

# Social Change and Health Policy in Venezuela

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*"You hear on the streets that in Venezuela we [people and rulers] have opened the gates on another possible world. The multitude is tempted to try out new and different life experiences."*

Judith Valencia

## Abstract

This work reviews social changes occurring in Venezuela during the last two decades, examining how they led to the development of a new health policy. Initially, the political context of the nineties is examined; this was a time when the neoliberal politics of the 1980's had a demonstrable impact on the living conditions and health status of the population. By 1999 social and political events led to a new Constitution which provided the juridical and legal framework for a new health policy. The

conceptualization of health and the model of health care which arose from the constitutional process are considered, as well as the reaction of the dominant economic and political sectors to the new policies imposed by constitutional mandate. The emergence of *Barrio Adentro* and other social missions is analyzed as an essential factor in the initiation of structural changes within the country and its health institutions. The *Barrio Adentro* program is described in detail, along with key steps in the development of the Venezuelan National Public Health System. Finally, the impact of these new health policies on the quality of life of the Venezuelan population is delineated.

## 1. Political Context and Health Status of Venezuela in the 1990's

The Alma Ata Declaration of 1978 and the commitment of all countries to adopt the Primary Health Care (PHC) strategy created the opportunity for a broad debate on problems of public health, as well as the development of new approaches to their solution. The reaffirmation of Health for All and its strategic principles - equity, universality, inter disciplinary and inter-sectoral work, social participation, and the development of appropriate and culturally acceptable technologies (OMS/UNICEF, 1978) presented a challenge for health care systems. Countries appeared to accept these principles with enthusiasm; in Venezuela a number of initiatives were undertaken to develop the principles of Primary Health Care (PHC) (Castellanos, 1982). Subsequently in 1996, the member countries of the Pan-American Health Organization (PAHO) gathered and reaffirmed their commitment to the goal of Health for All in the year 2000. (Sotelo and Moncayo, 1997)

During the final years of the eighties and throughout the nineties, neoliberal measures dictated

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by the World Bank (WB) and the International Monetary Fund (IMF), were applied in Venezuela, as they were in the majority of Latin America countries with the exception of Cuba. (Muntaner, Salazar, Wheel and Armada, 2006) The fundamental premise of these policies was the reduction the State's presence in the financing and implementation of social policies. The result was privatization of services, decentralization, price deregulation of basic necessities (including fees for private medicine), and greater openness to foreign investment. This openness manifested itself in the health sector through the appearance of private, multinational corporations offering health insurance and social security benefits. (Homedes and Ugalde, 2005), (Terris, 1999), (De Vos, De Ceukelaire y Van der Stuyft, 2006) The fundamental reason that these policies were applied in our countries was the universal problem of financial deficits in the region which, in turn was a consequence of the evolution of our countries as dependent capitalist economies. The power of international organizations, primarily North American, to provide financing meant the imposition of their social and economic models. (Armada, Muntaner and Navarro, 2001)

To some extent, the juridico-legal basis for the right to health care was established in Latin America during the mid-nineties. However, other values created obstacles to the realization of this right. The actualization of utilitarian theories in neoliberalism and in the new globalization promoted the liberalization of financial capital and asserted the predominance of the market. In this worldview, health care as a right is subordinated to market values. In the last fifteen years of the 20th century, health sector reforms were not designed to assure health for all, but rather to transform the health services sector into another segment of the market. (Guerra de Macedo, 2003) During this phase, new actors like the World Bank and the World Trade Organization (WTO) relegated the World Health Organization (WHO) to a secondary role. They assumed the responsibility for directing international health policy in such a way that the principles of PHC were distorted and abandoned. Examples of this were the various models of "on the cheap" care for the poor or "focused" programs which palliate

the effects of social exclusion and control popular discontent. (San Sebastián, Hurting, Breilh and Quizhpe, 2005)

In 2003 the World Health Report enjoined countries to take up again the commitment to fortify their health care systems under the principles of the PHC formulated in the Alma Ata Statement (WHO, 2003).

In Venezuela, the application of the WB and IMF packet of neoliberal policies became known as "the great turning point" (*el gran viraje*). (Fajardo-Cortéz and Lacabana, 1993) The result was a popular revolt in 1989: the "*Caracazo*," fueled by long-standing discontent and triggered by a price increase in public transportation and gasoline. The revolt left nearly 2000 dead, victims of the repressive actions of the Perez government (Terris, 1989) and led subsequently to two military rebellions in 1992 headed by the now current president, Hugo Chávez, and his political-military action group "Movimiento Bolivariano Revolucionario MBR200." (Feo and Curcio, 2004) (Harnecker, 2002) The Christian-Socialist government of Rafael Caldera came to power in 1994 with a coalition of parties ranging from the traditional economic elite and rightwing to parties considered leftist such as the Movement towards Socialism (*Movimiento al Socialismo*). This government soon declared itself in favor of the neoliberal proposals. (Gamboa, 2000)

According to the 1990 index of unmet basic needs, 44.4% of Venezuelans lived in poverty. Between 1989 and 1995 the general price index for goods and services increased by a factor of 20, and the food and beverages index increased by a factor of 40. Real mean household income dropped 66%, with 60% of the reduced income now required for food expenses. (World Food Encounter, 1996)

During the latter part of Caldera's term, a group of strongly neoliberal social security laws were passed. For example, the dissolution of the Venezuelan Social Security Institute was decreed and a door opened for private corporations to provide health care, pensions, and funds for what were called "labor risks." (PROVEA, 1998) (Sanoja, 2000) Human rights organizations denounced these measures stating that they dismantled the structure

protecting the right to health and replaced it with a mercantilist vision of the State as service provider within a “health market.” (PROVEA 1998)

The health care policies implemented during this period were characterized by reductions in public health expenditures; privatization of services through direct or indirect users fees within public health institutions; an increase in the use of private insurance for hospitalization, surgery, and maternity care among public sector workers; various stimuli and economic incentives for the construction of private health facilities; reduction of class size in the public universities training health care professionals (under the pretext that there existed a surplus of professionals); and a hiring freeze. Health care would be provided principally by the private sector. Primary care and the primary health care model would be abandoned. Diagnostic and treatment protocols would be dictated by the pharmaceutical and medical equipment industry. The deterioration of existing public health facilities would not be addressed, and new ones would not be built. (PAHO, 2006), (PROVEA 1998)

The reforms initiated in the mid nineties attempted among others things, to reduce the state’s role as a provider of services by setting up three competing models of health delivery: an open access public model where costs were recovered through user fees; a restricted social security model; and a private model of hospitalization, surgery, and maternity insurance for public sector workers and those who could afford to pay. Hospitals and other public establishments were transformed into social businesses. A fee structure was created in which costs were subsidized at different levels. Seventy five percent of the administrative and other personnel who were not direct providers of health services were cut. (Rondón, 1996)

Decentralization was another important element of Venezuelan health reform during the nineties. Two laws were approved in this respect: the "Constitutional Law for Decentralization and Delimitation of the Transfer of Public Power" and the "Constitutional Law for Election and Removal of Governors and Mayors." The first law dealt primarily with those services that would be progressively transferred to the states (*entidades*

*federales*), public health care being among the most important. Beginning in 1993, the newly elected governors began to request the transfer of these services; this occurred without any prior evaluation of the ability of the states to take on this new role. As a result, each government created its own model of health care institutions. These varied from corporations and foundations, to autonomous institutes and state health authorities. Decentralization brought an expansion and deepening of public service privatization as the urgent search for solutions to budget deficits continued. More and more health care functions were assumed by so-called "civil society" organizations; these were not-for-profit, non-governmental organizations in the form of foundations that had historically recovered costs through user-fees. (Rincón and Rodríguez, 2004)

The decentralization process promoted by neoliberal reforms worsened inequalities in access to health care through the reduction of federal government contributions to local services. In countries like Chile and Colombia, instead of reducing their costs, this policy further enriched private health care providers (Homedes and Ugalde, 2005) with an ever-increasing transfer of public resources to the private sector. The logic behind these neoliberal reforms has been to expand the reproduction of capital by decreasing management costs and transforming social services and benefits through continuous cycles of capital accumulation. (Laurell, 1995)

Public health is premised on the ability of a population to satisfy its basic needs. Thus poverty is the worst enemy of health. (Feo, 2003) The consequence of these “adjustments” for the population was a clear increase in poverty. By 1999, 67.7% of the Venezuelan population was living in poverty. In 1981 the poorest 40% of the population received 20% of the national income, while the richest 10% received 22%. By 1997 the poorest 40% received 15% of the national income, and by the year 2000 the richest 10% received 33%, evidence of a widening gap between rich and poor. (Feo, 2003) The deterioration in living conditions created a situation characterized as “epidemiological accumulation.” (Núñez, 1996) Epidemiologic

accumulation occurs when health problems related to basic needs—such as infectious and deficiency diseases—persist and grow worse while increases are also seen in morbidity and mortality related to degenerative and chronic diseases. To these are added the public health problems of urbanization, industrialization, and the expansion of a consumer society. These problems include violence (suicides, homicides, accidents), drug abuse, alcoholism, pollution, deterioration and destruction of the environment, and exposure to diverse toxic residues both in the workplace and in the general environment; all these problems lead to chronic illness.

During the 1990's, the prevailing curative model of health care and the dis-investment in the public health sector led to under-utilization of many of the public ambulatory facilities in Venezuela. Their capacity to respond to health needs was limited by cutbacks in both hours of operation as well as the supplies and medicines available for diagnosis and treatment. Cost recovery was implemented through "voluntary contributions" by users. The organization of services was fragmented, and this deterioration of the ambulatory system further overloaded hospitals, which had become increasingly, strained themselves due to similar budgetary pressures.

## **2. The Constituent Assembly and Health Rights**

In December of 1998 Hugo Chávez Frías was elected President of Venezuela, running on an openly anti-neoliberal platform. Among the first measures taken by the new government were the convocation of a Constituent Assembly with broad participation and the suspension of the prior government's privatization programs for social security and health care. In December of 1999 a new Constitution of the Bolivarian Republic of Venezuela (CRBV) was approved in a popular referendum. The new Constitution establishes the bases for the construction of a new Republic. The introduction sets forth these principles:

*[R]eshaping the Republic to establish a democratic, participatory and self-reliant, multiethnic and multicultural society in a just,*

*federal and decentralized State that embodies the values of freedom, independence, peace, solidarity, the common good, the nation's territorial integrity, comity and the rule of law for this and future generations; guarantees the right to life, work, learning, education, social justice and equality, without discrimination or subordination of any kind; promotes peaceful cooperation among nations and furthers and strengthens Latin American integration in accordance with the principle of non-intervention and national self-determination of the people, the universal and indivisible guarantee of human rights, the democratization of imitational society, nuclear disarmament, ecological balance and environmental resources as the common and inalienable heritage of humanity." (Constitution of the Bolivarian Republic of Venezuela.1999).*

In relation to health and social security, the CRBV makes health "...a fundamental social right and the responsibility of the State, which shall guarantee it as part of the right to life." (Article 83); "the State creates, exercises guidance over and administers a national public health system ... integrated with the social security system and governed by the principles of gratuity, universality, comprehensiveness, fairness, social integration and solidarity. ... Public health assets and services are the property of the State and shall not be privatized. The organized community has the right and duty to participate in the making of decisions concerning policy planning, implementation and control at public health institutions." (Article 84) "Financing of the public health system is the responsibility of the State ..." (Article 85) "All persons are entitled to Social Security as a nonprofit public service... The lack of ability to contribute shall not be grounds for excluding persons from protection by the system. ... The mandatory contributions ... shall be administered only for social purposes, under the guidance of the State. ... The Social Security system shall be ruled by a special organic law." (Article 86) In relation to the socioeconomic system, the CRBV indicates "The State reserves to itself ... the petroleum industry and other industries, operations and goods and services which are in the public interest and of a strategic nature." (Article 302) "All



waters are property in the Nation's public domain..." (Article 304) "The predominance of large land estates is contrary to the interests of society. Appropriate tax law provisions shall be enacted to tax fallow lands and establish the necessary measures to transform them into productive economic units, likewise recovering arable land. Farmers and other agricultural producers are entitled to own land..." (Article 307)

This Constitution became the main instrument to fight neoliberal policies and construct a new society based on the State's guarantee of fundamental social rights. The State was now a partner with all sectors of the society and was giving priority to organized communities.

The main health programs implemented to date by the Chávez government are (presented in chronological order): application of the Comprehensive Health Care Model (IHAM), the formulation of a Strategic Social Plan (SSP) and the implementation of *Misión Barrio Adentro*.

### 3. Comprehensive Health Care Model

In 1999, the Ministry of Health set as a priority the national-level restructuring necessary to provide comprehensive health care to the population via the creation of a National Public Health System. Among the important objectives of this model were the special emphasis given to health promotion, disease prevention, the participation of organized communities, and the strengthening of the PHC infrastructure. (Rincón and Rodríguez. 2004) Within the restructured Ministry of Health PHC principles formed the foundation for the Comprehensive Health Care Model of service provision.

This model supported the development of health care services which met the needs of individuals, families and communities. Care was no longer fragmented. By providing all possible services at the opportune moment, lost opportunities are reduced; this model incorporates a life-cycle and gender-sensitive perspective. Health promotion and disease prevention are integrated into daily clinical consultations within three major areas of practice: primary care for children and adolescents; women's health; and primary care for adults and the elderly. Any person seen within the ambulatory

network—regardless of age, gender or time of day—should receive all necessary preventive services that he/she requires, even though he/she may not have requested them. (Feo, 2003)

The 2000/2001 annual report by the non-governmental organization Venezuelan Program of Educational Action in Human Rights (PROVEA, *Programa Venezolano de Educación Acción en Derechos Humanos*) highlighted several positive aspects of the health system: the new constitutional framework for health, the government's approach to health, and the implementation of policies that revive a comprehensive approach to health. The report also noted that during this period medical services were increasingly available. The progressive elimination of users' fees had improved access to care. At that time the comprehensive care model had been implemented in 16 states. Aragua State had been a pilot for the model and there was evidence of both an increase in prevention-related activities and a decrease of emergency room visits in secondary and tertiary care facilities. (PROVEA, 2001)

### 4 The Ministry of Health's Strategic Social Plan

The Ministry of Health's Strategic Social Plan (SSP) is a political planning tool created to allow sustainable strategic changes which would substantially improve the quality of life for the Venezuelan population.

The plan lays out the organizing principles for implementing the Constitutional mandate to guarantee the right to health with universality, equity, popular participation, solidarity, and free care. With these principles in mind, the Ministry of Health set forth the following strategic directives for the promotion of health and the improvement in quality of life (Ministry of Health and Social Development. 2003):

- To harmonize the implementation of public policy with the ethical imperative of meeting social needs, such as improvement in well-being and health.
- To adopt a strategy of improving wellbeing and promoting health which preserves and develops the autonomy of individuals and communities.

- To reorient health care so that it is provided in a way that is regular, adequate, integrated, and equitable and is made available in public institutions for wellbeing and health at the national, state, and municipal levels.
- To build a new public institution with the capacity to lead, govern, and execute policy changes with respect to health and wellbeing within an intergovernmental framework of decentralization and participation.

The SSP provided the required philosophical and political framework within which to develop the general features of the National Plan of Social and Economic Development 2001–2007 with respect to questions of social equilibrium. It also became a fundamental tool for new health legislation and the construction of a National Public Health System. (PAHO, 2002)

### 5. Impact of the 2001-2002 political situation on health

With the approval of the CRBV, the Bolivarian government's main programs of social rights were now set in motion. A considerable increase in government social spending financed free health care and education, increases in the minimum wage and old age pensions, expansion of labor benefits, and the control of inflation, which decreased from 29.9% in 1998 to 12.3% in 2001. In terms of health and living conditions, extreme poverty (as measured by national indicators) was reduced from 20.6% in 1998 to 16.9% in 2001; child mortality rate fell from 21.3 per thousand live births in 1998 to 17.6 in 2001. (United Nations, 2004)

In 2001 a set of anti-neoliberal laws were passed. This included a land law, a law on fishing and the petroleum law; this latter would create the legal basis for the nationalization of the petroleum industry and the use of petroleum revenue for social purposes. Venezuela then went through a period of crisis provoked by efforts to destabilize and sabotage the government. These efforts included the April 2002 coup d'état (Golinger 2005), a strike by owners of industry and commerce, a paralysis of food and medicine distribution, a partial bank strike, and a doctors' strike. (People's Defense Foundation, 2004) The coup d'état, as well as sabotage in the

petroleum industry and the strike of the owners, were all supported by a large sector of the private media, both inside and outside of Venezuela. (People's Defense Foundation, 2004)(López, 2006) This turmoil resulted in a sharp deterioration of all social indicators, including health indicators which had seen three years of continuous improvement. Extreme poverty (as measured by national indicators) increased to 25% in 2002, inflation rose to 31.2% and unemployment to 16.2%. Child mortality rose to 18.6 (per thousand live births) in 2002 and to 18.49 in 2003. (United Nations, 2004)(SISOV, 2007)(INE, 2007)

### 6. The Conceptual Dimension of Health

The current social and political process in Venezuela developed from multiple social movements which had historically fought to create new health paradigms and oppose the advance of neoliberalism. Days of popular participation were created during the Constituent National Assembly in 1999. They established a democratic forum in which to discuss health as a right and the ways in which health is determined by the structural factors which condition wellbeing. Health came to be seen as part of a more general transformation of the country in which all social rights might be respected. This would involve democratic participation and a new socio-economic model based on an equitable distribution of wealth.

With the approval of the Constitution in 1999 work began on a new legal framework which involved the following conception of health:

*Health is the state of collective and individual wellbeing and quality of life; it is the result of material, psychological, cultural, biological, environmental, and social determinants and of the organization and functioning of the Health Sector."*

*Health is realized in the state of being and remaining healthy with the maximum development of each individual's potential according to his or her stage of life. Health is considered a matter of public importance and should be preeminent in all national policies and in any action that might generate capacities,*

means, and conditions to guarantee its full exercise as a right, under the guidance of the State.

*The government will use a primary health care strategy to guarantee the right to health, as well as to improve quality of life, collective welfare, and fair and universal access to conditions, resources and health care services. This strategy is responsive to all of the population's social needs and recognizes the diversity of human communities, territories, and social categories and the importance of bringing health care to where people live and work.*" (Ministry of Health 2006)

### **7. Birth of the Barrio Adentro Mission**

The difficulties faced by Venezuelan population in the years 2001 and 2002 set the stage for a new political relationship between local communities and the State. In their political actions, popular organizations showed increasing autonomy and coordination. In February 2003 the Municipality of Caracas contacted the Cuban Embassy in Venezuela to request the collaboration of a Cuban Medical Mission. The first doctors of the Cuban Health Brigade arrived in April of that year. They helped develop the *Plan Barrio Adentro* which was then implemented in several neighborhoods of the *Libertador* Municipality within the Metropolitan District. The Cuban doctors, both male and female, were lodged with local families who had offered to host them. Doctor's offices were installed and equipped in various locations throughout the community; mostly in homes. The arrival of these doctors, as well as their work in the community, was made possible by the presence of various local community organizations, such as the Urban Land Committees. (Alayón, 2005)

Interviews and field research have examined how local communities experienced this program. At first there was a certain incredulity that free medical attention would really be available and that it would be so close to their homes. There was also happiness and enthusiasm that they would now have a type of care to which they did not previously have access. Along with the doctors, other professionals

began arriving in the neighborhoods with the *Misión Barrio Adentro*. These included dentists, optometrists, and sports coaches. The presence of these professionals generated a growing mobilization and organization in the communities which led in turn to the creation of new Missions. The *Misión Barrio Adentro* and the pressure exercised by the communities on local and national government institutions generated new mechanisms of inter-institutional collaboration. (PAHO, 2006) (Ubieta, 2006)(Alayón,2005)

In December of 2003 a presidential decree extended *Plan Barrio Adentro* to the entire country, making it a permanent social mission. "The *Misión Barrio Adentro* will have as its objective the implementation and institutional coordination of a Comprehensive Program of Primary Health Care, the encouragement and implementation of various expressions of the social economy, and the transformation of the social, economic, and environmental conditions within communities under a new model of administration based on principles of inter-dependency, coordination, joint responsibility, and cooperation with the active participation of organized communities in the leading role." (Presidential decree for the creation of *Misión Barrio Adentro*, 2004). By the year 2006 *Misión Barrio Adentro* had created 8686 health posts for primary health care (Ministry of Health, 2006) which were being progressively moved into new facilities constructed within the neighborhoods to serve as community clinics.

As *Misión Barrio Adentro* was progressively expanded, the methods of the Cuban physicians – community censuses, diagnosis of community risks and health problems, and home visits – revealed the depth of the social deficits accumulated in these communities. This gave rise to new strategies and new missions. One example was the creation of Feeding Posts (*Casas de Alimentación*), a program operated under the auspices of the *Misión Alimentación*. These posts were set up to guarantee that the most vulnerable population groups (children, the elderly, and pregnant women living in extreme poverty) would get at least two meals a day. Managed by the community, they operate within neighborhood homes which are furnished with

equipment and sufficient food to feed 150 people daily. Similarly, *Misión Robinson* was created to address the problem of illiteracy and, in turn, uncovered the deficit in ophthalmological services for the treatment of eye disease. This led to *Misión Milagro*.

This primary care network provided free access to 106 essential medicines designed to cover the needs at this level of care. On the other hand, the need to create facilities that would have a greater capacity for intervention was identified. Thus *Barrio Adentro II* was conceived. It involved the construction and equipping of Comprehensive Diagnosis Centers and Advanced Technology Centers.

Another accumulated social deficit that came to light through *Barrio Adentro* was the need for rehabilitation services for people with disabilities. Comprehensive Rehabilitation Centers were then created.

*Misión Barrio Adentro* developed as a series of networks, growing progressively in their capacity to respond effectively to neighborhood problems in coordination with other social missions. Social missions are supra-sectoral organizations with access to special financing derived from petroleum revenues; this was made possible by the 1999 nationalization of the petroleum industry. In these missions, government institutions at all levels work in a coordinated way with the goal of increasing social inclusion and guaranteeing the universal human rights contained in the CRBV: health, education, food, land, shelter, and work. The missions constitute a social policy that is radically different from focused aid projects; they are motors for social change, creating new social networks, developing a new model of government, and acting on the social determinants of quality of life. The work of the social missions is coordinated by a National Commission chaired by the Minister of the respective programmatic area.

In addition to *Barrio Adentro* the following missions exist currently: *Misión Robinson I y II* (literacy and primary education), *Misión Ribas* (high school education), *Misión Sucre* (university education), *Misión Identidad* (birth registration and identification), *Misión Negra Hipólita* (care of

homeless children and adults), *Misión Piar* (care for mining communities), *Misión Mercal* (networks to sell subsidized food), *Misión Ché Guevara* (job and skills training), *Misión Milagro* (ophthalmologic care), *Misión Hábitat y Vivienda* (assistance to homeless families), *Misión Guaicaipuro* (assistance to native communities), *Misión Cultura* (cultural access and diffusion), *Misión Ciencia* (access to knowledge and production of technology and science), and *Misión Zamora* (land reform, access to agricultural financing and resources). Missions are named after people and events from Venezuelan culture and history. (Ministry of Popular Power for Information and Communication, 2007)

## **8. Theoretical and Political Aspects of the *Misión Barrio Adentro***

*Misión Barrio Adentro* developed from two currents; one was sociopolitical transformation and the other socio-institutional transformation. These currents simultaneously demonstrated the tensions and forces that pushed toward the creation of a new national public health system.

The arrangement of the missions in networks creates an open model allowing development and strengthening with new people and ideas. This model is flexible and efficient, and most importantly, it works because is based on a common ethical and political understanding of the long term goals of the country and the desired social results.

Examined from a critical perspective, the structure that evolves from the Missions is composed of interwoven elements that interact, provide feedback, and organize themselves in a permanent dialectic of order/disorder/organization. (Morín, 2000) This ongoing process incorporates uncertainty, chance, the unexpected, and the possibility that a new form, a new configuration may emerge. In this way the networks allow each actor and the group of actors as whole, to solicit and allow others to improvise when an opportunity arises to meet a need or when a need arises that creates an opportunity. This explains how the *Barrio Adentro* network of networks has been organized and grown in practice both in terms of structure and resources.



This perspective highlights a new subjectivity towards life, and particularly, towards the community. A different logic emerges (González, 1997) that is not “anti-logic” but rather a different use of reason and of symbolic and empirical data. This dialectical use is different from Cartesian and positivist ways of thinking. By giving a new meaning to public action, possibilities open for popular knowledge, for building self-esteem, dignity, identity, and a sense of ownership for new subjects – both individual and collective. People and subjectivities who, as they progressively meet their needs, become capable of redefining, rearticulating and transforming both their daily and community reality within a context of effective and progressive participation. This context makes possible the emergence and implementation of new definitions of values such as solidarity, equity, justice, and collective good.

In this way popular participation ceases to be simply an accessory to the political process and becomes the axis from which to both rejuvenate and direct the actions of the government. This occurs through working relationships based on the construction of popular power and in the collective appropriation of political, financial, social, and scientific resources to meet the needs and aspirations of the population. So the fundamental element in the creation of a new health policy is, in essence, participatory democracy. Popular participation overcomes political exclusion, it opens opportunities for citizens and governments to come together, and it expresses itself concretely in conscious and voluntary decisions regarding those matters that affect us directly and indirectly. (El Troudi, Harnecker and Bonilla-Molina, 2005)

### **9. Characteristics of the *Misión Barrio Adentro***

*Health Promotion and Prevention:* This is the priority in health promotion services which are directed to the improvement of living and working conditions, access to education and culture, physical exercise, environmental conservation, relaxation, and repose. The execution of the health promotion strategy is defined by the "Ottawa Charter" and is divided into five areas: creation of public policies, creation of a supportive social environment,

strengthening community action, human resources development, and reorientation of health services (WHO and Canadian Public Health Association, Canada's Health and Welfare, 1986).

*Social participation:* Participation occurs through health committees. Each committee works in association with a popular health post (the first level of care) chosen in an assembly of citizens and generally made up of 10 people. By the year 2006, 8951 health committees had been registered.

*Types of Facilities:* *Barrio Adentro* I (first level of care) is composed of popular health posts; *Barrio Adentro* II (second level of care) is composed of popular clinics, comprehensive diagnosis centers, comprehensive rehabilitation facilities and advanced technology centers; *Barrio Adentro* III (third level of care) is composed of general hospitals; *Barrio Adentro* IV (fourth level of care) is composed of highly specialized teaching hospitals.

*Coverage and Access:* To meet the requirements of universality and access, plans were made for the construction of popular health posts each covering 250 to 300 families. The key aspect of these centers is that they are located within the neighborhood and in the marginalized zones of the large cities. Land is often scarce in such neighborhoods so the support and commitment of the community is essential. For secondary care, plans were made for 600 Comprehensive Diagnostic Centers and 600 Comprehensive Rehabilitation Centers (IRR), each serving a population of approximately 40,000 to 50,000. Care was taken so that these facilities were built even in isolated regions and among the indigenous populations; this was done even when the population served was less than what was usually required. Each state would have at least one Advanced Technology Center depending upon the population density; there would be a total of 35 such centers in all. In order to complete the secondary care level, urban health posts were to be upgraded into popular clinics.

*Care was planned based on need, not on demand:* Placement of *Barrio Adentro* health posts within those neighborhoods that had been most excluded was undertaken at the request of the neighborhood health committees and taking into consideration preexisting health care facilities.

This avoided duplicating care – where such care existed already – while assuring that care was offered where there had been none before. The network of facilities and services provided by *Misión Barrio Adentro* grew out of needs and problems identified in a dynamic process of interaction within the communities. Once started, its expansion throughout the country was due to requests by local community organizations. As a result, implementation of the program responded to local realities.

*Organization of services by level of care:* Within the *Barrio Adentro* model, care is based on level of complexity. *Barrio Adentro* I is the first level. It deals with problems of a low techno-medical complexity; its capacity to respond to these particular problems is highly developed. Care is provided near the homes of the population. There is an emphasis on health promotion, disease prevention, and early diagnosis. This level is usually the entry into the health care system. *Barrio Adentro* II is the second level. It is characterized by intermediate complexity, access to more sophisticated diagnostic testing, short-term (less than 72 hour) hospitalization, availability of surgical procedures, and 24 hour obstetrical care for uncomplicated deliveries. *Barrio Adentro* III is the level for major illnesses, palliative and specialist care, and those cases which cannot be resolved at the two lower levels. Care is available 24 hours a day. *Barrio Adentro* IV, the fourth level of care, is responsible for highly complicated and specialized medical-surgical diseases. These typically are of high cost and risk and cannot be dealt with at the third level. These are national and referral facilities where teaching and research is carried out. Services at all four levels is free.

*Use of Appropriate Technology and Quality Improvement:* The levels of complexity within the health care system respond to the techno-medical complexity as well as to political, psychological, cultural, and social complexity, all of which play a role in the system's ability to respond to problems. (Rodríguez, 1991) This requires health care personnel properly trained to deal with each reality and armed with the technology needed to provide appropriate responses at each level of care. At the

same time, the organization of health care by complexity seeks to use available resources rationally and fairly. Organization into networks permits the efficient coordination of the full range of services and interventions provided by the system.

*International Cooperation and Solidarity:* In Venezuela, as in other countries, there is a serious shortage of health care personnel. Added to this is the uneven distribution of health care personnel: urban areas are favored over rural ones, and well off neighborhoods are favored over poor ones. With this in mind, it becomes clear that the only way primary medical care could be offered to marginalized communities in such a brief period of time was the presence of health professionals from the Republic of Cuba. *Barrio Adentro* becomes, therefore, the best example of the integration that might become possible through the Bolivarian Alternative for America (ALBA).

## **10. First Health Accomplishments**

Primary medical care coverage was achieved for 70% of the Venezuelan population for whom primary care was previously unavailable; this represented 18,604,196 inhabitants by the year 2003. The distribution of doctors per inhabitant became fairer. By 2005 those states with the greatest poverty (Human Development Index (HDI) below 0.7) had one doctor for every 1,068 inhabitants; states with an HDI above 0.7 had one doctor for every 1,236 inhabitants (PAHO, 2006).

Health care infrastructure grew significantly throughout the country. This was done in accordance with a plan that took into account local demographic and epidemiologic conditions. By 2007, 3,717 popular clinics had been built and equipped. The ultimate goal is to have a network of 6,569 clinics and to transform all traditional outpatient facilities by utilizing the *Barrio Adentro* model. At the present time there are 8,633 primary care health posts functioning in the country, including those still located in community centers and homes. In addition, there are 4,800 dentists, as well as 441 eye clinics (counting both optometry and ophthalmology services). By contrast in 1998, Venezuela had only 1,628 primary care facilities

staffed with medical personnel, 800 dentists, and no optometry services.

The *Barrio Adentro II network*, created to expand the capacity of primary care, currently contains 12 popular clinics (reconditioned tertiary outpatient centers), 417 Comprehensive Diagnostic Centers (70% of the planned goal), 503 Comprehensive Rehabilitation Centers (84% of the goal) and 22 Advanced Technology Centers (63% of the goal). In 1998, there was only one MRI machine and five CT scanners in the public sector; by 2007 there were 19 MRI machines [13 in the CDC, 3 in popular clinics, and 1 in the Latin-American Children's Cardiology Hospital (LACCH)]. Additionally, there are now 26 high resolution CT scanners (15 in ATC, 2 in the LACCH, 6 in popular clinics, and 3 in other hospitals). In 1998, only 78 rehabilitation centers existed in the public sector, currently there are 576 Comprehensive Rehabilitation Centers (Ministry of Health, 2007).

Between the years 2003 and 2007, 4,659 new comprehensive level I and II health care centers were built and equipped; services in these centers is provided completely free of charge. By contrast, in the eighties and nineties only 50 health public establishments were built (Ministry of Health, 2006).

The change in the availability and quality of primary health care services has been an important achievement; all physicians working in the Mission are specialists in general medicine. The network also counts on the services of dentists and optometrists.

The development of health promotion as a strategic goal marks a profound qualitative change in the way health care is provided. At the same time it offers a means for organizing and expanding social participation in health care. More than 140,000 people in all parts of the country have received training as health promoters. These individuals engage in ongoing professional development. More than 100,000 boys and girls have been trained as health promoters. In 2006 6,087 pregnancy groups, 5,443 breastfeeding groups, 7,336 teen groups, and 7,858 grandparents groups were set up at health care facilities; specific groups are also created for hypertensives, diabetics,

and smokers. The health promotion campaign created radio messages broadcast by 144 community radio stations throughout Venezuela.

## **11. Building the National Public Health System**

The creation of a National Public Health System (*Sistema Público Nacional de Salud - SPNS*) began with political will and the conviction that such a system was needed. During the 1999 Constituent Assembly large public discussions took place in which all sectors were represented. The Venezuelan Constituent Assembly was notable for the fact that its members were popularly elected. The people decided who was going to write the new Constitution. The Assembly members undertook extensive public consultations which were open to all interested parties: specialists in national and international health, unions, associations of health professionals, organizations from the private health sector, social organizations, and private citizens.

It was decided that in order to guarantee the right to health, the new Constitution must include the creation of a National Public Health System, governed by principles of universality, comprehensiveness, equity, and solidarity. The System was to be financed principally by the Federal government, with the possibility left open of additional funding through contributions and special fees. Health costs would not be passed on to the users of the systems; thus, the system would be completely free of charge for all users. (Feo and Curcio, 2004)

The CRBV stipulated that the National Public Health System be part of the Social Security System, that it be publicly funded, and that it could not be privatized. The Social Security System was also created in the Constitution. The Constitution required that it be governed by a special legal framework. (Constitution of the Bolivariana Republic of Venezuela, 1999)

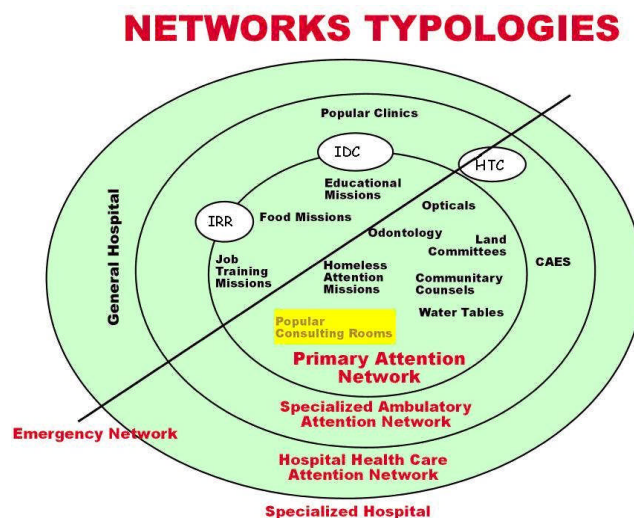
The law creating the Social System (*Ley Orgánica del Sistema de Seguridad Social - LOSSS*) was approved in 2002. The law created a health care service in conformity with the Constitution's mandate to guarantee the right to health as an essential human right (Article 52). The National Public Health System would guarantee health

protection to every person within the national territory without any form of discrimination (Article. 53). The NPHCS integrates into the Ministry of Health all structures, organs, programs, and services that — either totally or in part – receive government funding for the health services. This integration is decentralized, intergovernmental, intersectoral, and participatory, building upon the different competencies of national, state, and municipal authorities (Article 54). The National Public Health System is administered by the Ministry of Health and governed by a special law (Article 57). (Social Security System Constitutional Law, 2002).

As a consequence of the above, it was necessary to develop an additional law which would govern the provision of health care services and establish the National Public Health System. This process was complicated by pressure from politically and economically powerful groups, including unions, and confusion was created. The consequence has been a delay in the approval by the Venezuelan National Assembly of a new General Health Law (which has been in development since the approval of the Constitution). Thus it is the old 1998 General Health Law – based on a different model of health — which remains in effect in Venezuela until a new law is passed, at least in those articles where it does not violate the new Constitution.

Until the passage of a law that will unite the different health care providers under a single vision, organization, and administration, there will continue to be a multiplicity of actors in the health arena. The largest of these are the Ministry of Popular Power for Health, the Venezuelan Social Security Institute, and the Ministry of Education’s Institute for Prevention and Social Assistance. Adding in the various Departments, Ministries, and Health Institutes found at the state and local level to other health-related organizations, there are more than 400 health care service providers who receive at least some funding from the Federal government. This was the context for the creation of *Misión Barrio Adentro*, with its new model of conceptualization, management, and development of health services, and its integration of community participation into the program from the earliest stages. (Briggs and Mantinni-Briggs. 2007)

The Health Services Networks Project proposes 4 integrated health care networks (See Figure). The Networks Project emerged from workshops involving the main actors within health care: the Ministry of Health, the Cuban Medical Mission in Venezuela, the Caracas Health Department, the Social Security Institute, the Ministry of Education, and the National Council of Health Committees. The proposed networks are:



Source: Ministry of Health. Health Care Networks Project, February 2007



*Primary Health Care Network:* The center of this network is the community itself. The community is the site within which various local health organizations work together as well as alongside the government's social programs with a popular base (missions for education, nutrition, culture, sports; rural and urban land committees; technical commissions for water, academic centers, among others). The community is the site of the district's health care facilities, including installations of *Barrio Adentro I*, the Comprehensive Diagnostic Centers, the Comprehensive Rehabilitation Centers, the community dental offices, the community opticians, and the primary care network of the old health care system (which will be progressively integrated into *Barrio Adentro I*). The Primary Health Network is responsible for population health, conceived in the broadest terms. *Specialized Ambulatory Health Care Network:* This includes health care facilities which provide surgical and clinical specialists for conditions that are either handled in the clinic or are limited to 48 hours or less of hospitalization. These are the popular clinics and the Advanced Technology Centers of the new network, the Urban Ambulatory Centers types II and III and the type I hospitals of the old network. This network also includes participation by organized communities from within the network's catchment area.

*Hospital Network:* This network includes all conventional hospitals of type II, III, and IV (*Barrio Adentro III*) and the *Barrio Adentro IV* hospitals. Organized communities are involved in the planning and execution of these facilities as well as in the process of citizen control over administration.

*Emergency Network:* This network runs across the previous networks, providing an entry to them under emergency conditions. All health care establishments within the networks offer emergency services appropriate to their location and level of competency.

The Ministry of Health's networks proposal sets out two methods of organizing the social and territorial space at the state level: the Municipality, within which all 4 networks operate with city health and political authorities; and the Integrated Community Health Area (CIHA). The Health Area

is a system that would bring together social welfare, education and research. It would offer quality health care, utilizing modern therapeutic and diagnostic equipment, delivered by qualified specialists, and capable of handling 90% of the health problems of a community. It is within the Health Area that health personnel would be trained. The active participation of the organized community is a permanent part of such a structure. No rigid criteria exist for the scope and structure of the Health Area; to cover the health care needs of a Municipality there should be as many Health Areas as necessary. (Ministry of Health, 2007)

## **12. Improvements in wellbeing between 1999 and 2007**

Despite the difficulties that arise from the tension created by social and political changes that affect the basic structures of society, the new public policies of the State are designed to improve the quality of life of the people and to reduce social exclusion and inequality. An anti-neoliberal approach makes the guarantee of social rights the inalienable duty of the State. This is only possible with democratic participation. Self-determination and national sovereignty must be developed within the context of new, mutually supportive relations with other countries. This is the idea behind the Bolivarian Alternative for America (ALBA). ALBA proposes to integrate peoples through multiple forms of exchange involving both human capabilities and territorial wealth. (Valencia, 2005)

The reduction in the accumulated social deficits can be measured through several key quality of life indicators. Between 1998 and 2007, extreme poverty was reduced from 20.6% to 9.41%. (National Statistical Institute, 2007); the infant mortality rate fell from 21.3/1000 registered births to 13/1000 (Ministry of Popular Power for Health, 2006)(National Statistical Institute, 2007); participation in preschool education rose from 44.7% to 60.6% and enrollment in primary education from 89.7% to 99.5%. In two years 1,482,543 adults learned to read. During the entire period, inflation averaged 18.4%, a rate lower than that of the three previous governments' (22.7%, 45.3% and 59, 4%) neoliberal economic policies. (SISOV, 2007)

In 2007 Venezuela's minimum wage was the highest in Latin America while unemployment had been reduced from 16.6% in 1999 to 6.2% in 2007. (National Statistics Institute, 2007) These are the consequences of economic policies characterized by economic growth and increased social spending.

The sustainability of this new health care network requires a new type of health worker with the necessary skills and in sufficient numbers to meet Venezuela's needs. College programs are being developed in general community medicine, dentistry, general nursing, and health management (among other specialties). This cohort of future professionals is now between their first and third years of the 5 year curriculum. While the historic deficit in health care personnel is being resolved, the Cuba Venezuela Agreement has supplied health personnel, equipment, and technical expertise to the health care system.

A recent (2007) Pan-American Health Organization /World Health Organization position statement called for the renewal of primary care, its values and principles, and its emphasis on the right to health, equity, and solidarity. As the evidence presented in this paper demonstrates, the way to achieve the goal of "health for all" is through a social change that permits the development of health policies like those currently being built in Venezuela. (PAHO /WHO,2007)

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