . [subsequently decreasing] public sector salaries from 150–500 USD in 2015 to 1–10 USD in 2020" (ibid.).

Figure 7: Venezuelan Currency Hyperinflation from 2010 to 2020



Source: DolarToday, 2020 (Official government-approved exchange rates [in black on the graph] from http://www.bcv.org.ve/estadisticas/tipo-de-cambio): https://dolartoday.com/indicadores

Adding to this disparaging economic environment, foreign remittances decreased due to US and allies blocking state assets, "adding to the complexity of—and impediments to—bank transfers" (Drouhan, 2021). Venezuelan health outcomes (evidenced in Table 8 earlier) began to decline around the same time as Venezuela's inflation transitioned to hyperinflation.

As such, hardship now appears to permeate most aspects of life in Venezuela. Reflective of the 2021 UN report, inflation witnessed during the 2013 research trip had clearly transitioned into hyperinflation by the 2015/2016 research trip. This was also the result of increasingly harsher sanctions imposed by the US, European Union (EU), and allies—significantly increasing structural violence due to the decimation of SDOH. During this period, the Maduro government's revenue reportedly shrank by 99%, "with the country currently living on 1% of its pre-sanctions income" (OHCHR, 2021).

Many governments struggle with challenges of corruption, often replicating neoliberal logics and responding to the influence of corporate monopolies and export elites. In the case of Venezuela, as noted by previous examples of Venezuela's most corrupt leaders, Juan Vicente Gómez and Carlos Andrés Pérez, corruption was also quite endemic. Though Chávez may have sought to stamp it out, including through corruption hotlines, many of the challenges appeared to originate from a perpetual and embedded arrangement of professional bureaucrats (who were adept at switching political party 'hats' to retain lucrative public positions) and corporate influence, especially among the export elite. Thus, while corruption was an undeniable part of Chávez's tenure, the incredible wealth generated—especially during the prolonged period when oil was between $80-$170 per barrel—meant that few thought to pay attention as salaries were

paid, graft was overlooked, and nationalized wealth generated real change for an emerging middle class increasingly aware of their rights and a better life.

Thus, the tides began to turn when the purse strings tightened as oil reached lows of $38.19 in January 2016 (followed by a 20-year record low of $19.78 in April 2020)—coinciding with ever-increasing pressure from the US and allies. Endemic corruption and graft were once again visible, and very problematic—particularly as previously available funds to pay public salaries such as those for healthcare workers, and, especially, security personnel/police, dried up. Thus, while benevolent state-led policies (such as *MBA* and other Bolivarian social missions) may have increased Chavista support (especially among the non-insured) as Venezuelans had positively interacted with state institutions to their and their families' benefit alongside decreasing inequality—increasing corruption and negative interactions with other state institutions were on the rise at the time of the 2015/2016 research trip. Two moderate respondents were unlawfully jailed until they paid authorities a substantial bribe to be released (perhaps unsurprisingly given the salary delays due to increasing hardship and mismanagement).

Thus, after 2013, the positive health outcomes from 2003-2013 due, in part, to their bilateral agreement and reduction in inequality (reflective of the work of R. Wilkinson & Pickett, 2010), have been partially reversed because of a complex array of factors. Consequently, Venezuela's two-party political system, polarization, and decreasing support have created unique challenges to the politicized collaboration between Caracas and Havana.[195] Additionally, during

[195] It should be noted that, as argued in previous research as well as discussed in various conversations with Cuban medical personnel between 2013 and 2018, healthcare is inherently political. Previous publications have argued for a need to re-politicize medical personnel/systems with a 'health in all policies' approach as advocated by the World Health Organization (WHO, 2008b, p. 69-71), as well as utilize political economy perspectives in public health initiatives and analyses (C. Walker, 2015; 2021; C. Walker & E. Kirk, 2017). However, as noted by research experiences in Venezuela,

the 2015 National Assembly election in Venezuela, while observing the run-up to the election, several opposition nominees took aim at the Cuban involvement in the country as noted in Figure 11. Signs and slogans included "no to the Cubanization [of Venezuela]!" were evident in a few places around Venezuela, especially in Caracas's affluent neighborhoods.

Figure 8: "Cubanization" of Venezuela and the Ramifications of Politicized Medical Internationalism

Source: Author, 2016, Caracas (near La Florida area).

While the generational split among Chavistas has weakened some of the clearer divisions, Venezuela's two-party system has created significant geographic differences and physically separate environments along party lines. Many respondents in both research trips noted 'Chavista cafés', 'opposition neighbourhoods', 'Chavista parks', and even 'opposition beer'. The spaces of *MBA* have also been politicized (as noted in Figure 9).

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the Cuban parallel healthcare system was uniquely politicized in contrast with Cuba other medical internationalist endeavours such as South Africa, Pakistan, Qatar, Honduras, Nicaragua, The Gambia, Italy etc.

Figure 9: Politics of the Government

Source: Author, 2013, *CDI* in Carora (in Lara State).

Though the goal of MBA was to overcome medical exclusion, the images of Chavista leaders, Maduro and Chávez, alongside Cuban leaders and heroes such as Ché, Martí, and Fidel, has reinforced this divide. It has meant that almost all *MBA* health facilities have been symbolically aligned with the *PSUV* political party. Therefore, the Cuban-supported *MBA* system has become a de facto part of the 'politics of the government' instead of the politically neutral realm of the 'politics of the state'. This politicization of the public healthcare system has meant that Cuban personnel have become branded as part of the Chavista government, therefore politicizing their presence more than other Cuban medical solidarity efforts throughout Latin American and beyond.

The politicization of free public health spaces in *MBA* has added an element of 'exclusion' in a space that was ideally meant to be 'inclusive'. While *MBA*, as well as *Misión Sucre*, have helped to overcome structural violence as well as geographic, socio-economic, racial, and gendered exclusion for many people since its integration into the public healthcare system in 2003, those who wish to vote for another party other than *PSUV*, hope for a third-party option, or

abstain from voting altogether, might find the public healthcare environment of *MBA* and *Misión Sucre*, uncomfortable or even hostile.

This may not have been as apparent or as significant when the Chavista government was enjoying 60% to 75% of popular support prior to the 2013 presidential election. The majority against the Chavista government were mostly wealthy, often urban, sectors that could afford high-quality care at private facilities. However, this changed drastically. Not all who currently need the free healthcare services of *MBA* are inclined to vote for the Maduro government for any number of reasons (detailed above).

Additionally, not even Cuba's help has been unable to reverse the fallout from broader economic, material, and geopolitical issues. Problematically, their counter-hegemonic example and consequences from the politicization of the Cuban medical program in Venezuela may be significant. Thus, only time will tell if the Cuban medical program in Venezuela would survive a potential change in government in Venezuela—from Chavista to opposition—knowing that for many, Cuba equals the Chavista model.

Conclusion

"*Privatization is a neoliberal and imperialist plan. Health can't be privatized because it is a fundamental human right, nor can education, water, electricity and other public services. They can't be surrendered to private capital that denies the people from their rights*."
Hugo Chávez during his closing speech at the World Social Forum in Porto Alegre, Brazil. January 31, 2005
Cited in Sojo (2005)

The following quotation by a Caracas academic, specializing in human rights as well as involved in the adaptation of Cuba's *Centro Nacional de Educación Sexual*/National Centre for

Sex Education (CENESEX) program to advance the rights of the LGBT community (spearheaded by Raúl Castro's daughter, Mariela), perhaps best summarizes this chapter. In 2016, when asked about what the significance of Venezuela's subaltern example is as well as what the future might hold for *MBA, Misión Sucre*, and Venezuelan human rights, she replied: "*es complicado . . . muy incierto y muy muy muy complicado*/it is complicated . . . very uncertain and very very very complicated."

As such, it should now be clear that it is incredibly hard to disaggregate Venezuelan health outcomes from a variety of factors: Cuba's medical solidarity, geopolitical dynamics, fluctuating oil prices, US and ally hard and soft power pressure against the Maduro government, fragmented opposition agendas, power of the Venezuelan [export] elite, corruption, culture, economic [mis]management, modes of governance, impact of Colombia as a neighbour, migration, political agendas throughout all governmental levels (municipal, state, federal, supra-national etc.), role of the conventional medical personnel, as well as the impact of the media, among other variables. Of note is that this list is clearly not exhaustive.

It becomes apparent why Vincent Tucker's work on critical holism seemed to resonate particularly well during this part of the research process:

> A development economist can no longer afford to ignore politics, sociology, gender, ecology, culture; nor can a political scientist or sociologist afford to ignore economics. Most problems now faced in development require a combined approach, such as structural adjustment, currency instability, corruption, the environment, gender, poverty, conflict prevention, complex emergencies, post-conflict reconstruction. (Pieterse, 2010, p. 158, reflecting on the work of Tucker)

Thus, relying on single-causal analysis or narratives to explain Venezuela's complex and dynamic array of factors that shape health outcomes is not only disingenuous, but it also amounts to playing politics.

Just as opposition allegiance to US foreign policy efforts—causing devastating hardship to fellow Venezuelans—diminished their credibility, so has Maduro's restriction on freedom of assembly, jailing of political prisoners, and lack of respect of the 1999 constitution diminished his. As such, continued corruption, mismanagement, and the economic deterioration of Venezuela's economy had, and will continue to have, significant impacts on the health of the population (both directly and indirectly). It has worn down the effectiveness of the vertically integrated health system as healthcare personnel have struggled to generate enough income and have taken on various other employment opportunities at different geographic locations, potentially spreading COVID-19 and other transmissible diseases in a similar way as fragmentated and uncoordinated conventional neoliberal healthcare approaches have in North America.[196]

And yet, though its continued survival, it appears that *MBA* is somehow still *en route* to become the dominant health system, taking over completely from the conventional system eventually with Cuba's retreating ability to help. Additionally, Maduro promises to maintain Venezuela's strong relations with Cuba as noted in his praise on the date of the anniversary of the Cuban revolution: "We commemorate the anniversary of the triumph of the Cuban Revolution led by Comandante Fidel Castro. 60 years of sacrifices, struggle and blockade; the heroic Cuban

[196] This is a critique of the healthcare system and political responses (which will be contrasted further in the concluding chapter), not the workers themselves who—despite their best frontline efforts—face the burden of work, isolation, potential death from contagions, as well as facing an overwhelming burden to support themselves and their families.

people, an example of resistance and dignity before the world. Long live Cuba!" (Maduro as quoted in Granma, 2019). Thus, while leadership has changed in both countries, Maduro has carried on the warm relations (despite declining support in Venezuela for his leadership) with previous Cuban president, Raúl Castro, as well as current president, Miguel Díaz-Canel—continuing the legacy that Fidel and Chávez initiated, through thick and thin.

Thus, it is becoming increasingly possible that *MBA* will become the conventional system in Venezuela as health specialist training is ramping up in *Misión Sucre* while conventional healthcare personnel emigrate at comparatively larger numbers than their *MBA* colleagues (particularly specialists). As such, significant challenges remain from this significant brain drain of medical personnel from both the conventional system, and increasingly, from *MBA* (OHCHR, 2018; Page et al, 2019).[197] However, due to mismanagement by the Maduro government as well as geopolitical pressure by the US and its allies to diminish and reverse Venezuela's social-egalitarian counter-hegemonic example, health indicators appear to continue their downward trajectory along with increasing material shortages (despite a short bump in 2019 due to PAHO and UN help) (OHCHR, 2021).

Material shortages (including medical equipment and medication), hyperinflation, and insecurity have become quite significant and have limited the original successes—in terms of health outcomes—brought about mainly by the truly exceptional scaling up of healthcare human

[197] During research and interviews, it seemed that opposition sectors and conventional medical personnel mainly migrated to the US, Colombia, or Mexico. At the time of research in 2015/2016 most *Misión Sucre* graduates did not consider emigrating from Venezuela. Based upon continued correspondence and recent secondary research, it appears that there has been a small, albeit significant, shift in this trend as many people, from almost every background, are considering (or actively looking) for a way out of Venezuela. For those that stayed, many *MBA* personnel need to work 1-3 additional jobs to generate enough income in the face of crippling inflation. While *Misión Sucre* graduates seem to remain in their communities, pay and scarcity of resources were a significant problem. They often had to travel to major cities to simply do banking or track down increasingly scarce items/resources such as phones and batteries.

capital in *Misión Sucre* and *MBA*. While there had never been more per capita medical personnel in the history of Venezuela at the time of both research trips, with more being trained, material shortages have caused overall indicators to decrease. After the 2016 research trip, brain drain became a very significant issue as public services were subsequently reduced by "30 to 50 per cent of their personnel, including their most qualified ones (doctors, nurses, engineers, teachers, professors, judges, police officers, etc.), resulting in internal disorganization, increased workloads for remaining personnel, reduced services and a decline in their quality" (OHCHR, 2021).

Sadly, during the COVID-19 pandemic with its high mutation rate (some of which have proven increasingly resilient, infectious, and deadly), attempts by the UNDP and PAHO in 2020 failed to "release funds frozen in the Bank of England for buying medicine, vaccines, protective kits and medical equipment" (OHCHR, 2021). Highlighting the hypocrisy of advancing Global North neoliberal hegemony over human rights, funds have also "not been released for the purchase of COVAX via PAHO in 2020-2021" (ibid.).

Impressively, despite both countries' recent history of severe economic and geopolitical hardship, with help from Cuban medical personnel, they jointly launched a Venezuelan molecular biology laboratory in 2020 to help with testing, specifically implementing polymerase chain reaction (PCR) tests (one of the most accurate tests for COVID-19). On April 10, 2021, Venezuela had 638,772 suspected cases of COVID-19 (Ortega, 2021 as translated by the author).

- 18,230 of the suspected cases were admitted to care.
- 8,580 confirmed cases of COVID-19 were treated in *CDIs*, of which more than 90% had recovered.

- 2,287,830 rapid tests had been performed.

- 124,442 PCR tests were completed.

Additional assistance came from Cuba's Henry Reeve Brigade.[198] The Brigade provided care for 1,010 Venezuelans in hospital as well as outpatient efforts that reached an additional 103,000 Venezuelans (ibid.).

In contrast to their coordinated and continued fight for global health and against internationally transmissible diseases, over 1,000 Cuban doctors were expelled from Ecuador following the electoral loss of *ALBA* ally, Rafael Correa, by neoliberal president Lenin Moreno. Neoliberal measures soon destroyed, not only the healthcare system, but severely limited its ability to respond to the ensuing COVID-19 crisis. As noted in an interview conducted by Alejandro Pedregal with Don Fitz (2020), at the time:

> Cuban doctors formed the backbone of its health care system. Lenin Moreno was elected [over Correa] in 2017 and Cuban doctors were soon expelled, leaving public medicine in chaos. Moreno followed recommendations of the International Monetary Fund to slash Ecuador's health budget by 36%, leaving it without health care professionals, without personal protective equipment, and, above all, without a coherent health care system. At the time Venezuela and Cuba had a total 27 COVID-19 deaths, Ecuador's largest city, Guayaquil, had an estimated death toll of 7,600.

[198] This 'brigade' (named in honour of US citizen, Henry Reeve who fought on the side of Cuban independence during the 10 Years War with Spain from 1869 until his death on the battlefield in 1876) includes highly trained medical teams specifically trained for international medical emergencies such as the 2005 Guatemalan hurricane, the 2010 Haiti earthquake, the 2014 Ebola outbreak in West Africa, and, recently, the 2020 Covid-19 pandemic. Cuba sent almost 5,000 medical personnel to 40 countries to help in the fight against the pandemic.

Thus, despite severe levels of hardship throughout the country, with COVID-19 striking during some of the harshest sanctions and measures imposed by the US and allies as well as one of the lowest points economically, oil price-wise, and resource access, at the time Venezuela fared comparatively better than its neoliberal regional neighbours such as Ecuador (noted above), Brazil, Honduras, and Colombia as well as far better than the UK and US as seen in Table 9.

Table 9: Comparison of COVID-19 Statistics Between Venezuela and Other Countries on May 31, 2021

Country	Population (World Bank, 2021)	Cases per million (Schiffmann, 2021)	Deaths per 100k population (John Hopkins University, 2021)	Case fatality rate (John Hopkins University, 2021)
Venezuela (S)	28,515,829 (2019 est.)	8,208.05	9.22	1.1%
Cuba (S)	11,333,483 (2019 est.)	12,567.32	8.38	0.7%
Timor-Leste (S)	1,293,119 (2019 est.)	5,214.65	1.24	0.2%
Canada (M)	37,593,384 (2019 est.)	36,290.5	67.77	1.8%
United States (N)	328,239,523 (2019 est.)	102,313.18	181.10	1.8%
United Kingdom (N)	66,836,327 (2019 est.)	65,853.17	191.58	2.8%
Brazil (N)	211,049,527 (2019 est.)	77,196.93	218.87	2.4%
Colombia (N)	50,339,443 (2019 est.)	65,853.17	175.37	2.6%
Honduras (N)	9,746,117 (2019 est.)	23,645.47	64.60	2.7%
Mexico	127,575,529 (2019 est.)	18,536.59	175.20	9.3%
Jamaica	2,948,279 (2019 est.)	16,332.98	32.05	1.9%
Haiti	11,263,077 (201 est.)	1,236.72	2.73	2.2%
Indonesia	270,625,568 (2019 est.)	6,596.69	18.82	2.8%
Papua New Guinea	8,776,109 (2019 est.)	1,748.21	1.85	1%

N = Strongly Neoliberal
M = Mixed Neoliberal and Social
S = Strongly Socialist
* Data collected from World Bank, 2021; Schiffmann, 2021; John Hopkins University, 2021.

It is important to highlight the segments of the population most impacted in the conclusion of the UN report on sanctions:

> The Special Rapporteur notes with concern that sectoral sanctions on the oil, gold and mining industries, the economic blockade of Venezuela and the freezing of Central Bank

> assets have exacerbated pre-existing economic and humanitarian situation by preventing the earning of revenues and the use of resources to develop and maintain infrastructure and for social support programs, which has a devastating effect on the whole population of Venezuela, *especially those in extreme poverty, women, children, medical workers, people with disabilities or life-threatening or chronic diseases, and the indigenous population* [emphasis added]. (OHCHR, 2021)

It should be clear that Venezuela's most wealthy and powerful, including many leaders of the opposition (as representative of insured populations), would not appear on this list.

The ability of many of them to, not just turn a blind eye, but also actively support further sanctions disproportionately hitting the most vulnerable non-insured Venezuelan populations should be a reminder of the impacts of relational distance when coupled with dangerous neoliberal, neocolonial, classist and racist logics. During COVID-19 a simple math appears overlooked by Global North policymakers in their desires to expand hegemonic and corporate power over the Global South: sanctions (of which few have been evidenced to work as intended) create hardship that is disproportionally faced by non-insured populations.

These hardships mean that non-insured-turned-surplus populations migrate to other countries increasing the global transmission of diseases. Adding to the crisis wrought by public health devastation and Global North hording of vaccines, increased rates of transmission increase the chances of COVID-19 mutations (which, as frequently happened with C OVID-19, can become more contagious, more deadly, and more resilient to vaccines and other health measures). These increasing mutations mean that there are increasing chances for future

pandemics take on an endemic nature (much like the common flu, but significantly more deadly and economically devastating).

As such, despite its balanced take (noting the shortcomings, problems, and responsibilities of the Maduro government), the 2021 report by the OHCHR came under fire primarily from those most relationally distant to the ramifications of the sanctions, extreme hardship, and ensuing loss of life. This included various US-backed NGOs, civil society groups, and other affiliated allies.[199]

In sum, regarding the fierce geopolitical project against Venezuela (arguably even more fierce than currently faced by Cuba), after the overt US-backed coup in 2002, most pressure was via covert means through US-financial backing of opposition, NGOs, and civil society groups. The return to overt pressure began again after Maduro's 2013 election and really took off in 2015 with the first set of sanctions increasing in pressure over the following years as well as mitigating healthcare system maintenance and overall health outcomes. As such, healthcare, and health outcomes—requiring significant political economy analysis—can simply not be disaggregated from the geopolitical hegemony as well as from the logics of neoliberalism and neocolonialism. This will be an interesting point to contrast with the more implicit biopolitical neoliberal development project in Timor-Leste in the following chapter.

[199] Despite the importance of the 2021 UN Report calling for an end to US and ally sanction, it comes to a fairly interesting conclusion: "The Special Rapporteur calls on the Venezuela Government, working with the UN Resident Coordinator and [Office of the UN High Commissioner for Human Rights] OHCHR in Venezuela, to finish drafting clear and non-discriminatory legislation enabling and facilitating humanitarian work by international and national NGOs in Venezuela, and to guarantee security and integrity of their personnel. At the same time, she refers to the obligation of humanitarian NGOs to abide by standards of purely humanitarian activity" (OHCHR, 2021). As such, following biopolitical logics of the development and aid industry, it appears as though the UN is brokering with Venezuela choose contingent sovereignty through Global North charity/NGO-ization rather then supporting (through resources and human capital) the foundations of Venezuela's already expansive welfare state/solidarity efforts with Cuba—albeit with an important disclaimer for NGOs typically working with the US National Endowment for Democracy in that they must 'abide by standards of purely humanitarian activity,' not destabilization.

Thus, their subaltern counter-hegemonic example may be most applicable given the fallout from the COVID-19 crisis. The pandemic exposed the need for healthcare human capital, strong universal healthcare systems, working in cooperation and solidarity with other countries (not in contestation), as well as pursuing public policy 'alternatives' rather than responding to the dictates of neoliberal market logics, policies, and power. While the rapprochement between the US and Cuba during the Obama presidencies—involving an admirable amount of effort and sacrifice by personnel on both sides of the Florida Strait—appeared to show that a new diplomatic leaf had been turned, significant uncertainty about any warming relations has stalled throughout the Donald Trump and Joe Biden presidencies.

Spadoni highlights that, although Cuba's revenue decreased since its 2003 to 2014 golden era, and Venezuela's "oil shipments to Havana have declined since 2013 due to the . . . economic crisis amid falling oil prices, the economic lifeline that Venezuela has thrown to Cuba for over a decade is beyond question" (2021, p. 227). Thus, despite material shortages, economic hardship, hyperinflation, internal strife, polarization, collapsing oil prices, and the transitions of power, both countries appear united in their ties of solidarity. As such, their counter-hegemonic example appears to be able to survive with their biopolitical sovereignty intact.

However, the politicization of their counter-hegemonic solidarity may have ramifications as it has already made cooperation with Cuba a political target among Venezuelan opposition. If, and when, power in Venezuela does switch hands, from Chavista to opposition or an emerging third-party option, it remains to be seen whether this politicized and polarizing cooperation continues will continue (C. Walker & E. Kirk, 2017).[200] Chavistas as well as successive Cuban

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[200] Especially if Maduro takes a right turn as some have suggested (Gilbert, 2021; León, 2021; L. Perez, 2021).

leaders have attempted to retain, reinforce, and expand their welfare states through benevolent public policies funded by national resources/nationalized industries as well as by limiting Global North influence and the development industry/NGOs.[201]

Thus, as Birn and López note (2020, p. 279), and in contrast to conventional healthcare and Global North development approaches:

> The twenty thousand Cuban doctors who have participated in *Barrio Adentro* (now being replaced by recently trained Venezuelan doctors from low-income backgrounds) . . . *sharing the same [relationally close] spirit and lack of privilege* [emphasis added] (i.e., not the high-paid consultants typical of North–South aid) . . . [living] with families in the same neighborhoods where they practice. *Misión Barrio Adentro's* 'bottom-up' approach emphasizes mutual understanding between providers and patients, as well as the inclusion of local residents in decision-making around the activities that affect them most directly.

It is with this in mind, that the most significant contrasts between Cuba's approach to healthcare solidarity and the neoliberal development/aid industry were evidenced during research in Timor-Leste, the subject of the next chapter.

This Southeast Asian country, at the time of independence in 1999, was the poorest country in the world outside of Africa having been devastated by a 25-year genocide by Suharto's Indonesia. Unlike the Venezuela case, where the Cuban-supported *MBA* was a parallel system, most of Timor-Leste's primary public health system was structured and capacitated with the help of Cuba. Many subaltern lessons for Global North health systems can be learned from

[201] While not seeking the expansion of a welfare state per say, this echoes similar points made by former President Donald Trump's "Make America Great Again" (MAGA) and "America First" slogans. He promoted throughout both electoral races the "return" of American industries and use of US resources for US interests (Inman, 2020).

the Venezuelan example, while in Timor-Leste, some of the most impactful subaltern-knowledge production will concern lessons for alternatives to the neoliberal international development/aid industry. Thus, Global North countries may learn the most from Venezuela about re-shaping domestic healthcare approaches for domestic populations, while, as this dissertation posits, the Timor-Leste example evidences important international biopolitical lessons for how Global North can re-shape its foreign policy approaches to international development—from the neoliberal development/aid industry approach of development and healthcare as charity, to development and healthcare as dignity.

Chapter 5: Timor-Leste's Lesson for Respectful Subaltern Development Cooperation

> "*Mari Alkatiri, the then Economics Minister in the first Transitional Administration (and now the first Prime Minister of an independent East Timor), responding to this issue, asserted that he and his colleagues were 'successfully resisting' the multilateral banks over budgetary and infrastructure matters. Much of the World Bank willingness to engage in 'free market' social engineering was justified by a notion that post-conflict East Timor was 'ground zero,' in development terms*."
> (T. Anderson, 2003, p. 177)

This chapter is dedicated to the work and activism of Dr. Helen Hill—Order of Timor-Leste, *Profesora Convidada* at *Universidade Nacional Timor Lorosa'e*/National University of East Timor (*UNTL*), Honorary Fellow at Victoria University, and co-founder of the Australia-East Timor Association—who passed away May 7th, 2024. I was privileged to not only live with her during my tenure in Dili, but also to be mentored in Timorese history, policy and activism by her. Without Helen, this chapter would simply not have been as she opened many doors as well as helped me navigate the research landscape throughout Timor-Leste with patience, grace and no lack of great humour. Her unpublished book, as well as conversations around the table, became foundational for what follows.

Timor-Leste, commonly known as East Timor or *Timór Lorosa'e* in *Tetum* (one of two national languages alongside Portuguese), was an incredible and surprisingly rewarding research experience.[202] The goal of this chapter will be to detail its health-equity focused medical

[202] Sections of this chapter have been pre-published in a journal article titled, *From Cooperation to Capacitation: Cuban Medical Internationalism in the South Pacific* (C. Walker & J. Kirk, 2013).

cooperation with Cuba as well as contrast that cooperation with efforts by the Global North development/aid industry. Most interviews were conducted throughout various regions in a similar fashion as Venezuela via snow-ball sampling until a point of saturation in responses was achieved from various respondents including East Timorese medical personnel/patients/academics/government officials/members of the public, Cuban medical personnel, foreign academics, as well as expat development/aid workers and volunteers (who were primarily from Australia).

Unlike the high degree of anonymity needed in Venezuela, there was comparatively far less risk in Timor-Leste due to comparatively less violence and polarization. However, given the relatively small populations in various research areas, minimal identifiers were used such as areas of employment and initials. Where respondents had similar initials, numbers were added to ensure their responses were distinct from others.

This chapter begins by briefly situating the pre-Cuban 2003 agreement history of Timor-Leste: from Portuguese colonialism (1769-1975) to Indonesian Genocide (1975-1999) to United Nations Transitional Administration in East Timor (UNTAET) (1999-2002) primarily through secondary sources. With reference to Timor-Leste obtaining full independence in 2002, this chapter will then continue to utilize secondary sources to chart the early years of independence, including the development of its constitution, the geopolitical maneuvers by the Australian government to capture significant portions of its offshore oil reserves, and the state of various non-medical determinants of health.

It will then draw from Duffield's biopolitical critiques of the Global North neoliberal development/aid industry to contrast Cuba's bilateral approach to medical solidarity. This section

will re-engage familiar concepts such as institutional fragmentation, bunkerization, aid archipelagos, and contingent sovereignty to tease out differences between neoliberal charity and LASM dignity as well as between biopolitical palliation of surplus populations and south-south solidary capacitation efforts directed at insuring populations.

Primary research findings from the 2016 research trip will then be analyzed during my tenure as a research fellow at the National Centre for Scientific Investigation/*Centro Nacional de Investigação Científica* (CNIC) housed in *UNTL*'s Dili campus downtown. This will include reflections from the November 2016 g7+ meetings, as well as Global North outliers which sought to advance East Timorese capacitation *alongside* Cuba's LASM approach—not hierarchically *imposed upon*. A significant aspect of this section will involve reflections and interviews regarding criticism of Cuban-trained Timorese medical personnel as well as of the agreement itself.

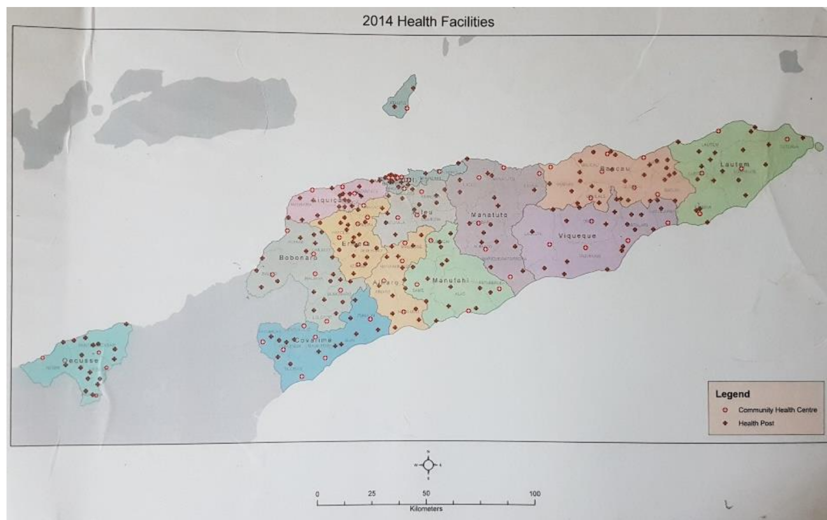
Lastly, this chapter will conclude with a few final thoughts as well as situate how Timor-Leste became a regional spark/rough blueprint for many other countries throughout the South Pacific that began to reach out to Cuba for help in meeting their healthcare/human capital needs. This particular aspect became the inspiration for a 2018 Global Affairs Canada (GAC) policy brief—titled, '*The Opportunities and Risks of Trilateral Development in an Era of Expanding South-South Cooperation: Canada's Role in a Multipolar World for Promoting Human Rights*—on the potential for triangular cooperation agreements. Thus, Global North countries are increasingly supplying material and financial resources in cooperation with Global South relationally-nearer human capital in order to advance public healthcare and education outcomes. An aspect that appears to remain underexplored.

Research Undertaken for This Chapter

Given the relatively small size of Timor-Leste, most primary research was based out of the capital, Dili, and involved (at times week-long) research trips throughout the country. Much like the Cuban-supported LASM medical education within Venezuela's *Misión Sucre* public education program, it was rapidly recognized that the only way to protect their population and ensure the longevity of Timor-Leste's health system was to develop a similar medical education program in Timor-Leste. Given the prohibitive cost and inconsistency of relying on external support/training, the goal was to ensure that capacity would grow based on the increase of local human capital to meet their own health needs in hopes to one day forego external charity and costs.

Two of the weeklong trips were to Atauro Island (situated 25 km due north of Dili), as well as the eastern region of Timor-Leste. These included tours of health centres in Lospalos (and surrounding Lautém area), Tatuala, Com, and Baucau. Additional research was conducted on shorter trips south and west of Dili at Gleno, Liquiçá, Alieu, Maubisse, and Hato Builico. Due to significant infrastructure challenges, especially the poor—albeit rapidly improving—state of roads, even the shortest research trips distance-wise would often involve significant travel time and logistics.

Figure 10: 2014 Map of Timor-Leste Health Facilities



Source: Author as given by the regional manager, 2016.

Observations and interviews were mainly conducted via snowball sampling included twelve Cuban healthcare personnel/teachers (in addition to a series of interviews with the Cuban Head of the Cooperation agreement and two focus group interviews in Gleno at the Cuban residence and the *Centro de Saude*), sixteen Cuban-trained East Timorese personnel (including three focus group discussions at *Klinika Vera Cruz* and *Centro de Saúde Formosa* in Dili, as well as the Hospital in Lospalos). Fifteen East Timorese patients were also interviewed alongside other tourists and Global North workers. All of these were often contrasted with observations and interviews of seven conventional healthcare workers and eighteen development personnel.

A series of interviews took place at *La'o Hamutuk* (the Timor-Leste Institute for Development Monitoring and Analysis) and the Bairo Pite Clinic (which housed the most comprehensive TB treatment centre in the country). Three days of interviews took place at the Guido Valadares National Hospital including some with Royal Australasian College of Surgeons (RACS) personnel and surrounding facilities in Dili (including the Psychosocial Recovery and

Development in East Timor known as PRADET). Eleven key policy personnel and academics were contacted via e-mail or phone to help situate the broader context of Timor-Leste's Cuban-supported healthcare and medical education system as well as the future direction of both programs.

As such, it was also an incredible research experience to be immersed in as well as in contact with Global North academics such as Helen Hill (1978; unpublished), David Webster (2016; 2017; 2020), Michael Leach (2008; 2013; 2017), Bob Boughton (2010, 2016, 2018; Boughton et al., 2013; Boughton & Durnan, 2014), Tim Anderson (2003, 2008, 2010a, 2010b, 2014). Charles Scheiner (researcher at the Dili-based *La'o Hamutuk* as well as supporter of the East Timor and Indonesia Action Network [ETAN]), and others whose work appears throughout this chapter.

This particular group of accomplished scholars and activists appeared to directly confront logics of neoliberalism and neocolonialism, often reflecting on deep historical and political economy considerations in their work, activism, and public engagement. Rather than reflect Global North hierarchical logics and knowledge production, throughout this research process, it was observed that this group was firmly on the side of the Timorese—often advocating for Timor-Leste's right to independence and welfare state control over national resources, industries, and public services rather than identifying with [neocolonial] aggressors of neoliberal knowledge- and policy-producing institutions such as the WB, IMF, and other corporate entities.

A History of Struggle for Self-Determination: From Colonialism to the Indonesian Genocide

"The East Timor story matters in its own right. It shows that there are no lost causes in international affairs and that power does not always determine the course of events."
(Webster, 2020, p. 210)

In terms of its colonial history, Timor-Leste was very much a Portuguese outpost while the Netherlands' rule over neighbouring Indonesia was comparatively more involved, developed more infrastructure and extractive capability (establishing the Dutch East India Company which would become a significant European power in its own right for nearly 200 years), as well as ended 25 years earlier than Timor-Leste in 1949 after a bitter, albeit brief, struggle.

On the eve of colonial independence following Portugal's Carnation Revolution on April 1974, overthrowing António Salazar's dictatorship, Timor-Leste was readying itself for full independence after 400 years of colonial rule which had left the country with limited infrastructure, services, and extractive capabilities. The Revolutionary Front for an Independent East Timor/*Frente Revolucionária de Timor-Leste Independente* (*FRETILIN*) began organizing in anticipation of a Timor-Leste free of colonial rule as noted in Helen Hill's landmark 1978 Masters thesis, *FRETILIN: The Origins, Ideologies and strategies of a Nationalist Movement in East Timor*. Reflecting on Helen Hill's seminal work, Leach highlights how the

> 'assertion of East Timorese culture' and 'nationalism of national unity' [were] primary themes of early *FRETILIN* nationalism. Two related economic themes of 'nationalism as economic advancement of Timorese peasants' and *'freedom from colonial or neocolonial economic control'* [emphasis added] were reflected in *FRETILIN's* earliest

> manifestations, which included positions on diversified agriculture over exports to improve diets, and matched by grassroots activities during the interregnum in power from August to December 1975, including Nicolau Lobato's cooperative projects in Bazartete, and Vicente 'Sahe' dos Reis training centre in Bucoli, and in new health clinics and vaccination programs. (Leach, 2017, p. 68)

Importantly, various projects like the literacy program in health clinics, would be "successful in attracting supporters to the party, and represent early examples of the state's role in nation-building: aiding identification with the emerging nation by demonstrating the way larger political communities could assist local villagers" (ibid.). Thus, both biopolitical and socioeconomic sovereignty as well as an independent public healthcare and public education system—by East Timorese and for East Timorese—were key elements of early nationalism and state building objectives.

Unfortunately, despite the "dual task of developing conventional 'third wave' nationalist ideas that expressed 'the right to self-determination' and 'opposition to Portuguese colonialism', while at the same time rejecting integration with Indonesia" (p. 69), other geopolitical plans were already in the works. On the event of East Timorese impending colonial independence, plans had been formulating amongst Indonesia's General Suharto and Global North allies—such as the US, Australia, New Zealand, the United Kingdom (UK), and Canada (whose intelligence services are known as the "Five Eyes" network as they often work together)—to formulate an Indonesian takeover of Timor-Leste nine days after Portugal withdrew.

Suharto and Friends: The Global North Gives the Green Light and Blind Eye to Genocide

> "*When [US Secretary of State and Nobel Peace Prize winner] Kissinger asked [Indonesian President] Suharto if he expected 'a long guerrilla war.' The dictator replied that there 'will probably be a small guerrilla war,' while making no promise about its duration. Bear in mind that Kissinger has already urged speed and dispatch upon Suharto. Adam Malik, Indonesia's foreign minister at the time, later conceded in public that between 50,000 and 80,000 Timorese civilians were killed in the first eighteen months of the occupation. These civilians were killed with American weapons, which Kissinger contrived to supply over Congressional protests, and their murders were covered up by American diplomacy, and the rapid rate of their murder was something that had been urged in so many words by an American Secretary of State*."
> (Hitchens, 2002)

The relationship between US Secretary of State, Henry Kissinger and Indonesian dictator, Suharto, would pave the wave for some of the most significant loss of life in the histories of both Indonesia and Timor-Leste. Suharto "came to power through the 1965–1966 elimination of the Communist Party of Indonesia (*Partai Komunis Indonesia-PKI*)" (Vann, 2015, p. 23), ruling as a "dictator, with US support, until 1998" (Bevins, 2017). He would oversee the "systematic extermination of up to a million Indonesians for affiliation with the [PKI] party, or simply for being accused of harboring leftist sympathies" (Bevins, 2017). His "New Order continued to use Red Scare tactics to justify corruption, human rights abuses, and unaccountability" (Vann, 2015, p. 23). During the 1965 mass murder of communists, sympathisers, and non-affiliated innocents, US declassified documents "confirmed that US authorities backed Suharto's purge" (Bevins, 2017). As these official US government documents evidence, "US officials knew most of [Suharto's] victims were entirely innocent [and that] US embassy officials even received updates on the executions and offered help to suppress media coverage" (ibid.).

Once Suharto felt he had sufficiently 'purged' his country of those who might have threatened his power (democratically or otherwise) or been critical of his rule, he would go on to

shift his focus to Timor-Leste, knowing that this tiny neighbouring country, sharing one of many islands in the South Pacific with Indonesia, was soon to gain its independence from Portugal. While Indonesia's Suharto was a devout 'anti-communist,' Cambodia's Khmer Rouge were explicitly communist. Yet both were backed by a morally flexible and opportunistic US foreign policy which allocated significant US military weapons/resources/logistics to help kill between one fifth and one third of both Cambodians and East Timorese (Oppenheimer, 2015; Vann, 2015; Bevins, 2017).

For Timor-Leste, occupation under Suharto's "one party political rule was characterized by terror and human rights violations, resulting in the death of 200,000 East Timorese (25% of the population), either killed or victims of starvation and disease" (Alonso & Brugha, 2006, p. 207). The unaccounted-for death from the next 25 years of structural violence and sites of large-scale massacres—many of which are still being uncovered (as most took place in rural areas outside the purview of media/other witnesses)—undoubtably puts that number closer to one-third of the East Timorese population (pers. comm, with East Timorese policy personnel and two academics specializing in Timor-Leste history, 2016).

The explicit violence incurred by Indonesian hard power would leave a considerable legacy. Additionally, Global North neoliberal soft power would also impact more subtle legacies of indirect structural violence in the years to follow, in both covert predation of resources and neoliberal approaches to development/aid. Thus, throughout this era, the Canadian government not only "remained silent while the Indonesian army was occupying East Timor by force," it also "'backed Indonesia in the realms of diplomacy, trade, and aid' and thus contributed to the occupation" (Webster, 2020, p. 21).

Malthusian Logic of the Neoliberal Development/Aid Industry

> *"At a time when the Indonesian military was forcing contraception on many young East Timorese women and girls, and when the military was slaughtering pro-independence East Timorese and organizing the 'transmigration' import of many Indonesian people, the World Bank was behind them. The World Bank had long financed birth control programs in developing countries, influenced by the old Malthusian view that poor people were poor because there were too many of them. So the Bank financed birth control programs in Indonesia. In 1990 President Suharto was even awarded the UN 'Population Prize' for effective birth control programs."*
> (T. Anderson, 2003, p. 174-175)

The above evaluation by Tim Anderson should come as a dire warning regarding the depths of dehumanizing neoliberal logic and its lack of consideration for Global South dignity and life. In many regions, especially those with an absence of welfare state securities and protections such as care homes, pensions, employment insurance, and public healthcare; children and grandchildren often become caretakers of their elders. As such, the impacts of a covert forced sterilization program's effect on the lives and livelihoods of East Timorese—when coupled with IMF and WB efforts to privatize as well as limit public services and securities—constitutes an egregious additional atrocity by these Global North institutions on those that had their opportunities to age with the love and support of children and grandchildren, taken from them. It also stands as another clear example of Global North institutional disavowal, whereby there is a clear acknowledgment of poverty and human rights abuses in Timor-Leste, without acknowledging Global North complicity and advancement of those abuses and poverty, instead absolving themselves through an ahistorical approach to capitalist 'development'.

Perhaps unsurprisingly, and as was the case with Indigenous peoples in Canada, sterilization programs and medical experiments created a deep distrust of colonizing healthcare

systems and bio-medical interventions such as vaccines, a challenge that was noted by Cuban medical personnel who sometimes struggled to advance health outcomes in the wake of this legacy. Imagine the incredible uproar if these genocidal neoliberal logics and policies, involving sterilization programs and medical experiments, were applied onto Canada or US relationally-nearer urban white and affluent populations without their consent?

Indonesia's transmigration policies were advanced as a way to relieve population pressures on the environment as well as to 'dilute' a geographically hostile East Timorese population who were against occupation and genocide. Thus, alongside other efforts to 'buy hearts and minds' of East Timorese through various subsidised services (which were largely absent as the furthest Portuguese colonial outpost), these multifaceted efforts by Suharto attempted to "make it look to outside critics as if it was promoting development" of an occupied population that had not given up on its resistance efforts despite the wave of Suharto-backed Indonesian migrants (Hill, unpublished, p. 4).

Therefore, transmigration at its very core was quite explicitly a tool of East Timorese dispossession and population management (especially as such a significant portion of the East Timorese population had been killed in the first five years).

> It involved the import of large numbers of Javanese and Balinese migrants, many of whom were given the land of East Timorese farmers. Other skilled migrants filled senior posts in East Timorese schools, hospitals and the public service. By 1984 as many as 400 'guided villages' for transmigrants (superseding resettlement areas) had been set up in East Timor, in areas able to be easily supervised and patrolled by the military, as part of a strategy to resist the growth of *FRETILIN* support. By the mid 1990s the East Timorese

population of 800,000 included about 150,000 Indonesian immigrants. (T. Anderson, 2003, p. 174).

In addition to forcing East Timorese families to three children, Suharto's military used deceptive recruitment strategies to lure East Timorese women into these sterilization programs under the guise of 'vaccinations' promoted as limiting the spread of disease/saving lives, often forcing injectable contraceptives (Depo Provera) on girls as early as high school (Hill, unpublished).

The population program, utilizing significant coercion and secrecy, recruited 60% of East Timorese in comparison to 20% of Indonesians—leaving a lasting legacy and changing East Timorese culture towards a serious mistrust of family planning, an understandable fear of biomedical interventions, and preferences for traditional Timorese healers (as was witnessed during 2016 research as well) (T. Anderson, 2003, p. 174; Hill, unpublished, p. 34). This context should be even more alarming given the need for vaccine uptake to reverse ever-mutating and increasingly-dangerous globally transmissible diseases such as COVID-19. Thus, East Timorese (as well as Canadian Indigenous populations) have a long history of tangible fear of such coordinated efforts by Global North institutions (both for-profit and governmental) which have operated to their detriment.

Thus, the aim and impact of "birth control, transmigration and repression were a coordinated strategy, intended to destroy the East Timorese identity—and the World Bank knew it" (T. Anderson, 2003, p. 174). Hence, 'family planning' under Suharto—with the backing and blessing of the WB/donor countries—was both coercive and, when combined with their programs of transmigration and massacre, constitute a large genocidal toolkit of East Timorese life. Incredulously, the WB—funded by Global North governments (largely from public

taxation) which are involved in the oversight the disbursement of such funds towards the biopolitical management of a Global South population—explicitly stated: "we believe that family planning projects are a suitable form of assistance in [Timor-Leste] . . . as they are capable of providing important economic and social benefits to all concerned" (p. 173-174).

Yet these relationally-distant global *financial* (emphasis added) institutions consistently position themselves as the biopolitical arbiters of Global South life while hardly dealing with the consequences, ramifications, or legalities of their direct and indirect measures. They somehow still receive significant funding from Canada, the US, and other Global North countries. In the case of Timor-Leste, while primarily being advocates of private foreign investment, the WB and its "associated donor countries, apparently saw themselves as best placed to decide what constituted 'best practice'" (p. 177). But, perhaps, it is because the relational familiarity of these racist neoliberal and neocolonial hierarchical policies by one population over another that they still appear content to do so while the relatively more egalitarian and humanistic approaches to Cuba's LASM solidarity appears foreign and worthy of embargos/sanctions to them.

In terms of Duffield's biopolitical work, this era soundly highlights the *paradox of liberalism* for both the development/aid industry as well as the Global North countries who are more interested in protecting their business 'rights' than the relationally distant 'human rights' of the Global South Other.

> NGOs have shown a tenacious ability to accommodate despotic rule as a necessary price of betterment. Development addresses the problem of surplus population through a liberal, educative trusteeship. It has no necessary association with either democracy or despotic rule and can be found in both. As a result, while decolonization provided an

> important opportunity for the internationalization of a liberal problematic of governance, development itself did not furnish a critical break with imperialism. (Duffield, 2007, p. 44-45)

However, while elements of the ahistorical and apolitical neoliberal development/aid industry would operate under this paradigm, many other deeply political counter-/non-hegemonic NGOs and civil society organizations such as ETAN, Canada Asian Working Group (CAWG), Oxfam, Amnesty International, and others stood with East Timorese throughout. These groups created significant pressure on Global North governments, disseminated information on the genocide, illuminated Global North hypocrisies/complicity, as well as documented the largescale atrocities Suharto enacted with Global North backing—especially after the 1991 Santa Cruz massacre was captured on film by Global North journalists, with US weapons on full display.

In 1998, Indonesia's economy collapsed. Significantly, "prior to the crisis, Indonesia had been Canada's biggest and fastest-growing export market to Southeast Asia" with "two way trade [reaching] $1.6 billion in 1997" (Webster, 2016, p. 189). As Indonesia's economy collapsed, bringing down trade with it, Canada's hesitation to address East Timor genocide/human rights abuses began to crumble. In addition to this, New Zealand, an important Commonwealth member and part of the 'official mind', also changed their narrative from irreversible to reversible (p. 189).

In the words of Audrey Samson in 1984, a member and co-founder of the Nova Scotia East Timor activist group (alongside her academic partner/activist, Bill Owen), "The occupation of East Timor is brutal and illegal. But I don't believe it is irreversible" (Webster, 2020, p. 66). As such, the mix of decreasing economic profit from the collapse of Indonesia's economy meant

that Global North corporations were not as interested in maintaining their privileged relationships, international pressure and public support for Timor-Leste was continuing to rise since the images of the 1991 Santa Cruz massacre sparked outrage, and the East Timorese counter-hegemonic resistance led by *FRETILIN*—which had never stopped their fight for biopolitical independence since its first taste of colonial liberation in 1975—was making it impossible for the geopolitical status quo to continue.

T. Anderson reflects on this period as well as the close relationship between a genocidal Indonesia and Global North governments and institutions:

> World Bank moneys intended for development purposes were diverted to the [Indonesian National Military/*Tentara Nasional Indonesia*] TNI -backed militias, which murdered and burned before and after the independence referendum in 1999. According to an Australian SBS [Special Broadcasting Service] investigation, the militias received at least A$ 12 million of World Bank moneys, as well as nine billion Rupiah of Indonesian Foreign Affairs money. Ben Fisher of the World Bank's Jakarta office is reported as saying that the Bank was aware of this diversion, but was unable to stop it 'short of stopping overall support' for the Jakarta regime. (T. Anderson, 2003, p. 175)

Suharto would resign from power in 1998 following a wave of protests and the economic collapse resultant from the 1997 Asian financial crises.

Under the new president Bacharuddin Habibie, despite originally being against an independent Timor-Leste, the East Timorese were eventually given the right to vote. However, after a resounding 78.5 percent majority vote for an independent Timor-Leste, the retreating Indonesian army alongside pro-Indonesian forces and militia in Timor-Leste conducted a

campaign of destruction, terrorism, and violence, killing over 2,600 people (Leach, 2017, p. 172), as well as "destroying 80 percent of the country's buildings, and forcing approximately 250,000 people to flee into West Timor" (Vann, 2015, p. 26). The defeated Indonesian army's 'Scorched Earth' operation targeted vitally important resources and structures. As such, "schools, hospitals, communications infrastructure and most public buildings were destroyed or severely damaged" (T. Anderson, 2003, p. 173).

Sergio Vieira de Mello (then UN Special Representative of the Secretary General) would reflect on the decimation faced by the East Timorese in December 1999 immediately after the campaign:

> The day East Timor won its right to independence was a day of great jubilation that quickly turned to one of the last nightmares of the 20th century. In September one thousand or more people were killed in East Timor. Three quarters of the population were driven from their homes. Most have now returned to find their possessions stolen and their life's work transformed to ashes. This country cannot produce enough food for itself . . . External trade has stopped . . . The country has some of the highest rates of tuberculosis, malaria and diarrhoea in the region, but there is no longer any health system. There are only twenty Timorese doctors for a population estimated at about 800,000. About half of the population is illiterate. Some teachers continue to teach but receive no salaries. Most of the technicians who ran public utilities, those who ensured there was electricity and running water, have left . . . Law and order rely largely on the goodwill of the inhabitants. There is no civil registration, no banking system, no official

> currency, no revenue system, not even an official language. We are starting from scratch. (de Mello, 1999, as cited in T. Anderson, 2003, p. 173)

Again, in contrast to the embargos and sanctions imposed by the US and allies on Cuba and Venezuela, Indonesia faced comparatively little repercussion for these actions as many of the worst atrocities were carried out with US weapons and resources as well as the documented backing of other Global North countries, particularly Canada and Australia.

Timor-Leste truly renders these selective Global North hypocrisies and disavowals bare. Canada, Australia, and other Global North countries would continue trade with Indonesia (albeit after a brief pause)—an internationally acknowledged human-rights abuser actively conducting genocide—place few disciplinary policies, freeze hardly any assets, use any other soft and hard power policy tools on Indonesia to the extent faced by Cuba and Venezuela, while denying their own Global North complicity in the advancement of these abuses. And yet, the explicit violence followed by extensive structural violence constituted one of the worst humanitarian crises in the world as this period in Timor-Leste remains as one of the worst genocides in the 20th century alongside Cambodia's—where more per capita lives were lost than nearly any other genocide.

The effects of the scorched earth campaign by Indonesia were not only immediately devastating but were still apparent during 2016 research as the destruction of this period was visible with much of the infrastructure—especially roads, bridges, buildings, as well as adequate drainage for flooding and sanitation—still appeared to be in need of repairs or complete reconstruction. In terms of healthcare capacity:

> Over 35% of health facilities were completely destroyed and more than 40% seriously damaged. Most physicians and senior management staff from central and district levels

> left the country and virtually all medical equipment and supplies were looted or destroyed. In the aftermath of the conflict, GDP declined by almost 40% and prices rose by around 200%. (Alonso & Brugha, 2006, p. 207)

Therefore, while the WB's "willingness to engage in 'free market' social engineering was justified by a notion that post-conflict East Timor was 'ground zero,' in development terms" (T. Anderson, 2003, p. 177), the WB, Canada, US, and other Global North allies helped furnish the 'ground zero' state of development in Timor-Leste—explicitly and implicitly profiting throughout. They would plan to use Timor-Leste's decimation as an excuse to push for neoliberal approaches to governance and development.

While the explicit violence incurred by Indonesian hard power would leave a legacy in Timor-Leste in the years to follow, Global North neoliberal soft power would also impact more subtle legacies of indirect structural violence, through both covert predation of resources and non-governmental approaches by the neoliberal development/aid industry. As such, this era remains an important part of Timorese history. Much of it extremely well-documented at the *Chega*! Exhibition in the Balide Prison in Dili—a must visit for anyone finding themselves in Dili seeking to understand the complex history of Timor-Leste.

Primary Research: Struggling to Confront Neoliberal and Neocolonial Logics in an Attempt to Embrace Subaltern Counter-Hegemonic Knowledge

Cuba provides an interesting contrast to hegemonic neoliberal Global North approaches to development by the World Bank, Canada, US, Australia, UK and others. In 2016, Dr. Juan Carlos Chaves Godoy (the National Coordinator of Cuban Doctors in Timor-Leste) shared

information, stating that 160 Cuban doctors were active in the country, serving in health centres across 12 municipalities. Since 2003, these doctors had treated around 13,000 patients, contributing significantly to saving lives and improving the health of the Timorese people. Dr. Godoy expressed pride in the doctors' ability to help and treat individuals in need (de Sousa, 2021).

Thus, between 2003 and 2021, over 1,000 Cuban doctors provided medical services in Timor-Leste, addressing a range of illnesses among the population (McLennan and Werle, 2023, p. 3). Reflective of many of the conversations with Timorese personal, the Timorese Vice Minister of Health shared the following sentiment during a brief conversation in 2016, "I would say that most of the improvements in the health outcomes of Timor-Leste are a result of the Cuban cooperation."

Timor-Leste's Prime Minister in 2021, Taur Matan Ruak, also praised Cuba's biopharmaceutical industry for its international award-winning products during a meeting with Cuban Ambassador Omar L. Marrero Betancourt. The discussion included updates on Cuban vaccine candidates and their potential. Marrero Betancourt also briefed the Prime Minister on the efforts of the Cuban Medical Brigade in Timor-Leste, emphasizing the commitment of Cuban health professionals to collaborate in the collective fight against the COVID-19 pandemic (Prensa Latina, 2021).

The missionary, mercenary, and misfit categorization of health and development workers who choose to work in rural, poor and marginalized areas provides a good starting point (albeit oversimplified) to assess their motivations. It should be noted that the intentions of health and development workers can be multiple, complex, intermixed and changeable. A key question then

became apparent: what is it that motivates a person to become a healthcare worker? Sometimes the quality of care and compassion (or *conciencia*, a duty to serve and treat patients as family and friends, as Cuban doctors are trained to) by the healthcare provider can be correlated to the intention that the healthcare provider is motivated by several questions:

- Does the person want to become a doctor because she is motivated by a lack of public healthcare in rural and poor areas like one respondent in rural Venezuela whose grandfather died due to an overwhelmed public healthcare system and a lack of ability to pay for private health services which had the resources to do the job, but care was predicated upon payment?
- Is it because healthcare provides a safe and steady job with steady income and job opportunities as some healthcare students have mentioned in Canada?

As such, when contrasting the (hegemonic) neoliberal development and healthcare industry with (counter-hegemonic) Cuban approaches, it is important to see differing cultures and logics manifest throughout the course of healthcare, health provider/patient interactions, development and implementation of policies, as well as the priorities placed on human capital, technology, health infrastructure, as well as cost allocation (private personal expense versus publicly funded).

By 2009, there were 845 undergraduate medical students registered, with 186 located at the "Medical School of [*UNTL*] (from year 1 to year 6), and 658 at various medical schools in Cuba (from year 1 to year 5)" (de Araújo, 2009, p. 1). In all cases the role of Cuban medical personnel is worth noting. The goal of the education process created in Timor-Leste has been summarized concisely:

> Timorese students have either been trained in Cuba or in small groups by Cuban physicians working at local hospitals and district health centres. Increasingly students from the region will be trained locally, instead of travelling to Cuba. Cuban medical personnel will also gradually withdraw, as the need for their cooperation decreases and their role as physicians and educators is filled by Timorese—who in turn will be able to use their Faculty of Medicine to train medical students from several South Pacific islands. The multiplier effect of medical personnel is thus the goal, with the intention of gradually reducing the number of Cubans as local practitioners fill the vacuum. (Kirk 2012, p. 82-83)

It is also important to highlight the decentralized version of the Timorese medical education system since all 13 districts of Timor-Leste have District Team Lecturers with training locations onsite.

The Coordinator, who oversees 13 districts, reports directly to the Dean of the *UNTL* medical school. In 2009 there were "78 certified lecturers distributed throughout the 13 teams, and 146 medical doctors, nurses and health technicians holding a certificate in pedagogy, who are also part of the district teams" (de Araújo 2009, p. 1). Thus, medical coverage for previously underserviced areas is implemented throughout the country instead of reinforcing a system that perpetuates the emigration of physicians, costs a substantial amount of resources, and uses technology which is often rendered ineffective in areas with limited access to reliable electricity.

Part of the challenge facing medical authorities in Timor Leste is resolving the differences between the public sector Cuban-trained doctors and those from earlier medical training programs that emphasize private practice. Besides working at hospitals performing

functions at outpatient and inpatient settings, the Basic General Doctors are "prepared to work at the facilities of the national health system and, particularly those of primary care such as health posts and villages, health centres at sub-districts and districts, which are the main venues to provide comprehensive health services" (de Araújo, 2009, p. 2).

In T. Anderson's article, he highlights an analysis from one of the first graduates of the Cuban-Timor-Leste medical program—Ildefonso Da Costa Nunes. Da Costa Nunes explains that medical practitioners from the traditional system:

> don't want to work in the sub-districts, they all go to private clinics ... but we can't think just of money, but rather how we can develop this country … those [patients] who go to a private clinic have money, and those who don't have money have to go to the public system … there has to be a balance between the private clinics and the public health system … we eighteen, we're going to do a project … which is social, which is human for this country. (T. Anderson 2010b, p. 187)

Thus, the medical personnel trained in traditional capitalist models find the challenges of working in rural areas or with impoverished populations hard to bear and prefer working in more lucrative and comfortable urban and affluent locations.

Thus, much like Cuba and Venezuela's counter-hegemonic approaches to healthcare, education, and alternative modes of non-financialized flows of trade seen in *ALBA*—seen as especially alarming by the Global North as it was powered by the social returns primarily based upon the nationalization of various resources and industries—Cuba's counter-hegemonic alternative model spread throughout the South Pacific following the original agreement with Timor-Leste.

Following Cuban involvement in Timor-Leste, representatives of south and western Pacific countries began "negotiations with the Cuban government to host Cuban doctors as clinicians and trainers and send students to *ELAM* to become doctors" (McIver et al. 2020, p. 2). Timor-Leste originally sent nearly "700 students to *ELAM* in 2003-2004, followed by—in cohorts ranging in size from 3 to 25—Kiribati in 2007, Solomon Islands and Vanuatu in 2008, Tonga and Tuvalu in 2009 and Fiji in 2010" (ibid.). However, despite hearing that training for other Pacific Island nations was taking place at the Cuban-supported medical education program in Dili, it was simply not the case—no other nationals were representative in the programs and, as such, the program did not appear to function as a third '*ELAM* of the Pacific'.

Importantly, none of the Cuban-supported clinics in Timor-Leste became politicised along party lines or contained significant Cuban or Timorese political party images, as was the case in Venezuela. Prominent figures such as Jose Ramos Horta and Xanana Gusmão, as well as Zacarias da Costa from the Social Democratic Party/*Partido Social Democrata* (*PSD*), Fernando 'Lasama' Araujo from the Democratic Party/*Partido Democrático* (*PD*), and Mari Alkatiri from *FRETILIN* had all publicly praised Cuban generosity and the significant impact their doctors have had on Timorese healthcare.

This might be because, unlike the parallel healthcare system in Venezuela, Cuba had basically helped create Timor-Leste's entire public primary care system instead of helping create a parallel system alongside a conventional system (as was the case in Venezuela). Additional support of the public health system in Timor-Leste at curative/specialist levels of care were primarily conducted RACS, NGOs such as the Psychosocial Recovery and Development in East

Timor (PRADET), as well as other international medical arrangements whereby tertiary and quaternary complex care were handled in neighbouring countries.

In 2011, Richard Marles, who was then the Parliamentary Secretary for the Pacific in the Australian Government, visited Cuba and entered into an agreement with the Cuban Ministry of Health to collaborate on health programs in Timor-Leste and the Pacific region (McDonald, 2011; Hill, unpublished, p. 30). Thus, unlike in Venezuela, where political polarization and the politicization of *MBA* facilities made Cuban cooperation politically divisive (arguable partially due to the two-party dynamic there), the politicization of Cuban involvement was simply not found among Timorese political parties (due to a comparatively healthier multi-party democracy and comparative lack of socio-political polarization than Venezuela). Rather, friction about Cuban involvement was mostly witnessed in the geopolitical wrangling found between Global North development and healthcare personnel with those who supported Cuban cooperation. Thus, not every donor country to Timor-Leste was in favour of Cuban cooperation despite appearances all East Timorese political factions were.

In research conducted by Australian academic Michael Leach, he found that reducing the rates of infant and child deaths necessitates a variety of approaches, including enhancing education (especially in the fields of science and nutrition) for girls, improving transportation systems for patients to reach hospitals and for healthcare professionals to assist in childbirth, and upgrading the training of local staff. Leach noted in 2008/9 that a recent assessment of a program revealed that in regions where Cuban doctors were active, the child mortality rate had dropped to 27.5 per 1000 live births, which is over 50% lower than in other parts of the country. There had also been a significant reduction in maternal mortality in areas where Cuban medical teams

operated (Leach as cited in Hill, unpublished, p. 27). Impressively, in a relatively short time after the agreement was established in 2002 the "infant mortality ratio was 60 per 1000 live births in 2000 but it had dropped to 46 by 2009. Child (under 5) mortality at 83 deaths per 1,000 in 2000 had dropped to 64 by 2009" (Hill, unpublished, p. 27).

Most medical training typically took place on the campus in Dili. Some training took place in the district hospitals and an even smaller amount received training at the local clinics. The graduates emerge from a curriculum that emphasizes "responsibility to society, critical thinking, flexibility and openness to knowledge exchange, quality with equity, long life education" (de Araújo 2009, p. 4). Thus, the teaching and learning processes are based on the approach of "'learning how to learn', creativity, innovation and solidarity with the changes and transformations in scientific knowledge, research, social insertion, inter- and trans-discipline thinking, inter-relation and inter-dependence with other professions, and education on good and productive citizenship" (de Araújo 2009, p. 4).

In a conversation with a researcher at *UNTL* on December 14, 2016, Dr. JM shared insights into the medical curriculum and its implementation in Timor-Leste. He noted that since the inception of the agreement, the curriculum had remained largely unchanged, with modifications primarily in basic diagnoses as new knowledge emerged. Timor-Leste was granted a 10% flexibility to adapt the Cuban curriculum to the local context. The curriculum includes a course on healthcare ethics and religion, replacing the 'citizens consciousness' course found in the Venezuelan first-year curriculum. As was the case in Venezuela, graduates in Timor-Leste are required to develop a final thesis on a public health plan addressing a specific health issue.

The engagement with healthcare professionals was robust from the outset, with each student mentored by one Timorese and one foreign professional. A sector-wide approach was implemented from the start, ensuring comprehensive coverage of healthcare delivery. Despite criticisms and acknowledged weaknesses in the system, Martins praised the Cubans for their patient-centred approach and their responsiveness to feedback. He noted that while some had criticized the Timorese graduates as being weak, there were plans in place for continuous training and upgrading of the doctors.

Improvements have been made in post-graduate training collaboration, although issues with the Minister of Education were noted. Remarkably, 90% of East Timorese specialists from the RACS are Cuban-trained graduates. Currently, two students are specializing, demonstrating the team-oriented approach of the program. Cuba was identified as the only country capable of meeting the scale of healthcare personnel needs in a short time. Despite collaborations with many countries, Cuba's human resources were uniquely suited to address the significant shortage of healthcare personnel.

The selection of medical students is managed by the Ministry of Education and has become increasingly competitive due to the decreasing availability of medical positions. This is a result of extensive training programs that have been conducted. Graduates are selected based on their high school grades, and with the reduced need for medical graduates, only 40 are being trained per year. All medical students conduct home visits and censuses, with each family receiving a visit from a doctor once a year. New graduates are required to complete 1-4 years of rural rotations. As health needs are being met, these postings are becoming increasingly permanent. If a student's grades are not high enough to qualify for the physician program, they

can be transferred to another health worker program. Bio-psycho-social learning is emphasized as an important aspect of their healthcare training.

Future plans include more training in human resources, particularly specialization, to strengthen the healthcare system to the point where patients no longer need to be sent abroad for treatment. Most of the training takes place at universities in Dili, with some also occurring in district hospitals and community health centres. These centres range from small groups of health workers to mini-hospitals staffed with doctors, nurses, midwives, and pediatric specialists. Not all villages had been able to secure a doctor yet, with some doctors reluctant to go due to access issues, lack of community connections, and remoteness. Private care is predominantly provided by Indonesian-trained doctors, who make up a small portion of the doctor population. Private pharmacies are typically run by Indonesians, Indonesian-trained Timorese, and Chinese. Charity and NGO health clinics and pharmacies also contribute to the healthcare landscape.

Professor of Nursing at *UNTL*, JP, expressed his belief that the Cuban training and agreement had been highly beneficial for Timor-Leste. He further asserted that the Cuban medical cooperation had significantly contributed to the positive health outcomes in the country. Despite conflicting accounts, he clarified that no Cubans taught in the school of nursing or midwifery.

Reflecting on these insights, it is evident that access to psycho-social healing, such as psychological services, is often skewed towards those with higher income. In Canada, for instance, the most vulnerable and economically disadvantaged individuals, who arguably need psychological healing the most, are often the furthest removed from these services due to geographical and socio-economic barriers. This observation underscores the importance of a bio-

psycho-social approach to healthcare. Most Timorese appear satisfied with the quality of care and training provided by the Cuban medical personnel and are generally content with the details of the agreement. The primary complaint, predominantly from foreigners, is the language barrier, as the Cubans often do not speak the local language or Portuguese.

Despite criticisms of the training and cooperation agreement during the 2016 research trip, it appears to have had a significant impact on the areas it targeted for improvement. As noted by Leach (2008), one specific objective of the cooperation agreement in Timor-Leste was the reduction of maternal and child mortality rates, especially in rural areas. A recent program evaluation found that in areas where Cuban doctors worked, child mortality was 27.5 per 1000, a figure more than 50 per cent lower than elsewhere in the country. Maternal mortality had also steeply declined in these areas.

In both Timor-Leste and Cuba, there were age restrictions in place for those wishing to pursue a career in medicine. In Timor-Leste, the maximum age to begin studying medicine is 25 years old, while in Cuba, it was 24 years old. These restrictions may be a result of the tuition-free education provided by the government, which could be an attempt to maximize the return on the tax dollars spent on education. However, it is important to note that these age limits may inadvertently exclude individuals who choose to pursue a medical career later in life. This raises the question of whether the opportunity to become a doctor should be universally accessible, regardless of age. Personally, I am of the belief that anyone should have the opportunity to become a doctor at any point in their lives, reflecting the diverse paths and timelines that individuals may take in their pursuit of a career in medicine and passion to help others.

The Cuban doctors were continually reinforced each academic year with 64 Timorese doctors trained by Cuban professors graduating in 2010-2011, 501 in 2011-2012, 245 in 2012-2013, "and 17 in 2013–2014, with an average of 50 students being admitted in each subsequent year" (Kirk, 2012, p. 83). Essentially, Timor-Leste will have 17 times the number of doctors it had in 2002—a truly remarkable achievement in such a relatively short time. Graduates of the *UNTL* Medical School are called *Médico Geral Básico (MGB)*/Basic General Doctors upon graduation. These new medical professionals were expected to have:

> skills in diagnostics and therapeutics, able to provide comprehensive medical services through promotional, preventive, curative and rehabilitative interventions on individuals, families, communities and their living environment, by applying clinical and epidemiologic methods, with a profound social focus, embedded in ethical and humanistic values, solidarity and good citizenship, called upon to transform the health situation in accordance with the expectations of the society. (de Araújo, 2009, p. 2)

Various conversations in 2016 with Dr. Tony, Chief of the Cuban Medical Brigade, also helped situate the research program and four levels of care in Timor-Leste.[203]

First Primary Care Level:

1. *Puestos Medicos* (First Contact Primary Care Clinics): These clinics operate at the Suco-level of government administration and involved these medical personnel:

[203] Interestingly, Dr. Tony had spent 8.5 years—from April 2003 to February 2011—working in Venezuela. He was the head of the *CDI* Salvador Allende in Caracas for 7 years while there.

- *Parteras* (Midwives): These skilled professionals play a crucial role in maternal and child health. They provide care during pregnancy, childbirth, and postpartum.
- *Enfermeros* (Nurses): Nurses are essential for general patient care, health education, and administering treatments.
- *Medicos Timorenses* (Cuban-Trained Timorese Doctors): These doctors, trained in Cuba, contribute to primary healthcare services.

2. *Centros de Salud Municipal* (Municipal Healthcare Centres): These centres are also considered part of the primary care level. and involved these medical personnel.

- *Parteras* (Midwives): As before, midwives continue to provide valuable maternal and child health services.
- *Enfermeros* (Nurses): Nurses remain essential for overall patient care.
- *Medicos Timorenses* (Cuban-Trained Timorese Doctors): These doctors contribute expertise to primary healthcare.
- *Medico especialistas de Cubano* (Cuban Medical Specialists): These specialized Cuban doctors enhance the range of services available.

Secondary Public Healthcare Level: Hospitalies Referales (Referral Hospitals)

Facilities and Services Provided:

- *Salon Operative* (Operation Theatre): Where surgical procedures take place.
- *Laboratorio* (Laboratory): Staffed by Cubanos, this lab handles blood work and other diagnostic tests.
- *Rx* (X-ray): Provides radiographic imaging.
- *V-Sonado* (Ultrasound): Used for diagnostic imaging.

- *Salas de Hospitalizacion* (Hospitalization Rooms): These rooms accommodate patients during their stay.

Healthcare Professionals Involved:

- *Parteras* (Midwives): Known for their expertise in maternal and child health.
- *Enfermeros* (Nurses): Essential for general patient care and health education.
- *Medicos Timorenses* (Cuban-Trained Timorese Doctors): Contribute to primary healthcare services.
- *Medico Especialistas de Cubano* (Cuban Medical Specialists): Provide specialized medical knowledge.
- *Cirujano* (Surgeon): Performs surgical procedures.
- *Oncólogo* (Oncologist): Specializes in cancer treatment.
- *Ortopédico Especialista* (Orthopedic Surgeon): Deals with musculoskeletal issues.
- *Anestesista* (Anesthetist): Administers anesthesia during surgeries.
- *Pediatra Especialista* (Pediatric Specialist): Focuses on children's health.

These Referral Hospitals were found in several cities across East Timor: Suai (serves as the capital of the Cova Lima District in the southwest of the country); Maubisse (a historic town situated in the hills, approximately 70 kilometers south of Dili); Baucau (the second-largest city in East Timor, located 122 kilometers east of Dili which serves as the capital of the Baucau District in the eastern part of the country); Oecusse/Pante Macassar (located on the north coast of East Timor and is the capital of the Oecusse exclave); and Maliana (a city in East Timor, situated 149 kilometers southwest of Dili).

Third Public Healthcare Level: *El Hospital Nacional Guido Valadares* (Guido Valadares National Hospital) situated in Culu Hun, on the eastern edge of Dili.

- Originally founded in 1982 by the Indonesian administration of East Timor, it was initially known as *Rumah Sakit Umum Pusat Dili* (translated as Dili Central General Hospital). During the 1999 crisis that led to East Timorese independence, the hospital was managed by the International Committee of the Red Cross (ICRC) until 2003. After the handover, it was officially renamed after Guido Valadares, a former member of the *FRETILIN* National Committee and Vice-Minister of Labor and Social Welfare in the Council of Ministers formed by *FRETILIN* in 1975.

Fourth Public Healthcare Level: *Junta Médica*

- *Junta Médica* is responsible for sending patients abroad for healthcare when the local healthcare system cannot handle their needs.
- Most cases are referred to Indonesia, Malaysia, and sometimes Singapore (with some going to Australia).
- Specialization: Malaysia often handles heart patients.
- Family Support: The government covers the cost for two family members to accompany the patient.
- Decision-Making: The *Junta Médica* determines which patients require overseas treatment.

In terms of specifics regarding Cuban cooperation, as of 12 November 2016, Dr. Tony provided the following details in an interview: 901 Timorese graduates had been trained in Cuba

as general medical doctors. These graduates were part of a bilateral program of medical cooperation between Cuba and Timor-Leste, which began in 2003 and helped address the shortage of medical professionals in Timor-Leste. There were approximately 30 Cuban medical specialists out of the 160 Cuban medical professionals in Timor-Leste in 2016. These specialists played a crucial role in providing specialized medical care to the population.

Dili

In 2016, I was able to spend time with some of the Cuba-trained personnel in both Dili and rural areas in order to understand the contributions they made as well as challenges they faced. Dr. JDJV, for example, a 32-year-old Cuban-trained Timorese doctor, had been serving the community at the Farmosa clinic in Dili. Despite the absence of permanent social workers in the clinic, they benefited from the support of international volunteers, such as Mr. J from Japan. Dr. JDJV's journey into medicine was not straightforward. Prior to his medical training, he spent four years studying agriculture at the *Fundação das Universidades Portuguesas* in Timor. He lived in his home region of Los Palos until 1996, a place that, at the time, had only one nurse, one midwife, and one hospital. For surgical procedures, residents had to travel to Dili.

Dr. JDJV's vision for healthcare was rooted in prevention and education. He believed in the importance of proactive activities that encourage the population to participate and take responsibility for their health. He emphasized the need for more health awareness in primary schools and views patients as bio-psycho-social beings. He also acknowledged the significant role of stress as a risk factor for perpetuating sickness.

Throughout his career, Dr. JDJV had worked with 2-3 Cuban doctors. He had observed a shift in the perception of Cubans from 2004 to 2016. Initially, there was a negative view of Cubans due to their communist background. However, with the return of Cuban-trained Timorese, including family members like uncles and sisters, the mentality had changed, and people had become much more positive about Cuban involvement. Dr. JDJV aspired to continue his studies and specialize in pediatrics. He also hoped to return to Los Palos in the future. His ultimate vision is for every community to have access to a doctor, a nurse, and a midwife, ensuring continuity of care.

On December 2, 2016, Dr. JL, a Cuban-trained Timorese doctor, was working at the Farmosa Clinic. A native of Atuaro, he graduated in 2012 and was one of six permanent Cuban-trained Timorese doctors in Atuaro. His colleagues include Dr. J1 (graduated in 2013), Dr. D1 (2012), Dr. Z (2013), Dr. J2 (2012, originally from Baucau), Dr. M (2012), and Dr. D2 (2012). Before the medical cooperation with Cuba, Atuaro had no doctors, only midwives and nurses, many of whom were still serving the community. The Ministry of Health did not place many conditions on Dr. JL, who is currently unsure about specializing, citing the high costs associated with private healthcare.

Dr. JL explained that the structure of the health system in Timor-Leste is hierarchical, starting from the local health post (*posto de saude*), progressing to the health centre (*centro de saude*), district hospital (*hospital distrital*), referral hospital (*hospital referral*), and finally, the national hospital. Training only took place at the referral and national hospital levels, which had medical specialists. District hospitals, on the other hand, lacked training programs, specialists, and sufficient resources or equipment to attend to patients.

Dr. JL was currently dealing with several health issues in his community, including respiratory infections, scabies (especially prevalent in Dili when there is no rain), allergies caused by dust, and diarrhea that comes with the rainy season. He believed there was a strong relationship between Timor-Leste and Cuba and appreciated the comprehensive support they received at the beginning of the cooperation. He noted that in the districts, people tended to seek out Cuban doctors over those from Indonesia. Dr. JL acknowledged the quality of medical training in Cuba, which had enabled direct access to doctors in the district, a service that was scarce before Cuban cooperation. He also recognized that good doctors are produced through training in Fiji, Indonesia, and Australia, but points out that these programs focused more on treatment rather than preventive or proactive health.

During research, I had the opportunity to converse with Dr. D1, a Timorese doctor who underwent rigorous medical training in Cuba before returning to his home country. After a full day of work at a public clinic, he also offered his services at a private Portuguese clinic. Dr. D1's journey began with a five-year and seven-month stint in Cuba, where he spent his first year studying alongside students from around the globe at the main campus. His subsequent four years were spent at different Cuban campuses, where he trained alongside other Timorese and regional counterparts from countries such as Kiribati, Palau, Tuvalu, Vanuatu, among others. His final year of training was completed in Timor-Leste, where he undertook rotations at Referral Hospitals in the municipalities of Baucau, Maubisse, Suai, Maliana, and Ocuesse.

Upon graduation, new doctors were required to serve in rural areas for a period of 2-4 years. The Cuban portion of the training concluded in 2007, shifting entirely to the *UNTL* campus in Dili. With the program now fully based in Timor-Leste, students commence their

clinical rotations at Referral Hospitals. After 4 or 5 years of general practice, students had the option to specialize. Dr. D1's first professional assignment was at the Bairro Pite Clinic in 2012, where he worked for one year and six months. He then worked full-time at a government public health clinic in the Colmera district, Dili, and part-time at a private Portuguese clinic. All Cuban-supported medical training in Timor-Leste was conducted through the faculty of medicine at *UNTL*.

Admission to the program was competitive, with students from both urban and rural areas vying for the opportunity to pursue a medical degree in Cuba. Dr. D1 believed that the training level of the Cuban program was on par with conventional medical programs, but with a greater emphasis on prevention and *conciencia*—a term he defined as "treating colleagues and patients like family, leading with the heart rather than the wallet." The education of Dr. D1 and his peers was entirely free, allowing them to graduate without any debt. This reflected Timor-Leste's vision of healthcare as a human right that should be freely accessible to all. As part of his duties, Dr. D1 conducted home visits at least once a year.

While no Cuban-trained doctors owned private clinics, some, like Dr. D1, worked part-time in other private clinics in addition to their full-time government/public health work. Dr. D1 felt that Timor-Leste needed the assistance of NGOs, even if they weren't capacitating locals, due to the lack of many services. He emphasized the importance of cooperation between all healthcare providers, whether they are NGOs, public, or private. However, he also acknowledged the presence of corruption, even between NGOs and the government.

Dr. M1, a Cuban-trained Timorese doctor who worked at the Vera Cruz community health clinic in Dili, alongside her colleagues Dr. D1 and Dr. M2., Dr. M1 hails from Lospalos,

where her parents resided. Despite her roots, she expressed no intention of returning there to work. Dr. M1 graduated in 2012, having spent 6.5 months learning Spanish as part of her education. Her work at the Vera Cruz clinic was part of a larger network of four community health clinics in Dili, which also included Farmosa, Becora, and Comoro. These health centres bore a striking resemblance to Venezuelan *CDIs* in their structure and function.

Interestingly, these health centres were devoid of any political alignment or imagery of political leaders or parties. The staff at these centres comprised a diverse range of healthcare professionals, including nurses, midwives (or *'parteras'*), pharmacists, and general medical doctors. Additionally, there were four lab technicians who handled blood work. However, physiotherapy services were not available at these centres and were instead located in the national hospital.

A noteworthy point from Dr. M1's interview was the presence of Cuban specialists at the health centres. However, all specialist medical training was conducted by other countries, such as Australia. Cuba had not yet begun to provide specialist training but at the time of research, plans were in place for Cubans to start providing specialist medical training for the domestic population at *UNTL*.

Dr. M2, like Dr. M1, is a Cuban-trained Timorese doctor who graduated in 2012. She shared Dr. M1's observations about the seasonal increase in certain diseases. According to Dr. M2, the rainy season sees a surge in cases of dengue, malaria, and diarrhea. TB is a major condition treated at the community clinic, particularly given the high poverty levels among the patient population. In response to this, the Ministry of Health had launched a special initiative targeted at eradicating TB. This initiative also targeted other diseases such as malaria.

Patients had noted a significant difference in waiting times between private and public clinics. This was an important consideration for many, given the potential impact on their health and well-being. Furthermore, the hands-on nature of Cuban medical training, as experienced by doctors like Dr. M1 and Dr. M2, was a noteworthy aspect of the healthcare provision at these clinics. This approach to medical education, which emphasized practical experience and patient interaction, was a defining characteristic of the Cuban-trained doctors working in Timor-Leste.

Eastern Region/Los Palos

The primary objective of this research trip was to identify one of the last sucos that was yet to have a Cuban doctor or Timorese medical graduate stationed. This goal aligns with one of the first tenets of the bilateral agreement between Cuba and Timor-Leste, which, as outlined before, stipulates the placement of a doctor in every suco. The research successfully identified such a suco outside of Lospalos, underscoring the widespread implementation of the agreement in other areas. Dr. JM from *UNTL* highlighted a challenge that some people did not feel connected to the most rural communities. These communities were often difficult to access, which may contribute to the disconnect.

This section of the dissertation focuses on the experiences and observations of two Cuban doctors, Dra. V and Dr. F, who had been working in Timor-Leste. Dra. V has had diverse experiences, having worked in Venezuela from 2003-2007 and 2011-2013, and in Cuba between 2007 and 2011. She had been stationed in Timor-Leste since 2014, spending one year in Viqueque and the current one in Los Palos. Dr. F, on the other hand, had been in Timor-Leste for a year.

Both doctors noted that Dili, the most developed part of Timor-Leste, was like a different world within the country. It was where most NGOs, programs, resources, and development took place. Prior to Cuban cooperation, there were no doctors in Los Palos. However, were nine East Timorese doctors in Los Palos and general medical doctors in most sucos around Timor-Leste at the time of research. The suco in the Los Palos area, that was one of the only clinics in the country without a staffed doctor at that time, relied on a midwife and nurse team.

The doctors identified several difficulties in providing care, including cultural differences and language barriers. Some people in certain Sucos only spoke a very local-specific dialect, making it hard for any medical personnel from any background to provide care. Health issues such as TB, thyroid issues from not consuming enough salt, and dental problems from not enough calcium and milk were prevalent. The hospital in Los Palos was not a 'referral' hospital, but a regular one. Despite having a room labeled "medical student room," there were no students at this hospital. The doctors emphasized a bio-psycho-social approach to patient care, recognizing that a patient's disease or illness or injury cannot be separated from other psycho-social, structural or systemic challenges that may also affect their health. A place like Los Palos had many impacts on a person's health that needed to be addressed, often simultaneously or even outside of hospital settings.

The doctors stressed that health problems can be at the community level and impact health, like no clean water to drink or cook with, poor access to a balanced diet, no electricity to read by or provide light to be safe by, etc. The doctors were required to do house visits, especially if patients had access issues. Every person in their community was required to have a check-up. They often had to contact the municipality to improve the health of certain

populations. For instance, at the market, older people suffered from access issues. There was no place to wash hands, and food was being contaminated by being washed from a contaminated water source.

Ambulances were used to move patients needing more complex care than the local hospital can manage on to Baucau. If Baucau did not have the ability, then another ambulance would move them on to Dili for treatment. The doctors stressed that it was important that a health system was based on geographic access, not just socio-economic access. All cataract surgeries were performed in Dili, while the local ophthalmologist handled minor procedures. The polyclinic catered to adults, while the Integrated Management of Childhood Illness program focused on children's health.

In the town of Los Palos, there was a single private clinic run by a doctor from the US. This clinic operated independently, with neither hostility nor collaboration with the local public healthcare system. The healthcare landscape in Los Palos was characterized by a pressing need for more general medical doctors to adequately cover the entire area. Once this need is met, the training can shift towards specialist training. Most of the specialist training took place in Indonesia, Fiji, and Australia. The unique challenges of working in Timor-Leste included navigating roads often occupied by animals, including dogs that frequently choose to rest in the middle of the road. Despite these challenges, healthcare workers reported enjoying the peace, quiet, and relaxation that comes with working in Timor-Leste.

Graduates from Cuba, Venezuela, and Timor-Leste all demonstrated a deep understanding of the importance of SDOH, a testament to the effectiveness of their training. However, the high number of impoverished people presented a serious challenge. Strengthening

the healthcare system will involve not only improving medical services but also ensuring that people can afford basic necessities such as good food, shelter, and sanitation.

The relationship between the Timorese and Cubans in Los Palos was generally positive. Significant strides had been made in disease control, with hardly any cases of malaria or dengue reported anymore. This success could be attributed to a strong focus on control measures and medicine, which had substantially lowered the rate of infection. Vaccines, which are mostly sourced from India and some from Pakistan, played a crucial role in this achievement. However, there were no Cuban pharmaceuticals available in the area.

The main critique of the healthcare system was the need for continued growth and expansion of the program. Access issues and a lack of specialists were significant barriers to improving health outcomes. Diabetes was not a significant issue in Los Palos, but there was a considerable problem with domestic abuse. Healthcare workers tried to educate patients about the dangers of alcohol consumption and alcoholism.

A tour of the local hospital revealed a diverse team of healthcare professionals, including midwives, nurses (with one focusing on mental health), general medical doctors, a nutritionist, an ophthalmologist, a dentist, a pharmacist, a lab technician, and a blood lab analyst. All medications were provided free of charge, further demonstrating the commitment to improving public health in Los Palos. However, it should be noted that their Japanese-donated x-ray machine was broken and getting the parts for repair was very difficult. Dr. FDPM, a 29-year-old native of Los Palos, had been practicing medicine in his hometown for four years since graduating in 2012. Similarly, Dr. AL, another Los Palos native, also graduated in the same year.

Most of the nurses in Los Palos had received their education from Timor-Leste, Indonesia, and Fiji. To date, the town had seen 54 General Medical Doctors graduate. These healthcare professionals made a commitment at the beginning of their education to practice medicine in any Suco (village) necessary. However, the rainy season poses a significant challenge, making access from Los Palos to Lori or Malahara nearly impossible. Despite these challenges, Lori housed a nurse and midwife, as well as had a doctor and nurse team located in nearby Lori II. Similarly, Malahara had a doctor and nurse team located at nearby Muapitme.

The research interviews conducted on 3rd December 2016, at the clinic in Tatuala, one of the furthest East towns in Timor-Leste, provided valuable insights into the healthcare landscape of the region. The clinic, run by nurse SPM, was staffed by three individuals at the time of the interview. Unfortunately, Dr. VG was away on a house call, leaving nurse SPM and assistant nurse AB to manage the clinic. Both nurse SPM and assistant nurse AB were graduates from Indonesia, bringing international experience to their roles. Nurse SPM had a commendable tenure of 24 years in nursing, having graduated in 1987. His experience included 6 years at the Tatuala clinic and 8 years at Cantes Mehara.

The presence of doctors in the region had been consistent since an unspecified agreement, with a few doctors from the WHO serving before that. However, it was noted that there were no doctors in the region prior to these WHO doctors. The primary health issues faced by the local population were respiratory in nature, with asthma and TB being the most prevalent. This information was crucial in understanding the healthcare needs of the region and planning appropriate interventions.

Atauro Island

Atauro, an island under the administrative jurisdiction of the capital city, Dili, is divided into five sucos. Much of the research conducted on the island was centred in Vila, with frequent excursions to Makili (alternatively spelled Maquili) and Beloi. A significant aspect of the research was the interaction with the residents of Atauro. On December 10, 2016, an interview was conducted with Jose and his family from Makili. As patients who had experienced the healthcare system in their village, they expressed a high level of satisfaction with the care they received, particularly noting the impact of the Cuban medical collaboration.

They appreciated the presence of doctors and health professionals from their own village and surrounding area, which they felt had brought a sense of familiarity and trust into the healthcare environment. This local representation in the healthcare workforce was seen as a positive development, fostering a stronger connection between healthcare providers and the community they serve. He emphasized the importance of this development, stating, "It means a lot for people to have grown up with or for us who have seen them grow up into adults, become the doctors for us."

Jose also highlighted the convenience and reassurance of having a doctor whom everyone knows. He noted that the presence of these new doctors and health centres in Makili had significantly improved the community's access to healthcare. "No matter what time of day or night we can always call if we need help," he said. Looking to the future, Jose expressed his anticipation for the construction of new health facilities. He acknowledged that the current facilities were not up to standard but remained optimistic about the imminent improvements. "I think it will benefit the community a lot," he stated. Finally, Jose commended the quality of

medical training provided to the new doctors. He observed that many people in the community had sought help from these doctors and subsequently recovered: "Before, we never had much help," he reflected, underscoring the transformative impact of these developments on the community's health outcomes.

Furthermore, Jose and his family held a positive view of the level of training that the Timorese graduates had received from Cuba. They believed that this foreign education had equipped their local health professionals with the necessary skills and knowledge to deliver quality healthcare services to their community. This endorsement from the patients themselves spoke volumes about the perceived effectiveness and success of the Cuban-Timorese medical collaboration.

It underscored the potential of such international partnerships in enhancing healthcare delivery in rural and underserved areas like Makili and was noted by another local respondent from Vila:

> Seeing our children and friends emerge as doctors and healthcare personnel is powerful, we begin to see ourselves differently. No longer as poor people looked down upon by rich city people or foreigners—where we simply wait charity so we can barely live—but we now see ourselves as a community with an ability to care and love and sustain ourselves. We believe in ourselves. And the next generation of children in our village will grow up knowing they can be the next doctor, nurse, midwife—or anything they could dream of—if they wanted to because they will have seen their own neighbours, friends and family become that. It fills me and my family with a pride.

Nurse J, a native of Vila, had been a cornerstone of the local healthcare system on Atauro Island. His journey began as a nurse assistant from 1985 to 1989, after which he underwent training as a nurse in Dili from 1989 to 1992. Since 1992, he served as a nurse in Vila, and in 2013, he took on the additional responsibility of becoming the chief of the Vila clinic.

The healthcare landscape on Atauro Island had evolved significantly over the years. Following independence, the island was initially served only by midwives. However, around 2003-2004, a wave of youth was sent to study in Cuba, and Cuban doctors began to arrive on the island. These medical students eventually returned and took over the positions held by the Cubans in medical clinics across the country, many of whom relocated to Dili. The Cuban doctors did not provide training on Atauro, but their care was well-received, and nurse J believed that the Cuban training has worked well on the island. In fact, there were plans to relocate a Cuban doctor to Atauro in January 2017.

The Vila clinic, the earliest of which was built during Portuguese times, had always been the site of the health centre. The back section of the clinic was constructed during Indonesian occupation, and the entire facility was renovated in 2014, accommodating the growing post-independence population. The healthcare system on Atauro operated on a rotation system, with all doctors making house calls. In cases of emergencies, patients were transported to Dili for secondary care based on the severity of their health issue. The modes of transport include planes by an Australian NGO, fast ferries, speed boats, and regular fishing boats.

Despite the modern healthcare facilities, many locals preferred to visit traditional healers out of respect for their grandparents and cultural beliefs as well as due to fear of the former Indonesian medical system which was used as a tool of genocide by Indonesia (backed by the

WB and global north allies) through forced sterilizations and medical tests etc. Often, if traditional healing methods failed to improve the patient's health, they ended up at the Vila health clinic. A group of traditional healers in Vila often treated patients with ointments and creams, but no pills, often attributing illnesses to curses or conflicts. Avoiding conflict was a significant aspect of Timorese culture, as it was often believed to contribute to illness. Therefore, maintaining positive relationships was crucial. If patients did not improve after visiting the health clinic or doctor, some often returned to traditional healers or try to resolve their conflict with a family or person from their past.

Nurse J believed that Cuban training was beneficial and stated that there was no private care on Atauro island. He emphasized the importance of public healthcare for the Atauro community, stating, "private healthcare would be difficult for our communities and families." Specialists, such as dentists, were sometimes called in from Dili if there was a need for many people to receive care by a certain specialty all at once. Nurse J noted that Cuban healthcare workers can get frustrated when patients did not come during pre-arranged appointment times or are late, but they were generally patient and provided good care regardless of the person or situation.

Despite some criticism of the Cubans, nurse J had seen mostly positive things and believed that people were entitled to their opinions. He personally received good care from the Cubans, especially when he was treated by them following a motorbike accident. When asked about his vision for healthcare on Atauro, nurse J believed it is at a good level and appreciated the progress made and plans in place. However, he suggested that Berau needed its own doctor, even if it was technically part of the Makili region, and that Beloi needed a midwife. He said

that: "everyone here works as a team. Doctors listen to nurses and vice versa. Everyone listens to each other. There is no hierarchy. The most important thing is the patient's health, not the ego of the healthcare worker."

On Atauro Island, outside of the health centre, two young doctors, Dr. D3 and Dr. I, served their community with dedication. Dr. D3, 30 years old at the time, graduated in 2012, and Dr. I, 31 years old at the time, graduated in 2014. Both believed that the criticism against the Cubans and their training is neither accurate nor fair. They suggest that the expatriates who opposed the Cubans could be driven by jealousy or outdated Cold War sentiments, viewing Cuba as a backward communist country with a nefarious agenda.

The Vila clinic, where they worked, was the community health centre and the primary provider of comprehensive care on the island. The clinic boasted a robust team, including four nurses, one of whom was nurse J, who had a keen interest in mental health and aspired to specialize in psychology. The team also included three midwives, two to three medics, two lab workers, two cleaners, two security personnel, and one driver who operated the ambulance covering the entire island.

Both Dr. D3 and Dr. I were drawn to medicine out of a desire to provide healthcare for their families and community. As Dr. I puts it, "I was always going to return here after my studies, this island is my family, the people here are a part of who I am." Despite the prevalence of nepotism in Timor-Leste, as in many parts of the world, some of the people interviewed came from humble backgrounds, families of fishermen, not doctors or village chiefs. Dr. D3, a resident of Vila and descendant of a family of fishermen, was a dedicated healthcare provider in Makili.

Despite his fear of hiking mountains, he was committed to serving his community, often making house visits to farms on top of the mountain when patients called.

He noted that all HIV and syphilis treatments, blood work, and diagnostic work were conducted in Vila. He acknowledged the significant influence of traditional medicine on healthcare in the region. He and the local midwife agreed that community members often preferred to visit traditional healers, especially for ailments like stomach aches. In some cases, people only sought his medical advice when traditional healing methods had failed. Conversely, if his expertise did not yield results, people often returned to traditional healers. Traditional healers often resorted to unique practices, such as dissecting a chicken, to diagnose a patient's problem. However, Dr. D3 noted that visiting a traditional healer could become problematic if patients waited too long to receive care for certain ailments or if they consumed something harmful.

Dr. D3 believes that Cuban training had been beneficial and particularly adept at adapting to local contexts. He noted that 80-90% of the curriculum was fixed by the Cubans, allowing for 10-20% to be modified by the host government. Dr. D3 typically worked the morning shift, as most of his patients visited him then unless their condition was serious. The entire community had his number and knew they could call him anytime for help.

The main challenges to healthcare in Makili included patient transport, with most people traversing the rough coastal path to Vila. TB, rashes, parotitis (inflammation of the salivary gland), and respiratory infections were prevalent. While there were cases of malaria and dengue 2-3 years ago, they had been eradicated through spraying. Dr. I was responsible for family planning and occasionally worked shifts at the Vila clinic. Dr. I believed that Cuban training had

been beneficial and posited that most criticism against Cuban healthcare stemmed from unfamiliarity with Cuba's unique approach to proactive and preventive care.

Pharmacist JS at the Vila clinic was another integral part of the healthcare community on Atauro Island. Originating from Macadade, located just over the headland on the south shore from Makili and the next headland from Berau, JS began his schooling in 2009 and graduated in 2010. He had been serving the Vila community for six years.

Pharmacist JS studied at the *Instituto de Ciencia de Saude*/Institute of Health Sciences, where he completed a one-year program. The curriculum, delivered by both Timorese and Cuban teachers, was predominantly Cuban. Pharmacist JS believes that Cuban cooperation had been beneficial, as those trained often returned to work in small villages and provided technical support. They were also trained to make house calls, a practice that had greatly benefited the people of Timor-Leste. While pharmacist JS acknowledged that the language barrier could sometimes be an issue with Cubans, he noted that those who had been on the island for a long time were proactive in learning Tetun. Pharmacist JS often served as a translator for Cubans who had difficulties with Tetun. Despite these minor challenges, he believed that Cuban personnel had been good overall.

Pharmacist JS highlighted the close-knit nature of the community, where everyone knew everyone else. Although he and others were supposed to work again in the afternoon after their lunch break, most patients simply came in the mornings. People would call them at all hours when they needed anything, reflecting the supportive nature of the community. Pharmacist JS noted that more remote areas often resorted to traditional medicine first. He believed that there was a need for more pharmacists on the island, as he was currently the only one. Initially,

pharmacist JS wanted to be a nurse or a doctor, but due to circumstances and the Ministry of Health's recognition of a significant need for pharmacists, he was directed towards pharmacy. Despite this shift from his original aspirations, he was content with his role as a pharmacist. He was required to visit every clinic once a month and often traveled to other coastal communities by boat.

In the rural community of Makili, traditional medicine played a significant role in healthcare, as observed by Timorese midwife AFP, who had been serving the community for three years. Born and raised in Makili, midwife AFP was trained by Timorese and completed most of her degree in Bahasa Indonesian, transitioning to Tetun towards the end of her education. She graduated from *UNTL* around 2012-2013. Midwife AFP worked alongside a doctor at the Makili clinic, which was bustling with activity. She attended to one or two births per month, most of which were normal. Complicated cases were referred to the maternity ward at the Vila clinic. Despite the workload, midwife AFP believed that rural recruitment was not an issue due to strong family and community ties in the area.

The clinic's facilities had not been improved since Cuban cooperation, but a new building was expected to be operational within the next year. Midwife AFP was uncertain if the new building would house more services. However, she firmly believed that the community had benefited from the addition of Cuban-trained doctors and that the medical agreement had been beneficial for Timor-Leste, improving the knowledge base of the workers. Midwife AFP's work schedule was Monday to Friday at the Makili clinic and Saturdays in Vila. She was about to go on maternity leave, and while no one was set to fill in for her, appointments could be made with Dr. D3. Although midwife AFP admitted to knowing little about traditional medicine, she did

provide family planning services, primarily using birth control pills or shots, which were provided free of charge.

The new health centre in Makili was set to be a comprehensive facility, housing a pharmacy, a maternity ward, a maternity clinic, a laboratory, a doctor consultation area, and an administrative office. Adjacent to the main building, there would be apartments for the doctor and the midwife. The centre would be staffed by a nurse, a doctor, and a midwife, ensuring that a range of medical expertise was available to the community. The training of personnel extended beyond general practice to include various specializations such as physiotherapy, ophthalmology, paediatrics, and neurosurgery. This specialist training was part of an open-ended agreement that aimed to enhance the healthcare provision in the region. The structure of healthcare delivery was designed to be preventive, with first contact clinics staffed by a doctor-nurse team leading to federal hospitals located in most of the major centres of each district.

In addition to the health centre in Makili, there were some community health facilities which functioned similarly to the *CDIs* in Venezuela. However, these were few and the range of services they offered varied greatly. Two of the more comprehensive facilities were observed in Vila and Los Palos, where there appeared to offer a decent range of coordinated team-based health services, albeit somewhat limited compared to *CDIs* in Venezuela. Importantly, these health centres did not appear to reflect the party politics of the government. Instead, they embodied the non-party affiliated politics of the state, focusing on the provision of healthcare to the community rather than political affiliations. This approach ensured that the focus remained on delivering quality healthcare to the residents of Makili and the surrounding areas.

An interesting dynamic was witnessed, particularly in Atauro. Public consultations were posted as being available through certain hours, much like Global North offices and other centres. In Vila and Makili, most patients would arrive during morning office hours for their check up or health issues. As such, throughout the rest of the day, few if any would arrive at the clinic.

Thus, after the siesta, medical personnel would sometimes lock up the clinic and go about their day despite the listed office hours. When asked if this was problematic, most healthcare personnel laughed and made me realize a significant difference in healthcare approaches from the strict Global North logics I had internalized as best practices. Most Global North/Canadian patients would (generally) never assume to go to a health centre after operating hours. They would either book in for the next available appointment, go to the nearest walk-in clinic during operational hours, or visit hospital emergency care centres if the need was severe enough. The East Timorese healthcare personnel, often after a chuckle, explained to me that their entire community was basically their family or extended relatives.

Their catchment of patients was often relationally close enough that they said most of their patients had their personal phone number and were encouraged to call them personally if they ever needed help. As was witnessed in Atauro specifically, these Cuban-trained Timorese did not appear to care much for strict office hours. If a patient called, they would chat over the phone about their health needs, give their location to the caller if they were mobile and wanted to have something looked after, pop by to visit the patients in their homes if they were not mobile, or tell them to meet them at the clinic if they needed additional supplies.

This appeared to happen at all hours. As such, this non-conventional approach, abhorring often strict logics of Global North service provision-during-opening-hours and 'by appointment only'—enforcing rigid limits on relational distance and space between patient and provider—was dismissed as extremely counter-intuitive by many Timorese health providers. As one Cuban-trained Timor-Leste doctor stated:

> I tend to carry a small bag of healthcare supplies wherever I go [such as stethoscope, gloves etc.] in case I run into anyone needing help. Just because the clinic is closed does not mean I stop being a doctor. If you have not realized, that patient is my cousin, that patient is a dear friend, that patient is a relative, this whole community is my family. This island is my family. In my mind, all of Timor-Leste is my family. Why would I ever deny care if someone was in need because of a sign on a door saying 'closed'.

This was not only witnessed, repeatedly, by Cuban healthcare personnel and Cuban-trained physicians in other places such as Gleno and Lospalos, but also by the nurses and midwives who were the backbone of the rural healthcare system, especially in Tatuala and other locations.

Thus, it became quite clear that such a relationally-proximate system such as this, with far less issues around inequality and alienation (as found in the relationally-distant Global North), simply did not fit neoliberal logics, systems, and structures of Global North 'fee-for-service' and private healthcare approaches. Many salaried Timorese doctors and healthcare workers, especially those trained by Cubans as well as the Timorese nurses and midwives who were the core of the health system throughout the genocide (and were not apart of the bilateral agreement), appear to see their job as one that is more important than status, income-generation,

strict relationally-distant protocols, and adherence to clinic hours. It was impressively reflective of *concienci*a and bio-psycho-social approaches to care that are the cornerstone of LASM.

As such, neoliberalism's valorization of exclusion coupled with ever-increasing inequality has the effect of fragmenting community bonds. People are less likely to look out for each other as well as can become culturally shaped towards competition and becoming more interested in "beating the Jones'" than in the formations of relational spaced and sense of community belonging/communal care. A system like this would appear quite alien to Global North free-market sensibilities where the opportunities to profit off of ill health and medical need, are substantial.

Yet, at its very core, this approach appears quite simple and effective. When psychological drives to have comparatively more than the Other and for-profit marketing, predating insecurities to turn *wants* into socially constructed *needs*, is not the current hegemony, it becomes quite apparent that subaltern knowledge about closing relational distance and creating relational spaces (transcending race, socio-economic status, gender identity, age etc.) can potentially lead to interesting considerations for healthcare and development. *Conciencia* becomes not some hypothetical and alien goal, it is counter-hegemonic way of interacting, relating, caring and healing.

Student researcher C, a foreigner (who are often referred to as '*malae*' in Timor-Leste), shared her healthcare experience in the country while she conducted her doctoral research. She had been treated for a throat infection and expressed satisfaction with the care she received, particularly noting the absence of any criticisms towards Cuban care and the work of Cuban-

trained Timorese health professionals. The treatment, which included vitamins, pain medication, and penicillin, was provided free of charge by Dr. A.

Student researcher C appreciated the prompt attention she received at the clinic, with the healthcare personnel willing to spend as much time as necessary to ensure optimal health outcomes in a tram-based setting. The treatment was successful, and researcher C was particularly impressed by the teamwork displayed by the healthcare personnel. She noted that Dr. A and a Timorese doctor, Dr. S, worked well together, with Dr. S under Dr. A's supervision. This collaborative approach to care was a highlight of her experience.

Student researcher C contrasted her experience in Timor-Leste with that in Canada, noting that doctors in Timor-Leste were more attentive and took a more holistic approach to healthcare. However, she also pointed out that there was a lack of supplies, such as bandages, and suggested that more resources for materials could improve the care provided. Despite never having visited a private clinic in Timor-Leste, researcher C speculated that a private clinic might have recommended additional, potentially unnecessary, supplements. She also noted that accessing private or NGO care would have required her to travel from Atauro island to Dili, a journey involving a small bus ride to Beloi and a boat trip to Dili. As a student traveling on a low budget, such costs would have been burdensome for her. As such, communities of Vila Maumeta and Lospalos, she noted, were especially grateful for the provision of free healthcare.

Student researcher C firmly believed that the criticisms often directed at Cuban and Cuban-trained healthcare personnel were unfounded, as she herself had received effective treatment from them. When asked about the role of private healthcare in Timor-Leste, she suggested that it should primarily serve foreigners working in the country, as she found the

public healthcare system to be excellent. She expressed a belief that the responsibility for building public healthcare capacity in Timor-Leste should not fall on NGOs, but rather on the government. To strengthen the healthcare system, she advocated for the government to invest more in medical supplies.

Student researcher C also shared her personal experience with Cuban healthcare when her daughter fell ill in 2015. She found that Cuban doctors, who treated her daughter in Brazil, demonstrated greater empathy towards underprivileged individuals, such as those living in rural and poor areas, compared to doctors from upper classes, as is often the case in Brazil. Finally, student researcher C expressed her belief that Timor-Leste was indeed receiving 'fair value' from its public healthcare capacitation agreement with Cuba. She reasoned that Timor-Leste, being a poor country with a lack of infrastructure, would not attract doctors who grew up in wealth. In contrast, she found Cuban doctors to be more skilled and willing to work with people from rural, poor areas, thus providing a valuable service to the country.

South and West of Dili

In the South and West of Dili, Timor-Leste, the healthcare system had been historically maintained by midwives and nurses. Prior to the country's independence, there were only 30-47 doctors serving a population of 1.1 million. These midwives and nurses, found in nearly every suco throughout the country, bad been and continue to be some of the most important and experienced front-line health workers. Their role has been increasingly supported by Timorese graduates from Cuban medical education programs.

One such individual was nurse trainee NG, a Timorese male who was currently training to be a nurse and was expected to graduate in 2019. He is the brother of one of the 2-3 Timorese refugees who fled to Canada during the Indonesian genocide. He was based at the Gleno clinic, which was staffed by three Cuban doctors, five Timorese nurses, and three Timorese midwives. Despite the challenges of learning in Spanish from Cubans, nurse trainee NG found it less difficult than learning from foreign teachers in English from countries such as Bhutan, China, and Australia.

Another key figure at the Gleno clinic was a Timorese female general medical doctor VV who graduated in 2013. She had worked in Gleno since her graduation and completed all her studies at *UNTL*, under the tutelage of Cuban teachers. Dr. VV believed that there was a need for a larger university with more specialist programs and advocated for increased cooperation between Cuba and Timor-Leste in this regard. She felt that the three Cuban doctors at the Gleno Clinic were sufficient. The main health issues she encountered at the clinic were respiratory issues and communicable diseases. Administrator JMM at the health centre in Gleno, oversaw an administrative building that held vital health statistics for the region. He also believed that Cuban cooperation had been beneficial for the healthcare system.

Cuban lab technician R, working in Baucau but visiting colleagues in Gleno, started his tenure in 2016 and planned to stay until 2018. Having spent four years in Venezuela from 2005-2009, he brought a wealth of experience to his role. He noted that Baucau offered more services than Gleno, largely due to its size and the recent upgrade of its hospital, now the second largest in Timor-Leste next to Dili. He also mentioned some trilateral collaboration with other countries.

Dra. M3, a female general medico from Holguín, Cuba, had been serving as a doctor in Gleno for over three years. She treated a range of health issues, including hypertension, diarrhea, respiratory problems, and skin conditions. She noted that local customs sometimes led to hygiene issues, and traditional healers' use of creams and ointments could cause irritations. A significant health issue she identified was the lack of access to healthcare. If patients could not reach them and they were unable to make house calls, patients often relied on traditional medicine, or their conditions simply worsened. She also highlighted the influence of strong Catholic traditions on sexual health in the region. Either due to lack of knowledge about disease prevention or religious pressures, condom use was often perceived as a sin. While she did not teach, she provided support and advice to Timorese graduates at the clinic.

Timorese Dr. M4 worked alongside two general medical doctors from Cuba, Dr. J and Dra. K. Twice a month, specialists from Dili, all Cuban, visited the clinic. The clinic, which operated as a community health centre, had nurses and doctors available 24 hours a day. It offered a range of services, including dentistry, laboratory testing, eye care, vaccinations, and maternity care. The primary care clinics operated from 8:30 am-11:45 am and 2 pm-5 pm, similar to the schedules in Venezuela and Cuba. More complex cases were referred to Dili.

The healthcare team worked together for the health of the patient, ensuring no fragmentation in care. One of the challenges Dr. M4 faced was balancing her work with caring for her six-year-old child. Despite the challenges, she was optimistic about the future of healthcare in Timor-Leste, especially if it continued to be free for everyone. She saw a need for more specialists, regardless of their country of origin, and appreciated that the students treated patients with a holistic, bio-psycho-social approach.

Dr. G2, a female doctor from Gleno, Timor-Leste, noted that most midwives and nurses in the region had graduated from Dili and Indonesia. She believed that Timor-Leste had greatly benefited from Cuban cooperation. Prior to this cooperation, there was only one nurse and one midwife for all of Ermera. As of 2016, there were 52 doctors in Ermera, with eight of them based in Gleno. Dr. G2 credited Cuban cooperation for providing good training to these healthcare professionals.

Nurse CB from Gleno, provided further insight into the evolution of healthcare in the region. Around 2001, doctors from the Philippines, Indonesia, and Australia were assisting in the area. However, in 2006, Cuban doctors began arriving in Gleno. Nurse CB believed that the arrival of the Cuban medical personnel significantly reduced mortality rates in the region. This was particularly significant given that, during the Indonesian occupation, there were only two nurses and one midwife serving the region. Traditional medicine was prevalent here, with many people initially seeking help from traditional healers before turning to clinics if their condition did not improve.

There were two private clinics in the area, both from Australia. However, nurse CB believed that there was no need for more private care. She emphasized the team-oriented approach of healthcare workers in the region. Since 1999, a midwife had been part of this team, contributing to healthcare services in Gleno. This collaborative approach, combined with the influx of trained professionals, had significantly improved healthcare outcomes in the region.

Three Timorese workers from Gleno also noted that the impact of Cuban medical cooperation on the health of rural communities in Timor-Leste was generally positive. The fairly consistent consensus among locals was that the cooperation had significantly improved their

community's healthcare. Prior to this cooperation, healthcare was limited or non-existent in many areas. The Cuban cooperation had filled this gap, providing much-needed healthcare services to these communities.

Criticism from outsiders, about the quality of training and care provided by the Cubans was largely dismissed by most local Timorese. They perceived this criticism as politically motivated and not reflective of their experiences. Some locals challenged these critics, noting that they did not provide their own doctors from their own countries to comprehensively train and staff rural health clinics as the Cubans had. They pointed out that while these criticisms were visible in Dili, few were willing to leave the comfort of the 'big' city to serve rural areas. They argued against foreigners critical of Cuban help and highlighted that Cubans had provided medical help at almost no cost. As such, the locals stated that foreign criticism without offering robust alternatives did nothing to improve their healthcare system.

As such, the projection of Western conventional medicine, often characterized by high degrees of privatization and expensive medical education programs, onto a country like Timor-Leste, which was identified in 2016 as a fragile state, can be problematic. A highly curative, privatized, and technologically-centric medical system would likely be confined to the capital city, Dili, serving only a small, wealthy portion of its population. Criticizing Timor-Leste's desire for a more public-focused, egalitarian, and low-resourced model based on the Cuban approach becomes problematic when the country cannot afford global north alternatives. These global north-based approaches would also likely exclude much of the population from accessing healthcare. Despite its flaws, the Cuban model, with its abundance of healthcare workers,

egalitarian low-resourced approach, and strong proactive and preventive focus, appeared to be a more viable option for Timor-Leste.

Cultural factors also played a significant role in healthcare in Timor-Leste. Maternal mortality was the highest in the region although it had decreased significantly from 260 per 10,000 live births in 2000, to 130 in 2010, and impressively down to 67 by 2020 (World Bank, 2024). The majority of women gave birth at home, assisted only by female family members and possibly a traditional midwife. If complications arose, a Western-trained midwife could be called upon, except in remote areas where the mother and baby might often die. Reluctance to go to the hospital for childbirth is partly due to fear of medical establishments, a legacy of the Indonesian occupation (involving the WB-assisted sterilization programme). During this time, people often had to pay bribes for services, and many did not realize that maternity services were now free. This cultural context, coupled with the historical sterilization program by Indonesia (assisted by the WB), presented unique challenges to healthcare delivery and maternal mortality in Timor-Leste.

With regards to differences in the few remaining Indonesian-trained doctors in Timor-Leste after occupation, two respondents at *UNTL* helped understand the dynamic between Cuban/Cuban-trained and Indonesian healthcare personnel during various interviews in 2016. They suggested that the difference between the Cuban-trained personnel and the Indonesian-trained personnel, largely comes down to motive. Most Indonesian-trained students enter private practice in Timor-Leste with income-generation is their main motive. By contrast, the Cubans and Cuban-trained personnel were mostly interested in providing services for their own families/friends/communities as their main motive.

Many Timorese patients noted that they often preferred the public clinics over private clinics where most doctors were trained in the Indonesian system. First and foremost, this was because the public system was free, and many Timorese were unable to afford or desired to spend limited income on expensive services. Additionally, many felt that Cuban training was not only adequate but had improved upon the services—especially in contrast to services that were available prior to full 2002 independence.

In one example, the private system nearly cost one respondent his daughter's life due to a very treatable health challenge that was consistently misdiagnosed in a variety of private care clinics throughout Dili. It was not until she was rushed to Dili's emergency hospital that Cuban doctors correctly diagnosed and treated her, saving her life. This Timorese respondent, an academic at the national university, also noted that this was a familiar example as many private for-profit clinics tended to prefer rapidly seeking a diagnosis in short time, writing a prescription (usually for antibiotics), then billing for service, before moving onto the next client.

The other respondent stated that, before Cuban medical doctors arrived, there were none or very few actual doctors in the sub-districts. Now, almost all the 442 villages had one doctor and one nurse providing care and nearly every sub-district had a health centre. He believed the Cuban doctors and medical personnel were excellent especially in the broader praxis of their medical system and delivery of healthcare that is a human right for all. He thought that the way they were trained to view and treat patients is truly different then the type of care received at for-profit clinics, whose interests were understandably motivated by generating income in addition to improving patient health. He believed the level of training for Timorese doctors had been sufficient given the condition of the country and lack of a strong education system emerging

from the genocide. He though that with time the system would become stronger and that the increasing education standards of graduates from the public education system would help ensure that the quality of graduates from the medical program would increase as well. For now, those already graduated would become better doctors through practice and experience.

When prompted to discuss foreign criticism of Cuban-trained Timorese graduates, he responded:

> you can't make quality in 5 years. There is no preschool education, the primary education is poor, the high school education is poor—with many students not even graduating from high school—5 to 6 years of post-secondary school is not going to produce 'first world' graduates. But quality will come with time, with practice, it is what the leaders in Timor-Leste had to do [in the absence of quality education], Xanana, Mari Alkatiri and Ramos Horta had the majority of their education come from their wealth of experiences.... these new doctors will be the same and slowly, as the country develops and the education system strengthens, the quality of our graduates will increase.

In another example, a colleague at *UNTL* also shared an experience at the *Osan Mean* (Gold) Clinic, a private clinic set up by Indonesian-trained physicians.

The doctors at the private clinic had medicated his niece for abdominal pain. After multiple appointments, the doctors only continued to provide pain killers. After the pain became unbearable, he took her to the National Hospital where two Cuban physicians quickly discovered she had appendicitis. Soon after admission to the hospital the appendix ruptured, and the Cuban doctors immediately began surgery. If it had been left for an estimated two hours longer, some in the hospital believed she would have died.

In another instance, a *UNTL* respondent had health issues after a trip to Brazil. After stints at various health clinics (where medics were unable to diagnose his condition), Chinese doctors (who thought it was a stomach issue), and traditional village healers (who thought it was a throat issue which is part of his family history), he was still having issues. In Thailand he had to be hospitalized for 2 days and was charged $1000 a night while there receiving treatment. He then visited one Cuban doctor who found out it was a problem with his thyroid. After another check up with another Cuban doctor, the doctor came to the same conclusion and since then he had made a recovery due to their diagnosis and follow-up. In this instance, only the traditional village healers and the Cuban doctors were able to find out what had ailed him since his Brazil trip.

Subaltern Positionality

In contrast to Cuba's counter-hegemonic approaches to health and development, a few Timorese were exhausted by hegemonic Global North discourse, the Global North performance of development, as well as the pressure to conform to Global North development themes and timelines. They appeared frustrated by short term 6-month contracts (an increasing trend down from the usual 2-year positions that were much more common throughout the 1990s and early 2000s) which exacerbated a relational disconnect. As one Timorese commented (2016), these relationally-distant workers:

> come to this country, look down on us, do not interact or talk to us, do not ask us for help or for our opinions. They show up every morning with their coffees, sit at their desks, and write a perfect [Global North] research report or policy paper with no connection to the

> reality and experience of us [Timorese]. We sit there, watch as six months go by, politely thank them for their perfectly written report, put it in storage to collect dust, then wait for the next one to arrive to do the same thing. (pers. comm. with Timorese, 2016)

This is also reflective of East Timorese sentiments found in the work of Sam Carroll-Bell (2015). One of the main issues is the conflict between the short-term, cyclical nature of development work, often referred to as the project life cycle, and the time it takes to establish enduring, long-term relationships.

A common sentiment among those interviewed by Carroll-Bell was that international NGOs and development workers did not allocate enough time to engage with the community before launching a project. They also felt that these workers were more focused on gathering data, drafting reports, and accomplishing their assigned tasks rather than truly connecting with the community. Consequently, the level of community involvement and commitment to the development process was quite low. It almost appeared as though development was happening 'around' many of those interviewed, with the process mainly involving government representatives, project managers, local leaders, and a select few others. Some observations made by Timorese are pertinent to this discussion:

> They just come, do their project, go back, and there is no change. Members always ask [International]NGOs to collaborate with them… INGOs must ask for ideas of the local people, NGOs implement their projects without consultation with the leaders… there is no clear objective in terms of operation and maintenance… Organizations get their data from the national level and just bring their stuff.

And: Many organizations come to the community to implement projects and then leave. They come with their projects and say, do this, do this and then leave. They only serve the needs of the donors. Because of this, sometimes the community members say, we hate the NGOs. [agricultural NGO representative] …

Similarly: Some advisors don't want to share knowledge. They just sit in front of computers, writing reports. In many programs, the local counterparts don't know about the budget. What's spent? What's left? Some (advisors) just do it for themselves and when their contracts are over, they never come back. [Timorese ministry official] …

Furthermore, the interviewees expressed frustration at a perceived unwillingness to learn more about their needs, wants, and ways: For planning, NGOs must go down to the village, sleep there, and then ask 'what do you want to do?' They should be there for a week asking 'what do you want?' [Timorese advisor to the government] …

And: NGOs never come to us, especially international agencies, to speak with us directly. If they did, they would understand our needs… We ask the international people to come to this village and see our situation… Because of this, we have never had a relationship with an NGO. [Villagers near Maubisse] ….

Many of the international NGOs forget that we have been living here for centuries, we outlived the Portuguese and overcame the Indonesians. We are not empty, we are capable of many things. We know what we need… but the development [NGOs] do not spend enough time in our community. They do not know what we really need. (2015, p. 324-326)

As such, despite the best efforts and empathic sentiments of many international health and development work, their empathy is often captured and misdirected towards agendas, ideas, and logics, which do not truly challenge the hegemony of neoliberal mal-development:

> It is great, for them. They get to come here. Some have won awards or have received huge grants. Bigger grants than the pay of entire departments here. The do their work they said they would do. But their work is only for themselves, for the foreign institutions that hired them [to preform development], and for their next job application or award. They pat themselves on the back and then leave and seem to expect us to thank them, which we do. We do not like to upset them. But I am not sure they truly care about us. (pers. comm. with an East Timorese from a local development organization, 2016)

Duffield's Critique of Global North Native Administration

An added complication is that the challenge of meeting the ongoing expectations of donors, technical advisors, and political actors often leads to resources being diverted away from local activities and projects. As one Listening Project participant noted to Carroll-Bell:

> Sometimes NGOs want to implement their own projects, and don't really see the problems the community confronts [international aid worker]… Another international development practitioner added: 'The target groups don't care for the targets of the donors or international politics. They want to see their situations improved. The NGOs or the implementing organizations are in between the two, managing the expectations of both sides. The expectations of our target groups may differ from those who give us money. We just have to admit that there may be a gap between the international funder and

> implementer'…Commenting on the effect of donor policies and expectations of change, one local NGO representative stated: 'You have to spend all this money within three months before the project closes and this is not helpful or realistic… There is pressure from the donor to implement a project, even when the community is not ready. This creates a lot of tension.' (2015, p. 326)

Carroll-Bell's research highlighted a challenge in international development efforts where the need to meet the expectations of donors, technical advisors, and political actors often results in diverting resources away from local activities. Participants in the Listening Project, including a Timorese NGO representative and an international aid worker, expressed concerns that NGOs sometimes prioritize their own projects without fully understanding the community's issues.

Additionally, there's often a discrepancy between the expectations of target groups seeking tangible improvements and the goals set by donors or international politics. The pressure to adhere to donor policies, such as spending allocated funds within tight timeframes, can create tension, especially when the community is not adequately prepared for project implementation.

As such, one unhappy Timorese cynically stated as such when reflecting on how hard it is to get supplies and resources into the country:

> You know what, I have started to welcome the next NGO, the next foreign development program. Because so many fail [because they are unaware about Timor-Leste local contexts], it has become a great way to get resources that are hard to come by. So when a NGO of foreign group says they are coming with their dozens of cars or computers, with their charity for us 'poor' Timorese, I say: 'let them come'. Let them do 'development' and

fail. Because it means that once they do fail, there will soon be a dozen new cars and computers [either] donated or for sale, and cheap. (pers. comm., 2016)

Thus, it was apparent that the Timorese were often quite aware of this dynamic. Yet many of them appeared to be very averse to upsetting Global North personnel or for creating further conflict with development institutions and funding. They often refused to critique or rock the boat and appeared very reserved in their opinions of Global North personnel and approaches, including Global North criticism of Cuban cooperation.

La'o Hamutuk identified a significant tension in the short-term, cyclical nature of development projects, where international NGOs and practitioners often bypassed adequate community engagement before project initiation. The prevalent focus on data collection and report writing rather than meaningful connection with community resulted in minimal engagement and limited investment in long-term development. Another challenge highlighted by *La'o Hamutuk* was the struggle to meet the expectations of donors, technical advisors, and political actors. Timorese NGO representatives and international aid workers stress the diversion of resources away from local initiatives due to the pressure to satisfy donor expectations. The conflicting interests between donor targets and local community needs created a delicate balance for NGOs, revealing a gap between expectations and goals.

The observed challenges had tangible repercussions on local communities. Many development projects were perceived as occurring 'around' rather than involving community members directly. The lack of consultation and understanding of local needs contributed to frustration among community members. Some advisors were criticized for prioritizing individual goals over sharing knowledge and building sustainable relationships. *La'o Hamutuk's* scrutiny of

NGOs revealed common pitfalls, including the implementation of standardized projects borrowed from other countries without adaptation to Timor-Leste's unique context. Lack of consultation with the local population and failure to collaborate with local institutions resulted in fragmented services and compromised project sustainability.

In 2017, the first Prime Minister of Timor-Leste, Mari Alkatiri, stated to reporters from Papua New Guinea and Fiji at a conference in Dili that countries such as Papua New Guinea and other Pacific Island nations should take control of how aid is administered within their borders. He recounted his experience of advocating for Timor Leste's independence alongside former President Xanana Gusmao. While many aid donors were eager to offer financial support, they made it clear that this aid, though free, came with certain stipulations.

Therefore, said Alkatiri, "governments should and must always tell aid donors who refuse to abide by your country's policies that 'We have money, you can take your aid away!'"(Post Courier, 2017). It becomes clear why, in 2006, then-Prime Minister Alkatiri asked Global North NGOs leave because of these dynamics while also praising the work of Cuban cooperation (pers. comm. with the Timor-Leste Ambassador to Singapore, 2016; Hill, unpublished)

In contrast to Global North hegemonic approaches, a worker at *La'o Hamutuk* (pers. comm., 2016) also recognized the counter-hegemonic Cuban medical project as an exception, positively impacting the lives of Timorese people, especially in remote areas. Despite criticisms about training, language barriers, and quality of care, patients expressed appreciation for the Cuban medical professionals and those trained under their guidance.

The addition of Cuban, and Cuban-trained, medical personnel did not usurp the experience or role of the nurse and midwife—many of which had years of experience as the only

healthcare providers in their respective region. The Cubans and Cuban-trained personnel understood that they were merely there to add to the care of the patient in a team-based patient-centred care approach. The idea of arbitrary hierarchies, to many of them, seemed ridiculous—especially when a newly trained doctor joins a team which had a nurse with over 20 years experience—as was the case in Tatuala (located in eastern Timor-Leste) and Villa (on Atauro Island). After the expansion of the health system and the addition of Cuban/Cuban-trained personnel, the nurse at the clinic in Villa, who had the most experience, was given the position of head of the clinic.

Thus, many nurses and midwives had the most experience and on-the-ground knowledge of experiential learning in rural and remote areas. They were understandably heavily relied upon and valued for their knowledge. In other health systems, often based upon status and income level, doctors often hold positions and are the main decision-makers regardless of context, experience, or a team-based patient-centred approach utilizing consultation among disciplines. The new graduates seemed to have an understanding that the opinions of the nurses and midwives with whom they work, should therefore be highly valued and not demeaned due to a social fantasy of status and power.

As many Canadian doctors and healthcare personnel have noted, the best doctors are often those who are able to listen to both the patient and their healthcare team in an honest and humble way. The worst doctors are often those driven by ego and a desire for a self-fulfilling position of power that their title gives them—regardless of the context or the wealth of experience that may be surrounding them at the time. Cuban doctors aren't trained to look down on their medical peers or nurses with whom they work. They are trained to value the opinions of

all health workers. This is a key point with regards to the criticisms that Cuban-trained personnel are often worse than the nurses that they go to work with. Unlike in Canada and other Western countries where the social fantasy seems to be that a doctor is superior to other health professionals, a fresh medical graduate from the Cuban program would not enter the field thinking that their new title of doctor somehow usurps the opinions and experience of the nurses and midwives with whom they work.

Global North Outliers: Royal Australasian College of Surgeons (RACS), Psychosocial Recovery and Development in East Timor (PRADET), and Pite Clinic

It is important to note that attributing the improvement of health outcomes only to Cuban cooperation is problematic because of the large amount of work done by local Timorese as well as NGOs in addition to any number of additional variables that affect the complex health outcomes of a country. Single-causal assumptions are not accurate in this regard, even given the impressive scope and scale of Cuban cooperation. Equally, if not more problematic, is the propensity of Global North development organizations to take the credit of improving Timor-Leste health indicators without mention of Cuban cooperation or acknowledging the limited reach of many of their NGOs outside of urban centres such as Baucau and Dili—especially problematic since the largest health outcome deficits were largely accomplished in rural areas which boosted the overall national average significantly.

The improvement in health outcomes since Cuban cooperation appears—by many in the Global North development/aid industry including the WB and IMF—to be a golden opportunity to promote their own work. As such, Timor-Leste's impressive rise in health outcomes is often

being attributed—not to the range of efforts by Cuba and local organizations, which often receive little to no mention in Global North development reports about Timor-Leste—but to the limited and often urban efforts of the development/aid industry. This is amplified by their business-savvy marketing teams in order to promote their efforts towards 'development success' in an effort to secure more donors and funding.

Statistics are often carefully selected and promoted by some NGOs with their donors about a rare 'Global North' development success that they advanced in Timor-Leste. These organizations receive more donations, as funders and charity-based organizations feel like their money is well spent, while simultaneously disavowing Cuban efforts. There is little mention of Cuban cooperation in NGO reports or promotional materials. Even reports by the World Bank do their best to only give passing mention on how Cuban efforts have impacted the development and health outcomes of Timor-Leste.

It is important to note that Global North outliers were observed with the work of the RACS, PRADET, as well as the Barrio Pite Clinic which all worked alongside and with the support of Timor-Leste personnel to capacitate Timorese. Timor-Leste's National University, in partnership with the Ministry of Health and RACS, provided postgraduate training in various medical fields, including general surgery, obstetrics, pediatrics, anesthesia, and internal medicine. Doctors who have served for a minimum of two years can enroll in an 18-month diploma course, which is considered a route to specialization.

The Ministry of Health is actively considering potential collaborations with Cuba, Indonesia, and several other countries for future international specialist training opportunities (Asante et al., 2014, p. 279-280). RACS and the Pite clinic coordinated with Cuban personnel to

continue advancing healthcare training of new Timorese grads. Some of the top graduates were then selected to go under specialist training through the RACS program, taking the best and brightest of the graduates to one-day, serve the complex health needs of their country.

Since 2014, RACS had been collaborating with major health sector partners in Timor-Leste to implement a Family Medicine Training Program (FMP). This program aimed to train and enhance the skills of junior doctors who had graduated from the Cuban medical system. The FMP, a two-year postgraduate training program, is designed to prepare these doctors for work in Community Health Centres in rural and remote areas. The program includes clinical training through rotations in various medical fields such as surgery, obstetrics and gynaecology, paediatrics, internal and emergency medicine, and community-based health. It also includes short courses in Primary Trauma Care and Emergency Life Support.

In the 2014/15 period, 36 trainees completed the first year of the FMP. In July 2015, 12 doctors began Post Graduate Diplomas in surgery, paediatrics and anaesthesia, while two others started Ophthalmology training. In September 2015, a second group of 25 trainees began their first year of the FMP. Simultaneously, 12 doctors began the second year of the FMP, which included community-based rotations in community medicine, family planning, and eye health. The RACS clinical team plans to continue their close collaboration with their Timorese counterparts to deliver training and strengthen departmental and hospital systems.

In an interview conducted on November 30, 2016, head paediatrician D for the national hospital, shared his insights on the state of healthcare in Timor-Leste. Despite being a paediatric specialist, head paediatrician D was tasked with training General Practitioners (GPs) due to a shortage of quality doctors in the districts. The Ministry of Health requested RACS, a group of

highly trained surgeons and specialists, to use the national hospital to train primary care specialists to meet the needs in the districts.

Head paediatrician D was given 40 of the 901 Timorese doctors who had graduated as of 2016 to train. He had initially wanted to test the top 120 doctors but was only given 38. This was because those selected would have to be put through the training course without having to compete for a finite number of spots. Unfortunately, many of the recruits were selected based on their family connections and social standings, leading to a high degree of nepotism. In a subsequent selection, 25 doctors were chosen from a pool of 72, yielding much better results. Of these 25, five were trained to become paediatric specialists. GPs were also flown in from Australia for training. Head paediatrician D noted that the top graduates he selected were starting to follow evidence-based medicine and were performing better than their Cuban-trained counterparts in many respects.

However, head paediatrician D acknowledged that Timor-Leste would not be able to afford the level of help Cuba has provided from any other country. The choice was between a small number of elite western-trained medical specialists, or many poorly-trained Cuban doctors willing to live and work in rural areas. The private healthcare sector in Timor-Leste is very small and urbanized, with a tendency to simply prescribe antibiotics. Additionally, head paediatrician D described the private health sector as 'terrible'.

Driven by a desire to help the poor rather than the rich elite, head paediatrician D has kept his distance from expat *malaes*. His work with Cubans had become increasingly collaborative in recent years, with the latest group being particularly cooperative. However, he noted that the Cubans he works with often lack a broader generalist understanding. Head

paediatrician D was hired to provide specialist training and advocated for and implemented a 2.5-year master's program instead of an 18-month diploma program.

Head paediatrician D identified several weaknesses in the current system. One major issue was the saturation of the health system due to large initial graduate classes, which resulted in many ill-prepared doctors. Those trained by Cubans were found to be poorly trained in public health, even lagging behind their neighbours in Kiribati. *UNTL* continues to produce Public Health graduates who are poorly trained, and the quality of Cuban professionals is below acceptable by western standards. Despite these challenges, head paediatrician D acknowledged the strengths of the Cuban-trained doctors. They are committed to their work in difficult situations and are willing to make house calls, demonstrating their dedication to the profession.

In the context of shared goals between Cuban healthcare and policy personnel and their Timorese counterparts, this criticism of the level of Cuba training seemed strange given their apparent alignment. However, upon further exploration, it was revealed that this dynamic was gradually receding, particularly since 2016. The acceptance of Cuban approaches and increased coordination with Cuban personnel were on the rise. This shift was largely attributed to the growing recognition within the development/aid industry that the health and wellbeing of the Timorese people were of paramount importance. This realization outweighed any attempts to discredit, disavow, or dismiss Cuban cooperation, which some had hoped would dissipate if they could sway enough Timorese minds.

The Timorese context is unique, with a nascent public health system and a dearth of healthcare personnel in rural areas at the outset. There are many potential challenges. The new Cuban-trained personnel, despite their best efforts to address the previously unmet local health

needs, might find the tasks overwhelming. Complicating matters further, many of these new medical professionals might lack mentorship or an experienced veteran to consult. Their patient base, which might have never had a family doctor, presents a novel relational dynamic. Consequently, they might be unable to consult the previous 'generation' of doctors about a patient's history, as there might not be a documented medical history to follow.

Despite the criticism from NGOs and others, the question arises: what would happen if the Cubans and Cuban-trained personnel were not there? Who else would be capable and willing to fill that void, and on such a scale? Who else would be willing to comprehensively train, especially given the resource-constrained environment with a lack of infrastructure and peer human capital, so that control can eventually be transferred to the Timorese?

Since the Cubans are a de facto part of the building of the Timorese public healthcare system, any shortcomings or negative outcomes are often attributed to them. This blame is assigned without considering the absence of a public, inclusive healthcare system prior to their involvement, or the lack of human capital and resources. Any mishap in the public healthcare system, and every unfortunate incident, is often construed as the Cubans' fault. However, before Cuban assistance, accessible public healthcare was almost non-existent, and no other country has offered to capacitate the public healthcare or train as many healthcare personnel as Cuba.

Indeed, no other country has stepped forward to capacitate the public healthcare system nationally like Cuba. Small-scale NGO programs cannot provide the level of training, without fragmentation, that Cuba had done. The importance of developing a robust public healthcare system, independent of outside help, is crucial so it can respond to shocks and pathologies of scale, institute national responses, and have the resilience to address disaster scenarios, whether

natural, national, or international. On December 15, 2016, Minister B, serving as the interim Prime Minister in the incumbent's absence, expressed his belief that Cuban cooperation had significantly improved the health outcomes of the country. He argued that other donor programs or NGOs have not had a greater impact than the Cubans, as they operated on smaller scales, almost at the level of pilot projects.

A doctor from Suai, part of the second group of students, shared that half of their education was focused on serving those in need in poor communities. By becoming part of the community, they believed that half the job of healing is done. These graduates were distinct from others, possessing a strong drive and motivation to work in the most vulnerable areas. By the time they return, healthcare and service to the people had become their passion. They almost acted like anthropologists, conducting a long study to become part of the community.

Despite some cases of malpractice, most of the criticisms against Cubans and their graduates occurred in urban areas. Basic healthcare is free, but dealing with complex health issues and quaternary care was often challenging and sometimes required sending patients overseas, which was costly. Expatriates, often the most critical of the public healthcare centres and services, tended not to use them and thus criticized something they had little or no experience with.

So far, other countries did not seem to be recruiting Timorese Cuban-trained doctors, so they had yet to suffer from brain drain like other countries in the region, especially Fiji. The Ministry of Health had forecasted a 20% emigration rate among newly trained doctors. However, the actual attrition rate may be significantly lower due to several factors. There is a robust

political commitment to employing these new doctors, and a guaranteed job in the public sector could substantially mitigate the risk of emigration.

This effect could be further enhanced if doctors were deployed near their families and home communities. Additionally, the Ministry of Health provided an incentive package for service in remote areas, which could benefit the new doctors and potentially motivate them to stay in rural practice. Lastly, the Cuban training program's ethos, which emphasizes community spirit and public service, could further mitigate emigration aspirations (Asante et al., 2014, p. 279).

The new doctors trained in Cuba expressed a desire to serve their communities, improve health, and work for the 'public good'. The Cuban training program, which primarily selects students from underprivileged backgrounds, had given these new doctors the opportunity to take significant strides in their lives. The only cost is a moral commitment to work in underserved communities. However, this altruism may diminish over time. A combination of incentives, such as deployment near family, subsidies for remote area service, effective payroll management, and opportunities for postgraduate training, could help maintain or even extend a doctor's service in rural areas (Asante et al., 2014, p. 279).

The Cuban-trained doctors also outnumbered the rest of the healthcare personnel; however, they were often discriminated against by doctors trained in Indonesia, Portugal, Australia, etc. These Cuban-trained doctors often wanted to specialize and continue training to prove their competence, a concept which threatened private doctors who tended to look down on the Cuban-trained graduates.

On December 15, 2016, Minister B, serving as the interim Prime Minister, expressed his views on the state of healthcare in Timor-Leste. He acknowledged that private healthcare serves as an alternative, but emphasized the need for proper regulation. He noted that private clinics often grapple with issues of malpractice, and patient care is sometimes compromised for the sake of generating income. Minister B also addressed the role of NGOs, criticizing their focus on Dili and their inability to scale beyond pilot projects. He pointed out that NGOs often expend significant resources on promotion and travel.

He suggested that donor countries could learn valuable lessons from Cuba, particularly in terms of living, treating, and integrating with rural and poor populations. He praised the Cubans for their long-term, stable, and reliable impact, which he claimed no other donor country or NGO had been able to match in terms of scale, duration, or stability. Minister B lauded the Cubans for their respectful partnership, stating:

> The Cubans are not patronizing, they do not give us leftovers, they do not tell us what to do or that we are inferior. They are partners. They respect us and our opinions and—importantly—they do all these things to our most vulnerable. (pers. comm., 2016)

He highlighted the progress made in Timor-Leste, which was nearing the end of its battles with TB, Dengue, and Malaria. However, he acknowledged the current challenge of changing the culture with regards to nutrition, sanitation, and recycling.

Addressing the issue of pollution, Minister B revealed that Dili generates 300 tonnes of garbage, 60% of which ends up on the ground. He stressed the need to halt pollution and shared that significant resources are now being allocated to clean the city. Reflective of the 2021 flooding issues in Dili, the system of drainage and sanitation becomes compromised in rainy

seasons as the capital city is built on a flood plain/marsh. During the rains in October-November, in what is known as a cyclical event, the water systems became overwhelmed cause what is known my many development workers, as "Dili belly" (a reference to "Delhi belly" in New Delhi, India).

Dili belly entails a seeming array of gastral intestinal/digestive challenges/sickness as the flooding contaminates the water system with pollution and effluence that had been collected throughout the dry periods. For me it entailed about a month-long battle with parasites. Despite insisting on payment (due to my positionality as a comparatively wealthy Global North male), the doctors insisted that I seek treatment at one of the local publicly run Cuban-supported clinics. It was there at *Klinika Vera Cruz*/Vera Cruz Clinic that I was properly treated, free of charge as anyone can, by local doctors being assisted by Cuban teachers.

Conclusion

The focus of this chapter was on Cuban and Timorese cooperation, especially as it is different from conventional Global North approaches to development. As such Cuba and Timor-Leste's counter-hegemonic cooperation have much to teach Global North development/aid industries as well as various NGOs which often operate within the frameworks of neoliberal and neocolonial logics. NGOs must introspectively question whether their actions contribute to the advancement of a welfare state or inadvertently undermine it. The pursuit of sustainable development, often narrowly focused on alleviating the symptoms of geopolitical injustice and inequality, is identified as part of the problem rather than a comprehensive solution. This is particularly evident in the case of Timor-Leste, where good intentions, charity, empathic capture,

and relational distance pose significant challenges that the future of international development policy and academia must confront.

NGOs, at their best, do meaningful work that extends beyond merely palliating symptoms of poverty. Some have even directed their efforts towards the capacitation and support of the Timorese, as well as the development of their welfare state services. This often involves the Timorese themselves, as exemplified by the Bairo Pite clinic's battle with TB and other treatable pathologies, as well as PRADET's endeavours to provide psychosocial services for individuals experiencing trauma, mental illness, and other psychosocial problems such as family violence. These initiatives are commendable and have the potential to serve as exemplars for other NGO initiatives.

However, neoliberal NGOs can also reflect Jean Baudrillard's concept of charity cannibalism, where "Other people's destitution becomes our adventure playground... [where we continually seek to] ... secure the conditions of the reproductions of the catastrophe market" (Baudrillard, 1994, p, 67). This phenomenon was observed and relates to Arundhati Roy's earlier reflections on the NGO-ization of the neoliberal development/aid industry.

When Cuba attempts to improve healthcare, it inherently relates to broader political policies, often informing aspects of housing, education, and nutrition. In contrast, NGOs often attempt to compartmentalize healthcare into an apolitical act, at times reducing the diagnoses of a single patient to a single disease or illness. The Cuban approach is more likely to consider if these illnesses are impacted by broader health determinants such as poverty, work, or psycho-social interactions.

The neoliberal development industry often manufactures 'success' by cleaning narratives of Timorese and Cuban efforts. While it was clear that a few individuals from the Global North were there to explicitly advance neoliberal and neocolonial logics, policies, and development, with most others, it was difficult to discern the mix of disavowal, empathic capture, and un-surmounted neoliberal/neocolonial logics. These individuals from the Global North grappled with their relational distance to the Timorese Other.

The comments directed at the Cuban cooperation seemed a bit clearer. Despite improvements made, the narrative over the Timorese development success story has been very apparent in many NGO marketing materials and development reports by the World Bank and others. It appears that, due to the omission of Cuban assistance, many reports and NGO marketing campaigns might be able to accrue the mediafication of legitimacy for their performative development approaches. These often attribute their success to single-causal small-scale efforts with comparatively large marketing efforts, often overlooking the complex interactions of history, SDOH, structural violence, as well as geopolitical and corporate efforts to internationalize a small nation's national wealth. This dissertation does not argue that the intentions of healthcare and development providers are wrong, but rather, they should not be stigmatized because of a problematic approach.

In conclusion, this dissertation does not contend that the intentions of healthcare and development providers are misguided, irrespective of their motivations (be it missionary, mercenary, or misfit). Instead, it argues against the stigmatization of these providers due to a problematic system and culture that prioritizes income generation and profit over the pursuit of social good and global betterment. There is a consistent need to establish a link between ideology

and practice, and vice versa. This is crucial to shift the paradigm from viewing development and healthcare as mere acts of charity to recognizing them as embodiments of dignity. This shift is essential for the evolution of a more equitable and humane global society. The future of healthcare and development lies not in charity, but in the affirmation of human dignity and the relentless pursuit of social justice. This is the goal that Cuba and Timor-Leste, not without their own challenges and mistakes, provide important subaltern lessons that Canada and International Development can, and should, learn from.

Conclusion: Healthcare Beyond Personal Agency to Confronting Unjust Systems, Structures, Logics As well as other Pathologies of Neoliberalism and Neocolonialism

> "*The inescapable fact is that when we build a society based on greed, selfishness, and ruthless competition, the fruits we can expect to reap are economic insecurity at home and international discord abroad*."
> (Tommy C. Douglas, 1971)
> "*Hitherto development has been something of a unitary field of theory and practice. As such it has been largely reflective of the ethos of the West and has either ignored or domesticated other discourses. Rethinking development in order to redress [its] problems . . . calls for of a plurality of discourses, a plurality of audiences and a plurality of terrains. The social scientific discourse of the West is not of itself adequate for this purpose . . . All this calls for a political and methodological commitment to dismantling systems of domination which are collectively maintained, and this includes totalizing theoretical systems."*
> (Vincent Tucker, 1999, pp. 15-16)

This dissertation posited that Cuba could possibly offer two significant lessons to the Global North/Canada: how to approach domestic healthcare development in the context of Venezuela, and how to be an effective actor in global development, as exemplified by the Timorese case. This involves transforming the development industry from a charity-based model predicated on projected notions of the 'Other', to a dignity-based model underpinned by a certain degree of governmentality and solidarity. However, writing this dissertation was, at times, a challenging endeavour, particularly when struggling to overcome my own embedded neoliberal and neocolonial ideologies.

Thus, one of the core challenges of this dissertation was to attempt (albeit imperfectly) to make implicit logics—which are embedded in the dominant global neoliberal hegemony—

explicit. As such, this dissertation argued that development and global health must critically engage—as well as de-naturalize—neoliberal and neocolonial hegemonic logics which assume inequality, inequity, and injustice are simply pathologies of personal agency, not pathologies of unjust or structurally violent systems whose roots are the detrimental logics of unfettered free-market capitalism and corporate greed.

Consequently, individuals entrenched in conventional private healthcare systems or neoliberal development programs may find the contents of this dissertation unsettling or even alarming, given the difficulty of confronting these deeply ingrained logics, projections, and disavowals. Hence why this dissertation and its challenging (to write) theoretical complexity was largely guided by Vincent Tucker's critical holism transdisciplinary challenge to reductionist academic tendencies and ego attachment to siloed disciplines.

As noted by Tucker, critical holism attempts to contest the anxieties and fears of incomplete knowledge as well as unsafe feelings of simply *not knowing*—simultaneously challenging one's own perspectives and logics while attempting to remain curious through the complexity of multiple scales and temporalities despite the perpetually-humbling state of incomplete knowledge. This transdisciplinary approach required significant effort to constantly reflect, reshape, as well as reimagine perspectives and knowledge. This included relational connections between people as well as with nature which, at times, felt overwhelming yet important to imperfectly navigate.

As noted by Tucker, the interplay of diverse viewpoints, which dialectically interact through a process of reciprocal critique and rectification, is an important recognition of the varying contexts of experience, articulation, and theorization. Critical holism helped navigate the

potential integration of the experiences of different societies, alternative viewpoints, and diverse cultures into the discourse of development and healthcare. In pragmatic terms, this approach challenges Western ideologies to engage in relational discourse with those from different socio-economic and cultural backgrounds, thereby subjecting their worldview to the examination and critical analysis of the 'Other' (Tucker, 1999, p. 16).

As noted, this transdisciplinary dissertation primarily engaged in the political economy of health and development in an attempt to make the implicit, explicit. To expose geopolitical covert projects as well as highlight deep hypocrisies in many Global North governments. It entailed attempting to understand how relational and ideological proximity to various profit-seeking transnational industries impact the biopolitical health outcomes of relationally-distant non-insured populations. Healthcare and health outcomes simply cannot be separated from power, political will (and lack of it), as well as the social determinants of health (SDOH). As such, this necessarily imperfect effort at subaltern knowledge production (struggling with my own positionality and deep libidinal charges to identify with Global North neoliberal and neocolonial aggressors), was a perpetually dynamic effort toward critical distance. This dissertation attempted to narrow dehumanizing relational distance of oppressed surplus life by prioritizing their voices and perspectives over neoliberal and neocolonial hierarchical logics that have—often—rendered their lives and lived experiences as mere statistics.

The following pages conclude this dissertation by reviewing several key points throughout previous chapters, reflecting on implications for Canada and other Global North countries, as well as incorporating some final thoughts on perhaps the most exceptional experiential learning experience in global health I have personally witnessed—the COVID-19

pandemic. As the research unfolded, it became apparent that this dissertation needed to be viewed through a more complex and contextual lens.

It was important to not exotify the Cuban medical approach or to assume it is merely *sui generis.* The parallels between Canadian and Cuban systems, understanding some of the challenges each faced, and determining which aspects could be strengthened, became areas of important exploration and consideration. Concepts such as 'social determinants of health/SDOH', 'fragmented care', 'patient-centred approaches to healthcare', and 'continuation of care' have all been incorporated into the discourse and experimentation of conventional Western medical systems. Yet, in many instances, Cuba had already experimented with these concepts, and the outcomes were fairly consistent during the presidencies of both Castro brothers. At the time of research, from 2012 to 2020, the Cuban system lacked fragmentation, ensured continuation of care, resisted corporate encroachment into medical services, adopted a patient-centred focus to relationally-proximate care, and included SDOH in comprehensive bio-psycho-social approaches within a health in all policies system.

While Cuba could be lauded for its role in decolonizing knowledge as well as facilitating some subaltern flows of information, it was not without challenges. Cuba made mistakes but continued to attempt to learn from them in their approach to global solidarity. The former Cuban Head of *MBA* in Venezuela's Anzoátegui State reflects on the important lessons and challenges over his journey:

> I do not pretend to make you think exactly like me. It is difficult for me to take away some kind of passion deeply rooted in years of work and compromise with ideas of social justice. I do know there have been many problems with implementing those ideas. The

> Soviet Union debacle was a very hard punch in our brains and hearts (I was there 5 years in the 70s). The present very hard and tense situation in Venezuela, the steps backward in Brazil and Argentina, our own problems, mistakes, and errors in different areas—all are situations and factors in a new international context that we have to consider without giving up our ideals and dreams. (pers. comm. with former Cuban Head of *MBA* in Venezuela's Anzoátegui State, 2017).

Indeed, as events have shown since undertaking research for this dissertation, the Cuban healthcare system has faced many serious challenges.

To a large extent this is due to the enormous cost of dealing with the COVID-19 pandemic, when Cuba focused its healthcare budget on developing vaccines to protect the population. The virtual closure of the tourist industry as a result of the pandemic dealt a major blow to the Cuban government coffers, given the industry's role as one of the major sources of hard currency.

The punitive role of the Trump administration was another major factor. US government policy led to over 400 offices of Western Union being closed down (thereby limiting remittance money from family members abroad—another major source of income). The Trump administration made all cruise traffic illegal, placed limitations on any ships visiting Cuban ports, declared hundreds of Cuban hotels off limits for Americans, prohibited any possible US investments in Cuba, and ended all major forms of US tourism on the island. The Biden administration has, with a few minor adjustments, maintained this policy towards Cuba. Finally, the role of the Cuban government has to be taken into account—and particularly its betting

(unsuccessfully) on investing limited income in the construction of 5-star hotels for the tourism industry.

The result of these various challenges has resulted in major difficulties for the Cuban government, particularly in terms of the health sector. The number of doctors and nurses involved in the healthcare service has dropped significantly: In 2021 there were 106,131 doctors practising, but this dropped to 94,066 in 2022. The decline in the number of nurses at the same time was less: 86,983 to 79,569. Also troubling was the increase in infant mortality deaths—from 4.0 per 1000 live births in 2018 to 7.5 in 2022 (ONEI, 2023).[204] The number of international medical brigades has decreased, to approximately 25,000 in 50 countries, which is down about 40%. Finally, the amount of government support for the production of medicines on the island has decreased, with a 40% deficit in the amount of medicines produced locally, covering 251 medicaments (OnCubaNews, 2023).[205]

At first glance this alarming deterioration in the healthcare service in Cuba would challenge the value of the Cuban model. Both domestically and internationally. However, such a conclusion misses the central point—that Global North countries, with significantly more income and resources, should learn from the 2003-2020 era of Cuban development and respectful international engagement with countries/populations in need (as highlighted by both East Timor and Venezuelan examples). Cuba provided comprehensive preventive and proactive healthcare around the world when many of the richest countries turned a blind eye while extracting profit through unequal terms of trade with Global South countries. Many of these Global North

[204] See tables 19.1 and 19.25 on ONEI website, found at https://www.onei.gob.cu/salud-publica-y-asistencia-social.
[205] See "BioCubaFarma reconoce un déficit del 40% en cuadro básico de medicamentos," OnCubaNews, July 19, 2023. Found at https://oncubanews.com/cuba/biocubafarma-reconoce-un-deficit-del-40-en-cuadro-basico-de-medicamentos/.

countries did this, including medically testing on Global South populations while denying Global South access to the knowledge produced by those tests due to TPI for-profit patent protections and TRIPS agreements. This has all occurred at the same time Global North governments continue taking the best and brightest from Global South countries for their own domestic health needs. This will ensure the continued spread of future pandemics to the detriment of global health, both in the North and the South.

To legitimize the healthcare legacy of Cubans both domestically and internationally, Cuba strived to excel in a Westernized version of healthcare while maintaining the promises of the 1959 revolution (as outlined in their Constitution), even surpassing its northern neighbour, the United States in various health outcomes such as infant mortality and life expectancy. In some respects, Cuban healthcare is not radically different from its northern neighbours, except for its emphasis on prevention/proactive health, a broader social medicine approach, viewing the patient in their entire bio-psycho-social spheres of health, decentralizing the education and health system, and making the profession accessible to all.

As such, Cuba presented an intriguing contradiction to the academic understanding of Michel Foucault's concept of governmentality, which some scholars have interpreted in a negative context regarding the practices and technologies of government. However, in terms of this dissertation, it has not only been helpful in understanding the decentralizing governmental rationalities of liberalism and neoliberalism but has helped frame the Cuban government's use of technologies and practices in their effort to improve healthcare, both domestically and internationally. These policies, in a unique way, had forged a compelling counter-narrative which emphasized inclusion over the glorification of exclusion, dignity over charity, and how to

continually seek the delicate balance between communal and individual rights. It could be argued that—without a certain degree of governmentality—market forces would have compelled Cuba to prioritize individual rights, glorify exclusion, as well as commodify insecurities and poverty (in line with the development/aid industry), thereby ultimately following the familiar trajectory of development and healthcare as charity rather than dignity.

With Foucault and Arturo Escobar leaving the concept of development largely in a state of ironic distance and inaction, it was important to look beyond mere critique in order to search for an evidencable alternative to Global North healthcare and development. Thus, Cuban healthcare solidarity might be a potentially beneficial subaltern alternative that the development industry could learn from, especially considering Cuba's remarkable history of success (Kirk, 2015; Kirk & Walker, 2012; Kirk & Erisman, 2009). In a certain sense, the disconnect in development policy, compounded by Global North saviour complex and empathic capture as understood through psychoanalysis, might be best explained via Georg Simmel's concept of critical distance.

Both Timor-Leste's and Venezuela's Cuban medical cooperation examples offered a plethora of insights, challenges, and potentially beneficial lessons for Canada. Canada faces a myriad of unique public health challenges, including: the fragmentation of its healthcare system; vast geographical distances leading to rural isolation; competition for limited healthcare workers among provinces; inadequate capacity-building in rural, impoverished, and marginalized communities; as well as numerous pilot projects and research initiatives that seldom influence policy, often due to a lack of political will. Other issues include the active recruitment of

healthcare personnel from countries vulnerable to health crises, the proliferation of private care, the interplay between for-profit medicine and public healthcare, and discontinuity of care.

Ultimately, the limits of a right to a dignified life for marginalized populations seeking care from Global North overwhelmed healthcare systems are frequently stymied and the considerations of potentially beneficial alternatives are ideologically narrowed down to a small range of largely ineffective options. These North American healthcare systems continue to struggle with SDOH despite its conceptual popularity in academic circles in the early 2000s as well as a social medicine approach globally advocated for in 1978 via the Alma Ata Declaration. Despite these estimable academic concepts and admirable goals of the Declaration, hegemonic neocolonial and neoliberal logics of have managed to continually place the profit for a wealthy few, some who created the opioid crises, over the well-being of the majority.

Relationally distant, exclusionary, and ideologically insulating archipelagos of affluence and power which, when combined with the bunkerization of space, was significantly more of a factor in Venezuela than in Timor-Leste and, especially, Cuba. In contrast, bunkerization of development and the aid archipelago was witnessed in Timor-Leste. Relational distance is something that can be overcome with relational proximity, humility, and efforts to surmount logics of exclusion, racism, neoliberalism, and neocolonialism.

As a nation emerging from the g7+ fragile state status, Cuban help to Timor-Leste offered one of the few comprehensive state-level bilateral agreements that avoided service/institutional fragmentation, upheld the representation of the domestic population (rather than disempower the host country through 'native administration'), responded to local needs at various scales, and bolstered the entire public health network by catering to the needs of the

Timorese government. This approach contrasted sharply with the dictates and shortcomings of the biopolitical Global North development/aid industry project (frequently following the direction of donors over the local needs of those affected), which often overlooks subaltern flows of information.

The debate over efficiency and corruption in state versus NGO development models was a prominent theme. Interestingly, there appeared to be a gradual acceptance or evolution of collaboration between Cuban personnel and some NGOs or expatriates, which is crucial given their shared goal of improving the health of the Timorese population. This complexity is particularly relevant in the Timorese context, as highlighted by Mark Duffield's research on development industry, institutional fragmentation, and the interplay between insured and non-insured populations. Cuban personnel have been able to embrace collaboration with NGOs and expatriates in Timor-Leste unlike in other cases of medical internationalism. Their shared objective of enhancing Timorese health underscored the importance of navigating complexities in a context like Timor-Leste. Duffield's work on the development/aid industry was especially helpful in understanding the importance of these particular development challenges as well as how the Cuban-Timorese collaboration could potentially overcome them.

Michael Woost's summary of the NGO-ization of development in Jan Nederveen Pieterse's book, Development Theory, provided a valuable lens through which to understand the origins of development/aid industry intention as well as its disconnection from the pitfalls of neoliberal globalization—prioritizing NGOs over the capacitation of state-level institutions. Ilan Kapoor's psychoanalytical work offered a particularly compelling explanation of this phenomenon. Despite the current neoliberal status quo, academia, health education, health policy

and political will should not succumb to ironic distance but instead engage ideology to challenge, and possibly even rescue, the notions of development and healthcare by stripping them of their power relations, approaching with humility via solidarity, from a place of critical distance, and ultimately advancing development as dignity.

Perhaps the most significant finding of this project was the realization that it was about more than just capacitating healthcare workers in traditionally underserved areas. As several respondents noted, witnessing their children, friends, and family become doctors as well as other healthcare personnel had a profound impact, altering their self-perception. They no longer saw themselves as a group of poor people—dependent on the charity of urban or affluent or international Global North populations—but as a community capable of caring for and sustaining themselves. This newfound self-belief, coupled with the knowledge that the next generation of children in their rural or marginalized community would grow up with the understanding that they could become the next doctor, nurse, midwife, or other profession they aspired to, instilled a sense of pride in them that they had rarely experienced before.

This transition from development as charity to development as dignity may be the most significant outcome of this research process. As noted by Tucker:

> development thinking must be underpinned by a conceptualization of culture as a dynamic and conflictual process. The political economy approach that is dominated development theorizing must be complemented by a theory of culture. However, development theory must not simply abandon its political economy approach, and it must also transcend the limitations of text bound literary theory and the political evasiveness of Eurocentric postmodernism. (Vincent Tucker, 1999, p. 17)

The future of development and healthcare must confront discursive power of neoliberal logic as its relational 'Othering' turns healthcare into 'medicine', students into 'units of income', patients into 'clients', proactive and preventive care into curative and palliative biotechnical profit-based medicine, workers into 'units of production', victims of military forays on behalf of extractive industries into 'collateral damage', welfare states into 'clientelist states', public health approaches into a 'wellness industry', as well as actual development into 'charity'.

It is evident that the majority of Global South countries cannot afford to depend on physicians or specialists from the Global North, particularly when compared to the affordability of Cuban medical personnel and their commitment to medical solidarity based on financial capability. The expenditure of approximately $50 per month per Cuban doctor by Timor-Leste starkly contrasts with the potential costs of scaling up their workforce or relying on Canadian physicians at standard Canadian wages—a task that Canada is both unwilling and unable to undertake due to a shortage of healthcare personnel as well as its reliance on brain drain from the Global South. Consequently, Canada, reflective of most other Global North countries, is both incapable and unwilling to support the actual development of welfare states and universal public healthcare in the Global South—instead contributing to policies that undermine the Global South through brain drain and support for neoliberal and neocolonial development approaches advocated by the World Bank (WB) and the International Monetary Fund (IMF).

The WB and the IMF have long been central players in shaping global economic policies. However, their track record raises significant concerns. Despite their professed goals of fostering development and reducing inequality, these institutions have consistently fallen short in achieving meaningful progress, particularly in the Global South. The WB and IMF have failed to

address global inequality adequately. Moreover, their policies have undermined public education and public health initiatives. For instance, during the COVID-19 pandemic, their actions (which decimated public health systems) exacerbated the international spread of the virus, resulting in economic turmoil and adverse health outcomes. These failures underscore the need for critical evaluation.

Rather than serving as impartial agents of development, the WB and IMF must be understood within the broader context of power dynamics. Their alignment with neoliberal ideologies and practices positions them as explicit tools wielded by the Global North. By perpetuating neocolonial power structures, they perpetuate the marginalization of the Global South. Given current global crises and the far-reaching consequences of the pandemic, it is imperative to reconsider our reliance on these institutions. A key recommendation emerging from this dissertation is to seriously contemplate abandoning or significantly reducing funding to the WB and IMF. Their complicity in adverse outcomes—both in terms of mortality and economic well-being—in the Global South necessitates a critical re-evaluation.

These institutions have consistently prioritized corporate interests over human lives. Their policies disproportionately affect non-insured populations, rendering them increasingly vulnerable. As such, they perpetuate a surplus population that remains at the margins of development. Paradoxically, the WB and IMF also function as implicit projects designed to evoke and capture empathy. Their rhetoric often appeals to those who genuinely seek justice and dignity for people in the Global South. However, this veneer of benevolence masks their complicity in perpetuating inequities and injustices. As such, the WB and IMF represent not only explicit tools of neoliberal hegemony but also subtle mechanisms that manipulate well-

intentioned, yet ideologically misguided, empathy. To foster genuine development, governments must critically examine their role and consider alternative approaches that prioritize human well-being over profit-driven agendas.

The suggestion that Timor-Leste should not collaborate with Cuba (utilizing Cuban personnel and training for the capacitation of their public healthcare system) is a pure form of disavowal, albeit often couched in patronizing language. The agenda pushed by many Global North countries, instead of the model advanced by Cuba, is to instead rely on NGO charity from the Global North—despite the lack of continuity of care, uncertainty of donors, refusal to work in the poorest and most rural communities, and a scale of operation that is a mere fraction of that of Cuban cooperation.

Perhaps if Canada and other 'developed countries' in the Global North ever manage to take care of their own citizens using their own human capital, they could begin to address the hypocrisy of depleting the healthcare human capital of the Global South and the exceptional double standards of promoting neoliberal and neocolonial ideologies through multinational development institutions such as the WB and IMF. In order to maintain a delicate balance between awareness and denial, their disavowal potentially involves a desire for self-preservation (continued sponsorship from Global North elites), protection (against 'non-insured' populations migrating from the Global South to the Global North), or avoidance of uncomfortable truths involving their complicity in mal-development. Therefore, their disavowal of the real impact of how inequality and inequity advance global epidemics such as COVID-19 should be a cautionary lesson that should not be overlooked.

Throughout this epidemic, the Global North simultaneously hoarded vaccines as well as enforced for-profit patents for essential healthcare supplies that could have helped control its spread as well as slow the emergence of dangerous and resilient mutations. Additionally, the continued poaching of the best and brightest human capital from the Global South, advancing Cold War ideologies and policies, criticizing Cuba's approaches to medical solidarity and human capital development, as well as promoting neoliberal development/aid charity as a viable solution, has been a geopolitical disaster devoid of genuine humanitarian logic and reasoning. This perhaps explains why those who are relationally distant remain 'charity-cases' and are not deemed deserving of the dignity and human rights that the Global North professes but simultaneously undermines.

If Canada and the US consider themselves the 'pinnacle' of development, why do both countries have such a significant number of 'internationally trained' physicians, which, according to the 2021 CIHI report, constitute more than a quarter of physicians in Canada? In contrast, Cuba has almost no internationally-trained physicians as a significant part of its domestic health system, met its own public health needs during the Castro eras, assisted in the development of universal public healthcare systems based on the requests of host countries, and strived, albeit imperfectly, to meet the health needs of the most vulnerable around the world, including in the most rural, poor, and marginalized populations. As such, the explicit and implicit hegemonic approach of Global North development—including its empathic capture of those striving to do their best—is long overdue for a serious reckoning.

COVID-19 has cast a light on the nature of Global North hypocrisies as well as the long-standing devastation these hypocrisies have caused. COVID-19 pandemic has also exposed great

weaknesses in private healthcare as well as the inaction of the development/aid industry in times of crises. It speaks to Duffield's notion of biopolitical surplus life and bunkerization, where freedom to move as well as leave is only an option for the wealthiest and those from the Global North. This is why charity instead of dignity is so problematic since this neocolonial system of charity-providers often leave when the going gets tough. In contrast, Cuba did the opposite, being first to send doctors to Italy, Spain as well as a myriad of Global South countries when most other countries shut their borders as well as hoarded medical supplies and vaccines.

Thus, Global North governments should confront their problematic reliance on Global South human capital as well as learn from Cuba's examples in both Venezuela and Timor-Leste about development that is based upon what the host country decides it needs for themselves in a way that genuinely capacitates. It must also contribute to social security and the advancement of public institutions. If Canada cannot contribute to scaling up human resources in a way that respects the desires of Global South countries, then perhaps it can learn from other countries, which have already engaged in triangular cooperation with Cuba, to advance welfare state development.

Healthcare versus Medicine

Throughout this dissertation, the terms 'healthcare' and 'medicine' have been used interchangeably to reflect the authentic dialogue between colleagues and respondents. However, it is crucial to distinguish between these two concepts. As underscored in the literature review, particularly by Ivan Illich, Foucault, and Tucker, 'medicine' is a specific framing—often intentionally constructed by the Transnational Pharmaceutical Industry (TPI)—that confines the

scope of 'health care' to the prescription and use of drugs. The foundation of this particular challenge also has its roots in how the Global North still relies on a simplified approach to medical education which over esteems bio-clinical approaches to healthcare to the detriment of SDOH (which contribute comparatively far more to the health outcomes of a country). This is a problematic limitation. Cuba, as well as the theoretical considerations of this dissertation, has helped evidence the potential to overcome these limitations.

In sum, critical holism endeavours to reconcile ideological differences and bridge the knowledge gaps that exist within isolated disciplines. These isolated disciplines often prioritize critique over synthesis, potentially driven by neoliberal ideological tendencies towards competition and hierarchical structures. LASM approach seeks to address the knowledge gaps inherent in traditional Global North biomedical methodologies and medical education, while simultaneously advocating for the political commitment necessary to implement a comprehensive health in all policies approach. The counter-hegemonic model exemplified by Cuba revealed the explicit hegemonic geopolitical project that opposed more egalitarian strategies, which could challenge neoliberal ideologies that intensify geopolitical inequality, inequity, and injustice. Cuba's bilateral agreements, which were based on the needs of the host countries, along with its Latin American School of Medicine (*ELAM*), underscore the importance of viewing development and healthcare as a matter of dignity, not charity.

The approach to medical education in Cuba's *ELAM* emphasizes the importance of *'conciencia'* (a sense of duty to treat patients as family members, not clients), the bio-psycho-social dimensions of health (which fully integrate the SDOH), as well as the importance of health equity and the empowerment of relationally-proximate marginalized and impoverished

populations to meet their own healthcare needs. The implementation of LASM in Venezuela provides evidence of subaltern knowledge that could be applicable in Global North contexts to reduce disparities between populations and effectively address issues of structural violence. The implementation of LASM in Timor-Leste highlights the importance of critical distance (found to be lacking in conventional neoliberal development approaches) and subaltern knowledge that could be applicable for international development to reduce disparities between Global North and Global South.

This is reflective of the growing body of evidence, including works by Paul Farmer, Richard Wilkinson, Kate Pickett, as well as this dissertation, which underscores how healthcare must extend beyond the simplistic equation: 'doctors + drugs'. Healthcare encompasses access to nutritious local food and housing, environmental protection, a well-trained community-based police force that helps combat discrimination and abuse, a legal system that supports the welfare of victims of domestic and intimate partner violence, access to jobs with living wages, recognition and support for informal labor and housework, efforts to overcome inequality, addressing the roots of structural violence, a robust public transport system, a banking system that supports the financially vulnerable, a business sector that prioritizes social good, international relations based on solidarity, the design and redesign of cities to be more pedestrian and bike-friendly, as well as access to inclusive and safe social spaces. These spaces, especially as found in the patient-centred team-based healthcare centers, should overcome barriers of exclusion faced by individuals of varying socio-economic levels, political ideologies, genders, sexual orientations, ages, races, and geographical locations.

In essence, this embodies the 'health in all policies' approach advocated by the World Health Organization in the Alma Ata declaration. There is no need to rewrite the book, it is already there. Other countries have utilized financial and material resources to cooperate with Cuba and help Global South countries meet their genuine needs from a critical distance that does not undermine sovereignty nor dignity. Therefore, perhaps there is a need for a global Hippocratic oath that seeks to overcome dangerous relationally distant logics to approach the future of health and development as an effort to heal the global body politic.

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