

*Reports on Venezuela*

**VENEZUELA'S BARRIO ADENTRO: AN ALTERNATIVE TO  
NEOLIBERALISM IN HEALTH CARE**

Carles Muntaner, René M. Guerra Salazar,  
Joan Benach, and Francisco Armada

Throughout the 1990s, all Latin American countries but Cuba implemented health care sector reforms based on a neoliberal paradigm that redefined health care less as a social right and more as a market commodity. These reforms were couched in the broader structural adjustment of Latin American welfare states as prescribed by international financial institutions since the mid-1980s. However, since 2003, Venezuela has been developing an alternative to this neoliberal trend through its health care reform program, Misión Barrio Adentro (Inside the Neighborhood). In this article, the authors review the main features of the Venezuelan health care reform, analyzing, within their broader sociopolitical and economic contexts, previous neoliberal health care reforms that mainly benefited transnational capital and domestic Latin American elites. They explain the emergence of the new health care program, Misión Barrio Adentro, examining its historical, social, and political underpinnings and the central role played by popular resistance to neoliberalism. This program not only provides a compelling model of health care reform for other low- to middle-income countries but also offers policy lessons to wealthy countries.

Health care reforms in most countries since the early 1990s, and particularly in Latin America, have followed a remarkably similar pattern, shifting from a preexisting system of public delivery, financing, and ownership to a greater involvement of the private sector (1–8). In most Latin American countries, including Venezuela, health care became less a human right guaranteed by the state and more a commodity acquired in the marketplace. This shift, often presented as the solution, was mainly fueled by the pressure of the structural

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adjustment programs (SAPs) adopted by many Latin American countries following the neoliberal paradigm prescribed by international financial institutions (IFIs) concerned with repayment of foreign debt (2).

Nonetheless, there is an exception to this trend: after a decade of adherence to neoliberal reforms, in 1999 Venezuela charted an alternative health care program guaranteed by the state. Driven by local demands through a process of participatory democracy, this new, bold health care reform is playing out in the country's most marginalized and underserved neighborhoods. Moreover, Venezuela's health reform is founded on an international cooperation model that emphasizes "South to South" solidarity, rather than the more typical channels of "North to South" aid. What are the main characteristics of this new, as yet little-known health care model, some of whose beneficiaries say is "the best thing that has happened in Venezuela?"<sup>1</sup>

In this article we review the main features of the Venezuelan health care reform, analyzing, within their broader sociopolitical and economic contexts, previous neoliberal health care reforms that mainly benefited transnational capital interests and domestic Latin American elites. We explain the emergence of the new health care program, *Misión Barrio Adentro* (Inside the Neighborhood), examining its historical, social, and political underpinnings and the central role played by popular resistance to neoliberalism. Finally, we suggest that this program not only provides a compelling health care reform model for other low- to middle-income countries but also offers relevant policy lessons to wealthy countries.

#### THE SOCIOPOLITICAL AND ECONOMIC CONTEXTS OF HEALTH SECTOR NEOLIBERALIZATION IN VENEZUELA

The deep funding cuts that characterized structural adjustment policies in most Latin American countries after the early 1980s gradually created conditions that fostered neoliberal reforms and the destabilization of the welfare state (2), and erosion of social services such as health care. As a result of SAPs throughout the 1980s, state-administered health care sectors deteriorated in quality, and their inefficiency and inequity increased. The only viable option in the 1990s seemed to be a shift to greater private sector management and delivery of health care services. In 1993, the World Bank's *World Development Report: Investing in Health* marked a second step in health care's neoliberalization (9), advocating for two overarching strategies: limiting state investment in health care to low-cost services that target the poor, and encouraging diversity and competition in the financing and delivery of health services by facilitating greater private sector involvement. These strategies have meant an increase of private, for-profit health insurance plans, coupled with the decentralization of service delivery and

<sup>1</sup> Based on interviews conducted by one of the authors in February 2005 in the Caracas *barrio* of Catia, one of the first neighborhoods to implement *Misión Barrio Adentro*.

administration under ever-shrinking budgets (7,10). As governments in Latin America privatized health care financing and delivery, several multinational corporations that sell financial, banking, investment, and insurance services entered the new, lucrative markets, often by partnering with Latin American companies owned and operated by wealthy Latin Americans. In Mexico and Brazil, for example, neoliberal health care reforms reduced access to health care services for poor and working-class people, burdened the public health care sector with higher-risk patients, and further compromised the quality of public services, while private insurance companies reported significant profits (3, 7, 11). Although neoliberal health care reforms failed to be fully implemented in most Latin American countries (8), and despite the increasing evidence of the ill effects of these neoliberal reforms on health and well-being (12–15), all countries but Cuba have undergone, to some degree, these health sector changes.

Compared with most of its neighbors, Venezuela jumped on the neoliberal bandwagon relatively late. The slower pace of reform may be attributed in part to Venezuela's large petroleum and natural gas reserves (16), which helped to expand welfare state policies throughout the 1950s and 1960s, even if the benefits were not equitably reaped (17). Nonetheless, fluctuating oil prices and massive spending to pay for imports and national capital projects raised the national debt and decreased oil revenues in the 1980s, contributing to a socioeconomic crisis—in 1989, close to 54 percent of Venezuelans lived in extreme or critical poverty. Seduced by the increasingly dominant neoliberal ideology, the elected president, Carlos Andrés Pérez, sought to address rising poverty in Venezuela by committing to a radical SAP named *El paquete*, which was supported by the World Bank and International Monetary Fund (18). The Venezuelan government reforms, with deep public spending cuts, privatization, trade liberalization, and restructuring of social programs to target the poor (18, 19), faced widespread public opposition and mobilization that helped spark two failed coup attempts and the impeachment of President Pérez in 1993 (20).

The erosion of welfare institutions throughout the 1990s fueled increasing calls for health care reform, and the new Venezuelan government procured two major health reform loans from the World Bank and the Inter-American Development Bank (21, 22). Both loans contained provisions to facilitate or support the restructuring of health sector financing, with an increased role for private financing and continuing support for the decentralization of social services. Decentralization, coupled with the fiscal austerity measures of the early 1990s, left the newly responsible regional and local levels of government with few options but to carry out an uncoordinated, *de facto* privatization of many health care services high in demand but short on supply (23). By 1997, 73 percent of health expenditures in Venezuela were private (23). The introduction of user fees in the public system made the deteriorating health services even less accessible.

In the late 1990s, a dramatic drop in oil prices led the Venezuelan government to once again seek loans from the IFIs. By 1999, poor Venezuelans comprised nearly

three-quarters of the population, with a very limited access to health care services through a precarious public system. The election in December 1998 of President Hugo Chávez, who campaigned staunchly against further IFI-prescribed neoliberal reforms, set the country in a new direction. Chávez's overwhelming and surprising victory was the political outcome of nearly two decades of popular mobilization against a corrupt Venezuelan regime and its increasingly neoliberal agenda (24). Once elected, and after extensive consultation throughout the country and with all sectors of Venezuelan society, Chávez called in December 1999 for a referendum on a new "Bolivarian" constitution, drafted by a special constituent assembly (25).

#### THE BEGINNING OF THE BOLIVARIAN HEALTH ALTERNATIVE

Three main articles in the new constitution had important implications for health care reform (26). First, health is viewed as a fundamental human right that the state is obligated to guarantee (Article 83); second, the state has the duty to create and manage a universal, integrated public health system providing free services and prioritizing disease prevention and health promotion (Article 84); and third, this public health care system must be publicly financed through taxes, social security, and oil revenues, with the state regulating both the public and private elements of the system and developing a human resource policy to train professionals for the new system (Article 85).

Among the alternative redistributive mechanisms to strengthen the Venezuelan welfare state created by the new Bolivarian government are the *misiones*, social programs created as parallel structures either completely outside the scope of government ministries or in collaboration with them, as a means to increase community participation and more efficiently meet the new constitutional imperatives. Misión Barrio Adentro aims to satisfy the constitutional requirements of health as a social right through a public health care system that spans all levels of care. It is a popular program based on the principles of equity, universality, accessibility, solidarity, multisectoral management, cultural sensitivity, participation, and social justice (27).

Barrio Adentro began in December 1999 after Venezuela suffered torrential rains that caused extensive flooding in the state of Vargas, affecting mainly *barrio* dwellers, the marginalized poor living in the hilly periphery of major urban centers. As part of its international solidarity programs, the Cuban government responded to the tragedy by providing a team of 454 Cuban health care workers who offered medical care inside the marginalized *barrios*. Based on this experience, the mayor of the Municipality of Libertador, which has the largest number of poor people in the Metropolitan Area of Caracas, requested the help of Venezuelan physicians in attending to the acute needs of the underserved populace. However, the majority of Venezuelan physicians refused, citing security concerns and a lack of infrastructure as their primary reasons. Behind these

explicit objections lay an organized opposition by the Venezuelan medical establishment to the health care reform efforts of the new Bolivarian government (28). In April 2003, after an agreement for a pilot project with the Cuban government, 58 Cuban physicians specializing in integrated family medicine were sent to various *barrios* in Caracas's periphery within the marginalized neighborhoods. A few months later, after witnessing the success of the pilot program, President Chávez officially dubbed the program "Misión Barrio Adentro" and supported its extension to the remaining states and their municipalities through the coordinated efforts of the Ministry of Health and Social Development and a cooperation agreement with Cuba. In December 2003, a multisectoral Misión Barrio Adentro Presidential Commission was created and charged with the implementation and coordination of a national Primary Health Care Program. Between April and December 2003, more than 10,000 Cuban physicians, dentists, and ophthalmologists began providing primary health care and dispensing free Cuban-supplied medications for poor Venezuelans in hundreds of *barrios*.

#### ORGANIZATION, ACTIVITIES, AND EARLY ACHIEVEMENTS OF BARRIO ADENTRO

Today, more than 20,000 Cuban health personnel and a growing number of Venezuelan health professionals make up the human resources in Barrio Adentro (29). Given the continued (though decreasing) reluctance of Venezuela's medical establishment to participate in the program, the government launched a massive training effort to replace, over time, the thousands of Cuban health workers with Venezuelans. According to the Ministry of Health and Social Development Barrio Adentro planning framework, its goal at the primary care level is to provide round-the-clock access through the construction inside historically marginalized communities of one community health center for every 250 families (27). By April 2006, of the more than 8,000 planned community health centers, more than 2,000 had already been built (29). Additionally, many health centers that are part of the preexisting primary health care infrastructure have been incorporated into Barrio Adentro. Each community health center has a multidisciplinary health team consisting of at least one physician specialized in integrated family medicine, a community health worker, and a health promoter. Moreover, each center is stocked with centrally purchased medications to be distributed at no cost to patients, as required. The health team personnel live in the *barrios* themselves. Participating Cuban physicians receive support from the *comités de salud* and the community. In addition to conducting consultations in the health centers, the health teams are responsible for carrying out daily neighborhood rounds to survey residents and making home visits to those too ill to go to the community health centers (27).

This integrated model of care emphasizes a holistic approach to health and illness through the coordination of Barrio Adentro with other *misiones* addressing education, food security, public sanitation, and employment, among other key social determinants of health. For example, people lacking potable water who suffer from recurring intestinal infections are not only prescribed the appropriate antibiotics but also encouraged to organize to demand adequate access to clean water. Health teams and patients are supported by Health Committees comprised of *barrio* residents, which are the organizational mechanisms through which *barrio* residents exercise their participation in primary health care delivery and management. In addition to the 8,000 planned primary health care clinics, Barrio Adentro plans to construct 1,200 diagnostic and rehabilitation centers (secondary care) and to upgrade the existing tertiary care infrastructure of 300 hospitals (29).

In terms of expanding access to health care, the results achieved by Misión Barrio Adentro have been impressive and may well produce a significant improvement in population health status. The next few years will be critical to evaluate the program and to assess its generalizability to other countries.

Despite the overwhelming popularity and success of Barrio Adentro and other *misiones*, these and other proposed reforms have elicited strong opposition from the upper middle class and elite sectors of Venezuelan society. This opposition resulted in a military coup attempt and a debilitating general lockout in 2003 and a presidential recall referendum in 2004, all aiming to remove the democratically elected President Chávez from office (30). However, with a mass mobilization by poor and working-class Venezuelans (who make up the vast majority in the country) in support of their president, all three measures failed (30). At the time of this report, President Chávez has a 75 percent approval rating (31), and the Bolivarian process and its counter-neoliberal health reforms continue to develop.

#### SOME LESSONS TO BE LEARNED

For the past 25 years, the neoliberal ideology that underpins IFI-sponsored health reform initiatives throughout Latin America has become the new conventional wisdom in policymaking (7). Its influence is surprisingly pervasive, given mounting evidence of its detrimental effects on health and equity throughout the region. Notwithstanding this evidence, numerous countries continue to adhere to neoliberal reform policies. Yet, the Venezuelan experience suggests that the neoliberal way is not inexorable. The Venezuelan example supports the thesis that a country's well-being is determined by policy choices that are more closely related to that country's political and ideological power relations (32)—which themselves are the synthesis of historical popular struggle—than to its income level.

The Venezuelan government, strongly aided by popular participation as explicitly established in its new constitution, has over a short period of time managed to allocate economic and social resources to geographic areas where they can improve the health and well-being of the population. The process is both

planned and implemented by government officials and defended and supported by mass organizations such as Health Committees throughout the country. In addition, as the role of Cuba demonstrates, health care reform in Venezuela has been facilitated not by the “policy-based lending” of IFIs but rather by a novel form of international cooperation based on a bottom-up process of democratic local needs assessments and “South to South” mutual aid. Indeed, the unique international cooperation so fundamental to Barrio Adentro suggests a remarkable challenge to the principles of conventional international health “aid.” Just as remarkable as the seeming pervasiveness of the neoliberal paradigm for health reform is Venezuela’s ability to break with this paradigm that in recent history has dominated the region, though with increasing resistance.

The lessons to be learned from the Venezuelan experience are not exclusive, however, to low- and middle-income countries. The notion, often taken for granted, that international health knowledge and expertise flow only from core to periphery needs to be challenged (33), and the Venezuelan case helps to further debunk this myth. Though many of the elements outlined in the 1984 Ottawa Charter for Health Promotion have failed to gain traction in wealthy countries, they are quite evident in Venezuela’s Misión Barrio Adentro. The mechanisms and, more importantly, the social and political contexts that promote and foster community participation in health care management and an emphasis on the social determinants of health in Barrio Adentro may serve as important insights to help increase the access and quality of health care in the marginalized communities of wealthy countries. For the moment, Venezuela has been able to build a compelling alternative to neoliberalism in community health that serves as an as yet little-known international health example for all countries.

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## REFERENCES

1. Laurell, A. C. La política de salud en el contexto de las políticas sociales. In *Salud, cambio social y política: perspectivas desde América Latina México*, ed. M. Bronfman and R. Castro. EDAMEX, Mexico City, 1999.
2. Laurell, A. C. Structural adjustment and the globalization of social policy in Latin America. *Int. Sociol.* 15(2):306–325, 2000.
3. Armada, F., Muntaner, C., and Navarro, V. Health and social security reforms in Latin America: The convergence of the World Health Organization, the World Bank, and transnational corporations. *Int. J. Health Serv.* 31(4):729–768, 2001.

4. Birn, A.-E., Zimmerman, S., and Garfield, R. To decentralize or not to decentralize, is that the question? Nicaraguan health policy under structural adjustment in the 1990s. *Int. J. Health Serv.* 30(1):111–128, 2000.
5. Schuyler, G. W. Globalization and health: Venezuela and Cuba. *Can. J. Dev. Stud.* 23(4):687–716, 2002.
6. Abel, C., and Lloyd-Sherlock, P. Health policy in Latin America: Themes, trends and challenges. In *Healthcare Reform and Poverty in Latin America*, ed. P. Lloyd-Sherlock. Institute of Latin American Studies, London, 2000.
7. Iriart, C., Merhy, E. E., and Waitzkin, H. Managed care in Latin America: The new common sense in health policy reform. *Soc. Sci. Med.* 52:1243–1253, 2001.
8. Homedes, N., and Ugalde, A. Why neoliberal health reforms have failed in Latin America. *Health Policy* 71:83–96, 2005.
9. World Bank. *World Development Report: Investing in Health*. Oxford University Press, New York, 1993.
10. Collins, C., and Green, A. Decentralization and primary health care: Some negative implications in developing countries. *Int. J. Health Serv.* 24(3):459–476, 1994.
11. Jasso-Aguilar, R., Waitzkin, H., and Landwehr, A. Multinational corporations and health care in the United States and Latin America: Strategies, actions, and effects. *J. Health Soc. Behav.* 45:136–157, 2004.
12. Kinman, E. Evaluating health service equity at a primary care clinic in Chilimarca, Bolivia. *Soc. Sci. Med.* 49:663–678, 1999.
13. Manfredi, C. Can the resurgence of malaria be partially attributed to structural adjustment programmes? *Parasitologia* 41:389–390, 1999.
14. Garfield, R. Malaria control in Nicaragua: Social and political influences on disease transmission and control activities. *Lancet* 354:414–418, 1999.
15. Jaggar, A. M. Vulnerable women and neoliberal globalization: Debt burdens undermine women's health in the global south. In *Recognition, Responsibility, and Rights: Feminist Ethics and Social Theory*, ed. R. N. Fiore et al. Rowman and Littlefield, Boulder, CO, 2003.
16. Naim, M. *Paper Tigers and Minotaurs: The Politics of Venezuela's Economic Reforms*. Carnegie Endowment for International Peace, Washington, DC, 1993.
17. Hellinger, D. Democracy over a barrel: History through the prism of oil. *NACLA* 27(5):35–41, 1994.
18. Buxton, J. Venezuela. In *Case Studies in Latin American Political Economy*, ed. J. Buxton and N. Phillips. Manchester University Press, New York, 1999.
19. Lander, E. The impact of neoliberal adjustment in Venezuela, 1989–1993. *Latin Am. Perspect.* 23(3):50–73, 1993.
20. Tulchin, J. S., and Bland, G. (eds.). *Venezuela in the Wake of Radical Reform*. Lynne Rienner, Boulder, CO, 1993.
21. World Bank. *Staff Appraisal Report: Venezuela Health Services Reform Project*. Washington, DC, 2005.
22. Inter-American Development Bank. *Program to Strengthen and Modernize the Health Sector*. Washington, DC, 2006.
23. Díaz Polanco, J. El papel del financiamiento en los procesos de reforma del sector salud: el caso de Venezuela. In *La reforma de salud de Venezuela: aspectos políticos e institucionales de la descentralización de la salud en Venezuela Caracas*, ed. J. Díaz Polanco. Fundación Polar, Caracas, 2001.

24. Lander, E. Venezuelan social conflict in a global context. *Latin Am. Perspect.* 32(2):20–38, 2005.
25. Ministerio de la Secretaría de la Presidencia. *Constitución de la República Bolivariana de Venezuela*. Caracas, 2000.
26. Feo, O., and Siqueira, C. E. An alternative to the neoliberal model in health: The case of Venezuela. *Int. J. Health Serv.* 34(2):365–375, 2004.
27. Ministerio de Salud y Desarrollo Social. *Barrio Adentro: expresión de atención primaria de salud: un proceso de construcción permanente*. Caracas, 2005.
28. Jardim, C. Prevention and solidarity: Democratizing health in Venezuela. *Monthly Rev.* 56(8):35–39, 2005.
29. Ministerio de Salud y Desarrollo Social. Barrio Adentro. 2006. [www.msds.gov.ve/msds/modules.php?name=Content&pa=showpage&pid=239](http://www.msds.gov.ve/msds/modules.php?name=Content&pa=showpage&pid=239) (February 15, 2006).
30. Gott, R. *Hugo Chávez and the Bolivarian Revolution*. Verso, New York, 2005.
31. Millard, P. Venezuela Chavez's approval rating at 70.5%. 2005. [www.globalexchange.org/countries/americas/venezuela/3036.html](http://www.globalexchange.org/countries/americas/venezuela/3036.html) (February 15, 2006).
32. Navarro, V. *Globalización Económica, Poder Político, y Estado del Bienestar*. Ariel, Madrid, 2000.
33. Birn, A.-E. Uruguay on the world stage: How child health became an international priority. *Am. J. Public Health* 95(9):1506, 2005.

Direct reprint requests to:

Dr. Carles Muntaner  
CAMH, Social Equity and Health Section  
250 College Street  
Toronto, Ontario M5T 1R8  
Canada

e-mail: [carles\\_muntaner@camh.net](mailto:carles_muntaner@camh.net)