VENEZUELA'S MEDICAL REVOLUTION: CAN THE CUBAN MEDICAL MODEL BE APPLIED IN OTHER COUNTRIES?

by

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DEDICATION

I would like to dedicate this research project to an old friend and mentor Therese Kaufmann. Though in her later years and facing many health challenges, her support as a friend, neighbour, tennis partner and caretaker has to be acknowledged as a pivotal person in my life growing up. Her generosity, friendship, compassion, patience and belief in me was truly extraordinary.

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ABSTRACT

This thesis analyzes the Cuban medical adaptation in Venezuela called *Misión Barrio Adentro* (*MBA*) and seeks to answer the question of whether *MBA* shows promise as a health system that improves medical accessibility for impoverished and marginalized populations. In many cases *MBA* succeeds by: utilizing a free universal health care system; locating health centres in previously underserved areas; providing medical education scholarships to populations from non-traditional backgrounds; creating a catchment system based on medical accessibility; scaling up the medical workforce to 60,000 community doctors by 2019; and broadening the very praxis of what health means in a Latin American social medicine approach. However, some challenges remain including issues of corruption, fragmentation, and polarization. Issues regarding internal and external migration of *Misión Sucre*-trained physicians remain to be comprehensively evaluated. However, the capacitation of non-traditional medical personnel, imbued with *conciencia*, is significant and could well become an important example for other countries.

LIST OF ABBREVIATIONS USED

AIDS	Acquired Immunodeficiency Syndrome
CDI	*Centro de Diagnóstico Integral* / Integrated Diagnostic Centre
CMDAT	*Centros Médicos Diagnósticos de Alta Tecnología* / High Technology Diagnostic Centre
COPC	Community-Oriented Primary Care
CP	*Consultorios Médicos Populares* / House Clinics
ELAM	*Escuela Latinoamericana de Medicina* / Latin American School of Medicine
GNI	Gross National Income
GNP	Gross National Product
HDR	Human Development Report
HFA	Health for All
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
LASM	Latin American social medicine
LDCs	Least Developed Countries
MBA	*Misión Barrio Adentro*
MDC	More Developed Country
MIC	*Medicina Integral Comunitaria*
NGO	Non-Governmental Organization
OPEC	Organization of the Petroleum Exporting Countries
PAHO	Pan American Health Organization
PDVSA	*Petróleos de Venezuela, S.A.*
PHC	Primary Health Care
R&D	Research and Development
SAP	Structural Adjustment Programme
STI	Sexually Transmitted Infection
TB	Tuberculosis
TED	Technology, Entertainment, Design
TPI	Transnational Pharmaceutical Industry
UN	United Nations
UNDP	United Nations Development Program
USA	United States of America
WB	World Bank
WHO	World Health Organization
WWII	World War Two

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CHAPTER 1 INTRODUCTION

"The efforts of Cuba and Venezuela, and the ALBA nations to meet the social needs, provide health care, and educate their populations are progressing, not without mistakes and miscalculations, but for the most part with results consistent with the socialist egalitarianism and humanistic solidarity they espouse. The United States has taken note of the contending philosophy developing in the south, but it is not interested in engaging in a 'battle of ideas' or intellectual debate with those whose concepts and values challenge the basic tenets of global capitalism. Instead, it employs a strategy that could be best described as a war on ideas, an intensive assault of disinformation meant to make sure that most people, not just in the United States but around the world, are never aware that there is an alternative to capitalistic values developing in the Western Hemisphere."

- Dr. Steve Brouwer, *Revolutionary Doctors*, 2011, p. 201-202

"*The identification of redressable injustice is not only what animates us to think about justice and injustice, it's also central … to the theory of justice*" (p. VII) … "*The impossibility of remaining silent on a subject is an observation that can be made about many cases of injustice that move us to rage in a way that is hard for our language to capture. And yet any analysis of injustice would also demand clear articulation and reasoned scrutiny*"

Amartya Sen, *The Idea of Justice*, 2009 p. 1

"Since all inquiries are cultural, I do not presume that this one does not"

- Dr. Paul Farmer, *Pathologies of Power*, 2005, p. 28

My interest in this topic is a mix of personal experience and previous research interests. I come from a family of rural medical personnel. My father is a family doctor and my mother a nurse. Growing up in this environment helped me develop an interest in rural health disparity. Over time my interest also shifted to medical accessibility for marginalized and impoverished communities as well, since some of my previous work experiences allowed me to see aspects of the health care system for first nations living on reserves here in Canada. The health care problematic facing these communities is one of the main motivators for my interest in this subject.

In addition to this, much of my past research has been on the Cuban medical model and Cuban medical internationalism. Throughout my research on the Cuban medical system, some have criticized the applicability of the research suggesting that the Cuban Paradox—where a 'developing country' with low-resources, limited technology, a flat-lined GDP and a 50-plus year economic embargo, can some how achieve health indicators that rival (and in some cases exceed) health indicators from developed

countries such as Canada and the USA—is *sui generis*. In other words, the example of Cuban health care is simply too unique to be replicated. Throughout my research on the Cuban system I was looking for the core aspects of health care delivery from the Cuban model that could be adapted to other health systems to possibly help solve myriad issues of rural, poor and marginalized health disparity.

My interest in health contradictions and challenges in Canada and the US, as well as the successes in the Cuban system, have made me think that some of the core aspects of the Cuban system could definitely provide some insight into possible creative solutions for health care—particularly in the developing world. I also feel that dismissing various aspects of Cuban social programmes as being only applicable in Cuba may actually overlook possible creative adaptations. This notion of being unique, at times, seems instead to narrow the scope of the impact that many of these interesting social programs might be able to accomplish elsewhere. Many scholars, such as David McNally in his 2002 book *Another World is Possible*, have attempted to write about similar alternative options to the global order. As Gary Olson writes:

> Cuban internationalism has taken empathy out of the abstract realm, brought it down to earth, and provided evidence that "Another World Is Possible." Perhaps that explains the embargo on information in what amounts to a "virtual taboo in academic and policy circles that has systematically failed to take into full account the country's remarkable achievements in the provision of health and education, despite its widespread recognition by communities in receipt of those services around the world." This glaring omission has all the characteristics of Noam Chomsky's classic formulation about "the threat of a good example." (Olson, 2013, p. 96)

Though these unique alternatives may be difficult to uncover, they in fact do exist and their potential should not be overlooked. I would make no argument for blueprinting an entire system (political, health care or otherwise) onto any country. However when broken down into its various components and foci, many possible lessons could be drawn from these important social experiments.

As a result my research has turned towards Venezuela in order to challenge the notion of whether the Cuban health care model, and the core lessons to be drawn from it, are truly of use only in Cuba; or if there are possible alternatives to traditional models of health care and current health trends that can be used to address the problematic of rural, poor and marginalized health disparity. Since Venezuela is the largest of the over sixty nations working with Cuba on improving their health systems, and having the most comprehensive adaptation of the Cuban medical system to date through its decade-long bilateral agreement that utilizes over 30,000 Cuban medical personnel, I thought that Venezuela would be a particularly good place to start this discussion. It was also a particularly pertinent starting point since a major part of the research question is whether this Cuban revolutionary medicine can actually take root in a country that was not shaped by an extensive violent revolution such as was the case in Cuba.

My central research question that guides this particular project is: does the Cuban medical adaptation in Venezuela show promise as an example of a health system that improves medical accessibility for rural, poor and marginalized populations? Or is the Cuban medical system truly *sui generis* and thus unable to be adapted elsewhere, particularly in developing countries?

1.1 "Are you Chavista or Opposition?"

However, this thesis was not without its challenges, I must highlight the overriding issue of political polarization in Venezuela that became the main difficulty for this project when I became immersed in the research in Venezuela. "Are you a Chavista or opposition?" was one of the main questions I, and the people I worked with, encountered on a daily basis. This might also be attributed to the current exceptionally complex political environment in Venezuela where two national elections, a state election, and death of their 14-year national leader Hugo Chávez all occurred in the previous 8 months.

Thus both political machines—the Chavistas and the opposition—were in high gear when I undertook my research, and the divide seemed particularly stronger then my research and contacts had previously noted. The media, and even many academics, were also dividing themselves according to this same dichotomy. The space for a balanced

academic middle ground seemed to be as hard to find as anyone in Venezuela calling themselves 'moderates'. This could also be the product of the emergence of a quasi 2-party system, where approximately 16 parties have united behind the Chavista, president Nicolás Maduro (who became the head of the United Socialist Party during his 2013 presidential election campaign and was nominated as the successor by Chávez himself upon Chávez's death), while the rest have united under Henrique Capriles Radonski (head of the opposition and leader of Justice First party).

Essentially throughout my research in Venezuela, the collection of information through conversations and interviews regarding the health system was not a straightforward process. Opposition opinions differed greatly from those of people identifying themselves as Chavistas. Venezuela, at some points, seemed to be two different countries limited by a clearly defined geographic border. It seemed that Venezuela was composed of two radically different countries. For instance, often the opposition people tended to have a higher socio-economic status, desired capitalism, went to private schools, utilized private health care clinics and hospitals, disliked Cuban involvement (including the use of Cuban doctors) in the country, and generally distrusted the Maduro government. On the other hand the Chavistas tended to be from lower socio-economic levels, desired socialism, utilized public education and health care centres, embraced Cuban involvement and medical personnel, and believed Maduro to be a good leader. I must emphasize that the division concerning Cuban medical cooperation was especially relevant to my study, with the opposition sometimes referring to them as "an army in white coats," "severely unqualified," or "turning Venezuela into another Cuba" etc. The Chavistas themselves often saw the Cubans as their own and embraced them as family, as well as protecting them against protesters and saboteurs.

This polarization often had an undesired effect, decreasing the clarity of my research at times, especially with certain respondents. Depictions of the health care system and education programme often differed wildly between opposition and Chavistas. It thus made it difficult to find the truth in some circumstances.

1.2 Outline

The course of this thesis will first start with the theoretical framework by touching on four key theories that guide the research question. It will utilize a *Structural Violence* approach to highlight the main problematic that this health system seeks to overcome through its targeting of the poorest and marginalized segments of the population. Next it will utilize Vincent Tucker's *Critical Holism* system to note the conceptual issue of health care being reduced to "health = doctors + drugs" in large part by transnational pharmaceutical industries (TPIs). This reduction is especially dangerous in its inability to address the aforementioned issue of *Structural Violence*. Then it will highlight the roots of the Cuban health care principles found in *Latin American social medicine* (LASM) in order to understand how Cuba has developed this broader conception of health that is different from the dangers highlighted by Tucker in his seminal work on *Critical Holism*.

Diane Stone's *Transnationalization of Policy Learning* will be utilized to give value to understanding the challenges of adopting the Cuban health care system. As she notes, the challenges of fully adapting policies from different countries and cultures is not just a question of employing the hard policy tools, but also the *soft policy tools* of values and culture as well. This analysis of *soft policy tools* will be especially important when underlining that in order to truly succeed in a Cuban medical adaptation, a country must also add the culture of duty to serve the indigent by targeting poorer segments of the population that are most vulnerable to illness, especially communicable diseases. The *soft policy tools* must also highlight how the notion of *conciencia* (consciousness / a sense of duty, commitment, compassion as well as a true comprehensive awareness of their patients being) is integrated into the medical education programme. Lastly, the *Transnationalization of Policy Learning* framework will also help understand why the next generation of Venezuelan medical personnel must have the ability to truly empathize with the patient and view them as a family and community member in their entire bio-psycho-social sphere of health where mind-body connections of well-being are also integrated into social and economic conceptions of health.

All of these theories will help inform and truly express what Venezuela's adaptation (the *Transnationalization of Policy Learning*) of Cuba's *Latin American social medicine* programme seeks to overcome by challenging current trends of medicine (as

seen in Tucker's *Critical Holism* critique) in order to address health disparity for the most vulnerable and traditionally underserved populations suffering from *Structural Violence*.

The literature review will then follow in order to highlight the key debates and broader discussions that situate the core of the research process. There are several key areas to be discussed: economic growth and health—is health without economic growth possible?; medical accessibility and the pathologies of poverty, especially with reference to rural and impoverished areas; the debate over private and public health care systems; an analysis of preventive and curative primary healthcare approaches; and lastly, medical education—backgrounds, cultures, and implications.

Chapter 3 will then follow with a brief analysis of health care delivery in pre-Chávez Venezuela in order to establish a quantitative base of indicators, as well as to situate the health system for the rural and marginalized populations. This chapter will then expand, analyzing Chávez's vision for health care as well as the creation of *Barrio Adentro* through the bilateral agreement between Cuba and Venezuela. Lastly the role of *Misión Sucre*, Venezuela's education mission, could not be overlooked since it may be one of the key points of analysis to understanding the real challenges of adapting aspects of a health care system and its *soft policy tools*.

Chapter 4 will highlight the core of the research findings. A brief overview of Cuba's medical involvement in Venezuela will be followed by an in-depth analysis of the complexities, successes, and challenges of Venezuela's now parallel health care system. In this discussion it is essential to highlight the complexities of Venezuela's healthcare system, since Venezuelans live in a semi-parallel health system with the traditional medical model at times awkwardly integrating with the Cuban-based *Barrio Adentro* health system. The fragmentation of the preventive-based *Barrio Adentro* programme with the curative-based traditional medical system is the core of this complexity. The demarcation lines where *Barrio Adentro* <u>ends</u> and the traditional system <u>starts</u> and vice versa are at times unclear and undefined in certain areas.

The main beneficiaries of the new health care model are undoubtedly the impoverished population of Venezuela. The accessibility of the medical education programme to persons of a non-traditional medical background is definitely unique and worthy of note. The decentralization as well as the conception and practice of the health

care at the primary health care levels are also an important factor. One of the most interesting aspects however, is the broad view of health care, similar to the Alma Ata Declaration, which attempts to accomplish a ‘health in all policies’ approach as noted by the World Health Organization.

Also important to highlight in this chapter are the challenges for the health system. Polarization, fragmentation, and corruption, as well as the ties to one side of the political spectrum may hinder *Misión Barrio Adentro* and *Misión Sucre* from broader acceptance by all segments of the population as an effective addition to the national health system. Most of these challenges will also require further study in order to see if these particular challenges get addressed. Finally, this thesis will end with the conclusion to reiterate the research findings, omissions, challenges, as well as the importance of examining this particular topic.

CHAPTER 2 THEORETICAL FRAMEWORK AND LITERATURE REVIEW

"There is nothing wrong with underlining personal agency, but there is something unfair about using personal responsibility as a basis for assigning blame while simultaneously denying those who are being blamed the opportunity to exert agency in their lives."
- Paul Farmer, *Infections and Inequalities: The Modern Plagues*, 2001

"We know that social structures kill and maim as surely as the bullet and the knife."
- Høivik, *The Demography of Structural Violence*, 1977, p. 59

2.1 Theoretical Framework

The main research question will analyze whether Cuba's support of Venezuela's preventive primary care medical model—embodied in *Barrio Adentro*—could be a successful low-cost, preventive and low-technology alternative to a West-centric high-tech model of curative healthcare for developing nations. In order to fully understand what this thesis proposes, a historical-comparative framework, which combines quantitative with qualitative methods (Neuman, 2000), has been utilized. The overarching theories that this research will make use of are Johan Galtung's (1969) analysis of structural violence, Vincent Tucker's (1996a) use of critical holism, an assessment of Latin American social medicine (LASM), and finally Diane Stone's (2004) ideas on the transnationalization of policy learning. Much of this theoretical framework will help situate the challenge of implementing an alternative medical model targeted at addressing health issues for impoverished segments of the population.

2.1.1 Structural Violence

'Structural violence' is a term most often attributed to Johan Galtung in his 1969 article "Violence, Peace and Peace Research". Structural violence reveals how certain social institutions or structures may cause a form of violence when they become harmful by preventing people from attaining their basic needs. One of the key points of structural violence is that it often does not accompany a physical image as an explicit act of violence, but rather constitutes a basic impediment to fundamental human needs. Thus it

is most often not seen as an explicit act of physical violence at all.[1] James Gilligan also adds to this definition of structural violence in his 1997 book, *Violence: Reflections on a National Epidemic*. He states that structural violence results in "increased rates of death and disability suffered by those who occupy the bottom rungs of society, as contrasted with the relatively lower death rates experienced by those who are above them" (p. 192) and he often typifies these as 'non-natural' or 'excess deaths'.[2]

Essential to this thesis is the understanding that structural violence is also used to illustrate a lack of access to efficient and effective health care since this also causes 'excess deaths'. Thus, there is a need for health care systems, and the medical personnel in them, to comprehend the larger-scale societal issues such as inequality, racism and classism in order to understand where the greatest need for care should be directed.[3] Farmer et al. aptly argue that the most dangerous flaw in traditional medical models is the commodification of medical services which places access to health care out of the reach of those who can't afford it (Farmer et al., 2006).

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[1] Structural violence is often closely linked to a lack of social justice. The idea of social justice was first utilized in 1840 by a Jesuit priest named Luigi Taparelli. It is essentially the attempt by a society to pursue justice among different social classes. Solidarity and equity are often considered the core values associated with social justice (Hörmansdörfer, 2009). Galtung also makes reference to social justice as well: "[i]n order not to overwork the word violence we shall sometimes refer to the condition of structural violence as social injustice" (1969, p. 171).

[2] Some examples of structural violence include institutionalized ageism, adultism, classism, ethnocentrism, elitism, heterosexism, nationalism and sexism.

[3] Gary Olson highlights 'two physician outliers' that comprehend larger-scale societal issues of structural violence. One is the Argentine-turned-Cuban revolutionary Ché Guevara and the other is the physician-anthropologist Paul Farmer (whose research provides an important perspective throughout this thesis). Olson highlights how empathy has inspired their contribution to medical debate and social medicine: "Guevara… turned away from being a doctor because medicine is limited to treating the symptoms of poverty. For him, revolution becomes the expression of empathy, the only effective way to address suffering's root causes. This requires melding the cognitive component of empathy with engagement, with resistance against asymmetrical power, always an inherently political act. Otherwise, empathy has no meaning…. Paul Farmer, the contemporary medical anthropologist, infectious-disease specialist, and international public health activist, has adopted different tactics, but his diagnosis of the 'pathologies of power' is remarkably similar to Guevara's. He also writes approvingly of Cuba's health programs, comparing them with his long work experience in Haiti. Both individuals were motivated early on by the belief that artificial epidemics have their origin in unjust socioeconomic structures, hence the need for social medicine, a 'politics as medicine on a grand scale.' Both exemplify exceptional social outliers of engaged empathy and the interplay of affective, cognitive, and moral components" (Olson, 2013, p. 103).

In Farmer et al's 2006 paper, *Structural Violence and Clinical Medicine*, they highlight how structural violence reveals how medical personnel are often underprepared to comprehend the larger social issues that perpetuate disease and pathologies of poverty—thus making them unable to alter or effectively deal with these broader issues. The Pan American Health Organization (PAHO), which is a branch of the World Health Organization (WHO), noted that "researchers have published myriad studies, based on sophisticated epidemiological and [sic] statistical methods, that confirm the fatal link between poverty, on the one hand, and more frequent illness and shorter lives, on the other. It is only logical that the abolition of poverty will lead to improved health and prolonged life" (PAHO, 2006, p. 79).

No other disease provides a better glimpse into the connection between the poverty and illness then Tuberculosis (TB). TB is one of the most effective indicators of structural violence's influence on health. It is, in essence, <u>the</u> health indicator of poverty and inequality. This is because the issues of structural violence—in this case the lack of well-ventilated housing, a balanced diet including fresh vegetables, and availability of a long and expensive cycle of drugs—increases the spread of TB. Thus it is a useful indicator as pathology of poverty since many of the poor and marginalized populations lack access to adequate housing, a balanced diet, as well as efficient and effective health services.

In his 2005 book *Pathologies of Power*, Paul Farmer notes that recently in Russia, and about 20 years ago in New York as well, economic policies and social inequalities (including racism) combined to create epidemics of dangerous drug-resistant strains of tuberculosis. Here he accurately depicts how these situations that produce these drug-resistant strains of tuberculosis constitutes "a human rights violation, a fact ignored by many in the human rights community" (p. 22). A similar relationship between poverty and other pathologies are also relevant including the spread of malaria, AIDS, and deaths from dysentery since all three of these pathologies are effectively stymied by an effective health care system.

The spread of treatable pathologies is especially troubling since medical personnel often end up overlooking social determinants of health which negatively impact access to efficient and effective health care. This issue is often particularly exacerbated in low-

income countries. In a medical policy framework, structural violence is essentially the result of ineffective and oversimplified social and policy structures, which means that the true positive change needed to address the roots of structural violence can only be produced by changing the processes in which structural violence is deeply embedded (Farmer et al., 2006). Thus one of the issues facing traditional health care models is the simplistic construction of the meaning of health care, especially clinical-based curative-focused systems. This places the locus of health mostly on the individual, while at the same time ignoring the larger structures and policies that create ill health, a critique upon which Vincent Tucker expands, as noted below.

2.1.2 Vincent Tucker's Critical Holism

Tucker's critical analysis of the western hegemonic medical ideology will provide the historical-comparative background to help understand certain conceptual issues when discussing public health—especially as this thesis seeks to expand upon a more holistic approach to health care. Tucker emphasizes that medical development is just as relevant and important a point of contestation and theoretical debate as economic and political development (1996a, 1996b, 1997). He provides a nuanced view of medicine that goes beyond the globalized reductionist and pervasive mentality that "health = doctors + drugs" (1996a, p. 17). This helps to show that the evolution of medical development is instead a much broader piece of the development problematic that is linked to myriad other development issues. Thus, medicine is not just the practice of doctors with medical degrees solving a singular health issue for one patient, but rather an ideological battleground where numerous health issues as well as issues of structural violence may actually be tackled by different levels of education, utilizing different access to resources, with different methods, occupying different scales of organization (from Community-Oriented Primary Care (COPC) to state-led universal medical programs), and ultimately different conceptions of what healthcare should be.

Tucker has also noted that the social construction of 'medicine as a business' is unfortunately replacing values to serve those in need, for whom health care is a basic right. In this sense, Western medicine has unfortunately sometimes become a larger negative factor in the conceptual construction of development than has been generally acknowledged. Chirac et al. (2000) argue that the discrepancy between the prevalence of

AIDS treatment and outcome between populations in developed and developing countries highlight a deeper and more complex problematic that goes beyond the capacity of the medical system.

They note that this discrepancy is a moral, social, political and economic issue as well. Thus, the "question of AIDS treatment leads to a wider reflection of the balance between public and private interests, between patent rights and rights of patients. Access to health care and to medical progress as a human right is a challenge that AIDS poses to humanity" (Chirac et al., 2000, p. 502). However, as Tucker highlights in his research, in many cases, Western medicine considers itself as being separate from the economic and political processes and has, to a large extent, managed to hide this connection. Tucker expands on why this has happened:

> Like colonialism, imperialism and modernization, modern medicine has always had monopolistic aspirations. The 'health care' industry, in the form of transnational pharmaceutical companies, has become one of the largest and most powerful industries in the world and its return on investment exceeds that of most other industries… Through a combination of coercive and persuasive strategies the [Transnational Pharmaceutical Industry] TPI has established itself as a major global actor capable of shaping development priorities, health thinking and practices, diagnostic procedures, doctor-patient relationships, household budgets, government health spending, and, in some instances, industrial health policy. Its global influence is such that in the mid-1970s Dr. Halfdan Mahler, Director General of the WHO, aptly described the situation as one of 'drug colonialism'…. The influence of the industry far exceeds its economic power. Pharmaceutical drugs have come to be perceived as the most typical representation of medicine—indeed they have become the most central part of, and have given their name to, the entire enterprise: medicine. (Tucker, 1996b, p. 111)

Tucker demonstrates how this system, based on pharmaceutical drugs, has constructed itself as a "potent symbol of modernization and development and were promoted as offering yet another technical fix for the social, economic and political problems which were 'endemic' to the 'Third World'" (Tucker, 1996b, p. 116). Therefore, the TPIs "have

shaped, in varying degrees, the belief system of virtually every society on the globe. Under their influence 'health for all' has virtually meant drugs for all" (Tucker, 1996b, p. 112). He also notes that this relationship began as early as the colonial era, when medicine was a huge part of the knowledge and technology system of development and had an immense impact on developing nations even then.[4]

This criticism is well suited to this thesis since an analysis of Cuba's Latin American social medical system and *Misión Barrio Adentro* (*MBA*) program will highlight a broader and more holistic view of medicine in what they term as the 'bio-psycho-social' spheres of health (Pérez, 2008). These 'spheres of health' directly attempt to target issues of structural violence. Thus, the critical analysis of the west-centric medical model will be compared to the holistic medical approaches that are found in Latin American social medicine (LASM).

2.1.3 Latin American Social Medicine

The focus of this thesis is the delivery of healthcare in Venezuela during the Chávez years, and its relationship to social medicine. Briggs and Mantini-Briggs have noted that "Venezuela is one of the most striking examples of Latin American social medicine (LASM)" (2009, p. 549). In order for Venezuela's medical programme to be sustainable, Cuban doctors have been training the next generation of Venezuelan medical personnel under a Cuban conception of LASM (PAHO, 2006). In actual fact LASM is an adaptation of the work of Rudolf Virchow from 19th century Europe. This conception of European social medicine eventually also found a home in Chile around the 1930s and then expanded to other countries such as Ecuador and Argentina. Within the next 40 years, LASM had spread into much of Latin America as both practitioners and scholars promoted the 'collective' instead of the 'individual' approach to health care.

[4] Other authors (see Gerth and Stolberg 2000a, 200b; Stolberg & Gerth, 2000a, 200b; Trouiller et al., 2001; Chirac, von Schoen-Angerer, Kasper, & Ford, 2000; von Schoen Angerer, Wilson, Ford, & Kasper, 2001; etc.) have also written extensively on the negative influence of TPIs in developing countries. In his 2005 book, *Pathologies of Power*, Paul Farmer outlines a more recent account of numerous debunked arguments (including how the cheap distribution of life-saving drugs would 'compromise' funding for research and development R&D) that the TPIs have used to validate their use of the patent system to suppress the widespread use of cheaper generically-produced alternatives. The 'patent rights versus patient rights' debate is most acutely expressed on note 11, pages 316-318 in Farmers book.

This approach to medicine stresses the "importance of political–economic and social determinants of health, and promotes holistic approaches to health–disease–health care processes" (Briggs and Mantini-Briggs, 2009, p. 549).[5] This is important since, instead of only documenting that:

> rates of infant mortality are higher in a particular minority group and analyzing individual risk factors, LASM and critical epidemiology scholars would document race- and class-based differences in access to health care, sanitary infrastructures, employment, and political representation and how they might produce higher levels of morbidity and mortality. These scholars promote practices and policies that treat health as a social and human right and extend universal and equal health care access, oppose the privatization of health and its transformation into a free-market commodity, and advocate strengthening the state's role in guaranteeing access to health services. (ibid.)

This is especially relevant when considering Tucker's critique of the reduced conceptualization of health care for much of the world, as well as the need to address what Galtung described previously as 'structural violence'. Essentially, when the World Health Organization calls for a need to have a "set of policies… known as 'health in all policies', which is based on the recognition that population health can be improved through policies that are mainly controlled by sectors other than health" (WHO, 2008, p. 64), they are in fact advocating for a very similar approach based on LASM principles. These ideas would then be put into practice via the administration of municipal and national public health systems (Briggs and Mantini-Briggs, 2009). Thus, *MBA* has developed into an alternative medical system for Venezuela based on LASM that views health care as a right for all. Though it is based on the Cuban medical model, this thesis will expand on some of the notable differences and adaptations in later chapters.

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[5] Briggs and Mantini-Briggs also note that there is another "related perspective that scrutinizes epidemiological categories and measures—'critical epidemiology'—stresses attention to the factors that produce health inequities rather than descriptions and analyses of observed disparities" (2009, p. 549).

2.1.4 Diane Stone's Transnationalization of Policy Learning

One of the main theoretical considerations that this thesis is based upon is Stone's (2004) 'transnationalization of policy learning'. This theory will provide the grounds from which my research will compare the effectiveness of 'hard transfer' policy tools that include structures, resource allocation, and practice—as opposed to the applicability of 'soft transfer' tools like norms and values. Here, the focus will be on the "role of international actors in policy/knowledge transfer processes to suggest… a dynamic for the transnationalization of policy results" (Stone, 2004, p. 1). These 'soft' forms of transfer are the diffusion of norms as an essential addition to the "hard transfer of policy tools, structures and practice," a process which is reflective of various aspects of the Cuban medical system (2004, p. 1). Both of these transfer types are interdependent, and both reinforce as well as sustain one another. The primary benefit of Stone's framework is that it gives a name and value to policy analysis tools that, in large part, go ignored when exploring the transfer of medical policies by giving 'values' and 'norms' just as significant a role, in certain contexts, as hard transfer agents.

Lastly, under this policy-learning framework, transnational networks—which are key modes for the disposal of practice and policy—will be highlighted in order to understand the transnational emerging nature or global governance employed by the synthesis of the Cuban and Venezuelan examples. The change in pedagogy and values of Venezuela's national medical goals will be assessed within Stone's 'hard' and 'soft' transfer policy tools that look at the changes to the Venezuelan medical model through Cuba's support of its *Barrio Adentro* program.

This is a key point of analysis with regard to *Misión Sucre*, which is the medical education system associated with *MBA*. In this case *MBA*'s decentralized medical structure is coupled with *Misión Sucre's* decentralized medical education system that also ingrains the 'hard transfer' aspects of policy tools, structures, and practice. The medical education system very actively makes sure that this 'hard transfer' is reinforced by the 'soft transfer' of norms and values that help make the utilization of hard transfer tools more effective (Stone, 2004). In this case, the patient is not seen as being a social burden to the tax system, but rather as an indicator of possibly necessary improvements to certain

elements within the entire system which again connects to the broader conception of health as found in LASM (Pérez, 2008; Brouwer, 2011).

The logic of a historical-comparative context of both Cuba and Venezuela will be coupled with the 'transnationalization of policy-learning' tools. This will endeavour to highlight what can be accomplished when a successful medical program (as is the case of the Cuban medical model and the similarities of the Cuban-supported *Barrio Adentro* medical system) attempts to be implemented alongside a West-centric embedded medical system—both with striking differences in hard and soft policy tools.

2.1.5 Summary

Is Cuba's support of Venezuela's preventive primary care medical model (*Barrio Adentro*) a successful low-cost and low-technology alternative to a West-centric model of healthcare for developing nations? This question is aided via a synthesis of the ideas expressed in Johan Galtung's structural violence, Latin American social medicine, Vincent Tucker's critical holism, and Diane Stone's transnationalization of policy-learning under a historical-comparative framework. The soft transfer of norms and values into *Misión Sucre's* medical education program, closely associated with *Barrio Adentro*, is further articulated by critical holism's understanding that medicine has to go beyond the limited view of 'doctors and drugs' in treating a singular medical issue. This holistic view is thoroughly incorporated into the *Barrio Adentro* program as patients and whole communities are situated within the more holistic 'bio-psycho-social' context that is an expression of Latin American social medicine. Having highlighted the key theories that inform this thesis, the next section will now follow with an analysis of the key debates and literature on health care.

2.2 LITERATURE REVIEW

This literature review will be used to help situate the main debates regarding medical systems in developing nations in order to understand whether the Cuban medical model, and its adaptation in Venezuela (as seen in the *Barrio Adentro* program), is able to provide effective and efficient lessons for other countries, in particular developing nations. In order to arrive at an accurate conclusion, five core questions and their corresponding debates will be analyzed.

The first question is whether health without economic growth is possible. This highlights one of the main international development debates for the past century—whether to focus on economic growth first, or to focus on services such as healthcare itself. The second question asks whether rural and marginalized populations suffer disproportionately more due to a lack of access to quality medical services than do their urban and affluent counterparts. The third question looks at what aspects of private and public healthcare systems should be adopted by developing nations in order to address medical accessibility. This question is crucial in understanding the role of the state versus the role of the market when addressing medical accessibility for rural and marginalized populations in developing countries. The fourth question will discuss primary healthcare foci, and specifically, the strengths and weaknesses regarding preventive and curative medical approaches in addressing health issues for marginalized populations. Lastly, Cuban and Venezuelan medical education will be analyzed since it is one of the key aspects that highlight the challenge in addressing 'structural violence', through a LASM approach as highlighted in the theoretical framework. This analysis will also tie together the previous issues by investigating whether reforming medical education is a prerequisite for achieving high health indicators. This last topic will help to solve some of the issues uncovered in the previous debates and will also be a main focus of Chapters 3 and 4—analyzing the Cuban medical model and its adaptation in Venezuela's *Barrio Adentro* program.

2.2.1 Economic Growth and Health Indicators—is health without wealth possible?

Since the end of the World War II (WWII), many development theorists have expounded on the need for economic growth as a main goal in order to achieve high health indicators.[6] It was after WWII that Harry Truman, then President of the United States of America, made his landmark speech regarding the 'First World's' future relationship with the 'Third World'. Truman stated in his speech that there was a need to embark upon a "bold new program... for the development... of underdeveloped areas"

[6] However, it must be highlighted that Basic Needs theorists contested this notion in the 1960s. For more on the basic needs conceptualization of health and development see Gunnar Myrdal (1963) and Dudley Seers (1969).

(Truman, 1949). It was after this speech when modernization theory, in the field of international development, became the dominant theoretical paradigm upon which to form development plans for Least Developed Countries (LDCs)—especially during the 1950s and 1960s.

The focus of early modernization theory was centred on evolutionism, diffusionism, structural functionalism and interactionism. This approach echoed one of Karl Marx's beliefs that "the country that is more developed industrially only shows, to the less developed, the image of its own future" (Marx, 1990, p. 91).[7] Here, the foundation of a linear path in the development of a country is hypothesized in international development thinking. This hypothesis eventually expanded to the point where modernization toward More Developed Country (MDC) industrialization by LDCs became the dominant goal in an effort to increase economic growth.

It was determined that economic growth was the first building block of 'development' for the global south. Under this evolution of theory into policy it was assumed that the 'trickle-down' effect of resources and wealth would happen once the country had stabilized its economy, and then had begun economic growth (as measured through an increase in GDP). Once this growth in GDP was initiated, then a country could finally begin establishing other services for its population such as medical accessibility and education. Thus, the creation of this seemingly altruistic and harmless concept where "the main purpose of economic development [was] to permit the achievement of a decent level of living for all people, everywhere," (Inkeles, 1974, p. 209) ended up cementing the connection to economic growth and subjugating the idea that health without wealth was possible (Inkeles, 1974).

Developed nations then, in turn, came to assume that the reason for their higher health indicators was due to their higher GDP as well as the ability to draw upon vast amounts of resources. Since the 1970s in particular, the state began to be seen as the cause of poverty, and rolling back the state[8] was the proposed solution. The neoliberal-based Structural Adjustment Programs (SAPs) promoted by the World Bank (WB) and

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[7] This is taken from a revised edition. The original quote is found in Karl Marx's initial 1867 German publication—*Das Kapital*.

[8] State rollback was the rallying cry of the new political economy ideology, which, in large part led to the institutionalization of the SAPs.

later the International Monetary Fund (IMF) were seen as the answer to the growing poverty of the underdeveloped world. These programs, influenced by the Chicago School's notion of free-market capitalism, were articulated in Milton Friedman's 1962 book, *Capitalism and Freedom.* In Friedman's influential list of policy changes and market expansion,[9] he proposes the removal of various government agencies in order to free the individual from the coercive and oppressive state. Privatization, trade liberalization, deregulation, and fiscal austerity were recommendations from Friedman's list that were adopted by the WB and IMF as conditions attached to developing countries loans.[10] The wholesale application of these SAPs meant that developing countries were forced into repayment schemes that demanded the rollback of state enterprises and services—including healthcare provision.

The reduction of health insurance disproportionately impacted the most vulnerable populations, especially the marginalized populations living below the poverty line including often neglected indigenous population. Rates of death and disease rose most dramatically in these groups after the implementation of SAPs. As highlighted by Brunelli (2007), reductions in healthcare expenditure can arguably be considered a form of "structural violence" (p. 11).[11] This is because such policies often isolated marginalized and rural populations from obtaining quality primary health care due to a lack of money and resources. This two-tiered system resulted in the middle–class and elite having improved private health care, while marginalized and impoverished populations were left with either inaccessible or inadequate primary care options (Sen and Koivusalo, 1998).[12]

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[9] This particular list is located in the most recent 2002 edition on pages 35-36.

[10] Only developing countries until recently were forced into this program of repayment where the risk involved in the loan was deemed not to be the responsibility of the Bank. For more contemporary examples of austerity measures being imposed on countries in the newest version of the SAPs as it is, for the first time, forced onto 'developed' countries, see Greece and Spain examples during 2011-2013.

[11] *Structural Violence* is a term most often attributed to Johan Galtung in his 1969 article *Violence, Peace and Peace Research*. *Structural Violence* is also key part of the theoretical framework which is highlighted in the previous section of this Chapter. *Structural Violence* analyzes how certain social institutions or structures may cause a form of violence since they can become harmful if they prevent people from attaining their basic needs.

[12] This will be discussed in greater detail in the next two sections.

In a specifically Latin American context, every country except Cuba was affected by a similar restructuring of their public health care systems. As Muntaner notes:

> 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, 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, 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 administration under ever-shrinking budgets. 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. Although neoliberal health care reforms failed to be fully implemented in most Latin American countries, and despite the increasing evidence of the ill effects of these neoliberal reforms on health and well-being, all countries but Cuba have undergone, to some degree, these health sector changes. (Muntaner et al., 2006, p. 804-805).

Later, in the middle of the large global financial reforms during the 1980s, the World Commission on the Environment and Development released the Brundtland Report in 1987 calling for countries to focus on increasing economic growth in order to develop other sectors of their society (such as education and health) in both MDCs and LDCs (Brundtland, 1987). This was a landmark call for reforms that re-affirmed the establishment of economic growth as the primary goal which, when achieved, would then assist meeting other objectives such as providing medical accessibility (ibid.). This mentality was also echoed by noted macroeconomist Robert Barro who, among others, believed he had provided evidence that life expectancy is positively correlated to economic growth. He used post–WWII data to form a generalized estimate in which a 10% increase in life expectancy was positively correlated to a 0.4% economic growth yearly (Barro, 1996).

Unfortunately, the 'economics first' mentality, where the market was considered the driver of economic development never produced the wide-ranging success it had promised. Instead, authors like Monk (2010) and Sen (2001) did much to reveal the lack of correlation between health and wealth. Monk discovered that there was solid empirical evidence which highlighted that the:

> pursuit of health is not necessarily linked to economic growth... health can be pursued at low levels of economic activity... [a] government's fiscal ability to finance health is not closely linked to economic growth... [and that a] government can finance health even when its total expenditure ability is restricted without worsening its financial predicament. (2010, p. 12)

Thus, it was found that a nation's high level of health indicators was achievable despite low levels of economic activity as seen in Monk's analysis of both health systems in Kerala (India) and Cuba. These health systems had successfully addressed the issues of medical accessibility for the impoverished segments of their population through efficient allocation of resources and human capital as well as their unique medical education.[13] The analysis by Monk and Sen provided a refreshing conceptual evolution in healthcare

[13] The Cuban medical model, and Venezuela's *Barrio Adentro* adaptation of it, are the focus of this thesis and will be discussed further in Chapter 3 to explain how positive health indicators are achieved despite having limited financial resources.

thinking since it has shown that the relationship between health and wealth is more dynamic.

This interesting relationship between health and wealth is also demonstrated through extensive statistical analysis done by Richard Wilkinson in his seminal 2010 book, *The Spirit Level: Why More Equal Societies Almost Always Do Better*, which he co-authored with Kate Pickett. Their work on the relationship between inequality and health is groundbreaking. In their findings, Wilkinson and Pickett show that in developed countries, when post-industrial societies have less inequality with a lower disparity of income between poor and rich, they tend to be generally healthier and happier in comparison with countries that have a larger disparity between the poor and rich in terms of wealth.

This provides an interesting link since they further revealed that symptoms of inequality also negatively impact all socio-economic levels of society. In addition to this, the anxiety created by the psycho-social stress over status and income gaps has shown to increase levels of violence and addiction, escalate mental health issues, increase teen pregnancy, and even reduce life expectancy. As noted in one Technology, Entertainment, Design (TED) talk, Wilkinson aptly summarizes this section by saying that the "average well-being of our societies is not dependent any longer on national income and economic growth. … [b]ut the differences between us and where we are in relation to each other now matter very much" (Wilkinson, 2011). Thus, if a country were to prioritize establishing medical accessibility to marginalized populations—as well as education and other social services—while at the same time ensuring that inequality does not grow unchecked, then a healthy and balanced economy may become established within this framework.

Though the success of a country has traditionally, and is still largely, measured in economic terms, increased attention is being paid to other indicators as demonstrated by Wilkinson, Pickett, Sen and others. Quantitative macro-level health indicators such as life expectancy, maternal mortality, and infant mortality have gained currency when considering *human development*. The evolution of this debate has recently come to its most cogent articulation through the United Nations Development Program's (UNDP) 2010 Human Development Report (HDR). This report finally acknowledged that the

correlation between economic growth and key health development achievements is lacking. The underlying point of this recent Human Development report is that the improvement of education and medical accessibility are desirable and effective goals for any country, regardless of income and economic growth. Essentially, the HDR report sums up this evolution of development thought by highlighting that:

> [m]uch development policy-making assumes that economic growth is indispensable to achievements in health and education. Our results suggest that this is not the case. This does not mean that countries can forget about growth—we have underlined that growth generates important possibilities. Rather, the results imply that countries do not have to solve the difficult problem of generating growth in order to tackle many problems on the health and education fronts. (UNDP, 2010, p. 50)

In taking the above argument further through the lens of critical holism, there is a need to identify with the 'whole means' of development in that "development can no longer be simply geared to material aims and achievements but must include non-material dimensions" (Pieterse, 2010, p. 164). Thus, there is a need to go beyond the traditional economic measure of development success and towards other, more varied and nuanced sets of indicators[14] that include health (measured by life expectancy, maternal mortality, and infant mortality).

The turn toward human development has helped position health indicators as a valid way to gauge the level of social development. This has also coincided with the rise of human-rights based approaches which, as noted in the Universal Declaration on Human Rights and Human Development Index, highlights that the state should take an active role in providing a universal healthcare system. This position was largely developed by Sen (1985), who believes that development "has been redefined as enlargement of people's choices and human capacitation" (Pieterse, 2010, p. 105). In this model, the state is perceived as contractually obliged to its citizens. It must provide:

[14] Reliance on a limited number of indicators to measure development is clearly problematic. This thesis does not advocate that the measure of development should be only health indicators, but merely that they are important and can add immensely to what a given population could (and should) consider 'development successes'.

"[s]afe drinking water and adequate sanitation; [s]afe food; [a]dequate nutrition and housing; [h]ealthy working and environmental conditions; [h]ealth-related education and information" and, particularly relevant to this Chapter, that all "services, goods and facilities must be available, accessible, acceptable and of good quality [which ensures that a f]unctioning public health and health-care facilities, goods and services must be available in sufficient quantity within a State" (United Nations Office of the High Commissioner for Human Rights, 2008, p. 3-4). The United Nations (UN) adoption of this framework highlights an attempt to institutionalize the turn towards human development and the acceptance of health indicators as a measure of development.

With this shift in ideology from 'wealth-first' to 'health-first' in one of the most popular development reports, the paradigm is finally beginning to move in another direction. It is an admission that helps situate what can be accomplished from an LDC's standpoint when addressing poverty, even when GDP may be stagnant and resources lacking.

2.2.2 Why are Impoverished, Rural and Marginalized Populations Often Overlooked When Providing Health Care?

The rural and urban disparity problematic has not been an entirely new issue for development thinkers to deconstruct. Around the world, rural and marginalized populations suffer from a lack of access to quality health care in both developed and developing countries. In Africa, many health systems were adopted from the colonial era, providing privileges for elites and urban centres. This often resulted in medical practitioners being concentrated within cities and often only providing quality health care to an elite who could afford their medical services, even if the country's population was largely rural (Kaseje, 2006).[15] This colonial heritage has remnants in other parts of the world as well. In addition to the colonial past, many developing nations have had to cope with the goal of the 'wealth first' approach of the late 1970s and the Structural Adjustment Programs (SAPs) of the time.

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[15] Even when there is a wealth of urban practitioners, these doctors often only offer their services to those who can pay, making impoverished segments of the population go without health care as well, despite being geographically located within the urban centre. This will be discussed later as it also corresponds with the 'private and public health' discussion.

As mentioned earlier, this pervasive mentality regarding the prioritization of economic growth was at its height when the World Bank and International Monetary Fund (IMF) attempted to spur LDC economies to cut back social programs in order to focus on opening up market access. As Creese and Kutzin (1995) highlight, these SAPs caused per capita public expenditures on healthcare to drop in a large number of LDCs. They explain that this reduced investment in health has meant that the:

> quality and quantity of public subsidized health services has fallen correspondingly. Utilization levels, particularly at rural health facilities, have declined. Outreach services no longer function, drugs are often unavailable, and health staff are unsupervised and sometimes unpaid for long periods of time. Rural populations have faced higher costs for health care in terms of transport and time to get to hospitals in larger towns, or by payments to private providers of treatment and medication. "Free" care has come to mean unacceptably poor care. (Creese and Kutzin, 1995)

Another impact of the shift to private healthcare during the era of the SAPs was that most companies focused on the extensive use of high technology, and curative healthcare instead of low-cost primary, preventive healthcare (Brunelli, 2007).[16] The focus of private healthcare was found in large hospitals and clinics, which were most often located in urban centres (Sen and Koivusalo, 1998). These private companies did not prioritize preventive community clinics which were needed to replace the government clinics that had been forced to close due to the SAPs. This had a huge effect on rural and marginalized populations.

Sen and Koivusalo (1998) note that rural populations often are unable to access public health facilities as they often have to travel long distances, frequently walking (sometimes aggravating the health issue or injury), or spending their meager resources on buses and taxis to get to medical facilities in urban centres. An additional issue for rural populations is that ill health and mortality rates increased when preventive health care measures—which often decrease the severity of injuries and preventable diseases—were

[16] The private and public provisioning of health care will be thoroughly discussed in the next section. An analysis regarding preventive and curative health care will be highlighted in the section after that.

removed (Brunelli, 2007). Unfortunately, this decline in rural health care access since the 1970s era of SAPs has continued to the present. Many developed countries have attempted to rectify this situation through aid and development assistance, yet for many underdeveloped countries this is often insufficient.

One of the nations with the best record for development assistance is the Netherlands. The Netherlands has been strongly involved in attempting to establish access to health care in LDCs since their foreign policy initiatives came to the realization that developing nations have a propensity to suffer from a "lack of funds, medicines and staff and an inadequate infrastructure [which] have resulted in abominable or virtually non-existent services, particularly in rural areas" (Netherlands Ministry of Foreign Affairs, 2009, p. 24). From an established developed country, curtailing this rural disparity has been hard, even though access to health care is given high priority in their aid funding.

In addition to these attempts, clear examples remain regarding countries that still need not just physical medical assistance, but also direction in guiding their rural health care measures. As Braveman and Tarimo show, in many countries:

> urban-rural disparities and disparities between large subnational regions of developing countries are often relatively well documented on a routine basis. In Nigeria, the average life expectancy in the Borno region is only 40 years, 18 years less than in the Bendel region; adult literacy (12%) in Borno is one-quarter of the national average. In Peru, the infant mortality rate in some rural areas was recently estimated at 150 per 1000 live births, while in the capital city Lima it was 50 per 1000. Urban–rural gaps may be widening in many nations, along with disparities between different zones within the same city. (2002, p. 1623)

Thus, the rural/urban disparity, and marginalized population access in urban centres, continue to be a major development problem (along with the health issues associated with it), and is even increasing in many countries.

As a recent report by the World Bank (titled *'Las Casas Maternas en Nicaragua'*) showed, "60% of adolescent pregnant women are from rural areas [and that t]he problem of youth pregnancy stems from the larger issues of rural versus urban access to education,

health services, and employment" (Milton, 2009). The greatest underlying needs, with regard to basic access to health and social services, remain in rural areas. Most of the:

> [e]vidence indicates that rural residents have limited access to health care and that rural areas are underserved by primary care physicians. In the developing and developed world, many rural individuals must travel substantial distances for primary medical care, requiring significantly longer travel times to reach care than their urban counterparts. Furthermore, some rural areas have a higher proportion of uninsured and individually insured residents than urban areas. (Milton, 2009)

Though rural and urban disparity may exist in both developing and developed countries, the consequences are clearly much more severe for LDCs.

Kaseje (2006) articulates how this can become a cyclical issue as well. He emphasizes that the poor are the most vulnerable populations to the risks of hazardous environments because they are often the least informed regarding threats to their health. This in turn creates a situation in which a segment of the population not only has a greater propensity to be immersed in extremely poor conditions of health, but is also involved in a vicious cycle as this unhealthy segment of the population subsequently produces even greater poverty, often accompanied by other issues such as inequality, safety, and corruption.

Therefore, if a healthcare system can efficiently and effectively provide adequate care to impoverished and marginalized segments of the population (especially in vulnerable rural and marginalized areas), those segments of the population have a better chance of being able to continue working, have an ability to retain their resources to cover other costs (such as food and housing), and help continue to provide for other family and community members.

In addition to marginalized and rural medical access issues, the debate surrounding private versus public health will add immensely to understanding the entirety of the medical dilemma in LDCs. The next section will look at which aspects of market and state-led health initiatives provide the most comprehensive access to medical care for marginalized and rural populations.

2.2.3 Which Aspects of Private and Public Health Care Systems Should be Adopted by Developing Nations in Order to Address Medical Accessibility?

There are various debates regarding public versus private healthcare systems (see, for example Stebbins, 1986; Williams, 1988; Bennet, 1991; Brunelli, 2007; Ginsburg et al, 2008; and Fitz, 2011). Almost all healthcare systems are a mixture of public and private interests with differing degrees of both found in each.[17] Of the two extremes, only the US in the developed world has no universal healthcare system or universal patient coverage. Besides this unique market-led health system, most health systems utilize a blend of market and government sources. Cuba would be considered at the opposite end of the spectrum from the US since it is one of the most comprehensive state-led health systems in the world—even if it contains certain market aspects.

In a position paper regarding universal healthcare systems, Ginsburg et al. (2008) ultimately conclude "[w]ell-functioning health systems all guarantee that all residents will have access to affordable health coverage for a defined set of benefits (that is, universal coverage)" (p. 65). Moreover, Fitz (2011) emphasizes that the removal of "profit from medical care lowers administrative costs, reduces over treatment, tempers the expansion of diagnoses, stops making people sicker by denying them preventive treatment, controls exorbitant incomes of doctors and helps focus research in needed areas." In a medical system based on the ability to pay, bad health results in a high demand medications, medical supplies, and medical advice. This means that while there is often a consistent demand for these products, access to them is often limited to only the very few that can afford to pay for them. Unfortunately Sen and Koivusalo note that, in the years following the 1978 Alma Ata declaration, health systems were still counter to:

[17] This is mentioned by Phil Deans (2000) in the Stubbs (2009) reading as a "blurring of the public-private distinction" (p. 6) as well as in Pieterse's (2010) book where "the boundaries between political and non-political, public and private spheres have become increasingly fluid" (p. 199).

> the principles of re-distribution and development, [with] the health sector in developing countries [being] increasingly influenced by private interests and by the principle of 'willingness to pay'. Health care reforms have, in effect, encouraged the growth of private providers in health care and further legitimized private services for the affluent sections of the population while limiting public provision to selective, basic services for the poor. (1998, p. 210)

This often increases inequity as the most marginalized and impoverished members of the population have to spend their meagre resources on health services and products that may not result in an adequate solution due to the lack of accountability often found in market-based health systems.

Thus, the government's role in providing universal access is a key element in the establishment of an efficient healthcare system—even though there is a broad range of healthcare hybrids. Why is it necessary to discuss the financing of health systems when analyzing the role of the state in development? It is important here to note that "[i]n developing and transition countries, 50% to 90% of healthcare spending is paid for by the patients themselves [whereas] in industrialized countries the figure is no higher than 30%, thanks partly to health insurance" (Netherlands Ministry of Foreign Affairs, 2009, p. 26).

In the most marginalized areas in developing countries there tends to be limited or poor quality health care. In these areas, non-governmental organizations (NGOs)[18] and informal market medical providers are often the only option for healthcare provision in the absence of government-run healthcare initiatives, even though history has shown that

[18] The reliance on NGOs for medical provision is one of the aspects that Pieterse (2010) believes drives the dependence of developing countries on exogenous factors. This also further strengthens certain aspects of neo-liberalism by highlighting that the "strength of NGO discourse is also a weakness: neglecting the role of the state. Thus the rise of NGOs may be viewed as de facto part of the neoliberal 'counter-revolution' in development" (p. 94). This NGO neo-liberal counter-revolution manages to establish the marketized nature of NGOs and "promote corporate causes" (p. 95). Ultimately the decentralization of responsibility resulted in the "breakdown of regulation (or informalization)… [where the] sites of power [reside] outside of the reach of the state, …[but] are within reach of donors, who in turn move in the orbit of their funders, state or private, and their cultural and discursive agendas" (p. 95). These NGOs are often "accused of neutralizing popular resistance and facilitating popular acceptance of structural adjustment" (p. 95).

major communicable diseases were “brought under control through public health measures” (Kaseje, 2006, p. 8). In its health development initiatives for developing countries, the Netherlands Ministry of Foreign Affairs believes that “the right to health requires decisive political action and the involvement of all sectors... [where c]ivil society plays a key role in ensuring governments put adequate policies in place” (2009, p. 9).

Pieterse also highlights that at the very root of the development problematic is the fact that the lack of state involvement results in the lack of accountability. He notes that:

> in several sub-Saharan African countries, much of the health care and welfare sector has been subcontracted to foreign-funded NGOs. What are not being replaced, of course, are the procedures of accountability, inadequate as they were…[Thus, under the Washington hegemony, t]he new policy agenda of civil society building and ‘NGO-ization’, community development and self-reliance, matches the new right agenda of government rollback and decentralization. Another problem is the alternative dependency through foreign-funded NGOs [where, a]ccording to Michael Woost, ‘we are still riding in a top-down vehicle of development whose wheels are greased with a vocabulary of bottom-up discourse’ (2010, p. 199).

This reliance on NGOs and market-based healthcare can have negative consequences for populations since it reduces the scope of health in the way that Tucker previously criticized, especially for those people in developing and marginalized areas who are often faced with greater health risks and are without adequate health services.

This section of the literature review has highlighted that, in most cases, medical accessibility should be available to the entire population of a nation if it is to be successful. Thus, the lack of a universal healthcare system is a strong contributing factor to the resultant ill health. In order to break the link between poor health and poverty, most research highlights the need for governments to take strong roles in providing medical accessibility. Closely related to this discussion is the debate on whether ‘preventive’ or ‘curative’ measures may be best for increasing a developing nation’s ability to improve medical accessibility and reduce poverty.

2.2.4 Primary Health Care Foci: an analysis of preventive and curative primary health care approaches

Most healthcare systems are hybrids of preventive and curative measures. However, all medical systems have different ways of focusing on preventive or curative health practices. As the structural violence caused by a lack of medical accessibility for rural and marginalized populations is the focus of this literature review, it will be important to gain an understanding of the first contact approaches typically utilized by primary health care. An analysis of curative and preventive health care focus is well-established in many academic journals and news reports. To give a brief understanding of how this analysis typically unfolds, it is important to note that the use of resources is one of the main foci.

In curative medical access, the effort of the medical system is generally directed at seeking a cure for an existing medical condition or disease (Stebbins, 1986). The focus on giving attention to ‘existing’ health issues rather than ‘potential’ health issues is where curative medical accessibility differs from the preventive health approach. In a preventive medical approach, proactive measures are employed to prevent diseases, injuries, and other medical conditions instead of re-actively waiting for those health issues to occur and then curing/treating the symptoms (ibid.).

Preventive health access measures take a broader look than curative measures by going beyond the assessment of the individual patient's health (as is the case in curative medical accessibility). The preventive approach will often look at the health level of the entire population in an effort to put in place public health policies to create a healthier environment in order to address the broader issues of structural violence. LASM supports this broader view of health, where the patient is then seen as a bio-psycho-social being, influenced by his/her environment. Thus, preventive medical care’s proactive method is directed at the prevention of ill health through immunizations, popular education, supportive community networks and the adoption of healthy lifestyles, all of which entails much more contact with health personnel and medical appointments.

The debate between these two health approaches is usually broken down into principles revolving around medical access. Weingarten and Matalon (2010) believe that a preventive medical care approach is not a better option than a curative approach. The basis of their argument revolves around how the “allocation of the large amount of

general practice staff time and resources required for systematic preventive medicine should not come at the expense of the care of the sick and the suffering" (p. 1). While they are in support of a preventive health access approach, Richmond (1984) as well as Spiegel and Yassi (2004), echo this idea by stating that a preventive model can be too expensive and may even consume an excessive amount of resources.

However, there are those who defend preventive health care and find that curative health services—at least those found in the US—often suffer from issues of a "lack of collaboration within the health system; fragmented care; patient discontent related to the inconsistent quality of care; excessive use of emergency rooms; and shortages of primary care physicians" (Dresang et al, 2005, p. 298). Elhauge reveals the issue of fragmentation to mean:

> having multiple decision-makers [that] make a set of health care decisions that would be made better through unified decision-making. Just as too many cooks can spoil the broth, too many decision-makers can spoil health care. Individual decision-makers responsible for only one fragment of a relevant set of health care decisions may fail to understand the full picture, may lack the power to take all the appropriate actions given what they know, or may even have affirmative incentives to shift costs onto others. All these forms of fragmentation can lead to bad health care decisions. (2010, p. 1)

Fragmentation is also a target of the WHO director general Margaret Chan who makes a plea for the need for a comprehensive, "integrated approach to [health] service delivery [as a] need to fight fragmentation" (Chan, 2007). This plea to fight fragmentation also shows that a focus on preventive or curative medicine, as well as private or public healthcare, should not hinder the entire system's medical accessibility—especially to the most impoverished. Leadership and direction are important components in most medical care systems (Chan, 2007; Dresang et al, 2005; Elhauge, 2010).

There are a number of forms and levels of proactive, preventive, curative and palliative health measures. The lines between them are often blurred and therefore difficult to isolate and analyze. Many health experts think that having market decision-making overly fragmented with a universal healthcare system often creates an inefficient

situation where there are ‘too many cooks in the kitchen’. These issues often entail having an unclear delegation of responsibility as well as creating issues of ‘who’ is to take charge of ‘what’ at ‘what’ level. Problems of responsibility and control often become unclear as well. The differing goals of overlapping systems (profit motives versus concern for public health motives) can create a precarious convergence of influential actors that can, in turn, become an obstruction to an efficient and effective medical system. Another issue is that fragmentation makes it impossible to negotiate as a single buyer with medical suppliers (Chan, 2007; Dresang et al, 2005; Elhauge, 2010).

With regard to the most impoverished aspects of the population in developing countries, other authors have aided in understanding the context of medical accessibility. In 1986, while doing his research in rural Mexico, Stebbins discovered that:

> underdeveloped countries are more likely to implement curative than preventive services for poor people, even while proclaiming the importance of preventive measures. In dependent capitalist economies, the rural penetration of state-directed health services perpetuates the privileged position of the political and economic elite. Based on research conducted in a highland Chinantec village in Oaxaca, this paper concludes that the recent health services program addresses symptoms rather than causes of disease and is not likely to significantly improve the health status of the people who are most in need of such assistance. (1986, p. 139)

Thus, the link between the perpetuation of inequality, the types of provision, and what Stebbins believes is needed in order to correct inefficient medical accessibility is revealed. Stebbins then expands upon his findings by providing a critical analysis regarding the treatment of patients for chronic health issues where a curative system often only causes a temporary relief of their symptoms. The curative approach of “treating symptoms, rather than causes… [leaves] intact the very conditions which need to be addressed[such as environmental and nutritional] if villagers' health status are to be significantly improved” (1986, p. 146) (Emphasis added).

By not only treating the symptoms and creating a health system that confronts the roots of structural violence, then the warning signs of poverty, inequality, and

marginalization can cause the preventive medicine approach to adapt to meet the challenges in a similar way that LASM advocates. It then becomes the warning sign from which to utilize resources effectively and efficiently, so that ill health does not progress up these chains of specialization and the ensuing expenditure of resources (Stebbins, 1986). However, the Global Health Watch 2 (2008) highlights that a 'perfect' balance between health measures has yet to be found in a way that could be blueprinted from health care model to health care model. They note that:

> national debates on the relative priorities of treatment versus prevention have subsided. Although there is consensus that both treatment and prevention are important, and furthermore are interlinked, it is not clear whether the optimum balance between different treatment and prevention strategies has been achieved within countries… [I]t is important to keep asking the question, if only to ensure that careful thought and consideration continue to go into the process of priority-setting (Global Health Watch 2, 2008, p. 274)

While the curative and preventive analysis is often viewed as a debate, the Global Health Watch 2 has underlined that it is difficult to draw a solid conclusion due to the issue of producing clear data with positive correlations as well as separating the very interlinked and interdependent health focuses themselves.

In fact, the Cuban health care model itself has a very preventive and proactive element to its health care system. However, this focus on prevention has not meant that their strong curative aspects of their health system are weaker because of it. Thus Cuba has a solid combination of both preventive and curative focuses. Therefore what makes the Cuban approach unique to a US health model is the high level of attention given to the state-led preventive and proactive care aspects. Sen and Koivusalo also summarize these points well. They outline that historical evidence:

clearly indicate[s] that in order to build an effective health system providing care according to need, it is essential to cover the largest number of people by pooling risks and resources. The current policy of allowing some people to opt out of the public health system into private services seriously hampers the continuity of public services through segmentation and inequality of access, and causes deterioration of quality by subsidizing private provision by the public sector alongside the general shrinkage of public resources. Rather than reform for 'betterment', the current process resembles a return to the colonial era when elite and minority classes enjoyed access to supposedly international 'quality' services, while the rest of society went without or depended on the services of charities and churches. (1998, p. 210-211)

Therefore, a comprehensive health approach would need the correct state-led engine, with the health of its population as its priority, in order to achieve comprehensive medical accessibility for marginalized and rural populations. This 'state-led engine' must also get to the root of this medical problematic and solve the broader issues created by structural violence. Medical education may be the key to addressing medical issues for developing nations. Therefore the final section will discuss the alternative medical education systems utilized by Cuba and Venezuela.

2.2.5 Is Reforming Medical Education in Developing Nations a Prerequisite for Improving Health Indicators?

So how is health provided, and funding achieved, in rural and impoverished areas of LDCs knowing that rural disparity remains, and marginalized population access to quality health care has still not been consistently addressed? As noted in the theoretical framework, medical education may be the key to understanding why a lack of quality primary care services for marginalized and rural populations has almost become institutionalized structural violence. This next section will look at how medical education has a reflexive relationship to: medical accessibility, private and public responses to medical provision, as well as preventive and curative foci. This section will then look at the Alma Ata declaration's call for medical reform. This section will end with an

investigation of medical education alternatives in Cuba, including its *Escuela Latinoamericana de Medicina* (ELAM) programme.

2.2.5.1 Alma Ata Declaration

The Alma Ata declaration had some lofty and admirable goals. This 1978 declaration was believed to be "a major milestone of the twentieth century in the field of public health, and it identified primary health care (PHC) as the key to the attainment of the goal of Health for All (HFA)" (World Health Organization, 2013). The creation of the declaration was a response to the failure of vertical disease-oriented programmes that were "focused on specific disease or intervention in contrast to more integrated and horizontal health systems development and, on the other, from the aspirations for an approach to health and health service provision emphasizing social justice and social rights" (Sen and Koivusalo, 1998, p. 202).

The premise behind the formation of this declaration was not only to move away from vertical medical programs toward more horizontal programs, but also to shift the focus of delivery and provision of health services towards being part of the whole "social and economic development of a nation. Any improvements in services, it was stressed, needed to take into account wider questions of national structures, priorities and goals" (ibid.). However, the unfortunate reality of the declaration's implementation has fallen very short, especially for those located in the rural and impoverished areas of the developing world. As noted by PAHO:

> The 25-year trajectory since Alma-Ata has certainly been dynamic, though not always in the sense of progress toward achieving the goal of Health for All [HFA]. The "missing decade" of the 1980s [in which SAPs were utilized extensively by the WB and IMF], the foreign debt crisis, military dictatorships and the struggle to recapture democracy, dominance of the free-market mentality and its neoliberal structural reforms these trends and events have formed the backdrop against which our peoples have struggled to improve their level of health through social justice and the building of a newly empowered citizenry. (2006, p. Forward)

In addition to this, development initiatives from the West have proven to be problematic in the developing world due in large part to the reliance on a curative system that requires a high level of resources and infrastructure—both of which are often in short supply in developing nations.

Also, as Tucker pointed out, the high use of resources and supplies in a curative-focused system is often mostly to the benefit of the Transnational Pharmaceutical Industry (TPI) which profits the most from this narrow ideological construction of health. Though the attempts to improve universal healthcare access by developing countries could be directly attributed to the declaration in many cases, some of the failure of Alma Ata's implementation can be attributed to the selective implementation of comprehensive primary health care. This was because in practice most nations focused on the cheapest options instead of the most effective types of medical intervention, a process which made the systems less comprehensive then needed (Walsh and Warren, 1979).

With the problems and critiques outlined in the previous sections as well as a global call for change from the Alma Ata declaration, this section of the literature review will now analyse two linked medical education systems. These systems function in comprehensive universal healthcare programmes that focus on preventive community-oriented primary care (COPC). The key to these education systems is that they specifically target medical access for rural and marginalized populations—a problematic that much of this literature has acknowledged, but failed to effectively address.

2.2.5.2 Cuba's Latin American School of Medicine—*Escuela Latinoamericana de Medicina* (ELAM)

In Cuba, family physicians are required to look at patients in the context of family and community. All are dependent on one another and are not seen as separate unrelated individuals. In Huish's 2008 article "Going Where No Doctor Has Gone Before", he identified that the real success of the Cuban medical school, the *Escuela Latinoamericana de Medicina* (ELAM), is the core sense of duty ingrained in the students. This sense of duty is what Stone would consider as a soft policy tool essential for making the hard policy tools truly effective. It is thus identified that "the importance of [the ELAM] project is the development of an institutional ethic that values success as a

graduate's ability to serve the indigent" (Huish, 2008, 552-3).[19] The health care team's duty is rooted in LASM service towards the communal good. The need for a high patient-to-physician ratio is also linked to the manner in which doctors' responsibilities go beyond regular duties and are utilized in community education about general health issues and environmental health which corresponds to the broad range of health indicators utilized by the health care team. (Spiegel and Yassi, 2004; Feinsilver, 1993; Pérez, 2008; Huish, 2008)

Rather than compartmentalizing each health aspect, as is done in many medical education systems, the Cuban medical education system ensures that the diverse aspects of health are conceptualized as interrelated and taught in a participatory manner in much the same way that Tucker advocated. Brouwer highlights one of the main courses of the Cuban education system, called 'Morphophysiology', which is an "interdisciplinary combination of all basic sciences that are taught separately in the traditional Flexnerian medical school" (2011, p. 121).[20] In addition to this comprehensive course, the first year

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[19] This 'ability to serve the indigent' is the broader re-focusing of health care in a way that addresses the roots of structural violence.

[20] Abraham Flexner wrote his landmark report, *Medical Education in the United States and Canada*, in the 1910s (with support from the Carnegie Foundation) on the need to reform medical education. Bowman notes that "Flexner wrote strongly against proprietary institutions, smaller schools, those that did not emphasize science or specialism, and those with little equipment. He considered 5 areas during his visits" (2003). These included: "1. school entrance requirements; 2. size and training of faculty; 3. sum available from endowment and fees and budget; 4. quality and adequacy of labs and qualifications and training of lab teachers; 5. the relationships between the school and its associated hospitals" (ibid.). However, in the years that followed, Flexner himself criticized the new direction of medical education, including aspects that he had first advocated for in the original report. Cooke et al. describe Flexner's reaction to the direction that medical education took after the release of the report. The way in which students encounter the knowledge base of medicine "has been profoundly influenced, as Flexner intended, by the assimilation of medical education into the culture of the university. Theoretical, scientific knowledge formulated in context-free and value-neutral terms is seen as the primary basis for medical knowledge and reasoning. This knowledge is grounded in the basic sciences; the academy accommodates less comfortably the practical skills and distinct moral orientation required for successful practice in medicine. However, Flexner had not intended that such knowledge should be the sole or even the predominant basis for clinical decision making. Within 15 years after issuing his report, Flexner had come to believe that the medical curriculum overweighed the scientific aspects of medicine to the exclusion of the social and humanistic aspects. He wrote in 1925, 'Scientific medicine in America—young, vigorous and positivistic—is today sadly deficient in cultural and philosophic background.' He undoubtedly would be disappointed to

medical education system also adds a "Community Health and Medicine component (social-medical sciences and social science) that includes introduction to social sciences, introduction to primary health care, social communication, and civics" (ibid.).

The second year expands through the study of basic sciences in "Human Morphophysiopathology", where the Medicine and Community Health aspect covers "public health, history of health, epidemiology and hygiene, medical research, community intervention and health analysis" (ibid.). This model situates the patient as part of the wider and interlinked bio-psycho-social spheres of health, and away from the narrow view of the patient as a singular ailment resulting from a singular diagnosis and treatable by a simple prescription (Pérez, 2008).

The sense of duty and revolutionary socialist mentality ingrained in the medical education drives the Cuban medical teams. Their preventive work and community-centred approach has helped forge strong community bonds. A healthy person is expected to have three check-ups a year at the *consultorio* and if a patient has noted risk factors, it is expected they will have four "depending on whether they are healthy, sick, at-risk or have special needs (i.e., an amputee or mentally ill)" (Fitz, 2011).

The patient often looks forward to appointments in much the same way as a visit from an old friend or family member would be. Iatridis makes this point best by noting

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see the extent to which this critique still holds true" (Cooke et al., 2006, p. 1341). Criticism is becoming more frequent 100 years after the original publication regarding the direction of medical education. This is because the adaptation of the Flexner report is also being influenced by the competitive, individualistic and highly material neo-liberal ideology. Cooke et al. note how the harsh, commercial environment of the marketplace "has permeated many academic medical centers. Students hear institutional leaders speaking more about 'throughput,' 'capture of market share,' 'units of service,' and the financial 'bottom line' than about the prevention and relief of suffering. Students learn from this culture that health care as a business may threaten medicine as a calling" (Cooke et al., 2006, p. 1340). Finally, some of the criticisms directed at the shift in medical education after the release of the Flexner report are directed at the expert-centric and individualistic culture that has become embedded in many Western medical systems. Kirch notes that this culture "may now work against the collaboration needed for greater integration across the medical education continuum, highly networked teams in discovery research, and interprofessionalism in clinical care. The question, as many authors suggest, is not whether medical education is being true to Flexner, but whether academic medicine is responding to the implications of post-Flexnerian education and whether it is able to embrace the cultural change needed to address 21st-century health care needs" (2010, p. 190).

that in Cuba, "[f]amily medicine integrates local health care and creates a more intimate relationship among the health practitioner, the patient, and the neighbourhood [which] also ensures continuity in the patient-physician relationship" (1990, 31). This is because, in Cuba, family physicians are required to look at patients in the context of family and community. All are dependent on one another and are not seen as separate unrelated individuals. (Feinsilver, 1993; Pérez, 2008, p. 269-270; Huish, 2008; and Iatridis, p. 1990, 29-34)

Until comprehensive education systems can be replicated with a similar sense of communal good, duty, and values, most healthcare systems will continue to fail in delivering quality preventive primary care to rural and marginalized populations that solves the complex issues of structural violence. Huish highlights the priorities of the ELAM system as they relate to previous sections of this literature review:

> ELAM is unique in the sense that its students receive an education centred entirely towards an ethical commitment to serve the destitute. Using important principles of empowerment theory, ELAM builds capacity among its students so they may eventually create broader organizational changes to health care in the locales in which they practice. It is hoped that when the graduates return to the field, they will be able to practice in clinics and treat preventable health problems through community-orientated primary care (COPC). (2008, p. 553)

Therefore, other medical systems need to have a medical education system that brings in potential doctors from impoverished and rural areas if medical accessibility is to be comprehensively addressed—thus going to the root of the structural violence problematic. It is crucial that the medical education system be made available and affordable to the communities that are in the largest need to get the high level of physician accessibility that the Cuban model achieves.

Thus, the medical school (ELAM), that is free to those foreign students from rural and impoverished areas, is an essential ingredient needed to make a potential LDC system achieve similar medical accessibility success as the Cuban model. The ELAM program highlights a clear and important lesson—most of the foreign medical students, who are all from poor and impoverished areas around the world, graduate from ELAM

with the realization that they could never have afforded to go to medical schools in their own countries. As a result, they 'buy in' and are generally prepared to return to their own, or similar impoverished communities (Huish and Kirk, 2007; Pérez, 2008). Possibly the best example of the adoption of the Cuban medical system is the rapid implementation of Venezuela's *Barrio Adentro* program which directly focuses on medical access for rural and marginalized populations, and which is the focus of the next chapter.

The culture of duty among Cuban and Venezuelan medical workers in the *Barrio Adentro* program is a result of their unique educational background. This unique background is one of the key strengths of the *Barrio Adentro* system that must be highlighted since it pairs a decentralized preventive medical system with a decentralized medical education system. The education system thus ensures that marginalized areas receive medical assistance in large part due to the practitioners themselves being drawn from, and educated close to, these areas. The non-traditional background of the medical practitioners in this decentralized medical system, and especially the decentralized nature of the *Barrio Adentro* education system, is one factor that makes these medical practitioners unique. Thus, it helps to ensure that the medical profession in *Barrio Adentro* program is not considered a sign of status nor entitlement; rather, it is a profession grounded in duty with the cumulative health of the community at its heart. This is an important distinction from other Lesser Developed Countries (LDCs) that often suffer from low rural/impoverished patient accessibility, and where this sense of community is often limited (Brouwer, 2011).

2.3 SUMMARY

Key themes and theories—such as structural violence, critical holism, Latin American social medicine (LASM), and the soft transfer of policy learning—help to guide this research. Structural violence, a major problematic facing poor and marginalized populations, helps understand that the roots of inequality, poverty, marginalization and exclusion cannot be solved by a reactive health system which simply maintains the status quo. Instead a proactive health system that is present in all government policies and advocates for positive change to those suffering from the lowest

health indicators and pathologies of poverty must be initiated (Galtung, 1969; Gilligan, 1997; Farmer 2005 and 2006).

Tucker highlights why traditional bio-medical models have not been the answer. The reductionist construction of health consisting of 'doctors + drugs' (often promoted by the Transnational Pharmaceutical Industry), weakens any comprehensive and effective response to structural violence, since it constructs health care as only a response to a singular illness, disease or injury (1996a). Instead, health care needs to be an active part of the system that challenges the roots of structural violence through health promotion, prevention and activism. Lastly, an understanding of the transfer of soft policy tools—the values, norms and culture—will make it possible to analyze the Cuban medical adaptation beyond simply a transfer of resources and human capital. Key to this study is how the Cuban notion of LASM is creatively adapted in a Venezuelan context to convert Venezuelan medical personnel into health care activists.

These themes and theories helped to situate various popular medical debates and questions. Five basic questions were raised during the course of the literature review. First, the issue of whether 'health without economic growth is possible', showed that a focus on economic growth above all else should not necessarily displace a focus on services such as health care, since even in periods of low growth, much improvement in health indicators can still be accomplished. A second question asked whether rural and marginalized populations suffer disproportionately due to a lack of access to quality medical services than do their urban and affluent counterparts. The literature review highlighted that this is very much the case.

A third theme of this research examined aspects of private and public health care systems. The literature review made clear that reliance on a highly privatized bio-medical model, coupled with a weak universal health care system, is unable to effectively address the roots of medical structural violence. A fourth question discussed the strengths and weaknesses of preventive and curative health care foci. This debate was important since *MBA* is tasked with supporting the traditional medical system by implementing a comprehensive preventive approach to health care which was almost absent in the traditional pre-Chávez medical system. The literature noted that, though a curative system is highly important, a preventive focus helps immensely to ensure an effective and

efficient health care system. Lastly, Cuban and Venezuelan medical education models were analyzed. This analysis is one of the key aspects that clarified how the medical education adaptation focuses on issues of structural violence through a LASM approach.

In many ways, the challenges outlined by many scholars critical of traditional medical education models are attempting to be addressed by a radically new model in contemporary Venezuela. There a preventive patient-centred approach, viewing patients within their natural environment, has been adopted with the goal of providing quality community-oriented primary health care. The admirable goal of *Alma Ata* was to provide Health for All (HFA) and the Venezuelan adaptation of the Cuban medical system—that is free to the patient, and seeks to be fully accessible in both rural and urban settings—is directed at meeting that goal. It is also based upon an education system promoting free programs to medical students. Having highlighted the key theories, questions and debates that inform this thesis, the next chapter will now follow with a brief analysis of health care in pre-Chávez Venezuela.

CHAPTER 3 THE TRANSITION TO REVOLUTIONARY MEDICINE IN VENEZUELA

"*As Albert Camus wrote, the doctor's role is as a witness—to witness authentically the reality of humanity, and to speak out against the horrors of political inaction... The only crime equaling inhumanity is the crime of indifference, silence, and forgetting.*"
- Dr. James Orbinski, 1988

"*[T]he world's poor are the chief victims of Structural Violence—a violence which has thus far defied the analysis of many seeking to understand the nature and distribution of extreme suffering. Why might this be so? One answer is that the poor are not only more likely to suffer, they are also more likely to have their suffering silenced*" (p. 280)…
"Can *we devise an analytic model, one with explanatory and predictive power, for understanding suffering in a global context?*" (p. 274)
- Dr. Paul Farmer, *On Suffering and Structural Violence: A View from Below*, 1996

The adaptation of Cuba's medical system, as well as the integration of their particular conception of Latin American social medicine, is not without its challenges in Venezuela. In order to understand the consequences of the implementation, this chapter will start with a brief analysis of health care delivery in pre-Chávez Venezuela in order to establish a comparative base on which to situate the health system for rural and marginalized populations. This chapter will then expand into Chávez's broad vision for health care and the creation of the 1999 Venezuelan Constitution as well as the ensuing creation of *Misión Barrio Adentro* (*MBA*) through the bilateral agreement between Cuba and Venezuela. Lastly, the role of Venezuela's free education mission—part of *Misión Sucre*—could not be overlooked since it is one of the key elements to understanding the challenges, successes and failures of adapting aspects of a health care system and its *soft policy tools*.[21]

3.1 VENEZUELA PRE-CHÁVEZ

In order to understand how the Venezuelan health system has evolved into its current state, a historical-comparative analysis is needed. This thesis analyzes the radical change in the health care system, as well as the comprehensive social programmes that

[21] As noted in the Theoretical Framework on page 14-16, soft policy tools include the adoption of norms and values that accompany the hard policy tools of human capital and resources.

were implemented after Hugo Chávez was elected in 1998. This will be accomplished through an overview of Venezuela's first public health care system and the state of the system itself in the years immediately before Chávez was elected. The first real attempt at a national public health care system arguably started in the 1960s. During this time Venezuelan governments had:

> Aspirations of building a viable public health system based on rudimentary facilities called *ambulatorios* or *consultorios*, small walk-in consulting offices that were located in both urban and rural areas. But as successive governments fell victim to falling oil prices and were party to rising corruption, the economy and society failed to sustain these efforts. One of the obvious reasons for the poor staffing and crumbling structures was diminishing resources. From 1970 to 1996 government funding for health decreased from 13.3 percent of the federal budget to 7.89 percent. A report from the Pan American Health Organization (PAHO) concluded: "Throughout the 1990s, the capability of the public health network to provide health services and resolve health problems became critically insufficient." (Brouwer, 2011, p. 75)

Despite the establishment of a public health system in the 1960s, certain indicators suffered soon after it started to take shape. One of the key health indicators indicative of the early part of this era is the relationship between malnutrition and infant mortality. PAHO highlights that in the "early 1970s it was estimated that at least 30 percent of all the country's children under 5 years old were suffering from some degree of malnutrition. Between 1968 and 1973, infant mortality rose from 46.7 to 53.7 per 1,000 registered live births" (PAHO, 2006, p. 7).

In addition to this, the influence of the International Monetary Fund (IMF) and World Bank (WB) was particularly damaging to most Latin American countries later in this era during the 1980s and 1990s. In this particular time period there was a general decline in the delivery of healthcare. As noted in the previous Chapter by Munater et al., only Cuba managed to escape the influence of these global banking institutions in Latin America. Venezuela became one of the later Latin American countries to be affected by their Structural Adjustment Programme's (SAPs):

> [I]n 1989, close to 54 percent of Venezuelans lived in extreme or critical poverty. Seduced by the increasingly dominant neoliberal ideology,[22] 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. The Venezuelan government reforms, with deep public spending cuts, privatization, trade liberalization, and restructuring of social programs to target the poor, faced widespread public opposition and mobilization that helped spark two failed coup attempts and the impeachment of President Pérez in 1993…. 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. 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. (Muntaner et al., 2006, p. 806)

Although the decline started shortly after the first attempt at a national health system, the 1990s saw the most rapid decline of Venezuela's public health system. The WB and IMF SAPs were largely to blame for the accelerated decline of the public health system during this era.

These austerity measures, combined with the decentralization of responsibility from the national government to local and regional governments, left these newly responsible governments with the burden of providing health care, but without the resources or supplies to do so. Thus, without any viable alternatives and a lack of support

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[22] Neoliberalism refers to a mode of thought that promotes free-market economics and reduction of state involvement. Paul Farmer uses the term neoliberal economics "to refer to the prevailing (at times contradictory) constellation of ideas about trade and development and governance that has been internalized by many in the affluent market societies... The dominance of a competition-driven market is said to be at the heart of this model, but in truth this ideology is indebted to and helps to replicate inequalities of power. It is an ideology that has little to say about the social and economic inequalities that distort real economies and instead, reveals yet another means by which these economies can be further exploited. Neoliberal thought is central to modern development efforts, the goal of which is less to repair poverty and social inequalities than to manage them" (2004, p. 312-313).

from the national level, a de facto and uncoordinated privatization of high-demand health services occurred. This meant that by 1997, "73 percent of health expenditures in Venezuela were private. The introduction of user fees in the public system made the deteriorating health services even less accessible" (Muntaner et al., 2006, p. 805).

By the end of the 1990s, Venezuela's public health was in a dire situation. Its delivery of care, organization, and management was based on a diseased-oriented model that had less focus on quality of life and health prevention—contrary to the basic principles of primary health care. This meant that the provision of care was:

> configured in terms of the limited capacity to provide services; it was haphazard and unproductive; it was organized around hospital and curative care; coverage was low; primary care was virtually nonexistent; schedules were irregular; and consultation systems were haphazard all of this contributing to reduced quality, access, and timeliness of response. It was a care model similar to those that had predominated in many European countries in the twentieth century and were later replaced by free universal public health systems. (PAHO, 2006, p. 9)

What is also important to highlight is that, despite the population increasing from 7.5621 million in 1960 to 23.867 by the 1999 (World Bank, 2013a), only one public hospital was built (in the 1980s) during this time (PAHO, 2006, p. 9).

Adding to this crisis was the challenge of retaining recently graduated doctors in the public health system—especially for the rural and poor neighbourhoods. Despite graduating approximately 1,200-1,500 qualified doctors per year throughout the 1990s from medical schools in the old network of elite universities, very few went into the public health care system. During this period, after the students graduated, more than half went directly into private practice, while an additional 10 percent also left the country, often to Spain in hopes of working in more lucrative private health markets. During this era, only "4,000 physicians, about 10 percent of all doctors in the country, were practicing in primary care or family medicine, and of these just 1,500 were working in

deteriorating public clinics" (Brouwer, 2011, p. 75).[23]

By the time of Chávez's election, deep social inequities had spread into access for medicine and health care. PAHO notes that the response capacity of the health care network was "critically insufficient." Long wait lists for specialized outpatient care and surgeries plagued the network. Shortages of essential supplies to provide necessary care were commonplace. The health network did not have the capacity or planning needed to prepare for, or mitigate, disasters and emergencies. The entire system, "created by public underfunding, led to the decision to privatize the health services and relieve the State of full responsibility for guaranteeing the right to health" (PAHO, 2006, p. 11). Thus, in pre-Chávez times, by 1999 poor Venezuelans comprised almost "three-quarters of the population, with a very limited access to health care services through a precarious public system" (Muntaner et al., 2006, p. 806).[24]

The reduction of health care access at that time also exacerbated the already high levels of poverty. Brouwer highlights that even Moses Naim, a strong critic of Chávez and Venezuela's Minister of Trade and Industry from 1989-1990, has acknowledged the extent of poverty. He noted in 2001 that in "the past 20 years, critical poverty ha[d] increased threefold and poverty in general ha[d] more than doubled…. Real wages [were] 70 percent below what they were in 1980" (Brouwer, 2011, p. 76). These issues were some of the most difficult challenges for Chávez when he was first elected.

[23] On Table 2 of PAHO's 2006 analysis the editors highlight characteristics of the Venezuelan health system prior to the implementation of *MBA* by noting that there was: "[s]ocial underfunding; [d]irect and indirect privatization; [h]ealthmarket relationship; [p]redominance of curative care; [g]rowth of private establishments; [d]eterioration of public infrastructure; [l]ack of preventive maintenance; [o]rganization of the work to comply with professional associations and unions; [o]verall lack of articulation, fragmentation of the health system; [a]bandonment of diagnosis and treatment protocols; [a]bandonment of the first level care; [h]ealth workers being trained to respond within the prevailing model; [g]rowth of the population not matched by expansion of the public network; [h]iring freeze; [r]educed schedules; [l]ow wages; [p]rivate insurance for hospitalization, surgery, and maternity; [o]bsolete medical equipment" (PAHO, 2006, p. 8).

[24] During the period from 1990 to 1998, "the impoverished population had less access to drugs because of cost-recovery policies. Drugs were sold through a network of private pharmacies, with the exception of certain very expensive treatments such as cancer drugs, antiretrovirals, and hormones, which patients had the option of obtaining through private nonprofit foundations. All Venezuelans were ensured access to a basic list of drugs through the Venezuelan Social Security Institute, but because of lack of progressive public funding of the Institute itself, availability was also very limited" (PAHO, 2006, p. 10).

3.2 CHÁVEZ'S VISION FOR HEALTH CARE

When Chávez came to power one of the first, very ambitious, changes he made was to the constitution. This particular change cannot be understated since it outlines the government's commitment to provide health care to its population. As Eva Golinger notes, the:

> 1999 Constitution was, in fact drafted—written—by the people of Venezuela in one of the most participatory examples of nation-building, and then was ratified through popular national referendum by 75 percent of Venezuelans. The 1999 Constitution is one of the most advanced in the world in the area of human rights. It guarantees the rights to housing, education, health care, food, indigenous lands, languages, women's rights, worker's rights, living wages, and a whole host of other rights that few other countries recognize on a national level. My favorite right in the Venezuelan Constitution is the right to a dignified life. (Brouwer, 2011, p. 77)

Thus the expansive view of health care as a human right is embedded in the Venezuelan constitution. It must be noted that though health is identified in Articles 83-85, Articles 80-82 and 86 also contain important distinctions from other constitutions that often omit rights to senior citizens, the disabled, social security, as well as the right to adequate housing.[25]

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[25] Below are the most applicable articles of the Venezuelan constitution to this thesis—Articles 83-85—which outlines the obligations of the government to the population: "Article 83: Health is a fundamental social right and the responsibility of the State, which shall guarantee it as part of the right to life. The State shall promote and develop policies oriented toward improving the quality of life, common welfare and access to services. All persons have the right to protection of health, as well as the duty to participate actively in the furtherance and protection of the same, and to comply with such health and hygiene measures as may be established by law, and in accordance with international conventions and treaties signed and ratified by the Republic.
Article 84: In order to guarantee the right to health, the State creates, exercises guidance over and administers a national public health system that crosses sector boundaries, and is decentralized and participatory in nature, integrated with the social security system and governed by the principles of gratuity, universality, completeness, fairness, social integration and solidarity. The public health system gives priority to promoting health and preventing disease, guaranteeing prompt treatment and quality rehabilitation. 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,

Articles 83-85 have the most important and direct implications for health care reform. As noted in Article 83, health became embedded as a fundamental human right that the state is obligated to guarantee. Article 84 stipulates how the state has the responsibility to develop and maintain a universal, integrated public health system that prioritizes health promotion and disease prevention while at the same time providing free services. And finally, in Article 85, the public health care system must also be publicly financed through social security, taxes 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" (Muntaner et al., 2006, p. 806). Thus, the government's creation of *MBA* is directed at fulfilling the constitutional guarantee 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" (ibid.).

3.3 CHÁVEZ AND THE CREATION OF *MISIÓN BARRIO ADENTRO*

The role of Cuba as both a model and as a direct influence on the Venezuelan medical system and medical education programme cannot be understated. Though *MBA* did not become a fully integrated component of the national health system until 2003, it is important to note that Cuban medical personnel were already there as a response to the destructive flooding in the state of Vargas in December 1999.[26] Muntaner et al. believe

implementation and control at public health institutions.
Article 85: Financing of the public health system is the responsibility of the State, which shall integrate the revenue resources, mandatory Social Security contributions and any other sources of financing provided for by law. The State guarantees a health budget such as to make possible the attainment of health policy objectives. In coordination with universities and research centers, a national professional and technical training policy and a national industry to produce health care supplies shall be promoted and developed. The State shall regulate both public and private health care institutions." (Bolivarian Republic of Venezuela, 1999)

[26] Often referred to as the 'Vargas tragedy', it is considered one of Venezuela's worst tragedies. Approximately 1,000 to 50,000 casualties were reported. Though much "debate exists regarding the accuracy of the casualty figures… even at the lowest estimates of 1000 killed, all of the 300,000 residents of Vargas State were affected in some way by the meteorological event in December 1999" (Stager, 2009, p. 68-69).

that the real start of *Barrio Adentro* began at that time, when a team of 454 Cuban health care personnel began providing medical care to many of the marginalized poor that were living on the hillside peripheries of many of the major urban centres. These *barrio* dwellers became the focus of Cuban medical teams as a part of Cuba's international solidarity programme (2006, p. 806).[27] [28]

However, the majority of the traditional Venezuelan medical personnel refused to provide care in the *barrios* despite requests from the mayor of the Municipality of Libertador—an area that contains the largest number of impoverished in the greater Metropolitan Area of Caracas. While most of the Venezuelan physicians refused to work in these devastated areas to help the most affected populations, often citing a lack of infrastructure and security concerns, the Cuban medical personnel responded to the request for help and assisted these vulnerable populations (Muntaner et al., 2006, p. 806).

This discrepancy between the willingness of the Venezuelan medical personnel and that of the Cuban health team to provide health care as a human right to the most vulnerable population, as outlined in the constitution, continued to influence Chávez's

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[27] It should be noted that the USA has attempted many times to undermine Cuba's solidarity missions through it medical prowess and medical internationalism programme. Olson notes: "As reported by Wikileaks, in July 2006 Michael Parmly of the US Interest Section in Havana sent a cable requesting "human interest stories and other news that shatters the myth of Cuban medical prowess." Washington prohibits the sale to Cuba of vital medical devices and drugs including the inhalant agent sevoflurane, the best pharmaceutical for applying general anesthesia to children, and dexmedetomidine, especially effective for treating elderly patients needing extended surgical procedures. The US firm Abbot Labs produces both of these. And Erwinia l-asparaginase, known commercially as Elspar, is denied to Cuban children suffering from lymphoblastic leukemia. The US firm Merck and Co. refuses its sale to Cuba. And Washington denies visas to Cuban medical specialists seeking to attend conferences in the United States, thus denying their access to state-of-the-art knowledge…. And there is the Cuban Medical Professional Parole (CMPP) immigration program which encourages Cuban doctors to defect to the United States. According to The Wall Street Journal, some 1,574 Cuban doctors in 65 countries have been issued visas under this program" (Olson, 2013, p. 2013).

[28] Kirk and Erisman asked Deputy Minister Jiménez in 2007 whether it was true that "medical internationalism was carried out solely to garner international diplomatic support." Her response was very interesting: "Even taking the most cynical view, namely that Cuba is sending doctors abroad to poor countries in order to win votes at the UN, why doesn't the industrialized world do something similar? Surely the most important thing is to save lives. That is precisely what our policy is doing." Kirk and Erisman continue by highlighting that sadly her challenge "is yet to be taken up by the First World" in a similar comprehensive way (2009, p. 179).

further request for assistance of Cuban medical personnel. Essentially, despite the creation of a radically comprehensive constitution with health care as a human right at its core, fulfilling the guarantees of the constitution was not without its issues. As the Pan American Health Organization (PAHO) highlights:

> Ratification of the new Constitution in 1999 sparked the collective construction of a new economic and social model. This model is guided, among other principles, by the affirmation that health is a fundamental social right guaranteed by the Venezuelan State, based on co-responsibility on the part of all citizens and guaranteed active participation by organized communities. These are the premises on which the new health system would be built. In keeping with the Constitution, in 1999 a presidential decree was issued that prohibited the collection of fees in the country's public establishments (PAHO, 2006, p. 21).

The collection of fees became contested to such and extent that in 2002, the Venezuelan Medical Federation, supported by the Caracas Metropolitan City Administration (which served five metropolitan *municipios* and a total population of 2,762,759 in 2001) protested the reforms outlined in the constitution. The Venezuelan Medical Federation and its supporters:

> called for a national work stoppage of the federation's members in connection with demands for wage-related benefits. The stoppage shut down the majority of outpatient clinics and public hospitals in Venezuela, seriously affecting access to health care in the country, especially in the metropolitan area of Greater Caracas. In the neighborhoods, many of the 81 existing outpatient clinics under the Caracas Metropolitan District shut their doors, and those that remained open did so for only a couple of times a week, providing service in return for a “contribution.” (PAHO, 2006, p. 21).

This is especially important to note when discussing how Cuba came to be involved in the creation of the broader public health care system. Cuban cooperation, which helped establish 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” (Muntaner et al., 2006, p. 804). The solidarity established between Cuba and Venezuela is directed at fulfilling the obligations outlined in the 1999 constitution that the traditional medical personnel were unwilling to accept. Eventually Chávez found the Cuban medical model, and its approach to health care as a human right, as an effective and efficient blueprint. Thus, the process of adapting aspects of the Cuban model into the public health care system began.

3.4 The Cuban Health Care System and its Adaptation in Venezuela

Cuba’s health care system has strong curative aspects but also possesses an exceptionally high level of proactive and preventive health care focus that sets it apart from most traditional medical models. The Cuban model provides Venezuela an example of how good health indicators, such as under-5 mortality rate of 6 per 1,000 live births in 2011, maternal mortality of 73 per 100,000 live births in a 2010 estimate, a physician density of 67.2 per 10,000 people in 2011, and life expectancy of 78 years (WHO, 2013), can be achieved with low resources.[29]

It is also important to note that Cuba did not always have these high health indicators. As Peréz notes, the rapid increase in health indicators happened shortly after the 1959 revolution by Fidel Castro:

[29] These health indicators are even more impressive given the huge disparity in economies. Cuba’s GNI (Gross National Income)—which is converted to U.S. dollars using the World Bank Atlas method, divided by the midyear population (2013b)—is $5,440 USD purchasing power parity in a 2008 estimate, compared to $50,120 USD in a 2012 estimate of the USA (World Bank, 2013a). Cuba also only has a GDP of $10,200 per capita purchasing power parity in 2010 compared to $50,700 in 2012 for the USA (CIA, 2013). Despite this, Keck and Reed offer an updated data set that compares USA health indicators to Cuba: infant mortality per 1000 live births—4.5 (2010) in Cuba compared to 6.42 (2009) in the US; infant mortality <5 per 1000 live births—6.0 (2010) in Cuba compared to 8.0 (2010) in the US; low birth weight as a percent—5.4% (2010) in Cuba compared to 8.15% (2010) in the US; and patient-to-doctor ration (inhabitants per physician)—147 (2010) in Cuba compared to 390 (2007) in the US. All these comparisons favour, at times greatly, Cuban health results over those of the US. Only life expectancy of 77.97 years (2010) is less than the 78.2 years (2009) of the US. This can only be viewed as a significant achievement of health policy, education, and implementation (2012, p. e2).

Table 1 Evolution of the Cuban Medical System from pre-Revolution to 2006

Indicator	1950	1960	2006
Total Population	5,850,000	6,976,000	11,277,705
Infant Mortality Rate	80.6	59.4	5.3
Maternal Mortality Rate	137.8*	96.7**	49.4
Average Life Expectancy	59.2	65.3	77.0 (2005)
Literacy Rate	76.4	76.4	99.8
Average School Level	-	-	9th Grade
% of the population in urban areas	49.4	54.9	75.5
* Rate for years 1950-1959			
**Rate for years 1960-1969			

Source: Pérez, C. (2008). *Caring for Them from Birth to Death: The Practice of Community-Based Cuban Medicine*. Lanham, MD: Lexington Books, p. 12.

This is important to highlight since it shows that it was through effective policy reforms, as well as the broader Latin American social medicine (LASM) conception of health, that Cuba was able to become a world power in health care. As Feinsilver notes, the leadership of Cuba has championed the notion of free universal health care as a basic human right, as well as the responsibility of the state to guarantee this right. It is also outlined in the constitution. In addition to this, the Cuban leaders believe that the health of the population is actually a metaphor for the health of the body politic.[30] This set of prioritization has established a "national health system that, over time and through trial and error, has evolved into a model lauded by international health experts, including the World Health Organization and the Pan American Health Organization" (Feinsilver, 2008, p. 2).

It has become a strong example of health care through a micro-level community-centred approach that ensures community members have access to medical services, no matter what the time of day or night, or how rural and impoverished the area (Pérez, 2008). Policies such as house calls ensure all patients, regardless of mobility, are able to

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[30] Harvey explains that the body politic is the "idea that there is an analogy between the social collective and the human body." He highlights that the origins of this analogy began "more than twenty-five centuries ago" (Harvey, 2007, p. 1). It was an analogy known to Plato and St. Paul, and had been used in the Middle Ages by state functionaries. Thus, the Cuban interpretation is that the health of the Cuban population is reflective of the role of the State. When the Cuban population is healthy, that means that the State system is functioning well. Therefore, if the population is unhealthy then the State apparatus is unwell and in need of a 'repair' or a 'cure'.

access local physicians. Healthcare providers function as a team, making for a more comprehensive approach to healthcare as a whole (Dresang et al, 2005). Often these teams consist of a family physician, nurse and a social worker (Pérez, 2008). This comprehensive approach, and the way in which the healthcare providers view a patient's health, are also a unique and effective aspect that must be noted.

Barrio Adentro essentially employs a very similar system that is supported by Cuban medical personnel, in a direct attempt to re-visit the principles of the Alma-Ata declaration, by providing healthcare from birth-to-death for every citizen. *MBA* is in fact a direct adaptation of the Cuban medical model that utilizes aspects of Cuban medical education as well as Cuban doctors, teachers and medical technicians, applying it to a Venezuelan context. Muntaner et al. note that after the initial solidarity shown by Cuba in the wake of the 1999 flooding, *Barrio Adentro's* integration into Venezuela's public health care system started in April 2003:

> after an agreement for a pilot project with the Cuban government, [when] 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. (2006, p. 807)

The goal was originally to utilize 8,500 state-led medical clinics in order to provide health care for even the most rural and marginalized populations by 2005. This proved to be overly ambitious, and by May 2007, 2,708 of these clinics had been built with another

3,284 under construction (Feinsilver, 2008).[31] Without the assistance of Venezuelan medical doctors from the traditional system, Venezuela has had to depend on Cuban medical personnel in order to staff many of these clinics—especially in underserved areas where private practice physicians are unwilling to serve. In order to ensure that medical access in Venezuela was being addressed as widely as possible. In 2006, a total of 31,439 professionals—including doctors, nurses, teachers, health technicians and technical personnel etc.—"were working in the primary care network. Of these, 15,356 were Cuban physicians in various health care centers the majority, nearly 13,000, in popular medical dispensaries or consultation points" (PAHO, 2006, p. 80).

The Cuban medical personnel worked alongside an increasing number of Venezuelan medical professionals. The 1,234 Venezuelan doctors (PAHO, 2006, p. 84) helped the Cuban effort to provide medical services to underserved populations.[32] In addition to this, to avoid the fragmentation that often plagues traditional medical systems, "the physicians visit the families under their care at regular intervals, [and] the situation of patients seeing two or three doctors is reduced to a minimum" (PAHO, 2006, p. 80).

However, due to the continued lack of participation from the traditional medical establishment,[33] the government launched a massive training effort to replace, over time,

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[31] Feinsilver highlights a critical article by the Lancet that notes, how funds "for the facilities built primarily came from the state petroleum company, *PDVSA* and amounted to US $126.5 million. Of the facilities that are operational, only thirty percent had doctors because of an overall shortage of doctors in the country despite the presence of the Cubans. Even though there were insufficient doctors to meet Venezuela's needs, approximately four thousand Cuban doctors were withdrawn from Venezuela by early 2006 to support similar programs in Bolivia and other countries. While this move may have been part of a larger Bolivarian initiative, it was a real setback to the *Barrio Adentro* Mission and the communities whose expectations had been raised" (2008, p. 5). This is important since Cubans have also faced similar criticism. However, one of the main responses to this criticism are the success that both systems have had through the increase of various health indicators despite some of their high structural aspirations being only partially met. These indicators will be highlighted later on.

[32] In fact, based on accessibility and an attention to knowing the target population through direct contact, between 2004 and 2005 "a total of 150,455,332 consultations were provided by the *Barrio Adentro* program. This is almost four times the number of consultations in the conventional outpatient services during the same period. Nearly 40 percent of the *MBA* consultations (58,863,346) were home visits" (PAHO, 2006, p. 81).

[33] This traditional medical system existed prior to the *Barrio Adentro* program. This system is based upon a neoliberal ideology, and suffers from many of the issues highlighted in the

"the thousands of Cuban health workers with Venezuelans… [where] 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" (ibid.).

Since the establishment in Venezuela of the *Barrio Adentro* program in 2003, Cuban medical professionals have gone to Venezuela in large numbers as key participants in trade agreements, the first of which was signed in 2000 and the second in 2005. Julie Feinsilver summarized the details of both 2000 and 2005 bilateral agreements between Cuba and Venezuela.[34] These agreements allow for preferential pricing for Cuba's exportation of professional services—including medical services, medicines, and medical equipment to un-served and underserved communities in Venezuela—in return for a steady supply of Venezuelan oil. There are also joint investments in strategically important sectors for both countries, and the provision of credit. Feinsilver goes on to outline other details of the agreements:

> The 2005 agreement called for Cuba's provision of 30,000 medical professionals, 600 comprehensive health clinics, 600 rehabilitation and physical therapy centers, 35 high technology diagnostic centers, and 100,000 ophthalmologic surgeries, among other things. To contribute to the sustainability of these health programs, Cuba agreed to train 40,000 doctors and 5,000 healthcare workers in Venezuela and provide full medical scholarships to Cuban medical schools for another 10,000 Venezuelan medical and nursing students [at ELAM]. Venezuela agreed to provide petroleum at a fixed number of barrels per day (53,000) in exchange for a fixed amount of services and goods. The exchange was calculated at world market

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previous sections of the literature review—especially the debates regarding private and public medicine as well as the influence of the WB and IMF SAPs.

[34] In April 2010 Chávez faced his critics whom thought that Venezuela was being exploited by Cuba in these trade deals. He addressed these critics by stating that Cuba's contribution to the Venezuelan people "is priceless" and then asked the opposition what it would cost if Venezuela had to instead "contract the services of 30,000 medics from the United States or Europe to work in the *barrios* and the poorest towns… live with the native populations… build the medical facilities, bring the equipment for the medical laboratories and operating theaters, and provide the medicines… How much would a capitalist country charge us to bring that size of an army of doctors and that sea of medicines for our people, and be on call 24 hours a day?" (Chávez, 2010) Unfortunately the opposition critics have yet to produce a valid response.

> prices for oil at a time when that price was far less than today's price. Therefore, Venezuela's subsidization of Cuba is far greater than originally anticipated.[35] (Feinsilver, 2008, p. 4)

Kirk (2010) highlights more recent terms of the agreement. In exchange for 120,000 barrels of oil a day, Cuba increased the number of professionals in Venezuela to approximately 40,000 (p. 56).[36] In monetary terms, the Venezuelan government designates $9.45 billion in loans and credit for Cuba. Of that total, approximately $5.65 billion is utilized as payment for the "Cuban personnel working in Venezuela (principally medical personnel and teachers)," while $2.4 billion is directed at purchasing subsidized oil. The last $1.4 billion is "allocated to finance seventy-six programmes in Cuba in several economic sectors" (Kirk, 2010, p. 43).

However, it must also be noted that *MBA* is only one of a number of social missions aimed at abolishing poverty. Moreover in terms of its role in the country, it is still in the process of being completely integrated into the National Public Health Program of Venezuela. This is an important distinction because it cannot be "analyzed as a limited intervention; rather, it should be considered part of the health system, which

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[35] Feinsilver notes some of the other complexities of the agreement: "It is unclear what proportion of the Mission *Barrio Adentro* expenditures, which are included in social expenditures, are also included in international politics expenditures. The overall point is that more is being spent on international initiatives than attending to domestic affairs. However, Venezuela's fast rising oil wealth has allowed the government to triple spending on social programs up to 2008 and this volume of spending has resulted in improved living standards for the poorest segment of the population" (2008, p. 5).

[36] It should also be noted that the bilateral agreements between Cuba and Venezuela has expanded to include: 20,000 scholarships for Venezuelan students to study at Cuba's ELAM, "the development of scores of new projects in various economic sectors…[the establishment of] dozens of education and health projects servicing some 19 million people" (Kirk, 2010, p. 21), as well as incorporating "larger numbers of personnel and numerous sectors including, among others, development aid, business ventures, health, education, sustainable energy, and tourism" (Kirk, 2010, p. 5). She further highlights that "the over-all nature of the agreements [are] based on the barter trade of (Cuban) personnel for (Venezuelan) development cooperation. In the case of Venezuela, there are of course other peripheral aspects, but for Chávez the crux of the agreements rests in the form of personnel—both Cubans working in Venezuela, and Venezuelan professionals being trained in Cuba and Venezuela. By contrast, these accords also provide the Cuban government with the means of working to diversify and improve their badly underperforming economy" (2010, p. 23).

includes an array of organizations, institutions, and resources devoted to health, including public health services and intersectoral initiatives" (PAHO 2006, p. 79) that are aimed at the broader LASM conception of health.

It is significant that, despite a stall in the economy, mostly due to low oil prices, in Chávez's first three years in office, poverty rates underwent a dramatic transformation. Indeed, Chávez's attempts to comprehensively address issues of poverty go beyond the limited focus of most traditional health care systems. As noted in the literature review of this thesis, health has a very strong relationship with poverty; ill health begets poverty and poverty begets ill health. One of the most important aspects of Chávez's tenure was the clear reduction in poverty. As noted by Brouwer:

> The poverty rate, 62.1 percent in 2003, was cut in half, to 31.5 percent in 2008. The extreme poverty rate declined by two-thirds, from 29.5 percent to 9.5 percent. The gross domestic product grew by 78 percent, and average income grew by more than 50 percent in real terms, that is, after adjusting for high rates of inflation. (Brouwer, 2011, p. 79)

This is critical to highlight since it begins to help refocus the notion of health care within the broader structures and policies that influence a population's health by addressing the more complex issues of structural violence. The 'health in all policies' approach by Chávez through other government initiatives, or *Misión*'s, can also be reflected in the success in the rise of health indicators.

One of the most significant changes since Chávez came to power has been social spending, and between 1998 and 2006 social spending per person increased by 170 percent. This change in social spending, from 8.2 percent of GDP in 1998 to 13.6 percent by 2006, cannot be overlooked. Neither can the billions of dollars from the national oil industry—*PDVSA*—which are unrecorded in central government figures but also go toward numerous social missions.

Under a true LASM approach which comprises an exceptionally broad view of health, other reforms were implemented: 15,000 *Mercal* food stores sell heavily

subsidized groceries;[37] free food is provided for impoverished adults as well as children attending school; there are free sports and recreation programmes, free work-training programmes, free education programmes, and free housing grants or interest-free loans. Perhaps the most important of all, there is free health care as well as the development of *MBA* (Brouwer, 2011, p. 80). After highlighting how *MBA* began its integration into the national health system, it is now important to analyze the process of integration.

Cuban support for *MBA* has continued to grow since 2003. By December 2006 a new managerial structure for the Ministry of Health was approved. Consisting of three vice–ministerial offices (Resources for Health, Public Health Networks, and Health Services Networks), this reorganization of Government health care networks and public health system management structures has made it possible to institutionalize *MBA* as the core strategy to address health exclusion. PAHO notes that this strategy has four phases:

- *Barrio Adentro I*, which comprises community health clinics established nationwide at the first level of care, serves as the entry point to primary health care and the national health system.
- *Barrio Adentro II* includes comprehensive diagnosis centers, comprehensive rehabilitation centers, advanced technology centers, and community clinics. The purpose is to ensure free access to appropriate, high–quality technology and strengthen the capacity and efficacy of the entire primary care network.
- *Barrio Adentro III* consists of village hospitals that provide intensive care and surgical and emergency hospital services.
- *Barrio Adentro IV* refers to highly specialized centers such as the Gilberto Rodríguez Ochoa Latin American Children's Cardiology Hospital. This phase of the strategy includes construction of new hospitals to respond to the growing

[37] As noted by PAHO, food "has been prioritized as an inalienable and fundamental human right through the Ministry of Nutrition. In 2008, a total of 659,419 tons of food products were acquired for the *Mercal* network (which supplies subsidized food products) and to conserve food inventories in order to achieve coverage and establish and maintain the strategic food reserves. Nationwide, 627,761 tons of food products were distributed through 16,626 commercial points of sale. About 9,386,100 Venezuelans benefited from the *Mercal* network in 2009, providing them with savings of up to 52% when compared to prices for regulated products and 74% compared to private supermarkets and other national suppliers. There were 1,987 community–based food committees in 2007 and 3,050 were established and registered in 2008, for a total of 5,037, an increase of 53.5%" (2013, p. 4).

demand for third– and fourth–level services to excluded areas. Specialty areas provided include ophthalmology, neuropsychiatry, pulmonology, gastroenterology, infectious diseases, nephrology, urology, endocrinology, and plastic surgery. (PAHO, 2013, p. 9)

While these phases are similar to the evolution of Cuba's own health system, some very notable differences are worth highlighting. Cuba's implementation was a top-down approach compared to the bottom-up system of implementation of *MBA* I, II, III, and IV—in that order. The expansion of *MBA* is attempting to reach all corners of Venezuela over the course of four separate phases, taking approximately two years for each phase's implementation (Brouwer, 2011). This is one of the most striking differences between these two systems, since instead of there being two years between each stage of implementation, the Cuban medical system took approximately ten years for every stage to be implemented.

Cuba's system started first with expanding hospitals and complex care centres before moving onto expanding the village and community hospital network. Next, the community-oriented primary care (COPC) centres were spread throughout the country to establish still greater access. Lastly, the Cuban system utilized first-contact primary care centres—the *consultorios* and *policlínicos*—to ensure that proactive and preventive care was being used to establish successful first contact solutions available 24 hours a day, 7 days a week. This has resulted in "80% of health problems are addressed by the 1st contact *consultorios* due to health promotion" (Dresang et al, 2005, p. 298).[38]

[38] Even with *MBA* filling in for the traditional system's lack of proactive and preventive care, it still has curative elements as well (of note through observations was the availability, for free, of dentists). Muntaner et al. highlight that, in general, *MBA* utilizes an integral care model where physician "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" (2008, p. 237). Health care provided through "*Barrio Adentro* I guarantees health promotion and curative care in the majority of cases…[however] patients require[ing] para-clinical diagnostic examinations or more complex procedure[s]" are moved to the second level of care" at *Barrio Adentro* II *CDI*s (Muntaner et al., 2008, p. 238).

This focus on prevention and proactive care is responsible for the Cuban health model being not only effective but also efficient.[39] The use of human capital instead of technology, as well as resources and specialization of a curative-focussed health system ensures that complex health cases get diagnosed and addressed early before moving up the chain of specialization (and greater cost). The emphasis on preventive and proactive health is also what makes *MBA*'s programme significant. Docksai highlights that the "clinics act as a first line of care that tackles multiple health risk factors before they morph into acute conditions that require costly hospitalizations" (2012).

Currently *MBA* is working to scale-up the medical workforce in Venezuela with the goal of providing health care for all. Though starting out as a humanitarian medical and health care project noted above, it has grown "to become a national public health care program committed to wiping out the national health care deficit" (PAHO, 2006, p. 1). In the Pan American Health Organization (PAHO) article titled *Mission Barrio Adentro: The Right to Health and Social Inclusion*, the authors have noted, *MBA* "is primary health care in its essential form. It is a strategy for restructuring and transforming the entire health system" (2006, Forward). The expansion of *MBA* is attempting to reach all corners of Venezuela over the course of four separate phases taking approximately 2 years for each phase's implementation (Brouwer, 2011).

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[39] As an example, the proactive aspects of the health system include attempts to decrease the use of tobacco. PAHO highlights that "Venezuela is a pioneer in the use of the Youth Tobacco Survey (EMTAJOVEN), which has been carried out nationwide among 13–15–year–old schoolchildren. The survey conducted in 2010 showed a significant decline in the number of young people-both male and female-who had ever smoked, from 21.9% in 1999 to 13.2% in 2010. Current use of other tobacco products also fell during over the period, from 8.7% in 1999 to 5.1% in 2010, representing a significant change for girls but not for boys. With regard to exposure to second–hand smoke, from 1999 to 2010 boys and girls maintained a high level of acceptance of the ban on smoking in public spaces: 87.3% in 1999 and 87% in 2010. The number of young people exposed to cigarette advertising on billboards in the previous month fell from 80.2% in 1999 to 73.7% in 2010; the difference was significant among boys but not girls. The proportion of youth exposed to cigarette advertising in newspapers and journals also fell significantly, from 80.4% in 1999 to 66.7% in 2010. Likewise, the share of young people who used objects sporting cigarette names or logos fell from 14.9% in 1999 to 6.2% in 2010. Survey results reflected a significant increase in the number of students who received antismoking education at schools-from 42.1% in 1999 to 76.4% in 2010" (2013, p. 9).

In PAHO's more recent analysis of Venezuela's four-year period from 2006 to 2010 they note that the main achievements in health have been:

- Availability of services was improved and public access to the National Public Health System was increased. The Maternal and Child Hospital and three other hospitals were built, increasing to 218 the number of hospitals administered by the Ministry of Health. The Latin American Children's Cardiology Hospital was also established for comprehensive medical and surgical treatment of congenital or acquired cardiovascular diseases among children and adolescents from Venezuela and abroad. The number of primary care clinics increased by 153%, from 1,433 in 2006 to 3,630 in 2009.
- The number of outpatient care centers in the network of neighborhood clinics (*Misión Barrio Adentro II*) increased by 90% between 2006 and 2009, from 529 to 1,006 establishments. A total of 477 new centers were built and equipped, bringing the number of comprehensive diagnosis centers to 466, comprehensive rehabilitation centers to 509, and advanced technology centers to 31.
- The rotavirus, seasonal influenza, and 23–valent pneumococcal polysaccharide vaccines were introduced into the national system, for a total of 10 vaccines that protect against 14 diseases. Likewise, 1,732 establishments joined the National Vaccination Program, bringing to 5,916 the total number of vaccination sites open in 2010. In 2010 transmission of measles and rubella remained interrupted and polio remained eradicated.
- In 2010 the onchocerciasis focal region in north–central Venezuela was declared to be in the post–treatment surveillance phase.
- From 2006 to 2010 Venezuela made significant progress in implementing the WHO Framework Convention on Tobacco Control through a strategy for smoke–free environments, smoking–cessation advice in health services, a tobacco advertising ban, and an increase in the tax rates on cigarettes and chewing tobacco amounting to 70% of the retail sale price.
- Universal access to antiretroviral therapy for people living with HIV/AIDS continued. In 2010 a total of 35,893 people had undergone treatment.

- The supply of special medications made it possible for mortality among patients with cystic fibrosis to drop to 0%.
- As part of its constitutional commitment to ensure access to free treatment, Venezuela joined the PAHO Regional Revolving Fund for Strategic Public Health Supplies (the Strategic Fund) in December 2010.
- In 2010 Venezuela initiated the National Public System for the Treatment of Addictions, which is integrated into the National Public Health System at three levels: (1) family and community centers, (2) centers that specialize in preventive and comprehensive care, and (3) socialist therapeutic communities. (PAHO, 2013, p. 2-3)

Though the successes of the hard policy tools have been fairly significant, including broader categories of health such as the "nutritional deficit (weight–for–age) in children under 5 [which] declined 21.6% between 2006 (4.5%) and 2008 (3.7%)" (PAHO, 2013), it is the soft policy tools of values, norms, and culture found in *Misión Sucre's* free medical education system that will arguably determine the longevity of Venezuela's health system. The first Venezuelan medical class graduated last February 2012 when over 8,000 doctors completed the 6-year Cuban-led curriculum (Pearson, 2011). Currently there are approximately 14,000 medical graduates under this new program, which will definitely impact health indicators in the near future.

3.5 *MISIÓN SUCRE*—THE MEDICAL EDUCATION MODEL

As noted previously, the impact of the SAPs had decimated the pre-Chávez public health system as well as the concept and practice of primary health care. Both had become increasingly removed from Alma-Ata's founding spirit of 'Health for All' (HFA) as priority was placed on the containment of public expenditures. The progress of implementing a primary health system was critically undermined at this point. The medical education system faired little better during this particular period and faced immense challenges.

During the 1978-1990 era Venezuela's universities strongly supported Alma-Ata's mandate to reform medical school curriculum. Unfortunately support was very

limited at the political level which made it impossible to introduce the reforms in health institutions or through academic curriculum changes. With the exception of small groups that kept the Primary Health Care (PHC) movement alive, "the techno-scientific medical model was imposed once again and medical studies were isolated from direct contact with the living conditions of the population" (PAHO, 2006, p. 15).

This is significant since the medical education component of *Misión Sucre* is, in many cases, about ensuring that the Cuban-trained medical personnel are very knowledgeable about the living conditions of the populations they work with (especially the poor and marginalized) through direct contact. In order to ensure *MBA* sustainability, many Cuban doctors are training the next generation of Venezuelan medical personnel under a Cuban conception of LASM (PAHO, 2006) that re-visits various PHC principles found in Alma-Ata. Muntaner et al. note that, 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" (2006, p. 807).

Though the hard transfer of policy tools of resources and human capital has been outlined, it is the soft policy transfer that is incorporated into the free medical education programme in *Misión Sucre* which must also be analyzed for its impact in attempting to change the culture, values and norms of the health care providers. The culture of duty (commonly found in many medical systems) among Cuban and Venezuelan medical workers is the result of their unique educational background which values success as the ability to serve the indigent (Huish, 2008). This unique background is one of the key strengths of the *Barrio Adentro* system that must be highlighted since it pairs a decentralized preventive medical system with a decentralized medical education system (Brouwer, 2011).

The education system ensures that marginalized areas receive medical assistance in large part due to the practitioners themselves being drawn from, and educated close to, these areas.[40] The non-traditional background of the medical practitioners in this

[40] A very interesting and unique adaptation of the empowerment of indigenous populations to provide effective health care is found in Venezuela. The 2013 PAHO study noted that in "2007 the Ministry for Indigenous Affairs was established by Presidential Decree No. 5103. Two projects have been launched by the Ministry; the first aims to provide prompt medical

decentralized medical system, and especially the decentralized nature of the *Barrio Adentro* education system, is what makes these medical practitioners unique (Brouwer, 2011). Thus, it helps to ensure that the medical profession in both Cuba and the *Barrio Adentro* program is not considered a sign of status nor entitlement; rather, it is a profession grounded in duty with the cumulative health of the community at its heart. This is an important distinction from other developing countries that often suffer from low rural/impoverished patient accessibility, and where this sense of community is often limited.

This sense of community helps to establish a *conciencia*—a sense of duty, commitment, compassion and empathy to treat patients as family—as well as situating their patients in their 'bio-psycho-social' spheres of health. This may be one of the most important aspects to analyze as the embodiment of LASM. Both the Cuban medical model and the *Barrio Adentro* system utilize their health teams to examine patients as bio-psycho-social persons that are subject to all three spheres of influence, and not just as individuals to be treated as a result of a singular biological issue. Pérez (2008) explains that the bio-psycho-social role of the doctor entails:

> addressing multiple dimensions of human life. When doctors ask what has caused disease in a particular patient they evaluate the microscopic physical level. They also look at how individual behaviour may impact disease. Then, the Cubans examine how material conditions shape and / or restrict particular decisions and actions. They also consider how culture impacts decision-making and how cultural practices emerge out of particular historical, political, and economic moments. Key also are mind / body connections, which are viewed as multiple

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care and a continuum of care for the most vulnerable indigenous populations and the second strengthens social participation and empowers indigenous communities. In 2008 the Comprehensive Plan for the Defense, Development, and Strengthening of Border Municipalities in the State of Zulia was approved and the Caura Plan was created to serve the indigenous communities affected by mining in the State of Bolívar. By 2010, a total of 2,886 indigenous communities were registered and 1,186 indigenous leaders were enrolled in the Comprehensive Community Medicine degree program. In 2012 they will complete their studies and become community physicians in health facilities in indigenous communities. In 2010, capacity was expanded through 28 facilities providing health care and counseling services for the indigenous population in the following states and the Capital District: Amazonas (1 facility), Anzoátegui (4), Apure (2), Aragua (1), Barinas (2), Bolívar (6), Capital District (2), Delta Amacuro (1), Monagas (2), Sucre (2), and Zulia (5)" (p. 6).

and dialectical.... Within the Cuban understanding of the bio-psycho-social paradigm, the materialist dimension is emphasized. Cuba's bio-psycho-social approach centres minds and bodies in particular social, economic, and physical environments. The bio-psycho-social paradigm is the key reason why Cuba has been able to transform the bodies of the population from bodies of deprivation to bodies of affluence even in the midst of extraordinary financial crisis and growing economic stratification (269).

The patient, as a member of a larger environment, can thus be prescribed changes related to issues surrounding their environment and community. This environment includes dietary advice as well as addressing issues that might arise from work and lifestyle. The medical team is integrated within the community and is responsible for making recommendations to improve the community's health.

The vertical integration of both systems is also important. This vertical integration entails a hierarchical health care catchment system to ensure a high level of control by delegating responsibility that reaches the local levels, including the most impoverished and rural areas in Cuba with the goal of providing the same approach in Venezuela. It means that knowledge of a patient's needs, shortages of medication, suggestions for improvement, and community health needs, are being shared with the people who can respond to make improvements quickly and effectively (Spiegel and Yassi, 2004).

Brouwer (2011) also highlights that the free medical education system associated with *Barrio Adentro* is the key to the overall medical program's success. This education system is one of the unique aspects of the program and Brouwer notes its significance by juxtaposing the traditional medical education model used by most nations. The decentralized community-oriented medical education system called *Medicina Integral Comunitaria* (*MIC*) or Comprehensive Community Medicine, aids in its ability to reach rural populations. Feinsilver also found that "Mission *Barrio Adentro* provided access to comprehensive health care for those segments of the population that previously did not have access to the health care system" (2008, p. 6).[41]

[41] Also of note is the fact that during the ELAM'S first graduation in August 2005, "Venezuelan President Hugo Chávez announced that his country would establish a second

3.6 SUMMARY

Though housing programmes, literacy campaigns, improved sanitation, free school from preschool to university, and access to comprehensive medical services have all contributed to the rise in the broad macro-level health indicators, Venezuela still experiences other challenges as well. One is the spike in migrants from other countries (mostly from Colombia) who tend to begin their new life in the various *barrios* around Venezuela and, most notably, on the hillsides of Caracas. In addition to the challenge of increased migration is the huge increase in violence and homicide rate. The Guardian compiled a sample of indicators that shows some of the successes and challenges of Chávez's government:

Table 2 Venezuela—Key Indicators

Indicator	1999	2009	2010	2011	2012	Source
Population growth (annual %)	1.9			1.5		World Bank
Population, total	23,867,000			29,278,000		World Bank
GDP per capita (current US$)	4,105			10,810		World Bank
Unemployment, total (% of total labour force)	14.5	7.6				World Bank
Colombian refugees (and people in refugee-like situations) in Venezuela	50			201,941		UNHCR
Mortality rate, infant (per 1,000 live births)	20			13		World Bank
Households (% of total declared) Extreme poverty—second half	19.3			7		Instituto National de Estadistica, INE
Population (% of total declared) Extreme poverty—second half	23.4			8.50		Instituto National de Estadistica, INE
OPEC Net Oil Export Revenues, Nominal (billion $)	14.4			60		OPEC, EIA
Inflation, average consumer prices (Percent change)	23.57	27.081	28.187	26.09	31.558	IMF
Intentional homicide, number per 100,000	5,968		13,080			UNODC
Intentional homicide, rate per 100,000	25		45.1			UNODC

Source: Sedghi, A. (2013), How did Venezuela change under Hugo Chávez? *The Guardian Online*. Retrieved from: http://www.theguardian.com/news/datablog/2012/oct/04/venezuela-hugo-chavez-election-data. Date Accessed 20 August 2013.

Latin American Medical School, so that jointly with Cuba, the two countries will be able to provide free medical training to at least 100,000 physicians for developing countries over the next 10 years. The humanitarian benefits are enormous, but so are the symbolic ones. Moreover, the political benefits could be reaped for years to come as students trained by Cuba and Venezuela become health officials and opinion leaders in their own countries. Today, some of the 50,000 foreign scholarship students who trained in Cuban universities as doctors and nurses in various medical disciplines since 1961 are now in positions of authority and increasing responsibility" (Feinsilver, 2008, p. 7-8).

The growing relationship between Cuba and Venezuela is of course significant since it is one of the core supports that explains how these many of the health indicators have shifted in response in the changes to the health system through the implementation of both hard and soft policy tools—most notably the changes made through *Misión Sucre's* medical education programme.

In summary, while the Chávez government has made substantial health care access improvements for most of Venezuela's 70 percent that once lived below the poverty line, and who are now emerging as a new middle class, the macro-level indicators have only highlighted these relations from a broad policy and economic standpoint. So while violence has risen,[42] and inflation continues to be a major challenge, many other indicators will now be analyzed in terms of a micro-level qualitative analysis, as experiences through the 10-week period of interviews and observation undertaken in Venezuela from April to June 2013. Thus, the challenges, shortcomings, success, and future of *MBA* and *Misión Sucre's* medical education model will now be discussed in further detail in the next chapter.

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[42] The high incidence of violence is especially prevalent for males aged 20-59. In a PAHO article they noted that the causes of death in all age categories had decreased in their particular rates of death except for this group of males. PAHO highlighted this increase in their analysis: "Adults in the 20–59–year age group comprised 51.4% of the estimated population in 2006 and 52.5% in 2010. Mortality in this age group rose from 314.7 per 100,000 in 2006 to 332.4 in 2009. In 2006 male mortality was 2.5 times greater than female mortality in this age group (451.8 men compared with 177.6 women per 100,000)…. The leading cause of death (32.1%) among women in this age group in 2006 was neoplasms (C00–D48); by 2009 that figure had fallen to 30%. Among men the leading cause of death was due to acts of violence (X60–Y36), which accounted for 36.5% of mortality in this group in 2006 and 38.2% in 2009. Among men in this age group, neoplasms (C00–D48) accounted for 8.3% of deaths in 2009. Among women, diseases of the circulatory system (I00–I99) accounted for 22.6% of deaths in 2006 and 21.6% in 2009; among men of this age, 17% of deaths were attributable to this cause in 2009" (PAHO, 2013, p. 5). This is especially relevant to the next chapter since it highlights one of the more contemporary health challenges that all levels that the health system struggles to respond to—the high trauma incidences of guns and knife violence as well as car accidents.

CHAPTER 4 RESEARCH FINDINGS: ASSESSING THE IMPACT OF REVOLUTIONARY MEDICINE IN LARA

"*Cuban doctors are so poorly trained they are dangerous to Venezuelan patients. What is worse is that they are teaching a generation of doctors here to be just as poorly trained.*"
- Regional opposition member in Carora, 2013

"*[One of the main challenges to MBA is the notion that] Cuban doctors and other health personnel are not 'Castro´s soldiers' or that 'Cuban medical students are not well prepared for the service'. I think this has been achieved; practice is the main criterion of truth.*"
- Cuban *Barrio Adentro* system state-level manager in Eastern Venezuela, 2013

The research of articles and publications found in Chapter 2 presented a clearer vision of Venezuela's medical system than was experienced during the ten weeks of research in Venezuela, entailed. The majority of research took place in the state of Lara in a town of approximately 100,000 called Carora which is the regional medical hub for the sparsely populated desert region of Torres. It was an interesting area to do research since the region of Torres was one of the most rural areas in Venezuela outside of the larger states of Bolívar and Amazonas (which both border the huge Amazon basin). After the scale-up of the medical system by the Chávez government, from state capital hubs like Barquisimeto (which is the capital of the state of Lara) to including regional capital hubs, Carora's medical system expanded from one major hospital to a new situation in which there were a high-technology centre, four integrated diagnostic centres/*Centros de Diagnóstico Integral* (*CDI*s), and 17 house clinics / *Consultorios Médicos Populares* (*CP*s), as well as a medical education branch of *Misión Sucre*, training medical students under the supervision of Cuban tutors.

The research entailed periods of observation of medical facilities in Caracas and Carora as well as the surrounding rural towns in the Torres region—Río Tocuyo, Arenales and Altagracia. In Carora the municipal hospital, three *CDI*s and one *CP* were toured. In the Torres region two more *CP*s as well as an *ambulatorio* II were also toured. Observations of various medical facilities were accompanied by interviews with various health care workers (social workers, nurses, doctors, accountants, hospital and *CDI* managers, as well as other medical personnel) and patients.

The interviews with *Misión Barrio Adentro* (*MBA*) personnel and patients, as well as the observations, were often contrasted with interviews of opposition academics,

doctors, and medical personnel from the private health care system—many within their private clinics. Due to the (often hostile) political climate in Venezuela, anonymity of all respondents has had to be strictly maintained for this research. The following is a list of the backgrounds of each respondent as well as the location of the interview.[43]

Table 3 List of Respondents

#	Background	Location	#	Background	Location
51	Patient of *MBA* / moderate	Caracas	70	Cuban *CDI* accountant	Carora
52	Patient of *MBA*	Caracas	71	*MBA* doctor / *Misión Sucre* teacher (received training in both medical education systems)	Carora
53	Patient of *MBA* / academic / moderate	Caracas	72	*MBA* patient	Torres region
54	Patient of *MBA*	Caracas	73	*MBA* doctor / *Misión Sucre* clinical teacher (trained in *Misión Sucre*)	Torres region
55	*MBA* manager and doctor/ *Misión Sucre* teacher (trained in the traditional medical education system)	Carora	74	*Misión Sucre* general medical student	Torres region
56	*MBA* nurse/ *Misión Sucre* teacher (trained in the traditional medical education system)	Carora	75	*MBA* nurse	Torres region
57	*Misión Sucre* nursing class	Carora	76	*Misión Sucre* general medical student	Torres region
58	*Misión Sucre* nursing class	Carora	77	*Misión Sucre* general medical student	Torres region
59	Regional head of vaccinations / *MBA* doctor / *Misión Sucre* teacher (trained in the traditional medical education system)	Carora	78	*Misión Sucre* nursing student	Torres region
60	Social worker (trained in the traditional medical education system)	Carora	79	Private doctor / opposition supporter	Carora
61	Social worker (trained in the traditional medical education system)	Carora	80	Private doctor / *Misión Sucre* teacher (trained in the traditional medical school)	Carora
62	Public health care manager	Carora	81	*MBA* doctor / teacher in *Misión Sucre* (trained in the traditional medical school)	Carora
63	*Misión Sucre* nursing student	Carora	82	Cuban state-level manager of *MBA*	Eastern Venezuela
64	*MBA* doctor / *Misión Sucre* teacher (trained in the traditional medical education system)	Carora	83	Public doctor / supporter of the opposition	Carora
65	Patient of *MBA*	Carora	84	Academic / supporter of the opposition	Carora
66	Cuban doctor / clinical teacher	Carora	85	Academic / member of the opposition	Carora
67	*Misión Sucre* general medical student	Carora	86	Patient of *MBA*	Caracas
68	Cuban *CDI* manager / doctor / clinical teacher	Carora	87	Patient of *MBA* / moderate	Caracas
69	Cuban doctor / clinical teacher	Carora			

The teaching facilities of *Misión Sucre* were also observed and two classes (including the teachers) were interviewed. Additional research also took place throughout a brief tour of Venezuela's western and northern regions, but most research outside of the

[43] Some details were omitted in order to ensure participants remain anonymous.

Torres region took place at *CDI* Salvador Allende in Caracas—the city where *MBA* originally started as a response to medical exclusion faced by residents of the slums. Some key *MBA* personnel were contacted via e-mail to help situate the broader context of *MBA*'s implementation as well as the future direction of the programme.

This chapter will include a thematic analysis of the challenges, successes and future of *Barrio Adentro* as well as *Misión Sucre*'s medical education programme. Key to this analysis is the question of whether the Cuban medical adaptation in this region shows promise for future adaptations in overcoming structural violence[44] for vulnerable populations—especially for the impoverished and rural sectors.

4.1 Polarization

As noted in the introduction, many of the research complications in this project arose from the divisive political and social environment in which Venezuela was currently immersed. Media reports, personal accounts, and interviews usually seemed to present two polarized interpretations of most Venezuelan topics—and *Misión Barrio Adentro* (*MBA*) was no exception.[45] Health care in Venezuela is definitely not apolitical.

[44] Structural violence is highlighted in the theoretical framework on pages 8-11. As Paul Farmer notes: "Structural violence is violence exerted systematically—that is, indirectly—by everyone who belongs to a certain social order: hence the discomfort these ideas provoke in a moral economy still geared to pinning praise or blame on individual actors. In short, the concept of structural violence is intended to inform the study of the social machinery of oppression. Oppression is a result of many conditions, not the least of which reside in consciousness" (2004, p. 307). In the case of Carora and Venezuela this is clearly applicable.

[45] As noted previously in the introduction, Venezuela seemed to breathe contestation and this may have been a result of significant events during the last eight-months (prior to the start of the research programme in April 2013). During those previous eight months there were two national elections, one in which Chávez won with 10 percentage points and the Capriles opposition conceded victory; and—after the untimely death of Chávez—the second election with less than a 2% difference in votes cast between the current president and official government candidate, Nicolás Maduro, and Capriles, the opposition candidate. After that election the Capriles opposition refused to concede defeat—with the United States being the only country to not recognize the Maduro government. This was further intensified by the state-level elections where, following Chávez's slide into ill health and being hospitalized in Cuba for medical attention, the Chavista leaders won all of the states except three. With Chávez's death throwing the nation into grieving, turmoil, confusion and ultimately uncharted territory, these three consecutive elections, accompanied by post-election accusations and violence, meant the political divide might have been at an all-time high for the nation.

The findings were nonetheless interesting, possibly even more so due to the politically charged environment. The politicized health care system meant that responses to various questions, especially regarding the roles of Cuban doctors, often lacked nuanced middle ground. The effort of much of the research entailed a difficult process of triangulating observations and responses during meetings, interviews and informal conversations with members of the opposition, Chavistas (supporters of Chávez), government, and moderates.

Put simply, many people in the health system are divided by political ideology. As noted before, the people of *Misión Sucre's* medical education programme and *MBA* are mostly Chavista. By contrast many, associated with the private health care system, are more supportive of the opposition stance. Those from the traditional medical system, but working in the public health sector, seem to be more evenly divided since increasing numbers of doctors from the traditional system have been joining the effort to help train the next generation of Venezuelan doctors in *Misión Sucre* under Chávez's vision of Latin American social medicine (LASM).

4.2 FRAGMENTATION

The challenges of *MBA* were definitely well highlighted in opposition interviews. Issues of fragmentation, the quality of Cuban medical training, the allocation of resources, the focus of health measures as well as others criticisms, were often outlined. Docksai also highlights the myriad challenges facing *MBA*:

> *Barrio Adentro* has borne its share of setbacks. Staff shortages set in, due in part to the established doctors' associations shunning it. For political reasons—some traditional doctors viewed *Barrio Adentro* as a rival, and many were suspicious of communist Cuba's involvement in the project—numerous doctors' associations went so far as to forbid their members from applying for jobs at its clinics. Economic setbacks before and during the 2008 global financial crisis likewise cut hard into the *Barrio Adentro* bottom line. Approximately half of the clinics initially built were shut down, and many more laid off staff and cut back hours of operation. (2012, p. 46)

After an immersion into the medical system as an observer and interviewer in Venezuela, the reality of the medical system came into focus, as a complex mix of two semi-parallel systems with its share of both successes and challenges was assessed. Though there was overlap of *MBA* and the traditional system in various rehabilitative areas, as well as some aspects of curative health, not everything was completely paralleled and looked similar to the diagram below:

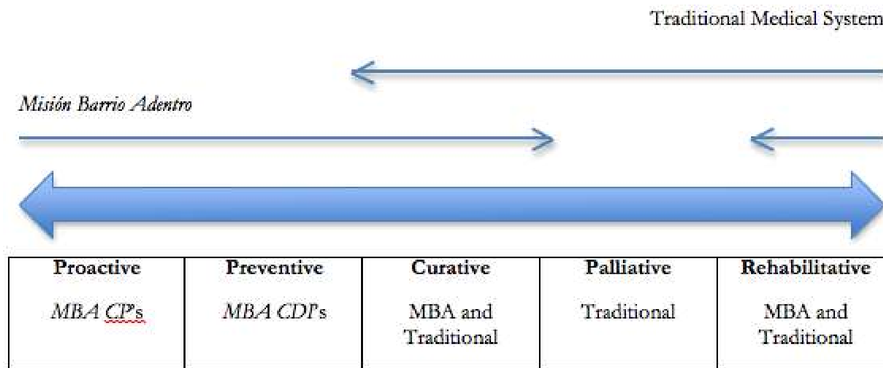

Figure 1 Diagram of the Semi-Parallel Health System in the Torres Region
Source: Author, based on interviews with *MBA* medical personnel in the Torres health region, 2013.

This figure highlights the allocation of human capital for both the traditional medical system and *MBA* along the spectrum of health foci. Despite *MBA* focusing human capital on proactive and preventive health to fulfill roles neglected by the traditional system, these systems overlap in certain areas to create a semi-parallel national health system.

The complexity of the health system was highlighted in a number of interviews where, in theory, *MBA* is supposed to be a somewhat separate entity that utilizes proactive and preventive health care (mostly absent in the traditional system) that targets rural and poor populations, but is also supposed to collaborate throughout the chain of health with the curative-focused traditional system. The traditional system still has its presence felt in rural communities through mandatory six-month placement in rural *ambulatorios*[46] after medical students graduate.[47]

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[46] As noted in the previous chapter, *ambulatorios* are small walk-in consulting offices that were located in both urban and rural areas.

[47] Some respondents highlighted that the entire placement was 1-2 years with a 6-month rural portion. Further interviews with personnel from the traditional education system

This complex mix, as some respondents highlighted, has created some barriers to the effective transition from preventive *MBA* care to the specialized traditional curative medical system.[48] Fragmentation may be further compounded by the different praxis and ideologies of the systems that tend to be predominantly divided along political lines. The politicization was also highlighted in interviews with physicians from the traditional public system who felt alienated since the implementation of *MBA*.

For some of them, the Chávez government often attacked traditional medical practitioners in the media as being greedy, poor examples of the service that a health care provider should aspire to offer. As noted in the previous chapter, this was because many doctors from the traditional model refused to serve in impoverished or underserved areas, while others even actively protested the arrival of Cuban doctors. However, during this time, some doctors who continued to serve in the front line of an overwhelmed public health system felt alienated and overlooked by the government, despite the duties and

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highlighted that many of the students refused to do any or some of their rural rotations and left *ambulatorios* often understaffed. (Respondents 56, 64, 71, 81, Torres Region, April-June 2013)

[48] Towards the end of this research period in Carora, the Venezuelan government announced that it would expand the *Misión Sucre*'s medical education system to include scholarships for specialists to address shortages and issues regarding the curative portion of *MBA*. One respondent, a doctor who graduated from the traditional system many years ago (and has helped in the regional implementation of *MBA* as well as teaching at *Misión Sucre*), highlighted some of the issues that led to this decision: "There was a problem with previous graduates from the traditional system who had taken advantage of the public health system to develop their private consultations. These doctors emphasized private health care and profit to such an extent that when the [*MBA*] community doctor programme arrived, instead of helping them consciously and voluntarily in their preparation to serve the communitiy, they instead rejected them. Often the traditional doctors, from what people consider 'distinguised universities', have a sense of professional zeal, and they say that doctors graduating from *Misión Sucre* are ill-prepared. However they make many criticisms without knowing much about the education of the community doctors at all. So instead of helping integrate those doctors from the community medical programme in a way that links with traditional medical specialists, many have decided instead to dismiss them as being sub-standard and instead choose to work only with their peers in the traditional and/or private system. However, since a medical system relies on efficient coordination and transitions of medical care levels, the comprehensive community medical program in *Misión Sucre* was modified. These new doctors will became present in hospitals with a view that, in the next 5 or 6 years, they will be different [*Misión Sucre*] specialists who will be accountable for the health of the enire country including the poor. In fact, since we [from the traditional system] have a great deal of experience, we should instead also be preparing and helping them integrate into the broader health system" (Respondent 55, Carora, May 2013).

sacrifices they had made to provide health care to their communities. They noted that a certain amount of criticism should be leveled at the broad statements made by the Chávez government since it had failed to recognize the contribution of those from the traditional health system who had served the public, often in difficult circumstances.

In addition to this, as some of these physicians have highlighted, they had committed to health care since it was their calling. They did not abandon their profession and turn to private health care, and as a result they felt like the media comments by the Chávez government promoted the idea that they were inferior when compared to the Cuban doctors. In actual fact no other medical education system was available when they took up the call to provide health care. This interaction between traditional physicians and the government has possibly exacerbated the friction between the two groups over the acceptance of *MBA*, and contributed to the view that Cuban doctors are a threat to their reputation and possibly livelihood. Though these doctors represent a small portion of the physician population, their comments should be noted. In addition to this particular group, there are many medical personnel and teachers from the traditional system who were actively helping to promote the integration of the *MBA* as well as teaching medical classes in *Misión Sucre*.

4.3 ACCEPTANCE OF THE CUBAN MEDICAL PERSONNEL

Few responses were more polarized than over the topic of the role and contribution of Cuban medical personnel. Most criticisms against Cuban involvement were disappointingly uninformed regarding the details of *Barrio Adentro* and the training of Cuban doctors, as well as their role and contribution in training a new generation of Venezuelan doctors. An overwhelming percentage of opposition respondent's fear was directed at the idea that the Chávez government would head towards 'communism'. Complaints range from Cuban doctors infiltrating Venezuela as 'soldiers in white coats', to being grossly under-qualified for the job, to Cuban medical personnel not understanding the unique health issues of Venezuelans (including the high incidence of

trauma cases from car accidents, as well as gun and stab wounds from the increased violence).[49]

These critiques and accusations are well known to Cuban personnel serving the Venezuelan populations as well. As one respondent highlights, many opponents to Cuban involvement:

> continue to say that Cubans are not really professionals, that in the educational programme many youngsters are admitted without a high enough educational level for a university programme, that many of the students have attitudinal problems, that the students graduate from *Misión Sucre* with a poor level of knowledge and skills, and that they are promoted because of political criteria instead of… achievement of educational excellence... They hate the Cuban government due to many years of propaganda against Cuba, and the fear to change may explain their view of us. Of course whatever mistakes committed by a Cuban professional, or a medical student of the community medicine programme, are used to denigrate the obvious achievements. There are things that should be emphasized. This is a very young programme, but errors and mistakes are the exception not the rule. (Respondent 82, e-mail correspondence in Venezuela, June 2013)

Though the involvement of the Cuban doctors is extremely controversial, the fact that Cuban medical schools, including ELAM,[50] are recognized by the US seemed baffling to members of the opposition and often caused a pause for reflection during discussions.

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[49] At the beginning of May, when asked about the number of homicides in Carora (population ~100,000), one respondent said that this year wasn't particularly bad: only 14 people had been murdered in the four months since January (Respondent 65, Carora, May 2013). In comparison Halifax, which has the second highest murder rate in 2011 (4.41 per 100,000) for cities in Canada, as well as a population approximately three times that of Carora, recorded 18 homicides for the entire year. (Arsenault, 2012)

[50] The medical education programme in Venezuela is at the same level as other Cuban medical schools as well as ELAM. In fact a number of students from the United States—including eight in 2013 (MEDICC, 2013)—have already graduated from ELAM and have returned home to practice medicine. Though United States federal government welcomes all Cuban medical-trained doctors, some United States ELAM students have encountered issues at the State level. Some States refuse to recognize Cuban degrees while others do. However, the high degree of medical training in Cuba can be summed up by a website of international

These criticisms of the lack of pertinent training and an emphasis on a curative approach may have had an element of truth during the early stages of the implementation of *MBA*. However, a 2008 survey on patient satisfaction highlighted public satisfaction with *MBA*:

> Household Survey was conducted to determine people's level of satisfaction with the health services. Results showed that 93.5% of users of the public–sector services provided by *Barrio Adentro* were satisfied with them: 75.4% were satisfied with outpatient services or public dispensaries and 71.2% were satisfied with the services provided in public hospitals.[51] Reasons given for dissatisfaction related to a lack of specialized doctors and problems with medicines. (PAHO, 2013, p. 9)

As noted previously, some arguments against *MBA* also included the heavy focus on preventive medicine and the inability to address the widespread trauma cases resulting in the high rate of gun and stab wounds[52] as well as car accidents. Though complex medical

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ELAM alumni: "The mission of ELAM is to make competent and cooperative doctors with the degree of MD (Doctor of Medicine), the same degree which is offered to medical graduates in all over the Americas including the US. The Latin American School of Medicine is officially recognized by the Educational Commission for Foreign Medical Graduates (ECFMG) and the World Health Organization (WHO). It is also fully accredited by the Medical Board of California, which has the strictest US standards-which means that qualified US graduates of the Latin American School of Medicine are eligible to apply for residency placements in any state of the US. It is preferred that ELAM students come from the poorest communities with the intent of returning to practice in those areas in their countries" (EUSSA, 2012).

[51] One manager of a regional hospital outlined the different types. "There are 4 types of hospitals [in Venezuela]: type I hospitals, which have 20-60 beds, are located in geographical areas with about 1500 inhabitants. The type II hospitals are in the capital of municipalities or parishes with 60-120 beds. These are for populations between 1500 and 3000 inhabitants. Then there is the type III hospitals, like [the one in Carora] is supposed to be, that are located in the capital with up to approximately 200,000 inhabitants. They have 200 beds for surgical patients, and deal with some complex cases apart from having the 4 basic services: internal surgery medicine, gynecology, obstetric, pediatric and sub-specialties. They also have auxiliary diagnostic services and auxiliary services such as the X-ray equipment, pathology services, specialized laboratories, intensive care units (for both adult and pediatric levels), as well as equipment to treat cancer patients with chemotherapy and radiotherapy." (Respondent 55, Carora, May 2013)

[52] At the time of research, an attempt to curtail violence was made through a significant

emergencies are often not addressed at either of the main *MBA* centres (the local *CP*s and *CDI*s) and go directly to the hospital level, from the interviews and observations it was clear that some of the *CDI*s were being refocused to help address complex emergencies to aid the hospitals. Employing intensive care doctors and nurses at all times has been made a priority for many of the *CDI*s. Thus, since its implementation, it appears that the programme has adjusted to meet this particular criticism in the *CDI*s that had been observed in both the Torres and Caracas regions.

In addition to the increased staffing of intensive and emergency personnel, a government announcement was made in 2013—that specialized medicine would now be included free of cost in the *Misión Sucre* medical education programme. As a regional Cuban medical manager notes:

> In January 2014 [*Misión Sucre*] will start a new step toward the strengthening of the PHC system in Venezuela. The PG [post graduate] programme will begin to train more than 6,000 specialists in General Comprehensive Medicine (*Medicina General Integral—MGI*). Residents will mostly be drawn from graduates of the first cohort of *médicos integrales comunitarios*. The vast majority of teachers and trainers will be Cubans of *Barrio Adentro*. The educational programme is very similar to that of Cuba with some modifications and adaptations to the Venezuelan context. I am participating in national workshops to set up the programme. [Most of the teachers] have a background as well as previous experience in training a little over 1,000 *ELAM* [Latin American School of Medicine] graduates. This training includes Venezuelans as well as those from other countries, plus some doctors who completed their undergraduate studies in some traditional Venezuela universities. The number of trainees will be significantly higher and will continue to grow as more students of the *Medicina Integral Comunitaria* programme graduate along the years to come. It means that by 2015, this group of students will join the programme which will then be joined by the second cohort and so on. Therefore, in a number of years, national cadres

increase of military and police presence that included military checkpoints at every entrance and exit of the city. The issue of car accidents still seemed to be given less attention as many roads could be considered in bad shape. There also appeared to be limited measures to clamp down on drinking and driving.

> will cover the whole local PHC system. Perhaps, in a few years, the extent of Cuban collaboration will be mainly further PG [post graduate] training, including advanced research. (Respondent 82, email correspondence, October 2013)

This means that specialist medical training, such as surgery, would be included in the medical education programme and also draw students from non-traditional (poor and marginalized populations) medical backgrounds in order to ensure that even the most complex curative aspects of the medical system will be even more accessible to all members of the population.[53]

There is also a very high awareness by Cuban medical personnel of the criticisms against them. Because they live within the communities they serve, they are very aware that segments of the population may dislike them or feel that they are enemies. In addition to the previous points of view of the opposition, some critics (Respondents 79, 83, 84, 85, Carora, 2013) suggest that the primary health care (PHC) focus on prevention has actually undermined the curative aspect of the health system by shifting the focus too far toward the preventive side of the medical spectrum. Regarding criticisms against the Cuban medical mission, one Cuban respondent highlighted that:

> The significance [of *MBA*] has been the establishment of an actual PHC system that has an impact on many health indicators as well as its recognition by community members. The aggressive words of the political adversaries to the [Chávez] government about Cuban doctors add to the significance of what has been accomplished since Chávez came to power, and what is currently being done. They cannot understand the concept of free health care, because they have the resources to pay extremely high fees of private doctors. One cannot deny the quality of most of the private practitioners, but as a rule they consider patients as clients, and their main purpose is to get as much money as possible out of them. Our approach is different, more humane and solidarity is our main motive. (Respondent 82, e-mail correspondence in Venezuela, June 2013)

[53] The significance of drawing people from non-traditional medical backgrounds will be highlighted in more detail later in this chapter.

In some interviews, opposition respondents interviewed stated that they were not opposed to some of the missions, even *Barrio Adentro*. They often only highlighted issues that they have with the government and talked at length about inflation and material shortages. Interestingly, a wealthy opposition academic noted, “if we had paid more attention to the poor before Chávez came to power, we never would have had to deal with the problem of Chávez being in power” (Respondent 85, Carora, May 2013). Some members of the opposition (including a statement made by opposition leader Henrique Capriles during the last election) suggest that, if they had been elected, they would not have overturned all of Chávez’s social programmes. They felt that some were important, and highlighted that wealthy sectors of society should have paid more attention to, and given more support for, the poor.

The training in Venezuela of the next generation of Venezuelan medical students by Cuban medical teachers (those who have the most knowledge on the subject), all seem to agree that medical education is at a similar level to that found in the Cuban system, but that it contains several adjustments to tackle the unique pathologies and health issues in Venezuela. This is perhaps one of the more interesting aspects of the implementation of *MBA*. This approach is in a constant state of evaluation, adaptation and evolution. In many cases it has the ability to recognize shortcomings, unique regional pathologies and challenges; and to make adjustments as well as additions to the programme. This is a unique example of how the government appears to recognize that the health of the body politic (the analogy that situates the health of the human body as the social collective) is linked to the outcomes of effective policies that address structural violence.

The medical system’s ability to inform government of structural health inequalities illustrates how, in many cases, the government actually has the political will to make radical changes. In the Torres region and other areas observed, these changes have made a significant difference for poor and marginalized populations—even though these populations are often overlooked and under-represented in many developed countries. Thus, changes in the health system are also accompanied by policy changes in other areas such as housing, sanitation, education and other areas in order to improve key

health indicators. This Latin American social medicine (LASM) adaptation highlights how a 'health in all policies' approach might look like for other countries.[54]

4.4 CHALLENGES OF CHANGE

Almost all respondents from various medical backgrounds and political views agreed on the main challenges to the health system—the need to change people's minds, habits and life styles. From dietary issues, to sexual health (especially teen pregnancy), to increasing exercise, and reducing alcohol consumption (especially the related issue of drinking and driving)—almost all respondents agreed that these problems were important, difficult, and could include a huge challenge to the current cultural norms of Venezuelans. According to Respondents 59 and 81 (Carora, May-June 2013), the Torres region itself currently has one of the highest HIV/AIDS rates in Latin America as well as one of the highest rates of diabetes and teen pregnancies in Venezuela, high rates of obesity, and abnormally high rates of respiratory issues (asthma).[55] Getting to the root of those issues would have to include a huge amount of political will, as well as a comprehensive approach. This would have to include the need to improve both education and access to the education system, addressing poverty, as well as take a comprehensive approach to health care in a way that comprises a 'health in all policies' approach.

Almost exclusively respondents from the Chávez side tended to highlight the role of the missions created by his government as an effort to address the broader issues of health and structural violence. Credit for the improvement in the health of Venezuelans has also to be given to other missions, often implemented with the help of the Cuban government. These missions embody the broader conceptions of what it means to keep a

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[54] As noted in the literature review, the World Health Organization believes population health can also be improved by policies that are not directly controlled by the health sector. Therefore all policies should have a level of focus on improving health and that every country should take a 'health in all policies' approach. (WHO, 2008)

[55] Since the implementation of *MBA* many successes have been noted: "In 2006, PAHO reported the significant improvement Venezuela made in 2004-2005 on diagnosing hypertension, ischemic heart disease, diabetes, cerebrovascular disease, and bronchial asthma—all thanks to *Barrio Adentro*, as Venezuela's conventional health systems showed no improvement on diagnosing these five conditions during this time period. More importantly, the report found much progress on provision of post-diagnosis monitoring and follow-up for these five conditions." (Docksai, 2012, p. 46)

population healthy. During the course of this research many respondents mentioned similar accounts:

> All the other "missions", especially those related to education, culture and sports [have helped contribute to health]. Undoubtedly, as more people improve their educational level, the more efficient the health educational activities are—especially as more youngsters are included in educational medical programme. Cultural and sport activities are part of the health promotion efforts. One good example is "bailoterapia" (therapy using dancing). (Respondent 82, e-mail correspondence in Venezuela, June 2013)

As noted in the previous chapter, the literacy campaign, subsidized food programme, housing initiatives as well as a myriad of other programmes have also had extensive impacts on the overall health of the body politic.[56] Since the creation of *MBA* and the other missions,[57] important health indicators have improved:

> UNICEF… reports progress on a range of key health indicators. Between 2000 and 2009, Venezuela's infant mortality rate fell from 27 per 1,000 births to 15 (beating Brazil and Colombia). The mortality rate among children under age 5 fell from 32 to 17 per 1,000 (trumping Brazil, Colombia, and Peru), and the adult mortality rate fell from 148 to 146 (edging out both Brazil and Colombia)…. [In addition to this],… the program [also isn't] prohibitively expensive. Venezuela's

[56] As noted in the previous chapter, body politic is the "idea that there is an analogy between the social collective and the human body" (Harvey, 2007, p. 1).

[57] An example that the majority of respondents highlighted was *Misión Milagre*. *Misión Milagro* has had a very direct effect on the health and is also highlighted in a PAHO report: "Working alongside Mission *Barrio Adentro*, Mission *Milagro* responds to the backed-up demand for eye surgery throughout Latin America. The integrated approach includes helping patients to get reincorporated in their families, jobs, and social life and make maximum possible use of their abilities. During the first phase, between July 2004 and March 2006, surgeries were performed on 176,000 patients in Cuba, 79 percent of them for cataracts, 19 percent for pterygium, and 2 percent for palpebral ptosis. Starting in October 2005, Mission *Milagro* has been incorporated in 28 hospitals with a total of 37 operating rooms in 15 states of Venezuela. As of May 200[6][sic], 18,294 interventions had been performed on a total of 17,584 beneficiaries (some of them patients with more than one condition). Of these patients, 2,694 came from fourteen other Latin American or Caribbean countries under Mission *Milagro* International cooperation agreements" (PAHO, 2006, p. 79).

> health expenditures now stand at 9% of the government budget, which is low for Latin America. (Docksai, 2012, p. 46)

In addition to these improved health indicators Robertson estimates that over 500 million consultations have taken place and over 1.4 million lives have been saved as a direct result of *MBA* (2013b). Clearly these programmes, in addition to the work of social workers, have helped improve solutions to many issues created by structural violence.[58]

Corruption in Venezuela also remains a widespread issue, even in the health system. Several respondents noted that at times medications, equipment and other supplies were being stolen from the public health system and sold to private clinics (Respondents 55, 62, 63, Torres, April-May 2013). These supplies were being sold at an increased charge to often obtain a sizable profit. Not only was the public system being affected through the loss of key resources, but also the resources (often free of charge for patients in the public system) were being priced higher in private care facilities. Essentially patients at private clinics were being overcharged for medications that would have been free under the public system.

This corruption naturally highlighted another question: is there an issue of medical personnel working in both the private and public systems? While some respondents said yes (Respondents 62, 63), many respondents said no (Respondents 64, 71, 79, 80, Torres, April-June 2013). However respondents did connect some of the corruption to medical personnel who worked in both sectors and trafficked medical supplies from the public system to their private clinics.

Some respondents also thought it unjust if a student trained at for free at *Misión Sucre* went on to private practice. However, the significance of internal medical migration from public to private practice was incredibly hard to uncover given that, at the time of writing, only two cohorts of medical students from *Misión Sucre* had graduated. Additional questions about the issue of external migration of *Misión Sucre* medical students to other countries, in a form of brain drain, was also difficult to assess for the same reasons. Many thought that the development of *conciencia*, having clinical training

[58] In addition to those indicators, the four stages of the Barrio Adentro network have delivered free healthcare from "7,000 local community clinics up to hospital level." (Robertson, 2013b). More analysis of Venezuelan health indicators is found in Chapter 2.

in or near the communities they grew up in, as well as focusing on the training of students from non-traditional medical backgrounds (from poor, marginalized and rural populations), would help create that 'buy in' to stay and support their previously underserved communities.

After highlighting the unique regional challenges to the health system, including the fundamental challenges of polarization, the acceptance of Cuban medical personnel, and the existence of corruption, it is important to understand the structure of the health system. This will help to make sense of how it strives to replicate LASM.

4.5 STRUCTURE OF THE HEALTH SYSTEM

As noted previously, in recent years Carora's medical system expanded from one major hospital[59] to having a high-technology centre, four integrated diagnostic centres/*Centros de Diagnóstico Integral* (*CDI*s), and 17 house clinics / *Consultorios Médicos Populares* (*CP*s), as well as a medical education branch of *Misión Sucre*. These

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[59] The main hospital was a major source of political division and controversy at the time of research. The state of Lara is governed by the political opposition and at the time was being investigated by the federal government for having withheld supplies to the Carora hospital which was located in the pro-Chávez region of Torres. As noted by one respondent who helped to manage the regional health system: "The Ministry [of Health] has its presence and network at all level states. The budget for its operation to pay staff and all employees means that 90% of that funds basically comes from the central [governement] level, and is administered in some states by the state government because of the decentralization process. [The state of] Lara has a partial decentralization and the resource that comes from the central level is administered by the state. For example, if [the central hospital is] going to make a request for a repair, or to buy some medications or any surgical medical equipment and requests an estimate, [the state government] gives us the freedom to ask the price, but the control and final payment is made by the state government through *Fundasalud*. That is to say, [the hospital in Carora does] not have direct control of the resources and only has the power to suggest what to buy. Often the hospital receives some medications which it had not requested… [This has meant that,] though funds and resources at the central [governement] level have been available to develop these hospitals to improve their operation, the Carora hospital has remained stagnant. Badly needed repairs, and an increase in human resources to improve their performance, have been unmet. Essentially the Carora hospital, which is a type III hospital, only operate as a type II in the classification of the ministry. Often the hospital at Carora has to refer patients to other type III hospitals, such as Antonio Maria Pineda, when the hospital should have been able to meet 90% of the Carora population's needs without sending them to Barquisimeto" (Respondent 55, Carora, May 2013). This story helps illustrate how politics play a part, at times detrimental, at some health care levels in Venezuela.

additional services were structured very similarly to the Cuban medical system with a focus on PHC in order to deliver a high degree of proactive and preventive health care at the *CP* level. If the *CP* was closed, or if the medical issue had advanced beyond the first contact PHC level, then the patient would be transferred to a more comprehensive 24-hour care centre at the *CDI*s. If more complex care was needed, then the patient would enter the regional hospital level. One Cuban respondent, who was in charge of helping manage *MBA* at the state level, also highlighted the influence of the Cuban system on *MBA*:

> [Both systems focus] mainly on community health care, a truly PHC system able to treat and prevent diseases, rehabilitate and promote health. The organization of PHC is very similar to the Cuban approach: family doctors live and work within communities (popular medical offices). In Cuba they are called *consultorios / casas del médico de la familia*, with the difference that there is a nurse with the physician; the *CDI* or *Centro de Diagnóstico Integral* / comprehensive diagnosis centre, in Cuba is called a polyclinic; the integral centre of rehabilitation is the same as in Cuba; in addition in many communities you can find dentist offices, some in the *CDI* or in medical offices. In some communities in Venezuela there are also *CMDAT* (*Centros Médicos Diagnósticos de Alta Tecnología*/high technology diagnostic entre), or simply known as *CAT*, as well as optical centres. All these institutions belong to a comprehensive health area; in Cuba we just call it the "*área de salud*". In Cuba, as a rule, surgery is not carried out in polyclinics but in hospitals. However in Venezuela some *CDI*s have surgery facilities, instruments and equipment for general surgery and traumatology due to the high demand in Venezuela resulting from frequent injuries of different causes including accidents, shootings, and stabbings, etc. (Respondent 82, e-mail correspondence in Venezuela, June 2013)

The high-technology centre houses the most complex diagnostic equipment for difficult medical cases. The vertical integration is similar to the Cuban model which helps overcome issues resulting from fragmentation, while at the same time ensuring a high degree of first contact primary care success with the possibility of early detection of a

pathology. If the cases become too complex to be treated at the lower level, the vertically integrated health system then moves the patient up the chain of expertise. Major trauma cases like car accidents as well as gun and stab wounds are still sometimes treated at the *CDI* level (specifically at a *CDI* such as *Andrés Sierralta de Santiago* in Carora), but are more often treated at the central hospital level in Carora.

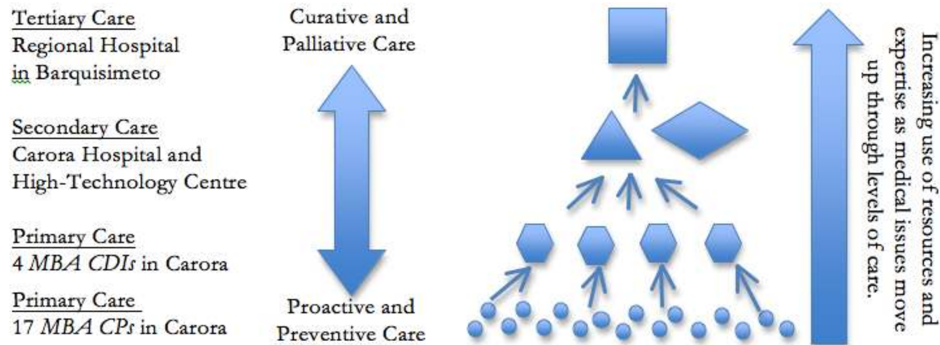

Figure 2 Diagram of Carora's Vertically Integrated Medical System
Source: Author, based on interviews with *MBA* medical personnel in the Torres health region, 2013.

The addition of *MBA* has thus made the Venezuelan health model very similar to the Cuban model with the addition of the 4 *CDI*s and 17 *CP*s that focus on the proactive and preventive community-oriented primary health care level. Iatridis highlights the Cuban system in a similar model:

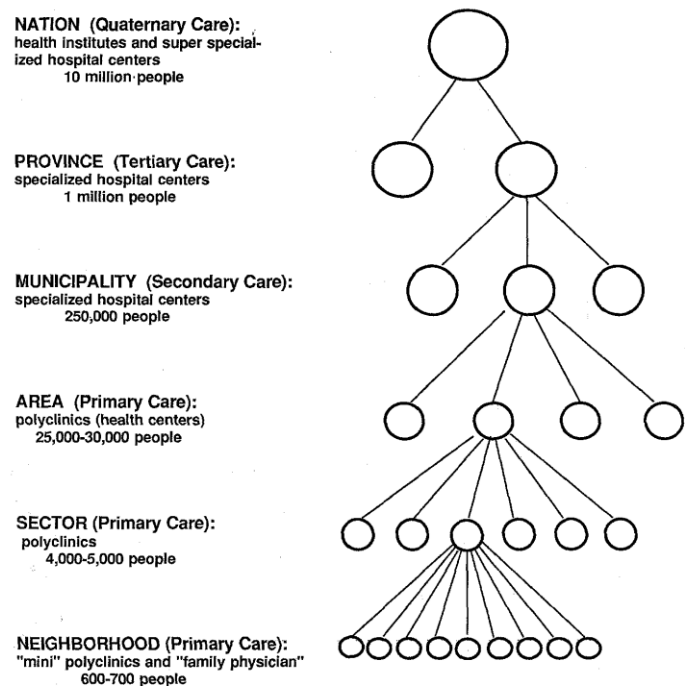

Figure 3 Diagram of Cuba's Vertically Integrated Health Care System

Source: Iatridis, D. S. (1990) Cuba's Health Care Policy: Prevention and Active Community Participation. *Social Work,* 35.1, p. 31

The similarities and differences are important to note, but the significance of the *MBA* programme is the replication of first contact primary care levels of the *CP*s and *CDI*s. They are the key structures that provide effective and efficient medical accessibility to even the most marginalized and poor populations.

The *CDI*s are perhaps the most intriguing and important part of *MBA*. They are the key cogs of the health system that are open 24 hours a day, seven days a week, and offer a very comprehensive set of medical services. In a tour of the complex at *CDI Andrés Sierralta de Santiago*, also known as *CDI de Brasil*, it was explained that there were a total of 39 Cuban medical personnel. The medical staff included: 1 medical coordinator, 1 statistical manager, 8 general medical doctors, 5 dentists, 4 physiotherapists, 1 physiotherapist with a doctorate, 1 podiatrist (who deals with the study and care of feet), 1 speech pathologist, 3 intensive health care doctors, 3 intensive health nurses, 1 emergency nurse, 1 endoscopy nurse, 2 x-ray technicians and 3 laboratory workers to check on blood work and other duties. An ophthalmologist and

gastroenterologist were shared between two *CDI*s, and a psychologist would rotate in periodically as well. This is a similar structure to most other *CDI*s that were observed.

The first *CDI* visited was *Barrio Nuevo* located in one of the more dangerous and impoverished neighbourhoods in Carora. It was staffed with 32 Cuban doctors. This particular *CDI* also had an obstetrician and a gynecologist. During the period of observation of this *CDI* there were 36 students from the *Misión Sucre* medical programme who were drawn from the local Torres region undertaking their medical rotations and observations under the guidance of their (mostly Cuban) medical teachers. All years, except 6th year students, were represented from the 6-year medical education programme at this particular *CDI.* This reinforced further observations and academic accounts done by Brouwer (2011), PAHO (2006) and others regarding the hands-on nature of the education programme.

While the Cubans were often housed in the residencies attached to the local *CDI*s, many also lived in houses provided by local citizens. The primary contact for the *Consultorios Médicos Populares* (*CP*) were often the houses of locals who would have a room set aside for the Cuban doctor to stay at, as well as another room for local medical examinations. These were located in strategically placed areas accessible to populations that often had the most limited medical accessibility prior to *MBA*. The proactive nature and easy access helped ensure that even the most trivial health questions from locals were treated with great sensitivity between 7 am and 4 pm. The doctors working in the *CP*s often did house calls as well as rotations in *CDI*s as well. If concerns were raised at any of these drop-in health examinations, the patient would be forwarded to the corresponding location most able to deal with the health needs including the *CDI*, public hospital or high-technology centre. This type of first contact with community-oriented primary care (COPC) is based on the Cuban model. It is hoped that one day similar successful results that see 80% (Dresang et al., 2005, p. 298) of health issues solved by first contact proactive and preventive health measures in Cuba can be achieved.

The regional hospital itself has been expanded since, before *MBA,* the hospital often only had two full-time doctors working there regularly, even when the demand for medical care was overwhelming. All accounts from both the opposition and Chávez supporters mention that in pre-*MBA* times the public hospital was regularly well beyond

capacity, understaffed, and lacking in essential resources and medications needed to serve the regional population of Torres. With only two full-time doctors to rely on at the hospital, many doctors had either given up, due to the stress of the environment, and/or gone into private practice to improve their lifestyle and wages.

As one regional director for the health system highlighted, before *MBA*, medical accessibility had been very limited. In particular, poor families with low incomes and weak social safety nets suffered disproportionately. Private medical care was predominant, and the government supported public hospitals poorly. Many of the doctors of those hospitals at the same time were involved in private practice and spent very short periods in the public health system. Unfortunately the situation in public hospitals on the curative side of the health system is still lacking. This is because time dedicated by specialists from the traditional system to medical care in public medical facilities remains low. As noted in the previous chapter the physician shortage was a large concern across Venezuela (Feinsilver, 2008; PAHO, 2006) and the Torres region was no exception (Respondents 55, 56, 59, 62, 63, 71, 72, 73, 74, 80, 83, Torres, April-June 2013).

4.6 *Misión Sucre* and Soft Policy Transfer

PAHO highlights that in 2006, the "reorganization of the public health system management structures and of the Government health care networks has made it possible to institutionalize the *Misión Barrio Adentro* as the strategy to overcome health exclusion" (PAHO, 2013, p. 9). How *MBA* is meeting the challenge of overcoming medical exclusion (often the result of poverty) highlights perhaps the most effective measure for improving medical accessibility to the most impoverished and rural communities. PAHO outlines that in total, 20,578 medical students had been added at different levels of care by 2013. This demonstrates the "advantage of providing training in the same impoverished communities from which most of the doctors come and in which they will work upon graduation" (PAHO, 2013, p. 11).

As can be seen, this challenge is being confronted by the capacitation process that occurs through the medical education programme drawing from those impoverished populations themselves in order to scale up their own population's medical services. As noted in a PAHO article analyzing the medical education programme and role of *CDI*s:

> The network of services in comprehensive community health areas also uses a comprehensive and intersectoral model of a continuum of free, universal health care for families and communities. *Barrio Adentro* has also incorporated an innovative human resource health education strategy into the comprehensive community health areas. The academic standards are high and participants are socially committed. The initiative began by training specialists in general comprehensive medicine through three years of postgraduate training. By 2010, a total of 984 specialists had been trained. At the same time, 837 comprehensive community dental specialists were trained and a 6-year undergraduate training programme was launched for comprehensive community physicians focusing on primary care. The programme to train community physicians occurs at the municipal level, training future doctors who have ties to the community and their place of origin, in an exercise based on solidarity and humanism. Training is carried out in primary health care centers (*Barrio Adentro* I and II) under the guidance of professionals from the Cuban Medical Mission in Venezuela, and in hospitals through clinical internships in various specialties (medicine, surgery, pediatrics, gynecology, and obstetrics, etc.) under the supervision of Venezuelan physicians. (PAHO, 2013, p. 11)

During interviews with a number of respondents it was made clear that for the first time in Venezuela's history, mothers, family caretakers, and part-time workers were able to obtain medical degrees because of the flexible hours available in the medical education programme as well as having other barriers, such as high tuition fees, removed (Respondents 56, 57, 58, 63, 64, 67, 71, 73, 74, 81, Torres, April-June 2013).

The medical education programme has indeed been structured in a way that part-time education is possible for those sectors of the population who were often the most vulnerable, financially disadvantaged, or were incapable of making a full-time commitment to education due to pressing responsibilities (that often included work or being a caretaker). As noted by one teacher at *Misión Sucre* who also helped manage health care personnel for the region:

> What happened in Venezuela is that there was a gap in medical training provided by traditional universities. During this time they reduced the number of doctors by limiting the enrollment for the neediest people by demanding higher grades and tuition fees. Since many from the poor sectors often don't have a lot of money or outstanding grades (because they often come from underresourced schools and face other difficulties resulting from poverty), only those from wealthier sectors of society were able to afford tuition and texts as well as attain the outstanding grades needed to get into medical school. It was in this way that they minimized medical training which had even created circumstances where, at times, no doctors were available in some public hospitals or clinics. The actions taken by President Chávez and the Cuba-Venezuela agreement to train 45,000 medical doctors in a period of 10 years are intended to solve this issue. So far we have succeeded in graduating 14,000 doctors—many from poor areas. These doctors come to serve and pay attention to their community's needs and are now educated closer to their communities because this is where the need was, and where the need still exists. (Respondent 55, Carora, May 2013)[60]

Thus the recruitment of students from non-traditional medical backgrounds is a key element of the medical capacitation process. The significant increase in the physician-to-patient ratio—from 18 doctors per 10,000 inhabitants in 1998 to 58 doctors per 10,000 inhabitants by 2012 (Robertson, 2013a)—is a very strong signal of the commitment to scale up the workforce.

It also became clear through a series of interviews and observations that the education programme is not training less qualified doctors and medical personnel, but rather that the medical education programme is now more widely available to a greater

[60] A recent article by Roberson noted that the numbers might actually be greater. As of 2013, *MBA* "is bearing fruit. Over 14,000 community doctors are now working in public clinics and hospitals throughout the country (8,160 graduated in December 2011 and 6,200 in December 2012) as part of an obligatory two-year urban / rural residency which all community doctors must complete after graduating. In fact the program is now being extended, with the Venezuelan government aiming to train a total of 60,000 community doctors by 2019. Meanwhile postgraduate programs are being prepared for those who are completing their residency and want to become specialists in a given area of medicine" (2013b).

variety of sectors of the population who were traditionally excluded from pursuing a medical degree due to cost, status, distance to school or time. This is significant. To solve structural violence in terms of a lack of accessibility to public health for the most vulnerable populations, a country must have the political will to make available all the services and education needed to train representatives from those very sectors of the population who were traditionally excluded from health care. If the plight of the poor rarely enters the consciousness of the affluent (Farmer, 2005, p. 31), then a concerted effort must be made to capacitate those who do comprehensively understand the plight of the poor. Hence the need to educate the poor to become doctors and medical personnel, since they already have an intimate knowledge of the pathologies of poverty. This may seem revolutionary to some, but in Cuba and Venezuela it appears to be common sense.

In addition to drawing students being from non-traditional medical backgrounds, also pertinent is the way in which these students are being trained. The transfer of soft policy tools—the values, norms and culture—by Cuban educators (and increasingly more and more Venezuelan educators as well) is also one of the most important aspects of the Cuban medical adaptation. Most often these soft policy tools can be attributed to the Cuban medical doctors who were in charge of the clinical training at the local *CDI*s, as well as the traditional doctors who migrated from the traditional system to teach at the *Misión Sucre* medical education programme. Their duty is essential to the success and longevity of *MBA* by reinforcing the importance of integrating the notion of *conciencia*, as well as training future medical personnel to view each patient in their broader bio-psycho-social spheres of health.

Conciencia—a sense of duty, commitment, compassion and empathy to treat patients as family—is integrated into the medical education programme through values that are taken as subjects or courses that include Citizen's Conscience, Latin American History, Community and Family Health, as well as others. The bio-psycho-social spheres of health are directly taught in Morphophysiology as well as Morphophysiopathology. Here is a list of the courses that complement the clinical training that provided by teachers in the medical education programme:

First Year:	Fourth Year:
- Morphophysiology I, II and III - Citizen's Conscience - Introduction to Primary Health Care - Basic Procedures - Primary Health	- Pediatrics I and II (Comprehensive Care) - Gynecology and Obstetrics I (Comprehensive Care) - Health Situation Analysis - Comprehensive Health Care - Comprehensive Health Care in specific environments (Including: School, Labor, Recreational, and Health Institution Environments) - Elective Courses
Second Year: - Morphophysiology IV - Human Morphophysiopathology I and II - The Psyche in the Health-Disease Process - Community and Family Health I and II - Medical Informatics I and II - Latin American and Caribbean Thought (The Health Situation in Latin America and the Caribbean) - Elective Courses	**Fifth Year:** - Clinical Surgery - General Surgery - Dermatology - Gynecology and Obstetrics I (Hospital Care) - Pediatrics III (Hospital Care) - Physical and Rehabilitative Medicine - Natural and Traditional Medicine - Tropical Medicine - Legal and Toxicology Medicine - Health Intervention - Elective Courses
Third Year: - Clinical Medicine I and II (Semiology y Propaedeutics) - Clinical Medicine III and IV (Internal Medicine I and II) - Pharmacology I (General Pharmacology) - Pharmacology II (Clinical Pharmacology) - Psychology of Health - Community and Family Health III and IV - Elective Courses	**Sixth Year:** - Comprehensive Adult Care - Comprehensive Child and Adolescent Care - Comprehensive Care for Women and Pregnancy - Comprehensive Family and Community Care - Thesis - Final Accrediting Evaluation

Figure 4 Comprehensive Community Medicine Courses in Misión Sucre

Source: Slides from medical teachers of *Misión Sucre* translated by the author, 2013.

In Paul Farmer's 2005 book *Pathologies of Power*, he consistently advocates that doctors should go beyond their basic duties (of often only curing various ailments with prescription drugs), instead becoming activists in solving issues of structural violence—very similar to the development of *conciencia* in *MBA* and *Misión Sucre*. In his book, he believes that doctors should make this a conscious part of their practice when they undertake the decision to become a physician. However, in the courses taught in *Misión Sucre* (as noted above) activism that seeks solutions to structural violence is institutionalized in their medical education degrees. Thus, it is not implied, but is instead made explicit in the development of *conciencia*. This highlights how the medical education programme also creates health care advocates who proactively help challenge the roots of inequality, poverty and marginalization instead of merely being members of a

profession that reactively provides prescriptions (in much the same way that Tucker criticized).[61]

This is not only institutionalized in the education programme but advocacy is also structurally integrated into the medical system itself. A recent PAHO article notes that comprehensive community health areas allow for interaction between the health services system that consist of *Barrio Adentro* I and II as well as "social networks and other services; a social territory serves as the base from which the primary health care services network links with social networks in the community and other social initiatives" (2013, p. 11). In Carora, this is very much the case for the community health region of Torres.

In addition to this, Cuban education brigades also analyze and make an effort to reinforce human and professional values while working with the next generation of medical professionals at the clinical education level. Besides the two courses directly related to the bio-psycho-social sphere of health, Morphophysiology and Morphophysiopathology, a Cuban medical manager highlights that:

> In the medical education programme you can find a couple of courses intimately related to the bio-psycho-social sphere (Psychology and Health Psychology), but additionally all subjects or courses of comprehensive community medicine (Community and Family Health, Community Health Diagnosis, Health Education and Promotion, Community Intervention Research and so on) are in many regards related to this sphere. In the final year, students in small groups have to write a community intervention health research plan, in which they work together with formal and non-formal community leaders. Most of the health research plans include an educational intervention to enhance the knowledge of community members of a disease or a group of diseases that have a high prevalence in the neighbourhood and try to modify non-healthy habits. Without the bio-psycho-social approach one cannot successfully develop that kind of research. (Respondent 82, e-mail correspondence in Venezuela, June 2013)

[61] An analysis of Tucker's critical holism is found on pages 11-13 of the theoretical framework.

Prevention, as well as the culture of duty to serve the indigent (Huish, 2008) is at the forefront of medical training, and this is observed most explicitly in the 24-hour "open door" policy of health care workers who were immersed in the poorest and most dangerous neighbourhoods. Patients cannot be turned away, and the community regularly defends the health care workers in areas where security is an issue. The physical locations of the *CDI*s themselves are also important. Though they are open to all socio-economic levels, they are often positioned in areas that are the most vulnerable in an effort to help tackle structural violence that stems from poverty and marginalization. Moreover, even those who protested against the presence of the Cuban doctors during the last federal election in 2013 are able to seek treatment by those same doctors. For the medical personnel inside the *CDI*s, health care accessibility is something that cannot have any borders, not even political.

Another important factor that has made the medical education programme successful is the increased focus on prevention and a noticeably proactive approach to health. Though often lacking in many traditional bio-medical models, many subjects interviewed highlighted that the focus on proactive and preventive health was almost absent in Venezuela prior to *MBA*. One Cuban respondent who helped implement *MBA* noted that:

> From the very beginning, and even before starting the programme itself, during the "*premédico*" (a course before being fully admitted into the programme), students spend most of the time in the PHC facilities. Each student belongs to a local medical office; he/she becomes part of the health [schedule] in the PHC setting, under the supervision of the family doctor (the vast majority of these doctors are specialists in Comprehensive General Medicine, some are residents of that specialty that continue the post graduate programme here, including the presentation and defense of a dissertation). The main work of those doctors is prevention of diseases, and the promotion of health, mainly through health education. Students learn very early how to perform what we call the health situation analysis (or diagnosis) and the action plan in order to modify the health status of the community. (Respondent 82, e-mail correspondence in Venezuela, June 2013)

In some interviews with various health care personnel in the private sector, as well as members of the opposition, criticism was raised about the level of training in *Misión Sucre*. However, when pressed for specific details of such weaknesses, it was made clear that these criticisms were not the result of personal accounts, since almost all of these particular respondents had refused to utilize the services of *MBA*. Instead they were mostly the results of political bias.[62] [63]

However when interviewing patients of *MBA* about the level of training and professionalism of the Cuban and Venezuelan *Barrio Adentro* programme, the responses were almost unanimously the same. These patients highlighted that, for most of them, this

[62] It should be highlighted that the *CDI*s had many revolutionary posters on display. Pictures of Chávez, Maduro, Fidel, Ché and José Martí were on many walls and often featured prominently in the waiting rooms. In addition to this, the waiting room TV almost exclusively aired TeleSur which was a news channel established by the Chávez government in an effort to overcome the majority media influence of the opposition and USA. In essence, the *CDI*s were not a politically neutral space for some.

[63] When asked about what role private health care can have in increasing medical accessibility for rural and marginalized populations, nearly all respondents stated that it offered very little. Even among private medical doctors, only one had said: "private clinics had done a fine enough job for the poor and rural inhabitants before Chávez" (Respondent 79, Carora, May 2013). Another private doctor simply stated: "private medicine for the poor is a contradiction in terms, private medicine never serves the poor and never will" (Respondent 80, Carora, May 2013). When asked about the role of private medicine in Venezuela, many public doctors also highlighted that in almost all cases, it would never be able to address issues of structural violence, and at worst, a dependency on only private medicine would make the issue of health care accessibility and structural violence dire. However, it should also be highlighted that many doctors didn't think the idea of private health care should be removed. A couple respondents highlighted that, in the absence or ineffectiveness of public medicine, private clinics would still be necessary. Thus, private health care can actually inform the shortcomings of the public system regarding medical accessibility and highlight possible additions or changes that should be made to improve it. As noted by one retired public doctor who is also a staunch opposition member, "If *Barrio Adentro* worked as well as it should, there would be no one going to private clinics" (Respondent 83, Carora, May 2013). Though this might very well be true in the future, at its current stage of evolution, and with much already accomplished in a short time, it still has a long way to go before achieving that degree of accessibility and acceptance from all socio-economic and political sectors. Interestingly, some public sector doctors did note that, if the financial elite were willing to pay for both an efficient and effective public health system, the option of reasonably-taxed hotel-style hospitals and exceptional health care/cosmetic care should still be something made available for those who could afford it.

was the first time they were able to receive medical attention for free.[64] They weren't turned away for not having enough funds,[65] nor where they turned away due to a health clinic being closed or overwhelmed. As Docksai notes:

> In 2004-2005, the program conducted more than 150 million consultations—four times as many as did Venezuela's conventional outpatient services. And in 2008, Venezuela achieved universal vaccination for the first time, affirmed Mirta Rosas, director of the Pan-American Health Organization (PAHO), during a visit to Caracas. [As of 2012], nearly 900 clinics are still running and are continuing an expansion of health-care availability that is nothing less than historic: Nearly 100% of the Venezuelan public now has access to health care. (2012, p. 46)

This level of accessibility is truly historic. For the first time economic,[66] racial, and

[64] Through the research process a couple of health challenges presented themselves to the researcher including asthma, a stomach parasite and slight food poisoning. Though having exercise-induced asthma prior to visiting, the asthmatic conditions were present throughout most of the time in Carora. The prevalence of asthma is one of the other unique health pathologies in the region due to the high heat and frequent humidity. All medical examinations and medications were given to the researcher without charge, since they are completely free to everyone. For all three health issues, the recommendations and medications (often made in Cuba) all worked according to the time outlined by the doctors at the health centres who often had local students (from *Misión Sucre*) with them as a part of the scaling-up of the national *Barrio Adentro* health mission.

[65] One respondent noted the difficulties of receiving health care under the pre-Chávez health system. The respondent's uncle had a severe stroke late one night, and so the respondent took his uncle to be treated at a local private clinic since the hospital was overwhelmed. The stroke patient was denied medical care initially since he was unable to remember the PIN # on his credit card to pay for the care that he needed. The health care providers at the clinic refused to provide medical care until a payment was made. They didn't want to take the nephew's word that he would pay them back so the nephew pleaded with the private health physicians to take the keys to his car as insurance until he could contact family members to help pay for the fees the following day. (Respondent 65, Carora, May 2013)

[66] *Misión Sucre* takes all qualified students who want to join the public health system. This is important because the impoverished and rural populations are now able to attend medical school whereas before they were unable to. One doctor said that her inspiration for entering medicine was due to the early death of her grandfather. At the time, only two doctors were working full-time at the central hospital. These two doctors were often very over-worked and were unable to adequately maintain the health of populations that couldn't afford private health care—which, to highlight previous pre-Chávez poverty indicators, represented approximately three-quarters of the population. In the private clinics and hospitals, treatment would often be denied based on ability to pay. Almost all graduates that could

geographic[67] barriers to health care access have been overcome. Understandably, those populations who were traditionally excluded from comprehensive health have become strong advocates for *MBA'*s continued integration into the health system.

4.7 THE IMPACT OF *MBA*

As an understanding of structural violence helps to highlight, ill health disproportionately affects marginalized and poor populations who often do not have the income to pay for quality health care, often live in under-serviced areas, (without proper sanitation, access to quality housing, an ability to purchase nutritious foods in decent quantities, and availability of drinking water). In addition, many lack the balanced and quality diet needed to avoid dietary issues, and are often the least able to attain quality education (due also to cost and distance).

Compounding this issue is the basic lack of understanding of people from lower socioeconomic status by those from middle to upper class levels of society. Essentially the plight of the poor hardly ever permeates the consciousness of the affluent (Farmer, 2005, p. 31). This research project also found that there is a genuine ignorance held by affluent populations regarding the plight of the poor. This is unfortunate since, as the head of the regional Venezuelan immunization programme noted, communicable diseases are everyone's problem, and although they often disproportionately affect the poor, they still impact the rich. Malaria, yellow fever and dengue do not care which socioeconomic level a person belongs to. (Respondent 59, Carora, May 3013)

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afford the traditional medical education model chose to work in the more lucrative areas of private health. So, while three-quarters of the population were considered below the poverty line and with only one-quarter of students most likely able to afford medical school taken from higher socio-economic positions of society, it becomes clearer why rural and impoverished segments of the population suffered disproportionately.

[67] One medical teacher from the local nursing school noted that one of the most helpful aspects of expanding the health care system in Venezuela is that patients can be treated closer to home and often in their communities surrounded by families and friends (Respondent 56, Carora, April 2013). The teachers recognized that being around your family and with the support of the community helps patients recover much better. This has a double effect since families no longer have to travel great distances in order to visit and help with the recovery process—and thus patient's families are less financially burdened as well. This is of key importance, since even one person's fall into ill-health can slide a whole family into positions of poverty if the health care is inadequate, unaffordable or inaccessible (Respondents 56 and 66, Carora, April-May 2013).

As noted in the previous chapter, Kaseje (2006) highlighted that most major communicable diseases were brought under control through public health measures. Thus, a clinical-based, privatized medical system, which often only adequately cares for the rich and urban populations, can actually inhibit the health of those same populations by ignoring the health of the poor and rural. In Venezuela, these pathologies include: malaria, dengue, sanitation issues such as parasites, schistosomiasis etc.

Thus, given the contagious nature of communicable diseases it means that it is also in the best interests of the rich to be aware of the plight of the poor; moreover, they should also help contribute to health solutions. Therefore, as noted in the literature review, the challenge of solving health disparities locates the solution outside the purview of clinical and private health-focused systems and into a much broader and more comprehensive conception of health. Given that health pathologies often travel through rural and impoverished communities to threaten the more populated urban and wealthy populations, it then becomes essential to employ a comprehensive approach to address communicable diseases.

In addition to facing the unique pathologies of the poor, by expanding the medical education programme and making it available to more rural populations, an understanding of regional health issues has also entered the hands-on clinical education programme for Venezuelan medical students. This was very true for the Torres region which, as noted previously by Respondents 59 and 81 (Carora, 2013), faces one of the highest HIV/AIDS rate in Latin America, one of the highest rates of diabetes in the country, and other unique issues such as increased cases of asthma.

It wasn't until *MBA* that Cuban medical personnel became aware of the issue of widespread diabetes and radically created changes to the public health and education system to address it. Previously, patients with swollen legs from type-2 diabetes traveled to Barquisimeto to get amputations at the suggestions of private medical clinics and the overburdened public hospital. Now, under the guidance of Cuban medical personnel, the education and medical system has provided an alternative approach. The diet of *arepas*, *conchapas*, and *empanadas* (all essentially fried corn with meat and/or cheese), as well as large quantities of soda and beer, has meant that the solution to the now correct diagnosis of diabetes can be addressed at a proactive level. Dietary advice and appropriate early

detection have been advanced especially since Carora established a centre for diabetes which aims at providing regional education measures as well as medical detection and treatment.

With regard to the high degree of sexually transmitted infections (STIs) found locally, comprehensive education programmes have been implemented. This type of education is very similar to that used for other pathologies that are present in the region. Yellow fever, dengue, malaria, schistosomiasis, and other health issues all have posters created by local medical students placed around visible areas in hospitals and other centres to make people aware of these diseases. The posters have information on symptoms, prevention, treatment, and spread of these health issues.

4.8 The Vaccination Programme

The success of the vaccination programme should also be mentioned. Chávez expanded the vaccination programme in 1999 in order to address a broader set of pathologies. Starting with vaccinations against tuberculosis, poliomyelitis, diphtheria, tetanus, pertussis, measles, rubella, parotitis, yellow fever, and tetanus toxoid, the Bolivarian Government subsequently added hepatitis B, meningitis and pneumonia due to haemophilus influenzae type B, rotavirus diarrhea, and influenza. As noted previously, the first universal vaccination programme was carried out in 2008 (Docksai, 2012, 46). The results are impressive:

> The rotavirus, seasonal influenza, and 23-valent pneumococcal polysaccharide vaccines were introduced into the national system, for a total of 10 vaccines that protect against 14 diseases. Likewise, 1,732 establishments joined the National Vaccination Program, bringing to 5,916 the total number of vaccination sites open in 2010. In 2010 transmission of measles and rubella remained interrupted and polio remained eradicated… Universal access to antiretroviral therapy for people living with HIV/AIDS continued. In 2010 a total of 35,893 people had undergone treatment… The supply of special medications made it possible for mortality among patients with cystic fibrosis to drop to 0%. (PAHO, 2013, p. 3)

The ability to counter the threat of different pathologies spreading into highly populated areas was one of the key strategies of the vaccination and prevention programmes. During interviews with the regional head of vaccinations for the region of Torres, a sub-section of the larger state of Lara, it was clearly outlined how the main vectors of dengue, malaria and yellow fever (among others) traveled to Venezuela. Knowing where these pathologies started, a mix of proactive health education measures and vaccinations were then integrated into an approach which targeted the main routes that these diseases took before they could reach densely populated centres of Maracaibo, Barquisimeto, Valencia, Caracas, and others. Aided by the Cuban state-led pharmaceutical industry, additional medications were flown into the country to counter the spread of these often deadly pathologies, as well as other health challenges.

The vaccination programme is thus a part of the broader focus on prevention. As noted by a manager of one of the regional hospitals:

> *MBA* relieves the traditional medical network. It reactivates the object of what primary health care is because it serves people in the same place where the people reside. People not only go to health centres because they are sick, but some health pathologies are even followed up. *Barrio Adentro* visits families at their home, identifies risk factors for disease, attacking them immediately to <u>prevent</u> people from getting sick. The culture of Venezuelans is that they will only go to a doctor when someone feels ill. However, many people do not seek medical help until the illness has gone very far and most do not go for routine check-ups enough to prevent many health issues before they start. But that is what is expected and it is the plan of the Ministry of Health to change the culture so that people go to health centres to keep track of their health… The key changes for the health system are going to be because of information gathered from the bottom that moves up to change policy. (Respondent 55, Carora, April 2013)

This focus on prevention and changing the culture is very important if a medical system is to truly respond to broader conceptions of health by informing the government of health risks for vulnerable populations. Much of the health advocacy and follow-up

with patients is done by social workers who work on the front line of the health system and poverty.

4.9 STRUCTURAL VIOLENCE AND THE USE OF SOCIAL WORKERS

One of the important decisions during Chávez's tenure was the greater inclusion of social workers. Before the expansion of health care, social workers from Barquisimeto would often have to visit Carora and follow up on specific referrals. Now an increasing number of social workers are being drawn from the local population and educated in Carora. This is important to note since the success of the duties carried out by the social workers has been primarily attributed to the fact that they are from the communities themselves, and are therefore most familiar with the structural, social and cultural issues facing those communities.

They have a prominent place near the entrance of the public hospital and help those patients most vulnerable to issues of structural violence by being a voice for the voiceless through research and advocacy. Their duty, often neglected or not taken seriously in other countries, helps to inform various medical and government personnel about broader issues that affect health, including the non-medical determinants of health. These include education, housing, sanitation, social well-being, nutrition and employment issues—all of which are central to overcoming structural violence, but are sometimes overlooked by the narrow view of health in a traditional bio-medical system.

The social workers have been a part of *MBA* directly since 2005, often at the *CP* level as well, in order to establish proactive and preventive health needs even to rural areas. Since *MBA* they have been given greater resources as well as influence in decision-making, and often function as researchers and managers at the primary care level for the promotion and prevention of health issues. They operate outside of the hospital as well by visiting families and work areas. They are also involved at the tertiary level of care with inpatients inside the hospital. Sometimes the social workers respond to the needs of people who have been referred to the hospital but do not have the support of family or friends as care-takers and advocates. This situation often happens if the family is no

longer in contact, if family members are suffering from their own challenges,[68] or if the patient is alone and the rest of the family has passed away. At this level of health they also do rounds in the hospital in order to find out if a patient faces unique challenges or has certain needs, and often work closely with the diabetic, maternity, and mental health departments at the hospital.

Unfortunately, the role of the social workers is still not fully understood by others in the medical community, even in the Carora hospital itself. However, the impact for patients and families who have received help from social workers has been substantial since they are often the key actors in getting to the root of structural violence such as poverty, family issues, education, and disability (Respondents 60 and 61, Carora, May 2013).

4.10 SANITATION

This is an area that has resulted as a byproduct of *MBA*. Since the implementation of *MBA* and the vertical integration of the health system the government has responded to myriad health issues due to information uncovered through the effort of social workers and other health care personnel. One of the most important adjustments the government has responded to, after suggestions from health care workers, has been the issue of sanitation. The levels of dysentery and parasite-based pathologies have become more

[68] One respondent highlighted the close relationship between poverty and health. At the time the respondent's wife was in the eighth week of hospitalization in Barquisimeto (which is 1.5 hour drive away) for heart issues, and most recently a blood infection. Since this had happened, the husband had been obliged to work a lot more and leave sports and other interests that contributed to his health and well being. His son has also had to work as a taxi driver to help cover the costs of supporting her. If they had put her into a private hospital for the type of care that she needed, the respondent estimated that the costs would be 2,000 *Bolívar Fuerte* (BFs) a night, which is approximately $320 USD. This financial burden would be overwhelming since the average teaching wage for him is approximately $200 per month. As it is, he is still burdened even without covering those costs, and his master's degree has been put on hold due to caretaking and extra work. This example highlights how one person's medical burden can often push a whole family towards poverty. If a free and accessible public health system had not been available, then the immersion into poverty would have been even worse and possibly resulted in a loss of life. Clearly if a family member's life is in danger, in most cases the priority of family income shifts to saving that person's life. This shift in funds can mean many other family members begin the process of falling through the financial cracks when forced into a pay-first health system. (Respondent 65, Carora, May 2013)

actively addressed when health care workers were given the ability to inform policy to make changes to popular education and building issues. Sewage and garbage location, for example, were actively targeted in the Río Tocuyo area when it was found that the high rates of dysentery and digestive parasites were increased during the floods when the water levels would overflow and spread garbage and effluence throughout drinking sources. Proper treatment and water towers were then put in place as an additional measure by the Chávez government (Respondents 55, 56, 73, Torres, April-May 2013).

4.11 PRACTICE IS THE CRITERION OF TRUTH

The transformative nature of *MBA* appears to be quite impressive. Venezuelans with health insurance but who occasionally used *Barrio Adentro* were very surprised at the quality, effectiveness and efficiency of the programme. The following are accounts collected from interviews of patients who were in dire straights. For them *MBA* was their last resort when their comprehensive health insurance plans were unable to provide care in the area they were visiting.

As an alternative, at the suggestion of people in the community, they went to seek treatment at the local *CDI*. One respondent was incredibly surprised at the speed of care for her broken arm. Within 20 minutes she had been x-rayed and attendants were already at work preparing a cast. Her medical treatment was finished within 40 minutes from when she first entered the door of the *CDI* (Respondent 51, Caracas, April 2013). Another person received treatment for food poisoning which was also quickly diagnosed, and they were given oral rehydration packets as well as being monitored for a period of time (Respondent 54, Carora, April 2013).

Both accounts highlight another interesting issue about the current state of the culture of health insurance among members of the upper middle class with steady employment. Many members of the population view *MBA* as only a sub-standard system for the poor populations and refuse to seek treatment there. Instead they are most likely to utilize the often, very costly, health insurance plan which their company has paid for.

After interviews with a number of patients opposed to Chávez who eventually went to the *CDI*s for medical care, since they or their families were unable to afford private medical alternatives, it was clear how radical some of the transformations could

become. On two occasions, elderly opposition patients were brought to *CDI* faculties by their moderate and Chavista family members. Both respondents were fiercely against Cuban involvement and opposed to seeking treatment by a Cuban doctor. However, after all other options were exhausted, and the regularity and expense of treatment became too expensive, the respondents reluctantly visited the *CDI*s (Respondents 52, 86, Venezuela, April-June 2013). After interviewing the family members and elderly respondents it was clear how radical the ideological transition was. In one case it was an entire 180-degree turn where one elderly respondent said that, after getting treatment by the Cuban doctors, she realized that many of the Venezuelan doctors seemed cold and uncaring. After observing the interactions of these two respondents with their Cuban caretakers it became clear how *conciencia* was initiated from the very first interaction.

The Cuban doctors, trained to see their patients as family members and empathize with their bio-psycho-social spheres of health (especially in the Morphophysiology and Morphophysiopathology courses listed above), greeted both respondents as a member of their family with a warm embrace and '*Hola abuela'* (hello grandmother) for the one respondent (Respondent 86, Caracas, June 2013) and a '*Hola tío'* (hello uncle) for the other (Respondent 52, Caracas, April 2013). It was not a sterilized and unfeeling appointment with the doctor on one side of the desk running through the list of symptoms and asking questions to find a quick diagnosis. Rather it was an interaction that started with a hug and the doctor holding the hand of the grandmother, asking her how she and her family have been. The level of empathy and connection in almost all observations, including these examples, were fairly consistent.

As many Cuban doctors have noted, though a patient might show up for treatment of a biological illness, the mind-body connections to health must always be understood (Respondents 66, 68, 69, 82, Venezuela, May-June 2013). A patient heals better in the environment of friends and family, and when that environment can be recreated at *MBA* health centres, then the challenge of healing has been started. As one doctor noted, "we receive patients as a family and not as a source of income. In this way we have sometimes found that the greatest need for a patient's well-being is social and emotional. Some patients just need someone to talk to. As a doctor we should never push the patient away and say 'that it is not our job'. Building a relationship is building a community, and

often the mental health of a patient is more important than simply medicating a patient" (Respondent 66, Carora, May 2013). This may be one of the most important points witnessed during these interactions between *MBA* personnel at *CDI*s and *CP*s. When profit is taken out of medical appointments and services in a system in which the approach is 'time is money', then medical personnel can truly get to the root of the health issue, instead of merely medicating the issue, and moving on to the next client.

4.12 SUMMARY

The success of *MBA* is most profoundly felt by the poor and marginalized populations. Almost all respondents who had visited their local *CDI* had positive experiences to share. The criticisms of the programme seem limited, since most directed at the programme itself came from people who have never actually visited a *Barrio Adentro* facility. Socio-economic and political alignments are also one of the main reasons for this opposition. Definitely an effective and efficient universal health care system appears to be the long-term vision for the programme. However, its acceptance by all socio-economic levels as well as the deeply-rooted polarization and politicization may limit a smooth transition into the greater health system.

As noted previously, although *Barrio Adentro* is actually available for all, many people still believe that is only for the poor population. This has made it harder to gain acceptance throughout all social strata. Indeed some opposed to it prefer to abstract the entire mission as being of sub-standard care, and one that might even be harmful to seek help from. Again, the abstraction of the programme may also be related to the politicization of healthcare found in Venezuela, with little politically neutral space.

The main criticism, even from Chávez supporters, is that *MBA* doesn't go deep enough to assist people in many rural areas and has yet to become significantly operational or even fully functional. The implementation of curative training is also only starting and will have to be analyzed to see how it transitions into the broader medical project. One of the most accurate criticisms comes from one manager of the Cuban medical mission:

> Not all is positive. There are problems and difficulties. For example, for us working in a huge state with 28 health areas and many students, transportation means are scarce, and so the systematic control and assessment are limited, and although we use different means of communication, it is not the same as being there to conduct a proper assessment, especially if you bear in mind that the majority of professionals in PHC facilities have very limited teaching experience. (Respondent 82, e-mail correspondence, June 2013)

Most of the teachers in the *MBA* programme are still Cuban, and the programme still has a number of hurdles to overcome. Indeed there remains a large amount of human capital yet to be developed before Venezuelans will be able to comprehensively take over the reins of all aspects of *MBA*.

To be sure, as was always made apparent from interviews with many *MBA* medical personnel and others, *Barrio Adentro* is young and still evolving. While this is true, its impacts are still fairly impressive given the short amount of time it has been in effect. Infant mortality and mortality for children under 5 have almost been halved, and adult mortality improved enough to put Venezuela ahead of Colombia and Brazil (Docksai, 2012, p. 46). In addition to this approximately over 500 million consultations have taken place and 1.4 million lives have been saved in less than a decade (Robertson, 2013b). Even "Henrique Capriles Radonski, Chávez's conservative rival in the 2012 Venezuelan presidential election, has stated that [if elected] he [would] keep the mission in place because it 'belongs to the people'" (Docksai, 2012, p. 46).

When Tucker, throughout his writing on critical holism, warned of the construction of medicine as being 'doctors plus drugs equals health', he highlighted how corporate medicine has narrowed the scope of what is possible in a health system. When a physician is able to spend the time evaluating the patient in the entire bio-psycho-social sphere of health, and can create a healing environment based on empathy with mind-body connections at the fore, then the reflexive nature of the physician and the system creates medical personnel as health advocates. These health advocates do not stop at constructing health as mere prescriptions, but can instead become active agents of change that help uncover the root of the problem in a true LASM approach. Conversely, when the doctor

has a patient base, in which time equals profit, than medicine can become a factory of profit that narrows the scope of what can be achieved. Instead of becoming a health advocate, the physician is instead reflexively moulded into constructing the patient as a commodity where time is money.

With currently 14,000 doctors already graduated in the new community medical system, and many more medical personnel ready to graduate over the coming years to replace the almost 30,000 Cuban medical personnel, the improvement in those key health indicators may not plateau any time soon.[69] Since this is only the second year of graduates (with approximately 180 graduating from the state of Lara this year alone), more analysis will be needed to further assess the impact of future medical graduates who look to become the majority population in what was once a badly understaffed medical system. Additional research will also be necessary to evaluate the medical specialist education programme and its unique impact on pushing *MBA* beyond its proactive and preventive boundaries and onto curative roles. Does the Cuban medical adaptation show promise for improving the health of rural and marginalized populations in Venezuela? The short answer is yes, but again, much more time is needed in order to analyze the effectiveness of the soft transfer of policy tools for the Venezuelan graduates of *Misión Sucre*.

[69] What is also impressive is that, even before the programme has finished its full evolution, in true medical solidarity Venezuela is helping other countries also scale-up their own medical system. Regionally Bolívia and Ecuador are following a similar path, and Venezuela and Cuba have committed to creating a comprehensive health system in earthquake- and cholera-ravaged Haiti.

CHAPTER 5 CONCLUSION

"We see patients as a family and not as a source of income. In this way we have sometimes found that the greatest need for a patient's well-being is social and emotional. Some patients just need someone to talk to. As a doctor we should never push the patient away and say 'That it is not our job'. Building a relationship is building a community, and often the mental health of a patient is more important than simply medicating a patient"
- Cuban Doctor, Carora, May 2013

This research project attempted to answer the question: does the Cuban medical adaptation in Venezuela show promise as an example of a health system that improves medical accessibility for impoverished and marginalized populations? Key to understanding this question was an analysis of whether the Cuban medical system is truly *sui generis*, or whether aspects of the Cuban medical system can take root in another country. The obvious challenges to this adaptation are that Venezuela did not undergo a violent revolution that included an entire overhaul of the government, as well as the implementation of a socialist system which evolved over 50 years. Moreover Fidel Castro did not have to face several of the challenges that Chávez faced when he took power in 1998 through a liberal democratic process. Most of the main opposition—military, corporate media and the socio-economic elites—did not flee or were not forcibly removed. While some members of the opposition integrated into the new system, most continue to contest the social processes that Chávez envisioned and implemented. This contestation is clearly very much a part of Venezuela today and seems to have increased in the last year as the country became more polarized.

While the Cuban medical model and achievements may in fact be *sui generis* in their entirety, when broken down into their various elements—such as the structural components (facilities, production of pharmaceuticals, vaccination programmes, method of teaching and allocation of other resources), as well as the overarching focus (proactive, preventive, curative, palliative and rehabilitative), and finally the medical education system itself—it is clear that an adaptation of certain elements of the Cuban model is possible. More importantly, the adaptation of these elements, especially for the poor and

marginalized populations of Venezuela, also shows that a similar level of success achieved by the Cuban system, is possible.

However, while similar success is possible, the 'how' and the 'why' of the implementation are much more complex to explain. Many questions remain to be answered. How was the Cuban programme adapted in a Venezuelan context? How did the Venezuelan population embrace the programme as well as accepting the Cuban medical personnel? How has *Misión Sucre's* medical education programme integrated key aspects of the Cuban medical education programme such as the development of *conciencia* and the need to view the patient in the bio-psych-social sphere of health? Why is the process of scaling-up of the work force not just about adding more medical personnel, but rather about capacitating health personnel from non-traditional medical backgrounds in order to provide much-needed medical services to their rural, poor and marginalized communities? Why are some segments of the population opposed to the integration of this programme? And lastly, what are the challenges, successes and the very future of the programme? These additional questions help to form the base for this thesis to grasp the significance of this adaptation, as well as to understand its impact on the impoverished and marginalized populations.

Key themes and theories—such as structural violence, critical holism, Latin American social medicine (LASM), and the soft transfer of policy learning—helped to formulate and indeed to guide this research. Structural violence, a major problematic facing poor and marginalized populations, helps us to understand that the roots of exclusion, poverty, marginalization and inequality cannot be solved by a reactive health system which simply maintains the status quo. Instead a proactive health system that is present in all government policies and advocates for positive change to those suffering from the lowest health indicators and pathologies of poverty must be initiated (Galtung, 1969; Gilligan, 1996; Farmer 2004, 2005 and 2006).

Tucker highlights why traditional bio-medical models have not been the answer. The reductionist construction of health consisting of 'doctors + drugs' (often promoted by the Transnational Pharmaceutical Industry), weakens any comprehensive and effective response to structural violence, since it constructs health care as only a response to a singular illness, disease or injury (1996a). Instead, health care needs to be an active part

of the system that challenges the roots of structural violence through health promotion, prevention and activism. This rejection of such a reductionist model then leads to the question of what medical alternatives might show promise in addressing the issue of medical exclusion for poor and marginalized populations.

In light of Cuba's unique adaptation of Latin American social medicine (LASM), it becomes clear what an alternative approach to health care might look like. This approach to medicine stresses the "importance of political–economic and social determinants of health, and promote[s] holistic approaches to health–disease–health care processes" (Briggs and Mantini-Briggs, 2009, p. 549). Lastly, an understanding of the transfer of soft policy tools—the norms, values and culture—make it possible to understand why and how the Cuban medical adaptation is more than simply a transfer of resources and human capital. The adaptation is also a transfer of an entire alternative system of viewing the patient, families and communities in a humanistic way, based on underlying feelings of solidarity, a process which changes the health care worker-patient relationship. This study seeks to illustrate how the Cuban notion of LASM has been creatively adapted in a Venezuelan context to convert Venezuelan medical personnel into health care activists.

These themes and theories helped to situate various popular medical debates and questions. Five basic questions were raised during the course of this research. First, the issue of whether 'health without economic growth is possible', showed that a focus on economic growth above all else should not necessarily displace a focus on services such as health care, since even in periods of low growth, much improvement in health indicators can still be accomplished. A second question asked whether rural and marginalized populations suffer disproportionately due to a lack of access to quality medical services than do their urban and affluent counterparts. In both the literature review and primary research, this was very much the standard case.

A third theme of this research examined aspects of private and public health care systems. Again, in both the literature review and in primary research, it was made clear that reliance on a highly privatized bio-medical model, coupled with a weak universal health care system, is unable to effectively address the roots of medical structural violence. A fourth question discussed the strengths and weaknesses of preventive and

curative health care foci. Though the Cuban medical model contains a high degree of both approaches, it was clear the medical adaptation of *Misión Barrio Adentro* (*MBA*) was aimed at filling the almost absent aspects of proactive and preventive health care present in Venezuela's pre-Chávez traditional medical system. Lastly, Cuban and Venezuelan medical education models were analyzed. This analysis proved to be one of the key aspects that made it clear how the medical education adaptation would help address issues of structural violence through a LASM approach in a robust and long-term way.

After the review of literature, data, and media articles, an immersion into primary research began in Venezuela. For a period of ten weeks, observations and interviews were collected in the Torres region (mostly in the town of Carora which has a population of approximately 100,000), but also in other areas of both northwest Venezuela and Caracas. Many of the findings confirmed the extensive research previously done by Brouwer (2011) as well as by PAHO (2006 and 2013). Other interesting findings resulted during this time including several challenges to the Cuban medical adaptation.

The primary challenge was political. As noted extensively in both the Introduction and Chapter 3, Venezuela's health care system is not apolitical. The adaptation of certain aspects of the Cuban model was a topic that was highly contested among both Chávez supporters and the opposition. Hopefully the politically divisive nature of this issue in Venezuela is only temporary. The dichotomies of 'Capitalism' versus 'Socialism' also strengthened the political divide. (As some of the more extreme members of the opposition claimed, "all Chavistas are communists", while the extremist members of the Chávez supporters labeled the opposition as "fascists"). This issue seemed to be leaving little middle ground[70] for moderates, as well as making difficult a civil dialogue between the two sides. The media also played a major role reinforcing this dichotomy and polarizing discourse. Few, if any, news outlets sought balance in their reporting. TeleSur

[70] The process of abstraction was starting to create physical and geographic divides, where "opposition neighbourhoods" and "socialist stores" seemed to be entering into the dialogue of more and more Venezuelans. On a few occasions, Chavistas would refuse to go into a store or buy a product if the owner was known to support members of the opposition. The opposition also took a similar approach. The exclusion of Chavista space was highlighted most strongly by the avoidance of *MBA* medical centres by members of the opposition—especially those from the socio-economic elite.

did its part to support the Chávez position while CNN's Latin American branch supported the Capriles opposition. Unfortunately one of the victims of this dichotomy may have been present in the fragmentation of the overall medical system itself. It remains to be seen whether the political fervour will eventually recede and more space will open up for civil dialogue, as well as for a community of critical thinking moderates.

Not only did this polarization affect the health system, but additional challenges were also present in the adaptation of the Cuban model. As noted in a recent PAHO article:

> In Venezuela, as in the rest of the countries in the Region, there is a need for professional health care workers and technicians and there is fragmentation among publicly funded institutions that provide health care. This presents barriers to developing a strong national public health system, and decreased fragmentation and segmentation among entities that provide health services is needed. Two strategies for strengthening the national public health system should be highlighted: 1) functionally integrating health facilities in the context of comprehensive community health areas (*Areas de Salud Integral Comunitaria—ASIC*), and 2) increasing the number of health professionals through creative training programs. (PAHO, 2013, p. 11)

Fragmentation and polarization of the health system were also apparent in Carora. As noted in this PAHO report, as well as the previous chapter, there appeared at times to be a lack of cooperation between the preventive-focused *MBA* health system and some of the medical professionals from the traditional medical model. In addition to this, fragmentation of the system of funding was a major issue for the municipal hospital in Carora.

This research found that the legacy of Chávez's medical implementations since taking power (based largely upon various aspects of the Cuban model) can be summarized in the following manner (with the Cuban-run *MBA*- and *Misión Sucre*-specific initiatives in bold):

1. Having the cooperation of the Cuban government to provide comprehensive health care and medical training immediately in underserviced areas based on solidarity and humanism. This is based on a unique agreement whereby both governments give what they have—oil and medical personnel—not what they have left over.

2. Explaining the government's commitment to provide effective and efficient health care for all made explicit in the Constitution—very similar to the Alma Ata Declaration which advocated a 'Health for All' (HFA) approach. (**Partially connected to *MBA***)

3. Having the political will to create a 'health in all policies' approach that affects change in other areas of policy in a LASM approach. (**Partially connected to *MBA***)

4. Engaging social workers to help inform and prescribe changes in order to address issues of structural violence by being the voice of marginalized and poor populations. (**Partially connected to *MBA***)

5. Creating two additional tiers of health facilities located in traditionally underserviced locations.

6. Ensuring that these two tiers support the traditional medical system (in ways previously absent) by focusing on proactive and preventive health care in a truly community-oriented primary care (COPC) approach.

7. Being adaptive to unique pathologies (e.g. diabetes, malaria, dengue and STIs), as well as other challenges (e.g. implementing proper sewage and water accessibility programmes), effectively. (**Partially connected to *MBA***)

8. Having a comprehensive vaccination programme that is available to all. (**Partially connected to *MBA***)

9. Actively creating other missions to address the broader aspects of policy that can also affect the roots of structural violence and health outcomes (e.g. education, housing, subsidized food programmes, etc). (**Partially connected to *MBA***)

10. Making *Misión Sucre's* medical education programme free to those who meet the requirements.

11. Geographically decentralizing *Misión Sucre's* medical education system so that more people, especially from rural populations, can be trained closer to their homes.

12. Ensuring that *Misión Sucre's* medical education system does not include the barriers of high tuition and extraordinary requirements that had prevented people from non-traditional medical backgrounds from being trained in the traditional medical system.

13. Significantly scaling-up medical personnel (estimated to have an extra 60,000 doctors by 2019) with the explicit goal of abolishing medical exclusion. Significant is the capacitation process for rural and marginalized populations by ensuring that medical personnel are graduating from those sectors of the population in order to replace the Cuban medical brigades that are providing health care in traditionally underserviced areas. These medical personnel have an intimate knowledge of the unique challenges—especially the pathologies of poverty—facing their communities.

14. Educating the next generation of Venezuelan medical personnel to view their patients in their bio-psycho-social spheres of health instead of merely treating a singular disease, illness or injury. This is very important in order to turn medical personnel into health care activists.

15. Making proactive and preventive health, as well as *conciencia*—a sense of duty, commitment, compassion and empathy to treat patients as family—an integral part of medical training and duties.

What is important to note is that there are both similarities and differences between the Cuban medical model and its adaptation in Venezuela. This is a critical point to make. Though the Cuban medical model as a package can arguably be considered *sui generis*, when broken down into various components and analyzed, similarities to other health systems can be encountered. Moreover the aspects that make the Cuban medical model and its adaptation in Venezuela successful in its effort to solve issues of medical structural violence for the poor and marginalized, can also be found to varying degrees in other medical systems.

Indeed many health systems contain a certain degree of proactive and preventive focus and the social determinants of health are similar to the broader view of LASM. Moreover the idea of a universal health system providing health for all—as the Alma Ata declaration promoted—can be found in many countries. Additionally, almost all systems contain varying degrees of private and public health—even the Cuban medical model

contains certain market-based aspects. As a result, although copying an entire medical system onto another country may be impossible, the example of the Cuban medical adaptation highlights that certain aspects of a successful medical system may indeed offer promising examples for other countries. When successfully adapted, these specific aspects potentially highlight important lessons that other medical systems could then assimilate as well.

This study of *MBA* has shown that the Cuban medical adaptation in Venezuela is just that. It is a nation-wide medical experiment that attempts to draw out those key elements of the Cuban medical system that can be used effectively in the Venezuelan context. The objective is to improve the health for large sectors of the population who traditionally suffer the most from a lack of effective health care—the poor, rural and marginalized. PAHO notes how this has been accomplished since it is an integral part of a larger public health system:

> Mission *Barrio Adentro* is one of a series of Social Missions that are aimed at abolishing poverty. Structurally, it is in the process of being integrated into the National Public Health Program of Venezuela. Thus, it cannot be analyzed as a limited intervention; rather, it should be considered part of the health system, which includes an array of organizations, institutions, and resources devoted to health, including public health services and intersectoral initiatives. Since January 2004, the main purpose of Mission *Barrio Adentro* has been to provide the population with complete primary health care coverage. (PAHO, 2006, p. 79)

Thus, many of the successes in health indicators can also be attributed to the other programmes implemented by the Chávez government that help address the causes of structural violence. Though the role of *MBA* directly addresses health care exclusion for the poor and marginalized, it clearly works in concert with other missions. In a true medical advocacy approach, it also helps to inform and improve those other missions.

In some cases it still has far to go: the most rural areas still lack comprehensive care; fragmentation between the traditional medical system and *MBA* remains a major challenge. Moreover, belief in Cuban medical influence as a positive force is a hurdle that prevents many from utilizing the free health services. As one respondent said:

> This is indeed a different medical education programme. Whether it is the best, or better for local conditions will need time in order to make a full evaluation of the functioning and outputs of this project. When I analyze this topic, I always remember the SPICES model launched by British medical educators. This programme fully accomplishes the requirements of that model, though not without certain difficulties. One of the challenges is that many of the facilitators and tutors were educated in the traditional model without community orientation. Their traditional training lacked time with hands-on education and connections with the community. They instead were trained in advanced medical faculties and a great percentage of their time was spent in hospitals where there was a high level of resources and expertise—especially human resource education for health. (Respondent 82, e-mail correspondence in Venezuela, 2013)

Hence, as the respondent highlights, one of the other major challenges is that many of the teachers in the medical education programme do not have hands-on experiences in community health areas where sometimes resources are lacking.

In addition to this, the training of these *Misión Sucre* medical teachers also lacked an activist approach to health that, in turn, is needed to address the deeper issues of structural violence. So, while their level of training is certainly high, many of these teachers are attempting to train the next generation of Venezuelan doctors for a medical system that they are not entirely familiar with. Situating the patient in their bio-psycho-social sphere of health will undoubtedly be a little harder for someone to teach when it wasn't the original medical model in which they were immersed. However, an evaluation of the effects of this traditional training will be difficult to assess given how young this medical programme is.

In many cases *MBA* succeeds by: utilizing a universal health care system available to all for free; locating health centres in previously underserved areas; providing scholarships to populations from non-traditional medical backgrounds to capacitate the most vulnerable populations; creating a catchment system based on medical accessibility and physical geography; scaling up the medical workforce; and broadening the very praxis and ideology of what health means in a true LASM approach. One of the major

successes of the approach has to be the development of political will that has both listened, and responded to, the challenges facing the poor and marginalized. Realizing the impact of the reflexive relationship between health and poverty, and by going to the root of this issue in a very short period of time (only 11 years old), is historically unprecedented for any country. Though many challenges remain, presently poor and marginalized populations (as well as some rural populations) have remarked on the impact that free and accessible health care has had—and in this case most responses were positive.

Though the main limitation of this research is a matter of timing, with important observations and evaluations yet to be revealed, the positive impact for traditionally underserviced populations has been substantial. As noted by many respondents, *Misión Barrio Adentro* is an ongoing process. However, this process has already made impressive improvements in health indicators as well as increasing the capacitation of populations that were traditionally excluded from being integral parts of their own medical solutions. The scale-up of 60,000 community doctors in Venezuela by 2019, medical personnel who are imbued with *conciencia* and trained to view their patients in bio-psycho-social spheres of health, could very well become an important example for other countries that another world is possible—a world that takes care of its most vulnerable, not through charity, but through empowerment, capacitation and dignity.

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