

# **UNLIKELY PARTNERS: CHALLENGES FOR AN AUSTRALIA-CUBA COLLABORATION IN PACIFIC HEALTH**

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In June 2010, at a joint press conference in Perth, the foreign ministers of Australia and Cuba expressed their wish to work together in a range of areas, in particular health aid programs in the Pacific and Caribbean regions (AMFAT 2010). From the Australian side this was a change from the previous conservative government, which had maintained a low key but emphatic opposition to a Cuban presence in the Asia-Pacific region. Former Foreign Minister Downer wrote to Papua New Guinea (PNG) Health Minister Peter Barter claiming that ‘bringing in Cuban doctors could contribute to destabilised security in the Pacific’ (AAP 2007). The Labor Government took a different view. Early indications are that Australia’s conservative government, elected in September 2013, will continue this new approach.

Such collaboration has its own logic: both countries have great capacity to assist the Pacific island nations, and there is always value to be found in genuine efforts at cooperation and complementarity. However the move also raises the question: how might these two very different systems work together, when they have such distinct aims and methods? Clearly there is some mutual goodwill, but effective collaboration requires some key accommodations between what could be called a ‘modified neo-liberal’ system of aid and one that emphasises building human capacity and public systems. What are these to be? There are also practical questions: how would collaboration in health worker training deal with language and syllabus differences?

I suggest these questions are best understood through a comparative historical study of stated aims, underlying ideology, interest and action. Practical characterisation of the two countries’ health aid systems and their differences can help explain the possibilities and problems faced in

collaboration. This article will therefore consider the history, ideas and character of the two systems, including their impact in the Pacific islands and Timor Leste, before returning to the challenges for this unlikely partnership.

## **Unlikely Partners**

Then-Foreign Minister Stephen Smith visited Cuba in November 2009. This was the first visit to Cuba by an Australian Foreign Minister since 1995. Smith said the visit was ‘a fresh start to our relationship, to enhance the good working and productive relationship between Australia and Cuba’ (AMFAT 2009). Seven months later he welcomed Cuban Foreign Minister Bruno Rodriguez to Australia, revealing that the two countries had already signed agreements on ‘general political and bilateral cooperation’ as well as on ‘sporting matters’ and were looking at further agreements on cultural contacts and development assistance (AMFAT 2010). The major focus was cooperation in health assistance. Smith observed: ‘Cuba is internationally renowned for the medical assistance work that it does ... we're looking at what we can do together, in the Pacific, and also potentially in the Caribbean, in terms of collaboration on development assistance in the medical area’ (AMFAT 2010). Noting that Cuba already had health programs in six Pacific island countries and more than 900 East Timorese medical students undergoing training, Rodriguez was similarly positive: ‘We could have [an] excellent exchange in our programs of international medical cooperation in this region’ (AMFAT 2010).

As demonstrated in Table One on the following page, in international terms, Australia and Cuba have both made excellent progress on health at home. Ranked second (after Norway) on the UN’s Human Development Index (HDI) rankings, Australia is equal fourth in the world for life expectancy (82 years). Cuba ranks 57<sup>th</sup> in HDI, near the top of the ‘high human development’ band, but less than might be because of low average incomes. HDI is a composite of average incomes, life expectancy and educational attainment. However Cuba’s average life expectancy (79.3 years) is equal highest (with Costa Rica and Chile) in the developing world, while its child mortality rate is the lowest in the Americas (World Bank 2013; UNDP 2013).

Both Australia and Cuba have very low levels of infectious disease sharing, for example, HIV infection rates of 0.1% (UNDP 2013: Table 7). A key reason why Cuba remains an important example for other developing countries is that it has made its advances with limited resources. According to the UN tables of average income rank minus HDI rank (a measure of the efficient use of resources to achieve broader human development) Cuba is first in the world, by a long way, at 44. Australia has a strong positive score of 15 (UNDP 2013:Table 1). By way of contrast, many oil rich countries, like Kuwait and Qatar, have significant negative scores. Cuba shows that small countries with limited resources can achieve very good results with a strong and sustained commitment to education and health (World Bank 2004:158; MEDICC 2008; Kirk and Erisman 2009; Brouwer 2011).

**Table One: Child mortality and education – Australia, Cuba and the Americas**

	Under Five Mortality per 1000 Live Births*		Primary School Completions as Percentage of Relevant Age Group *		GNI per capita (\$US PPP adjusted) **
	1990	2011	1991	2011	2012
<b>Australia</b>	9	5	na	na	34,340
<b>Cuba</b>	13	6	94	99	5,539
<b>Canada</b>	8	6	na	na	35,369
<b>USA</b>	11	8	na	104	43,480
<b>Chile</b>	19	9	na	95	14,987
<b>Costa Rica</b>	17	10	80	99	10,863
<b>Uruguay</b>	23	10	95	104	13,333
<b>Argentina</b>	28	14	99	107	15,347
<b>World Average</b>	87	51	81	91	10,184

Sources: \*World Bank 2013, World Development Indicators, Table 1.2;

\*\*UNDP 2013 Table 1.

However, Australia and Cuba have made their achievements in health through very different systems. The Australian health system might be characterised as a hybrid ‘liberalised public’ system, with a focus on treatment. The public foundation is one of public health guarantees for all citizens (through Medicare), which facilitates universal access to a wide range of health care services, free or heavily subsidised, as also to heavily subsidised essential drugs (through a Pharmaceutical Benefits Scheme). The range of essential treatments to which subsidies apply is quite broad, but ‘elective’ treatments outside those definitions (for example, joint replacement and dental surgery) can be extremely expensive. This system has been substantially liberalised, allowing private practitioners and companies to draw directly on public subsidies. Most Australian doctors act as private businesses and therefore focus on treatment and procedures. Commercialised health services are the norm, but the public system underwrites much of it. Preventive and educational programs are generally run by separate government programs (see ANPHA 2013). The Australian system is similar to many in western Europe but different to that of the USA, which has no universal access guarantee and includes the corporate direction of treatment under a system called ‘managed care’ (eg. Scutchfield *et al.* 1997).

Cuba’s health system (in contrast to the typical developing country pattern of a nurse-centred system, supplemented by some private doctors) is a doctor-centred public system with its focus on prevention and education. A very wide range of services are available free of charge to Cuban citizens including, for example, dental treatment and cosmetic surgery. Cubans only pay for specially imported drugs or prostheses, while non-residents pay for the more elective or specialised services. The Ministry of Public Health (MINSAP) is the employer of virtually all the salaried doctors, dentists and nurses. Commercialisation of health services, when it occurs, is either through state clinics, which offer specialised services to wealthy foreigners, or through bilateral agreements with wealthy states such as Venezuela, Brazil and Qatar (Kiernan 2013). In these operations there are benefits for both the health professionals and MINSAP.

While both systems have achieved very good results, their operations rest on some quite different assumptions. In the Australian case, health services are seen as consumer commodities, albeit publicly subsidised. The quantity of treatments and procedures are generally seen as meeting consumer demand – the so-called ‘demand side’ components of ‘health

seeking behaviour' – and thus high levels of service are often taken as indications of an effective system (*eg.* Irvine 2002; Russell 2008). This focus on treatment may be somewhat constrained by professional ethics, however it is the dominant model and is reinforced by the regime of payment for service. Specialist care, including access to technology, is the expensive pinnacle of this commercialised world, and the privileges of that wealthy elite are jealously guarded (see MEDICC 2008).

In the Cuban case there is a far greater emphasis on mass training and the deployment of human resources. Doctors are trained to work with less technology and fewer drugs, and to spend time talking with patients ('the educational chat') about maintaining their health and dealing with their particular conditions. Importantly, doctors and other health professionals are trained as public servants who will work in well-coordinated public systems (MEDICC 2008). Setting up a business to commercialise health services (a 'private practice') is considered unethical and is not permitted in Cuba. Thus before we get to the questions of training and health cooperation, the two systems show some clear ethical, cultural and political differences.

### **Australian Aid: Modified Neoliberalism**

A somewhat different characterisation must be made of the two countries' health cooperation programs; these differ from their domestic systems, substantially in the Australian case. While Australian public health institutions have been built up from a combination of citizen pressure, private doctor pressure and state mediation (*eg.* De Voe and Short 2003), the aid program has been subject to some rather different forces.

The Australian public strongly supports foreign aid (84-85% in 1998 and 2001), if it is used for humanitarian purposes and to help poor people. Yet very few agree with aid being used 'to assist trade' (7% and 3% in 1998 and 2001) or to enhance Australian commercial benefit (19% in 1992) (Newspoll 2001; Saulwick 1992). Nevertheless, private investor groups have demanded access to the aid budget and successive governments have used aid for regional influence. The result is that, while there are adaptations in different countries, the foundation of Australian aid has become an amalgam of strategic leverage and corporate subsidy – what might be called a 'modified neoliberal' system.

Subscription to multilateral agreements such as the Paris Declaration (OECD 2005), calling for greater recipient ‘ownership’, better coordination and accountability, has not significantly changed this.

The entire aid program is described in ‘headline’ dollar terms, heavily subsidises mostly Australian-based management companies and engages with ideas of market formation, including in health services. Those are the neoliberal elements. The principal modification of this system comes through pursuit of hegemonic influence by investment in global and regional organisations, and by local administrative influence in ‘whole of government’ programs. The latter is focussed far more on management, and in particular financial management, than on public institution building. Other adaptations have been made according to local circumstances, including the presence of other aid donors. So for example there has been greater engagement with government agencies in Timor Leste, where there are other donor countries; while the program in PNG has made greater use of private contractors (*eg.* Parmanand 2013; Lewis and Cornish 2013).

Cuban aid programs, on the other hand, stay closer to the domestic approach of human capacity building and building public systems. The programs generally set human targets, such as numbers of health professionals and scholarships. The means of financing these goals follows, and this differs depending on a country’s capacity to either contribute or ‘compensate’. In most cases Cuba finances its own programs, in particular the salaries of its doctors and the costs of training medical students. The main departure, linked to Cuba’s economic reforms of recent years, has been the introduction of fees (‘auto-financing’), mostly for post-graduate medical training but also for the under-graduate training of students from some wealthier countries (like the USA). For developing countries, these fees are usually incorporated in government-to-government agreements, rather than in individual user-pays regimes. This is not, as is sometimes said (Cuba Standard 2011), the creation of a ‘for profit’ system but rather an application of ‘selective compensation’ charges in those countries with a capacity to pay (MINSAP 2010:10). A characterisation of the two domestic health systems and their respective health cooperation programs is outlined in Table Two on the following page.

**Table Two: Characterisation of health and health aid systems**

	<b>Australia</b>	<b>Cuba</b>
<b>Domestic health system</b>	Liberalised public system	Strong public system
<b>Health cooperation (aid) system</b>	Modified neoliberal system	Building human capacity and public systems

Contrasting with Cuba, Australian aid is almost always expressed in dollar terms. The Australian Agency for International Development (AusAID) managed about 90% (\$4,370m) of the total Australian aid budget of almost \$4.9 billion in 2011-2012. The rest was managed by a range of government agencies, principally the Australian Federal Police, the Australian Centre for International Agricultural Research (ACIAR) and the Department of Immigration and Citizenship (AusAID 2013a). AusAID, which was merged into the Department of Foreign Affairs and Trade in late 2013, contributed large sums to international organisations, in particular the World Bank, the Asian Development Bank, UN agencies and funds such as the Global Fund to fight AIDS, Tuberculosis and Malaria. In 2012 A\$2.35 billion, almost half the Australian aid budget, went to these global programs (AusAID 2013a). Large sums also go to regional organisations. AusAID's regional strategy for East Asia, in particular, funds political organisations such as ASEAN and APEC to help build political partnerships, manage economic integration and control trans-boundary matters (AusAID 2010:8-9).

Australian aid is mostly focused on the Asia-Pacific region, though it extends to the Middle East, Africa, Latin America and the Caribbean. AusAID says it 'increasingly' uses 'partner government systems', but many of its programs are so large they have to be managed 'by Australian or international companies' (AusAID 2013a). Indeed, a group of mainly Australian-based private companies manage many hundreds of millions of dollars in the AusAID budget (see Table Three on the following page). As private, for-profit commercial operations, their budgets and accounts were mostly kept private ('commercial in confidence') by AusAID. This common feature of neoliberal systems, where private commercial agencies provide public services, seriously erodes public accountability.

**Table Three: Top Six AusAID contractors, 2012**

	<b>Contractor</b>	<b>Headquarters</b>	<b>Contracts signed in 2012, \$Am.</b>
<b>1</b>	Coffey International Development	Canberra	580.8
<b>2</b>	Cardino Emerging Markets	Brisbane	452.5
<b>3</b>	GRM International	Brisbane	411
<b>4</b>	SMEC	Melbourne	207.8
<b>5</b>	URS Australia (US subsidiary)	Sydney (USA)	187.7
<b>6</b>	Charles Kendall and Partners	London (UK)	176.8

*Source:* Parmanand 2013

Waste on foreign advisers, in the name of ‘capacity building’ was recognised by AusAID, which a few years ago said: ‘Currently, none of Australia’s programs has formal systems for monitoring and reporting on adviser performance ... [perhaps] capacity building ... has been too tied to the adviser model’ (AusAID 2008:33-4). A move was therefore made to ‘ensure better value for money and greater effectiveness’ from such advisers (AusAID 2013a). Nevertheless, new schedules still allow for very high rates of pay. Remuneration tables from 2010 set fees of between \$8,000 and \$20,000 per month; a sum 2 to 4 times Australian average wages and 10 to 100 times East Timorese wages AusAID (2012b). Spending in health aid followed AusAID’s general pattern of ‘inline’ finance and advisers, and contracted services. Australia’s global health aid budget was \$640m in 2012-13. The range of health projects included providing medical materials, construction of facilities, short-term training, supporting country diagnostic and treatment programs, and subsidising other government programs (AusAID 2013c). AusAID provided support for nurse training and some scholarships for doctor training in Australia and Fiji but, unlike the Cubans, large scale health worker training was not a feature of its health programs.

In Timor Leste and the Pacific islands Australian aid has been diverse and, frankly, fragmented. AusAID said it invested \$344m in Timor Leste, in a wide range of projects, over 2010-2013. These included helping develop new seed varieties, infrastructure for water and sanitation,

building or repairing classrooms, and repairing rural roads (AusAID 2013b). Many of these projects were contracted to large Australian management companies. AusAID also contributed directly to government programs, sometimes through other agencies. For example, in 2008 AusAID contributed A\$23m to a multi-donor 'Health Sector Strategic Plan' managed by the World Bank. This program was said to include health service delivery, support services, coordination and planning functions and program development, including by use of foreign consultants (World Bank 2008).

In PNG, after a period of bypassing government with corporate contracts, AusAID returned to direct engagement with national programs. In health this has meant providing from 17% to 20% of funding for a national health plan, over 2011-2013. Given the necessarily wide scope of programs within such a plan, any particular AusAID objectives became submerged in national objectives. Scholarship funding was said to comprise 16% of the Australian contribution, but actual details of persons trained neither appeared in the schedule nor the indicators of the bilateral agreement (AusAID 2012c).

Under some pressure for public accountability the agency introduced an annual 'review of aid effectiveness', an internal process which generally paints a rosy view of agency work (AusAID 2012a). This review has been criticised, not just because it is not independent of the department, but because with few 'clear objectives' assessment is hardly possible (McCawley 2010). The overall goals of the aid program (where they suggest outcomes) are merged, in the 'whole of government' approach; that is, joined with the goals of corresponding governments. For example, AusAID's 'strategic goals' included: 'More than 10 million children will be vaccinated ... more than 1 million additional births will be attended by a skilled birth assistant', and so on (AusAID 2012a:3-4). These are decent goals, but it is hard to see what the Australian contribution may have added, except by its fraction of finance to the various regional governments which bear the main responsibility. This lack of specific accountability made it quite easy for AusAID to, on the one hand, claim credit for national or regional achievements (credit which might better attach to local government and other aid partners) and, on the other, to delegate blame for failures to others.

It is more difficult for Australian aid to avoid its share of responsibility for the failures in PNG, where Australia has been the main aid partner for

almost 40 years. AusAID argued that Australian aid ‘contributed to notable improvements in Papua New Guinea since the country’s independence’, including improvements in life expectancy, infant mortality and education (AusAID Public Affairs 2004). However, while it is true that PNG’s infant mortality fell and adult literacy rose since independence in 1975, these achievements were less than average improvements in developing countries. For example, by 2003, while PNG’s adult literacy rose just over 1% from its 1990 rate, the developing country average rose 14% (United Nations Development Programme 2005:Table 1). It is notorious that there are virtually no doctors in rural PNG. On the other hand, PNG had substantial financial advantages, with exports at over 40 per cent of GDP for more than twenty years, and steady foreign aid flows (mostly Australian) often at around 10 per cent of GDP (World Bank 1988, 1999). One anomalous outcome of these failures in human development is that AusAID invested in HIV/AIDS education materials but not in adult literacy; yet at least 40% of the population remains illiterate (UNDP 2013:Table 8) and unable to access health promotion materials. The situation is probably worse. According to an AusAID commissioned survey in five of PNG’s twenty-two provinces and districts, when the semi-literate were combined with the illiterate, actual literacy rates in four of the five provinces were ‘less than 15%, while in New Ireland Province the literacy rate was 25%’ (ASPBAE and PEAN 2012:4). This reflects badly on the commitment to education of both the PNG Government and Australian aid.

A key assumption of Australia’s modified neoliberal approach is that finance remains the leading factor and headline figures remain meaningful because aid ‘transfers resources’ and helps build ‘resources pools’. The idea that ‘increasing aid flows’ is foundational to development is promoted by some influential advisers (eg. Sachs 2001). However it is also well known that much of this aid ‘boomerangs’, or returns to the ‘donor’, in the form of salaries for highly paid foreign workers and profits for foreign companies which have the inside running on lucrative aid contracts (eg. AID/Watch 2005). AusAID has defended itself against these ‘boomerang aid’ accusations, claiming the term is ‘a simplistic concept’ that points to the benefits to Australian companies and individuals and ‘to the exclusion of companies and individuals in developing countries’. The agency claimed longer-term benefits to local businesses and industry are ‘not taken into account’ (AusAID 2005:8). Nonetheless, complaints of the ‘boomerang’ persist. The La’o Hamutuk

group in Timor Leste estimated that, of the more than \$5.2 billion in total aid moneys allocated to the country between 1999 and 2009, only \$552 million or 10.6% actually entered the Timorese economy (La'o Hamutuk 2009).

Waste and extreme inequality may help us understand the 'failure' of most bilateral aid, particularly in neoliberal aid regimes, as regards their stated aims. Systematic studies have demonstrated this failure. Boone (1995) found that aid 'does not significantly increase investment or growth', regardless of the form of government. Similarly, aid did not help 'growth' in PNG (Feeny 2005). One influential study suggested aid should be made conditional on 'good governance' programs (Burnside and Dollar 1997), despite the resentment at earlier 'conditional' regimes (see Shah 2010). However a later study contradicted the claim that 'the impact of aid depends on the quality of state institutions and policies', saying aid failed across all manner of 'recipient' regimes (Levine and Roodman 2003). Two IMF studies then looked at the impact of aid on infant mortality. Masud and Yontcheva (2005) found that bilateral aid did not reduce infant mortality (but NGO aid could), while 'only government education expenditures' reduced illiteracy. A subsequent study found that 'doubling health aid' could lead to a 2% reduction in infant mortality (Mishra and Newhouse 2007); but this was miniscule compared to the relevant targets of the Millennium Development Goals.

The most important defect of most foreign aid (neoliberal or otherwise) is that it undermines processes of self-determination and democratic development in developing countries. No aid program is democratically accountable to those it serves. None of the multilateral declarations on aid resolve this central problem. Aid recipients remain the objects of charity. This is particularly the case if aid does not engage in substantial training, creating 'exit strategies' rather than remaining as a semi-permanent industry. In the latter case the additional problems of inflation, dual economies, aggravated inequality and failures in training and capacity can accumulate (see Anderson 2012).

## **Cuban Aid: Building Human Capacity and Public Systems**

In a parallel and distinct system, Cuban doctors have provided support in primary health services since the early 1960s and Cuban medical

personnel these days (about 38,000 in 2012) surpass those of the combined G8 countries (Kirk and Erisman 2009:3). The key Cuban advantage in recent years has been in genuine, large scale human capacity building. Many thousands of Cuban doctors have been sent to work in dozens of developing countries but, for every Cuban doctor deployed these days, there is usually an offer of several medical scholarships. This is a longer term, mass training strategy which means that, after a decade, Cuban doctors are being replaced by local doctors. It is an approach that helps avoid building dependent relationships.

A central feature of the Cuban system is that doctors are trained to work as salaried public health professionals, rather than private vendors of health services. Departing from the western Flexnerian (individualistic and expert-centric) medical education model, they focus on rural and marginalised populations (Brouwer 2011). They are also trained in large numbers so as to collaborate in maintaining that public service ethos and to help minimise the ‘brain drain’ through an emigration that affects every relatively poor country. On the provision of doctors, as Cuba is a low wage country but with a strong ‘social wage’, there is an added advantage: however they are paid, Cuban doctors do not contribute to the inflationary economy introduced by most other foreign workers. I have already characterised this approach as one of building human capacity and public systems. There is no single financial model. Cuban programs are generally financed by the Cuba government, or through various forms of co-financing - sometimes called ‘compensation’ - depending on the capacity of the recipient country (see MEDICC 2008).

In recent years, associated with other economic reforms, there has been a consolidation and increase in these ‘compensation’ measures. A group called Servimed brought together 16 Cuban institutions that had been providing health services to foreign individuals for some years; but this is far from the introduction a ‘for profit’ health service system (Cuba Standard 2011). There are no private shareholders or private service providers, and charges are raised only for those with a capacity to pay. A commercial arrangement for compensation in exchange for health services with Venezuela, established a decade earlier, has now been extended to Brazil, Qatar and other countries. Cuban doctors are also increasingly paid their salaries by local governments, at local rates. Yet thousands of students from poorer countries and communities still receive Cuban scholarships, and thousands of Cuban doctors are still seconded from their public sector jobs at home to work in poor countries.

The policy of self-financing under the new system, in particular by greater use of 'compensation' in those countries 'whose economies permits it' (MINSAP 2010:10) is best seen as the broader application of selective 'compensation' charges, within Cuba's international programs.

Cuba is a socialist country, with strong public institutions. Its internationalism and health aid is linked to those ideas, including the Latin American ideas of 'social medicine' (eg. Allende 1939; Anderson 2010b). However the more recent version of doctor training is more humanist than socialist, and does not engage in political indoctrination. Principal architect of the program, former Cuban President Fidel Castro said: 'In the ELAM [Cuba's Latin American School of Medicine] we will not teach political material ... [but rather] complete dedication to the most noble and human of its tasks: to save lives and preserve health' (Castro 1999). In this way Cuba minimises possible conflict with the large variety of countries which have students under training.

Nevertheless, there has been hesitance from some countries over relations with socialist Cuba. Commenting on Cuban educational aid in Jamaica and Namibia, Hickling-Hudson observed a common theme of 'ambivalence' about accepting Cuban aid, both because of local professional jealousies and fear of jeopardising relationships with the USA (which maintains virtually permanent economic sanctions against its small island neighbour). However Cuban training clearly helps develop self-sufficient education and health capacity and is usually an offer 'too good to refuse'. It also has some specific post-colonial advantages. These 'south-south' programs show a way into the 'radically new relations ... necessary to the decolonization process, of building independent capacity and quality in education and other fields' (Hickling-Hudson 2004:305-9). The result is that very few governments can resist a Cuban health assistance offer, and the principal resistance comes from local private health workers, who fear an undermining of their position (MEDICC 2007; MEDICC 2008)

Analysts differ somewhat over Cuba's motives. Some see its program as an assertion of 'soft power', or as creating a 'symbolic capital' which can be drawn on for material or political benefit (Feinsilver 2006). Others suggest it is more deep rooted and complex. Cuban medical internationalism can be seen a principled humanitarian project which may at times have diplomatic, trade or political benefits, but is not formulated simply to that end (see Kirk and Erisman 2009:170-83). The

link to Cuba's 'battle of ideas' (see Kapcia 2005), a broad program of 'revolutionary morality', draws more on the humanism of Cuban independence hero José Martí than on the European revolutionary Karl Marx. Fidel Castro argues that the 'secret' of Cuba's approach: 'lies in the fact that human capital is worth far more than financial capital. Human capital involves not only knowledge, but also – and this is essential – conscience, ethics, solidarity, truly humane feelings, spirit of sacrifice, heroism, and the ability to make a little go a long way' (Castro 2005). Observing that ethos in practice struck a chord with East Timor's former Health Minister, Dr Rui Araujo, who characterised Cuban training as having 'a profound social focus, embedded in ethical and humanistic values' (Araujo 2009). Margaret Chan, director general of World Health Organization, said that Cuba's medical colleges were 'a commitment and a contribution to a better training of the health professionals that the world needs today' (Escambray 2009). The Washington-based World Bank, while recognising Cuba's achievements in health, questions the economic sustainability of the system (World Bank 2004:157-8). Half a century of Cuban internationalist practice makes the World Bank criticism seem more ideological than practical; however Cuba's recent reforms, including the creation of Servimed, certainly do address the question of sustainability.

Cuba assumes a global shortage of health workers, particularly in rural areas, and recognises the 'brain drain' (emigration of skilled professionals) as a serious problem affecting developing countries. Cuban doctors themselves, for example, leave the country at a rate of up to 2% (Jiménez 2007). However in most developing countries the figure is much higher. For example, from the 1980s to the end of the century Ghana lost 60% of its doctors; while post-independence Zambia lost over 90% of its locally trained doctors (Kirk and Erisman 2009:114). The story in the Pacific is little better. There are almost as many Fijian born doctors in Australia and New Zealand as in Fiji; while Australia and New Zealand also had more nurses and midwives from Samoa, Tonga, Fiji and Niue than were working in those island states (Negin 2008). In the Solomon Islands, until the Cubans took in 90 students, doctor training only equalled the rate of doctor emigration (Alependava 2012). It is only with Cuban training that the Solomon Islands has arrived at the possibility of growing its overall numbers of doctors; and doctors trained with a public service ethos.

The recent Cuban health programs in Timor Leste and the Pacific Islands have had a considerable impact. Timor Leste was first, with a program growing from a meeting between leaders in Kuala Lumpur, in 2003. Some students were sent to Cuba for training at the end of that year, and a small group of Cuban doctors arrived in Timor in April 2004 (Medina 2006). However the scale of the program increased over the next three years. In December 2005 Cuban President Fidel Castro increased the offer to one thousand scholarships, along with a brigade of up to 300 health workers. The rationale for these numbers was to help build the entire public health system, generating a doctor to population ration of one to one thousand (Araujo 2007, 2008). Cuban doctors were attached to the National Hospital but the majority were sent to the rural areas, beginning the core of a rural doctor-centred health service, including the practice of house visits (Rigñak 2007). By 2013, after 732 doctor graduations, Timor Leste had risen from a country with one of the lowest rates of doctors to one of the higher rates (WHO 2013).

After Timor Leste, Cuban health programs grew rapidly within the region. Students from Kiribati were studying alongside the Timorese students, when I visited them in 2007 and 2008; they were joined by those from several other Pacific Islands soon after. There had been a program in Nauru in 2004, but this collapsed (Asante *et al.* 2012), only to resume in 2009. By 2012 the Solomon Islands had 90 students and eight other island states were taking advantage of Cuban training. While there were far fewer Cuban doctors in the Pacific Islands than in Timor Leste, the 33 Cuban health personnel in the Solomon Islands, Kiribati, Tuvalu and Vanuatu accounted for a quarter of all the combined medical workers in those countries (Asante *et al.* 2012:6). By 2012 Cuba was the main provider of doctor training to the Pacific Islands. Table Four on the next page gives a country-wise breakdown of those students and graduates, at November 2013.

The views of the first Timorese medical graduates are instructive. A strong sense of dedication and humanism comes from the training and resonates with many of their own cultural values. ‘In Cuba they taught us to work, but to work with love ... we have the responsibility to teach people so they can participate actively in the prevention of illness’ said Dr Colombianus. In her 2010 graduation speech, on behalf of the first eighteen doctors, Dr Ercia said: ‘We do not seek wealth for ourselves, but rather to serve the people with dedication and a spirit of humanism ... according to the teachings of God’. Similarly, Dr Ildefonso said: ‘we

eighteen, we're going to do a project which is social, which is human, for this country' (Anderson 2010b).

**Table Four: East Timorese and Pacific Island medical students under Cuban training, at November 2013**

Country	In training (began)	Graduated
<b>Timor Leste</b>	c. 300 (2003)	732
<b>Solomon Islands</b>	90 (2008)	0
<b>Kiribati</b>	31 (2005)	0
<b>Vanuatu</b>	25 (2008)	0
<b>Nauru</b>	9 (2009)	0
<b>Tuvalu</b>	19 (2008)	0
<b>Tonga</b>	6 (2012)	0
<b>Palau</b>	3 (2012)	0
<b>Fiji</b>	8 (2012)	0

*Sources:* CMB 2008; Tulloch, Delgado and Hearn 2012; other personal observations and communications, at September 2013.

There were some tensions, probably based on jealousy, as these first graduates entered the health system in Timor Leste (Anderson 2010b). A large group of doctors trained with a public servant ethos was confronting an older elite culture, where doctors are rare and enjoy a special status. However a Timorese culture strongly rooted in community solidarity, inclusive Christian ethics and an independent spirit has taken many elements of the Cuban approach (free services, house visits, popular adult health education programs, student training in the hospitals) to heart. Timor Leste may be forming its own version of social medicine (Anderson 2010b).

### **Challenges for Collaboration**

Despite the different systems, there seems to be great potential for an Australia-Cuba partnership in health cooperation. Early indications are that Australia's recently elected (September 2013) conservative government will continue the relationship with Cuba, initiated by the Labor government. In many respects, given mutual goodwill and a

willingness to cooperate, the strengths of the Australian and Cuban programs could combine well. Cuba has a developing country focused and proven practice and training curriculum, along with a powerful labour and teaching force; but limited financial, logistical and technological resources. Australia has the latter as well as considerable medical expertise and institutions. Well resourced, large scale capacity building in the islands, including coordination and integration of health services would be widely welcomed by the island populations, if they were to be involved as full partners.

However Australia and Cuba maintain different and fairly strong mindsets about how and to what end their programs are developed. Australia purports a regional hegemonic role, in alliance with Washington, which in turn seeks to contain the influence of independent powers, in particular China. Cuba is apparently not seen as a particular threat in this regard, as it has no regional ambitions but mainly promotes a global public service ethos, maintaining its focus on mass training and public institution building; themes which are neither prioritised nor negated in the Australian system. Australia, for its part, seeks influence in peak bodies and often operates in a unilateral way. For example, former Prime Minister Kevin Rudd's 'Port Moresby Declaration' on regional cooperation, while announced in the PNG capital, was not subscribed to by any PNG leader (Rudd 2008). Australian ministers speak of bilateral agreements with Cuba; however Cuba has stressed unique tripartite agreements, including each of the island states. That is why Cuban Foreign Minister Bruno Rodriguez, while in Australia, welcomed the opportunity for 'enhancing triangular cooperation' with the Pacific islands and 'triangular cooperation' in the Caribbean, with the Haitian Government' (AMFAT 2010). The Australian mindset may have difficulties with this more contingent approach. Yet the island states are the primary players facing the tremendous challenge of deploying new graduates and building and managing their public health institutions. This is a substantial management task, involving an expansion of doctors in what had been mainly nurse-based public systems, and managing tensions with the existing private clinic networks.

The question of facilities and training faces not only a language barrier but curriculum differences. Australian training is typically more clinically focused, while Cuban pedagogy combines, clinical, epidemiological and social medicine, with a strong emphasis on prevention and promotion embedded in doctor practice (Botello 2010).

The Cuban doctors themselves have fewer language problems than Australian doctors in Timor Leste, where Portuguese is stronger than English and where there are now a large number of Spanish speaking students and doctors, to assist. However in the Pacific many of the Cubans need extra language training. English training and internship supervision are apparently areas in which AusAID has already expressed a willingness to assist (Monzon 2013). However that leaves the major question of how to jointly develop the existing island medical colleges: in Fiji and Port Moresby (in English and with a western curriculum, largely financed by Australia) and in Dili (in Spanish, created by the Cubans). What values would a joint curriculum emphasise? While there has been talk of collaboration in post-graduate training, it was notable that by late 2013 the 10 Australian specialist training positions (through the Royal Australian College of Surgeons, in Dili) and the 30 Cuban positions (mostly in Dili) were developing separately (Dias 2013).

A joint Cuban-Australian team prepared a report in early 2012, noting the dimensions of Cuban cooperation in the region and suggesting that the main challenges for cooperation were: ‘information and disinformation’, accommodating the large numbers of medical graduates (including public service management, while providing for internships along with additional infrastructure and equipment), harmonising the Cuban and Pacific [Australian] health systems (integrating the groups from different training backgrounds, consolidating national standards and addressing language problems) and recognising equivalence of qualifications (Tulloch *et al.* 2012).

I suggest building on, expanding and slightly re-orienting these challenges. First, there must be an accommodation on some essential matters, while recognising that distinct Australian and Cuban aims and motivations will persist. The key areas of accommodation require involvement of the island states in the agreements, including any agreements on institutions, training curricula and the coordination of major programs. This extends to the question of facilities and colleges, which will demand substantial investment, in finance, construction and technology. Virtually every area of challenge includes a challenge for the island states themselves. They cannot be left out.

Second, the human resources management challenge is indeed formidable. It is already being faced by Timor Leste which, despite some delays, did manage to employ and deploy 486 new doctors over 2010-

2013. Management capacity, weak in all the islands, is necessary not just to deploy new doctors but to maintain ongoing training and professional development, to select and train new managers and teachers and to ensure that the 'brain drain' is minimised. This management process also requires investment in training and facilities. Support for and development of the three established island medical colleges – in Fiji, Port Moresby and Dili – and regional access regimes for students, is at the centre of this. Again, it will be important for the islands states to be involved in the question of values, priorities and orientation of management and training. Their circumstances are quite different to those of both Australia and Cuba.

Third, the recognition of equivalence of qualifications, including for the purpose of cross-over training, has to be addressed at least in those countries with training facilities. This recognition is typically dealt with by way of bilateral agreement, and that could be done between Cuba and Australia. For the islands it might be best considered in a multilateral way, through one of the Pacific Island groups. Finally the question of 'information and disinformation' is certainly a challenge to be addressed, given some of the history of parochialism in aid programs. This would certainly be helped by improved communications, amongst the parties to health cooperation, and some ongoing coordination of programs. Better information sharing between the active parties is foundational to any wider information sharing.

There seems to be great potential for Cuban-Australian collaboration in Pacific health. However consideration of this partnership should be informed by a sober recognition of differences between the two systems. There is unlikely to be a full integration of aims, so the focus must be on identifying and addressing some key practical accommodations. One of these, for the Australian side, must be acceptance of the need for larger-scale doctor training and stronger public institution building, in the island nations. The challenges are not small but, with the existing good will and commitment along with an intelligent recognition of differences and complementary strengths, it is quite plausible that all involved might find a way through the challenges.

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