

Health for All: Alma Ata is Alive and Well in Venezuela

Joan E. Paluzzi and Fernando Arribas García

In 1978 the Declaration of Alma Ata asserted that health is a fundamental human right and “Primary health care is the key to attaining this target as part of development in the spirit of social justice.” Thirty years later we find the partnership between the Venezuelan and the Cuban governments realizing the promise of “Health for All” for the people of Venezuela. For this reason, we are honored to serve as the guest editors for this special edition of the journal *Social Medicine/Medicina Social* examining the robust health sector reform that has been underway in Venezuela since 2003. As an example of a “counter-reform” which explicitly challenges the prevailing policies and organizational practices in global health, the events in Venezuela have international significance.

Misión Barrio Adentro is one of the many widespread social sector programs (Missions) developed within the framework of the ongoing Bolivarian Revolution and initiated following the election of President Hugo Chávez in 1998. *Barrio Adentro* can be translated “inside the neighborhood”, a concept which establishes the ‘street credentials’ of the Venezuelan reform as a legitimate exemplar of an engaged model for social medicine in the 21st century. *Barrio Adentro* is heir to the tradition that many, including physician/anthropologist Howard Waitzkin and his colleagues¹, refer to as the “Golden Age of Social Medicine.” Social medicine flourished in 1930s Latin America, propelled by pioneers like Max

Westenhofer and Salvador Allende Gossens of Chile. The direct line of descent for this uniquely Venezuelan version of social medicine can be traced through the Cuban public health system upon which much of it has been modeled.

In a period of 5 years the *Misión* has created a health system – ranging from primary to tertiary care – that is both free and accessible to all Venezuelans. Traveling across Venezuela during two successive summers, we were repeatedly struck by just how pervasive *Barrio Adentro* has become within a relatively short period of time. At every stop along the way, in large cities and tiny rural *pueblos*, anyone on the street or along the road who was stopped and asked for directions to the nearest *Barrio Adentro* neighborhood clinic responded without hesitation.

One of the most important elements of this reform is its actualization of the concept of health as a fundamental human right. As further indication of the Venezuelan commitment to this principle, the obligation of the State to assure the full realization of this right has been explicitly encoded into Venezuela’s national constitution. Additionally, this reform has established an example of a national public health system that has supported and mobilized focused political will and widespread community engagement to rapidly create a national health system that is characterized by broad accessibility across a large, geographically and culturally diverse nation.

Corresponding Author:
Joan E. Paluzzi, Ph.D.
Anthropology Department
University of North Carolina Greensboro.
E-mail: jepaluzz@uncg.edu
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¹ H. Waitzkin, C. Iriart, A. Estrada, and S. Lamadrid 2001. Social medicine then and now: Lessons from Latin America. *American Journal of Public Health* 91 (10):1592–1601.

The Venezuelan example holds great promise for countries struggling to develop sustainable primary health services. The concept of health as a fundamental right provides a notable contrast to the thoroughly privatized system in the United States where the discussion of health as a human right rarely finds its way into the ongoing and as of yet, ineffective, political debate on “the health care crisis”. These two themes are related in that the unquestioned acceptance of market-regulated healthcare in the US has worked its way into international policy vis-à-vis the influence of the US government in setting international development and financial policy. Lack of educational, health, and other basic infrastructures are just some of the barriers to large-scale and rapid development of primary systems in many of the poorest countries of the world. The continued imposition of the neoliberal ‘Washington Consensus’ development model with its intractable ‘one-size-fits-all’ *modus operandi* constrains the ability of many heavily indebted, poor countries to prioritize the social sector reforms that are essential to reverse decades of imposed neglect.

With healthcare as its “product”, privatization inevitably and thoroughly commodifies health services. The services, supplies, and medicines needed to maintain health become situated within the market and are therefore vulnerable to the manipulations of market dynamics, transforming them from basic necessities into profitable commodities. With this commodification and through the reproduction of existing socio-economic hierarchies, ultimately health itself is commodified by making accessibility and often quality of basic healthcare dependent upon an individual’s access to cash. For decades, many of the countries in Latin America, including Venezuela, experienced repeated waves of neoliberal structural adjustments that have been characterized by widespread privatization of human services, including healthcare. This in turn has exacerbated the existing and significant inequalities within these societies and created new opportunities for their expression within essential social sectors such as health and

education². The lucrative profits assure that the small minority that benefit from the healthcare market will continue to be invested in maintaining (or reasserting) privatization. In Venezuela, it may be inevitable that the vested interests who wish to maintain the primacy of the market model will continue to directly and indirectly challenge the current reform.

Unlike the prioritization of primary, neighborhood-based healthcare services in Venezuela, the current international health development model promotes vertical, disease-specific programs. On the one hand, they serve an important function in addressing the most visible and, in some cases, the most lethal health issues in places like sub-Saharan Africa. On the other hand, these highly focused programs are also uniquely suited to current international development policies which reflect the priorities of wealthy donor countries and to a system where policy is dictated by health economists from the rich countries rather than health providers from the poor ones. The cost of a vertical program is easily quantifiable per “unit” (the full treatment regimen for a single patient); it is relatively simple to control access to the programs; and there is a relatively narrow, easily manageable range of accountability for administration and funding oversight. Yet this apparent rationality is utterly myopic.

Without accessible primary health services, many, if not most of the people who contract HIV, TB, and malaria do not have a mechanism through which they can be diagnosed and referred into these programs for treatment. Further, poverty creates vulnerability to a wide range of health issues; the

² See for example: N. Homedes, A. Ugalde. 2005. Why neoliberal health reforms have failed in Latin America. *Health Policy* 71 (1): 83 – 96; T.L. Karl. 2003. The vicious cycle of inequality in Latin America in T.P. Wickham-Crowley and S.E. Eckstein (eds.) *What justice? Whose justice? Fighting for fairness in Latin America*. University of California Press: Berkeley CA.; J.P. Unger, P. De Paepe, G. Solimano Cantuarias, O. Arteaga Herrera. 2008. Chile’s Neoliberal Health Reform: An Assessment and a Critique. *PLoS Medicine*, 5(4): 542-547;

current priorities in international public health have created a situation in which hundreds of millions of impoverished people in the world may or may not have access to a treatment program for one of three major infectious diseases (TB, malaria and AIDS) but have absolutely no recourse for the diagnosis and treatment of other life-threatening conditions, acute injuries and illnesses, or chronic diseases. Curing someone of their TB is a hollow victory if they subsequently die of tetanus, diabetes, cholera, work-related injuries or one of the other myriad, treatable conditions whose incidences are conditioned by the impact of poverty on human health.

Combining (across organizational and institutional borders) the resources currently dedicated to the major infectious diseases, eliminating duplication of services, and ending competition for resources would provide the fiscal means to begin 'planting' the disease-specific vertical programs within comprehensive primary systems. This would require a paradigm shift at the top levels of international health and among donors where territorialism, competition, and instant gratification in terms of quantifiable outcomes have dominated for decades. Comprehensive and universal primary care and the societal advantages it confers may require careful analysis across generations to fully appreciate its long-term impact on illness outcomes, disease prevention, and the health and development of children. Ultimately, the most significant collective advantage conferred by universal access to healthcare will emerge from the ability of healthy citizens to contribute to the growth and development of their society. This holistic vision of health and human experience is ill-suited to the narrow quantification of the cost/benefit ratio analysis which continues to be the current gold-standard of assessment within international healthcare capitalism.

Listening to members of communities across Venezuela describe the positive and immediate impact of accessible primary and secondary health services on the quality of their and their communities' lives provided us with a glimpse of what an alternative, more comprehensive systems-assessment model that seeks to incorporate both qualitative and quantitative information might look

like. For example, the assessment process, like the basic tenets of the social medicine system it seeks to evaluate, should incorporate the fact that individual health issues cannot be completely understood or addressed without contextualizing health and illness experience within the larger social, economic, and ecological environment in which people live and work.

The contributing authors in this edition include an international group of physicians, public health specialists and other scholars, many of them directly involved in the design, implementation, and assessment of Venezuela's new national health care system and the development of its concurrent educational infrastructure. The significance of *Barrio Adentro* as a counter-reform in relation to the current international public health system paradigm is underscored by the fact that all of these authors explicitly contextualize the emergence of *Barrio Adentro* as a deliberate and reasoned alternative to the neoliberal privatized model that has existed for decades in Venezuela.

Carles Muntaner and his colleagues provide us with a brief history of public health in Venezuela, the impact of structural adjustment on the system, and the formation, organization, and expansion of *Misión Barrio Adentro*. Due to the short amount of time (less than 5 years) that the program has been operating on a national scale, there is a limited amount of data available to perform impact assessments. However, utilizing surveys obtained in 2004-2005 they present a quantitative system-development profile that illustrates the rapid scale-up of the new system as well as early but nonetheless promising changes in epidemiological patterns that may indicate its positive impact.

One of the great constraints on health systems throughout the world is the lack of trained personnel. There are multiple reasons for this however, it is no coincidence that, in many of the poorest countries in the world, structural adjustment has also had a negative impact on the educational sectors with standard neoliberal tactics such as privatization, cutbacks in government spending on education and the initiation of user fees that position even primary education beyond the reach of millions of poor children. Comprehensive healthcare coverage requires large numbers of educated

professionals and technicians. In his paper on the training of public health professionals, Oscar Feo begins with a discussion of neoliberalism and the transformation of public health education into a “private good for individual consumption” within its context. He demonstrates the damaging consequences of this transformation and concludes with a description of the steps currently underway in Venezuela to reverse the influence of this privatized perspective on the education of public health workers.

Through an agreement with the journal, *MEDICC Review*, and the permission of authors Eugenio Radamés Borroto Cruz and Ramón Syr Salas Perea their study of the “university without walls” in Venezuela is reprinted in this edition. They describe the collaboration between the Venezuelan and Cuban governments to completely transform the education and training of primary care physicians. This has been accomplished within a very short period of time and on an impressive scale. They also provide interesting details of the structure and curriculum.

US medical student, Rebecca Trotzky-Sirr spent a year in the western Andean region of Venezuela studying the community-based health system and shares her impressions of that experience.

The political and social reform in Venezuela has designed and implemented (in 5 years) a public health system that is grounded in the assertion that health is a fundamental human right; prioritizes the engagement of community members; and demonstrates that there are viable alternatives to the current international development model. Quite an accomplishment.

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Other resources on Venezuela’s public health system include:

The PAHO report entitled, *Mission Barrio Adentro: The right to health and social inclusion in Venezuela*, available in English at:

http://www.paho.org/English/DD/PUB/BA_ENG_TRANS.pdf

Alvarado, Martínez, Vivas-Martínez, Gutiérrez, and Metzger. 2008. Social change and health policy in Venezuela. *Social Medicine* Vol.3 (2):95-109. Available at:

<http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/229/436>

The Bolivarian Republic of Venezuela Ministry of Health: <http://www.mpps.gob.ve/ms/>



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