

## **Social Medicine in Timor Leste**

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‘Social medicine’, a Latin American concept, notably developed by Salvador Allende in the 1930s, links up a broader model and ethos of public health with processes of social transformation. In recent years that influence has spread to Timor Leste, through a very large Cuban health cooperation and training program. This paper considers to what extent an endogenous ‘social medicine’ might be developing in Timor Leste.

Almost a thousand new doctors are emerging in a system which had less than one hundred, and they have been trained with a public health service ethos which has begun to confront a system dominated by a small, established profession embedded in a elite culture and a network of private clinics. This clash of cultures, in terms of vision and ethos, is quite similar to that seen in many other countries - such as Bolivia, Venezuela and Honduras - with large Cuban health training programs. In Timor Leste, as in those other countries, jealousy and obstruction have, at times, undermined the potential for collaboration and cooperation, leading to some uncertainties.

However the transition to a Timorese form of ‘social medicine’ has three distinct advantages: first, the large scale of the new training program; second, a sympathetic culture; and third, potential leadership and political will. Less certain is the exact form of East Timorese social medicine. That will have much to do with the model of development and social transformation adopted by the country, in coming years. However the ideas seem set to be absorbed into a domestic culture of community solidarity, inclusive Christianity and independence.

This paper studies the idea of ‘social medicine’ from its advocacy by Allende in Chile in the late 1930s, through the powerful Cuban solidarity aid programs, to elements of a synthesis emerging in Timor Leste. It discusses Cuban pedagogy in Timor Leste and a clash of cultures, before moving to Timorese adaptations and the beginnings of an endemic social medicine. This is an interpretive history, making use of past analyses, contemporary information on the Cuba-Timor Leste health program and the East Timorese responses. It includes a number of interviews and direct observations of pedagogy and practice.

### **Social medicine: Chile, Cuba, Timor Leste**

The focus on social medicine seems to arise from both wider visions of, and systematic failures in, public health. There have been developments in Europe and the USA (Sidel 2006) but, for the purpose of this story, I will start in Latin America, which has a distinct and powerful social medicine tradition. Guzmán (2009, 114) notes ‘significant differences’ between the Latin American social medicine approach and the WHO’s Commission on ‘Social Determinants of Health’, largely a creation of European social epidemiology. While both are wider views of public health, Latin American social medicine stresses social transformation and ‘emancipation’ from dysfunctional capitalist social structures (Guzmán 2009, 114-118). From its Portuguese heritage, subsequent anti-colonial struggles and the large Cuban aid program after independence, Timor Leste has had reason to look to the Latin American experience.

The most prominent exponent of social medicine there was the former President of Chile, Dr Salvador Allende. As a young man, Allende said he was ‘exposed to the tragedy of poverty ... lived in poor neighbourhoods as a boarder and came to know at first hand the misery, lack of housing, lack of medical care and lack of education of the Chilean people’ (in Winn 2005, 133).

This experience, backed by the ideas of German doctors Rudolf Virchow and Max Westenhofer, at the University of Chile in the 1920s, led Allende to describe ‘medicine’ as far more than just a clinical project. The idea of ‘social medicine’ had already been promoted in Chile’s labour movement, for example by Luis Emilio Recabarren, leader of the salt workers union. But Allende, a medical doctor and political candidate, ‘refused to discuss specific health problems apart from macro-level political and economic issues’. He designated tuberculosis a ‘social disease’ because it had improved as much by socio-economic advance as by medical intervention. He linked poor housing to infectious disease and argued that addictions and alcoholism were rooted in social misery (Waitzkin 2001).

It was as health minister in the Popular Front Government in 1939 that Allende became recognised as Chile's leader in 'social medicine'. In his book 'Chile's Medical-Social Reality' he explained his vision:

to reclaim the social wealth and the economic potential of the nation, control it, direct it, foster it in the service of all the inhabitants of the republic, without privileges or exclusions ... to reacquire the physiological capacity of a strong people, recover its immunity against epidemics; all of which will allow a better performance in national production while also providing a better disposition and spirit to live and appreciate life (Allende 1939).

In 1952, as a senator, Allende introduced the law that created Chile's National Health Service, which was 'the first national program in the Americas that guaranteed universal access to services' (Waitzkin 2001). Allende as President pursued a radical social democracy, but this was cut short by the US-backed military coup in 1973 (see e.g. Smirnow 1973). The health councils had generated only limited mass mobilisation, public sector medicine was not sufficiently strengthened and the state was ultimately unable to defend itself against the military coup (Waitzkin 1983, 245).

After the coup Chile retreated from social medicine ideas, and pursued greater use of private insurance. However the country maintained a number of social programs – such as in housing, nutrition and access to hospitals for mothers and babies – and expanded these in the 1990s, after the dictatorship (Bosworth, Dornbusch and Labán 1994; Burdick, Oxhorn, and Roberts 2009). These social programs have helped Chile – despite great inequalities – to achieve relatively good health outcomes within Latin America (OECD 2010).

However Cuba and Costa Rica developed the strongest public health systems and the best health outcomes in Latin America. Both were influenced by Allende's social medicine ideas. Costa Rica copied the Chilean system, when building a large public institution, the Caja Costarricense de Seguridad Social (CCSS). This began as an autonomous body in 1943, was embedded in the 1949 constitution, and became a tripartite (employee, employer and state) contributory system in 1961 before finally providing universal coverage in 1974 (Editec Editores 2005 CCSS 2005; Anderson 2007). The creation of the CCSS was a long social democratic process. In Cuba, on the other hand, a revolutionary process transformed a highly unequal and heavily privatised system, defended by a military dictatorship. While the term 'social medicine' was given to an earlier contributory scheme in Cuba (Thorning 1945), Cuban social medicine is better understood through the ideas and practice of 'The Revolution', after 1959.

Commitment to health became a central part of Cuban revolutionary social transformation, as also of its internationalism. The Cuban Revolution promoted participation within community and popular organizations (neighbourhood committees, women's, labour and youth organisations), within a firm state framework. This participation was essential to developing initiatives in literacy, sport, hygiene and various forms of public education (see De Vos et al 2009, 30-31). Cuban social medicine began with social solidarity at home, then extended into its international relationships, mostly with African and Latin American countries.

The Argentine doctor, Ernesto 'Che' Guevara, a friend of Allende's, had also seen the poverty and hunger that lay behind disease. He had seen the stunting caused by malnutrition and argued:

The principle upon which the fight against disease should be based is the creation of a robust body ... our task is now to orient the creative abilities of all medical professionals towards the task of social medicine ... not only to visit and become acquainted with the people ... But to find out what diseases they have, what their sufferings are, what have been their chronic miseries for years and what has been the inheritance of centuries of repression and total submission (Guevara 1960).

Foreshadowing the enormous Cuban health solidarity programs, that would reach almost every part of Latin America and many African countries in future years, Guevara asked: 'What would have occurred if two or three hundred peasants had emerged, let us say by magic, from the university halls? .. [they] would have run ... to help their brothers' (Guevara 1960). The country's remarkable international program grew, as the internationalist extension of its revolutionary socialism, and of its social medicine.

Health in Revolutionary Cuba went through several extended phases. These have been described as the creation of an integrated national health system, through the 1960s, consolidation of this single public system in the 1970s and the introduction of higher medical technology, research and services in the 1980s (Delgado Garcia 1996). Associated ideas in health and in health internationalism, also developed through these periods. International programs began in the early 1960s, but became strong in the late 1970s, as capacity and human resources grew. Cuba sent doctors to Chile after a huge earthquake in 1960, despite a lack of doctors in Cuba at that time. The first medical mission to Algeria was also organised rapidly, in 1963 when José Ramón Machado Ventura led a group of 50 doctors, dentists nurses and technicians to that newly independent country (Glejeses 1996, 164-165). The Algerian program marked the beginning of Cuba's health aid 'missions', to assist capacity building in newly independent countries.

Solidarity with and practical support for other African liberation struggles and newly independent states drove Cuba's early medical 'missions', through the 1960s and 1970s. At times, Cuba also provided military aid, notably in Angola (Kirk and Erisman 2009, 6-7). As Glejeses convincingly argues, these early medical and military assistance missions were largely autonomous moves by the Cubans, and not part of a power play by their Soviet bloc allies; indeed the Soviet Union was worried by some of the Cuban initiatives (Glejeses 1996). The larger Cuban medical missions in Latin America from the late 1970s never included Cuban troops. Cuba did offer military aid to the Sandinistas in Nicaragua, but mostly after they had won power in 1979 (Eckstein 2003, 173). Further, Cuban medical assistance to Nicaragua was maintained after the Sandinistas were electorally defeated, in 1990 (Castro 1990). The Cuban leader, Fidel Castro, constantly referred to the legacy of the 19<sup>th</sup> Century independence leader Jose Martí, who had stressed broader notions of education, culture and national unity (Martí 2002).

It becomes apparent that, to understand Cuban 'social medicine' we need to understand both its context and its role within Cuba's strategy of social transformation. What then made Revolutionary Cuba so internationalist? Feinsilver (1993, 17, 26) suggested a central ambition of making Cuba a 'world medical power', pointing to the wish to help drive social transformation through such 'soft power'. But 'soft power' to what end? The World Bank noted that Cuban achievements at home in health owed much to 'the sustained focus of the political leadership on health for more than 40 years ... universal and equitable health care', the concentration on rural health and a unified public system maintained by 'highly motivated staff' (World Bank 2004, 157-158). Yet this does not quite capture the full project. Kirk and Erisman (2009, 183) suggested that greater weight be given to the 'genuine humanitarianism and ideological commitment to the less fortunate' that comes from the Cuban Revolution's ideology. Certainly Cuba saw internationalism as central to its ideological and moral 'mission'. I suggest that international solidarity was also an important part of its survival strategy: Cuba remained constantly under threat from the greatest military power on earth, and needed to widen its network of friends. The Cuban leadership realised very early on that they could not defy the big powers and build a different society if they themselves were isolated.

Despite deep economic recession in the 1990s, following the collapse of its trade relationship with the Soviet Union, Cuba maintained the best health indicators in Latin America and went on to build the most powerful international health aid programs in the world. It has been pointed out that the Cuban health program 'undoubtedly reaches more people than the work of all the G-8 countries together, as well as that of the World Health Organization (WHO) and the Nobel Peace Prize recipient Médecins sans Frontières (MSF)' (Kirk and Erisman 2009, 170). It is an extraordinary and unique force in the world.

The combination of humanitarianism, international solidarity and the drive for social transformation in Cuban social medicine can be seen in Fidel Castro's 1999 announcement of an ideological 'battle of ideas'. This notion was developed by Castro during a political campaign to return a small boy, Elian Gonzalez, from the US to his father in Cuba. Solidarity was re-emphasised – no-one would be 'left to their fate' and the transformatory and revolutionary role of education was stressed (Minrex 2010). This also applied to Cuban internationalism. To a group of Cuban medical graduates Fidel Castro said:

the human impact, the impact in solidarity, the influence in the field of health that a group of doctors giving their services freely [in Latin Americas and Africa has] is very great ... Our mission is much greater than to capture a few dollars. Our mission is to create a doctrine in relation to human health, to demonstrate an example of what can be done in this field (Castro 1999a).

Helping build good public health systems was seen as part of an ideological battle with neoliberal privatisation and consumerism. That same year, at the inauguration of the Latin American School of Medical Sciences (ELAM), a substantial expansion of the international training program, Fidel Castro pointed to the need to build capacity within the Central American and Caribbean states that had just been hit by two terrible hurricanes. He stressed the moral and the systemic imperatives of this mission, adding: 'in the Latin American School of Medical Sciences we will not teach political material, as we do to our young Cubans in our universities.' There would be freedom of religion, while food and social activities would be appropriate to each culture. 'The most important thing will be its complete dedication to the most noble and human of its tasks: to save lives and preserve health.' (Castro 1999b). The moral and cultural-educational elements of Jose Marti's thought are evident.

Cuban social medicine has been able to share some important lessons. For one thing – on top of its extraordinary generosity of spirit – Cuba had experience in 'making do' with limited resources. For another, it was prepared to borrow and adapt ideas to its own circumstances. For example, in the 1980s, under international influences, Cuba moved from 'preventive health' into 'health promotion'. Then in health education, it borrowed from a US pedagogy which emphasised a circular relationship between experience, observation and reflexion, conceptualisation and practice (Ochoa Sato et al 2004).

The Cuban synthesis in social medicine stresses revolutionary solidarity and internationalism. Waitzkin (1983, 235) argues that 'the consolidation of state power, mass mobilisation and resolution of the contradiction between the private and public sectors were key elements in Cuba's success' in social medicine. While the Cuban system is unique, it has a traditional base and, with some flexibility, has borrowed from other countries.

In this context we come to the development of social medicine in Timor Leste, a young country which only definitively gained its independence in 2002. To understand what might be the elements of a distinct form of social medicine we need to look at the influence of Cuban pedagogy in Timor Leste.

### **Cuban pedagogy and a clash of cultures**

The Cuba Timor-Leste health cooperation program brought with it large scale training which, while it did not contain Cuban political teachings, carried many of the values of Cuban social medicine. Much of this was immediately appreciated in Timor Leste, but there was also a clash of cultures, which became more apparent as the country's new doctors were about to graduate. In this section I will outline the program, identify the values and approach of Cuban social medicine in Timor Leste, then indicate aspects of the clash of cultures.

The program began in 2003, shortly after independence, with some dozens of Cuban doctors and scholarship places for Timorese students. However it rapidly grew into the largest health cooperation program outside Latin America. By 2006 there were more than 250 Cuban health workers and an offer of one thousand medical scholarships (Anderson 2008). A large contingent of Cuban doctors were attached (alongside some other foreign doctors) to the national and regional hospitals, but the majority were sent to the rural areas, thus starting the core of a rural doctor-centered health service (Rigñak 2007). Cubans rapidly formed an absolute majority of doctors in the country. Some aid money was at first used to contribute to the costs of these doctors, but as of 2006 the Cuban Government was paying the wages of all its doctors (PMC 2006). Cuban doctors in a host country work under the direction of the Health Ministry, as public servants. They work on two year contracts, being flown home for a one month holiday, in the middle of their contract. The idea is for the Cuban doctors to be gradually replaced by East Timorese graduates.

There is no doubt Cuban medical training is of a high standard. Cuban medical certificates are recognised in a wide range of countries, including in the U.S.A. (ECFMG 2008). Indeed, despite the frozen political relations between the US and Cuba, US graduates from Cuban medical colleges are registered and practising back at home (e.g. Edwards 2008). By 2010 more than 900 East Timorese students were in medical training, more than 200 of these in a Faculty of Medicine in Timor Leste itself, created in late 2005 (CMB 2008). After 2006, no more students were sent to Cuba; rather all new students were enrolled in Timor Leste's new Faculty of Medicine. The training was developed under a Cuban system, but with collaboration from the Timor Leste government. Dr Rui Araujo, Health Minister from 2002 to 2007, wrote that the medical training emphasised 'responsibility to society ... critical thinking, flexibility and openness to knowledge exchange' (Araujo 2009, 3). This Faculty, staffed by Cubans, was built within the National University, with links to the Ministry of Health. It needed an East Timorese rationale. Araujo said the training of doctors in Timor Leste was focused on 'the health of individuals, families and communities ... [and not just] the disease of individuals' (Araujo 2009, 3). Here we see the initial articulation of an East Timorese notion of social medicine.

On September 3, 2010, the first group of eighteen East Timorese doctors graduated, amid much celebrations, at the National University. They had already done a one year internship in Timor Leste, after their six years of studies in Cuba. These eighteen were immediately signed up as 'General Basic Doctors' (medico basico general), and plans were put in to place to have them do two years 'social service' working in the rural areas (or sub-districts) of the country. The views of these new doctors tell us something about the country's emerging approach to health care, particularly as another 900 medical students are coming close behind them.

However let us look first at the Cuban approach to training. The move to carry out more training within Timor Leste was part of a general shift in Cuban thinking, as Dr Yiliam Jimenez, Vice-Minister and Director of Cuba's health cooperation programs points out: 'We are returning to the tutorial method, supplemented by information technologies and other teaching aids, so that students from low-income families can be educated in classrooms and clinics in their own communities, where their services are so sorely needed' (in Reed 2008). The creation of medical training within Timor Leste, as well as in Cuba, did not signify a simple shift into the classrooms of the National University (UNTIL) in the capital, though that happened, too (Rigñak 2008).

Students began to train with the Cuban doctors, in their various posts throughout the country. These students rapidly learned Spanish and followed the doctors, translating for them, watching them practice and taking part in preventive health classes. In the district hospitals and larger health centres they began to alternate classroom time with attendance at clinic. Timor Leste had never before had resident doctors at the sub-district level (Medina 2006). Despite the large commitment in Dili, the presence of twice as many doctors outside the capital (CMB 2008) introduced a new pattern of health services to the country, including the practice of house visits, at village level (Rigñak 2007). Eventually, the expanded primary health care, including skilled birth assistance, began to show up in national indicators. According to the 2009 Demographic and Health Survey, infant mortality in the country fell from 60 in 2003 to 44 in 2009 (IRIN 2010). It is not clear how reliable this data is, and there will be some other factors involved; however the presence of more than a hundred Cuban doctors in rural areas since 2004 is likely to have made a contribution.

The Cuban approach was explained by the Cuban Dean of the Faculty in 2010, Dr Emilia Botello, while discussing the final year internship of the country's first doctors:

Students are trained in their final year in four modules, focussing on the health of the child, the family, the woman and the adult – in each of these they take a clinical, epidemiological and social point of view ... to have an integral focus on the individual, not only on the illness but on all relevant factors ... from the social point of view, what might be done to change things (Botello 2010).

This was a broader and more participatory form of medicine, which began with traditional clinical medicine but had grown into a transformatory model:

The Cuban system of medical training begins with the traditional model ... developed with flexibility in the curriculum, towards a medicine which is more preventive than curative ... one has to include in the process not only the doctor, or the medical team, or the health system, but also the society – the communities and other social systems ... Cuban medicine is not just the practice of clinical methods – the student is trained to be able to practice clinical, epidemiological and social methods, to involve and recognise, in society, what are the factors that affect health (Botello 2010).

This approach is reflected in comments by one of the new doctors, Colombianus da Silva:

In Cuba they taught us to work, but to work with love – as a doctor, a scientific doctor but a doctor with a heart. More than the work to cure illnesses, we have the responsibility to prevent it, to teach people so they can participate actively in the prevention of illness (Da Silva 2010).

Along with the others, Colombianus had practised under individual Cuban doctor supervision, in his country's rural areas. In the months after their arrival in August 2009 they had treated infectious diseases (malaria, cerebral malaria, tuberculosis, dermatitis, parasites, leprosy), delivered babies, attended emergency hospital receptions, sutured wounds (including caesarean wounds), participated in minor procedures, held regular consultations, vaccinated pregnant women and babies, developed educational materials on natural and traditional medicines, organised educative health discussion groups, including old peoples' discussion groups, and tried to assist in cases of malnutrition (Royuela Reyes 2009). Colombianus reflected the Cuban view of health workers as active social agents with a wider view of medicine:

My vision is not to sit in an office, waiting for sick people to come to me, rather we – as they showed us in Cuba – will go to them first, see how they are living, what they are eating, are they washing or not? .. we have to do this altogether, with everyone, with all sectors ... We as doctors have to have a wide vision, so that we see the whole person (Da Silva 2010).

This wider view is affirmed by former health minister Araujo, who continues to play an active role in the development of his country's new doctors. He says Timor Leste would see: 'protection of health as an essential strategy to elevate the quality of life; the humanisation of health services delivery, characterized by service with greater affection and commitment'. Levels of participation would see persons under care 'involved in his/her self-care because he/she is well informed and educated'. Scientific and popular knowledge were to be combined

to maintain a dynamic body of knowledge, which sustains the collective wellbeing and reinforces health and social development; the provision of comprehensive health care services, which takes women and men as indivisible beings within a determined and changing social context (Araujo 2009, 3-4).

Nevertheless, there were two forms of resistance to this new approach. The first was a form of cultural resistance, from a society which simply had not had much contact with doctors or hospitals or, if they had had such contact, the experience was bad. The health system in Timor Leste had been nurse-based, with very limited services. Pregnant women in rural areas were not used to going to a health centre to give birth, but Cuban doctors had gradually encouraged them to do so (Martín Diaz 2007). Even in the capital, some women who had come to clinics for pregnancy checkups, would give birth at home, sometimes resulting in the death of the baby (Llero 2010). And mothers were reluctant to take sick babies to a district hospital, because they associated the hospital with death: it was seen as a place where people went to die (Calderón Reynoso 2010). There may be myths and taboos about medical treatment, but this last point must have had a powerful impact. If a hospital was associated with the terminally ill, and was regarded as

‘the end of the line’, it is completely logical that mothers would feel great fear in taking their children to such a place.

The second form of resistance came from covert jealousy amongst many of the established, elite culture of doctors, and from sections of the Catholic Church, which had long been the patron of the educated elite. Elements within the Church, along with the US Embassy in Dili, had opposed a Cuban training program from the beginning. The Cubans, for their part, had tried to accommodate any fears that might have been generated about ‘communist indoctrination’, by facilitating the regular celebration of mass and visits by church figures (Betancourt 2007), and by fairly open access to the colleges. Dr Araujo, amongst others, tried to avoid the large health training program becoming politicised, seeking the support of all sectors, including a role for the Church. Nevertheless, at the graduation ceremony in 2010, that history did not go unremarked. In a prepared speech on behalf of all the new doctors, Dr Ercia Da Conceição put on the record:

We know that during our study in Cuba the previous government received much criticism from many institutions, including the Catholic Church ... [however] we dedicated ourselves as Timorese looking for experience and intelligence in Cuba, but to return and live as Timorese ( Da Conceição 2010).

Despite this tension, some religious groups in the health sector, such as Klinka Pas in Becora, led by former Catholic nun Maria Dias, have provided strong support for the Cuban program. Indeed, when one Timorese intern suggested, during his final exams in 2010, that an obstacle to pre-natal women’s health and family planning might be the Church, the Cuban Dean of Medicine quickly reminded him that some of the best family planning in the country was taking place in religious institutions, such as the one in which the exams were being held – Klinka Pas. Religion itself was not an obstacle to preventive health, she reminded the intern, and they had to work within their country’s culture and institutions.

The other key culture clash, with the small but influential medical profession, showed up in various ways. There was some non-cooperation with the new interns, on their arrival back in Timor Leste from Cuba. In some district hospitals there were breakdowns in communication between the interns and their Cuban mentors, on the one hand, and the Timorese doctors (Dias 2010). There was also Timorese doctor resistance to the Cuban doctors taking students through the hospital. Nevertheless the Cuban practice of treating most health clinics and hospitals as teaching clinics has become more accepted (Aparacio Alvarez 2010). Health Minister Dr Nelson Martins was very reluctant to acknowledge the Cuban role in his country, even though they dominated practice and training. On two visits to universities in Australia over 2009-2010, Dr Martins said nothing about either the Cuban doctors or their medical students, even when discussing the primary health system, which relied on them.<sup>1</sup> This attitude led to uncertainties in mid 2010 over the registration and placement of the new doctors. Nevertheless, they were all registered as doctors in September and their placement in eighteen separate rural areas proceeded in November 2010 (Araujo 2010).

While some cultural and individual conflict may have been associated with these tensions, I suggest the root of it lies in the different modes of medicine the groups represent: one a community service, public system approach and the other a private practitioner, fee-charging system. Very similar tensions have been seen with the Cuban programs and private, local health professions in other countries, such as in Honduras, South Africa, Venezuela and Bolivia (MEDICC 2008). An important difference in Timor is that the established medical profession is very small and the incoming health worker cohort is very big. One of the new doctors, Ildefonso Da Costa, spelt out some of this difference, along with the ideas of the new group of doctor to make some changes:

The Timorese doctors don’t want to work in the sub-districts [like the Cubans], they all go to private clinics ... but we can’t think just of money, but rather how we can develop this country ... those

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<sup>1</sup> This writer’s observations, based on presentations by Dr Martins at the University of NSW on 7 August 2008 , and at the University of Sydney on 17 February 2010.

[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 (Da Costa Nunes 2010).

Just what that project is, and what sort of new 'balance' will emerge between Timor Leste's social medicine and the private clinic system, remains to be seen.

### **An East Timorese synthesis**

It seems that Timor Leste's health system will soon adopt a form of social medicine, but it is not yet clear exactly what form that will take. However I suggest it will have some endemic features, influenced by - but not copying - Cuban revolutionary social medicine, and different from Allende's model, based on radical social democracy. After presenting some reasons for the likelihood of such a change, I will consider some likely elements of the new model.

The numbers tell part of the story. Prior to September 2010, Timor Leste had no more than 75 doctors; the new cohort trained by the Cubans will be more than 900. The Cubans are committed to meeting Fidel Castro's 2005 promise of 1,000 places, and the main constraint on this in recent years has been underinvestment in the Faculty. Only about 30 new enrolments were taken in 2010. The distinct ethos of training will make a difference, especially as many of these young professionals are likely to be 'upwardly mobile' in the institutions of their own country.

More than this, there is strong acceptance of some of the essential elements of the Cuban approach: social responsibility and solidarity, equal access and a more human approach to health care. In other words, there is cultural sympathy with important elements of the Cuban approach, despite cultural differences. Rural care by the Cuban doctors, including house visits, have been generally very well accepted. And this treatment has been extensive. By 2008 Cuba doctors had provided an estimated 2.7 million consultations, in a population of one million (CMB 2008). Cultural sympathies also help explain the high success rate of the East Timorese students. In 2006 Timor Leste's Prime Minister's Department reported that 'Timor-Leste's 498 students in Cuba are considered to be the best among thousands of overseas people studying medicine in terms of results and discipline' (PMC 2006). The following year, in Cuba, I was told the same thing. There had been 100% promotion amongst a 300 strong group of 3<sup>rd</sup> year medical students (Betancourt 2007). While several dozen students from one Latin American country - a much wealthier country than Timor Leste - had been sent home, as they were undisciplined, got drunk a lot and were not studying, the East Timorese students took greater advantage of the opportunity they had been given. They were said to be very hard working and mutually supportive ('muy solidaria') (Betancourt 2007); probably highly conscious of the commitments they had made to return home and help their communities.

I suggest the country will adopt a form of social medicine due to the scale of the training program, its apparent success, the demonstrable cultural sympathies and the existence - despite tensions between the ministry and the program in 2010 - of some political will and potential leadership. The graduation ceremony of September 2010, which attracted most of the political leadership of the country, is testament to this.

Likely dimensions of a Timorese model of social medicine would include community solidarity, an inclusive Christian ethos (perhaps including elements of liberation theology) and an independent and self-sufficient spirit. Much of this is already well established in East Timorese culture and history, through successive anti-colonial struggles, including struggles for the very existence of whole communities, and of the East Timorese nation.

Evidence for this can be seen in recent statements by protagonists of the new system. Writing about Timor Leste's medical certification, Dr Araujo spoke of the need for new practitioners to have 'comprehensive ... promotional, preventive, curative and rehabilitative' skills, which would be combined:

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 (Araujo 2009, 2).

Ideas of solidarity and independence were stressed by Dr Ercia da Conceição, in her important keynote address at the September 2010 graduation ceremony, on behalf of the country's first eighteen doctors:

Many people still cannot read and write ... to escape from this path requires building high quality education, because if all Timorese are intelligent nobody can manipulate us, no-one can defeat us and this nation will be strong and will never fall into the hands of others (Da Conceição 2010).

Her East Timorese audience would have understood what she meant by the phrase 'falling into the hands of others'. Dr Ercia also emphasised community service and Christian responsibility:

We do not seek wealth for ourselves but rather to serve the people with dedication and a spirit of humanism that does not see race, locality, religion, gender or political parties, but which services all people according to the teaching of God ... and so once more we as doctors declare that we are ready to receive orders and work in any part of the country (Da Conceição 2010).

Similarly, in an interview just before graduation, Dr Julia da Silva Morais seamlessly mixed her Christian background with Cuban humanism: 'If God wishes it, I will graduate in September, I promise I will serve my Timorese people, with a lot of affection. I will serve, as they Cubans say, like a human being' (Da Silva Morais 2010).

Uncertainties that face this developing social medicine would seem to include the extent to which future governments will maintain strong public investment in the health sector, the evolving 'balance' between the private clinic system and the public health system, and the extent to which the ethos of social medicine influences the evolving social democracy of the country. These, it seems to me, are matters yet to be resolved.

## **Conclusion**

This paper began by tracing the idea of 'social medicine' from Chile to Cuba to Timor Leste, through the powerful Cuban cooperation program. I accept Guzmán's (2009) idea that Latin American social medicine is a wider and more dynamic concept than European epidemiology or a 'social determinants' approach, but I assert that there are different forms of social medicine, conditioned by distinct histories and cultures.

Chilean social medicine was a central aspect of that country's radical social democracy, which stalled when the political project was derailed by a military coup. Cuban social medicine, was conditioned by that country's revolutionary solidarity and internationalism, drawing on Jose Martí's ideas of unity and a strong, secular moral culture. The Cuban solidarity model grew alongside that country's need to find allies in face of a powerful and hostile neighbour. Cuban pedagogy has been very important in the development of Timor Leste's post-independence health system; but to what extent will it influence the creation of an endemic East Timorese form of social medicine? I suggest the Cuban influence is very important, but that endogenous factors are also important, and that social medicine in Timor Leste will necessarily be an East Timorese synthesis.

Any such development in a small country would be in the face of a global system that has commodified health services and systems. While the Nordic countries have maintained universal coverage and mostly public health systems (Lundberg, Yngwe, Stjärne, Björk and Frtzell 2008), the OECD has urged developing health systems based on 'innovation' (financial rewards for new health products and services) and competition (private investors adding to 'consumer choice'), and has promoted health care systems 'as a source of economic growth' (extending formal economies into the health sector) (OECD 2003). Social medicine flies in the face of this powerful current.

Despite such opposing forces, Timor Leste is about to adopt a form of social medicine due to the scale of Cuban training, the cultural sympathies and - despite some clash of cultures - potential political will and leadership. Likely elements of a Timor Leste synthesis are community solidarity, an inclusive Christian ethos and an independent spirit. There is strong popular support for a health system which embodies 'humanism, solidarity and good citizenship' (Araujo 2009). What remains unclear is the depth of sustained state investment in public health, how far the public system will displace the private clinic system, and to what extent East Timorese social medicine will influence the country's overall mode of development and social transformation. Nevertheless, this small country seems ready to take yet another bold and independent step.

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