[Health Inequalities in Venezuela]
Regional Health Inequalities

Health inequalities can be studied at four different levels: global, international, domestic and subpopulations. The choice and number of indicators used to analyze health inequalities within the four levels mentioned should be chosen based on the availability of information and the indicators that most aptly represent the larger proportion of a given population. Examples of health inequality indicators include: life expectancy, maternal mortality rate (MMR), infant mortality rate (IMR), morbidity rate, healthcare access and healthcare use. Defining what health inequality means is important because it can have a different connotation depending on where it is being used and who is using the information to convey a message. Generally, health inequality refers to the gap that exists between poor and rich populations that result in avoidable health status differences where the poor are less capable and willing to obtain a better quality of life. Health inequalities can occur through social, political, economic and environmental influences and thus can be analyzed and avoided or mitigated in some form or another.

The overall global population health transition is increasing health inequalities for reasons that are suitably represented in the demographic and epidemiologic transition models. The demographic transition model suggests that the proportion of dependents is growing in richer countries because people are living longer lives and are having fewer children as a result of advances in technology, education and health care. Conversely, less developed countries will continue to have a growing proportion of younger individuals. In the epidemiologic transition model the causes of death are shifting from communicable infectious diseases (CID) to non-communicable chronic diseases (CD), such as cancer, heart disease and diabetes.

Latin America and the Caribbean (LAC) is one of the regions of the world that attracts particular attention in reference to health inequalities. One author noted that LAC is the region of the world with the highest degree of social inequity [1]. “According to the Pan American Health Organization [2], LAC region faced an important demographic transition, with a significant decline of mortality and fertility rates, and an increase of its population from 331 million in 1950 to more than 823 million in 1999, which represents almost 14% of the world’s population.” [3]. The global population health transition poses what many researches are naming a “double burden” of diseases for developing countries, where younger individuals have to deal with CID’s and the older individuals in the population now have to fight against CID’s and CD’s. In 2005, the average life
expectancy for the LAC region increased to 74.6 years, but this increase is accompanied by increasing CD occurrences, which account for about 60% of all deaths in the region (Proposed strategic plan 2008-2012. Situation analysis in the region. Economic and social trends). Although the LAC region has achieved many advances in reducing the proportion of CID’s that occur, the burden is still significant. CID’s were attributed to 716 thousand deaths in the region in 2001 [4].

Research and available data on the existing health inequalities in the LAC region is limited due to several variables. Many studies conducted depend on self-reported facts and questionnaires that vary depending on who is conducting the study. Self-reported health problems tend to be bias in them­selves because of traditional preconceived myths of illness, social and/or economic status, gender, et cetera. These types of reports are also likely inaccurate because there’s typically only one person from the household answering questions (the woman) while the children and men are at work or school. While the same question may be asked in each country, response options are different and therefore, represent a varied set of data. Furthermore, a lack of a standardized definitions or understanding/education level about CD and CID’s in each country’s citizens, especially in the more rural areas, leads to misrepresentation and lack of reporting. For example, in one study, “In Chile, the category was “health care”, and the results will depend on how people in that country interpret this term. In Ecuador, it is not possible to tell whether care was sought from a physician, a nurse, or a traditional healer, and in Jamaica, all potential caregivers, from physician to healer to pharmacist, are lumped together in one category.” [5]. Moreover, research reports produced on health inequalities use different parameters/indicators to assess the inequalities. For example, some studies might use household income to differentiate between higher and lower income families while other studies might use household expenditures. Also, the amount of data available on a particular country might simply be proportional to the population size of that country [5].

Within the LAC region, disparities exist from country to country and one indicator that can be used to assess the health inequalities is the Human Development Index (HDI). The HDI uses four indicators: life expectancy at birth, mean years of schooling, expected years of schooling and gross national income per capita [6]. Based on these four indicators and data obtained between 1980 and 2011, the HDI ranked the top five countries in the LAC region as Chile, Argentina, Barbados, Uruguay and Cuba. The five lowest ranking countries within the LAC region are Haiti, Guatemala, Nicaragua, Honduras and Guyana. The five countries that fall in the middle of the HDI for the LAC
region are Saint Kitts and Nevis, Venezuela, Jamaica, Peru and Dominica. The population in Chile has a life expectancy at birth of 79.1 years, 9.7 mean years of schooling and $13,329 gross national income (GNI) per capita [6]. In contrast, Haiti has a life expectancy at birth of 62.1 years, 4.9 mean years of schooling and a GNI/capita of $1,123 [6].

The United Nations and 23 international organizations developed the Millennium Development Goals (MDGs), which is a set of eight goals deemed as significant indicators of poverty and its' reduction by the year 2015. The Poverty Reduction, MDG and Human Development Area are part of The Regional Bureau for Latin America and the Caribbean (RBLAC) of the United Nations Development Programme (UNDP). These eight goals provide a comprehensive understanding of the state of human health in the world and thus, are being used here as another method to describe the particular health inequalities in the LAC region.

1. Eradicate extreme poverty and hunger. MDG reports indicate the following countries as having no progress: Colombia, Dominican Republic, Ecuador, Haiti, Nicaragua and Paraguay. The following countries are characterized as “achieved” or having “fast progress”: Argentina, Brazil, Chile, Cuba, El Salvador, Guyana, Jamaica and Venezuela.

2. Achieve universal primary education. MDG reports indicate the following countries as having little to no progress: Uruguay, Argentina, Bolivia, Brazil, Ecuador, El Salvador, Haiti, Honduras, Nicaragua, Panama, Paraguay and Venezuela. The following countries are characterized as “achieved” or having “fast progress”: Cuba, Belize, Chile, Colombia, Costa Rica, Dominican Republic, Guatemala, Guyana, Jamaica, Mexico and Peru.

3. Promote gender equality and empower women. MDG reports indicate the following countries as having little to no progress: Uruguay, Bolivia, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Panama, Peru and Venezuela. The following countries are characterized as “achieved” or having “fast progress”: Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Mexico, Nicaragua and Paraguay.

4. Reduce child mortality. MDG reports indicate the following countries as having little to no progress: Belize, Bolivia, Chile, Colombia, Haiti, Honduras, Jamaica, Panama, Paraguay, Uruguay and Venezuela. The following countries are characterized as having “fast progress”: Argentina, Brazil, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Mexico, Nicaragua and Peru.
5. Improve maternal health. MDG reports indicate the following countries as having no progress: Haiti, Panama, Paraguay, Uruguay and Venezuela. The following countries are characterized as having “fast progress”: Argentina, Belize, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala and Guyana.

6. Combat diseases. MDG reports indicate the following countries as having no progress: Bolivia, Guyana, Honduras and Panama. The following countries are characterized as “achieved” or having “fast progress”: Argentina, Chile, Colombia, Cuba, Dominican Republic, Guatemala, Haiti, Peru and Venezuela.

7. Ensure environmental sustainability. MDG reports indicate Haiti has gotten worse, characterized as “reversal” in progress, while the following countries have little to no progress: Dominican Republic, Guatemala, Ecuador, Guyana, Jamaica, Nicaragua, Panama, Paraguay, Peru and Uruguay. The following countries are characterized as “achieved” or having “fast progress”: Argentina, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, El Salvador, Honduras, Mexico and Venezuela.

The eighth goal in the MDG’s is to create a global partnership for development. One of the significant measures of health inequality, which is part of the MDGs, is gender inequality of health and healthcare. Women face the most health problems with issues of violence, reproductive health, occupational and environmental hazards, osteoporosis, and breast cancer [7]. It is estimated that 70,000 women die unnecessarily from illegal abortions and every year, four million women in Latin America have an illegal abortion [8]. Disease, whether chronic or infectious, is another significant measure of health inequality. A 2001 report indicated that of the entire LAC region’s population, 716 thousand died of CIDs and 2,187 died of CDs. Sanitation and access to water is another major indicator of health for a country, which was also included in the United Nation’s MDGs. Progress for this area based on MDG data brings the LAC region coverage of sanitation from 68% in 1990 to 79% in 2006. “Unfortunately, the urban and rural disparities of drinking water use are extreme in LAC countries. For example, the coverage in rural areas is 50% to 75% in Bolivia and Brazil, whereas it is 76% to 90% in Cuba.” [9]. Nutrition, IMR and MMR are among the indicators used to determine the progress of a few of the MDGs. Chronic under nutrition, which stunts growth, and nutrient deficiency are significant issues in the LAC region [10]. On the other hand, obesity is becoming a major problem in the LAC region. According to PAHO, the frequency of overweight
children in 2002 was 25-30%. Gender inequality plays a role here as well because women who stay at home are less likely to be involved in physical activity. The IMR in the LAC region has decreased steadily by 4% in the last decade [11]. MMR was 130 out of 100,000 live births in 2005, which is a significant improvement from estimates in 1990 [12].

National Health Inequalities

1. Historical perspective of Venezuela’s Healthcare System

The current Venezuelan healthcare system began to take shape in 1999. Hugo Chavez, the newly elected Venezuelan President, boasted sweeping health care changes during his campaign and soon implemented a socialized approach to the Venezuelan healthcare system after his election. [13] After winning the Presidential election, Chavez began writing a new Constitution for Venezuela. In writing a new constitution for Venezuela, Chavez created a new framework for public health care. In effect, the new system provided healthcare for all Venezuelan citizens regardless of their socio-economic status or age. The new universal nature of Venezuelan healthcare was a direct result of the economic turmoil Venezuela encountered due to its crumbling oil prices and increases of privatization of public welfare programs (such as healthcare) during previous presidencies. Instead of the Venezuelan government being the primary financier for Venezuelan healthcare though, citizens of the state fund the system by paying taxes. [14] Thus, Venezuelan healthcare became viewed as decentralized and as locales and community members funded its progression while providing meaningful insight as to the direction healthcare should take- the Venezuelan government is not solely responsible for the overall health of its people. [14] As a result, healthcare in Venezuela takes the form of socialized medicine where all citizens benefit from its usage and publically funded institutions.

Prior to the current public healthcare approach, Venezuela practiced primary and selective healthcare coverage. According to one research article, “In the 1960’s and 1970’s, China, Tanzania, Sudan and Venezuela initiated successful programs to deliver a basic but comprehensive program of primary health care services covering rural populations.”[15] Then, in 1978, the Alma Ata Declaration was adopted by the World Health Organization and allowed for primary health care to become completely widespread throughout Latin America. However, this eventually caused a problem within Venezuela’s healthcare system, as not many people could afford primary health care and its benefits. Venezuela’s primary export, oil, began to decrease as a
source of revenue and the majority of Venezuelan people could not purchase healthcare plans. Then, "selective primary health care" was born. It offered Venezuela a chance to obtain selective coverage under the advice of medical experts. Such experts advocated the juxtaposition of internationally recognized programs like controls on population growth, oral rehydration methods, national vaccinations and immunizations, breast-feeding programs, and ways to reduce child mortality. [15] However, the primary and selective healthcare methods proved to be inefficient and a burden to Venezuela's poor and or socio-economically indigent. Thus, as the previous paragraph described, a socialized approach to universal healthcare under Hugo Chavez’s Presidency became enacted into law.

2. Epidemiologic Transition in Venezuela

While the burden of communicable diseases in Venezuela remains relatively high due to various factors such as poor healthcare in rural areas (Business Monitor International, 2009), the country has been experiencing an epidemiologic transition standard to much of the world. The country's mortality rates due to chronic diseases have surpassed those due to communicable diseases, and will continue to grow with time. Venezuela's rising burden of non-communicable diseases in the country can be attributed to lifestyle changes such as urbanization and a workforce that has shifted more towards office-based employment [16].

As shown in Figure 1, between 1995 and 2000, estimated mortality rates due to circulatory diseases were nearly three times higher than those due to communicable diseases in both males and females. Additionally, the Business Monitor International (2009) estimated that in 2008, “non-communicable diseases accounted for 79.9% of disability-adjusted life years (DALYs) lost to all diseases and injuries in Venezuela” (para. 1). These numbers will continue to rise, with DALYs lost to non-communicable diseases expected to grow by 20.6 percent by the year 2030 (See Figure 2). That source has also indicated that “The country's ageing population will contribute significantly to the growth in the non-communicable diseases burden as the number of people over 60 years old is forecast to grow three-fold over the next 25 years” [17].
Health programs will likely continue to reduce the problem of communicable diseases in coming years, however many health-related challenges will remain for Venezuela. Steadily increasing rates of circulatory diseases, cancer, and other non-communicable diseases will need to be a key focus of the country’s healthcare system.

3. Domestic health inequalities in Venezuela

Despite the implementation of health programs such as Barrio Adentro, which have greatly reduced health inequalities in Venezuela, the country is not without its disparities. Most of the focus of such programs has been on urban areas, neglecting the more impoverished rural parts of the
country, allowing a great deal of inequality to remain. One example of a disparity is the use of improved drinking-water sources and improved sanitation facilities.

Water sanitation and quality are important aspects of a population’s health, as a lack of either can contribute to a variety of diseases and illnesses, and “the risk of infant mortality is definitely higher when there is not basic sanitation, and safe drinking water” (Roche, 2007, p.11). Data distributed by the World Health Organization (2012) shows that in 2005, 94 percent of Venezuela’s urban population was using improved drinking-water sources and improved sanitation facilities, while the rural areas showed only 75 percent of the population using improved drinking-water sources, and a significantly lower 57 percent using improved sanitation facilities (See Table 1). The difference in the percent of the populations using improved drinking-water sources is itself a revealing number, but the 34 percent difference in the use of improved sanitation facilities indicates a substantial disparity in the equality between urban and rural areas of Venezuela. These figures suggest that the overall health of the rural population is likely inferior to that of the urban populations.

<table>
<thead>
<tr>
<th>Location</th>
<th>Time Period</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
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<td>93</td>
<td>71</td>
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<td>89</td>
<td>45</td>
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</tr>
</tbody>
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Table 1. Urban and Rural Populations Using Improved Drinking-Water Sources and Sanitation Facilities [19]


In addition to the illnesses and overall health problems that these disparities can cause for a population, inequalities between rural and urban areas frequently have a devastating effect on children. According to a report released by the United Nations Children’s Fund (2012), “Investment in hygiene promotion, sanitation and water services is also among the most cost-effective ways of reducing child mortality” (p.58). So along with other risk factors, a lack of quality water and sanitation can contribute to increased mortality rates, causing rural areas to suffer greater burdens of infant mortality (IMR). Figure 3 illustrates the differing IMR’s between several states. The graph also includes the subpopulation attribute of housing adequacy, but for the purpose of domestic inequalities, the graph can demonstrate that rural, less dense, regions endure higher rates of infant
mortality than urban regions. The graph shows that the two Venezuelan states of Distrito Capital and Miranda, which are the country’s most dense and populated states (Instituto Nacional de Estadística, 2011), face significantly lower infant mortality with a rate below 20 deaths per 1,000 births, while those states with more rural populations suffer rates above 30 deaths per 1,000 births. In fact, the rural Amazonas state has an infant mortality rate of nearly 40 deaths per 1,000 births (See Figure 3).

![Figure 3](http://www.cisor.org.ve/fotos/file/Roche07.pdf)

It is evident that the rural regions of Venezuela suffer greatly from health inequalities in the nation. Rural Poverty Portal (n.d.) has stated that, “although the Bolivarian Republic of Venezuela is one of the most highly urbanized countries in Latin America, poverty in the country has a prevalently rural dimension” (para. 2). The combination of poverty and health programs that may neglect the rural population, work together and allow such disparities to perpetuate in Venezuela. The country will need to focus on those populations in order to reduce disparities such as those involving drinking-water and sanitation or infant mortality rates.

4. **Subpopulation Health Inequalities in Venezuela**

It is estimated that there are over 400,000 indigenous peoples in Venezuela that represent about 2% of the total country population [22]. These people make up 32 indigenous communities, 19 of which are located in the Amazon [23]. In the last census report by the Pan American Health Organization in 1992, over half of these communities lacked access to safe, reliable drinking water
or sanitation. These groups disproportionately suffer morbidity mainly from tuberculosis, malaria, malnutrition, diarrhea as well as parasitic and respiratory diseases [24].

Venezuela, along with other governments representing the indigenous tribes of Amazonia, finds that providing social and healthcare services to these subgroups are a challenge. This is not only due to the remote locations of the groups but also due to the differences in cultural views and beliefs towards medicine. To combat these issues, the Venezuelan government has enacted legislation to guarantee human rights to all indigenous people in its constitution and kick-started social and health initiatives. Mission Guaicaipuro is a program initiated in 2003 by Chavez as part of a series of socioeconomic programs to restore rights to Venezuela’s indigenous peoples [25]. Venezuela also enacted a requirement that all new physicians complete a rural service obligation [23]. In addition, the 2002 constitution aims at bridging a cultural gap by recognizing “indigenous patients’ right to culturally appropriate treatment and establishes doctors’ duties to take local beliefs and cultural norms into account” [23]. The Venezuela Ministry of Health has also started an electronic database to record, track and assess the needs of the indigenous Amazonian communities [23].

One group that has been particularly affected is the Yanomami, an indigenous tribe in Southern Venezuela. They have lost a majority of their population to diseases introduced by miners entering their land in last few decades. This group has the highest known infant mortality rate for all of Venezuela with 76 to 250 deaths per 1000 births [26]. The Pan American Health Organization cites such wide disparities a result of “environmental degradation and contamination of the ecosystems in which indigenous communities have traditionally lived, loss of land and territory, and a decline in abundance or accessibility of traditional food sources…” [26]. Social and health services are absent in this area so hundreds of people have gone into Brazil in search of medical care [28].

5. **Venezuela’s response to its health inequalities**

Part of President Hugo Chavez’s new Venezuelan Constitution was to implement a more socialized or universal healthcare system and set up a “Barrio Adentro” approach. [29] Barrio Adentro in the English translation means, “Inside the Neighborhood.”[29] Soon after implementation, thousands of small medical buildings were built for local communities which allowed for any citizen, wealthy or poor, to be evaluated by a professional medical physician and be treated for any ailments. The success of Barrio Adentro in responding to Venezuelan health
inequities is quite astounding. According to one article, “During the first five years of existence, Barrio Adentro has improved access and utilization of health services by reaching approximately 17 million impoverished and middle-class citizens all over Venezuela.”[29] Barrio Adentro is a comprehensive strategy that provides publically funded healthcare, dental care, and overall wellness to Venezuelan citizens. The program has gained immense support in not only Venezuela but surrounding countries as well. A 2012 news article from “Venezuelanalysis.com” mentions how Barrio Adentro is “…changing the world’s conception of health care.”[30] Barrio Adentro has been extremely popular with the people in Venezuela and, for good reason. Venezuelans previously had limited access to primary and selective healthcare due to economic concerns. As well, their former Constitution’s negligence for their overall well-being did not provide adequate provisions for the benefit of Venezuelans. Hugo Chavez’s recognition of such inequities has essentially eradicated the formerly deteriorating healthcare system for Venezuela. It essentially replaced it with one providing adequate healthcare coverage and an equitable approach for all Venezuelans in need of medical attention. Now, Barrio Adentro is becoming increasingly popular and may soon serve as a model for other countries to follow. In fact, a 2009 journal article stipulates, “…we suggest that Barrio Adentro not only provides a model for health care reform in other countries in the region, but also offers important lessons for other countries in the world, including those with most powerful economies.”[29] To conclude, the success and positive impacts that the Barrio Adentro methodology capitulates has helped the Venezuelan population respond very well to combat their former health inequities. Without the response from President Hugo Chavez and the Venezuelan population, the former health inequities may have never been controlled.
References


[8] Illegal abortions 'killing South American women'. *BBC News*. (n.d.)


http://www.healthofnations.com/countries/profile/venezuela


