

Challenging the Neoliberal Trend

The Venezuelan Health Care Reform Alternative

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ABSTRACT

Throughout the 1990s, all Latin American countries but Cuba implemented to varying degrees health care sector reforms underpinned by a neoliberal paradigm that redefined health care as less of a social right and more of a market commodity. These health care sector reforms were couched in the broader structural adjustment of Latin American welfare states prescribed consistently by international financial institutions since the mid-1980s. However, since 2003, Venezuela has been developing an alternative to this neoliberal trend through its health care reform program called *Misión Barrio Adentro* (Inside the Neighbourhood). In this article, we introduce *Misión Barrio Adentro* in its historical, political, and economic contexts. We begin by analyzing Latin American neoliberal health sector reforms in their political economic context, with a focus on Venezuela. The analysis reveals that the major beneficiaries of both broader structural adjustment of Latin American welfare states and neoliberal health reforms have been transnational capital interests and domestic Latin American elites. We then provide a detailed description of *Misión Barrio Adentro* as a challenge to neoliberalism in health care in its political economic context, noting the role played in its development by popular resistance to neoliberalism and the unique international cooperation model upon which it is based. Finally, we suggest that the Venezuelan experience may offer valuable lessons not only to other low- to middle-income countries, but also to countries such as Canada.

MeSH terms: Barrio Adentro; health policy; health care reform; Venezuela; Latin America

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Beginning in the early 1990s, health care sector reforms throughout Latin America (indeed, most of the world) have followed a remarkably similar pattern – a shift to greater private sector involvement from a pre-existing system of public delivery, financing, and ownership.¹⁻⁸ Notwithstanding country-specific differences in modality and process of reform,² in most of Latin America, health care has become less of a human right guaranteed by the state and more of a commodity acquired in a marketplace. Much of this shift reflects the broader structural adjustment policies many Latin American countries have adopted following the neoliberal paradigm prescribed by international financial institutions (IFIs) concerned with repayment of foreign debt.² The effect of neoliberal hegemony in health care reform and other social policy-making has been significant: Latin America remains the most unequal region in the world. Over the past two decades, poverty levels have risen and an estimated 130 million Latin Americans (of a total regional population of 450 million) have little, if any, access to formal health care services.^{5,9}

Nonetheless, there is an exception to this trend: since 1999, after a decade of adherence to neoliberal reforms, Venezuela has charted a new, bold course away from neo-liberalism. Health care in Venezuela is now guaranteed by the state as a public service. Driven by local demands through a process of participatory democracy, this alternative health care reform is playing out in the country's most marginalized and under-served neighbourhoods. Moreover, Venezuela's health reform is founded upon an international cooperation model that emphasizes "South-to-South" solidarity, rather than the more typical channels of "North-to-South" aid. What is this relatively unknown Venezuelan health care model, whose beneficiaries, based on interviews conducted by one of the authors, are calling it "the best thing that has happened in Venezuela," and how did it develop?

To address these questions, this paper explores the Venezuelan health care reform program – *Misión Barrio Adentro* (Inside the Neighbourhood) – that since 2003 has challenged the seeming inevitability of neoliberal health reforms. We begin by analyzing the neoliberal models of health care reform in Latin America, and more

specifically in Venezuela, within their broader socio-political economic contexts. Arguing that neoliberal health care reforms are of benefit mostly, if not exclusively, to transnational capital interests and domestic Latin American elites, we then seek to explain the emergence of Barrio Adentro. We examine the historical, social, and political underpinnings of Barrio Adentro, noting the central role played by popular resistance to neoliberalism. We conclude by suggesting that Barrio Adentro not only provides a compelling health care reform approach to other low- to middle-income “majority-world” countries, but that it also offers relevant policy insights to “Northern” countries such as Canada.

Health Care Reform in Latin America in its Political Economic Context

From the end of World War II (WWII) to the early 1980s, most Latin American countries gradually strengthened their welfare states, primarily reaching urban industrial workers, who had spent decades mobilizing to improve workplace and social conditions.^{10,11} Welfare state social policy was based partly on the assumption that domestic markets inefficiently and inequitably distributed the gains of economic growth to the population and the state needed to take an active role in “correcting” these “market failures” in order to secure the welfare of its citizens.¹² Such “corrections” implied state expenditure and management of health care, social security, education, and other social services. Although inefficiently and inequitably stratified into parallel, hierarchical systems, until the end of the 1970s, social services, including health care, expanded in most Latin American countries, aiming at greater social equality.

Beginning in the 1970s, a series of important challenges to global capitalism took place that culminated by the early 1980s in a serious threat to the United States (US) and European commercial banking sectors’ solvency, in turn sparking profound changes in the role of Latin America’s welfare states.¹² The first shock came with the introduction of variable exchange rates and a consequent new set of international trading rules as a result of the US government’s decision to suspend the fixed-price convertibility of its dollar for gold, thus breaking with the WWII-era

Bretton Woods agreement. Coupled with substantial oil price increases in 1973 and 1979 due to OPEC embargoes, the new international trading system generated large trade deficits for many developing countries. Latin American governments were forced to borrow massively at the relatively low interest rates of the time from IFIs and, indirectly, US and European commercial banks to secure the foreign currency necessary to pay for imports and attenuate the effect of trade imbalances.* As Latin American countries’ debts rose, a severe recession in OECD countries in the early 1980s led to a rise in international interest rates, leaving many Latin American countries unable to service their rising debts.

The impending collapse of the US and European financial sectors holding most Latin American loans prompted the IFIs, themselves heavily influenced by US and European governments, to dramatically shift their lending policies. The new *quid pro quo* for securing a loan from the IFIs became guaranteeing national budget surpluses through structural adjustment programs (SAPs), thus allowing countries to service, if not pay back, their foreign debts. Simultaneously and to justify the severe austerity requirements, an increasingly dominant neoliberal ideology established the new, though unsubstantiated,¹² conventional wisdom: the interventionist welfare state had “failed” and an unhindered free market was the best means through which to achieve social and economic prosperity, including the reduction of poverty and social inequality.⁷

A part of what is often termed “globalization”, the socio-economic and ideological implications of the changing global economic order described above are increasingly being identified as pathways to detrimental changes in population health status.¹³ For Latin American (and many other) welfare states, the changes were drastic – unprecedented cuts to state spending including social services such as health care, privatization, deregulation, capital flight due to instability, and new liberalized international trade practices that emphasized the export of primary products at the expense of domestic production.¹⁴

* See ref. 10, pp. 113-16 for a detailed discussion on the political economy of Latin American descent into indebtedness.

The period of structural adjustment in Latin America that began in the early 1980s was the first step in what Laurell describes as a two-phase process of destabilization of the welfare state.² The erosion of social services such as health care that resulted from the deep funding cuts that characterized structural adjustment policies in most Latin American countries gradually created conditions that fostered neoliberal reform of those social services. State-administered health care sectors reeling from the results of structural adjustment – deteriorating quality, greater inefficiency and inequity throughout the 1980s – turned in the 1990s to what appeared to be the only viable option: a shift to greater private sector management and delivery of health care services.

The publication of the World Bank’s 1993 *World Development Report: Investing in Health* marked the second stage in health care’s neo-liberalization.¹⁵ The Report advocated two overarching strategies to improve health in low- and middle-income countries: 1) limit state investment in health care to low-cost services that target the poor; and 2) encourage diversity and competition in the financing and delivery of health services by facilitating greater private sector involvement. Throughout the developing world, this has meant the introduction of private, for-profit health insurance plans, coupled with the decentralization of service delivery and administration under ever-shrinking budgets.^{7,16} By the time *Investing in Health* (1993) was published, the World Bank had become the major international health lender, using its financial and political influence to leverage significant changes to countries’ health care systems.⁸ In Latin America, the Inter-American Development Bank (IDB) followed in the World Bank’s footsteps to provide health-reform loans that favoured a shift to greater private sector involvement in health care systems.³

Given the increasing evidence of the detrimental effects of these neoliberal reforms on health and well-being,^{13,14,17-19} those beneficiaries of such reform seem to have been transnational corporations based mostly out of the US, Europe, and Canada together with domestic Latin American elites linked to the transnationals’ subsidiaries.^{3,7,20} 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, Latin America's two largest countries, neoliberal health care reforms have worsened access to health care services for poor and working class sectors, stressed the public health care sector with higher-risk patients, and further compromised the quality of public services. All the while, private insurance companies, foreign and domestic, have reported significant profits.^{3,7,20}

Although neoliberal health reforms failed to be fully implemented in most Latin American countries,⁸ all but Cuba have partially undergone these changes. Venezuela was no exception.

Venezuelan Structural Adjustment and Health Neoliberalization

Compared to most of its neighbours, Venezuela was late to adopt neoliberalism. The slower pace of reform may be partially attributed to Venezuela's significant petroleum and natural gas reserves, the largest and second-largest in the Western hemisphere, respectively.²¹ Indeed, the expanding welfare state common throughout the region in the 1950s and 60s was bolstered in Venezuela by its steady oil revenues, even if the benefits were never reaped equitably.²² While its neighbours reeled from the cumulative effects of variable exchange rates and the mid-1970s oil crisis, Venezuela's international reserves exceeded US \$11 billion in 1981, helping to resist calls for neoliberal structural adjustment.²¹

Nonetheless, fluctuating oil prices and massive spending to pay for imports and national capital projects led Venezuelan governments to borrow heavily from the late 1970s to the mid-1980s. Rising national debt and decreasing oil revenues in the 1980s contributed to a socio-economic crisis with close to 54% of Venezuelans living in extreme or critical poverty in 1989. That same year, Carlos Andrés Pérez was elected president for a second time (his first period in office was during the mid-1970s oil boom), promising jobs, economic growth, and a return to good times.^{21,23}

Seduced by the increasingly dominant neoliberal ideology, Pérez sought to

address rising poverty in Venezuela by committing to radical structural adjustment.²³ The program, dubbed *El paquete*, adhered faithfully to SAPs prescribed throughout the region by the World Bank and International Monetary Fund, its major financiers. In return for a US \$7 billion extended fund, the Venezuelan government promised deep public spending cuts, privatization, trade liberalization, and social program restructuring to target the poor.^{23,24} However, the zeal to implement the reforms was faced with widespread public opposition and mobilization that helped spark two failed coup attempts and the impeachment of President Pérez in 1993.²⁵ Yet the reforms continued under his successor.

The health sector was not spared from *El paquete*, and in accordance with Laurell's thesis, the erosion of welfare institutions throughout the 1990s fuelled increasing calls for health care reform. The new Venezuelan government procured two major health reform loans, one from the World Bank, the other from the Inter-American Development Bank.^{26,27} Although these loans were less explicit about their aims to foster greater private sector involvement in health care (perhaps due to a Venezuelan government reluctant to elicit further public opposition), both generally followed the neoliberal tone set in *Investing in Health*. For example, both loans contained provisions to facilitate or support the restructuring of health sector financing, preferably toward an increased role for private financing. In addition, the loans continued support for a social services decentralization process that had begun in 1989 as part of *El paquete*.

Decentralization, coupled with the fiscal austerity measures of the early 1990s, left the newly responsible regional and local levels of government with few options but to carry out an uncoordinated, *de facto* privatization of many health care services high in demand but short on supply.²⁸ By 1997, 73% of health expenditures in Venezuela were private.²⁹ The introduction of user fees in the public system made the increasingly poor-quality health services even less accessible.

Matters were made worse leading up to the December 1998 presidential election by a dramatic drop in oil prices that led the Venezuelan government to once again seek

loans from IFIs. For the vast majority of poor Venezuelans, who by 1999 comprised nearly three quarters of the population, the only access to health care services was through a precarious public system.

However, the election of a new president, Hugo Chávez, in December 1998, who campaigned staunchly against further IFI-prescribed neoliberal reforms, set the country in a new direction. Chávez's overwhelming if surprising victory that month is arguably the political aggregate of nearly two decades of increasing popular mobilization against a corrupt Venezuelan regime and its increasingly neoliberal agenda.²⁹

Once elected, Chávez moved quickly to fulfill one of his most important campaign promises. He called for a referendum to adopt or reject a new constitution drafted by a special constituent assembly. Following extensive consultation throughout the country and from all sectors of Venezuelan society, in December 1999, Venezuelans approved a new "Bolivarian" Constitution.³⁰

The Bolivarian Alternative to Health Care Reform

Feo and Siqueira outline how the constitutional changes covered the health sector.³¹ Three constitutional articles in particular have had major implications for health care reform in the country. Article 83 enshrines health as a fundamental human right that the state is obligated to guarantee. Article 84 stipulates the duty of the state to create and manage a universal, integrated public health system providing free services and prioritizing disease prevention and health promotion. In addition, it firmly states that public health care services cannot be privatized. Article 85 details that this new, integrated public health care system must be publicly financed through tax, social security, and oil revenues; that the state will regulate both the public and private elements of the system; and that the state will develop a human resource policy to train professionals for the new system.

The new government moved quickly to develop alternative redistributive mechanisms to strengthen the Venezuelan welfare state and fulfill the demands of the new constitution. Among them figure prominently the "Misiones", social programs created as parallel structures either completely

outside the scope of government ministries, or in collaboration with them, as a means to increase community participation and meet the new constitutional imperatives more efficiently.

Two factors help explain this “paral-
lism.” Despite large oil revenues and relatively large state expenditures on various social programs throughout the 1950s, 60s, and 70s, corrupt government bureaucracies failed to breach the social inequity gaps. In addition, despite Chávez’s victory and the constitutional reforms, the state bureaucracy initially remained largely opposed to the new President’s intended changes. Therefore, to counter the obstacles that some Ministerial bureaucracies presented and as a response to considerable grassroots community organizing, the Misiones were initially largely independent of the Ministries.

One of the most popular and successful Misiones developed is *Barrio Adentro*. *Misión Barrio Adentro* aims to satisfy the constitutional requirements of health as a social right through a public health care system that spans the primary, secondary, and tertiary levels of care. Moreover, it is underpinned by the principles of equity, universality, accessibility, solidarity, multi-sectorial management, cultural sensitivity, participation, and social justice.³²

The program’s beginnings date to December 1999, when Venezuela suffered torrential rains that caused extensive flooding in the state of Vargas. The most affected were *barrio* dwellers, the marginalized poor living in the hilly periphery of major urban centres. The Cuban government, as part of its international solidarity programs, responded to the tragedy by offering a team of 454 Cuban health care workers who offered medical care inside the marginalized *barrios*.

Based on this experience, Freddy Bernal, an ally of President Hugo Chávez and the mayor of the Municipality of Libertador (both the largest municipality and home to the largest number of poor people in the Metropolitan Area of Caracas), requested the help of Venezuelan physicians, asking them to go into the *barrios* to attend to the acute needs of the under-served populace. However, the majority of Venezuelan physicians refused, citing security concerns and a lack of infrastructure as their primary reasons. Behind these explicit objections

lay an organized opposition by the Venezuelan medical establishment to the health care reform efforts sparked by the Bolivarian government and the country’s new constitution.³³ Undeterred, Mayor Bernal then reached an agreement for a pilot project with the Cuban government and, in April of 2003, 58 Cuban physicians specializing in integral family medicine were sent to various *barrios* in Caracas’ periphery to practice primary care inside the marginalized neighbourhoods themselves.

In September 2003, 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 Venezuelan Ministry of Health and Social Development (MSDS) and the Cuban Medical Commission in Venezuela. Further cementing Barrio Adentro’s institutionalization, in December of 2003 President Chávez created a multi-sectorial “Misión Barrio Adentro” Presidential Commission charged with the implementation and coordination of a national Primary Health Care Program. Between April and December of 2003, under a cooperation agreement involving energy, over 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*. Today, over 20,000 Cuban health personnel and a growing number of Venezuelan health professionals make up the human resources in Barrio Adentro.³⁴ To address sustainability and given the current medical establishment’s continued though decreasing reluctance to participate in the program, the Venezuelan government has launched a massive training effort to replace, over time, the thousands of Cuban health workers with Venezuelans.

According to the MSDS Barrio Adentro planning framework, its goal at the primary care level is to provide ‘round the clock’ access through the construction of one community health centre inside historically marginalized communities for every 250 families.³² To date, of the over 8,000 planned community health centres, close to 2,000 have been built.³⁴ Health centres

that are part of the pre-existing primary health care infrastructure are being incorporated into Barrio Adentro.³² Each community health centre has a multi-disciplinary health team consisting of at least one physician specialized in integrated family medicine, a community health worker, and a health promoter.³² In addition, each centre is stocked with centrally-purchased medications to be distributed at no cost to patients as required.³²

The health team personnel live in the *barrios* themselves and receive support from the community.³² In addition to conducting consultations in the health centres, the health teams are responsible for carrying out daily neighbourhood rounds to survey residents and making home visits to those too ill to visit the community health centres.³² The model of care emphasizes a holistic approach to health and illness through the coordination of Barrio Adentro with other *Misiones* addressing education, food security, public sanitation, employment, and other social determinants of health. For example, patients lacking potable water presenting recurring intestinal infections are not only prescribed the appropriate antibiotics but also encouraged to organize to demand adequate access to clean water.

Health teams and patients are supported by Health Committees comprised of *barrio* residents. Indeed, *Misión Barrio Adentro* stipulates that the creation of a community health centre is contingent upon the establishment of a Health Committee. As such, Health Committees are the organizational mechanism through which *barrio* residents exercise their participation in primary health care delivery and management. In addition to the 8,000 primary health care clinics it aims to build, Barrio Adentro is planning to construct 1,200 diagnostic and rehabilitation centres (secondary care) and to upgrade the existing tertiary care infrastructure of 300 hospitals.³⁴

The foregoing description of Barrio Adentro bears a significant resemblance to the Cuban model of health care that has for decades been a consistent if often ignored successful example for much of Latin America.³⁵ That said, the distinctiveness of Barrio Adentro is highlighted by Cuban physicians themselves; they note the difference in levels of direct participa-

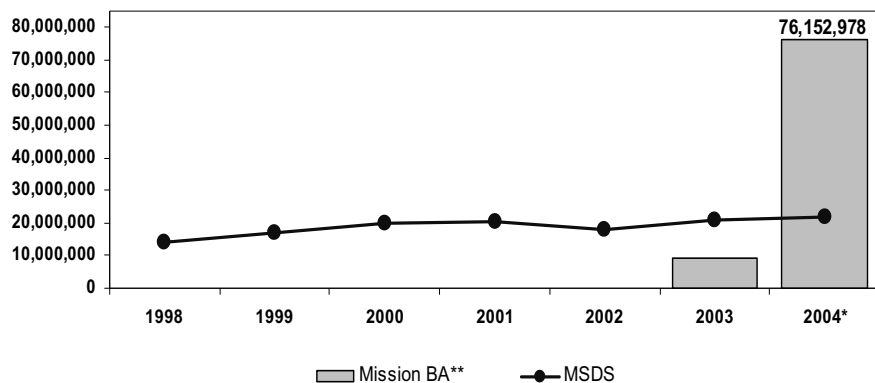


Figure 1. Comparison of the number of medical visits conducted by the Ministry of Health and Social Development (MSDS) and Barrio Adentro (BA) (1998-2004)

tion shown by Venezuelans organized in Health Committees.³⁶ Still, the Cuban health care model's influence is palpable, which, given its proven record, should bode well for Barrio Adentro.

As we see in Figure 1, in terms of expanding access to health care, *Misión Barrio Adentro* has been impressive and may well be able to generate a significant improvement in population health status. Indeed, recent PAHO data³⁶ suggest positive health outcomes associated with Barrio Adentro, including a reduction in child mortality from diarrhoea and pneumonia. The next years will be critical to evaluate the program, including a cost-effectiveness analysis, and to assess its generalizability to other countries.

Nonetheless, despite (or perhaps because of) Barrio Adentro and other Misiones' overwhelming popularity and success, these and other proposed reforms have elicited opposition from the upper middle class and elite sectors of Venezuelan society. This opposition resulted in a military coup attempt and a debilitating general lockout in 2003 and a presidential recall referendum in 2004, all aiming to remove the democratically elected President Chávez from office.³⁷ The mass mobilization by poor and working class Venezuelans (the vast majority in the country) in support of their President led to the failure of all three measures.³⁷ At the time of this report, President Chávez has a 70% approval rating,³⁸ and the Bolivarian process and its counter-neoliberal health reforms continue to develop.

DISCUSSION AND CONCLUSION

For the past 25 years, the neoliberal ideology that underpins IFI-sponsored health reform initiatives throughout Latin America has become the new conventional policy wisdom.⁷ Its influence is surprisingly pervasive, given mounting evidence of its ill effects on health and equity throughout the region. Notwithstanding this evidence, numerous countries continue to adhere to neoliberal reform policies. Yet, the recent Venezuelan experience suggests that the neoliberal way is not inexorable. Further, the Venezuelan example supports the thesis that a country's well-being is determined by policy choices which are more closely related to a country's political and ideological power relations³⁹ – which themselves are the synthesis of historical popular struggle – than to its income level.

The Venezuelan government, aided by popular participation as established in its new constitution, has over a short period of time managed to allocate economic and social resources to geographic areas where these can improve the welfare of the population. The process is both planned and implemented by government officials and defended and supported by mass organizations such as Health Committees throughout the country. In addition, as its relationship with Cuba demonstrates, health care reform in Venezuela has been facilitated not by the "policy-based lending" of international financial institutions, but rather by a novel form of international cooperation based on a bottom-up process of democratic local needs assessments and "South-to-South" mutual aid. Indeed, the

unique international cooperation so fundamental to Barrio Adentro suggests a formidable challenge to the principles of conventional international health "aid".⁴⁰ Just as remarkable as the seeming pervasiveness of the neo-liberal paradigm for health reform is Venezuela's ability to break with this paradigm that in recent history has dominated the region, though with increasing resistance.

The "lessons to be learned" from the Venezuelan experience are not exclusive to low- and middle-income countries. The often taken for granted notion that international health knowledge and expertise flows only from core to periphery is questionable,⁴¹ and the Venezuelan case presented here helps to further debunk that myth. Though many of the elements outlined in the 1984 Ottawa Charter for Health Promotion have failed to gain traction in Canada, they are quite evident, on the ground, in Venezuela's *Misión Barrio Adentro*. The mechanisms and, perhaps more importantly, the social and political context that promote and foster community participation in health care management and an emphasis on the social determinants of health in Barrio Adentro may serve as important insights to help marginalized communities in Canada increase their access to quality health services. For the moment, Venezuela has been able to build a compelling alternative to neoliberalism in community health that serves as an as yet little known international health example for all countries.

REFERENCES

1. Laurell AC. La política de salud en el contexto de las políticas sociales. In: Bronfman M, Castro R (Eds.), *Salud, cambio social y política: perspectivas desde América Latina México*, D.F.: EDAMEX, 1999;239-52.
2. Laurell AC. Structural adjustment and the globalization of social policy in Latin America. *Int Sociol* 2000;15(2):306-25.
3. Armada F, Muntaner C, Navarro V. Health and social security reforms in Latin America: The convergence of the World Health Organization, the World Bank, and transnational corporations. *Int J Health Services* 2001;31(4):729-68.
4. Birn AE, Zimmerman S, Garfield R. To decentralize or not to decentralize, is that the question? Nicaraguan health policy under structural adjustment in the 1990s. *Int J Health Services* 2000;30(1):111-28.
5. Schuyler GW. Globalization and health: Venezuela and Cuba. *Can J Development Studies* 2002;23(4):687-716.
6. Abel C, Lloyd-Sherlock P. Health policy in Latin America: Themes, trends and challenges. In: Lloyd-Sherlock P (Ed.), *Healthcare Reform &*

- Poverty in Latin America*. London, UK: Institute of Latin American Studies, 2000;1-20.
7. Iriart C, Merhy EE, Waitzkin H. Managed care in Latin America: The new common sense in health policy reform. *Soc Sci Med* 2001;52:1243-53.
 8. Homedes N, Ugalde A. Why neoliberal health reforms have failed in Latin America. *Health Policy* 2005;71:83-96.
 9. Perry GE, Arias OS, López JH, Maloney WF, Servén L. Poverty reduction and growth: Virtuous and vicious cycles. Washington, DC: World Bank, 2006.
 10. Huber E. Options for social policy in Latin America: Neoliberal versus social democratic models. In: Esping-Andersen G (Ed.), *Welfare States in Transition*. London: Sage, 1996;141-91.
 11. Mesa-Lago C, Cruz-Saco MA, Zamalloa L. Determinants of social insurance/security costs and coverage: An international comparison with a focus on Latin America. In: Abel C, Lewis C (Eds.), *Welfare, Poverty and Development in Latin America*. New York, NY: MacMillan, 1993.
 12. Weeks J. The contemporary Latin American economies: Neoliberal reconstruction. In: Halebsky S, Harris RL (Eds.), *Capital, Power, and Inequality in Latin America*. Chicago, IL: Westview Press, 1995;109-35.
 13. Labonte R, Schrecker T. Globalization and social determinants of health: Analytic and strategic review paper. Ottawa, ON: Globalization Knowledge Network, Institute of Population Health, University of Ottawa, 2006.
 14. Jagger AM. Vulnerable women and neoliberal globalization: Debt burdens undermine women's health in the global south. In: Fiore RN, Lindemann Nelson H (Eds.), *Recognition, Responsibility, and Rights: Feminist Ethics and Social Theory*. Boulder, CO: Rowman & Littlefield Publishers, 2003;195-209.
 15. World Bank. *World Development Report: Investing in Health*. New York: Oxford University Press, 1993.
 16. Collins C, Green A. Decentralization and primary health care: Some negative implications in developing countries. *Int J Health Services* 1994;24(3):459-76.
 17. Kinman E. Evaluating health service equity at a primary care clinic in Chilimarca, Bolivia. *Soc Sci Med* 1999;49:663-78.
 18. Manfredi C. Can the resurgence of malaria be partially attributed to structural adjustment programmes? *Parasitologia* 1999;41:389-90.
 19. Garfield R. Malaria control in Nicaragua: Social and political influences on disease transmission and control activities. *Lancet* 1999;354:414-18.
 20. Jasso-Aguilar R, Waitzkin H, Landwehr A. Multinational corporations and health care in the United States and Latin America: Strategies, actions, and effects. *J Health Soc Behav* 2004;45(extra issue):136-57.
 21. Naim M. Paper tigers & minotaurs: The politics of Venezuela's economic reforms. Washington, DC: Carnegie Endowment for International Peace, 1993.
 22. Hellinger D. Democracy over a barrel: History through the prism of oil. *NACLA* 1994;27(5):35-41.
 23. Buxton J. Venezuela. In: Buxton J, Phillips N (Eds.), *Case Studies in Latin American Political Economy*. New York: Manchester University Press, 1999;162-84.
 24. Lander E. The impact of neoliberal adjustment in Venezuela, 1989-1993. *Latin American Perspectives* 1993;23(3):50-73.
 25. Tulchin JS, Bland G (Eds.). *Venezuela in the Wake of Radical Reform*. Boulder: Lynne Rienner Publishers, 1993.
 26. World Bank. Staff Appraisal Report: Venezuela Health Services Reform Project. 2005. Available online at: http://www.wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/1999/04/28/000009265_3961007072638/Rendered/PDF/multi0page.pdf (Accessed February 15, 2006).
 27. Inter-American Development Bank. Program to strengthen and modernize the health sector. 2006. Available online at: <http://www.iadb.org/projects/Project.cfm?project=VE0091&Language=English> (Accessed February 15, 2006).
 28. Díaz Polanco J. El papel del financiamiento en los procesos de reforma del sector salud: el caso de Venezuela. In: Díaz Polanco J (Ed.), *La reforma de salud de Venezuela: aspectos políticos e institucionales de la descentralización de la salud en Venezuela*. Caracas, Venezuela: Fundación Polar, 2001;124-45.
 29. Lander E. Venezuelan social conflict in a global context. *Latin American Perspectives* 2005;32(2):20-38.
 30. Ministerio de la Secretaría de la Presidencia. Constitución de la República Bolivariana de Venezuela. 2000.
 31. Feo O, Siqueira CE. An alternative to the neoliberal model in health: The case of Venezuela. *Int J Health Services* 2004;34(2):365-75.
 32. Ministerio de Salud y Desarrollo Social (MSDS). Barrio Adentro: expresión de atención primaria de salud: un proceso de construcción permanente. Caracas, Venezuela: MSDS, 2005.
 33. Jardim C. Prevention and solidarity: Democratizing health in Venezuela. *Monthly Rev* 2005;56(8):35-39.
 34. Ministerio de Salud y Desarrollo Social (MSDS). Barrio Adentro. 2006. Available online at: <http://www.msds.gov.ve/msds/modules.php?name=Content&pa=showpage&pid=239> (Accessed February 15, 2006).
 35. Spiegel J, Yassi A. Lessons from the margins of globalization: Appreciating the Cuban health paradox. *J Public Health Policy* 2004;25(1):85-110.
 36. Organización Panamericana de la Salud. Barrio Adentro: derecho a la salud e inclusión social en Venezuela. Caracas: OPS/OMS; in press.
 37. Gott R. *Hugo Chávez and the Bolivarian Revolution*. New York: Verso, 2005.
 38. Millard P. Venezuela Chavez's approval rating at 70.5%. 2005. Available online at: <http://www.globalexchange.org/countries/americas/venezuela/3036.html> (Accessed February 15, 2006).
 39. Navarro V, Shi L. The political context of social inequalities and health. *Soc Sci Med* 2001;52:481-91.
 40. Birn AE. *Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico*. Rochester, NY: University of Rochester Press, 2006.
 41. Birn AE. Uruguay on the world stage: How child health became an international priority. *Am J Public Health* 2005;95(9):1506.

RÉSUMÉ

Au cours des années 1990, tous les pays latino-américains sauf Cuba ont mis en œuvre à des degrés divers des réformes de leur secteur de la santé soutenues par un système de pensée néolibéral qui redéfinissait les soins de santé comme une marchandise plutôt qu'un droit social. Ces réformes de la santé s'inscrivaient dans les efforts généraux d'ajustement structurel des États-providence d'Amérique latine, uniformément prescrits par les institutions financières internationales à partir du milieu des années 1980. Cependant, depuis 2003, le Venezuela travaille à une solution de rechange à la tendance néolibérale : un programme de réforme des soins de santé appelé *Misión Barrio Adentro* (« dans le quartier »). Dans cet article, nous situons *Misión Barrio Adentro* dans son contexte historique, politique et économique, et nous analysons les réformes néolibérales du secteur de la santé en Amérique latine d'après le cadre politique et économique du Venezuela. Cette analyse montre que les principaux bénéficiaires, tant des grands ajustements structurels des États-providence latino-américains que des réformes néolibérales de la santé, ont été les intérêts capitalistes transnationaux et les élites des pays d'Amérique latine. Nous présentons ensuite dans le détail les aspects politico-économiques de *Misión Barrio Adentro* comme facteurs de remise en question du néolibéralisme dans les soins de santé, en soulignant le rôle joué par la résistance populaire au néolibéralisme dans l'élaboration du programme et le modèle de coopération internationale unique sur lequel il repose. Enfin, nous suggérons que l'expérience du Venezuela pourrait être riche en leçons, non seulement pour d'autres pays à faible revenu et à revenu intermédiaire, mais aussi pour des pays comme le Canada.