Venezuela's *Barrio Adentro:* Participatory Democracy, South-South Cooperation and Health Care for All

Carles Muntaner, MD, PhD[1,2], Francisco Armada, MD, PhD[2], Haejoo Chung, RPh, PhD[2], Rosicar Mata[3], Leslie Williams-Brennan, Bsc, BScN, RN[2] and Joan Benach, MD, PhD[4]

Preface

In the 1990s Latin American countries, with the exception of Cuba, undertook reforms in their health systems. In general, they followed a pattern similar to that adopted in other parts of the world by pursuing a neoliberal agenda that included the promotion of changes designed to achieve greater participation of the private sector in the funding and delivery of health services. Despite the different modes of reform, all strengthened the view of health as a consumer commodity and favored abandonment of the concept of health care as a right guaranteed by the state. Most of the changes implemented corresponded to the policies of structural adjustment, in accordance with the neoliberal paradigm recommended by international financial institutions with the aim of guaranteeing payments of the external debt (1-4). After several years of application, the negative impact of neoliberal health policies has been demonstrated by its inability to improve coverage or access to health services. These consequences coincide with the general failure of neoliberalism to improve quality of life; thus, Latin America remains the region of the world with the greatest inequalities between social classes.

These persistent inequalities have motivated a variety of political responses in Latin America, including proposals advocated by liberal left-wing sectors in various countries of the region that are contrary to neoliberalism and include the promotion of policies to reverse privatization of health care while asserting it as a right guaranteed by the state. The amendments to the Venezuelan health system are one of the earliest examples of this type of reform. From 1999 onward, after a decade of implementing neoliberal policies, a marked adjustment in the health system was initiated to establish health as a fundamental right guaranteed by the state in a context of broad participation of organized communities and international ("South-South") cooperation.

This article describes the primary health care reforms in Venezuela, formalized as "*Misión Barrio Adentro*" (Inside the Neighborhood) from 2003 onwards. We begin with an analysis of the neoliberal model that existed in Venezuela at the time changes in health policy were initiated. This is followed by an explication of *Barrio Adentro* in its historical, political, and social context, pointing to the central role played by popular resistance to neoliberalism. We continue with a description of its operation, consolidation, analysis of the first indicators of the program's impact on health, and the discussion of the main challenges to a guarantee of sustainability. We conclude by

From the:
[1] Centre for Addictions and Mental Health, Canada
[2] University of Toronto, Canada
[3] Ministerio Del Poder Popular Para La Salud, Caracas Venezuela
[4] Universitat Pompeu Fabra, Spain
Corresponding Author: Dr. Carles Muntaner
Email: carles.muntanerb@gmail.com
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suggesting that *Barrio Adentro* not only provides a model for health care reform in other countries of the region, but that it also offers important lessons for countries throughout the world, including those with the most powerful economies.

In conducting this study, a variety of political actors were interviewed who had been involved in the development of the health system in both Venezuela and Cuba. This included patients, officials from the Venezuelan Ministry of Health, doctors, and members of community health committees. A review of the Venezuelan press, legislation passed by the government's National Executive, grey literature from the Ministry of Health, and official epidemiological registries was also performed. Finally, two of the authors of this article also participated in the implementation of *Barrio Adentro*.

Without a doubt, the different political, economic and cultural contexts of Latin American countries have influenced the recent development of their social policies. This would explain why the development of social security systems, including health care, from the end of the Second World War until the early eighties, was related to the struggle and gradual organization of urban industrial workers (5, 6). It also helps in understanding the impact of the various crises of global capitalism on the social policies of the continent, from the crisis generated by the breaking of the Bretton Woods agreement to the mandates of structural adjustment policies imposed by multilateral financial organizations (principally the World Bank, the International Monetary Fund, and the Inter-American Development Bank) (5).[1]

Structural adjustment programs, despite the lack of scientific evidence (7), were fundamental in determining the changes carried out in health systems in the region during the 1990s. Financial organizations promoted structural adjustment programs as an attempt to rectify the perceived failure of the State as guarantor of social protection through the substitution of the free market as the best mechanism to achieve economic and social prosperity (3). Reductions in state expenditures on health and the subsequent deterioration of health services during the 1980s were drastic (1, 8), which justified the presentation in the 1990s of privately managed and delivered services as the only viable option for health systems. It was in this context that the World Bank published the *World Development Report: Investing in Health* (9) in 1993 wherein it defines the two main strategies for improving health in countries with medium and low incomes: 1) limit state investment in health care to reduce costs in order to form a macroeconomic environment beneficial for private sector investments that facilitate economic growth, which in turn should plausibly increase household income and subsequently reduce poverty; 2) promote competition and diversity in the funding and delivery of health services by facilitating increased incorporation of the private sector. This publication constituted much more than an academic exercise given the enormous political and financial influence of the World Bank in the formulation of public policies in the countries of the region and its role in directly funding health reforms (4).

The reforms introduced a variety of mechanisms for the administration and funding of health services and other areas of social protection, particularly pensions and attention to occupational risks. Furthermore, decentralization was promoted as a mechanism for abating the national governments' involvement in efforts to facilitate privatization. Numerous private entities materialized to administer resources for health, and there was an enormous increase in the participation of private sector in the delivery of health care services. The negative effects of these neoliberal health reforms have been widely reported (8, 10-13) and illustrate the fact that the only beneficiaries have been transnational corporations based in Europe and North America in alliance with the local elites involved in the

[1] See (10) (pg. 113-116) for a detailed discussion on the political economy of Latin American descent into indebtedness.

administration and delivery of health services and other aspects of social security (2, 3, 14).

Although following different trajectories, the neoliberal reforms in health were implemented in the majority of Latin American countries (4). Venezuela was no exception, and it is precisely from this context, as described below, that a set of changes in health policy was initiated.

Policy Modifications and Neoliberalization of Health in Venezuela[2]

Venezuela joined the neoliberal movement in Latin America relatively late, which some authors attribute to the strength of its dominant oil economy (15). In any case, apart from oil, Venezuela followed a pattern of deepening external debt between the end of the 1970s and the mid-1980s. The failure of policies intended to promote equitable distribution of oil-generated earnings, the increase in the national debt and a decline in oil revenues during the 1980s contributed to the socioeconomic crisis, which reduced 54 percent of the population to extreme or critical poverty by the end of 1989. That year, the Social Democrat, Carlos Andrés Pérez was elected president for the second time following a campaign in which he promised the return of the economic boom experienced in the 1960s, during his first presidency (15, 16).[3]

Following the dictates of the dominant neoliberal ideology and using the justification of combating growing poverty, Peréz embarked on the execution of a plan in agreement with recommendations prescribed for the region by the World Bank and the International Monetary Fund. The plan, nicknamed *El Paquete* (The Package), involved profound reductions in public expenditure, privatization of public enterprises, increased opportunity for oil exploitation by foreign parties, liberalization of commerce and a poverty reduction program (16, 17). The initial enthusiasm for the implementation of these reforms soon faded; the policy quickly faced extensive popular opposition and Pérez was subsequently removed from power in 1993 following a trial for corruption(18). In terms of health care, this period saw the decentralization of a broad network of existing public services, with control passing from the national government to some regional governments. This accentuated the existing fragmentation of providers and public funders of health services and accelerated their deterioration.

After a transition government lasting approximately one year, Rafael Caldera, a Christian democrat, won the 1993 elections promising to discontinue the neoliberal policies. In practice, however, the opposite happened, with the focus on a plan known as *Agenda Venezuela*, which followed the neoliberal recipe. The Venezuelan government obtained two substantial loans for health reforms, one from the World Bank and the other from the Inter-American Development Bank (19, 20). Both sought to facilitate a re-structuring of health-sector funding, preferably giving an increased role to private funding.

The decentralization of high-demand health services, combined with the fiscal austerity of the early 1990s, left the responsibility for the management of poorly equipped health facilities to regional governments, who indirectly favored privatization of many services through a variety of mechanisms, principally through "cost recovery"; in other words, users pay for services rendered (21-23). By 1997, 73 percent of health expenditures in Venezuela was private (21). The clearly apparent deterioration of public health services was presented as an irrefutable rationale for the initiation of radical reform of the health system towards the end of that presidential period. The plan copied the Chilean and Colombian models of separating funding and delivery of services as well as tackling individual health care and population-based health care and promotion separately. This stimulated private investment in health care by promoting capitalist competition

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2 See analyses of the implementation of neoliberalism in Venezuela (14)

3 This was Pérez's second presidency. His first period in office was during the mid 1970s oil boom.

between different providers of lucrative services. The proposal was transformed into legislation which additionally included pension reform which imitated the Chilean "miracle" in the administration of pension funds (24).

It was within this context of neoliberal social policies, with two thirds of the population living in poverty or extreme poverty, coupled with a dramatic fall in oil prices, that Hugo Chavez was elected in December 1998. This victory was interpreted by some authors as the political consequences of two decades of increasing popular mobilization against corrupt Venezuelan regimes and the growing neoliberal political agenda (25). The newly elected government began to revolutionize policies in a manner consistent with the reforms outlined by the president in his anti-neoliberal speeches during the electoral campaign.

Initial Stages of *Barrio Adentro*

Chávez undertook profound changes in public policies. In the case of health care this consisted of the preparatory steps to the creation of a new system. First on the agenda was the suspension of the so-called "Caldera Laws", which had regulated the conversion of the existing public health system to one of private administration and delivery of medical services. This action disrupted the privatization process within the Venezuelan Social Security Institute, which is charged with the management of the national health care system and (formal economy) workers' pensions. It is an extensive public health system second only to the national system and managed by the former *Ministerio de Sanidad y Asistencia Social* in coordination with regional governments. Next, the new government implemented a variety of strategies to eliminate barriers to health care, which entailed: A) a decree to immediately suspend charging patients for emergency services in public institutions; B) implementation of a new *Model of Integral Health Care*; this changed the organization of primary care by age groups, procedures and medical specialties favorable to service providers, into a new arrangement oriented around the needs of patients and C) improved equipping of primary health care centers through a special plan involving equipment and infrastructure improvements. Third on the new government's agenda was the reinforcement of a preventive approach to health, transferring the emphasis from curative to health promotion and disease prevention. This first stage corresponded to the period 1998–2000 and included the important political definitions regarding health established in the Bolivarian Constitution.

In terms of defining health policy, the most notable aspect has been the constitutional process, culminating with the establishment of various constitutional principles regulating health policies. The new constitution was approved in December 1999 through a national electoral process. The most substantive change with regard to the previous (1961) constitution was recognition of health as a fundamental right, and the duty of the State to guarantee it.

Three articles in the constitution contain the main definitions for the health sector in the country. Article 83 defines the characteristic of health as a constitutional right linked to the right to life. Article 84 stipulates the creation and administration of an integrated, universal public health system that provides free services and prioritizes disease prevention and health promotion as a duty of the State. Furthermore, it explicitly prohibits the privatization of public services. Finally, the public character of funding is established in Article 85, which specifies the government's fiscal resources and worker's social security premiums.

The Ministry of Health subsequently published the *Social Strategic Plan*, which details the conceptual framework for the practical implementation of Constitutional precepts, with the emphasis on equality, universality, and social territoriality, and tackles questions of gender, ethnicity, social class and community participation (26). Following this concept, different health legislation projects have tried to outline the principles and organization of the system, although at the end of 2006 there was still no health

legislation meeting the precepts set forth by the 1999 Constitution.

These Constitutional precepts reflect popular political demands that seek to better define and actualize health as a right. Steps taken between 1998 and 2002 managed to check the advance of neoliberal policies and eliminate barriers to access, but they were still far from satisfying the popular demand for improved health services. In this sense there was a need to continue the search for other alternatives. Responses were facilitated in two ways: 1) Similar needs in order to achieve universal literacy had led to the development of a *sui generis* organizational strategy, later known as a "mission". A "mission" was aimed at concentrating efforts of different sectors and public organizations in order to rapidly satisfy urgent social needs, increase community participation, circumvent bureaucratic obstacles, and to employ the organizational and logistic facilities of the Armed Forces in the development of civil social actions. [4] 2) The catastrophic flooding and landslides in the state of Vargas in December of 1999 required an immediate response to meet the health needs of the affected population and demonstrated the support of the Cuban Government, which provided medical and paramedical personnel.

The need of the population for better access to health services became exceedingly evident in Caracas during 2002 through demands made by organized community groups, corroborated by social studies conducted by the city council of the municipality of Libertador. To meet these requirements, the city council designed a plan to provide basic health care through "*Casas por la Salud y la Vida*" (Houses of Health and Life) in certain metropolitan areas ("marginal neighborhoods") that were lacking any type of public services. In January 2003, the government of the municipality invited local doctors to participate in the new program. The response was minimal and justifications given included concerns about personal safety and lack of the infrastructure needed to practice medicine. Based on the humanitarian support provided by Cuba during the Vargas tragedy, Caracas Mayor Freddy Bernal, with the support of President Chávez, agreed on a pilot project with the Cuban government. In April 2003, 58 Cuban doctors specializing in integral general medicine (a form of family medicine) were established in several peripheral neighborhoods (*barrios*) of Caracas, to provide primary health care. Health team personnel live in the same barrio in which they work (28) and an assistant known as a "*Defensor de la Salud*" ("Defender of Health"), is chosen from the community and trained by the Ministry of Health to provide basic support to the physicians. This way of providing health care was initially supported by extensive participation from organized community groups, mainly the urban land committees [5] who, together with the team from Libertador city council and the Cuban Medical Mission proceeded to elaborate preliminary work plans for the doctors and conduct a survey of the community's living conditions. Initially, doctors were housed in dwellings voluntarily provided by community members. Their presence in the communities, availability to see primary care patients at any time of the day and night, and close coordination with community organizations, were key to the program's high level of acceptance.

In September 2003, after the pilot program had been evaluated and deemed to be a success, President Chávez baptized the program with the name *Misión Barrio Adentro*, and converted it into a national plan. It is defined as an initiative aimed at satisfying the constitutional requirement of health as a social right through a public health system. Moreover, it is supported by the principles of equality, universality, accessibility, solidarity, multi-sectoral administration, cultural sensitivity, and social participation and justice. The

[4] A detailed account of this events can be found in (27).

[5] *Los Comites de Tierra* are organizations devoted to the legalization of land ownership among city dwellers.

participation of the community is recognized as fundamental to the creation and development of the initiative (28).

In order to facilitate development of the program, in December 2003, (officially inaugurated in January 2004) a multi-sectoral presidential committee "*Misión Barrio Adentro"* was established. The committee, administered by the "*Oro Negro*" (Black Gold) Civil Association was responsible for the implementation and coordination of the Primary Health Care Program, with participation by the ministries of Health, Labor, Energy, Defense, the president of PDVSA[6] and *Frente Francisco de Miranda* (an organization of defenders of social rights) and the mayors of two Caracas municipalities, Sucre and Libertador (29).

The expansion of *Barrio Adentro* to the national level was undertaken in 2004. The first stages increased geographical coverage within Caracas and finally to the rest of the country. During this initial phase, efforts were concentrated on the creation of medical centers, providing housing for the doctors, conducting a census of the community corresponding to each center, characterization of the living conditions of each community, and reorganization of community participation through the formation of health committees. Numbers of cooperating doctors, medical centers and health committees increased from 13 community medical centers at the end of 2003 to 2,708 by mid 2007. The number of cooperating doctors rose rapidly from the initial group of 54; by 1998 there were 1,628 physicians, and 19,571 by mid 2007. The number of health committees grew from 2,124 in 2003 to 8,951 in 2006. This initial implementation and exploratory phase allowed for the progressive development of a particular model of care, strongly influenced by positive aspects of the Cuban health care system (see figures 1 and 2).

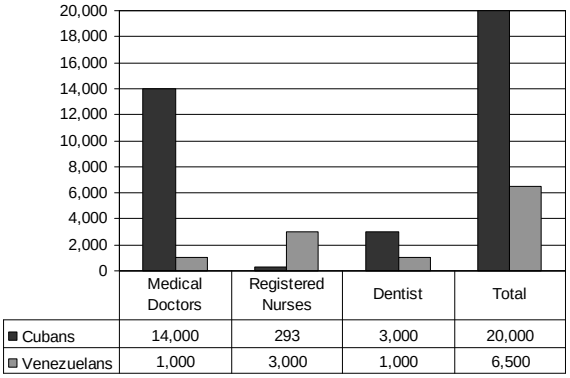


Figure 1. Number of Cuban and Venezuelan medical personnel, May 2nd 2005

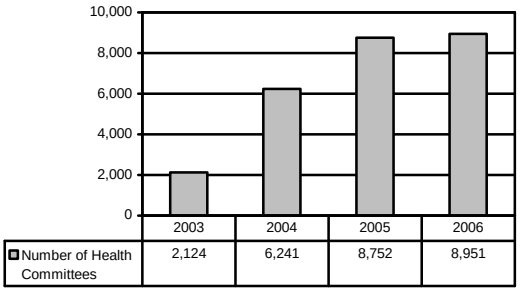


Figure 2. Number of Health Committees (Comités de Salud), April'03 - May'06

At the primary level, the health care model of *Barrio Adentro* has the following characteristics:

(A) It utilizes an integral care model.
(B) In general, scheduling is uniform with medical consultation and curative care taking place in the mornings, while afternoons are dedicated to visits in homes and other locations;
(C) There are defined catchment areas with each neighborhood medical center providing coverage for between 250 and 400 families, each with their own family medical record in addition to the individual clinical record.

[6] PDVSA: *Petroleos de Venezuela* S.A. the State oil company of the Bolivarian Republic of Venezuela, responsible for the exploration, production, refining, transportation and trade in hydrocarbons.

(D) A paradigm of health promotion is utilized in all activities undertaken, including visits to schools and work places.

(E) *Barrio Adentro* is participative. The design and realization of all activities is controlled by decisions made by the community, while residents of the neighborhood participate in administration and delivery of primary health care (30).

(F) Each medical center has an educational function, facilitating the training of community health promoters and health technicians (both undergraduates and graduates) (31). Closely linked with the teaching aspect is scientific research into the population's health problems (see, for example (32-36).

(G) The intersectoral nature of this model of care emphasizes a holistic approach to living conditions through coordination of health actions with other social interventions.

Political Resistance

Implementation of *Barrio Adentro* produced specific negative reactions from the political opposition, consisting of three main objections. First, the private press repeatedly objected to the presence of Cubans in the country, presenting it as an attack on national sovereignty. Second, the traditional medical association, *Federación Medica Venezolano* (FMV), controlled by opponents of the government, argued that Cuban professionals, medical science, and pharmaceutical products were of low quality. They subsequently filed a lawsuit in attempt to have it declared illegal for Cuban doctors to practice in Venezuela. Ironically, this generated a popular response in defense of *Barrio Adentro* and weakened the opposition posed by the FMV to the presence of the Cuban doctors. Finally, many patients referred by *Barrio Adentro* were refused admission to the established public hospitals (37). This was resolved in Caracas by concentrating referrals to two hospitals, the *Hospital Militar*, and the *Hospital Universitario de Caracas*, where there was extensive sympathy for the program.

Second Phase of *Barrio Adentro*

The success that resulted from extending primary care coverage, the unmet demands for secondary level care, and the need to guarantee sustainability of the system all led to the additional development of a group of interventions after 2004, which we classify here as the second stage of *Barrio Adentro*. Six main objectives were identified: 1) consolidation of primary-level care, 2) opening up of secondary-level care, 3) hospital and specialized care programs, 4) plans for rapid large-scale training of Venezuelan health personnel, 5) reinforcement of policies for collective health, and 6) institutional adaptation.

1) Consolidation of primary level care

To enable the consolidation of primary level care, known as *Barrio Adentro I*, a plan was initiated to provide all primary medical centers with appropriate infrastructure, furniture, and equipment. The plan projects establishing approximately 6,000 centers; in some cases erecting new buildings, in others, remodel existing ones. Given the magnitude of the task, the responsibility for new construction was assigned to 40 different organizations, both national and local (regional and local councils). At the end of 2005, 1050 primary health care centers have been completed (30) See Table 1, page 239.

2) Opening the second-level of care

Health care provided through *Barrio Adentro I* guarantees health promotion and curative care in the majority of cases; however many patients require para-clinical diagnostic examinations or more complex procedures. In response to these needs a second level of care was planned through a program named *Barrio Adentro II*. The opening of 600, secondary care establishments known as "*Centros de Diagnostico Integral*" (CDI) (Integrated Diagnostic Centers) was planned for

Table 1. Major Achievements of *Barrio Adentro I*, 2005

	Conventional System	*Barrio Adentro* System
Physicians in primary care	1,500	13,000
Coverage	3,5 million	17 million
Primary health care centers	4,400 (1,500 with physicians)	1,050 (finished)
Primary care dentists	800	4,600
Nurses or aids in primary care	4,400	8,500
Opticians	0	441
Promotion and Prevention Activities	Varies, by health center	In the health center and out in the community
Medication dispensing	Varies according to supply	103 medications for the most common presenting illnesses; Popular Pharmacies

the entire country. By the end of 2006, three hundred CDIs had begun to operate. Each of these centers provides services that include 24-hour emergency service, paraclinical laboratory tests, ultrasound, endoscopy, X-ray, electrocardiography and ophthalmology. In addition, each center has on average three intensive care beds and one in every four CDIs has an operating area for emergency surgical operations.

The CDIs complement an earlier secondary care initiative, the program of "Clínicas Populares" (Popular Clinics): small hospitals with capacity for elective surgical interventions, maternal and pediatric care, and a series of medical specialties not present in the CDI (obstetrics, internal medicine, traumatology, ophthalmology, general surgery). Between 2004 and May 2007, 44 of these centers opened, all of them employing Venezuelan personnel.

Barrio Adentro II includes other services which improve the system's capacity to resolve health problems, including the *Centros de Alta Tecnología* (CAT) (High Technology Centers) (see Table 2). At the national level, there were plans for 35 of these centers. The first began operation in March 2006, and by March 2007, 12 were completed. The CAT exclusively provides diagnostic support services, performing nuclear magnetic resonance, computerized axial tomography, 3-D ultrasound, mammography, bone densitometry, video endoscopy, electro-cardiography, and more complex clinical laboratory tests.

Finally, *Barrio Adentro II* includes a third type of establishment, the *Salas de Rehabilitación Integral*; (SRIs) (Integral Rehabilitation Facilities) (see Table 4) which are paired with CDIs. Six hundred are planned throughout the country. The SRIs are intended to cover one shortcoming that became evident in *Barrio Adentro I*— care for the disabled. They provide electrotherapy, ultrasound, laser therapy, hydrotherapy, pediatric and adult physical therapy, occupational therapy, and speech therapy. The first SRI opened in 2006 and by mid-2007, 432 were operational. In 2004, here were only 63 public sector services of this type in the entire country and they employed both Cuban and Venezuelan personnel.

Community participation has also been an important element within the process of construction, equipping and opening of the various types of establishments for *Barrio Adentro II*. Each CDI/SRI pair has a catchment area of between five and twenty primary health centers

Table 2. Health care activities at the Hospital Cardiológico Infantil Latinoamericano "Dr. Gilberto Rodríguez Ochoa"

		Number 20/08/06-31/12/06	Number 1/01/07-23/07/07	Total
Interventions	Surgery	234	328	562
	Hemodynamics	129	257	386
	Total	**363**	**585**	**948**
Indicator	Diagnostic Imaging	2,354	4,974	7,328
	Echocardiograms	1,065	1,774	2,839
	Laboratory Exams	28,839	50,003	78,842
	Blood Bank Donations	566	680	1,246

and each has a Health Committee. With the goal of facilitating community participation, seven simultaneous Assemblies of Health Committees corresponding to each center, were convened during 2006, organized through the national press and television. The Health Committee members met with building and equipment installation contractors, representatives of the Ministry of Health and of *Misión Medica Cubana* (The Cuban Medical Mission). These Assemblies were involved in defining the operation of this new level of the network and enabling members of the community to resolve various problems related with their implementation.

3) Hospital and Specialized Care Program

Barrio Adentro III includes integration of the 300 existing public hospitals in the country. It began in 2006 and was re-formulated in 2007. The focus of this phase of the project is on improvement in infrastructure, equipment, and personnel training, for which 1.3 million Bolivares have been allocated.

This third phase also includes as a special component the installation of a network offering radiation therapy and chemotherapy. The national plan projects the opening of 18 of these specialized centers throughout the country (target coverage 85% of the population) of which 9 were fully operational by the end of 2006. The remainder were scheduled to open during 2007. This component is particularly important given that cancer is the second leading cause of death in both men and women.

Barrio Adentro IV involves the construction of a dozen new general hospitals, each with a specific area of hyper-specialization. The two main objectives of these facilities are to achieve high specialization in areas of strategic importance to the country, while simultaneously broadening general hospital coverage (particularly in areas with low beds-per-population ratios). This program was formalized in December 2006 with the creation of an institution responsible for its administration. Although initiated as an independent project, the *Hospital Cardiológico Infantil Latinoamericano* (HCIL) (also known as "*Hospital Dr. Gilberto Rodríguez Ochoa*") inaugurated in August 2006 (see Table 2) corresponds to this phase of *Barrio Adentro* and has served as a model for the other hospitals. However, unlike the other hospitals in development, HCIL does not have an area of general hospitalization, and instead is highly specialized in the care of patients with congenital cardiopathic conditions.

Parallel with the development of *Barrio Adentro II*, two additional programs were established for high-impact areas of health care.

The first, known as *Misión Milagro* (the Miracle Mission)**,** treats cataracts and other common vision-related pathologies. This program, formally constituted in 2006, emerged following the development of extensive adult education programs (*Misión Robinsón*), which identified many people with vision conditions that created a barrier to learning. The second, *Misión Sonrisa* (The Smile Mission) is also a credit to the "mission" strategy. Primary care dental services, available through *Barrio Adentro* performed necessary extractions that often render patients partially or totally edentulous and in need of dental prosthesis. Therefore, this mission is aimed at caring for these patients and contemplates the installation of 140 laboratories throughout the country.

Deliberations on the Impact of *Barrio Adentro*

To rigorously ascertain the impact any health care system has on an individual's quality of life is a difficult challenge. In the present case, the complexity is even greater as we are dealing with a system still under construction, and thus subject to frequent modifications. Moreover, *Barrio Adentro* arises in a context of interaction with other public policies and initiatives that are having considerable impact on the quality of the population's living conditions. Nevertheless, in this section we will present preliminary data regarding the impact of *Barrio Adentro*.

Empirical evidence from four different perspectives of the program's impact is presented. First, patient interviews reflect a significant degree of satisfaction with services received in four particular areas: 1) Quality of care (which is described as "warm", "human"); 2) Accessibility – centers are geographically close to users, care is free, and hours of availability are extensive: 3) The provision of medicines free of charge (38) and 4) Waiting times to receive care are significantly reduced (in comparison to hospitals). Another indicator of patient satisfaction is reflected through surveys, which illustrate the degree of acceptance of *Misión Barrio Adentro* with satisfaction values reported at over 60%. A further (indirect) indicator is the political activism initiated by health committees in defense of the program when the right-wing opposition has attacked it.

The increase in access to health services is a clear indication of the improvement in quality of life experienced through *Barrio Adentro*. With the completion of 1050 primary health care centers at the end of 2005 and the location of the new medical centers, geographical barriers to health services were reduced. Moreover, these centers were equitably distributed among the regions and were preferentially situated in areas with a lower density of services, particularly in peripheral city areas. With respect to medical consultations, in 2004 and 2005 three times as many took place in the Barrio Adentro network (150 million) when compared to the traditional network (58 million).

Finally, epidemiological indicators for the years 2004 and 2005 suggest some of the other possible impacts of *Barrio Adentro*. There was an increase in the diagnosis and follow-up of patients with chronic diseases such as hypertension and diabetes, in whom, subsequently, a lower incidence of complications is expected (see Figures 3 and 4, pages 244-245). With regard to certain infectious diseases, the number of cases has risen (suggesting more detection) while the number of deaths has diminished (suggesting better follow-up and opportunities for treatment). For example, between 2003 and 2005, cases of diarrhea among children under 1 year of age rose from 241,360 to 435,396 (80.4% increase), whereas the number of deaths fell from 1148 to 574 (50% reduction). Similar trends in morbidity and mortality have been observed among children aged 1 to 4 years with the same patterns also occurring for pneumonia, again observable both in groups under 1 and aged from 1 to 4 years. These records suggest that the increase in accessibility has meant coverage of a hitherto unmet need, and consequent avoidance of deaths.

Discussion and Conclusion

The Venezuelan experience, with the construction of a new publicly funded health system seeking to quickly reach universal coverage and based on a strategy of primary health care, demonstrates the validity of incorporating

health as a universal right and confirms the relevance of principles contained in the Alma Ata and Ottawa Declarations. Implementation of *Barrio Adentro* provides rigorous evidence about the feasibility of setting up a public health system when the necessary political volition and community organization exists and naturally, in a context where power relations and the reigning ideology favor public policies of this type (39).

Development of *Barrio Adentro* is occurring in a political context clearly opposed to neoliberal policies and one that recognizes health, education, and employment as fundamental rights and seeks a rapid improvement in the population's living conditions, promoting greater equality in the distribution of wealth. At the international level, this context is characterized by the government pronouncing itself in favor of the integration of Latin America, promotion of a multi-polar system, opposition to free trade agreements that prioritize purely economic aspects (ALCA[1]) and supportive of proposals involving alliances based on solidarity and complementarity, such as the "*Alternativa Bolivariana de América"* (ALBA) (The American Bolivarian Alternative).

The experiences of *Barrio Adentro* are useful for the development of primary health care, not only in developing countries but also those of the periphery and semi periphery[2]. *Barrio Adentro* constitutes a valuable experience for countries with political processes that emphasize social rights and are seeking to satisfy their population's demands for health, as is the case in Bolivia, Ecuador, and Nicaragua. On the other hand, the successful and rapid increase of primary health care coverage may be of interest in countries with existing universal systems where some political actors now argue for the need to abandon public systems in order to open the door to alternatives with greater private participation, as in Canada. It may also serve those who seek evidence to support the need to abandon privately organized schemes in favor of public alternatives providing greater coverage and equity, as in Colombia and Peru. The political and social context and the mechanisms that encourage and promote community participation in the administration of health care and the emphasis on social determinants of health in *Barrio Adentro* may serve as important elements to help marginalized communities of other countries to increase access to quality health services.

Another aspect in the analysis of *Barrio Adentro* is its contribution towards a different model of international cooperation between countries of the periphery ("South-South"). The solidarity of the exchange between Cuba and Venezuela constitutes a crucial aspect for the feasibility of *Barrio Adentro*. It presents a model of South-South international relations, where aspects of solidarity and complementation predominate, as opposed to the imposition and competitive characteristic of neoliberal health policies conditioned by their funding through multilateral organizations (29). Cuba and Venezuela have signed a number of agreements, which have led to benefits for the populations of both countries and complementation of the strengths of each nation. Thus, while contributions from Cuba have facilitated an unprecedented rate of development of the health system in Venezuela, Cuba has achieved and continues to develop greater energy stability. This form of cooperation corresponds to the Venezuelan government's proposal of the ALBA initiative, which has led to similar exchanges with Argentina, where Venezuela provides energy resources in exchange for health-related goods and services. A further manifestation of this change of paradigm in exchanges is the *Misión Milagro* initiative, which has allowed thousands of American patients to have cataract operations free of charge in Venezuela and in Cuba.

The process of construction of a public National Health System, as established in the Constitution of the Bolivarian Republic of Venezuela is clearly in progress. *Barrio Adentro* has led to enormous advances in medical care

[1] ALCA : Área de Libre Comercio de las Américas (Free Trade Area of the Americas)

[2] We used World Systems Theory[40] because it models the power relations between rich and poor countries and does not assume a linear view of "development".

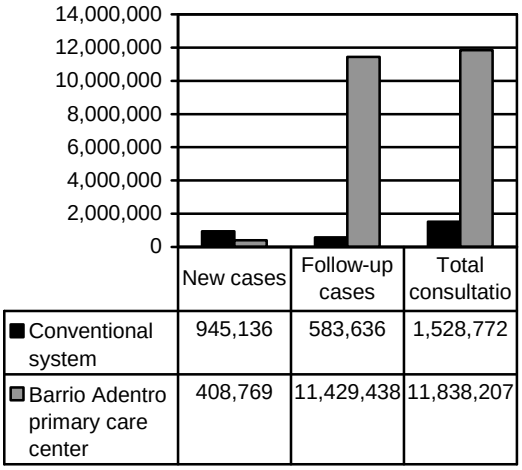
coverage and universalization of the right to health; the culmination of its phases III and IV will further extend coverage, resolving the needs for care at tertiary and higher levels. However, there remains a tremendous amount of work to be completed. One of the most notable tasks pending is the integration of the multiple public health systems currently in existence. Incorporation of some institutions from the traditional network into *Barrio Adentro*, and implementation of an occupational scheme for doctors, which stimulates full-time dedication to a single establishment (39) represent initial steps in this direction. But the services depending on the Ministry of Health remain fragmented with regional governments local councils, Venezuelan Social Security Institute, IPASME [3] and hundreds of public health,service providers. The integration of these systems is not merely a constitutional precept; it is also one of the main aspects required to guarantee the sustainability of *Barrio Adentro*.

Reinforcement of preventive and health promotion policies has contributed to a positive impact on quality of life, which is exemplified through the development of aggressive anti-smoking policies, reinforcement of immunization programs, introduction of vaccines for rotavirus, and reinforcement of health education to combat dengue and malaria. However, the considerable political and media attention regarding the development of the primary system for care of *individual* health has led to postponement of both further integration of collective health policies and the management of particularly serious public health problems, such as violence or traffic accidents. Similarly, it has strengthened the medicalized model of health care at the expense of a more integral conceptualization.

Despite the importance and innovation of the *Barrio Adentro* primary health care initiative, there is limited scientific literature regarding this model and there is little research currently underway. Many aspects of the implementation process need to be systematically explored (for example, community participation and cost-benefit ratios) in order to appreciate questions of scale and performance enhancement in any attempt to apply the lessons learned to similar initiatives in other parts of the world, where access to health services is limited.

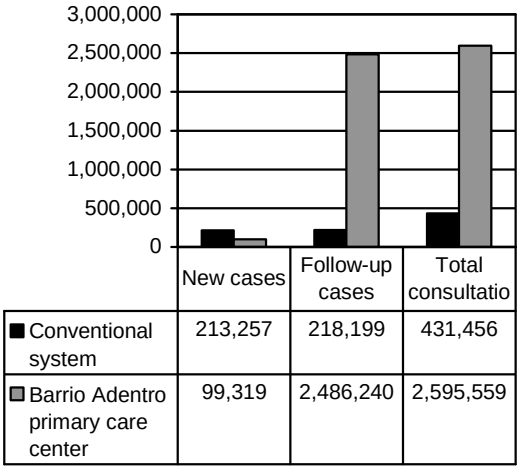
[3] Instituto de Previsión y Asistencia Social para el Personal del Ministerio del Poder Popular para la Educación

Figure 3. Detection of New Cases and Follow-Up Visits, Conventional System and *Barrio Adentro* Primary Care Centers, 2004-2005



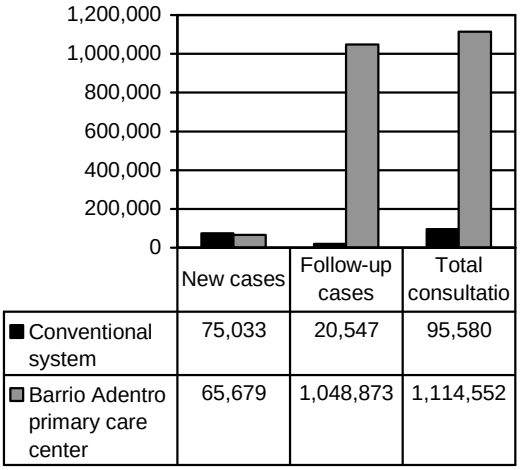
	New cases	Follow-up cases	Total consultatio
Conventional system	945,136	583,636	1,528,772
Barrio Adentro primary care center	408,769	11,429,438	11,838,207

a. Arterial hypertension



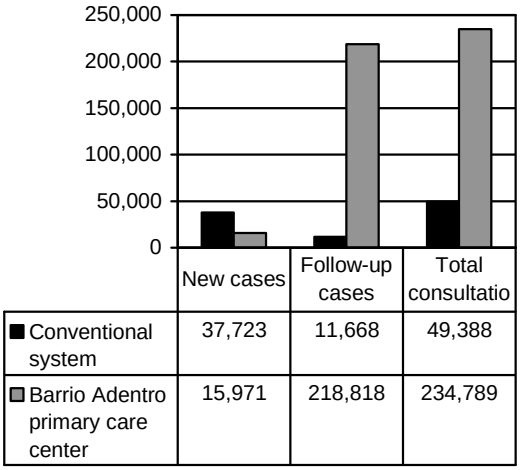
	New cases	Follow-up cases	Total consultatio
Conventional system	213,257	218,199	431,456
Barrio Adentro primary care center	99,319	2,486,240	2,595,559

b. Diabetes



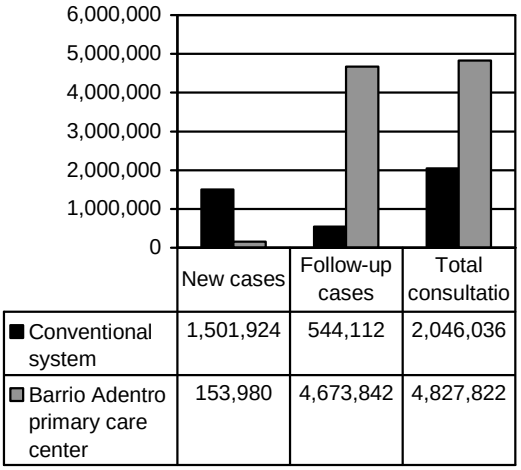
	New cases	Follow-up cases	Total consultatio
Conventional system	75,033	20,547	95,580
Barrio Adentro primary care center	65,679	1,048,873	1,114,552

c. Ischemic cardiopathy



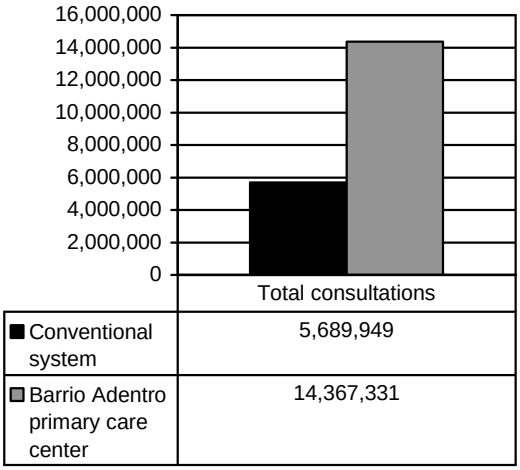
	New cases	Follow-up cases	Total consultatio
Conventional system	37,723	11,668	49,388
Barrio Adentro primary care center	15,971	218,818	234,789

d. Cerebrovascular disease



	New cases	Follow-up cases	Total consultatio
Conventional system	1,501,924	544,112	2,046,036
Barrio Adentro primary care center	153,980	4,673,842	4,827,822

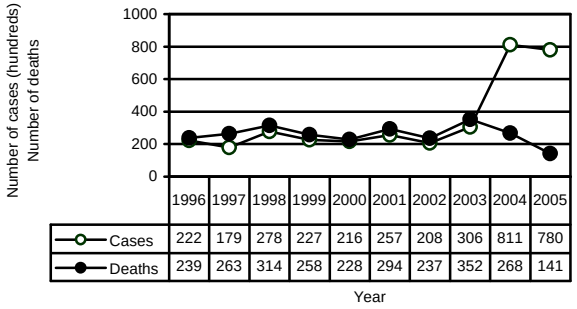
e. Bronchial asthma



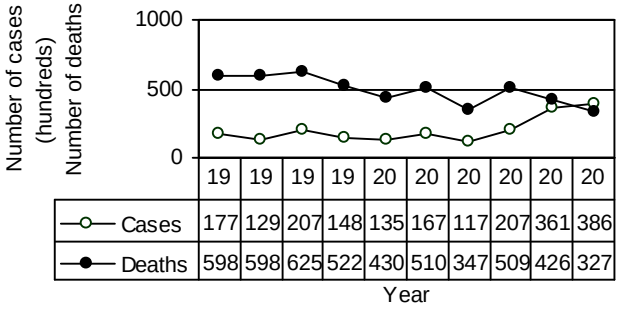
	Total consultations
Conventional system	5,689,949
Barrio Adentro primary care center	14,367,331

f. Dentistry

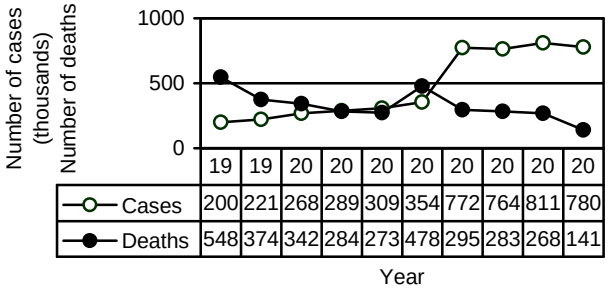
Figure 4. Cases and deaths from various pediatric diseases



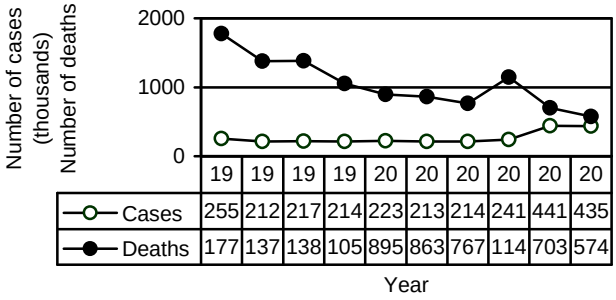
a. Pneumonia, children of 1~4 Years of Age



b. Pneumonia, children of 1 Year of Age



c. Diarrhea, children of 1~4 Years of Age



d. Diarrhea, children of 1 Year of Age

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