

Neoliberal Policies and their Impact on Public Health Education: Observations on the Venezuelan Experience

Oscar Feo

Abstract

This article discusses the impact of neoliberal policies on the training of specialists in public health and describes the Venezuelan experience. In Venezuela, like other countries of the American continent, public health schools had been transformed from institutions under the direction of the Ministry of Health to a model in which training took place under market conditions. Education in public health became a private good for individual consumption, and schools, lacking official funding, survived by offering courses in a market that did not necessarily respond to a country's health needs. The conclusion discusses the current Venezuelan experience in which the State has resumed control of the training of specialists in public health, making it more democratic, and adopting an educational model centered around practice and whose purpose is the mass training of leadership teams to bolster the National Public Health System.

In order to comment on the impact of neoliberal policies on training in public health we must first briefly review the following themes

1. Basic concepts such as neoliberalism, globalization, and health systems.
2. The impact of neoliberal reforms on health.
3. The Venezuelan situation: basic principles for the training of professionals and technicians in

health within the framework of a model of independent and sovereign national development.

4. Final reflections: challenges for the coming years.

Neoliberalism

From a progressive perspective, neoliberalism has become one of the most important explanatory models for understanding what is going on in the world. We understand neoliberalism not as an economic doctrine, but rather as a phase in the development of capitalism that imposes an understanding of the world and organizes society as a market. Chomsky (2001) points out that the essential feature of the globalized world is the imposition of a way of thinking — of a means of conceiving the world, society, the production and distribution of goods, and the relations between nations — that is known as *neoliberalism* and has become the economic paradigm of our time. It is a form of global government without a global State, in which a group of institutions closely linked to large corporate financial interests dominate the world to satisfy their goals and to maintain control of societal life by private interests, with a single objective: to maximize their profits and benefits.

What we know as neoliberalism is built upon by three major principles:

1. Market fundamentalism, extolling free movement of capital, free trade and the free flow of the factors of production (except for the

Venezuelan MD, Public Health and Workers' Health Specialist. Lecturer at the Universidad de Carabobo. Current Executive Secretary of the Andean Health Agency. E-mail: oscarfeo@msn.com

workforce, which continues to be subjected to various restrictions).

2. The dismantling of nation states, the disappearance of boundaries for economic activity, and the loss of power and sovereignty of peripheral nations. This has been called the monarchy of capital. State sovereignty is seen as having collapsed in the face of globalization, with sovereignty nowadays being based on the market.
3. The homogenization of cultures and customs, imitation of patterns of consumption, reinforcement of a consumer ideology that generates 'reckless consumption' and an alienation that creates expectations of a standard of living which are not consistent with reality. Galeano has called this the culture of "use and discard" with resulting environmental degradation and exhaustion of natural resources.

Neoliberalism promotes a range of actions to further its interests:

1. Privatization: This occurs not only in the sense of the transfer of companies from the public to the private sector, but also in the conversion of social rights into marketable objects. Health and education, traditionally considered to be citizens' rights, become economic interests and, in many countries, are integrated into circuits of accumulation. The privatization of social security pension funds has evidently become one of the most attractive resources for financial capital, becoming a highly profitable area. In some countries even water is being privatized.
2. Deregulation of the labor market: The neoliberal model produces unemployment, flexibilization and casualization of labor, greater informal employment, and a considerable increase in industrial accidents and occupational diseases.
3. Targeting social programs: Nations and international institutions tend to design measures to combat the severe problems they classify as poverty and social exclusion. They do not realize that the fundamental problem is not poverty, poverty being only a symptom of the inadequate

and unjust distribution of social wealth. Consequently, in the absence of structural social policies designed to address the real problems of the economy (not only of individual countries, but of the world) they design programs which target the poor.

4. Speculative investment: This involves largely short-term capital operations where the objective is to obtain speculative gains, dissociated from the production of material goods. It is estimated that 95% of the operations in foreign exchange markets consist of speculative activities. Amin (1997) holds that the displacement of productive activity by speculation is the real cause of the capitalist economic crisis. In short, highly speculative financial markets are core protagonists of the neoliberal globalizing process.

Neoliberal Globalization and Health

Globalization is generally understood as a natural evolutionary process resulting from developments and breakthroughs in computer science and telecommunications. Stiglitz (2002) relates it to the globalization of the economy and the removal of barriers to 'free trade' and points out that one of its basic features is the acceptance of triumphant US capitalism as the only possible route to progress. Others see it as a global expansion of transnational capital based on a new international division of labor, in which commodities lose their nationality and cannot be considered as coming from any particular country. SELA (the Latin American Economic System) considers it to be a new form of colonialism that has replaced the old-fashioned forms of domination by a more sophisticated model which prevents a better distribution of wealth and increases the concentration of power and capital. All these conceptions represent various facets and dimensions of globalization.

In order to understand what goes on in the health care sector, we must first understand the impact of globalization on quality of life and health services. One of the basic features of the globalized world is the concentration of capital and the increase in

inequity and poverty. Neoliberal globalization has made the rich richer and the poor poorer. In the last decade the poor have come to make up more than one third of all humanity and have increased at an extraordinary rate. Today, 2.5 billion live in conditions of poverty. This is the paradox of a world that grows richer as it produces ever greater wealth, but concentrates it in ever fewer hands.

Contrary to the assumption made by many theoreticians and institutions around the world, the fundamental problem and the greatest obstacle to development is, of course, not poverty (which is understood to be a symptom of the problem) but the unbalanced concentration of capital and the very unjust distribution of social wealth.

From being conceived as social rights, health and education have become mechanisms for profit and private investment, opening up the possibility that large amounts of money which was previously regulated by the State can now be managed by finance capitalists. Health and education have come to represent some of the most attractive and profitable markets, with international institutions among their most active promoters.

Health Systems

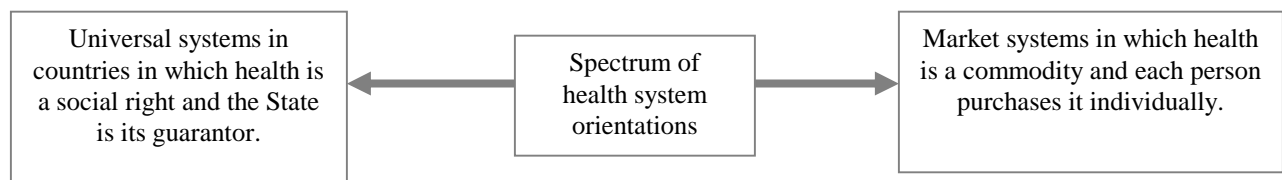
A health system can be defined as a set of institutional responses, programs, and activities that a society constructs to satisfy the health needs of its population. In general, the aim of a health system should be the promotion, protection, and restoration of the health of a population or community. In political terms, a health system is the institutional response that a nation develops to deal with the issues of health and disease of its inhabitants. The health system is therefore a political answer, a “social construction” and, as such, it responds to the

dominant political-ideological conceptions within each State, particularly in relation to the conceptualization of health and to the role of the State in guaranteeing and providing it. Consequently, each country builds its health system according to the concepts, principles and values underpinning that society.

The Venezuelan Constitution approved in 1999 defines health as a **fundamental social right** which must be guaranteed by the State as part of the right to life. In order to guarantee this right, provision is made for the creation of a National Public Health System (SPNS) which is transsectoral, decentralized and participatory in nature. Other countries (such as the USA and many others in Latin America) which are under the influence of neoliberal policies promoted by international financial institutions have had imposed on them the concept of health as a private commodity. Although this is not made explicit—since many continue to see it as a right—in practice they end up leaving health to the marketplace. Bush said in his last electoral campaign that for him the ideal health system was one in which each citizen could pay for the services he requires. Likewise, we hear the Health Minister of one of the countries in the American continent saying that health should be put on the market, and that the State should only intervene to guarantee health care for the poor and the destitute.

There is a clear difference between these conceptions. On the one hand, health is seen as a right guaranteed to all individuals by the State, with no distinction of any kind; and on the other, health is treated as a commodity which is acquired in the interplay of supply and demand, with a State guarantee only for the poor.

Around the world there are various models of health systems to be found along a very varied spectrum between these two polar conceptions:



In short, each State builds a health care system according to its political and ideological criteria in order to address the problems of health and disease of the population. In Europe, for instance, within the framework of the welfare state which was dominant following the Second World War, the concept of health as a social right took hold and various models of health systems were created. Despite their diversity, the State is fundamental in all of them. In the vast majority of Latin American countries mixed health systems were created, expressing a combination of influences, and social security institutions were developed for the salaried workforce in parallel with ministries of health for the rest of the population. This situation gave rise to health systems fragmented across multiple public institutions covering different sectors of the population, generating huge inequities in access and in distribution of public funding. During the '90s these health systems suffered the onslaught of neoliberal health sector reform, which privatized services with disastrous consequences. A handful of countries have developed National Public Health Systems including Brazil, Cuba, and now Venezuela.

In summary, to properly characterize a health system we need to distinguish the following aspects, among others:

1. The dominant conception of health : social right or individual private commodity.
2. The model of care which defines the organization of services: comprehensive services or fragmented ones oriented primarily to the treatment of sickness.
3. The character and management of establishments offering health services.
4. The type and sources of finance for the system.
5. The role of citizens in its organization and control.
6. Outcomes obtained in terms of health of the population.

The Impact of Neoliberal Reforms on the Health Sector

In the 90s health policies in the Americas were marked by the proposals for Health Sector Reforms widely promoted by international financial institutions. It should be stressed that these reforms were not isolated processes, but rather part of much broader programs of State reform, known as 'structural adjustments', which were developed from proposals generated by the Washington Consensus.

What came to be known as the 'Washington Consensus' was simply a set of economic policy measures generated at a 1989 meeting of experts from the International Monetary Fund (IMF), the World Bank, the US Federal Reserve and the US Congress which took place in Washington (in the midst of the crisis within socialism). The main objective of the meeting was to draft a set of proposals to integrate into the market economy those formerly socialist countries emerging from the dissolution of the Soviet Union. These were characterized by centrally-planned economies. However, the Washington Consensus was applied as a uniform recipe to all countries of the 'developing world'.

These policies, applied in most of the countries of the Americas and widely promoted and funded by international financial institutions, are summarized in the proposal to **reduce the involvement of the State and facilitate the dominance of the market**. There is an extensive bibliography about the catastrophic impact of these measures, but given his singular importance we will only mention Stiglitz, Nobel Laureate in Economics, whose books "Globalization and its Discontents" and "The Roaring Nineties" describe their application and failure. Armada (2001) reviewed the letters of intent signed by the IMF and each of the countries and notes their astonishing similarity. Each include health and social security reforms which promote 'economic efficiency', the targeting of basic care at the poorest, and the development of 'basic benefit packages' within the framework of proposals to increase the involvement of the private sector and privatize various aspects of health service provision and health insurance.

These reform proposals came with loans which increased foreign debt and financed special reform units, which became elitist units absorbing resources and stewardship from the ministries of health. This gave rise to a class of consultants who, following the dictates of the banking world, prepared useless studies and imposed reforms. The reforms which were characterized by four main principles:

1. Separation of functions: The reforms were based on the criterion (which we do not share and which merits wider discussion) that the functions of a health system are fourfold: stewardship, financing, insurance, and service provision. The Reforms would leave ministries of health only in charge of stewardship. The remaining functions would be transferred to other actors, generally in the private sector, thus giving rise to the process of privatization.
2. Decentralization: This was seen as a means of reducing the involvement of the State, transferring functions and administrative competencies to regional and/or local levels, even those that lacked the resources or expertise required to carry them out. This was often an intermediate step before privatizing services. We must distinguish these decentralizing processes, which scatter and anarchize systems, from the other type of decentralization conceived as a political instrument for the transfer of power and resources in order to strengthen local governments and communities.
3. Targeting: This dealt with the development of projects aimed exclusively at the poorest people, leaving the rest of the population to market forces. This undermines the universality of health care and generates limited programs conceived as basic packages exclusively for the poorest sectors of the population.
4. Financing Mechanisms: All of these proposals included financing by various means of cost recovery or direct payment for services by the population, creating inequities and economic obstacles to accessing services and generating social exclusion in the field of health. Today

almost 30% of the population of the Americas lacks permanent access to health services.

In short, within the context of neoliberal reform, the concept of health as a privatized consumer commodity was imposed, with the details to be negotiated between individuals and private enterprise, leaving the State only responsible for guaranteeing healthcare to the poorest sectors of the population. This dynamic favored ad-hoc projects, rather than regular programs, degrading the Ministries of Health—whose capacity and stewardship were reduced, generating significant weakness in public health systems.

The Impact of Reform on Public Health Training

In the field of public health education, a neoliberal logic was imposed which sees education—particularly at the postgraduate level—as an individual consumer good to be acquired in the marketplace. Supply increases when individual demand is high, with little control or regard for quality. Numerous schools and private courses arose throughout the continent, offering costly, elitist undergraduate and postgraduate degrees in health sciences and public health aimed at satisfying individual demand and generally bearing little relation to social needs and the actual health situation of the population. The proliferation of private schools of medicine to satisfy the needs of a market which was limited but had high purchasing power is astounding. Venezuela was one of the few countries which did not authorize the creation of these schools in the private sector. However, as in many other countries, the training of specialists in public health became a private commodity with numerous programs being promoted by universities lacking experience in the field but responding to a growing demand from professionals wanting to be certified as specialists in order to get a job. Training leadership teams for the public health system ceased to be the State's responsibility and was transferred to universities and the private sector. Neoliberal policies turned postgraduate courses into profit-making businesses. Postgraduate qualifications became a commodity designed to satisfy personal expectations, usually at very high cost and without

any academic value. Many of these courses were excessively theoretical, elitist, exclusive, removed from reality, and marked by foreign concepts.

These courses shared the following features:

1. Predominance of a medicalized conceptual model, focusing on disease rather than on a comprehensive conception of health.
2. Fragmented, typically Flexnerian education, focusing on theory and academic knowledge, isolated from reality and with little reflection on social practice.
3. This type of education, brought into the marketplace and ignoring the needs of the country, was aimed at resolving individual needs and basically produced professionals for the private sector, despite their training often taking place in public places and with public funding.

Public Health in Venezuela Today

Our Constitution defines the features of the National Public Health System (SPNS), stating in Article 84: *“In order to guarantee the right to health, the State shall create, exercise stewardship over and administer a national public health system that crosses sector boundaries and is decentralized and participatory in nature, integrated with the social security system and governed by the principles of free access, universality, comprehensiveness, equity, social integration and solidarity.”*

For years we have pointed out the importance of a comprehensive integrated health system, which in addition to providing initial interventions, allows for routine follow-up. However, in practice we have built a fragmented model, based on supply and on each institution’s capacity to respond, which does not guarantee the population a real solution to their problems. It separates cure from prevention, does not define a point of access, lacks any efficient mechanism of reference and cross-reference, and has a hierarchical structure with hospitals as the core of the system. In conclusion, the current model does not respond to people’s health needs and does not produce an organized system. On the contrary, it

generates inconsistencies which hinder its operation.

It is an ethical imperative that we build a National Health System which meets the needs of the population with quality and responsiveness, which functions in a comprehensive, interdisciplinary, and transparent manner, is accountable to its social foundation, and works towards goals agreed upon with the community.

In Venezuela after 1999, President Chávez’s popular victory made it possible to break with the neoliberal model serving imperialist interests and a period of national reconstruction began. Efforts were made to create a participatory democracy within the framework of a State based on the rule of law and social justice.

Within this framework the most important health measures can be summarized by four points:

1. Suspension and reversal of the neoliberal policies approved in 1998 that promoted privatization of health services.
2. Identification of a set of public policies aimed at defining a strategic plan and a new model of health care, based on comprehensiveness and on linking health to quality of life.
3. The beginning of a special program called *Barrio Adentro*, with the goal of guaranteeing inclusion and healthcare coverage for millions of people who live in marginal urban sectors and who had traditionally been excluded from the health system and access to services. The *Barrio Adentro* program, supported by Cuban solidarity, has become the core for development of the new National Public Health System, organized in a series of networks, as follows:

The **Network of Popular Medical Clinics**, serving as the point of access to the national health system, geographically distributed to provide one for every 250 families. It follows a model of comprehensive care with widely participatory and cross-sectoral criteria. It is also the point of entry to the network of social programs run by the Venezuelan State, linking action on health with programs and missions on education, sport, culture,

food, popular economy, housing and environment—all part of the endogenous model of development taking shape in the health sector as a combination of actions promoting quality of life and health, as well as measures for prevention and treatment of disease. This model—with all its vicissitudes—is being implemented with the active involvement of Cuban solidarity.

The **Network of Diagnostic Centers and Popular Clinics**, which so far includes 426 comprehensive diagnostic centers (CDI), some 500 comprehensive rehabilitation facilities (SRI), 40 popular clinics and 20 high-technology centers (CAT), equipped with the appropriate diagnostic capability and critical capacity for ensuring timely diagnosis, treatment, and rehabilitation. The network is growing and the aim is to reach 600 CDI and SRI in the coming months.

The **Network of People's Hospitals and Specialist Hospitals** exists for cases requiring hospitalization.

The system is controlled by the Ministry of Health, which itself is undergoing reconstruction. The Ministry has embarked on the design and administration of a National Health Policy that will ensure the comprehensiveness of programs ranging from health promotion (in the context of cross-sectoral social policies for promoting quality of life) to individual treatment of disease. In keeping with the intergovernmental nature of the health system described in current legislation, this Ministry must work together with state and municipal levels as an integrated whole in implementing the national policy of guaranteeing the right to health care and improving the quality of life of the whole population.

Basic Principles for Training in Public Health in Venezuela

The training of professionals and technicians required by the health sector and especially the new National Health System makes it necessary to develop new educational policies which break away from the dominant paradigms of traditional training in public health. This should be implemented as part of a strategic alliance with universities and other

training centers, but it is essential that these thoroughly integrate the new realities and policies of health education with the following general principles:

1. Education without exclusion

For many years the State of Venezuela trained its medical professionals and leadership personnel in the School of Public Health and the School of Malariology, the latter directly attached to the Ministry of Health. This changed radically at the end of the 80s with the application of neoliberal policies within education, which meant that the State abandoned its responsibility for training leadership teams and postgraduate courses were turned into 'consumer goods'. In Venezuela the reversal of this situation began with the transformation of the School of Malariology into the Institute of Higher Studies in Public Health (IAESP), and subsequently the elimination of fees and the resumption of training as a responsibility of the State. The Ministry of Health began to select and send its leadership teams for training in accordance with the needs of the State.

The basic principle underlying the policy on training in public health is universal access to and democratization of postgraduate courses, transformed from a costly, elitist form of training into postgraduate courses at the service of the health system, offering intensive training of the leadership teams required by the National Health System. From courses with only a handful of students each year, postgraduate courses throughout the nation's regions now have hundreds of students who receive training in real contexts.

Barrio Adentro became a giant school of medicine where, under the careful supervision of highly trained faculty, several thousand students receive undergraduate training for careers in medicine and nursing. Training also takes place at the postgraduate level, producing over 3,000 specialists in comprehensive general medicine.

2. New educational model

Training of this sort requires a departure from traditional strategies and spaces in a way fully

convergent with the new institutionality. This is the second change of direction in training: the community, the neighborhood become the learning environment. The popular medical practices and diagnostic centers of *Barrio Adentro* become a great national university for health and constitute the axis of development of the new institutionality of the National Health System. The teaching/learning process moves into service provision under a system in which ‘work study’ and ‘transformation in practice’ form the central axes of action by course participants. This necessitates rethinking the educational model, making it truly andragogical: responsive to the needs of the health system; producing expertise to enable knowledge and resolution of problems; with a flexible, dynamic curricular structure that is self-assessable and able to provide a rapid response to the needs of the National Health System. In short, the new training policies are divorced from old teaching paradigms, breaking out of the classroom and encyclopedic and theoretical conceptions. Combining forms of mass education with quality and social relevance will produce professionals who are reflexive, capable of tackling and resolving complex situations, integrating ethical values and principles of teamwork, and who are wholeheartedly committed to putting their knowledge to the service of the community.

Final Reflections: Challenges for Public Health in the Coming Years

In order to strengthen the National Health System and link it to the ongoing creation of a new model of society, the health sector needs to successfully meet the following challenges:

1. To reaffirm health as a basic right and to continue to confront market-centered ‘neoliberal’ policies, reversing those elements of privatization which still persist in health and education.
2. To combat and narrow the vast social gaps which exist in the distribution of disease, death, and access to health-related goods and services, effectively guaranteeing the right to health for all

- citizens, reducing existing inequities, and putting an end to social exclusion in health.
3. To bolster the National Health System by furthering the *Barrio Adentro* program, with a conceptual model which focuses on health and life, incorporates strategies of participation, comprehensiveness and cross-sectoral operation, and accepts health and disease as social processes, resolving contradictions between collective and individual, biological and social, curative and preventive aspects, favoring the promotion of health and prevention of disease, acting on the determinants of health and not just on its manifestations. This implies challenging individualist, medicalized conceptions centered on disease and technology.
 4. To reduce and solve the existing huge social debt, improving health service performance, raising its critical capacity, clearly defining the model of health care, reinforcing the ambulatory network and primary care, and increasing the efficiency and capacity of hospital care.
 5. To maintain and reinforce a policy which guarantees a suitable contribution of financial resources for operational costs and a policy of renewal and preventive/corrective maintenance of the technological equipment installed in dispensing institutions, and to guarantee the continuity of health policies in the face of the tendency for policies to change each time a new Health Minister takes office.

Given this situation, there is an enormous challenge before us: to link all work in health with the creation of a new society based on values and principles that are radically different from those of the individualism and consumerism which prevailed for many years: values and principles such as solidarity, honesty, teamwork, internationalism, and regional integration.

This implies strengthening a system of public health that is consistent with the new country, enabling resolution of the major health problems of our people by acting on their determinants—a system of public health which embraces the development of a new theory and new practice in

order to render the right to health and the fight against inequalities a reality, a system in which the struggle for collective well-being within a society is based on social justice and built on democracy and participation for all, as we strive to show that another world is possible and that *Health for All* is not a dream but a reality that is already taking shape.

References

Akin, J.S., Birdsall, N., & de Ferranti, D. (1987) Financing health services in developing countries. An agenda for reform. World Bank, Washington DC. [original citation: Banco Mundial (1990). Financiamiento de los Servicios de Salud en los países en desarrollo. Washington DC: Autor. Also found elsewhere: "Banco Mundial. El financiamiento de los servicios de salud en los países en desarrollo. Una agenda para la reforma. Boletín Oficina Sanitaria Panamericana. 1987;103-(6):595-742." and "BANCO MUNDIAL: Financiamiento de los servicios de salud en los países en desarrollo: Programa de reformas. Washington, D.C., 1990.]

Amin, S. (1996). The Challenge of Globalization. Review of International Political Economy 3(2). [cited by Feo in Spanish, but originally published in French as: Les Défis de la Mondialization. Paris: Edit. L'harmattan.]

Armada, F.; Muntaner, C. & Navarro, V. (2001). Health and Social Security Reforms in Latin America. International Journal of Health Services, 31 (4), 729-768.

CEPAL (1999). Panorama Social 1988. Santiago de Chile.

Chomsky, N. (1998). Profit Over People. Neoliberalism and Global Order. New York: Seven Stories Press.

Constitution of the Bolivarian Republic of Venezuela. (1999). Gaceta Oficial de la República 5.453 (Extraordinaria). Marzo 24, 2000.

Feo, O. (2003). Repensando la Salud. Propuestas para salir de la crisis. Análisis de la Experiencia Venezolana. Maracay: Universidad de Carabobo

Friedman, M. (1962). Capitalism and Freedom (1). USA: University of Chicago Press.

Friedman, T. (2000). The Lexus and the Olive Tree. New York: Anchor Books.

Pan American Health Organization (1992). The Crisis of Public Health: Reflections for the Debate. Washington DC: PAHO.

Pan American Health Organization (2002). Public Health in the Americas. Scientific Publications, No. 589 Washington DC: PAHO.

Sonntag, H. (1997). América Latina: La Patria Grande. In: Democracia para una Nueva Sociedad (pp. 187-211). Caracas: Nueva Sociedad.

Soros, G. (1998). The crisis in global capitalism. New York: Public Affairs Press.

Stiglitz, J. (2002). Globalization and its Discontents. New York: W.W. Norton & Co.

Testa, M. (1993). Pensar en salud. Buenos Aires: Lugar Editorial.

World Bank (1993). World Development Report 1993: Investing in Health. Washington DC: Oxford University Press.

There are currently more than 20,000 young people in their first, second, and third year of medical studies in 853 multi-purpose classrooms in 318 municipalities throughout the country. Beginning this year, 500 students from several Latin American countries and from Africa will be entering their first year.