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Critique of Substantive Justice

Substantive Justice and Healthcare System Reform in Cuba: Challenges for Real Equity

Justicia Sustantiva y Reforma del Sistema de Salud en Cuba: Desafíos para una Equidad Real

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ABSTRACT

This article explores the current challenges facing Cuba's healthcare system from the perspective of substantive justice, focusing on the pursuit of real—not merely formal—equity. Although Cuba has long been recognized for its universal and free public healthcare model, recent years have revealed emerging tensions related to resource shortages, territorial inequalities, and differentiated services among population groups. Through a critical review of recent health policies and interviews with healthcare professionals, the study assesses whether ongoing reforms are effectively advancing the right to health with genuine equality. The paper argues that substantive justice

requires more than nominal access—it demands quality conditions, dignity, and citizen participation. It concludes by proposing structural reform strategies grounded in social justice, institutional transparency, and sustainability, as foundations for achieving real healthcare equity in the Cuban context.

Keywords *substantive justice, healthcare system, equity, Cuba, health reform*

RESUMEN

Este artículo examina los desafíos actuales del sistema de salud cubano desde la perspectiva de la justicia sustantiva, con un enfoque en la equidad real y no solo formal. Si bien Cuba ha sido históricamente reconocida por su modelo de salud pública universal y gratuito, en los últimos años han surgido tensiones vinculadas a la escasez de recursos, las desigualdades territoriales, y la coexistencia de servicios diferenciados entre sectores de la población. A partir de una revisión crítica de políticas sanitarias recientes y entrevistas con profesionales del sector, el estudio evalúa hasta qué punto las reformas en curso logran materializar el derecho a la salud con criterios de igualdad efectiva. Se argumenta que la justicia sustantiva exige no solo acceso nominal, sino condiciones de calidad, dignidad y participación ciudadana. El artículo concluye proponiendo líneas de reforma estructural que integren los principios de justicia social, transparencia institucional y sostenibilidad, como base para avanzar hacia una equidad sanitaria real en el contexto cubano.

Palabras clave *Justicia sustantiva, sistema de salud, equidad, Cuba, reforma sanitaria*

A. Introduction

The conceptualization of health as a fundamental social good and a basic human right serves as the cornerstone of contemporary bioethics and international health law. Within the framework of substantive justice, health is not merely the absence of infirmity but a prerequisite for the exercise of all other human capabilities and liberties (Sen, 2002). Unlike procedural justice, which focuses on the equal application of institutional rules, substantive justice demands that the outcomes of social systems—specifically the distribution of health results—reflect a genuine commitment to rectifying historical and structural disadvantages. In the global South, the pursuit of health equity is often stymied by the tension between market-driven efficiencies and the deontological obligation to provide universal care.

Equity in healthcare systems implies that individuals with equal needs should receive equal treatment (horizontal equity) and that those with greater needs should receive more intensive support (vertical equity). When health policies fail to account for the social determinants of health—such as housing, nutrition, and socioeconomic status—the resulting "formal" equality often masks deep-seated "substantive" inequalities. Therefore, analyzing health policy through the lens of substantive justice requires an interrogation of whether institutional frameworks truly mitigate the "*lottery of birth*" or merely provide a veneer of accessibility while the most vulnerable populations continue to suffer from disparate morbidity and mortality rates (Daniels, 2008).

The importance of equity in healthcare systems extends beyond clinical delivery to encompass the moral legitimacy of the state. Substantive justice provides a robust analytical tool for health policy analysis because it shifts the focus from "access" (the theoretical possibility of receiving care) to "attainment" (the actual realization of health potential). In the context of Latin America, historical inequities have necessitated radical departures from traditional Western healthcare models to address the needs of marginalized populations. Social justice in health demands that the state act as a guarantor of equity, intervening to ensure that life expectancy and quality of life are not determined by one's position in the social hierarchy (Marmot, 2005). Furthermore, the relevance of substantive justice becomes apparent when examining how resources are allocated during times of economic scarcity; it mandates that cuts must not disproportionately affect the primary care sectors upon which the majority of the population depends. By prioritizing the needs of the least advantaged, a system grounded in substantive justice seeks to create a "fair equality of opportunity," ensuring that health status does not become a barrier to social and political participation.

The Cuban healthcare model, established following the 1959 Revolution, has long been cited as a global exemplar of a state-funded, universal system that prioritizes primary care and preventative medicine. Historically, the Cuban government successfully integrated the *Consultorio del Médico y la Enfermera de la Familia* (Family Doctor and Nurse Program) to create a community-based approach that localized healthcare delivery. This model was built on the principle that health is a social responsibility, leading to health indicators—such as low infant mortality and high life expectancy—that rivaled those of highly industrialized nations (Whiteford & Branch, 2008). However, the collapse of the Soviet Union and the subsequent "Special Period" introduced severe resource constraints, testing the resilience of this egalitarian structure. While the system maintained its universalist

rhetoric, the physical infrastructure began to deteriorate, and shortages of essential medicines became a recurring challenge. The Cuban model's transition is characterized by a struggle to maintain its ideological commitment to "health for all" while navigating the harsh realities of a centralized economy under a long-standing trade embargo. This historical trajectory illustrates a unique experiment in socialized medicine where the state's role as the sole provider has been both its greatest strength and its most significant vulnerability during periods of economic crisis.

In the further, in the contemporary era, the Cuban healthcare system faces unprecedented emerging pressures, including severe economic constraints and a rapidly aging population. Cuba is currently experiencing one of the fastest demographic transitions in the Western Hemisphere, with an increasing percentage of citizens over the age of sixty. This shift necessitates a costly pivot from infectious disease management to the treatment of chronic, non-communicable diseases such as hypertension, diabetes, and oncology-related conditions (Spiegel & Yassi, 2004). Simultaneously, the reforms introduced to modernize the Cuban economy, such as the *Tarea Ordenamiento* and the expansion of the non-state sector, have inadvertently created new social stratifications. These economic pressures have led to an exodus of medical professionals seeking higher wages in other sectors or abroad, undermining the quality of domestic care (Salud Integral y Comunitaria, 2024). As the state attempts to optimize its healthcare budget through the consolidation of services and regionalized specialized care, there is a growing concern that rural populations may face increased barriers to access. The tension between maintaining a free-at-the-point-of-use system and the rising costs of medical technology and pharmaceuticals creates a precarious environment where the traditional Cuban commitment to equity is being re-evaluated against the necessity of fiscal sustainability.

The central research problem addresses a critical contradiction: Do current healthcare reforms in Cuba ensure substantive justice and real equity, or do they merely preserve the formal appearance of universality? While the Cuban Constitution guarantees health as a right, the material conditions for exercising that right have become increasingly bifurcated. Substantive justice requires that the quality of care remains consistent across different social strata, yet reports of "informal payments" and the preferential treatment of patients with access to remittances suggest a burgeoning "shadow" inequity within the public system (Brotherton, 2012). The research objective is to determine if the restructuring of the primary care network—intended to increase efficiency—has inadvertently widened the gap between the

healthcare experiences of different socioeconomic sectors. If substantive justice is the goal, then reform must be measured not by the survival of the institution, but by the preservation of equitable health outcomes. This inquiry explores the extent to which the decentralization of some services and the centralization of others have affected the "geographic equity" of the system. By investigating these dynamics, this study aims to provide a nuanced critique of the Cuban model's ability to uphold its social contract in a globalized, resource-poor environment.

Identifying the structural barriers that hinder effective equality in healthcare access and quality is essential for understanding the limits of the Cuban reform process. One of the primary barriers is the "dual-track" reality of the healthcare infrastructure, where facilities dedicated to medical tourism and the political elite operate with resources and technology that are often unavailable to the general public. This disparity creates a "segmented" justice that contradicts the revolutionary ethos of a classless healthcare system. Furthermore, the lack of medical supplies—ranging from basic antibiotics to reagents for laboratory tests—frequently forces patients to rely on personal networks or the black market to obtain necessary treatments, a phenomenon that privileges those with social or financial capital (Feinsilver, 2010). Another structural barrier is the deteriorating condition of many polyclinics and hospitals, which face chronic shortages of water, electricity, and sanitation supplies. These physical limitations are compounded by administrative bottlenecks and a lack of transparency in how resources are allocated between primary prevention and high-cost surgical interventions. Until these structural deficiencies are addressed, the "right to health" remains an abstract legalism rather than a lived reality for all Cuban citizens.

The emergence of socioeconomic stratification in Cuba has introduced new complexities into the pursuit of real equity. The influx of foreign currency through tourism and remittances has created a "dollarized" segment of the population that can bypass the limitations of the public health system by purchasing medicines abroad or incentivizing healthcare workers through informal "gifts." Substantive justice is undermined when social capital becomes a prerequisite for timely diagnostic imaging or specialized consultations. This stratification is particularly evident in the "second-tier" effects of the healthcare system, where the quality of the "hotel" aspects of hospital stays (food, bedding, fans) differs vastly based on a family's ability to provide for the patient. While the medical act itself remains free, the "burden of care" shifted to the family has grown significantly. This burden is not distributed equally; it falls most heavily on low-income

households who lack the means to offset the system's deficiencies. Consequently, the research must analyze how the "informalization" of healthcare costs acts as a regressive tax on the poor, effectively eroding the egalitarian foundations of the Cuban model.

Cuba's renowned "*medical internationalism*"—the practice of sending thousands of doctors abroad for humanitarian and commercial missions—presents a complex challenge for domestic equity. On one hand, these missions generate vital foreign exchange that the state claims is reinvested into the domestic healthcare sector. On the other hand, the large-scale deployment of medical personnel has led to "internal shortages" of specialists and family doctors in various provinces. Substantive justice is compromised when the state prioritizes the export of medical services to meet macroeconomic goals at the expense of the wait times and quality of care for its own citizens (Kirk & Erisman, 2009). The "re-ordering" of the domestic health force to cover these gaps often results in overworked practitioners and a decline in the thoroughness of community-based preventative care. This paradox raises the question: can a nation maintain substantive justice at home while serving as a "medical power" abroad? The research suggests that the benefits of internationalism are not always felt equitably across the domestic population, as the "hard currency" earned does not always translate into improved local clinic conditions.

In the 21st century, substantive justice in healthcare is increasingly tied to technological access and digital health literacy. In Cuba, the lack of widespread, high-speed internet and modern diagnostic equipment in rural areas creates a "technological divide" that impacts the quality of care. While Cuba has made significant strides in biotechnology—producing its own vaccines and interferon—the "bench-to-bedside" pipeline is often clogged by a lack of basic infrastructure to deliver these innovations to the average patient in a timely manner. Equity is not just about having the technology; it is about the "democratization" of that technology. Current reforms that centralize high-tech equipment in provincial capitals may increase "technical efficiency," but they often decrease "access equity" for those living in remote areas. For the Cuban reform to achieve substantive justice, it must incorporate a strategy for the equitable distribution of medical innovation, ensuring that life-saving treatments are as accessible to a farmer in Guantánamo as they are to a resident of Havana. This requires a shift from a centralized "center-periphery" model to a more networked approach that leverages tele-medicine and improved patient transport.

B. Theoretical Framework

1. The Concept of Substantive Justice

The theoretical point of departure for this analysis is the distinction between formal and substantive justice. Formal equality, often associated with the Kantian tradition of procedural fairness, mandates that laws and services be applied consistently to all citizens without overt discrimination. However, in the realm of public services, formal equality often proves insufficient, as it fails to account for the disparate starting points of various social groups. Substantive justice, by contrast, moves beyond the "letter of the law" to interrogate the actual distribution of social goods. As argued by Ronald Dworkin (2000) in *Sovereign Virtue*, a truly just society must ensure that citizens are not disadvantaged by circumstances beyond their control, such as genetic predispositions or the socioeconomic status of their family of origin. In the context of healthcare, substantive justice requires that the state actively intervenes to rectify the "brute luck" of illness or poverty. This involves a shift in focus from the provision of identical services to the pursuit of equitable outcomes. Consequently, substantive justice is intrinsically linked to the lived experiences of individuals, prioritizing human dignity and the removal of systemic barriers that prevent marginalized populations from achieving the same health status as their more privileged counterparts.

In the evaluation of public services, particularly within socialist or post-socialist frameworks like Cuba's, the tension between formal and substantive equality is palpable. Formal equality is achieved when the state provides a universal clinic or hospital accessible to all "on paper." Yet, as Amartya Sen (2009) elucidates in *The Idea of Justice*, justice cannot be realized solely through the creation of institutions; it must be assessed by the "realizations" or capabilities that individuals actually possess. A healthcare system may offer free consultations (formal equality), but if the patient must travel long distances without transport or cannot afford the supplementary nutrition required for recovery, the substantive equality of that service is negated. Substantive equality demands that public services be "difference-sensitive," acknowledging that a rural laborer and an urban professional require different levels of institutional support to achieve the same functional health. This necessitates a redistributive logic where resources are disproportionately allocated to those with the greatest barriers, ensuring that the "right to health" is not merely a legal abstraction but a tangible reality that respects the agency and dignity of every citizen.

A robust framework for substantive justice must center on the concepts of health outcomes and human dignity. Traditional metrics of

healthcare success often rely on aggregate data, such as national life expectancy or physician-to-patient ratios, which can obscure deep pockets of inequity. A substantive approach, inspired by Martha Nussbaum's (2011) *Creating Capabilities*, suggests that justice should be measured by the extent to which a person can live a life of "normal length" and "bodily health." This perspective emphasizes that the quality of the lived experience—the dignity with which one is treated in a clinic, the cleanliness of the facility, and the reliability of the treatment—is as vital as the clinical intervention itself. When patients in Cuba report that they must bring their own bedsheets or lightbulbs to a hospital, the substantive justice of the system is compromised, regardless of the absence of a medical bill. Dignity is eroded when the state fails to provide the material conditions necessary for professional and compassionate care, leading to a "devaluation" of the patient's experience. Therefore, any reform must be scrutinized for its ability to restore this dignity and ensure that health outcomes are decoupled from an individual's social or political capital.

2. Equity in Healthcare: Defining the Scope

Equity in healthcare is a multidimensional concept that serves as the operational arm of substantive justice. It is fundamentally distinct from "equality" in that it recognizes the necessity of unequal treatment to achieve fair results. As Margaret Whitehead (1992) famously defined it, health inequity refers to differences in health that are not only unnecessary and avoidable but also considered unfair and unjust. In a healthcare system, equity serves as the primary metric for assessing whether the distribution of resources aligns with the moral obligations of the state. It requires a rigorous analysis of who receives care, who provides it, and how the burdens of financing and delivery are shared across society. Without a commitment to equity, healthcare systems—even universal ones—tend to gravitate toward "inverse care laws," where those with the least need for healthcare consume the most resources, while those with the highest disease burden are left behind. Understanding the mechanisms of equity is therefore essential for diagnosing the structural failures within the Cuban model as it undergoes economic liberalization.

To precisely evaluate the Cuban reforms, one must apply the concepts of horizontal and vertical equity. Horizontal equity refers to the principle that individuals with the same healthcare needs should receive the same level of care, regardless of their location, race, or income. In Cuba, the erosion of horizontal equity is often seen in the "Havana-centrism" of specialized services, where those in the capital have access to diagnostic tools that are unavailable in the eastern

provinces. Vertical equity, on the other hand, requires that individuals with greater healthcare needs (such as those with chronic disabilities or the elderly) receive more resources than those with fewer needs. As Paul Farmer (2003) argues in *Pathologies of Power*, a "preferential option for the poor" is a moral necessity in medicine. If reforms in Cuba prioritize the "efficiency" of the system by cutting "underutilized" rural clinics, they may violate vertical equity by removing the only point of contact for the most vulnerable. A system grounded in substantive justice must balance both: maintaining a high standard of universal care while implementing targeted "pro-poor" interventions that address the specific vulnerabilities of disenfranchised groups.

Equity cannot be achieved within the walls of a hospital alone; it is inextricably linked to the social determinants of health (SDH). These are the conditions in which people are born, grow, live, work, and age. Sir Michael Marmot (2015), in *The Health Gap*, demonstrates that the social gradient in health—the fact that the lower one's socioeconomic position, the worse one's health—is a result of the unfair distribution of power, money, and resources. In Cuba, while the state has historically excelled at managing the "proximal" determinants (e.g., vaccination, sanitation), the "distal" determinants are now in flux. The housing crisis, food insecurity, and the psychological stress of the ongoing economic crisis are "upstream" factors that generate health disparities before a patient even enters a clinic. A substantive justice framework requires health policy to be integrated with broader social policy. If the Cuban healthcare reform focuses only on clinical efficiency while ignoring the deteriorating nutritional status of the population or the lack of potable water in certain municipalities, it fails to address the root causes of inequity.

3. The Right to Health in International Law

The right to health is firmly established in international law, most notably in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). This legal framework provides a normative structure that transcends national ideology, holding states accountable for the "highest attainable standard of physical and mental health." According to the Committee on Economic, Social and Cultural Rights (General Comment No. 14, 2000), the right to health is not a right to be healthy, but a right to a system of health protection that provides equality of opportunity. For Cuba, which is a signatory to various international human rights instruments, these obligations are not optional. The international legal framework emphasizes that states have a "minimum core obligation" to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights. This includes

access to basic shelter, food, and essential drugs. When economic reforms lead to the systemic unavailability of essential medicines, the state's compliance with international human rights standards comes into question, regardless of the external factors (like the US embargo) that may contribute to the scarcity.

Under international human rights standards, the state's obligation to the right to health is categorized into the duties to respect, protect, and fulfill. The duty to *respect* requires the state to refrain from interfering with the enjoyment of the right to health; the duty to *protect* requires the state to prevent third parties (such as private pharmacies or informal providers) from infringing upon it; and the duty to *fulfill* requires the state to take positive measures to ensure that the right is realized. In the context of Cuba's transition, the duty to fulfill is particularly critical. As the state moves toward a more "market-oriented" economy, it must not abdicate its role as the primary provider and regulator. International law also prohibits "retrogressive measures"—policy changes that result in a decline in the enjoyment of the right to health—unless they are justified by a lack of resources and after a careful consideration of all alternatives. Therefore, any Cuban reform that reduces the accessibility of care must be scrutinized under this "non-retrogression" principle to ensure that the most vulnerable are not bearing the brunt of economic adjustment.

The AAAQ framework is the gold standard for evaluating healthcare delivery through a human rights lens. Availability refers to the presence of functioning public health facilities, trained personnel, and essential drugs in sufficient quantity. Accessibility has four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. In Cuba, while physical accessibility remains high due to the density of clinics, "economic accessibility" is becoming a barrier as patients are increasingly expected to provide their own medical consumables. Acceptability requires that all facilities and services be respectful of medical ethics and culturally appropriate, including gender sensitivity. Finally, Quality dictates that services must be scientifically and medically appropriate and of good quality.

As noted in *Global Health Law* by Lawrence Gostin (2014), the failure of any one of these pillars undermines the entire system. In Cuba, the "Quality" and "Availability" pillars are currently under the greatest strain due to equipment failure and the "brain drain" of medical staff, creating a "hollowed-out" system where the building exists (Accessibility) but the care does not (Quality).

The integration of substantive justice with the AAAQ framework provides a comprehensive lens through which to evaluate the Cuban

healthcare system's transition. Substantive justice provides the moral imperative (the "why"), while the AAAQ framework provides the technical criteria (the "what") and the social determinants provide the context (the "where"). Real equity is only achieved when the state ensures that the AAAQ standards are met for all, specifically targeting those who fall behind the social gradient. In a climate of economic reform, the Cuban government faces the challenge of "re-validating" its commitment to these principles. If the reforms lead to a system where "Quality" is only available to those who can pay, or if "Availability" is curtailed in rural areas to save costs, the system has transitioned from a model of substantive justice to one of formal, yet empty, universality. This theoretical framework thus sets the stage for a critical empirical investigation into the current state of Cuban healthcare, moving beyond ideological praise or condemnation toward a rigorous assessment of the lived reality of the Cuban patient.

C. Legal and Institutional Framework of the Cuban Healthcare System

1. Constitutional and Legal Foundations

The right to health in Cuba is not merely a policy objective but a constitutional mandate that serves as the bedrock of the nation's social contract. Under the 2019 Constitution, specifically Article 50, the State reaffirms its responsibility to guarantee health as a fundamental right of all citizens. This legal obligation is characterized by its "unconditional" nature, asserting that the State must provide free and universal access to all medical services, from primary prevention to complex surgical interventions (Constitute Project, 2019). Scholars such as Lamrani (2021) observe that this constitutional framework differentiates the Cuban model from neoliberal counterparts by placing the "duty of care" exclusively within the public domain, effectively making private healthcare practice illegal and unnecessary. The legal architecture is further bolstered by the Public Health Law (Ley de Salud Pública), which codifies the principles of accessibility, regionalization, and community participation. This institutional framework ensures that the Ministry of Public Health (MINSAP) maintains centralized stewardship over health policy, while assuming full fiscal and administrative responsibility for the health status of the population. As a result, the legal foundations create a "state-as-guarantor" model that seeks to eliminate financial barriers to care at the point of service, a key requirement for substantive justice.

In the Cuban legal context, state responsibility is operationalized through a single, integrated National Health System (SNS) that prohibits the fragmentation typical of multi-payer systems. This "integrated"

approach is designed to ensure that coverage is not only universal in name but comprehensive in practice. Expert analysis by Feinsilver (2023) highlights that the Cuban state views health as a strategic asset for "medical diplomacy" and social stability, which justifies the high budgetary allocation—historically exceeding 10% of GDP and reaching 24% of the general budget in 2025 (P4H Network, 2025). This massive public investment is intended to buffer the system against the "commodification" of health, ensuring that resource allocation is determined by epidemiological need rather than market demand. However, the legal mandate for universal coverage is increasingly challenged by the "material reality" of the US embargo and internal economic inefficiencies. While the state remains legally responsible, the "attainment" of the right to health is frequently hampered by the unavailability of essential medicines and the deterioration of hospital infrastructure, leading to what some critics call a gap between "constitutional de jure rights" and "socioeconomic de facto reality" (ResearchGate, 2025).

2. Organization of the Healthcare System: The Three Tiers

The organizational structure of the Cuban healthcare system is famously tiered into primary, secondary, and tertiary levels to maximize efficiency and reach. The primary level is the foundation, consisting of over 10,000 *Consultorios del Médico y la Enfermera de la Familia* (neighborhood clinics) and a network of regional polyclinics. This level is designed to resolve approximately 80% of all health concerns through a community-based approach (Cuba Platform, 2024). The secondary level comprises provincial hospitals that handle specialized care, emergency services, and surgeries, accounting for about 15% of medical interactions. Finally, the tertiary level includes highly specialized national institutes and research centers that treat the remaining 5% of cases involving complex pathologies.

This hierarchical organization is intended to ensure a "seamless" referral system where the family doctor acts as the gatekeeper and advocate for the patient. By regionalizing services, the system seeks to provide "geographic equity," ensuring that even those in remote mountain areas have a direct link to the most advanced medical institutes in Havana.

A defining feature of the Cuban institutional framework is its radical prioritization of prevention over cure. The model utilizes "geographic empanelment," where a medical team is assigned to a specific population (usually 600-700 people), allowing for proactive risk stratification and continuous surveillance (PHCPI, 2024). Unlike the

"reactive" models of Western medicine, the Cuban system mandates "active screening" (*pesquisa activa*), where doctors and students go door-to-door to identify health risks before they become clinical crises. This community medicine approach views the patient as a "biopsychosocial" entity, integrating social determinants—such as housing conditions and family dynamics—directly into the clinical record. Experts note that this "high-touch, low-tech" strategy has allowed Cuba to achieve infant mortality and life expectancy rates comparable to the United States, despite spending a fraction of the cost per capita. The integration of public health and clinical medicine ensures that the system is not just a network of hospitals but a "social monitoring" tool that promotes wellness as a collective endeavor.

3. Recent Policy Reforms: Reorganization and Decentralization

Faced with a burgeoning economic crisis and an aging demographic, the Cuban government has recently embarked on a "reorganization, compaction, and regionalization" of health services. These reforms aim to optimize the use of scarce resources by consolidating specialized services in "center-of-excellence" facilities rather than maintaining under-resourced units in every municipality. While the government frame this as a move toward "technical efficiency," some scholars warn that it may introduce new barriers to physical accessibility for rural populations (ResearchGate, 2025). Decentralization is another key pillar of the reform, granting municipal and provincial health departments more autonomy in managing their budgets and logistics. However, this shift occurs in a context where "autonomy" often means managing "scarcity," as local authorities struggle to procure supplies that were previously centrally distributed. The tension between the need for fiscal sustainability and the commitment to universalism is at the heart of these structural changes, representing a "pivotal moment" for the system's long-term survival.

One of the most controversial shifts in the Cuban institutional framework is the emergence of "differentiated services," which cater to medical tourism and the diplomatic corps. Facilities like the Cira García Central Clinic operate on a hard-currency basis, offering high-quality amenities and technologies that are often absent in the "socialized" sector. While the revenue from these services is theoretically "re-invested" into the public system, the existence of a "dual-track" system creates a moral and legal paradox for a nation founded on egalitarianism. Experts such as Brotherton (2012) argue that these differentiated services signal a "fragmentation of justice," where the quality of one's healthcare experience begins to reflect their access to

foreign currency. This development challenges the "Substantive Justice" framework by introducing a market-based stratification within a state-run monopoly. The reform process must therefore grapple with how to utilize medical exports to fund domestic health without creating a "two-tier" system that erodes the dignity and equity of the average Cuban citizen.

In response to the limitations of the national budget, new financing mechanisms are being explored, including partnerships with international NGOs and "self-financing" models for certain pharmaceutical innovations. However, the most significant "new financing" is perhaps the most informal: the shift of the burden of care from the state to the family. In the "Special Period 2.0," families are increasingly responsible for providing medicines, surgical supplies, and even hospital food (State Department, 2020). This "informal privatization" represents a profound shift in the institutional reality of the Cuban system. While the "medical act" remains free, the "ancillary costs" are rising, creating a regressive financial barrier for those without remittances. This highlights a critical challenge for real equity: if the state cannot "fulfill" its financial obligations to provide the material basis for care, the legal guarantee of a "free" system becomes an empty formalisms. Substantive justice requires that the state finds sustainable financing mechanisms that do not rely on the private wealth of citizens to fill the gaps in public provision.

The institutional stability of the Cuban health system is currently threatened by a significant "brain drain" of its most valuable resource: its personnel. Low salaries—compounded by the high cost of living and the "ordering" of the economy—have led to an exodus of doctors and nurses to the private sector (e.g., as "*cuentapropistas*" in tourism) or abroad. Recent data suggests that the "export" of medical services, while a vital source of national income, has left domestic clinics understaffed, leading to longer wait times and a decline in the quality of primary care (ResearchGate, 2021). The government has responded with stricter regulations on travel for certain specialists and modest "incentive" payments, but these have yet to stem the tide. From a justice perspective, the "right to health" of the Cuban population is compromised when the state's human resource policy prioritizes "hard currency" missions over domestic clinical needs. Real equity necessitates a "human-centered" management strategy that values and retains medical professionals within the national system.

The Cuban health system remains a "priority sector," with a significant portion of the national budget allocated to its maintenance. The government budget specifically earmarked 30% of health spending for the geriatric population, reflecting the urgent need to address the

challenges of an aging society. This targeted spending is an attempt to achieve "vertical equity" by directing resources to those with the highest chronic disease burden. However, the success of this allocation depends on the state's ability to stabilize the macro-economy and secure international supply chains for pharmaceuticals. The "future" of the Cuban model likely lies in its ability to innovate within these constraints, potentially leveraging its strengths in biotechnology and primary care to create a "resilient" model that can withstand chronic scarcity. As experts note, the Cuban system is at a "crossroads" where it must choose between a slow decline into a "hollowed-out" universalism or a bold reinvention that preserves its core values of equity and justice in a new economic reality.

D. Empirical Findings: Equity and Inequality in Practice

1. Resource Scarcity and Service Quality

The contemporary Cuban healthcare landscape is increasingly defined by a profound "material precariousness" that challenges the system's foundational promise of universal excellence. Empirical data up to 2024 indicates a critical shortage of basic medical supplies, with the national basic medicine list experiencing deficits exceeding 40% (Ministerio de Salud Pública, 2023). This scarcity is not limited to specialized pharmaceuticals but extends to fundamental clinical consumables such as surgical gloves, sutures, and diagnostic reagents (Human Rights Watch, 2024). As documented by recent ethnographic studies, the "clinical quality" of care has been compromised as medical practitioners are forced into a state of "resource-constrained improvisation." When diagnostic equipment remains non-functional due to a lack of imported spare parts, the substantive justice of the system is eroded. Patients often face months-long waiting lists for elective surgeries, which in some cases leads to the deterioration of treatable conditions into chronic illnesses. This decline in service quality represents a "hollowing out" of the right to health, where the physical structure of the clinic remains accessible, but the therapeutic capacity of the institution is significantly diminished, violating the "Quality" pillar of the AAAQ framework (Gostin, 2014).

The repercussions of resource scarcity on health outcomes are beginning to manifest in demographic indicators and patient mortality data. While Cuba has historically maintained an infant mortality rate (IMR) below that of many industrialized nations, recent trends show upward fluctuations, reaching 7.1 per 1,000 live births in certain provinces during 2023 (ONEI, 2024). This shift is often attributed to the combined effects of nutritional deficiencies among pregnant women and the lack of specialized neonatal supplies (Pan American Health

Organization [PAHO], 2023). Expert discourse suggests that the "resilience" of the Cuban population is being tested by the breakdown of the pharmaceutical supply chain. Chronic patients—particularly those with hypertension, diabetes, or cancer—frequently report "treatment interruptions" due to the unavailability of medications in state pharmacies. These interruptions lead to preventable complications, such as strokes or diabetic ketoacidosis, which place an additional burden on an already strained emergency care system. The disparity between the "preventative rhetoric" of the state and the "curative failure" in the clinics creates a disconnect that undermines the lived experience of health as a realized right, contradicting the core obligations of the state to ensure the highest attainable standard of health (Sen, 2002).

The "personnel crisis" in the Cuban health sector is not merely a quantitative problem but a qualitative one. While the physician-to-patient ratio remains high on paper, the "effective presence" of doctors in neighborhood clinics has faced unprecedented pressure due to medical internationalism, the "brain drain" to the private sector, and practitioner burnout (Erisman & Kirk, 2018). Those who remain in the public system often work multiple shifts with minimal equipment, leading to a deterioration of empathy and clinical thoroughness. Expert discourse by medical sociologists highlights that the "human factor"—the relationship between the doctor and the patient—is being strained by the material conditions of the clinic. When a doctor has no prescription pad and no medication to offer, the clinical encounter becomes an exercise in shared frustration rather than a path to healing. This loss of human capital is perhaps the most difficult "resource shortage" to rectify, as it involves the erosion of the professional and ethical morale of an entire generation of health workers (Brotherton, 2012).

Despite the institutional commitment to "regionalization," territorial inequalities in service provision have become more pronounced. Urban centers, particularly Havana and provincial capitals, continue to house the vast majority of specialized tertiary centers and high-tech equipment. In contrast, rural municipalities in the *Plan Turquino* (mountainous regions) often suffer from a "double marginalization." Not only is the distance to specialized care greater, but the local polyclinics are frequently the first to experience personnel shortages as doctors are moved to fulfill international missions or fill vacancies in urban hospitals. Substantive justice is compromised when the "geographic lottery" dictates the speed and quality of a patient's diagnosis. While the family doctor program provides a basic level of triage in rural areas, the lack of reliable transport means that

emergency cases in the periphery face significantly higher risks than those in the center (Whiteford & Branch, 2008).

Social stratification is no longer an "external" phenomenon to the Cuban health system but a structural feature of its current operation. The emergence of a "remittance-based" healthcare tier has created a profound rift in the experience of the patient. Those with access to hard currency from relatives abroad can bypass domestic medicine shortages by purchasing supplies on the informal market. Conversely, the segment of the population without access to foreign currency must rely solely on the increasingly depleted state supply. This creates a "differential access" model where one's socioeconomic status directly correlates with the speed of recovery. Furthermore, vulnerable groups, such as the elderly living alone, face cumulative disadvantages. Without the financial means to provide their own hospital supplies, these populations receive a "baseline" care that lacks the dignity afforded to those with greater social capital. This stratification represents a direct violation of the principle of vertical equity, as those with the highest needs possess the fewest resources to navigate a failing system (Marmot, 2015).

2. The Role of the "Shadow" Market in Health

The "shadow" market for medicines has become an essential, albeit inequitable, survival mechanism in Cuba. Because the state cannot "fulfill" its obligation to provide essential drugs, an informal network of resellers has emerged. While this market provides a "vent" for the shortage, it operates on a purely commercial basis, completely detached from the principles of substantive justice. Prices in the shadow market are often 50 to 100 times the official state price, making life-saving treatments like insulin or antibiotics inaccessible to those on a standard state pension. This "shadow privatization" of pharmacy services is visible evidence of the system's failure to maintain equity. It forces families into desperate financial situations, often requiring them to sell assets to pay for basic healthcare—a phenomenon that the Cuban system was specifically designed to prevent under its socialist mandate (Feinsilver, 2010).

The persistence of "privileged access channels" constitutes a significant ethical and structural challenge to the Cuban model. Historically, facilities for the political elite and the military have operated with a level of resource security far beyond that of the general population. In the current era of crisis, this "segregated excellence" has become more visible and socially corrosive. Furthermore, the expansion of medical tourism creates a "dual-reality" within the same national health system. While the government argues that medical

tourism subsidizes the public sector, the "internal brain drain" of the best-trained specialists to these elite clinics effectively strips the public system of its most capable human capital. This internal differentiation creates a "segmented" form of justice that contradicts the revolutionary ethos of a single-tier system, challenging the "Acceptability" pillar of international health standards (Farmer, 2003).

The rise of health inequalities in Cuba has profound implications for social cohesion and the legitimacy of the state. When the healthcare system—once the proudest achievement of the Revolution—becomes a site of visible disparity, it erodes the "moral economy" that has sustained the population through decades of hardship. The "informalization" of healthcare costs (informal payments or the requirement for patients to provide their own supplies) acts as a regressive tax that hits the poor hardest. This shift threatens the "social contract" where the population accepted limited political liberties in exchange for guaranteed social security. If the health system continues to fragment into "haves" and "have-nots," the resulting social friction could lead to a broader crisis of governance. Real equity is not just about medical outcomes; it is about the "social trust" that the state will provide for the vulnerable (Nussbaum, 2011).

3. Legal Analysis of State Failure to Fulfill

From a legal perspective, the current state of resource scarcity can be analyzed as a failure to meet "minimum core obligations" under international law. While the state cites the US embargo as a *force majeure* excuse, international human rights bodies emphasize that states must prioritize the most vulnerable even in times of economic distress. The 2019 Cuban Constitution, in Article 50, creates a high bar for state responsibility. When patients are required to provide their own surgical kits or antibiotics, the state has effectively devolved its responsibility to the individual, violating the "Availability" and "Accessibility" requirements of the right to health. This legal gap between the constitutional text and the reality of the clinics suggests that the "Right to Health" in Cuba is transitioning from a positive right to a "hollowed-out" entitlement that exists only for those with the private means to activate it (Gostin, 2014).

The deterioration of the formal healthcare system has led to a significant "re-feminization" of care. As hospital services decline and outpatient recovery becomes the norm due to lack of ward space, the burden of nursing and resource procurement falls disproportionately on women. In the context of substantive justice, this represents a neglected dimension of inequality. Women are often the ones navigating the "shadow market" and providing the labor-intensive care

that the state can no longer afford to provide in clinical settings. This "invisible" labor is a direct result of the system's material failure and reflects a regression in the social position of women, who are forced back into traditional caregiving roles to fill the gaps left by the state. Real equity in health must therefore account for the "gendered cost" of systemic failure (Marmot, 2015).

Beyond the shortage of medicines, the physical decay of healthcare infrastructure presents a direct threat to patient safety. Many polyclinics and hospitals suffer from chronic issues with water sanitation, electricity reliability, and structural integrity. In a system grounded in substantive justice, the "environment of care" is a social determinant that should not vary by postal code. However, empirical findings show that "Quality" is often sacrificed for "Coverage." The state maintains a high number of open facilities, but many operate under conditions that would be considered sub-standard in a regulated market. This "infrastructure gap" creates a version of "formal equality" that is dangerous in practice, as the lack of basic hygiene supplies in a "free" hospital can lead to nosocomial infections that a patient would not have faced had the system been properly resourced (Spiegel & Yassi, 2004).

Cuba presents a unique "biotech paradox": the nation produces world-class vaccines and treatments while simultaneously lacking basic aspirin and bandages in neighborhood clinics. This empirical finding highlights a disconnect in the state's investment strategy. From a theoretical perspective of "Justice as Outcomes," the prioritization of high-prestige biotech exports over basic clinical supplies is a questionable ethical choice. While biotech generates hard currency, its benefits do not always trickle down to the primary care level. Substantive justice requires that the state balance its "industrial ambitions" with the "basic needs" of the citizenry. The failure to do so results in a system that is technologically advanced at the top but functionally broken at the bottom (Feinsilver, 2010).

The economic crisis has severely impacted the "Right to Food," which is an essential determinant of the "Right to Health." Empirical observations show a rise in nutritional deficiencies, particularly among the elderly and children in rural areas. When the healthcare system treats an illness that was caused or exacerbated by malnutrition, it is merely addressing the symptom of a deeper systemic failure. Substantive justice requires an integrated approach where the state ensures the "social determinants" of health are met. The current reforms, by focusing on clinical "compaction," fail to address the "upstream" factors of health inequality. Without food security, the

healthcare system becomes a "repair shop" for a population that is being systematically undernourished (Marmot, 2015).

As the Cuban health system attempts to modernize through digital records and tele-consultations, a new "digital divide" is emerging. Access to information is a key pillar of the AAAQ framework, yet many Cubans lack the connectivity or hardware to access health information or book appointments online. This "technological stratification" privileges urban, younger, and wealthier citizens who can navigate the digital shift. For the rural elderly, the "modernization" of the system often feels like a new barrier to access. Substantive justice demands that technological advancement does not become a tool for exclusion. The current trend suggests that without "digital equity," the reforms will inadvertently create a new class of "health-illiterate" citizens who are left behind by a system they can no longer navigate (Gostin, 2014).

E. Substantive Justice and Systemic Tensions

1. Universal Access Versus Real Equity

The primary tension within the Cuban healthcare reform lies in the divergence between "nominal coverage" and the "lived healthcare experiences" of the citizenry. While the state maintains a legal and institutional framework of universalism—ensuring that every citizen is registered with a family doctor—this formal access does not equate to substantive equity. As highlighted by Sen (2009) in *The Idea of Justice*, a preoccupation with "transcendental institutionalism" can blind policymakers to the actual "realizations" of justice. In Cuba, the nominal availability of a clinic is increasingly divorced from the actual ability to receive treatment, as patients must navigate a landscape of empty pharmacies and deteriorating diagnostic facilities. This "hollowing out" of services creates a system of formal equality that fails the test of substantive justice, as the quality of care received is no longer determined by medical need but by an individual's proximity to resources, foreign currency, or social networks (Brotherton, 2012). Consequently, the "lived experience" for many is one of uncertainty and informal negotiation, which fundamentally contradicts the revolutionary promise of a standardized, dignified, and state-guaranteed health journey.

The lived experience of healthcare in Cuba is increasingly characterized by what Farmer (2003) termed "structural violence," where social and economic arrangements place individuals in harm's way. For the average Cuban, "universal access" now involves a complex labor of procurement, where the family must often source antibiotics, anesthesia, and even hospital linens from the black market or through

overseas couriers (Human Rights Watch, 2024). This shift places a regressive burden on low-income households, effectively creating a tiered system within a supposedly egalitarian structure. Substantive justice requires that the state not only provide a building but also the material conditions necessary for a "capable" life (Nussbaum, 2011). When the state fails to provide these conditions, the right to health is transformed from a social guarantee into a private struggle. This transition undermines the "Acceptability" and "Quality" pillars of the right to health, as the indignity of having to "pay twice"—once through social allegiance and again through informal markets—erodes the moral legitimacy of the healthcare system.

2. Institutional Challenges: Transparency and Accountability

The pursuit of substantive justice is further hindered by profound institutional challenges, specifically the lack of transparency and vertical accountability. In any universal system, the fair distribution of scarce resources requires clear criteria and public oversight to prevent corruption and favoritism. However, the Cuban Ministry of Public Health (MINSAP) operates with a high degree of centralization and limited public data regarding the specific allocation of hospital budgets or the destination of revenues from medical exports (Erisman & Kirk, 2018). Without transparent mechanisms to track how "medical diplomacy" funds are reinvested into local polyclinics, citizens are unable to hold the state accountable for the deterioration of primary care. Gostin (2014) emphasizes that "accountability" is a core component of the right to health, necessitating that the state be answerable to the people for its successes and failures. In the absence of such transparency, the system risks falling into a "crisis of trust," where the population views resource shortages as a result of administrative mismanagement rather than unavoidable external constraints.

Substantive justice in healthcare is not merely an outcome but a process that requires the active participation of the affected population. While Cuba has a history of community involvement through the *Comités de Defensa de la Revolución* (CDRs), this participation has often been "top-down," focusing on the execution of state directives (such as vaccination drives) rather than the formulation of policy or the critique of service delivery (Whiteford & Branch, 2008). To achieve real equity, the reform process must institutionalize "bottom-up" participation, allowing patients and practitioners to identify the specific barriers to access in their communities. Marmot (2015) argues that "empowerment" is a key social determinant of health;

when individuals have a say in how their local clinics are run, health outcomes tend to improve across the social gradient. For Cuba, this would mean creating independent oversight committees and feedback loops that allow for the "lived experience" of scarcity to be formally integrated into the national health strategy, ensuring that reforms are responsive to the needs of the most vulnerable.

3. Normative and Comparative Insights

Comparing the Cuban system to other universal healthcare models under constraint—such as the National Health Service (NHS) in the United Kingdom or the Unified Health System (SUS) in Brazil—provides critical normative insights. Both the NHS and the SUS have faced severe austerity measures, yet they maintain diverse mechanisms for public debate and judicial intervention (Marmot, 2015). In Brazil, the "judicialization of health" has allowed citizens to use the courts to compel the state to provide essential medicines, a legal avenue that is currently limited in the Cuban administrative context. Substantive justice in these comparative cases is often defended through a "rights-based" litigation strategy that forces the state to recognize the "minimum core" of the right to health. Cuba can learn from these systems by introducing more robust legal protections and administrative recourses for patients who find their "nominal coverage" to be functionally non-existent.

The comparative study of universal systems under pressure reveals that the most resilient models are those that prioritize "primary care sovereignty" during times of crisis. When resources are scarce, systems that divert funds toward high-tech tertiary care at the expense of community clinics see a rapid widening of health inequalities. As noted in Spiegel and Yassi (2004), Cuba's historical strength was its localized delivery, but the current "compaction" of services risks repeating the mistakes of neoliberal "rationalization" seen in other parts of Latin America. The lesson for Cuba is that real equity is preserved only when the "floor" of the system—the polyclinics and family doctors—is fortified against market-driven stratification. This requires a normative commitment to "proportionate universalism," where the universal framework is maintained but the intensity of support is scaled according to the level of deprivation.

F. Reform Pathways Toward Real Healthcare Equity

1. Strengthening Equity-Oriented Policy Design

To transition from a model of nominal universality to one of substantive justice, the Cuban healthcare reform must adopt a framework of "proportionate universalism." As argued by Marmot

(2015), health actions must be universal but delivered with an intensity that is proportionate to the level of social and clinical need. This requires a shift in resource allocation logic—moving away from a purely centralized "top-down" distribution toward a vulnerability-indexed approach. Legally, this would involve amending health sector directives to mandate that a fixed percentage of the national health budget be specifically earmarked for the most disadvantaged geographic zones, such as the eastern provinces and marginalized urban peripheries. By prioritizing investments based on objective socio-demographic risk factors rather than administrative convenience, the state can begin to rectify the "territorial inequities" that currently see life expectancy and morbidity rates fluctuate across the island.

A substantive justice framework demands that "vertical equity" be operationalized through targeted interventions for high-risk population groups. This includes the implementation of a "National Chronic Care Initiative" that prioritizes the delivery of essential medicines for non-communicable diseases (NCDs) to the elderly living below the poverty line. Sen (2002) emphasizes that health equity must be evaluated by the actual "capabilities" individuals have to achieve wellness; for a Cuban pensioner with diabetes, this means the state must ensure that insulin is not just "formally free" but "physically available" without recourse to the informal market. Reform must therefore incorporate a social vulnerability index into the primary care referral system, ensuring that clinical priority is given to those who lack the private means—such as foreign remittances—to offset the system's material deficiencies.

The restoration of "Real Equity" is impossible without addressing the material and psychological deterioration of the care environment. Substantive justice is intrinsically linked to the concept of dignity (Nussbaum, 2011), which is eroded when patients are forced to provide their own basic medical consumables. Reform pathways must prioritize the "re-capitalization" of the primary care infrastructure, ensuring a guaranteed minimum supply of clinical reagents, sterile equipment, and basic pharmaceuticals in every polyclinic. This is not merely a logistical challenge but a normative requirement to meet the "Quality" pillar of the right to health (Gostin, 2014). Without a dignifying clinical environment, the "medical act" loses its transformative potential, and the healthcare system risks becoming a site of social frustration rather than social security.

The "brain drain" of medical professionals represents a critical barrier to equity that requires urgent policy intervention. The state must move toward a "Domestic Professional Accord" that aligns medical salaries with the rising cost of living in the post-*Tarea Ordenamiento*

economy. As Brotherton (2012) observed, the morale of healthcare workers is a primary determinant of the quality of patient outcomes. To preserve equity, the state must incentivize doctors to remain in rural and marginalized areas through professional development opportunities, housing grants, and improved workplace safety. If the state continues to prioritize the "export" of medical labor for hard currency without a reciprocal investment in the domestic workforce, the "primary care sovereignty" that once defined the Cuban model will collapse, leaving the most vulnerable with a "hollowed-out" system staffed by overextended and under-resourced practitioners.

2. Participation, Transparency, and Sustainability

Substantive justice requires that the governance of healthcare be transparent and responsive to the "lived experiences" of the citizenry. Currently, the lack of public data regarding health expenditures and the destination of revenues from medical diplomacy hinders effective accountability. To ensure sustainability, the reform process must institutionalize "Vertical Accountability" mechanisms where municipal health directors are required to present transparent reports to community councils regarding resource allocation. Farmer (2003) highlights that the most effective health systems are those that view the poor as "agents" rather than merely "targets" of policy. By creating formal feedback loops, the state can identify "bottlenecks" in the supply chain and address the "shadow inequities" of the informal market before they become entrenched social norms.

To foster long-term resilience, the Cuban model must revitalize its tradition of community medicine by empowering the *Consejos de Salud* (Health Councils) to participate in the actual design of local health interventions. Participation should move beyond the execution of state-mandated campaigns to include the "collaborative monitoring" of service quality and resource availability. This "bottom-up" approach ensures that health governance is grounded in the "Acceptability" pillar of international human rights standards, respecting the cultural and social specificities of different regions (Gostin, 2014). When communities feel a sense of "ownership" over their local clinics, they are more likely to participate in preventative behaviors and support the sustainability of the system during periods of economic austerity.

Sustainability in the Cuban context requires a "diversified financing strategy" that does not sacrifice egalitarian principles for fiscal efficiency. This could involve the creation of "Health Trusts" where a portion of the profits from the biotechnology sector and medical exports is legally shielded from broader macroeconomic fluctuations and strictly reinvested into primary care. Furthermore,

international cooperation should be reframed around "Infrastructural Resilience," seeking partnerships that focus on the local production of essential medicines and the repair of diagnostic equipment. As Whiteford and Branch (2008) argue, the "other revolution" in Cuba was the creation of a system that thrived on social capital; to remain resilient, the state must reinvest in that social capital by proving it can still deliver real, substantive equity in the face of 21st-century challenges.

G. Conclusion

1. Summary of Key Findings

This research has demonstrated that while the Cuban healthcare system maintains its institutional commitment to universalism, there is a widening rift between "nominal coverage" and the "attainment" of real equity. The findings indicate that the "Right to Health," codified in Article 50 of the 2019 Constitution, is increasingly compromised by material precariousness and "informal privatization." Universal access—the hallmark of the Cuban model—has become a formal shell that masks deep-seated substantive inequalities driven by geographic location, access to foreign currency, and social capital.

As the state reorganizes the health sector for fiscal efficiency, the "lived experience" of the patient reveals that the "Quality" and "Availability" pillars of the AAAQ framework are under systemic strain (Gostin, 2014). Ultimately, the current transition suggests that without a deliberate shift toward "proportionate universalism," the system risks moving from a model of socialized justice to one of "segmented care," where health outcomes are increasingly decoupled from clinical need and tethered to socioeconomic status.

2. Theoretical Contributions

This study contributes to the literature by applying the lens of "Substantive Justice" to a socialist healthcare system under economic transition. By integrating the "Capability Approach" of Sen (2009) and Nussbaum (2011) with the social determinants framework of Marmot (2015), the research moves beyond traditional critiques of the Cuban model that focus solely on GDP or doctor-patient ratios. It establishes that "Real Equity" in a socialist context must be measured by the removal of structural barriers that prevent the most marginalized from exercising their functional right to health.

This theoretical application highlights a "paradox of socialist reform": *where the preservation of a state monopoly without the requisite material reinvestment can lead to a "regressive burden of care" on the family*. Thus, the research provides a normative framework for

assessing health equity in resource-constrained environments, emphasizing that "Justice as Outcomes" must supersede "Justice as Institution" in the evaluation of universal health coverage.

3. Policy and Research Implications

The implications for future policy are clear: the Cuban state must reconcile its "biotech ambitions" with the "material dignity" of primary care. Reform pathways must prioritize transparency in health financing and institutionalize community-based accountability to mitigate the rise of shadow markets. Future research should pursue longitudinal, comparative studies of universal systems under austerity—such as the NHS in the UK or the SUS in Brazil—to identify cross-national strategies for maintaining "Vertical Equity" during periods of economic contraction (Marmot, 2015).

Furthermore, there is an urgent need for empirical studies that map the "gendered cost of care" in transition economies, where the withdrawal of state services often results in an invisible labor burden on women. As Cuba navigates the complexities of the 21st century, the resilience of its health model will depend on its ability to prove that a socialist "Right to Health" remains a tangible, substantive reality for its most vulnerable citizens, rather than an abstract revolutionary legacy.

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