Looking south to find the medicine

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# of my heart

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It has taken over seven hours in plane, twelve hours overnight by bus, and thirty minutes squashed in the back of a jeep to finally arrive at the kind of medicine I want to practice. With a Fulbright scholarship in my hand, and a year gleefully stolen between my third and fourth years of medical school at the University of Minnesota, I soak in the values of the Venezuelan health system. With this academic freedom, I am witness to the dramatic social transformation of a country embracing the philosophy of universal access to medicine. Venezuela has designed a network of free neighborhood clinics that focus on underserved communities, based on experiences from Cuba. To complement my time observing these newest clinics, I am studying at one of the oldest universities in Venezuela, the Universidad de Los Andes. Today our public health class travels curvy mountain roads to listen to an unexpected leader in community health.

Visiting the hand-constructed adobe homes of formerly landless *campesinos* in the Andes Mountains we find Señora X Caramoto. She astounds us with her decade-long determination to improve her community's health. As community organizer in CampoVisita Aldea Ecologia "el Estanquillo" La Gunilla, she describes her community's fight to build homes on formerly "useless" farmland—terrain too rocky to make a profit growing sugarcane. Her land, in a difficult but ultimately successful undertaking, provided the foundation for safe housing for twenty-eight families. Years of collaboration between the community, government, and local nonprofit organizations have brought clean water and consistent electricity. Later, back

The hands of 93-year-old Maria Virginia Gonzalez, who suffers from thrombosis. © Carlos Cazalis/Corbis

Above, the author in Maturin. Courtesy of the author.

Left, Señora Rosario Lobo rents out her front room to Barrio Adentro in Mucuy Alta. Above, Dra. Lourdes Quintero with two first-year medical students studying at Barrio Adentro. Courtesy of the author.

at the university, dentists, firefighters, nurses, nutritionists, and doctors all discuss how public health is a strategy that facilitates the process of social change. Indeed, it is these social issues that build the base for the expansion of universal health care in this South American country.

One of the most refreshing aspects of Venezuela is the fundamental belief that every person deserves access to quality health services. "Salud es por todos, para todos, con todos," says my professor—"Health is for everyone, with everyone, on behalf of everyone." No one bats an eye, and I can almost hear the collective agreement, "Of course!" echoing in my classmates' heads.

Health has been a constitutionally defined human right in Venezuela since 1947,[1] as it is in most countries beyond the United States. However, under the Chavez administration, it is also viewed as a "deber" or a "duty" of citizens.

"Have you ever seen a eighteen- or nineteen-year-old man coming willingly for a well-person check up?" a nurse comments to me in the hallways. She continues, "It's striking to see teenage men taking their health seriously. But now they do it. Because for the first time they see their personal health as deeply connected to the health of their community and country."

In addition to my public health class, I am volunteering in one of the newest Chavez initiatives, Misión Barrio Adentro. This program provides free dignified health care for all, implementing the dreams inscribed in Venezuela's constitution. Since President Hugo Chavez's election in 1998, medical services have been rearranged in a huge expansion of free primary care services. The first wave of expansion occurred from 1998 to 2002, with growth in average yearly traditional ambulatory clinic consults rising from about twelve million visits before Chavez's government to more than nineteen million afterwards. The most significant wave of clinic expansion occurred with the foundation of Misión Barrio Adentro in April 2003. Barrio Adentro, according to the program's mission statement, creates a national health system based in

> the values of free, universal, global, equal, social integration and solidarity; in which the active participation of the community plays a fundamental role.[2]

Within a year of the implementation of the program, yearly clinical consults increased over sixfold above the pre-Chavez baseline to seventy-six million.[3,4] I am here to learn more about how the transformation to universal access to health services looks and feels.

How does a country with a GDP per capita of $6,900 (one-fifth of the US GDP)[5] pay for such an enormous health care program? In 2000, a Cuba-Venezuela trade agreement provided Venezuelan oil for Cuban doctors to drive this expansion.[6] The agreement exemplifies the emerging South-South trade alliances that maximize the competitive advantage of each country, bypassing the structural adjustments (conditions for international loans that usually reduce public expenditures in health care) that are typically demanded by international financial institutions.[7–9]

As of 2006, nearly twenty-thousand Cuban physicians, nurses, and optometrists have traveled to Venezuela to provide care in rural and urban poor communities. Cuban doctors are well versed in providing free health services—more Cuban doctors provide care to the underserved worldwide than there are American Peace Corps workers. Barrio Adentro is modeled after the medical system in Cuba in which neighborhood doctors serve every 250 to 500 families, a ratio suggested by the Organización Panamericana de la Salud (Panamerican Health Organization). Venezuela confidently aims to have a doctor for every 250 families or 1250 citizens.[10] *Consultorios* (ambulatory clinics) are open in the morning, and physicians spend the afternoon making home visits or engaged in community programming.

Early in the morning, I see young people lining up outside of a neighbor's home, which serves as the consultorio's office, waiting to have a visiting bioanalyst-cum-phlebotomist draw blood. These patients were unable to pay for routine lab screens of cholesterol, hemoglobin, and blood sugar under the previous health system.

This day, a family stops in the clinic to receive the results of previous lab tests. They discuss their growing concern for the grandmother, who has been waking frequently at night with

urgency to go to the bathroom. The family worries. After ruling out organic pathology such as infection, the doctors inquire about subtle mind-body connections. One asks, "I know your grandma was a school teacher for many years and recently retired. What kind of activities is she participating in? Do you think she might be manifesting her sadness? What can we do to make sure she is better included in community activities?" Around lunch time, a local farm worker visits to talk about her ongoing fatigue. She has neither time off nor bus fare to travel to the city and a different clinic. This is her only resource for finding solutions. If she needs labs, referrals, or medications, she'll get them. Time and time again, patients arrive at the doorstep emptyhanded, and receive quality health services.

Doctors in Barrio Adentro rely on interrelated social service networks that address food, housing, education, environment, work, transportation, security, employment, and recreation. The system is based not just on treatment, but on promotion of health and prevention of disease. Things aren't perfect in these clinics—as one Venezuelan doctor reminded me, "perfection doesn't exist." But as I follow behind doctors walking up stony mountain paths to personally visit an elderly man and review his recent history of high blood pressure, I wonder if this is the future in community-based primary care. If it can be done here, why can't it be done in the United States?

Although Cuba has been instrumental in the program's functioning, the ultimate goal in Venezuela is to create a sustainable endogenous public health care system. To that end, the Chavez government has created a health care track within new universities that will train thousands of new Venezuelan doctors to serve in traditionally excluded communities. A variety of factors in Venezuela contribute to the traditional geographic and economic misalignment among physicians providing services and patients needing those services, just as they do in the United States. However, educating physicians raised in poor and underserved communities has been a key feature of Chavez's health education programs.

In fascinating contrast to the stressful and competitive process of applying for admission to medical school in the United States, Venezuela's newest medical education institution opens its doors to all high school graduates. And not only is the medical school free, students also receive a small stipend for living expenses ($100/month). Before officially entering medical school, students enroll in a six-month introductory premedical course, which starts at a fundamental level and progressively builds the skills of those who have had no higher education. Students learn how to read for retention and use the library, as well as attending classes in biology, chemistry, and physics. To these newest students, medical course directors write, "The sustainability of our health programs . . . especially given the context of other Latin American countries where millions of your brothers are completely excluded from receiving medical attention and services, demands the formation of professionals with the highest level of scientific, technical, ethical, and humanistic preparation. This program will allow you to successfully complete the work of guaranteeing the health of our communities, as an indispensable condition of our Development."[11] While medical students still memorize the Krebs Cycle, there is also a palpable enthusiasm for being a part of a growing, energetic movement to bring health to the community.

Time will tell whether the next generation of Venezuelan doctors, emerging from the ranks of traditionally excluded neighborhoods, and trained in community-based and universally available primary practice, will succeed in equalizing years of health care inequities. For now, I am rotating through clinics where I know all my patients can get quality medical services, regardless of insurance status or ability to pay. Although I wake in a foreign land, I finally feel at home.

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