

Press Release  
July 19, 2007

“Re-examining the Cuban Health Care System”  
Article in UM’s *Cuban Affairs* Journal Reveals Details

Coral Gables, FL.-Contrary to what Michael Moore’s documentary, “Sicko,” would lead you to believe, Cuba’s health care system is far from perfect.

Although it has long been praised as one of the revolution successes, Cuba’s health care system works for foreigners but often fails its own citizens. That is the conclusion of an article titled “Re-examining the Cuban Health Care System” included in the latest edition of the online journal, “Cuban Affairs,” published by the University of Miami’s Institute for Cuban and Cuban-American Studies.

The author, University of Oklahoma Professor Katherine Hirschfeld, spent nine months in the island living with a Cuban family and interviewing family doctors, medical specialists, social workers, nurses and patients as part of her research.

The article details the realities of the health system “where the best clinics and hospitals only serve the political elites and foreigners and scarce medical supplies are often stolen from hospitals and sold on the black market.”

Through personal observations and interviews, Hirschfeld details the three levels of healthcare in Cuba. One for foreigners paying in hard currency; an excellent system with great equipment and medication. A second one for the military and high government and party officials. Again, this system is excellent. On the contrary, the one most Cubans deal with is poor; there is a shortage of equipment and medication; and now many of the physicians serving them are sent abroad for humanitarian purposes.

Please see this very enlightening article (see attachment).

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## Re-examining the Cuban Health Care System: Towards a Qualitative Critique

**Katherine Hirschfeld**

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1531 Brescia Avenue, Coral Gables, 33146-3010;  
Tel: 305 284-CUBA (2822), Fax: 305 284-4875, Email: [cubanaffairs@miami.edu](mailto:cubanaffairs@miami.edu)

## **Introduction**

Based on such key statistical indicators as infant mortality, longevity, infectious disease rates, and provision of health services, Cuba appears far superior to neighboring countries. The vast majority of scholarly analyses of Cuba's health care system have been positive, and the Cuban government continues to respond to international criticism of its human rights record by citing this praise for its achievements in health and medicine (Chomsky, 2000; Limonta and Padrón, 1991; Weiner, 1998). In fact, some scholars continue to argue that despite the debilitating economic crisis brought on by the collapse of the Soviet Union, Cuba's health system remains superior to neighboring countries such as the Dominican Republic (Acosta, 1997; Chomsky, 2000; Whiteford, 2000; Whiteford and Martinez, 2001).

My own research, however, suggests that the unequivocally positive descriptions of the Cuban health care system in the social science literature are somewhat misleading. In the late 1990s, I conducted over nine months of qualitative ethnographic and archival research in Cuba. During that time I shadowed physicians in family health clinics, conducted formal and informal interviews with a number of health professionals, lived in local communities, and sought to participate in everyday life as much as possible. Throughout the course of this research, I found a number of discrepancies between the way the Cuban health care system has been described in the scholarly literature, and the way it appears to be described and experienced by Cubans themselves. This paper will provide a brief overview of several of these issues, with the goal of offering a more balanced and ethnographically informed portrait of the Cuban health care system. A final section will discuss these issues in the context of the assumptions social scientists have historically made regarding the nature of health and health systems in socialist countries.

## **The Formation of a Critical Perspective: A Short Fieldwork Vignette**

Conducting qualitative ethnographic research in Cuba is not easy. North American anthropologists have historically been viewed with suspicion by the Cuban government, and in

some cases research permission has been revoked for individuals who took a critical perspective or inadvertently broached the issue of political dissent (Lewis, 1977; Rosendahl, 1997). In my own case, the overwhelmingly positive portrayal of Cuba in the medical anthropology and public health literature meant that I arrived on the island with very favorable expectations. I never anticipated my research would evolve into a critique.

After just a few months of research, however, it became increasingly obvious that many Cubans did not appear to have a very positive view of the health care system themselves. A number of people complained to me informally that their doctors were unhelpful, that the best clinics and hospitals only served political elites and that scarce medical supplies were often stolen from hospitals and sold on the black market. Further criticisms were leveled at the politicization of medical care, the unreliability of health data and the overall atmosphere of secrecy surrounding the prevalence of certain infectious diseases such as HIV and tuberculosis. Anecdotes of medical malpractice and bureaucratic mismanagement seemed common. The Cuban health care system, as described by Cubans in informal speech, seemed quite different from the Cuban health care system as described by North American social scientists and public health researchers. This is not to say that Cubans had nothing positive to say about their health care system, only that negative personal experiences also seemed common. Intrigued by this discrepancy between the academic literature and my fieldwork observations, I began informally collecting information on patient dissatisfaction and complaints.

### **Doing Critical Research**

Unfortunately, research exploring negative aspects of the Cuban health care system cannot be undertaken with methodological rigor. Public criticism of the government is a crime in Cuba, and penalties are severe. Formally eliciting critical narratives about health care would be viewed as a criminal act both for me as a researcher, and for people who spoke openly with me. As a result it can be very difficult for foreign researchers or other outsiders to perceive popular dissatisfaction, and few Cubans are willing to discuss dynamics of power and social

control in a forthright manner. Conversations on these topics can be quite cryptic, and meanings are deliberately obscured.

Eliciting critical narratives regarding the health care system therefore necessitated informal research methods, and much of the information I gathered on these topics is fragmented and anecdotal. This should not be taken to mean that the data are insignificant. To the contrary, it is worth pointing out that a number of the conclusions social scientists have previously made about Cuba and the Cuban health care system have not been based on any ethnographic or qualitative research. When social scientists interested in health care have gone to Cuba, their research appears to have been of short duration and most likely mediated through the use of government-provided translators or guides (3). As Paul Hollander has pointed out, short term “hosted” visits to socialist countries have historically resulted in painfully inaccurate assumptions about the nature of life in these societies (Hollander, 1998).

In order to obtain more reliable information about negative experiences in the health care system, I abandoned my formal research agenda and my role as a researcher and instead strove to learn from an insider perspective by taking on a “membership role” (Adler and Adler, 1987). As a number of anthropologists and sociologists have demonstrated, research on politically sensitive topics necessarily limits one’s methodology. The data gained from informal participation in sensitive areas, on the other hand, while not as analytically rigorous, can provide a wealth of insight that more distanced or objective methods may not (Ferrell, 1998).

In my case, abandoning a formal researcher role and taking on a membership role meant that I spent more time in my social role as visiting student and adopted daughter in a Cuban household than I did in my formal role as scholarly researcher. In this context I became much more aware of peoples’ expressions of dissent and dissatisfaction as well as the local idiom for discussing politically sensitive topics. Instead of formal interviews, I carried on ordinary conversations with people in the course of everyday events such as waiting in food lines and social visits. I was carefully never to ask politically sensitive questions, but simply listened to people and gently probed for more information when they volunteered this information

themselves. Much to my surprise, people seemed quite willing to discuss these kinds of issues off the record.

These experiences led me to conclude that any foreign researcher who did not strive to take on a membership role could easily draw a number of erroneous conclusions even from ostensibly confidential interviews in Cuba. People simply would not voice negative opinions in the context of researcher-interviewee interactions. Questionnaire data would be similarly unreliable. In fact, most Cubans I spoke with informally seemed to view questionnaires as tools to elicit popular reiteration of the party line. As one friend stated, "We know we're supposed to be moving toward democratic reforms and be able to speak out, to criticize. But people are still scared. Any kind of survey or opinion poll makes them afraid. No one will say what they really think."

My increased awareness of Cuba's criminalization of dissent raised a very provocative question: *to what extent is the favorable international image of the Cuban health care system maintained by the state's practice of suppressing dissent and covertly intimidating or imprisoning would-be critics?* Obviously it is not possible to empirically answer such a question. It is, however, important that the question be asked, if only rhetorically. Previous research in anthropology and public health theorizing the nature of socialist health systems has not typically addressed issues of authoritarianism, dissent or social control in socialist countries (1). The possibility that favorable health indicators may be produced by very different means in Cuba than in other countries--means that individual doctors and patients experience negatively--has not been examined.

The main goal of this paper will be to correct this imbalance by exploring (and implicitly validating) two key areas of criticism Cubans commonly make of their health care system in informal speech: 1) material shortages and inefficiency; and 2) authoritarianism and the criminalization of dissent. Ultimately I will argue that Cuba (like the former Soviet Union) could be more usefully thought of as an "ideocratic" state, where political power is used to support and defend Marxist ideology. As retrospective studies of the Soviet health system have

shown, this unique configuration of ideology and power can produce very favorable health statistics, but can also lead to subjectively negative experiences for individual doctors and patients.

### **Material Shortages and Inefficiency**

One of the most readily apparent problems with the health care system in Cuba is the severe shortage of medicines, equipment, and other supplies. This problem is by no means limited to the health sector. Cubans often have tremendous difficulty obtaining basic consumer goods and other necessities, including food. In the official Cuban media and in much of the social science and public health literature in the United States, these shortages are described as resulting from the U.S. trade embargo (Barry, 2000; Garfield and Santana, 1997; Garfield and Holtz, 2000; Nayeri, 1995; Simons, 1996). This assertion is not entirely incorrect--the U.S. trade embargo certainly exacerbates material shortages on the island.

When speaking informally, however, many Cubans state that their government deliberately maintains economic policies that create material shortages that exacerbate the effects of the embargo. There is some logic to these statements. A number of Cuba's economic privatization efforts do not appear to have been designed to alleviate material shortages for the Cuban populace, but to increase hard currency earnings for the Cuban government (for a complete overview of this argument, see Crabb, 2001). As one friend jokingly described,

What we have here is a mixed economy. People call it 'socio-cap.' It's not socialism, and it's not capitalism. Instead it's the worst of both. There is inequality and poverty [of capitalism]. And also long lines [for food and other goods] and inefficiency [of socialism]. We still have nothing to eat. (4)

A number of key sectors of the economy (such as health) remain governed by centralized planning, which inevitably leads to chronic material shortages and inefficiency. In a centralized economy, forces of supply and demand are inevitably out of balance, leading to overproduction

of some goods and underproduction of others. As a result of these shortages and inefficiencies in the formal, planned economy, black markets (or informal economies) emerge as an alternate source of goods and services (Eckstein, 1994; Perez-Lopez, 1995; Verdery, 1996). These kinds of illicit economic activities undermine the effectiveness of centralized planning and exacerbate the inherent inefficiencies of the system. Furthermore, the formal economy could not function without this parallel black market, given that planners simply could not insure the necessary supplies of raw materials.

This pattern is quite apparent in Cuba. One study, for instance, has estimated that the average Cuban household spends between fifty and seventy percent of its income on black market goods (Eckstein, 1993:142). During my field research I observed an overwhelming popular reliance on the black market or informal economy to satisfy basic consumer needs, including health needs. Nearly everyone I knew was to some extent dependent on goods and services procured via informal reciprocity networks of friends and relatives (usually referred to as “*socios*”). The popular term for this practice is “*sociolismo*,” a term Cubans jokingly use to describe the lived reality of their socialist system.

A Cuban friend, alternately amused and exasperated at my naivety regarding these issues, described the relationship between the formal and informal economies to me rather more bluntly as follows,

It works like this. If my brother is well-connected politically, he can get a good job in a tourist hotel. Not only does he get to earn some American dollars, he also gets access to the hotel’s storeroom [which represents a supply of desirable consumer goods that are unavailable to most Cubans]. One day he may walk away [steal] with some towels for his neighbor, who has none. Say the neighbor works in a factory bottling beer. To repay his *socio* he’ll smuggle a case of beer out of the factory and give it to the hotel employee. The hotel employee will then trade the beer to the maid for a supply of soap, which he’ll either give to his *socios* or sell on the black market. Everybody does it. It’s the only way to survive.

In my experience, the health sector often appears to be characterized by these kinds of informal exchange networks. In one of my study communities, for instance, no one used the formal health sector at all for commonplace medical complaints (colds, flu, muscle strains,



arthritis) for the duration of my fieldwork. Instead, *socios* were tapped for medical consultations, surgical supplies, dental equipment, pharmaceuticals (often sent by relatives from Miami) and folk advice, while the local family doctor clinics were often bereft of both patients and supplies. Two short case studies illustrate these dynamics.

### **Case 1: Pepe's Tooth (as told by Pepe)**

When one of my wisdom teeth started coming in it hurt terribly so I made an appointment with a friend of mine who's a really good dentist to take it out. Well, when we first tried to schedule it there weren't enough materials available, so we had to put it off for a while, until he could hoard back enough stuff [surgical materials]. First there weren't any needles. Then no sterile water, then no surgical thread. About three or four months went by before we could actually do the surgery. He had gradually stashed things away as he found them, and then, since he was a friend of mine, he had me come in on a Saturday when the clinic was closed to do it.

### **Case 2: Sylvia's Tooth (as told by Sylvia)**

They [the dentist] tried to give me acupuncture instead of anesthesia when I had a tooth pulled. These two nurses poked needles in my head, but I don't think they really knew what they were doing...As soon as the dentist started to work on my tooth I let out these screams, screamed like crazy, and they still stood there talking... Luckily a nurse friend of mine was working in the next room and she came and gave me a shot [of Novocain]. 'Here' she said, as she pulled the syringe out of her pocket, 'I saved this back for you.' Thank God she showed up.

These two cases illustrate the necessity of having strong social networks in Cuba. Without *socios* to procure supplies even routine medical or dental procedures can be difficult or impossible to endure. Furthermore, this form of theft is commonly accepted and carries no moral stigma.

Unfortunately, these practices serve to bankrupt the formal economy, leaving it almost an empty shell, while much of the actual business of medicine (diagnosis, treatment, and obtaining pharmaceuticals) is conducted through personal networks of *socios* using pilfered medical supplies. A number of reports from the former Soviet Union illustrate a similar pattern

(Feshbach and Friendly, 1992; Ledeneva, 1998; Knaus, 1981). As Ledeneva (1998:29) has described,

Getting into a good hospital, a hospital already filled to capacity, or the hospital with the right specialization for one's illness still required *blat* [the Soviet equivalent of *sociolismo*]. Surgical operations at the best medical centres were, and still are, organized by *blat*: 'When I had this problem my friend arranged that I be hospitalized in the regional clinic where he worked and not in the city hospital to which I was affiliated.' To arrange an appointment with a well known doctor also implied a personal contact or acquaintance. Doctors were important people with whom to cultivate relationships because, in addition to providing access to hospital beds, *blat* with the doctor could sometimes make the difference between whether he or she listened seriously to the patient and gave a good diagnosis during a visit or only dealt with the matter perfunctorily.

In such a situation, it is easy for the Cuban government to point to the empty shell of the formal health sector as evidence of the negative impact of the U.S. embargo. Again this is not to say that the embargo has no health costs, only that a true assessment of the costs of the embargo cannot be reckoned without also measuring the medical goods and services circulating in the informal economy. Unfortunately, economic transactions in the informal economy are difficult to assess, and the Cuban government is not likely to encourage such lines of inquiry.

### **The Politicization of Health and Health Care**

Many Cubans (including a number of health professionals) also had serious complaints about the intrusion of politics into medical treatment and health care decision-making. There is no right to privacy in the physician-patient relationship in Cuba, no patients' right of informed consent, no right to refuse treatment, and no right to protest or sue for malpractice. As a result, medical care in Cuba has the potential to be intensely dehumanizing.

To elaborate, these values (privacy, autonomy and individualism) form the cornerstone of medical ethics as understood in most Western health systems (Brock, 1987). Privacy and autonomy underlie the practice of informed consent, as well as other legal codes that ostensibly

protect patients from potential abuses (unwanted treatment, inappropriate treatment or untested experimental treatment) of modern medicine. Legislation giving patients these rights was enacted in the United States as a deliberate response to the perceived excesses and ethical lapses of medicine in the 1940s and 1950s.

A number of scholars have argued that the notion of privacy, or an autonomous realm of personal thought and behavior, is even key to the Western conceptions of selfhood and identity (Bryant, 1978; Goffman, 1960; Ingham, 1978; Lifton, 1961; Shweder and Bourne, 1984; Young, 1978). As Shweder and Bourne have stated,

We find it tempting to argue that Western individualism has its origins in the institution of privacy--that privacy promotes a passion or need for autonomy, which, for the sake of our sense of personal integrity, requires privacy (p. 194).

In Cuba, however, values such as privacy and individualism are rejected by the socialist regime as “bourgeois values” contrary to the collective ethos of socialism. Given these dynamics it is not surprising that several noted Cuban dissidents, as well as North American psychiatrists interested in the psychological dimensions of socialism have described the subjective aspects of life in socialist regimes in terms of a literal assault on the self. These scholars have described tremendous emotional and psychological trauma resulting from these dynamics (Arenas, 1994, 1993; Kleinman and Kleinman, 1986; Kleinman, 1986; Lifton, 1956; 1961).

As a result of this devaluation of autonomy and individuality, the health care system in Cuba is often quite paternalistic and authoritarian, and politics intrude into medical practice in a number of subtle and overt ways. The eradication of the private sphere means that all activities, whether in the household, community, or clinic become the object of medical-political scrutiny. Cuban family doctors are expected to attend to the “health of the revolution” by monitoring their neighborhoods for any sign of political dissent, and working closely with CDR officials to correct these beliefs or behaviors. Family doctors are also expected to report on the “political

integration” of their patients, and to share this information with state authorities. Political integration refers to such activities as participation in volunteer labor brigades, membership in mass organizations as well as exemplary work records.

The extent to which family doctors actually engage in political (or economic) surveillance of their patients appears highly variable—some doctors appear eager to win political points by informing on their patients while others struggle to maintain at least some confidentiality. In one clinic, for instance, I observed several patients unselfconsciously confide potentially "subversive" activities or sentiments (mostly involving household activities in the informal economy) to their family doctor, who appeared to sympathize accordingly. It was clear that the relationship of trust and caring between these doctors and their patients was forged out of their mutual ability to protect these confidences.

On the other hand, I also observed one physician who considered it part of his duty to the revolution to use his intimate knowledge of patients and their families to further the agenda of the government. He was unpopular, and many people in his medical district chose to pursue their health care exclusively in the informal economy--his clinic was often empty. The use of *socios* as health professionals both strengthened kin or friendship bonds within these informal networks, as well as allowing patients to subvert the political aspect of a formal medical visit with a militant doctor.

The intrusion of politics in medical care is also illustrated by the militaristic rhetoric used in Cuban medical textbooks and other health publications detailing the ideology and practice of socialist medicine. This military model strongly emphasizes discipline, hierarchy, and complete obedience to political authority for all doctors. One introductory textbook, for instance, (Rigol et al, 1994:28) described the role of the "revolutionary" doctor as emblematic of "*un militante de la salud*" ("a health militant"). Another source revealed that the standard medical school curriculum includes several semesters of mandatory classes in "preparación militar"--or military training (MINSAP, 1979). This training is designed to underscore the role of the physician in the "war" against imperialism and underdevelopment. One description of the ideal revolutionary

doctor included such personal traits as "simplicity, modesty, and honor" as well as "patriotic-military preparation necessary for the defense of the revolution and socialism on the national or international scale" (MINSAP, 1979:39).

Two short case studies are useful in illustrating the authoritarian and paternalistic dimensions of the Cuban health system:

### **Case #1: Reproductive Choice**

The Cuban Ministry of Health [MINSAP] expects physicians to structure their clinical interventions to achieve the Ministry's annual health goals. As with other sectors of the economy, MINSAP sets statistical targets that are viewed as the equivalent of production quotas. The most carefully guarded of these health targets is the infant mortality rate. Any doctor who had an unusually high rate of infant deaths in his or her jurisdiction would be viewed as having failed in a number of critical respects. One of the family doctors I worked with in Havana was quite politically militant and took these health goals very seriously. One day during my clinic observations I observed her scheduling an ultrasound for a pregnant woman.

"What happens if an ultrasound shows some fetal abnormalities?" I asked.

"The mother would have an abortion," the doctor replied casually.

"Why?" I queried.

"Otherwise it might raise the infant mortality rate."

### **Case Study #2: Medical Malpractice**

One family doctor told me that she once led an instructional seminar for medical students at the University of Havana. During the seminar they reviewed several problematic cases, one of which involved a patient who had died due to mistakes made by a doctor. The case was included as a warning to the students to be careful in following established treatment protocols and surgical procedures.

After the seminar, one of the medical students approached the doctor and told her that after reading the case file, she realized that the patient in the case study was actually a close relative of hers. She said that the doctors who treated him told her family he had died of natural causes, and she was very traumatized to find he had actually died from malpractice. The doctor running the seminar sympathized with the student's grief and anger, but told her it would be better if she kept quiet and made no complaint against the hospital. To do so would be to risk being labeled a political dissident or a counterrevolutionary. The student reluctantly concurred.

In the first case, the patient is granted no autonomy to make her own reproductive choices. The clinical sphere is not a private space where doctors and patients discuss medical options and come to a joint decision on how to proceed. Instead, the clinic is a political space and decisions are often made according to the larger statistical and political goals set by the national Ministry of Health. There is no right to privacy in the doctor-patient relationship to protect clinical medicine from this type of political intrusion.

The second case also illustrates the disempowerment of individual patients that results from the devaluation of individuality and autonomy. Collusion between physicians to cover-up medical mistakes is not uncommon, and has been documented in a number of health systems, including the United States and Japan (Langlie, 2002; Larimer, 2001). The key difference in the Cuban example concerns the right of patients or family members to publicly criticize their doctors and assert a right for compensation in known cases of malpractice. Such a course of action implies a notion of individual rights, and a willingness to assert those rights. In the Cuban system, patients are not accorded individual rights in this way, and any attempt to assert otherwise would likely result in some form of political sanction.

### **Problematizing the State**

These issues--the criminalization of dissent, the denial of individual rights, and the eradication of the private sphere--are in my opinion, fundamental in understanding the dissatisfaction and negative experiences that doctors and patients often report in Cuba. Previous analyses of the Cuban health care system, however, have focused almost exclusively on statistical health indicators and have not examined these issues. This oversight is significant, and merits some discussion.

Historically medical anthropologists have not problematized the nature of power in revolutionary socialist societies. Instead, most of these scholars have maintained a definition of "socialism" that implicitly characterizes these regimes as progressive and egalitarian (Singer and Baer, 1989; 1995; Singer, 1990; Singer, Baer and Lazarus, 1990). Power relations have not been

discussed in these analyses, even in the post-Soviet era. Correspondingly, the criminalization of dissent in Cuba and other revolutionary Marxist regimes has received little (if any) attention. What is a dissident? What is a counterrevolutionary? Examining these questions provides some insight into the darker aspects of socialist regimes and socialist health systems, and offers a potential explanation for the discrepancy between the laudatory tone of the scholarly literature and the criticisms voiced by individual doctors and patients I spoke with in Cuba.

In official Cuban government rhetoric, dissidents or critics are defined as “reactionaries” or enemy agents devoted to subverting the egalitarianism and social justice of the revolution. Their activities and beliefs are defined as political treason, and their criticisms are often dismissed or rejected as “imperialist propaganda.” There is no possibility of legitimate dissent within the socialist system. This position has often been implicitly validated by the social science and public health literature on Cuba, which has not traditionally acknowledged or analyzed the criticisms dissidents have made regarding the Cuban health care system (5).

Are all dissidents in Cuba reactionaries and enemy agents seeking to discredit the government? My own ethnographic experience, as well as a number of published narratives (Arenas, 1994; Llovio-Menendez, 1988; Mendoza and Fuentes, 2001; Valladares, 1986) suggest otherwise. In many cases it appears that the label of dissident is used to penalize or discredit anyone who challenges the authoritarianism of the state or attempts to assert individual rights in the face of what can be extremely dehumanizing conditions. An ethnographic example is useful in illustrating these dynamics:

### **Ethnographic Vignette: Who are the Counterrevolutionaries?**

The niece of a friend in Santiago was admitted to a special school for young artists in Havana. While she was there it was common knowledge that the staff of the school was stealing food intended for the students and selling it on the black market. As a result the students were often forced to survive on reduced rations. One week the students were left with nothing to eat but white rice and they spontaneously erupted into a loud demonstration of protest. Government officials quickly arrived on the scene and demanded, “Who are the counterrevolutionaries who have organized this demonstration!?” Students were interviewed one by one and pressured to inform on their classmates--to reveal covert ‘imperialists’ who were ostensibly responsible for the

protest. Eventually the situation was resolved and no one was arrested, but the students remained cowed for the remainder of their time in the institute. My friend sighed after recounting me this story. "Can you imagine? Nothing but white rice for an entire week..."

This anecdote reveals the way dissent is constructed by the revolutionary government in Cuba. Anyone who speaks out or protests is vulnerable to being labeled a counterrevolutionary regardless of the actual circumstances or seeming legitimacy of the complaints. This pattern appears common to all socialist countries. Not only is dissent prohibited but great effort is put forth to discredit those who voice criticism, claim dissident status, or attempt to emigrate (see Parchomenko, 1986).

### **Theorizing the Socialist State: "Ideocracy" and Health**

A number of political theorists have attempted to explain these dynamics by examining the relationship between Marxist theory and state power in socialist regimes. These theorists have linked the criminalization of dissent and the eradication of the private sphere to the extreme progressivism of Marxist revolutions (Buber, 1996; Luow, 1997; Kolakowski, 1977; Talmon, 1960). In other words, revolutionary movements are predicated on a belief in the collective unity and rightness of "the masses." The singularity of the revolutionary vision, and its presumed historical irreversibility means that those who speak out in opposition subsequently become defined as "traitors" or "enemy agents" seeking to undermine the historical destiny of the nation. The mandate for unity and collective progress towards a utopian future effectively outlaws dissent. Critics of the regime are subsequently viewed with great hostility, as serving to impede the collective, predestined progress of the nation (and humanity) as a whole (Talmon, 1960:113).

These theorists have gone on to assert that these dynamics result in the creation of "ideocratic" states. According to Remington (1988) in an ideocratic state, political power is used to maintain the legitimacy of revolutionary ideology--a practice that includes aggressively policing speech and other cultural productions. In other words, in a socialist regime--*ideological dissent or deviant beliefs are equated with political treason and heavily criminalized.*



In this sense Marxist revolutionary movements differ from other kinds of utopian philosophies (such as religious or millenarian movements, for instance) in that the coercive powers of a secular, rational, *state* are deployed to police dissent and bring the projected utopian world into being. Vaclav Havel has described this configuration of ideology and power as follows,

[Under socialism] reality does not shape theory, but rather the reverse. Power derives its strength from theory, not from reality, and inevitably power begins to serve the ideology rather than the other way around. Not only does this ideology guarantee power in the present, but it increasingly becomes the guarantor of its continuity (quoted in Gleason, 1995:185).

These observations illustrate the necessity of including state power as a variable in analyses of socialist health systems. Understanding the relationship between ideology and power in a socialist state provides an useful explanatory model for the discrepancies between the positive image of Cuba as reported in international social science and public health literature, and the negative experiences and criticisms reported in informal speech by many doctors and patients.

In an ideocratic state, political power is used to maintain the legitimacy of the ruling doctrine--in this case, Marxist theory. If Marxist theory predicts that health and health care delivery will improve in a revolutionary regime, then political power will be used to insure that this pattern becomes manifest in the revolutionary state. These efforts can take several forms. On the one hand, great emphasis is often placed on constructing hospitals and health facilities, and equalizing access to health resources. Many early Soviet and Cuban publications, for instance, emphasize this element of concern for health and health planning, and health statistics were often used to illustrate the superiority of the socialist regime (Berman, 1953; Sweezy, 1949; Hollander, 1997).

On the other hand, "revolutionary" health efforts can also include such practices as deliberate manipulation of health statistics, aggressive political intrusion into health care

decision-making, criminalizing dissent, and other forms of authoritarian policing of the health sector designed to insure health changes reflect the (often utopian) predictions of Marxist theory. All of these practices have been extensively documented for the former Soviet Union and China (Cockerham, 1999; Feshbach and Friendly, 1992; Fitzpatrick, 1999; Garrett, 2000; Guillemin, 1999; Hoch, 1999; Lifton, 1976; Knaus, 1981; Tulchinsky and Varavikova, 1996).

During the Soviet era, however, the true extent of these practices was virtually unknown in the West. Western social scientists interested in the question of socialist health frequently cited favorable health statistics from the USSR, China, and Cuba, but did not look critically at the ways state power was used to create and maintain these health indicators. In some cases it is likely that the socialist system did genuinely improve health and health care delivery. In other cases, it is likely that state power was used in a way to as to give the illusion that such positive changes were taking place by imprisoning dissident physicians, intimidating would-be critics, and manipulating health statistics.

### **Conclusions: Socialism, Public Health, and Social Science**

In the introduction to this paper I raised a somewhat radical question: *to what extent is the favorable international image of the Cuban health care system maintained by the Cuban government's practice of suppressing dissent and covertly intimidating or imprisoning would-be critics?* The goal of the paper has not been to answer this question so much as to argue for its relevance in assessing the Cuban case. When speaking informally, Cubans often make critical comments about their experiences in the health care system. To my knowledge, however, these locally articulated criticisms are not included in social science or public health articles on the Cuban health care system. As a result of this omission, the scholarly literature on Cuba implicitly validates the point of view of the Cuban government--that shortages are caused solely by the U.S. trade embargo, and that that the complaints of dissidents are not legitimate.

The ethnographic data and analysis presented here are intended to challenge these assumptions. I have tried to illustrate that material shortages are endemic to all centralized,

planned economies, and that in addition to devoting resources to hospital construction and expansion of the health sector, ideocratic states often use very authoritarian tactics--tactics that individual doctors and patients can subjectively experience very negatively--to create and maintain favorable health statistics. When issues of state power and social control are factored into the analysis, it becomes possible to see how Cuba's health indicators are at least in some cases obtained by imposing significant costs on the Cuban population--costs that Cuban citizens are powerless to articulate or protest, and foreign researchers unable to empirically investigate.

At this point, it is important to clarify that taking a critical perspective toward Cuba and Cuban health care does not imply a casual dismissal of the ideals of the Cuban Revolution or the compelling rhetoric of social progress and equality that has accompanied Cuba's health initiatives. As Peter Berger has pointed out, "a critique is not an attack, but rather an effort to perceive clearly and to weigh human costs" (1986:71). My primary goal in this work, therefore, has been to use ethnographic data to illustrate some of the human costs of Cuba's "socialist health and health care," and to challenge the case for Cuban exceptionalism with respect to some of the problems that have been described for other socialist health systems such as the former Soviet Union.

## Notes

1. There is a small but significant body of literature in medical anthropology devoted to exploring the relationship between capitalism, socialism, health and health care. This subfield is usually referred to as “critical medical anthropology” and its focus is outlined in the works of Baer, Singer and Johnsen (1986), Baer (1989; 1990), Singer (1990), Singer and Baer (1989; 1995), and Baer, Singer and Susser (1997). Other noted social scientists and health professionals have also contributed to this literature and shaped the approach of critical medical anthropologists, including Howard Waitzkin (1983), and Vincente Navarro (1976; 1978; 1986; 1989) and Ray Elling (1989). The focus of this scholarship has typically been applying Marxist critiques to health conditions and health problems of capitalist countries and capitalist health systems. The socialist alternative to capitalist health and medicine is usually described by these scholars in rather idealistic terms, based on the predictions of Marxism rather than empirical investigation of health conditions in socialist states.
2. Given the sensitive nature of such comments, extra care has been taken to insure confidentiality. All names in this paper are pseudonyms, and in some cases genders, ages and geographical locations have been changed to further conceal identities. Phrases marked as direct quotes were not tape recorded. Instead I made notes to myself in my field notebook as soon as possible after the interview or conversation took place.
3. To my knowledge, Scheper-Hughes, (1993) and Waitzkin and Britt (1989) offer the only two medical anthropology studies of the Cuban health care system based on firsthand visits and qualitative research. Unfortunately, these authors provide little or no information describing the circumstances of their research, their research methods or the duration of their time in Cuba. Another work that deserves mention here is Julie Feinsilver’s (1993) *Healing the Masses*. While this book offers a very engaging and complete analysis of Cuban health policy, it does not include qualitative community research or clinic observations.
4. A short overview of Cuba’s recent economic reforms will better contextualize this remark. After the fall of the Soviet Union the severe economic crisis in Cuba forced new economic reforms. Farmer’s markets were legalized, along with a number of small business operations, such as family-run restaurants, bicycle repair, and so forth. The holding of American dollars was legalized until recently, and the state developed a dual economic policy. Economic centralization and rationing were kept in place for most goods and services but at the same time hard currency markets were opened offering a number of specialized goods that were unobtainable elsewhere. Most Cubans, however, (especially those outside of the city of Havana) have excluded from participation in the privatized sectors of the economy, which are largely restricted to political elites. In recent years even these limited reforms have been reversed, privatization has diminished, and the economy has become recentralized in many sectors.
5. Despite the claims of Waitzkin and Britt (1989) that even “skeptical observers” have found nothing to criticize in the Cuban health care system, there is a small but compelling body of dissident literature in which criticism of health conditions and the health care system figures

prominently. See Brown and Lago (1991), Eberstadt (1986), Mendoza and Fuentes (2001), Smith and Llorens (1988). For more general critiques (including Marxist critiques) see Edwards (1993), Halperin (1994), Human Rights Watch (1990), Llovio-Menedez (1988), Timmerman (1990).

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### About the Author

**Katherine Hirschfeld** is Assistant Professor at the University of Oklahoma. She has a B.A. in Anthropology from the University of Massachusetts and a PhD in Anthropology from Emory University. Hirschfeld has worked as a consultant for the Carter Center in Atlanta, the Pan-American Development Foundation, and the United States Agency for International Development. Her book, Health, Politics and Revolution in Cuba Since 1898 was published by Transaction Press in 2007.