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From Rich to Refugee: The Collapse of Venezuela's Healthcare System

John Pierce

University of Mississippi. Sally McDonnell Barksdale Honors College

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From Rich to Refugee:
The Collapse of Venezuela’s Healthcare System

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By John M. Pierce

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Approved:

___________________________
Advisor: Dr. Katherine Centellas

___________________________
Reader: Dr. Oliver Dinius

___________________________
Reader: Dr. Miguel Centellas
Abstract

Health system reform is a popular topic around the world. Politicians argue over how to effectively provide health coverage to the most people while ensuring the sustainability of the system. The debate is extremely complex and there is no general consensus on what is the best form of health provision. Due to the fact that most healthcare systems have so many different strengths and weaknesses it is difficult to study and compare which policies are working. Thus Venezuela’s recent healthcare collapse provides a dramatized source for healthcare officials to study in attempt to discover what were the major causes of the health systems collapse.

Venezuela also sought to implement one of the newer trends in the healthcare debate prior to its collapse, a preventative health program. This allows for health care officials to also study the possible benefits and dangers of adjusting to a new style of health provision. I study the collapse in an effort to provide insight into what factors allowed for a healthcare system to fail so extravagantly and to analyze which aspects of a preventative health system Venezuela was successfully able to implement. I found that extreme political polarization of health infrastructures and lack of health investment created a health system that was weak at its core. Venezuela sought to alleviate its issues with short-term policies that never addressed the core problems, which allowed for the issue to manifest and cause other difficulties within the healthcare system. Through this study I hope that other countries will able to successfully implement aspects of Venezuela’s preventative health programs, while avoiding many of the difficulties.
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I. Introduction

What is the best way for a government to provide healthcare for its citizens? This question has been heavily discussed for many years and has resulted in various different types of healthcare systems around the world. Although my research focuses on the Venezuelan healthcare system, I hope it will provide an example that can influence how the United States and other countries approach healthcare reform in the future. Around the world, healthcare reform is at the forefront of many political agendas, and new attitudes toward health systems have begun to develop.

It is important that we not only study the successes of other healthcare systems throughout the world, but also that we study the failures of other countries as well. These failures can be used to ascertain what mistakes were made and how specific systems and programs can be improved upon. The Venezuelan example can be useful to show other countries what mistakes can be made when attempting to shift perspectives on health care.

A new trend in healthcare provision is to work with both healthy and sick individuals to prevent and reduce the spread and development of sickness. Ideally this would allow for healthcare systems to spend less money on expensive reactionary measures and decrease disease prevalence. Last year in the United States alone, illness cost the economy $227 billion in lost productivity (Jaspen, 2012). This loss is the result of employees either not being able to attend work or not being able to perform at their best due to illness. These numbers reveal why preventative health care measures have gained so much attention worldwide.

However, there are many critics that claim this shift toward health management is unsustainable and impractical. This argument is centered around “skepticism, inertia and competing interests” (Woolf, 2008). Due to the fact that health management does not bring in the
large profits that come with reactionary medicine and that health habits are difficult to change, skeptics see it as an inefficient form of healthcare (Woolf, 2008). These arguments are coupled with the idea that a preventative, more expansive approach to health services would require a much larger investment in healthcare resources, new healthcare facilities, and more physicians with high salaries.

What these individuals do not realize is the power of non-specialized primary healthcare workers. These workers require much less training than hyper-specialized healthcare providers and allow for healthcare to be expanded to a larger number of people. The expansion in healthcare coverage comes from the different perspective taken when implementing preventative systems. In reactionary healthcare systems information is unidirectional with patients coming to physicians to treat a problem. In a preventative system health becomes a “bidirectional clinician-community collaboration…delivering better care to the good of all parties” (Woolf, 2008). This approach toward healthcare has been successfully implemented and maintained in Cuba for many years in what has become known as the Cuban anomaly and has resulted in one of the best healthcare systems in the world all while operating with limited resources.

In the early 2000s, Venezuela began establishing healthcare programs that reflected many of the systems that had been successful in Cuba. This included an increased focus on preventative health and a much larger role for community health workers. Following the recent economic crisis Venezuela’s health system has failed at an unbelievable rate. For many critics, the recent epic collapse of the healthcare system proves that the success experienced by the Cuban healthcare system is merely an anomaly. This creates the question, “Was the fall of the Venezuelan healthcare system the result of its efforts to implement a health system based on preventative care?”
I argue that the collapse of the Venezuelan health system was not caused by its decision to implement policies based on preventative medicine or merely the result of an economic crisis. It is the result of a health system that had been inadequately funded for decades, followed by an attempt to implement widespread horizontal programs using temporary solutions that allowed for the severity of the crisis to grow unchecked until those provisional solutions could no longer hide the issues. The economic crisis served as the catalyst that exposed the underlying issues that led to the epic downfall of Venezuela’s health system.

II. Methodology

The collapse of Venezuela’s health system has occurred at an unforeseen rate. This collapse has largely been written off as a byproduct of the economic hardships that have devastated the country. I argue that the economic failure merely served as a catalyst for a system that was destined to fail. This report combines quantitative and qualitative data to reveal an astonishing history of apathy, empty governmental promises, and many failed adjustments all of which played a substantial role in creating a health system that was able to maintain a façade of success while catastrophe lay waiting.

In the study I created a database consisting of various statistical indicators provided by the World Bank, such as health expenditure as percent of a country’s GDP and the number of hospitals per 1000 individuals, to prove that Venezuela’s shortcomings in the health sector are a far cry from a new development. The World Bank served as the best source for these indicators because it provided consistent data that allowed for trends and developments to be easily identified.

Health expenditure as a percentage of GDP served as the most efficient and effective way to analyze how a country prioritizes its health system. The indicator given is neither influenced
by the size nor the wealth of a specific country, thus allowing for cross country comparisons 
based on how much each country invests in its health system in comparison to its other 
expenditures. I used this indicator to compare Venezuela’s level of health expenditure to that of 
the world average, the regional average, and fragile and conflict affected areas. I use these 
regions to demonstrate that Venezuela has historically invested astoundingly little in its 
healthcare system.

I use the number of hospital beds per 1000 individuals, which includes hospital beds in 
both the public and private setting, to study how equipped a healthcare system was able to serve 
a population as well as how the system’s functionality changed over time. As healthcare services 
are developed and extended, access to these services will be increased through more and better 
facilities. I reveal that Venezuela has historically had a healthcare system that has struggled to 
expand health services to a large portion of its population.

This is an exceptional revelation because Venezuela was seen as one of the wealthiest 
countries in the region and, in conjunction with the widely accepted idea that wealth is a 
precursor for health, should have had a health system that was far more expansive than the 
regional average. I argue that one of the primary reasons for Venezuela’s failure to develop a 
more extensive health system was due to its extreme dependence on oil. I use these studies to 
argue that Chavez inherited a dependent and ailing health system when he came to power 
following the Bolivarian Revolution.

In the period following the Bolivarian Revolution I used speeches made by government 
officials, policy changes, interviews, and newspaper and journal articles to study the decade prior 
to the collapse. Due to one of the interviewees’ request to remain anonymous, I use the 
pseudonym Dr. Fernández when citing information from that interview. I combined the speeches
made by government officials and secondary sources to establish the empty rhetoric of the Chavez/Maduro presidencies. These speeches often consisted of bold claims regarding the health system that later proved to be unsubstantiated by the secondary sources and the policy changes demonstrate a failure to consider the long-term success of the health system.

By combining the analysis of health prior to the Bolivarian Revolution with the adjustments and developments with regard to health following the revolution, I reveal many of the major factors that led to Venezuela’s health system’s vulnerability. I argue that this revelation serves as evidence that the collapse of Venezuela’s health system was not a result of the decision to implement preventative health measures and that preventative healthcare measures continue to hold great potential for healthcare systems around the world.

III. Context

The current condition of the Venezuelan health system is nearly beyond belief. Across the country citizens protest the conditions of their healthcare system as they fight for their lives. Above is a picture of a young child at one of these protests after he had been diagnosed with
non-Hodgkin lymphoma. The sign he holds says ‘I want to be cured’ followed by the words ‘peace’ and ‘health’. He, like many others in the country, was unable to be treated due to the lack of proper medicines and equipment in the country (Berry, 2016).

In March of 2015, Doctors for Health produced a survey that revealed that 44% of operating rooms were not functional, 94% of labs lacked the necessary resources to run properly, and 60% of medicines and medical supplies were unavailable (Lohman, 2015). Since then conditions have continued to deteriorate as fewer and fewer medications become available and healthcare facilities face increasingly difficult conditions.

Once controlled diseases like malaria are now causing their worst epidemics in over 75 years and viruses such as HIV and AIDS are becoming increasingly impossible to control due to a lack of necessary antiviral medications (Herriman, 2016)(Pestano, 2016). The Venezuelan physicians equate their situation as being like doctors at war as they find themselves prescribing 40-minute cold showers because they have run out of anti-fever medication (Reyes, 2016). Today many Venezuelan hospitals do not even have food and water and have become a “dormitory for the dying” (Gutman, 2017). The Human Rights Watch even went as far as to state “we have rarely seen access to essential medicines deteriorate as quickly as it has in Venezuela except in war zones.” (Lohman, 2015).

The current conditions and extreme lack of resources within Venezuela’s health system seem to serve as evidence for the argument that a shift toward preventative medicine is inefficient and unsustainable. I argue that Venezuela’s failures do not serve as evidence of the inefficiency of a preventative health system, but instead point to various mistakes made by both the Chavez and Maduro administrations when implementing the system. In fact, I believe that
some of the systems established, if implemented properly, could be beneficial in many countries around the world.

The preventative health system I am referring to is primarily in the form of the Barrio Adentro program. Following the Bolivarian Revolution changes were made to the constitution that outlined access to healthcare as a human right. To expand access to healthcare throughout the country the Chavez government established the Barrio Adentro program to create a new form of community-oriented healthcare (Cruz, Perea & Rojas, 2010). The program would be run with the help of Cuban physicians that were a part of a doctors for oil agreement between the Cuban and Venezuelan governments. The program served as an alternative to the neoliberal policies that were common throughout Latin America and offered an opportunity to test a health system mirroring that of the Cuban anomaly.

It is considered such an anomaly because Cuba has been able to maintain very high health outcomes despite economic struggles. The conventional assumption is that wealth is the best way to generate health and that it is a necessary precondition for generating health (Spiegel & Yassi, 2004). Samuel Preston was one of the first individuals to produce a study that created the wealth-health theory. In 1975 he created a graph that became known as the Preston Curve, “which demonstrated a positive correlation between national income levels and life expectancy” (Bloom & Canning, 2009). His study has been expanded upon and serves as a foundation for the belief that wealth must precede health. The wealth-health theory argues, “the gains from rapid economic growth flow into health gains,” thus creating a better functioning health system (Pritchett & Summer, 1996). Wealth allows not only for more money to be invested in the health system, but also improves access to food, clean water, sanitation facilities, education and other social influencers of health (Bloom & Canning, 2009).
This theory has led most of the policy decisions with regard to healthcare and has powered the arguments of many proponents of a profit driven system. Such a system relies on treating a problem after it has manifested because treatment is seen as more profitable for the providers than a preventative approach (Woolf, 2008). This approach fails to recognize the potential economic benefits that can result from seeing health as a long-term societal investment. For critics of a health system that depends heavily on preventative care, what has happened in Venezuela reinforces the idea Cuba is an anomaly and that countries should not shift away from serving as reactionary systems.

What these critics fail to realize is the importance of nonbiological factors that influence health outcome. Studies have shown that “a population’s health is shaped 10% by the physical environment, 20% by clinical health care (access and quality), 30% by health behaviors (themselves largely determined by social and physical environments), and 40% by social and economic factors” (Los Angeles County Department of Public Health, 2013). Investing in a preventative system is a long-term solution that allows for many issues that plague health systems to be avoided before they begin. Although a preventative approach may not receive the same level of profit as the reactionary approach through treatments, the economic savings that result from preventing disease is much higher.

Undoubtedly there are pros and cons to any form of health system. A shift toward preventative care frequently necessitates less access to the most extreme forms of specialization and often requires longer waiting times in order to receive a procedure. A shift toward more reactionary care necessitates less widespread, holistic health care provision for a population and can lead to more expensive procedures.
Due to the fact that health systems are fairly new, a consensus best approach is far from having been established. However, I believe that it is important to study both preventative and reactionary measures in an effort to create better health systems that are able to implement successful and practical preventative health measures while maintaining the integrity of essential reactionary systems. In studying the failures of the Venezuelan system I hope to prove the potential benefits of an increased emphasis on preventative health while revealing the several components that allowed for the health system to deteriorate so quickly.

Although Venezuela suffered an economic collapse that undoubtedly hindered its ability to provide health care, Venezuela’s healthcare system has fallen apart at a rate generally only seen in war torn areas (Lohman, 2015). This suggests that there were multiple issues present that allowed for one of the most extravagant failures in modern healthcare history to occur. In less than a twenty-year span Venezuela went from one of the most advanced countries in Latin America to a country where surrounding hospitals are equating the situation to a refugee crisis (Lopes, 2016). With my research I hope to prove that the failure of the Venezuelan healthcare system was not due to its decision to shift its focus toward preventative and primary care nor its economic collapse, but due to years of mismanagement that was hidden under the surface and negligent responses to healthcare issues as they arose.

With the presence of large health systems being relatively new, I maintain that both successful and failing health systems serve as potential learning opportunities for health systems throughout the world (WHO, 2007). Countries across the globe are in the middle of large health system reforms and the Venezuelan health system provides examples of both systems that have the potential for good and policies that have the potential to cripple a health system. As various
countries look to implement new policies acknowledging the potential of preventative care they must avoid the mistakes made by Venezuela, which have led to a human rights crisis.

IV. A History of Apathy

In order to understand how the Venezuelan healthcare system has deteriorated so quickly it is important to first understand the conditions of that system at the start of the 21st century. During the 1960s and 70s Venezuela benefitted from a large oil boom that made it the country where workers “enjoyed the highest wages in Latin America” (Ellner, 2005). Thus, according to the wealth-health theory that was discussed earlier, it would be expected that Venezuela would also have one of the better health systems for the region as well. Although data is extremely limited for that time period, the WorldBank’s statistics for hospital beds per 1000 individuals provides an interesting glimpse into how well the healthcare system was able to serve its citizens as well as the importance placed on health during that time period.

In 1970 the average for hospital beds per 1000 individuals in Latin America and the Caribbean stood at 3.46. With Venezuela being one of the most developed countries in the region during this time one would expect that it would at least meet the regional average. However, throughout the 1970s Venezuela never had more than .343 hospital beds per 1000 individuals in any of the years provided. This set the tone for a society to invest and maintain little importance in its health system even when times were good. This trend was maintained throughout the latter half of the 1900s and in 1996, a few years prior to the Bolivarian Revolution, Venezuela still only had 1.47 hospital beds per 1000s individuals compared to the regional average of 2.26.

Although this does represent an increase from the abysmal level seen in the 1970s, it shows how the trend of the insignificance of healthcare was maintained up to the point of the Bolivarian Revolution. It is important to point out that Venezuela as well as many other countries
went through significant political and economic turmoil in the 1990s; however, these statistics merely seek to prove that Venezuela historically placed especially little importance in its health system prior to the election of Hugo Chavez. A key aspect in understanding why Venezuela failed to develop its healthcare system can be found from its relationship with oil.

**The Oil Curse**

In the mid 1900s economists believed that resource wealth would help countries develop quickly as they were able to invest in roads, schools and other infrastructures (Ross, 2012). This belief was driven by modernization theory and the idea that “increases in a country’s income per capita would lead to improvements in virtually every aspect of its political well being” (Ross, 2012). Studies by multiple scholars, such as Sachs and Warner, have since shown that resource wealth can prove extremely detrimental to countries in what has come to be known as the resource curse (Sachs & Warner, 2001). The resource curse has shown to only be true with regard to mineral resources and more specifically oil. Not only are these countries more likely to experience political instability, but also they are less likely to develop important infrastructures such as healthcare and education (Ross, 2000).

In Latin America, many countries were dependent on a small number of goods to provide wealth for the entire country. This created a series of booms and busts for these countries as they were subjected to the demands of the global economy. As Latin American countries grew and developed, many were able to grow past their state of dependency and achieve more stable growth. Venezuela did not. As the oil industry grew throughout the world, so did Venezuela’s dependency on oil. Venezuela quickly became one of the richest countries in Latin America as it built its economy around the oil industry.
The exportation of oil allowed for Venezuelans to become some of the richest individuals in South America, and it allowed for Venezuela to trade with a large number of countries to fulfill any of its needs. However, this created a dangerous situation where health was linked to oil revenue. This reveals an important trend about the Venezuelan government and its views toward healthcare. Healthcare was not seen as a separate entity that should receive constant funding and support. Instead, it was of secondary importance and was largely dependent on the oil industry. This reveals the growing systems of dependency that have permeated Venezuelan society ever since oil became the primary commodity.

Although this is a concerning trend, it is further amplified by the policies implemented in Venezuela in the late 1900s and early 2000s. Venezuela sought total societal reform during the Bolivarian Revolution. Venezuela moved away from the neoliberal policies that were so common in other parts of Latin America during this time due to the belief that such policies, as stated by President Chavez at the World Summit in 2002, created an environment beneficial for “the privileged elite who have destroyed a large part of the world”. It would be expected that with a change in societal policies and views there would also be a change in economic investment. However, with regards to health and healthcare infrastructure, the revolutionary rhetoric proved to be unsupported.

Venezuela implemented large social programs focused on health, such as the Barrio Adentro program, which will be discussed in depth later, and began efforts to provide healthcare to more people with a more universal healthcare program. Unfortunately, Venezuela failed to invest in the necessary institutions that would make these changes sustainable. Government expenditures in both health and education remained constant during these changes. Coupled with the fact that Venezuela’s expenditures on health and education were already relatively low, the
stage was set for the systems of dependency established by years reliance on oil to have an even more devastating effect. The statewide programs that Venezuela sought to implement required constant, substantial support in order to be fully successful. Without constant support, these programs are not provided with the funding necessary to be maintained.

It was not just the healthcare systems and social programs that were established on oil. The individuals that worked within the Venezuelan healthcare system were also impacted by its oil dependency. Due to their similar beliefs, Venezuela and Cuba often worked together. Ironically, in 2004 Chávez and Castro signed a joint declaration declaring that neoliberalism “acts as a mechanism to increase dependence and foreign domination” (Peet & Hartwick, 2015). This shared disgust toward neoliberalism drove Venezuela and Cuba to forge close economic ties and closed systems of trade. One of the most important exchanges of goods between the two countries became the exchange of Venezuelan oil for Cuban doctors. This reveals the irony in the joint statement made by Chávez and Castro because this exchange multiplied the Venezuelan healthcare system’s dependency on oil.

The arrival of Cuban doctors provided a false sense of security that allowed for the government to continue a low level of investment in the healthcare sector. This false sense of security came from the appearance of a wealth of educated healthcare professionals within the country. However, the Cuban physicians were only required to serve in Venezuela’s healthcare system for a short amount of time and were sent back to Cuba following their service. This meant that the inflow of educated healthcare professionals was determined by Cuba’s oil requests.

As is the case with many situations of dependency, this allowed for many of the major problems facing the healthcare industry and other aspects of internal development to stay hidden.
under the surface for many years (Sachs & Warner, 1999). Instead of seeking to create the needed infrastructure that would have allowed the healthcare sector to develop and become independent, the Venezuelan government chose not to make any of the long-term changes necessary to move away from the dependency experienced by the healthcare sector. This reinforces the idea that the Venezuelan government liked the idea of creating a healthcare system that represented a larger amount of the population but did not view healthcare as important enough to warrant a change in government expenditures.

V. A Failed Transition

The Chavez administration took over just prior to the 21st century and although Venezuela was one of the most resource rich countries in the world, the country had endured significant political and economic turmoil. As I have shown earlier, the Chavez administration adopted a healthcare system that was already well below the regional average. Not only was the healthcare system already susceptible, but Venezuela also suffered from a large brain drain following the revolution that largely decreased the number of physicians in the country.

However these complications do not necessitate the eventual failure of the Venezuelan health system, merely that the health system had long been neglected and that it was in a vulnerable position prior to the Bolivarian Revolution. It is important to point out that although there are many differences between the two countries, Cuba also experienced large economic and political turmoil just prior to the Cuban Revolution but was able to create and maintain a successful healthcare system. Seeing that Venezuela’s new, expansive preventative health program, Barrio Adentro, was largely created with the help of Cuban healthcare planners, the system implemented should have been able to survive many of the situations that its counterpart survived in Cuba (Muntaner, Benach, & Armada, 2006). The rest of this project will focus on the
many variables that caused Venezuela’s health system to become such a failure and in order to understand these factors it is important to first have a better understanding of the Bolivarian Revolution.

**The Bolivarian Revolution**

In the late 1990s Hugo Chavez became the president of Venezuela in what is known as the Bolivarian Revolution. The revolution was seen as one for the people and was a movement in opposition of the neoliberal policies that were common throughout Latin America. It established a new, leftist government that sought to alleviate many of the difficulties faced by the poor and create a more egalitarian society. Chavez provided “great hope and excitement in the ranks of Latin America’s poor, the huge majority of the continent’s population” as he sought to provide a new form of revolutionary socialism (Gott, 2011).

With the revolution came a “mobilization and concomitant sense of empowerment on the part of the popular classes” creating a powerful but difficult to manage governance (Self, 2008). As the revolutionary government developed it experienced a “progressive radicalisation” that has caused extreme polarity within the country where everyone was essentially either *chavista* or *anti-chavista* (Self, 2008). It is important to note that the term *chavista* is not limited to supporters of Hugo Chavez; it serves as a broader term that identifies supporters of the Bolivarian Revolution in general and continues to serve as an identifier for supporters of President Nicolás Maduro, the successor of Hugo Chavez.

The extreme polarity between the ideals of the Bolivarian Revolution and the prior government played a role in the development of new institutions and programs “developed outside the institutions of the *ancien régime*” (Gott, 2011). Although this thesis is focuses on health and the health system’s functionality, political polarization transcends into nearly every
aspect of Venezuelan life making it impossible to address the issue without acknowledging the extent to which political beliefs influences perception within the country.

The Barrio Adentro program, which will be discussed in depth later, is an example of one of the new institutions created outside the old realm that would carry political connotations upon its creation. The extreme polarity also makes it tremendously difficult to find data or information that address any aspect of Venezuelan society, including the health system, without a large amount of bias. In Venezuela nearly every opinion is influenced by political ideology and these beliefs are so deeply rooted that it is hard for any common ground two be found between chavistas and anti-chavistas. The current economic crisis also makes it difficult to distinguish the effectiveness of various programs; however due to the fact that the health system fell apart so quickly and so dramatically, it is possible to analyze the factors that caused it to fail in such a grandiose manner. Due to the fact 40% of a population’s health is shaped by social and economic factors, it is crucial to analyze the social changes that came with the Bolivarian Revolution as well (Los Angeles County Department of Public Health, 2013).

Social Factors of Health

One of the primary reasons that preventative healthcare measures have gained so much attention is that they acknowledge and work with the nonbiological factors that influence health. With the rise of noncommunicable diseases throughout the world it makes sense that preventative measures would help manage the progression of these diseases. This means that Venezuela’s decision to implement large-scale preventative health programs should also have been partnered with an increased focus on the nonbiological factors that influence an individual’s health.
Studies have shown that “a large share of the burden of disease is preventable through early interventions not only within but also outside the health system in sectors such as education” (Mckee, Figueras, & Saltman, 2011). Not only does education serve as a major factor in health outcomes, it is also one of the most accepted long-term routes to combat poverty and inequality (Psacharopoulos & Woodhall, 1993). An educated population is seen as a valuable form of internal investment (Psacharopoulos & Woodhall, 1993). With this information one would expect the Bolivarian Revolution to have caused an increase in the importance placed on education. These studies show that education would have supported the revolution’s desire to combat poverty and equality while improving health and quality of life. However, Venezuela continued to dedicate a small percentage of its GDP toward education (World Bank, 2009).

This led to very low rates of secondary enrollment and reveals that a large percentage of Venezuela’s population was uneducated (World Bank, 2015). The importance of this with relation to healthcare becomes highlighted when paired with the ambitious programs proposed by the Chávez administration. When looking into the connection between education and health it is important to realize that “according to cross-national studies of the factors correlated with life expectancy, literacy and other measures of education are more closely related to life expectancy than per capita income or even the number of doctors per capita” (Psacharopoulos & Woodhall, 1993). Many of the programs established by Chávez, such as Misión Barrio Adentro, relied on granting more autonomy to communities to increase healthcare standards. This becomes extremely hard when the community is uneducated and does not understand the systems the government wants to enact. Many of these systems require full community participation, which becomes an unrealistic requirement when a large percentage of the population is uneducated.
The inspiration for many of these programs came from Cuba’s health care system. Cuba has successfully implemented primary healthcare centers that rely on local involvement to raise the health of the community. However Cuba also invests much more in its education system and has a highly educated population. This population is much more capable to function with a higher level of autonomy than a less educated population.

Not only did Chávez’s rhetoric prove to be empty through the failure to invest more in education, Venezuela continued to show apathetic levels of investment in its health care sector following the election of Chávez. With this revision to the constitution it would seem that a change in the percentage invested in health care would be imminent. However when it came to long-term investments Chávez once again seems to have made empty promises.

This is just another example of the empty rhetoric with regard to healthcare that reveals the lack of importance placed in the healthcare system. All of the speeches and proclamations about the importance of providing health for all was undermined by the truth that Venezuela did not do anything to invest in its own system. Without the proper investments in place the programs that would follow the Bolivarian Revolution become mere fronts to create a façade of a developing health care system.

**Health Following Bolivarian Revolution**

In 1999 President Chávez called for a referendum of the constitution. The referendum resulted in new articles that established health as “a fundamental human right that the state is obligated to guarantee (Article 83),” the responsibility of the government to “manage a universal, integrated public health system providing free services prioritizing disease prevention and health promotion (Article 84),” and that the state would be “regulating both the public and private
elements of the system and developing a human resource policy to train professionals for the new system (Article 85)” (Muntaner, Benach & Salazar, 2006).

One would expect that following such a powerful revolution and constitutional changes there would be large transformations in governmental policies and investment patterns, especially due to the fact that during the revolution “Chávez promised change and solutions for the country’s pressing problems, especially those related to poverty and inequality” (España & Pedro, 2008). Although Chávez did implement flashy, reactionary programs, he ultimately failed to make key transitions that would be necessary for Barrio Adentro and the healthcare system in general to be successful in the long run. Even chavistas criticized these programs as lacking local input and being somewhat of a show (Jiménez, 2016). Much of his “over the top rhetoric” proved to be full of empty promises when looking at many of the deep-rooted changes that would need to occur if Barrio Adentro was to be sustainable (España & Pedro, 2008).

A strong example of the Chavez governments’ empty rhetoric toward healthcare can be found in the percent of Venezuela’s GDP that was directed toward healthcare. As can be seen in the graph below, Venezuela’s health expenditure as a percent of its GDP was extremely low in the years leading up to the Bolivarian Revolution. Although the 1990s represented a time of neoliberal trends resulting in “de facto privatization of many health care services,” political, and economic turmoil, the percent of its GDP dedicated toward health reinforces the fact that health historically held very little importance in Venezuela. It is easy to envision that this pattern would change following a revolution that created universal healthcare and established health as a human right; however this proved to be far from reality.
As can be seen in the graphs above, Venezuela continued to dedicate an extremely low amount of its GDP toward healthcare following the revolution. This represents a stark contrast from what was indicated from the rhetoric of the Chavez administration. This low level of investment continued despite the relative stability brought with the Chavez administration. Following the Bolivarian Revolution the government expenditure on health care as a percentage of GDP remained one of the lowest in Latin America. The only other countries in the region that have consistently dedicated as little of their GDP toward health are small Caribbean nations. The graphs also present an interesting comparison that reveals that Venezuela expends a similar amount of its GDP toward health as countries that are classified by the World Bank as being fragile and conflict affected areas.

This seems to be one of the most devastating mistakes leading to the future demise of Venezuela’s healthcare system. The majority of countries that establish health as a fundamental right to its citizens dedicate large amounts of their GDPs toward the healthcare sector (World Health Organization, 2013). In essence, Venezuela began creating reactionary, short-term plans that completely lacked investment in the long-term infrastructure that would be needed for the healthcare system in Venezuela to be successful.
Even President Maduro has had to acknowledge the severity of the crisis by requesting aid from the United Nations (Brocchetto, 2017). This highlights the significance of studying what aspects of the Bolivarian Revolution instigated one of the most dramatic collapses of a health system in history.

VI. Misión Barrio Adentro

The Barrio Adentro program was a popular installation following the election of Hugo Chavez in the early 2000s. The program was introduced in 2003 in order to offer, “free health care provided by physicians in neighborhood settings” (Cooper, 2015). The program was designed to extend health services to underserved communities and lessen geographical barriers to health. It is this program that gained the attention of the global community as an attempt to fully utilize the benefits of preventative medicine.

The program was modeled after Cuba’s community-based Family Doctor Program; however Barrio Adentro relied heavily on unpaid community health workers. These volunteers organize themselves into local Comités de Salud that each partnered with a Barrio Adentro clinic (Cooper, 2015). The committees work in two-story tall neighborhood based clinics and work alongside a resident physician. The majority of the physicians serving in the Barrio Adentro program were provided by Cuba with over 10,000 healthcare officials coming to Venezuela from April to December of 2003 (Muntaner, Benach, & Salazar, 2006).

The community health workers were responsible for the day-to-day tasks of the clinic and ensuring everything was in order for the doctor to see the patient. They also served the important role of serving as the bridge between the doctors and the community. They escorted doctors on house calls, conducted neighborhood censuses, and assisted with local health fairs (Cooper,
Having individuals serve in this role allows for a community to feel like they can identify with the members of the healthcare system.

These community health workers were people from the neighborhood that could identify with the issues many members of the community were facing. In the United States the healthcare system is often seen as hierarchical, consisting primarily of wealthy white physicians and white female nurses. Thus leading to many members of society feeling disenfranchised by the healthcare system and unable to identify with the individuals making the decisions about their health.

Barrio Adentro introduced the opportunity for community engagement and the possible benefits that can come from health autonomy. These programs allow for the extension of health services to new populations and create the possibility for communities to develop localized health strategies. It is estimated that, assuming 30% of the national population in the top tax bracket already had access to primary care, nearly 100% of Venezuelans had access to primary medical care in 2006 (PAHO, 2006). When compared to the state of the healthcare system less than a decade earlier this represents an incredible achievement.

In the years immediately following the implementation of Barrio Adentro infant mortality statistics had begun to improve, 8,500 health committees had been established by 2005, and 30,000 health workers were participating in the system by 2006 (Armada et. al, 2009) (PAHO, 2006). A study performed in 11 different neighborhoods in 2006 revealed that nearly 25% of people surveyed had participated in community health work (Hellinger, 2011).

This serves as evidence of the importance for other countries to study and implement similar programs that use community health workers to extend health services to more individuals and improve health outcomes. Barrio Adentro was once even praised by the WHO
and UNICEF for the work it was doing in Venezuela (WHO, 2005) (UNICEF, 2005). Barely over a decade ago it seemed like Venezuela had created a variation of healthcare provision that would change the way the world thought about healthcare.

However, by July of 2007 Douglas León Natera, chairman of The Venezuela Medical Federation, reported that up to 70% of Barrio Adentro clinics had been either abandoned or left unfinished (Matheus, 2007). Today even more clinics have been left abandoned and the majority out of the 20,000 Cuban physicians and nurses has gone home (Sonneland, 2016). Their absence has exposed many of the underlying flaws that have permeated throughout Venezuelan health systems. The economic collapse provided the catalyst needed to expose the vulnerability of Venezuela’s health systems.

How then did Venezuela go from the progress it had made by 2006 to a health system in shambles? Does the failure of the health system as a whole serve as evidence that the early promise of Barrio Adentro was too good to be true? The answer to these questions will shape how the world looks at health system development and influence how preventative health measures will be implanted in the future. Although on a much smaller scale, understanding what caused the failure of Barrio Adentro allows for a simplified view of what caused the entire health system to fall apart so dramatically.

**Downfall of Barrio Adentro**

Once a source of pride of the Bolivarian Revolution, Barrio Adentro serves as an anecdote of the many failures that went into the collapse of Venezuela’s healthcare system. It demonstrates the tendency for systems to be built upon reliance, the effects of the brain drain, failures in education, lack of investment, and the continued presence of empty rhetoric from the government. These flaws surrounding the Barrio Adentro program have led it down the path to
large percentages of abandonment with few functional aspects remaining; a path very parallel to that of the healthcare system as a whole.

As was mentioned earlier Barrio Adentro was a program created outside the realm of the “ancien régime” (Gott, 2011). Health and health programs are not excluded from the effects of political polarization in Venezuela. Although this may be true to some extent in most countries, the Venezuelan medical establishment used organized opposition to combat the reform efforts of the new Bolivarian government (Jardim, 2005). The medical establishment was able to do this by doing things like “citing security and a lack of infrastructure” as cause to not participate in the new Barrio Adentro program (Muntaner, Benach, & Salazar, 2006). From the start Barrio Adentro was created as a system outside of the established health systems.

Although this was an aspect of health policy that was made difficult by political opposition, President Chavez failed to diffuse the tension and establish an environment where Barrio Adentro was seen, not as a separate institution, but as an extension of the healthcare system that was already established. His failure to do so created two healthcare systems that were never able to fully work together. Even though Cuba was also plagued with political polarity following their revolution, Che Guevera stressed the importance of health provision being dependent on the entire collectivity (Guevera, 1960). He realized that health outcomes were the result of many different aspects of an individual’s life and that the entire health system would have to work together with societal help as well. Instead of finding a solution to merge the potential of the new Barrio Adentro program and the medical establishment, Chavez used the country’s oil wealth to provide a new labor force that would direct Barrio Adentro.

Venezuela’s tendency to build programs and systems around its dependency on oil is present in the majority of governmental actions. Creating so many new clinics so quickly
required a sudden flow of physicians to previously underserved areas. With many Venezuelan physicians refusing to work in the new peripheral system, the Chavez administration created a trade that provided Cuba with oil and Venezuela with Cuban physicians to staff the new clinics (Muntaner, Benach, & Salazar, 2006).

By 2006 out of around 30,000 health care workers participating in the Barrio Adentro program, 15,356 were Cuban physicians compared to only 1,234 Venezuelan physicians (PAHO, 2006). This created a false sense of security derived from using temporary agents to build a permanent system. The façade this creates of a sustainable program is similar to the façade that Venezuela has often times promoted for its healthcare system overall. Venezuela has used sensationalist reactions that gain public backing and are designed for short-term success, but a failure to think about the long-term success of the healthcare system has led to its ultimate demise.

The Cuban physicians were only meant to stay a limited amount of time in Venezuela from the beginning. Chavez’s desire to eliminate Venezuela’s dependency on global powers merely led to the doubling down on its dependency on oil to solve the countries problems. This builds a system that from the beginning would succeed or fail all depending on Venezuela’s ability to trade its oil. If Barrio Adentro were to succeed, Venezuela would eventually have to come up with a solution to slowly work out of its dependency on foreign physicians. Unfortunately this solution, like many others, was never reached. The dichotomy between the Barrio Adentro program and the established medical institutions plays another role in why this solution was never reached.

Not only did this difference create health systems that lost efficacy as a result of their different ideologies, but it also created two systems that seemed to compete with each other. Due
to the fact that Barrio Adentro was aligned with the ideals of the Bolivarian government and the established medical institutions were seen as a form of opposition, very little funds were directed toward traditional medical institutions such as hospitals and medical equipment.


The terrible conditions of the hospitals can be seen from the image above. This patient suffered from a stab wound but was forced to wait for hours because the hospital did not have the necessary equipment to perform the procedure he needed. As can be seen from the walls, floors, outlets, and the little medical equipment that is in the room, the horrible conditions hardly seem like a new development. The photo, taken in Barcelona, Venezuela, a city of nearly one million inhabitants, reveals a long underfunded hospital ward that is at its breaking point.

In Venezuela, hospitals and other healthcare infrastructures were subject to policy changes made by officials that did not think about the well being of those infrastructures. Félix Oletta, the ex Minister of Health, pointed out this flaw when he stated, “La experiencia ha demostrado que no se puede gestionar un hospital a distancia. No se perciben sus necesidades, se retrasan las decisiones…” (Ovalles, 2013). This reveals how the government both allowed and
caused the failure of the healthcare system, as well as why it took so long for the healthcare crisis to become evident.

Many health care professionals saw very little long term plans to develop Venezuela’s existing health care system and were some of the first individuals to feel the effects of Venezuela’s lack in health spending (Dr. Fernández, 2017). These individuals felt that there was very little incentive and no signs that Venezuela wanted to make the investments in the established health system and were forced to leave the country (Dr. Fernández, 2017). For physicians like Dr. Fernández, a physician that grew up in Caracas and had dreamed of working in a local children’s hospital, this decision was extremely. Dr. Fernández and many other physicians wanted to stay in Venezuela but saw no choice but to leave a system that was no longer being investing in or supported. Dr. Fernández worked in Venezuela as long as possible but eventually she found it impossible to do her job with the deteriorating conditions forcing her to leave the country. The evidence of this can be seen in figure 1 and figure 2, the graphs mentioned previously that demonstrate how little Venezuela invested in its health system under the Chavez administration. It also serves as evidence as to why Venezuelan hospitals are in such bad shape today. Many of which are extremely dated, are barely operational, and sometimes lack the most basic resources such as food and water. This led to a large exodus of Venezuelan physicians. Thus increasing the need for Cuban medical aid.

**Brain drain**

As the flux Venezuelan physicians out of the country developed it went somewhat unnoticed and failed to garner much attention (Herriman, 2016). This was due to Venezuela’s trade agreement mentioned earlier that included the trade of Venezuelan oil for Cuban health professionals. Throughout the early 2000s physicians found themselves in increasingly difficult
work conditions (Dr. Fernández, 2017). Offers to work abroad became increasingly appealing for many physicians (Dr. Fernández, 2017). These physicians had spent years training in Venezuela’s health education system and were expected to take on the burden of working in underfunded hospital systems throughout the country. Although there were many Cuban doctors in the country in the early 2000s, most of them were limited to working within the Barrio Adentro program and with underserved populations.

The presence of Cuban doctors served as a buffer that absorbed the impact of Venezuelan healthcare professionals leaving the country. This buffer created an environment where a devastating lack in personnel could arise at any time. As more Venezuelans left the country and as fewer Cuban doctors came to Venezuela, the gravity of the situation became increasingly evident. Venezuela’s continued sense of apathy toward the healthcare system allowed for the situation to go from bad to worse.

As was mentioned earlier, this trend seems to be tied in large part to Venezuela’s trend to view all decisions through the production of its oil. Healthcare investments and policies were all seen as secondary issues that all took the back seat to oil. This is an extremely dangerous view to take on healthcare, especially in a system that claims to provide universal coverage. The healthcare sector requires consistent support so that it can develop on its own and serve as point of constancy regardless of the economic activity within the country.

Chávez prided his government on providing an alternative to the capitalist systems, such as the World Health Organization (WHO) and UNICEF, which dominated much of global development (WHO, 2005) (UNICEF, 2005). He claimed that his decision to break away from these systems would allow for Venezuela to become more independent as it took on a much larger role in world politics.
Ironically during Chávez’s presidency, Venezuela increased its level of dependency on oil to new levels (Stratfor, 2016). Venezuela began making deals with other countries and largely relied on oil as it sought after independence from the “corrupt neoliberal institutions” (Chavez). This proved to be a double edged sword for Venezuela. Although it was able to achieve independence from many of the institutions the Chávez government saw as greedy and corrupt, it achieved this independence only by increasing its reliance on its oil industry. Venezuela’s increasing reliance on oil for its economy allowed for its major health institutions to become increasingly vulnerable. The medical establishments that opposed Chavez were not the only institutions were government funding and support proved inadequate, the initial support for Barrio Adentro quickly faded away as well.

**Lack of Support for BA**

The initial excitement for the possibilities of Barrio Adentro eventually washed-out as the government’s support of the extensive program rapidly dissipated, allowing for it to slowly crumble. Many individuals that sought to establish a clinic found that they had to struggle with the government in order to get the funds and resources they needed (Cooper, 2015). Even some supporters of the Bolivarian Revolution argued that “nongovernmental organizations could more effectively manage some aspects of health care” in a more effective manner (Cooper, 2015).

This frustrated many of the community health workers because they saw governmental cooperation as something they were guaranteed by law in accordance with the 1999 referendum. In 2006 a disused office building was designated to be transformed into a Barrio Adentro clinic that would provide rehabilitation services; however, three years later the construction of the clinic was still incomplete (Cooper, 2015). Stories like this are common throughout many Barrio Adentro work cites. Other circumstances have led to the government providing the resources but
leaving the community to build the clinic. This demonstrates an attitude of negligence toward the program that the government once so proudly advertised. The government’s trend to become more and more apathetic toward the Barrio Adentro program is symptomatic of its apathy toward the healthcare system in general.

![Immunization, DPT (% of children ages 12-23 months)](chart)

*Data provided by the WorldBank Database

The primary focus of Barrio Adentro was to provide primary and preventative care, especially to the most vulnerable populations. An efficient form of preventative care can be found in the form of immunizations. They provide a cost-effective solution for diseases and they can easily be delivered to a large population. Although there was an initial surge in immunization rates in the years directly following the creation of Barrio Adentro, by 2006 those numbers had begun to drop significantly. This supports the argument that the government’s health initiative started strong but quickly deteriorated due to a lack of support.

Barrio Adentro also provides a concrete example of the effects that the brain drain had on various health service programs throughout the country. As an increasing number of physicians left the country a large number of vacancies were left in the hospital system. These jobs were
hardly desirable compared to the working conditions in other hospitals around the world; however for Cuban physicians that had been placed in Venezuela, it provided a more appealing alternative to some of the difficult conditions presented with working for Barrio Adentro (Dr. Fernández, 2017).

The work conditions were so bad in some places that seven Cuban doctors that had defected while in Venezuela attempted to indict the Cuban and Venezuelan governments for “esclavitud moderna” (Noticias24, 2010). The doctors were forced to work “en lugares con una alta tasa de delitos comunes y políticos, incluyendo zonas selváticas” (Noticias24, 2010).

Due to the fact that many of the Barrio Adentro clinics were strategically placed in low-income and rural areas, Cuban physicians saw the opportunity of working in a hospital in a bigger city as a form of social mobility (Dr. Fernández, 2017). As the Cuban physicians began to fill holes in the larger hospital systems, new holes were created within Barrio Adentro. This forced many Barrio Adentro programs to be either staffed by less qualified individuals or to be left abandoned. It becomes much more evident why Barrio Adentro, and Venezuela’s health system as a whole, fell apart so quickly after looking at the accepted literature on successful health systems.

**Fundamentals for Health System Improvement**

As debates continue about the best approaches to healthcare it is important to realize that “there is no single set of best practices that can be put forward as a model for improved performance” (WHO, 2007). Although there have long been individuals that have worked with health, organized health systems have only existed for about a century (WHO, 2007). Health systems are extremely complex in nature and are subject to a large number of local, geographical, and cultural controls that influence what is needed for a healthcare system to work
at its best. With that said countries should study healthcare systems in order to analyze whether specific programs and systemic changes would work in their country. It is also important to realize the complexity of healthcare systems and realize that they are “more than the pyramid of publicly owned facilities that deliver personal health services” (WHO, 2007). Due to this complexity, the best method to determine a health system’s performance is through its impact on health outcomes (WHO, 2007).

As mentioned before there is no one set of best practices with regard to health system improvements; however, well functioning health systems have certain shared characteristics (WHO, 2007). According to the World Health Organizations framework for action these characteristics include: service delivery, health workforce, information, medical products, vaccines and technologies, financing, and leadership and governance (stewardship). Although Venezuela sought to establish a new form of healthcare, one more similar to that of Cuba’s, many of these characteristics appear to hold true even in alternative forms of health provision.

These characteristics serve, as building blocks that promote effective health systems that are able to improve performance and promote good health. However it is also important to realize that the framework highlights the importance of the inter-dependence of each part of the health system.

Separating the characteristics into six building blocks allows for simplicity and clarity but the successful implementation of these building blocks requires for an integrated response that is appropriate for the situation. In analyzing a few of these characteristics of a successful health system suggested by the WHO, it will become clear that the historic collapse of the Venezuelan health system was caused by much more than just an economic collapse.
One of the key characteristics identified by the WHO for a productive health system is a well-performing health workforce. This is a complicated aspect of the Venezuelan health system that has experienced large amounts of fluidity. In the early 2000s Venezuela did have a serviceable health workforce by most standards. As was discussed earlier, a significant part of this workforce was provided by Cuba and was not meant to be a permanent fixture in the health workforce of Venezuela. However following mass migrations of doctors out of the country and Cuban physicians returning home, today Venezuela finds itself with a severe shortage of physicians.

Another attribute is a well-functioning health information system. This means that information on statistics such as health determinants, health system performance, and other key indicators are made transparently available. This has been far from the case in Venezuela. Government officials have staunchly denied the severity of some of the issues facing the healthcare system, health statistics have become increasingly scarce, and any comments made that portray the health system in a negative light are seen as attacks against the revolution (Forero, 2015) (Finnegan, 2016). Even as late as June of 2016 Delcy Rodíguez, Minister of Foreign Affairs, proclaimed “No hay crisis humanitaria. No la hay. Lo afirmo con total responsabilidad.” This has allowed for the government to claim any criticisms of the health system as fake news and has made it difficult for any progress to be achieved within the healthcare system. The effects of Venezuela’s failure to provide a well-functioning health information system have been amplified by its failure in health financing, another one of the six building blocks for a successful health system.

Effective health systems are charged with using funds wisely to help serve the maximum amount of people, regardless of what type of health system it is. One aspect of this service that is
highlighted by the WHO is a health system’s ability to protect its citizens from devastating out-of-pocket expenditures. Following the Bolivarian Revolution this should not have been an issue because of the guarantee of free universal healthcare added to the constitution. However, due to Venezuela’s general lack of investment in its healthcare system, it is easy to imagine that out-of-pocket expenditures on health do exist. Few would imagine just how much Venezuelans pay out of pocket for their healthcare.

As can be seen in the figure above, Venezuelans pay much more out-of-pocket than their Latin American counterparts and well over twice as much as their Columbian neighbors. This reflects the effects caused by Venezuela’s continuous lack of monetary investment in the healthcare system. Not only has this lack of investment put a monetary strain on its citizens, it has also created extreme shortages in medical products, vaccines, and technologies.
It is the responsibility of a healthcare system to ensure “equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use” (WHO, 2007). As has been the case in the previous building blocks required for a good health system, Venezuela has extravagantly failed to provide these products to its citizens.

Today even the most basic of medications are in short supply. People are dying of preventable causes due to a lack of the medical supplies needed to save their lives (Forero, 2015). Diseases that had long been held at bay are now making larger comebacks than ever and there are no resources to fight them from quickly spreading. This is the result of multiple governmental failures that could have easily been preventable.

Venezuela imports a large part of its medical technologies and supplies. This requires a great deal of investment from the government to ensure that the healthcare system has enough resources to merely provide basic care for its citizens. Even as shortages have continued to plague the country Venezuela continues to dedicate less and less money to important essential medicines (Forero, 2015). Not only has the government failed to dedicate the required funds for the most basic of needs, the government has made it difficult for foreign entities to send any form of medical aid because they argue it compromises the country’s sovereignty (Sonneland, 2016).

Another key factor that has influenced the shortage of medicines and medical technologies in Venezuela has been the price controls established by the government (Naim & Toro, 2016). In order to provide low cost products for its citizens the government established set prices to which the pharmaceutical and other medical companies were forced to adhere (Lohman, 2015). These prices were so low that many of these companies were forced to shut down thus
deepening Venezuela’s reliance on other countries to provide the resources needed to maintain a functioning health system.

The effects of these shortages are some of the most visible indicators of the failure of the health system. Venezuela is now facing its worst malaria crisis in decades and was one of four countries in 2015 where the incidence of malaria increased (Herriman, 2016). This serves as just one example of the multiple diseases that have begun to manifest themselves throughout Venezuela. Unfortunately it seems that there is little hope for an immediate response from Venezuela’s healthcare system due to the fact that 80% of all medicines are scarce or unavailable and “a majority of medicines included in the World Health Organization’s Model List of Essential Medicines were not available to pharmacies” (Sonneland, 2016) (Lohman, 2015).

As was mentioned earlier, health provision requires an interdisciplinary approach and when one aspect of the health system is failing it strongly influences other aspects of the system. This becomes apparent when analyzing Venezuela’s performance in service delivery. Although it is easy to limit thinking to healthcare providers when thinking of service delivery, “effective provision requires trained staff working with the right medicines and equipment, and with adequate financing” (WHO, 2007).

Venezuela’s inability to provide neither adequate financing nor sufficient medication and equipment has crippled its ability to deliver health services. Not only has it crippled its service ability, but also, as has been discussed earlier, it has motivated a large number of trained health workers to leave the system. This has far reaching consequences that are not limited to those that have previously been discussed.

One physician described working in one of the hospitals in Venezuela as supervising the death of patients (Dr. Fernández, 2017). With none of the necessary medications, physicians feel
helpless as patients die in the hospital of preventable causes. This proves to be too much for many physicians, causing them to leave the country. As they leave and the shortage of trained health workers becomes more evident, Venezuela is being forced to adjust its health education program.

Venezuela has now created shortened health training programs and many individuals are being granted the title of doctor without having to meet many of the requirements that were long associated with that distinction (Dr. Fernández, 2017). Now service delivery has not only been hindered by the absence of resources and funding necessary, but the personnel delivering health services are increasingly less qualified. The compilation of these failures reveals abhorrent amount of mismanagement and negligence on behalf of the Venezuelan government.

“The leadership and governance of health systems, also called stewardship, is arguably the most complex but critical building block of any health system” (WHO, 2007). The government and health leadership is charged with guiding and managing a health system as it develops and ensuring that it is able to provide the necessary services to its citizens. In Venezuela this has proved to be far from the case.

In a country where nearly everything is it politicized, any admission of err would be seen as a criticism of the government and its beliefs. This has led to a constant cycle of new individuals in health leadership positions. From 2007-2016 there have been 11 different individuals serve as the Minister of Health. The stubborn denial of any flaws in governmental practices has led to instability and the destruction of the health care system (Garcia-Navarro, 2016). The dramatic failures of the government to provide health leadership and guidance serves as the source of Venezuela failing to establish nearly all of the six building blocks for a functioning healthcare system.
Based on the WHO’s statement that “maintaining a network of under-resourced hospitals and clinics, while human and financial resources were increasingly pulled into vertical programmes, increased pressures on health systems sometimes to the point of collapse,” it seems that more individuals would have predicted the fall of the Venezuelan healthcare system long before it happened (WHO, 2007). Even without the economic collapse the health system was in a downward spiral with a government that failed to acknowledge the most pressing issues that it faced. Hopefully by further studies into the fall of this healthcare system other countries will be able to learn from Venezuela’s mistakes and take into account the devastation that can follow the fall of a healthcare system.

**Conclusion**

Health systems are extravagantly complex. Due to the countless factors that influence health outcomes within a country it is difficult to define exact guidelines for how a country can better its health system. This makes it extremely difficult to study and analyze healthcare systems, as we have been able to seen in the United States with the recent attempts to remedy the Affordable Care Act. The case study provided by Venezuela serves as a great teaching point for other countries because it offers an extreme of what can happen when a health system is mismanaged. Venezuela’s dramatic failure provides insight into which decisions can have a devastating outcome as well as what aspects of a preventative health system prove beneficial. Were it not for such a dramatic collapse the trends established in Venezuela would be much more difficult to decipher and the extreme polarization of the country would make it difficult to achieve a uniform perspective on the health reform’s outcome.

It appears that although many different factors played into the collapse of the healthcare system there were some major points that can influence how other countries implement health
system reform. The first point is that a change toward universal health coverage requires a dedicated investment in the health sector. Many of the issues that were identified within Venezuela’s health system were a result of it being a system that was outdated and underfunded.

Another key takeaway from Venezuela’s failure comes from the relationship between Barrio Adentro and the typical medical institutions such as hospitals. Cuba was able to have hospitals at the core of its healthcare system and an expansive preventative healthcare program that supplemented that core. With Venezuela it appears that there was an obvious disconnect and that the two systems were never able to function as two parts of the same system. Countries must realize this as they begin to implement new preventative health measures. As Che Guevara put it 1960, health is the result of the collective and when these new preventative health measures are added they must be added as an extension of the health system already in place (Guevara, 1960).

These two issues reveal how the Venezuelan healthcare system collapsed from the inside out. Without investment in healthcare infrastructure and the presence of a dichotomy between the new preventative health programs and the preexisting medical institutions, the core of Venezuela’s health system began to fall apart. Dr. Fernández lamented that instead of correcting the issues at the root of Venezuela’s healthcare concerns, the Venezuelan government would create new programs that would allow the original problems to fester and worsen. This reveals why it seemed like Venezuela had reached a tipping point as soon as the health crisis had become evident. Many of the issues plaguing the system had continued to grow and be covered up by temporary solutions until the health system reached the point of collapse.

Other countries can study this example as evidence for how to avoid a similar humanitarian crisis. Countries can also study Venezuela to discern which aspects of Barrio Adentro are worth implementing. Although the program was plagued by issues and the actions
by government officials ultimately led to its demise, many countries can look to expand upon the early promise it showed as they seek to utilize the potential of preventative medicine. Through this study hopefully countries will be able to better their own health systems, while avoiding the many difficulties that plagued Venezuela. Future studies will be needed to analyze the causes of the collapse on an individual level to gain a better idea of how the collapse could have been avoided. This study merely serves to reveal the nature of the collapse and what aspects of Venezuela’s health system are worth maintaining. The complexity of health systems and the current conditions in Venezuela make it a difficult to gain information on the topic. Hopefully the current conditions will improve and a more relaxed environment will allow for more information to be attained as the issue continues to be explored.
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