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The Gift of Health  
Socialist Medical Practice and Shifting Material and Moral Economies in Post-Soviet Cuba

Drawing on ethnographic data collected over 13 months of fieldwork in family doctor clinics in Havana from 2004 to 2005, I examine the shifting moral and material economies of Cuban socialist medical practice. In both official ideology and in daily practice, the moral economy of ideal socialist medicine is based on an ethos of reciprocal social exchange—that is, the gift—that informs not only doctors' relationships with the Cuban state and with individual patients but also the state's policies of international medical service to developing nations. The social and economic upheavals after the fall of the Soviet Union, however, have compelled both the state and individual doctors to operate in a new local and global economy. The gift remains the central metaphor of Cuban medical practice. Nonetheless, as ideologies and practices of gifting and reciprocity encounter an emerging market economy, gifts—whether on the level of the state policies of international humanism or in patient–doctor relations—are open to new significations that highlight the shifting material and moral economies of post-Soviet Cuba.

Keywords: [Cuba, health care and medicine, state, socialism, the gift]

The life of a single human being is worth a million times more than all the property of the richest man on earth...far more important than good remuneration is the pride of serving one’s neighbor. Much more definitive and much more lasting than all the gold that one can accumulate is the gratitude of a people. And each doctor, within the circle of his activities, can and must accumulate that valuable treasure, the gratitude of the people.


It’s a new era. All of a sudden, money is necessary. As always, money crushes everything in its path. Thirty-five years spent constructing the new man...Now we’ve got to make ourselves into something different, and fast. It’s no good to fall behind.

—Pedro Juan Gutiérrez, Dirty Havana Trilogy, 1998
In a televised session in 2004 celebrating the 20th anniversary of Cuba’s Family Doctor Program, Fidel Castro declared Cuban health workers a “moral collective, profoundly ethical, that constitutes the very essence of the Revolution.” Such pronouncements became extremely familiar during my fieldwork on reproductive health care in Havana. Since the 1959 revolution, the provision of universal public health care has been central to the socialist vision of an egalitarian society and to official narratives extolling the victory of moral and social justice over capitalism’s materialism, utilitarianism, and inequality (Castro 1967; Feinsilver 1993; Gerassi 1968). Yet although the busy and often overworked doctors with whom I interacted universally expressed pride in their work, they rarely expressed these heroic sentiments of official narratives. Indeed, a number reflected with some anxiety about the changing relationship between material prosperity and moral standing in Cuba’s new post-Soviet economy.

Soon after Castro’s speech, I chatted with an older obstetrician who proudly regaled me with stories about the care given to the health-compromised newborns that passed through the neonatal intensive care unit of her hospital. When I asked her about the changes she had experienced during her long tenure in the Cuban health care system, she surprised me with a comment that at first seemed to be a non sequitur:

I’m delighted when a child recuperates his or her health…To heal the sick, yes, that is a moral compensation…But when I leave here I want to go to the stores too, buy some makeup, shoes, go to a restaurant, repair my house…and one feels, well, why have I sacrificed so much…Because human beings…live to consume…Che [Guevara] knew that, he talked about the “new man,”…that we were going to have a better standard of living, material things.

It was months later before I grasped that for her, my question about “changes in the health care system” implied far more than policy initiatives or institutional reorganizations; it cut to the heart of the shifts in the moral and material economy of socialist medicine in post-Soviet Cuba. After the fall of the Soviet Union, Cuba was plunged into a devastating economic crisis known as the Special Period. As the country plummeted from the ranks of the socialist “second world” to join the “third world,” the tightening of the U.S. embargo further exacerbated the crisis. Average daily caloric consumption dropped 33 percent between 1989 and 1993, from over 2,800 calories per day to just over 1,800 (Chomsky 2000). Transportation came to a standstill as oil reserves ran low, and daily rolling blackouts were so long that Cubans joked about alumbrones (intermittent light), rather than apagones (blackouts).

Emerging from the crisis demanded a radical rethinking of Cuba’s economic direction. The government has been forced to garner desperately needed income by opening the tourist sector, legalizing certain categories of entrepreneurial activity, and, beginning in 1993, allowing individual families to receive remittances. The effects of these shifts, as well as the resultant dual economy (in which state workers earn in pesos but many consumer goods are only available in dollars), have reverberated throughout Cuban society. Prior to the crisis, physicians, engineers,
and university professors represented the apex of socialism’s social and economic hierarchy (Mesa-Lago and Pérez López 2005). Now, many of these professionals see the emergence of a new social and economic landscape, since the income of Cubans with access to the tourist, remittance, or informal economies may now well surpass the levels possible for state-salaried workers. In this unexpected context, the doctor cited above speaks for many of her colleagues when she contests the ideological opposition between morality and material gain, arguing that moral rewards, although a primary motivation for her labor, must also be accompanied by a sense of material well-being. In so doing, she selectively interprets Che Guevara’s “new man”—Guevara in fact argued ardently against the introduction of a Soviet-style system of material incentives (Bernardo 1971)—highlighting instead the early revolutionary promise that those who participated in the grand collective sacrifice of a new society would be rewarded with a better standard of living for all (Gerassi 1968).

Shared by professionals in other formerly socialist countries in Eastern Europe, the concern of doctors about their declining material status is by no means unique (e.g., Ledeneva 1998; Patico 2005; Rivkin-Fish 2005). With increased monetization, many professionals have experienced a tension between socialist ideologies of moral standing and new social hierarchies based on wealth. Their anxiety about the correspondence between material rewards and moral position reflects a broader uncertainty about changing social and economic relations and whether the value of their work will be gauged by the measures of a market economy or by older socialist standards (Patico 2005).

The situation of Cuban doctors in post-Soviet Cuba thus offers a fertile site in which to conceptualize these tensions of a changing society, contributing to a small but growing body of anthropologically oriented research on medical practice in socialist and postsocialist contexts (e.g., Brotherton 2005, 2008; Brown and Rusinova 1997; Rivkin-Fish 2005; Salmi 2003). In this article, I examine how, in both official ideology and in daily practice, the moral economy of ideal socialist medical practice is based on an ethos of reciprocal social exchange—that is, the gift—that informs not only doctors’ relationships with the Cuban state and with individual patients but also the state’s policies of international medical service to developing nations. The social and economic upheavals after the fall of the Soviet Union, however, have compelled both the state and individual doctors to operate in a new local and global economy. The gift remains the central metaphor of Cuban medical practice; nonetheless, as ideologies and practices of gifting and reciprocity encounter an emerging market economy, gifts—whether on the level of the state policies of international humanism or in patient–doctor relations—are open to new significations that highlight the shifting material and moral economies of post-Soviet Cuba.

As a final introductory comment, I wish to draw attention to the difficulties in writing about Cuba in a highly polemic international context. The Cuban state has made its superb health achievements central to its claims to modernity and moral legitimacy (Feinsilver 1993). As a consequence, discussions of the transformations within the health care system are frequently read as an attack on the entire socialist project. In this article, my intention is to move away from simplifying and polarizing discourses that treat Cuban health care primarily as a vehicle through which to
debate the mandate of the socialist government. The commitment to health care as social justice is, in my opinion, both laudable and self-evident. This commitment is not just articulated on the state level; more particularly, it is borne out in the daily practices of Cuba’s doctors who labor, often under demanding conditions, for the well-being of others.

Notes on Research Context and Methodology

The data for this article are drawn primarily from 13 months of research, conducted in Havana between 2004 and 2005, on reproductive health care and changing familial practices in contemporary Cuba. Issues of gifting and reciprocity did not form an explicit part of my research interests, yet as I immersed myself in clinic life, my attention was drawn to the pervasiveness of gift giving in daily medical practice. In turn, medical professionals’ conflicting interpretations regarding the practice and meaning of the gift became central to understanding post-Soviet Cuba’s changing moral and material economy.

My research access was enabled through the same strategies of favors and social networking that I later observed in the clinics. After prolonged efforts to secure interviews with representatives of the Ministry of Public Health, I came to understand what Cubans meant when they said, “Here, nothing can be done, but everything can be resolved” [No se puede hacer nada, pero se puede resolver todo]. To “resolve” was to turn to networks of friends, kin, and acquaintances—socios—to obtain “on the side” what could not be realized through formal state mechanisms. The Cuban joke that their system is one of socioismo, rather than socialismo (socialism), captures the pervasiveness of such reciprocal relations as a means of navigating state bureaucracy and material shortages (Lewis 1977).

These observations compelled me to enlist my own social networks, and, shortly thereafter, a neighborhood family doctor invited me to join her clinic as a participant-observer. From November 2004 until July 2005, and for a follow-up month in November 2005, I observed prenatal and neonatal health care consultations twice a week in her busy clinic. The doctors also permitted me to accompany them on home visits, on several overnight emergency shifts, and introduced me to other medical personnel in their social and professional networks. Through these contacts, I observed: weekly ultrasound consultations, as well as two ultrasound training sessions for doctors about to be sent to Venezuela; intermittent reproductive health consultations in two other family doctor clinics; counseling sessions with the neighborhood family psychologist; and visits to several neonatal intensive care units around Havana.

Although social networks and an “economy of favors” (Ledeneva 1998) had facilitated my entrée into my research site, they also dictated its limits. My selection of both research sites and informants was thus opportunistic; the reach of both my own and the doctors’ networks determined the sites that I could and could not access. Over the months of my fieldwork, I spent between five and 15 hours weekly with a core group of seven doctors and nurses. In addition, I was able to speak with and observe 15 other family doctors and specialists for periods spanning several hours to several months. This material was complemented by extended open-ended interviews, lasting between one and three hours, with 32 women and
18 men, as well as with 13 academics and policy advisors, about transformations in family and social life in the post-Soviet period. Some interviews were audiotape recorded with the permission of participants. During participant-observation, or when interviewees expressed concern about audiotaping, I took extensive field notes and wrote up the encounter immediately after the event. All interactions took place in Spanish, and the translations are my own.

My research was conducted exclusively in the city of Havana, where emergent social and economic stratifications are more pronounced than in the rest of Cuba. For the most part, my fieldwork was conducted in neighborhoods that were neither considered well off nor socially and economically marginal. In often crumbling buildings, families with new household appliances acquired with dollars from the remittance, tourist, or entrepreneurial economy lived side by side with severely overcrowded households where members survived on state salaries and small-scale dealings on the black and gray markets. Because of their social, economic, and racial diversity, these neighborhoods provided an ideal setting to observe the transformations and tensions of the post-Soviet economy.

Gifting and Reciprocity in Representations of Ideal Socialist Medical Practice

One afternoon I accompanied Janet, a family doctor, on a home visit. Turning off the busy street, we entered a narrow alleyway that opened up into a dim concrete courtyard overlooked by what Cubans often described as un palomar (a pigeon coop)—often dilapidated buildings where each high-ceilinged floor was divided both horizontally and vertically. In the small but clean single-room home of a young couple and their newborn, we observed the woman breastfeeding and chatted to the couple about the baby. As we stood up to leave, the woman signaled us to wait, returning with a plastic bag stuffed with women’s polyester underwear sent by a relative in Miami. To my great surprise, she urged us to choose something to our liking, not relenting until we had each selected an item that we guessed would fit. Thanking her, we left the building and were immediately intercepted by an elderly woman whom Janet had attended earlier that morning; she proffered a small cup of strong, sweet Cuban coffee and a ballpoint pen.

The sight of patients placing small jam jars of coffee or a plastic bag containing a soda or a sandwich on the doctor’s desk soon became a commonplace aspect of the clinic experience. Such regalitos, or “little gifts,” went generally unremarked, and doctors acknowledged their receipt with little more than a smiling nod and a “thank you.” One morning, however, I sat with a student doctor as she went through a routine physical examination with a pregnant patient. As we chatted, the previous patient reentered the clinic and presented the doctor with half a loaf of the dry bread sold cheaply next door. After she had departed, the pregnant patient scoffed, “What are you going to do with that? Just bread by itself? Not even a sandwich?” Fixing her with a stern look, the doctor responded, “It doesn’t matter, it’s the thought that counts.”

Faced with this direct challenge as to the worth, or meaning, of this exchange, the doctor was at pains to stress that the value of the bread resided not in its monetary worth or even its utility, but in the “thought” that it embodied. Practices of gifting were pervasive in the family doctor clinics and were a primary means by
which patients showed their respect and appreciation for doctors’ care and attention
during their long hours of service.5 Indeed, despite doctors’ relatively low financial
remuneration for their labor, gifts—and not monetary payment—were the only
socially appropriate means to acknowledge their work. Gifts were thus carefully
distinguished from either payments or bribes: unlike the ethos of a market economy,
the aim was not an equivalent repayment of a debt to discharge both parties’ mutual
obligations. Nor was it compensation for the doctors’ assumption of risk, as with
a bribe, because in these instances family doctors were simply fulfilling the routine
health obligations that their position demanded. Rather, they were tokens of the
esteem in which the recipient was regarded and a symbol of the giver’s appreciation
for aid rendered—the physical embodiment of, in Guevara’s felicitous phrasing,
“that valuable treasure, the gratitude of the people.”

Since the early years of the revolution, doctors have been considered exemplars
of the socialist ethos of self-sacrificing labor for the betterment of the collectivity
(Granma 2004; Rojas 1986). Emerging state narratives linked the development of
socialist medical practice to a new kind of citizen—el hombre nuevo.6 This “new
man” would eschew material incentives and self-interest and instead toil for the
good of the people and the advancement of the socialist project. In 1960, Guevara,
himself a fully qualified doctor, declared, “Today one finally has the right and even
the duty to be, above all things, a revolutionary doctor, that is to say a man who
utilizes the technical knowledge of his profession in the service of the revolution and
the people.” Through collective and selfless labor, he argued, the “new man” would
demonstrate his dedication to both the people and the revolution: “Individualism, in
the form of the individual action of a person alone in a social milieu, must disappear
in Cuba” (Gerassi 1968:115).

In their work as a “moral collective,” official narratives portrayed doctors as
engaged in tireless labor to accumulate not monetary remuneration, but the in-
calculable “treasure” of gratitude. Socialist medical practice would be embedded in
relations of reciprocity and solidaridad (solidarity) that were explicitly contrasted to
the individualism and profit making considered to characterize both prerevolution-
ary medicine and society generally. Renouncing private practice, the “new doctor
would put self-sacrificing duty before profit, placing his or her career in the hands of
the revolutionary leadership. For many physicians during the revolutionary fervor
of these early years, medical service was just one aspect of the vast social, economic,
and political transformations that comprised, as one eminent physician of the period
wrote, “the sacred obligations contracted by the troops of the Liberation Army”
(Danielson 1979:134).

The “sacred obligation” that these young doctors had assumed, however, was
indeed an obligation. Cuban medical training under the revolution, like all schooling
in Cuba, was (and continues to be) provided free of charge. This training was
framed both as a gift of the revolution and the duty of the “new man.” Yet as
Marcel Mauss argued long ago, there is no “free gift.” The gift is simply one act in a
temporally delayed cycle of reciprocity that draws giver and receiver into irrevocable
relationships of debt and obligation (Mauss 1990:59). In 1960, Guevara articulated
a new ethos of medical practice, excoriating a group of recent medical graduates
who had demanded payment before performing the rural service mandated in return
for free medical education. Had the students in question been peasants, rather than
from the formerly elite classes, he declared, “[They] would have run, immediately and with unreserved enthusiasm, to help their brothers. They would have requested the most difficult and responsible jobs in order to demonstrate that the years of study they had received had not been given in vain” (Gerassi 1968:116).

In these representations, the moral economy of Cuban socialist medicine established an ongoing reciprocity—between doctors and patients, doctors and the state, the state and the population—that bound them together in solidarity-enhancing exchange. Having accepted the state’s gift of medical training, new generations of socialist doctors were honor bound to reciprocate through their self-sacrificing and unending commitment to the uplift of the masses and their dedication to the ideals of the revolution. In turn, the populace, freed from the tyranny of suffering and disease, would lend their labor to the construction of the new socialist nation. In Mauss’s words, “By giving one is giving oneself, and if one gives oneself, it is because one ‘owes’ oneself, one’s person and one’s goods, to others” (1990:46).

In their polemics against utilitarian philosophies and their diminished sense of the person as an independent entity extracted from social flow, both Mauss and Guevara theorized the gift economy as a social system entirely apart from that of the market. In representations of ideal Cuban medical practice, social solidarity was achieved through the spirit-laden and continually circulating gift. The obligation to give and to receive thus resulted in ties of social solidarity as collectivities were bound together within and between generations in a system of “total services” that was both reciprocal and compulsory (Mauss 1990). It was through their participation in this reciprocal exchange, as well as their selfless labor for the population, that doctors derived their moral and social status as symbols of the revolution.

Gift Giving in the Clinic: Gifts as Both Gratitude and Social Investment

State narratives thus represent socialist medicine as an altruistic practice embedded in social relations organized around an understanding of exchange and value radically different from that commonly associated with the market. Yet as I sifted through the ethnographic data from the medical clinics, I also came to see in patient–doctor relations a slightly different vision of gifting and reciprocity. Although the family doctors with whom I worked dutifully fulfilled their routine obligations to all of their patients, gifts from patients were not simply a token of gratitude and a solidarity-enhancing exchange. They were also strategic exchanges, investments in social relationships that could then be drawn on to receive special access or attention (Bourdieu 2002).7

Recent ethnographies of medical practice in former Soviet bloc societies have underscored the pervasiveness of informal networks and reciprocal relations of favors as a means to ensure personalized attention or to obtain scarce goods and services (Brotherton 2005; Brown and Rusinova 1997; Kligman 1998; Rivkin-Fish 2005; Salmi 2003). While traditional economically-oriented analyses have typically interpreted such practices as evidence of corruption, Alena Ledeneva (1998) argues that this “economy of favors” was embedded in a Soviet system that engendered two ethical scales: official values of absolute egalitarianism often stood in tension with the actual practice of social relations in which participation in informal relations of exchange—one’s willingness to help others—was its own form of morality. Yet, she insists, “It is not the case...that one was generally adhered to and the other
not, rather it was a complicated mixture which [was] intrinsic to being a Soviet citizen” (Ledeneva 1998:67). Although she suggests that money has replaced personal connections in post-Soviet Russia, others, working more specifically in health care, have demonstrated how patients continue to mobilize informal relations in the hope of acquiring more affordable medical service or of ensuring better treatment in a system notorious for its impersonal attitudes toward patient care (Brown and Rusinova 1997; Rivkin-Fish 2005; Salmi 2003).

Such analyses highlight both the continuities and changes in the context, use, and meaning of social practices of favors and gifting after the dismantling of the socialist bloc. In Cuba, reciprocal networks were pervasive even during the Soviet-subsidized period (Lewis 1977; Rosendahl 1997). The post-Soviet state’s inability to provide many of the services and pharmaceuticals that its physicians prescribe has heightened the importance of both local and transnational informal social networks as a means to achieve health goals (Brotherton 2005). Although doctors and patients alike described Cuba’s free and accessible health care as one of the revolution’s most important achievements, informal practices of gifting and reciprocity also formed the basis of social strategies through which patients hoped to sidestep official ideology of equal and undiscriminating access. During my fieldwork, these tactics took on additional importance because the family doctor system had been considerably taxed by the mass mobilization of physicians to serve in other countries, particularly in Venezuela (discussed in more detail below). Many family doctor clinics had been closed or consolidated; by the end of my fieldwork only ten of the 44 family doctors originally working in the zone where I conducted most of my research still remained.

In the context of frequently overworked doctors and an overburdened medical system, gifts were a means to construct the informal social relationships that distinguished the giver from others (Ledeneva 1998; Rosendahl 1997). Given the state’s commitment to free and accessible health care, patients were never denied access to routine care or to pharmaceuticals when they were readily available. As the following anecdote illustrates, however, when situations demanded a doctor’s additional effort or attention, individuals ensconced within informal networks could receive favored access to medical goods and services, as well as more personalized care.

One busy morning, a young woman entered the ultrasound clinic accompanied by her mother, a nurse. The young woman had had an abortion six weeks prior and was concerned that she had not yet menstruated. The doctor reassured her that she saw no pregnancy sac in the uterus, but then scanned her fallopian tubes closely. Turning to the nurse, she informed her that she suspected an ectopic pregnancy, but could not be sure. “This machine is old and doesn’t visualize well. You need a transvaginal ultrasound to make certain,” she told her, “but they only have those at the hospital and the wait list is long.” Pausing, she asked, “You don’t have a way of obtaining one?” The nurse shook her head worriedly, saying, “No, I only work here in the polyclinic, I don’t know anyone over there.” The doctor persisted, but when the nurse again shook her head, she responded, “Come back tomorrow, and in the meantime, let me see what I can do for you.” When the young woman and her mother left the office, the doctor explained to me, “I’ll go out of my way for her. I have friends up there, so we’ll see what I can do. She’s a good person—and she has friends in other polyclinics and sometimes gifts me the transducer [ultrasound] gel when I run out.” A week or so later, I encountered the nurse on the street and
asked whether her daughter had been able to bypass the ultrasound waitlist. She responded, “Yes, thank God. That doctor is such a good person, she really cares. I’m going to give her a gift to show her how much I appreciated it.”

Gifts and favors were therefore in constant circulation as both patients and doctors drew on personal relations to achieve desired goals. Gifts spoke to both the past and the future; they demonstrated gratitude for past service yet were also an investment in social relationships that could prove useful in the future. Expectations of overt reciprocity were rarely openly admitted, however, and special attention tended to be articulated within the language of help and friendship. One day, for example, I accompanied a friend who had “resolved” a late abortion at a local polyclinic through developing a relationship with the admitting nurse. As she stood in line, clutching the bottle of perfume and soaps that she intended to give as a thank-you present, she reiterated to me the long list of personal and medical obstacles that had prevented her from receiving an abortion within the designated time frame, concluding, “In Cuba one has to resolve everything through friendships” [En Cuba hay que resolver todo por via de amistades]. Doctors’ participation in informal relations was thus mutually understood to be motivated by an ethos of altruism and care in the face of an often impersonal system. Indeed, patients, adapting official rhetoric to their own practices, frequently described those doctors who refused to grant special requests as lacking the socialist ethos of solidaridad.

Although practices of gifting and reciprocity are still very much in evidence in Cuban medical practice, the social and economic stratifications that have emerged in the post-Soviet economy are complicating this system. For those without access to dollars, the shortages of the post-Soviet period have meant a greater reliance on informal relations to fulfill basic needs. For others enjoying a newfound prosperity, money is now emerging as an alternative strategy for achieving health goals, particularly given the emergence of fee-for-service medical tourism (Brotherton 2008). In turn, for many doctors, these changes are threatening the moral meaning of the gift economy both in medical practice and in the broader conditions of socialist life.

The Changing Material and Moral Economies of Post-Soviet Cuba

A man walks into the bar of the hotel Habana Libre and orders a drink. The bartender asks if he knows that the prices are in American dollars, not Cuban pesos. “Don’t worry,” said the man, “I’m a bellboy at the Hotel Nacional.” After a few hours, the man’s wife walks into the bar and, seeing the check, begins to wail, “How can we pay for this, we don’t have $40!” Puzzled, the bartender says, “But isn’t he a bellboy at the Hotel Nacional?” The wife shakes her head angrily and says, “Oh, when he drinks he always suffers from delusions of grandeur. He’s just the chief neurosurgeon at Almerijeras!” [Havana’s most prestigious hospital]

—Cuban joke

During a rare slow period in her clinic, I listened to a family doctor reminisce about life as a medical student in the 1980s. Sighing, she commented, “Things have really changed. Now, everyone is looking for ways to make more money. I even
thought of selling tamales on the side [por la izquierda].” Recalling her husband’s indignation at this prospect, however, she remarked, “He was right, I studied years, sacrificed years, to become a doctor. I don’t earn much, but I do have my dignity, and the day that my patients see me selling tamales on the street is that day that I lose their respect.” She continued,

But this is the problem here, the social pyramid is inverted, the professionals are on the bottom and the masses are on top, those who study a lot earn little, and those who don’t study earn a lot. . . . I adore my country, that everyone gets free medical attention, everyone receives free education . . . even if they don’t have money. That part of socialism is very important. But igualitarismo [distributive policies based on the ideology of absolute egalitarianism] is bad—that everyone receives the same, no. Everyone should receive according to the work that they do, their contribution to society, because this igualitarismo affects everyone, [and because of it] people don’t respect professionalism.

In this commentary, she gives voice to two interrelated concerns. The first is a generally held anxiety about a new imbalance between material prosperity and moral standing. During the period of Soviet subsidization, the differential between highest and lowest paid workers was about 5 to 1 (Evenson 2001). In 2002, however, the minimum monthly income of a state worker was about 100 pesos ($4), whereas university professors earned about 300–560 pesos ($12–$22) and a doctor 300–650 pesos ($12–$25). A tourist taxi driver, by contrast, could expect to make around $100–$400, and a person who rented rooms to tourists could bring in between 250 and several thousand dollars (LeoGrande and Thomas 2002; Mesa-Lago and Pérez López 2005). At the same time, rations have been reduced to cover only about ten days of food per month, while the real wages of state workers (some 77 percent of the workforce) dropped 44.4 percent between 1988 and 2000 (Mesa-Lago and Pérez López 2005). In this context, underscored by the anecdote with which I opened this article, many state-salaried professionals point to a sense of declining material status relative to the more consumerist lifestyles enjoyed by many with access to dollars through tourism, remittances, or private self-employment.

But for most doctors with whom I spoke, the critical issue is not simply one of financial compensation; it is a sense that the new conditions of post-Soviet life threaten to destabilize the reciprocity that should underlie socialist moral hierarchies.10 Although applauding the governmental guarantee of health care and education, they question the broader applications of the ideology of igualitarismo in a new and more stratified Cuba. A leading psychologist, for example, contended that the concept of “socialism-the-giver, the protector, the sustainer” meant that some individuals now felt entitled to receive without in turn contributing to society. Both academics and lay observers often expressed fears that the economic changes in Cuban society have placed socialist values of education, solidarity, and self-sacrifice in tension with individualistic strategies of economic mobility that garner new markers of status—money, conspicuous consumption, and new forms of leisure.

Yet although other professionals consider leaving high-status but low-paying jobs for better-remunerated ones in the tourist industry, or ply their skills as
entrepreneurs, the pivotal role of doctors in Cuba’s monetary and moral economy puts them under particular constraints. Given the government’s commitment to universal public health care as a key aspect of social justice, as well as its financial investment in medical training, doctors are prohibited from practicing medicine privately. Some health professionals, like other state workers, supplement their income by working in second jobs as waiters, taxi drivers, or through participation in the informal economy (Mesa-Lago and Pérez López 2005). In the clinics in which I worked, for example, one nurse handmade fishnet stockings for sale to Cubans with dollars, while another sold fruit juice from her home. Others, however, feel that such informal activity could undermine their sense of professional respect in their own eyes as well as those of their patients. Differing responses among doctors thus point to a wider tension about the basis of respect and its relation to material status in the new economy.

For many doctors, as I discuss in the next section, Cuban policies of international medical humanitarianism provide a much-desired opportunity to earn additional financial capital without abandoning either their field or the socialist commitment to reciprocal and collective moral labor. During one of the frequent blackouts at the polyclinic, I sat in darkness with several nurses and doctors who had gathered to wait it out in companionship. The conversation turned, as it inevitably did, to the costliness of consumer goods for those earning only state salaries in Cuba’s post-Soviet dual economy. After reminiscing nostalgically about the abundance of cheap products during the Soviet-subsidized 1980s, one nurse wondered aloud, “Where did they all go?” while another joked in response, “Now we’re going to have canned sardines from Venezuela!” As they gossiped about the number of friends and colleagues who had been mobilized on medical “brigades” to Venezuela, a doctor commented wryly, “Whether overseas or ‘on the side,’ doctors do what they have to do” [Por afuera, por la izquierda, los médicos resuelven sus necesidades]. As medical professionals search for alternative ways to garner the new capital necessary in post-Soviet Cuba, many have turned to the state’s “gift of health”—its international medical service.

The International Gift of Health: Medical Service in Venezuela

Policies of international humanism have been an integral part of Cuban socialism since its inception, and over 100,000 doctors have served in some 103 countries. International “missions,” as they are often called, are consonant with broader ideologies of socialist medicine as part of a collective and self-sacrificing historical struggle for social justice that is founded in an ongoing and diffuse reciprocity. Having received the gifts of education, health, and political enlightenment under socialism, doctors are called to repay their debt through their work for humanity both within and outside Cuba. Doctors serving overseas are frequently considered “ambassadors for socialism” (Feinsilver 1993), and during my fieldwork Cuban media featuring Cuban doctors on international missions universally framed doctors as embodies of the socialist values of morality, sacrifice, and solidarity.

In providing medical and humanitarian aid to countries struggling with war, natural disasters, and chronic poverty, policies of international medical assistance
are an important source of moral legitimacy for the socialist government. Such “medical diplomacy” (Feinsilver 1993) can also reap substantial economic benefits for Cuba’s government since the good will fostered through programs can also be parlayed into material benefits in the form of loans, aid, and favorable trade terms. Indeed, health workers have played an increasingly important role in the solidification of new political and economic alliances as the Cuban government has sought to strengthen Cuba’s position in the post-Soviet global economy. The current medical mobilization to Venezuela, the largest in Cuban history, is the clearest example of this exchange; in 2005, an estimated 20 thousand Cuban doctors and dentists (BBC 2005)—about one-quarter of Cuba’s medical personnel—were serving on bilateral contracts that guaranteed the Cuban government favorable terms on nearly a hundred thousand gallons of Venezuelan oil per day (Forero 2006). Health workers, and the income that they provide for the government, have in fact become one of Cuba’s most significant “exports”; together with biotechnology and pharmaceutical products, they comprised around 37 percent of Cuba’s total export market in 2007. Although most missions have taken place in poor and underresourced countries, Cuba’s unstable economic situation after the fall of the Soviet Union means that policies of international humanism—particularly in Venezuela—have become an increasingly important source of economic and political support.

The state’s use of the “gift of health,” as both solidarity-building exchange and as strategic investment, is mirrored on the ground as doctors turn to international service to bolster their economic position in a new Cuba. Although values of socialist solidarity, humanitarianism, and reciprocity undoubtedly motivate many doctors to commit to international medical aid, both medical professionals and laypeople were also likely to attribute this service to the higher pay (doctors overseas make $150–$375 per month and their salaries are raised to $50 a month on their return), as well as the opportunity to purchase consumer goods that, given the embargo, are unavailable in Cuba or available only at high cost. During my fieldwork, I was frequently told an apocryphal story in which poor Venezuelans encountering Cuban doctors marvel, “We thought you were communists, and here are you are, spending like a capitalist!” Although many physicians referenced financial necessities in addition to humanitarian desires, one put it more bluntly than most, remarking, “Fidel is blind if he thinks that doctors go to Venezuela because of their internationalist spirit. They go to spend money, to buy the things that they need—a video player, clothes, shoes, a computer—to earn money.” Contrasting “internationalist spirit” with economic and material motivations, this doctor suggests that the rhetoric of self-sacrifice and solidarity is simply a mask for consumerist desires. For most, however, this distinction may not be so clear cut at a time when longstanding values of internationalism are coinciding with pressing domestic economic concerns.

Although ideologies of reciprocity and solidarity are still central to Cuban medical practice, the social and economic convulsions of the post-Soviet order have necessitated new strategies for the state and its doctors. This, in turn, has complicated the meaning of the gift as the central metaphor in both international and local medical practice.
The Problem of the Gift

Near the end of my fieldwork, I visited a family doctor at her home. As we chatted, I admired her finely tooled leather cigarette case, a gift from a patient. “It’s beautiful, isn’t it?” she remarked, “I diagnosed an illness and helped her to resolver a consultation with a specialist, and she gave me that to say thank you.” She went on,

People search me out… but I demand respect… the revolution gave me the opportunity to study, but I worked for this degree, and the only thing I have to defend is my integrity as a person and my professionalism, because I don’t own my house, I don’t have a car… And so it really bothers me when people come in offering money for something, like to get an abortion after the time limit… I much prefer it if they come in, explain their circumstances, and ask for help, and if I can help them, that they give me a pack of cigarettes or something to say thank you.

Contrary, perhaps, to expectation, the perceived affront in this hypothetical encounter lies not in the patient’s request for an abortion outside the legal time frame, but, rather, by the ambivalences with which this encounter is freighted. This is, in part, a problem of timing. Describing the strategy of gifting, Bourdieu notes, “It is all a question of style… for the same act—giving, giving in return, offering one’s services… can have completely different meanings at different times” (2002:6). As I have argued, the temporal ambiguity of the gift is central to its moral meaning; the gift of gratitude for a past service may at one and the same time be a gift of strategy, an investment into the future. To enter the clinic proffering a gift for an immediately requested favor “unmasks” the strategy behind the gesture, revealing it, in Bourdieu’s words, as “forced” and “interested.” In this context, this doctor’s indignation stems from the implication that she would not extend as much help as she could to all patients seeking her care, regardless of her own material gain (see also Rivkin-Fish 2005). It is through her altruistic and selfless labor, she insists, that she lays claim to her moral status as a healer and demands “respect” from the population.

But it is not just timing that is of concern. As patients’ gifts of bread, coffee, and cigarettes suggest, giving a gift that is not monetarily equivalent to the labor performed is key to establishing the financial disinterestedness of the doctor’s service and thus her moral status. In practices of gifting, what is evaluated is not the value of the goods exchanged, but the quality of the relationship expressed (Ledeneva 1998: Rivkin-Fish 2005). Established social and moral hierarchies are reiterated and reaffirmed; entities are bound together in relations of reciprocal exchange.

For many raised in the gift economy, the offer of money threatens to upset this finely calibrated moral system by suggesting that aid is given for pecuniary interests, rather than altruistic reasons (Ledeneva 1998:165; Mauss 1990). Of course, patients’ own perceptions of such encounters are unclear (I did not speak personally with anyone who admitted to the illegal practice of giving or accepting money for medical services rendered by family doctors). Given popular acknowledgment of doctors’ relatively poor remuneration, patients with dollars from outside state
sources may view money as a desirable gift or appropriate payment for an overworked and underpaid professional, rather than as a bribe. Yet for some doctors, the offer of money threatens to undermine the meaning of their moral labor. While acknowledging the state’s gift of a free medical education, this physician argues that it was through her labor and sacrifice that she attained her social, moral, and professional status; to impugn the morality of her labor was thus to attack the only thing that she felt that she had to “defend.” The suggestion of equivalence, bribery, or simple payment for service implied in the offer of money undermines her understanding of an exchange based on respect and gratitude that is key to her moral status.

The meaning of the gift thus depends on abiding by the “rules” of the game. Yet for many in this new Cuba, the rules are now in doubt. Gift relations have not lost their importance in daily social practice, as I have illustrated, but money has become another means of social differentiation. By offering money for service, or through accessing Cuba’s fee-for-service medical resources that provide goods and services scarce within the public health care system (Brotherton 2008), some patients are now hewing to a new mode of market relations that is emerging side by side with older practices that relied heavily on systems of favors and reciprocity. Given Cuba’s growing economic differentiation, those with money can now achieve desired goals through alternative means. New contradictions and tensions have arisen in Cuba’s post-Soviet economy as money—rather than moral standing gained through adherence to state socialist values of education, volunteerism, and self-sacrificing labor—becomes an increasingly important indicator of social status and mobility.

It is in this complex moment, as social relationships shift in response to a new global and local political–economy, that the concerns of Cuban doctors must be located. Many feel that Cuban moral and material life has fallen out of step; for them, state policies and socialist moralities based on relations of reciprocity are being undone by the social realities of the new economy. As doctors struggle to get by in post-Soviet Cuba, the distinction between a gift and a bribe, charity, or payment, so central to doctors’ moral and social standing—in their own eyes, as well as for the state and many of their patients—threatens to blur. Returning to the comments of a doctor previously cited on the effects of igualitarismo, I quote at some length:

This igualitarismo affects everyone, people don’t respect professionalism, and they don’t respect me. They come to my clinic with a piece of bread, or a bar of soap, and say, “hey, my dear, give me a prescription for this.” First, I’m not your dear, I’m a doctor and you should give me the respect that I deserve… Second, I’m a professional and I’ll give you a prescription for the medicine that I think that you need. It bothers me when people think, “oh, the poor doctor, she doesn’t earn anything, she can’t even afford soap, I’ll give a little piece of soap in return for a prescription.”… I can buy my own bread, my own soap, and I’m going to do the best possible for my patients because they’re my patients, not because they give me things.

This doctor’s heartfelt commentary suggests, in this instance, the unmooring of the meaning of the gift in tandem with shifting social and economic hierarchies.
For the doctors I observed, the vast majority of gift relations were understood to be based on social relations of gratitude and reciprocity. Yet on those occasions when doctors perceive that certain social relations are no longer anchored in “respect” or moral hierarchy, the status of the gift can also be called into question. Whether a piece of bread is a gift from a grateful patient or a condescending act of charity is open to interpretation, and takes its cues from the wider social context. The spirit of the gift depends on the quality of the relationship on which it is thought to rest; for many doctors, when the gift loses its foundation in a consonance of moral and material life, it loses its significance as part of broader moral exchange and takes on new meanings that are potentially very different from those that once grounded Cuban medical ideology and practice.

Conclusion

Writing against the impoverishment of human relations under a market economy, Mauss argued that in the system of the gift, material and moral life cohered to forge near-indissoluble bonds of social solidarity. Cuban society is still characterized by a strongly held collective ethic of solidarity based on the concept of the reciprocal gift, of which Cubans are immensely and rightfully proud, and that underlies socialist medicine both in state policies of international humanism and in the interactions of Cuban doctors and their patients.

Yet as doctors’ commentaries make clear, socialist morality is not simply ineffable or affective; it also rests on material foundations that involve socially valued forms of satisfaction, respect, and gratification. In post-Soviet Cuba, socialism’s moral and material economies are rapidly diverging as the state’s ability to ground its ideological social vision economically has weakened. Many Cubans, given the ongoing struggle to provide for their families, have withdrawn from the state economy in search of more lucrative forms of income. In so doing, they are pursuing alternative concepts of social status that privilege economic standing over socialist notions that envisage morality in terms of self-sacrifice and reciprocity.

With the shifts in the Cuban economy, market forces stand in a profound tension with the ideology of the gift. In this shifting landscape, with its different and competing versions of morality and status, the gift can be wrenched from its embeddedness in solidarity-creating exchange. It can be imbued with alternative meanings, becoming a charity that inverts the statuses of giver and receiver, an expected nonreciprocal flow from state to citizens, or simply an atomistic, utilitarian, and contractual exchange of goods.

Less than 50 years ago, when Che Guevara first proposed revolutionary medicine as a crucial step in creating the “new man,” he could not have foreseen how complicated “that valuable treasure, the gratitude of the people” would prove to be. The provision of free universal health care and the education of thousands of doctors is certainly one of socialist Cuba’s most significant accomplishments. There are some indications, however, that Raúl Castro is envisaging a direction for Cuban socialism somewhat different from that followed by his brother. In July 2008, he responded to the concerns of doctors and many other state workers about the correspondence between moral labor for the collectivity and material standing, declaring, “Socialism means social justice and equality but equality of rights and opportunities, not
salaries. Equality does not mean egalitarianism. This is, in the end, another form of exploitation, that of the exploitation of the responsible worker by the one who is not, or even worse, by the slothful.” As both the Cuban state and individual Cubans now struggle to find their own balance between new and old social orders, the experience of doctors, once again, will be central.

Notes

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1. In the form of the 1992 Cuban Democracy Act and the 1996 Cuban Liberty and Democratic Solidarity Act, popularly known as the Torricelli and the Helms-Burton Acts, respectively.

2. A peso is worth about $.04. From 1993 until October 2004, both U.S. dollars and convertible pesos (CUC) circulated as parallel currencies to the Cuban peso. In 2004, under threat from the United States, Cuba withdrew the dollar from circulation. For ease of reference, however, I continue to refer to the CUC as the dollar.

3. This is not, however, to subscribe to an evolutionary narrative that argues that Cuba will inevitably become “capitalist” (cf. Burowoy and Verdery 1999).

4. All names are pseudonyms. In operation from 1984 to 2008, the Family Doctor Program sought to place a doctor on every urban block. Family doctor clinics operated under the umbrella of a polyclinic that provided emergency care and outpatient specialty services. Patients could also be referred to hospitals for specialist attention or to receive in-patient care.

5. Doctors live in the community they serve and are expected to be available to help the inhabitants of their assigned areas “24 hours a day, 7 days a week” (Granma 2004).

6. Although the reality was far more complex than admitted by ideological accounts, such narratives took on additional political significance given the departure of some two-thirds of the country’s estimated 6,000 physicians in the early years of the revolution. For an excellent overview of the development of Cuban health care, see Buell (1935), Draper (1962), and Danielson (1979). I thank an anonymous reviewer for bringing these to my attention.

7. I thank an anonymous reviewer for suggesting that I put Mauss and Bourdieu “in conversation.”

8. These departures also motivated the 2008 reorganization of the Cuban family doctor system as a system of more dispersed clinics. Although there has been no detectable change in health indices, many Cubans—accustomed to immediate access to neighborhood medical care—view this as a negative consequence of the alliance with Venezuela.

9. Because urinary and blood tests for pregnancy are not provided through the state health care system, pregnancies are often diagnosed through ultrasound.

10. This concern references a long-standing debate in Cuba about socially responsible systems of work incentives and distribution of wealth. As originally formulated, the ideal communist distribution would be realized according to the precept, “From each according
to his ability, to each according to his need.” By the late 1960s, plagued by inefficiency and low productivity, the government had moved to a Soviet-style combination of material and moral rewards: “From each according to his ability, to each according to his work.” At the same time, the government maintained its commitment to policies of igualitarismo as a means of maintaining social egalitarianism, arguing that the return to socialism was just a temporary delay until the birth of the “new man” permitted the creation of an economy based entirely on moral motivation, a sense of duty, and social solidarity.


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