

Introduction

MY FIRST EXPOSURE TO VENEZUELAN HEALTH CARE was a dance party in a high school courtyard. Old people grooved to salsa music blaring from a boom box. They passed around pieces of homemade cake and juice spiked with whiskey. Little boys kicked a *fútbol* while the girls took turns riding rusty mountain bikes. They cruised around the rutted concrete, shrieking and skidding to avoid collisions. A contact brought me to the party for my research, but I had no idea why.

I came to Venezuela to study a government health program called Barrio Adentro (Inside the Barrio).¹ Barrio Adentro was a cornerstone of the leftist government of Hugo Chávez that aimed to reverse decades of unequal access to health care by focusing on the poorest and most underserved communities. The ambitious project employed thousands of Cuban doctors to work in neighborhood clinics. As a medical anthropologist I was intrigued by this investment in free and universal access to health care. It flew in the face of global trends in which governments offloaded responsibilities for health care to private companies, nongovernmental organizations, and individuals. No other country was attempting something like Barrio Adentro. This was a historic moment when people experienced a radical transformation in their health care. More than a change in medical institutions, health care under Chávez made disenfranchised people feel valued and empowered by the government. Although Venezuelans' lives have changed dramatically since this period, this book remains a unique account of how poor people experienced this radical social and political change.

This first day of fieldwork demonstrated that studying government health care would mean observing more than what happened inside clinics. At the school that day I met Lilian, a woman with a mane of bleached hair who



FIGURE 1. Grandparents Club practicing *bailoterapia* in a public school courtyard, 2006. Photo by the author.

presided over the festivities.² Lilian's red shirt and cargo vest identified her as a government worker, providing the first clue that what I was observing was not just a party. I explained my desire to research Venezuelan health care, hoping Lilian would inform me about new clinics in the neighborhood. Instead she nodded to confirm I was in the right place, waved her arms around the courtyard, and yelled, "Yes! Yes! Look around, all of this is therapy!"

Only after talking to Darwin, a Cuban sports trainer who welcomed me with a hug and a homemade cocktail, did I learn that the partygoers belonged to a Grandparents Club (Club de Abuelos), a Barrio Adentro program to promote community health. The Venezuelan government employed him to lead dance therapy (*bailoterapia*) classes to help with high blood pressure, heart disease, and other medical concerns (fig. 1). The club was celebrating its members' June birthdays, which explained the refreshments, though subsequent research revealed that *bailoterapia* classes were dependably playful (they just had less cake).

Because people were having so much fun, at first I could not believe this was a government health program. As Darwin led the older adults in a series of vigorous dance moves, some ignored his cues and danced to their own beat. Dancers reached out to people on the sidelines and called out, "¡Baila! ¡Suda!" (Dance! Sweat!). Old women pulled me into their row, demanding that I exercise with them. People laughed and cheered, growing breathless

with exertion. When an unexpected downpour began, nobody missed a beat. We hurried up the stairs to a covered stage and continued dancing.

The pleasure that people took in government-sponsored *bailoterapia* classes exceeded the gratification we might expect when feeling our bodies becoming stronger. Grandparents Clubs were fun for their own sake. People took joy in dancing and group outings to the beach. Before Barrio Adentro, they said, nothing like this existed for older adults: a safe public space for socializing and exercising. Some people expressed satisfaction that the government was taking older people's well-being into account after what they perceived as decades of neglect. Knowing that the clubs were government sponsored produced its own kind of pleasure.

When I began research in Venezuela I did not expect to observe people taking pleasure in health care. I definitely did not anticipate writing an entire book about the pleasures of government medicine. Yet as I accumulated field notes and interviews, I was forced to acknowledge that joy, excitement, and satisfaction were central to people's experiences of Barrio Adentro and other government health programs. Participants expressed pleasure even in medical encounters with their doctors, in clinical sites that we typically do not associate with such a feeling.

One example of this is Teresa's story. Teresa was a retired secretary and longtime Santa Teresa resident who experienced encounters with Barrio Adentro doctors as a source of gratification. Teresa seemed proud of her strong constitution and self-reliance, even at the age of eighty-seven. Her petite frame belied an outsized personality that she expressed in impassioned, often belligerent discussions on topics such as the lack of manners among Venezuelan youth and proper fitness regimes for aging adults. Teresa volunteered family remedies for herbal and plant medicine but insisted that she never got sick. She openly scorned pharmaceuticals, saying she did not trust them and did not want their "toxins" inside her body.

Yet by her own admission, Teresa badly needed medical care. She had suffered knee pain for eleven years because she had no money to pay private practice physicians and did not have health insurance through her former employer, where the injury occurred. Teresa also was developing blurred vision. She learned about Barrio Adentro in 2003 from a stranger who noticed her struggling to descend a staircase. At the clinic a Cuban doctor diagnosed her cataracts and referred her for two Venezuelan state-funded trips to Havana for treatment, in which two hundred other Venezuelans participated. The surgeries included airfare, accommodation, and meals for

three weeks. Teresa relished her memories of the food, gift bags, and toiletries she received, calling the experience, “Beautiful, totally beautiful!”

A spry yoga aficionado, Teresa was convinced she was right about most things and rarely expressed approval of other people’s behavior. She commonly attacked medical professionals she had met in the past for being rude and uncaring. Teresa reserved her rare praise for Barrio Adentro doctors. In field notes recorded after one of my first encounters with Teresa, I wrote:

“[The Cuban doctors] are very good,” she told me. “They will treat you well, spend time with you, and look you in the eyes. . . . The Venezuelan doctors here are not good. They will never look at you, and they only spend two or three minutes with you.” About two years ago she was seeing a doctor, and he was writing down what she said without looking at her, and she confronted him about it.

Teresa explained that doctors in Venezuela often treated poor patients with disdain, but Barrio Adentro doctors (whether Cuban or Venezuelan) treated them with compassion and solidarity. I followed Teresa for a year as her knee was treated in government clinics. She strategized her use of medical sites to get fast and personalized care at each stage of the process. She questioned neighbors and local doctors to find the closest Barrio Adentro diagnostic center that would provide same-day radiology services. After suspecting a hospital doctor of corruption because he told her she had to pay for testing before he could provide a diagnosis, she found another doctor she viewed as more trustworthy at a different government clinic.

A few months after surgery Teresa sought me out and reported she had completed thirty of forty prescribed physical therapy sessions at a Barrio Adentro rehabilitation clinic, demonstrating her progress with some energetic kicks. The eighty-seven-year-old grandmother urged me to acknowledge the intensity and height of her kicks, which she said were all due to the Barrio Adentro doctors. For Teresa, engagements with state medical services were pleasant, vital experiences. She seemed to enjoy the long process of optimizing her body and health. She felt she was receiving the kind of care she deserved.

Teresa understood these experiences of patienthood as politically meaningful. In her memoirs, which she was writing when I met her in 2008, she recorded:

Thank God! Thanks to President Hugo Chávez, for having consolidated and strengthened Barrio Adentro with all the missions that comprise it. . . .

Doctor Ana Martinez, Orthopedic Surgeon, from the “new generation” of doctors, operated on me, and God grant her long life, energy, and love so that

she can continue working for the poor. She knows how to treat patients with care and respect, and these are the things that every patient needs and yearns for in those critical moments.

Finally, the suffering in my knee has disappeared! . . . Do you know how much this kind of surgical intervention costs? From eleven to twelve million bolívares [approx. US\$5,200].³ How much did it cost me? Absolutely nothing. They did exams, MRIs, bone density tests, X-rays, electrocardiograms, etc., etc. All for free! I did not spend a single bolívar.

Teresa's astonishment that a government might care about her knee exemplifies a pattern of enthusiasm that my interlocutors expressed about Barrio Adentro. Teresa celebrated access to medical services she could not gain access to in the past. She took pleasure in encounters with government doctors and government medical care that exceeded their therapeutic results. Her memoirs commented on the significance of being taken seriously by the state. Teresa was free from the pain in her knee, but she was also excited because the government was treating her (and people like her—"the poor") as deserving of compassionate medical care.

Health care was a deeply political issue for poor Venezuelans who, like Teresa, had long lacked reliable access to adequate biomedical care. Biomedicine refers to what many in the United States simply call "medicine," which is rooted in biology and physiology. Biomedical professionals like doctors and nurses focus on curing diseases by means of technical interventions. I sometimes use the term "biomedicine" to clarify what I mean because many medical traditions coexist in Venezuela. Teresa and other poor people might not have had access to biomedicine, but they relied on a variety of other healing practices and specialists.⁴

Historically, Venezuelan society was divided along stark class lines. Vast income inequalities meant that while a small elite enjoyed access to high-quality private biomedical clinics whenever they needed them, the majority poor and working classes often suffered long lines, indifferent doctors, and inaccessible treatments from an overstretched network of public hospitals. This dynamic began changing at a moment of significant political upheaval in 1998 when Hugo Chávez won successive national elections by emphasizing the injustice of socioeconomic inequalities and promising to redistribute national wealth. Never before had a radical, pro-poor, leftist president been elected to power. He promised to empower historically disempowered groups—the poor, indigenous people, women, Afro-Venezuelans—exciting people who felt excluded from formal politics. Chávez spoke directly to these

people and promised them a greater role in determining their quality of life and the shape of their government. Barrio Adentro was a big part of the government's promised changes, the idea being to revolutionize health care by making biomedicine community based and universally accessible.

Stories like Teresa's provide insight into how people in Venezuela responded to health care during a high point of government investment in health and suggest that the new programs differed in meaningful ways from preexisting medical services. But as stand-alone stories, they do not explain why pleasure, satisfaction, and excitement were common responses to Chávez-era government health programs. Analyzing these stories systematically in cross-cultural and historical context reveals how ordinary people like Teresa experienced periods of momentous political change. These kinds of responses are not commonly reported in research on people's experiences of health care in Latin America.

PLEASURE IN MEDICINE

Decades of research on how people experience government health care in Latin America show that poor and working-class people, particularly women and indigenous people, often experience humiliation, dehumanization, and disrespect when seeking government medical services.⁵ This research argues that engaging with state health care reinforces the marginalization of already vulnerable groups in Latin America.⁶ In 1990s Venezuela, Charles Briggs, an anthropologist, and Clara Mantini-Briggs, a physician, observed government officials and the media blaming indigenous people for a deadly cholera outbreak that had in fact been caused by failures in the public health system. Briggs and Mantini-Briggs explain that marginalized groups in Venezuela were victims of medical profiling, which they defined as "differences in the distribution of medical services and the way individuals are treated based on their race, class, gender, or sexuality."⁷ These Venezuelans were viewed as "unsanitary subjects" unworthy of access to health care.⁸ The anthropologist Rebecca Martinez also documented dehumanizing and unequal treatment among poor Venezuelans, this time among women with cervical cancer in a public hospital in the 1990s. Many consultations lasted less than two minutes, and doctors often failed to speak directly to patients. Doctors did not explain upcoming cancer surgeries or even cancer diagnoses because, as they told Martinez, they figured working-class and poor patients possessed a "low

cultural level” that made them unable to process the information.⁹ These examples from Venezuela reflect a broader trend: a history of medical anthropology research in Latin America that depicts engagement with government health care by poor people as something to be avoided, not embraced.¹⁰ Unequal access to health care and indifferent, even dehumanizing treatment by medical professionals is widespread in the region, and something that my Caraqueño research participants confirmed was true for them in the past.

Rather than take this pattern for granted, we should ask why anthropologists of Latin America rarely describe government health care as pleasurable or empowering.¹¹ It seems true that as the examples above suggest, government medicine in the region often entails dehumanizing and unpleasant treatment. Experiencing displeasure and disempowerment in medical encounters seems especially likely when patients are women, indigenous, and poor or working class. At the same time, it is possible that people have positive encounters with government medicine that we have not documented as thoroughly. Twenty years ago the anthropologist Judith Farquhar criticized the field of medical anthropology for failing to pay attention to the positive aspects of health care. Her description still characterizes the field on the whole.

Reading medical anthropology could easily convince one that medicine everywhere is a pretty grim and ghoulish business. Healing technologies of all kinds seem invariably to address suffering and death, and the apparently universal power relation of “doctor and patient” casts the victim of disease as also a victim of social inequality or of structuring cultural models. . . . I take a slightly different tack, . . . to propose that medical practice might at times be a source not just of domination but of empowerment, not just of symptom relief but of significant pleasure.¹²

A tendency to focus on disempowerment in biomedical encounters reflects a broader trend in cultural anthropology of studying suffering, oppression, and inequality. In 2016 the anthropologist Sherry Ortner declared that the main trend in anthropological research since the 1980s was “dark anthropology,” which she defines as “anthropology focused on the harsh dimensions of social life (power, domination, inequality, and oppression) as well as on the subjective experience of these dimensions in the form of depression and hopelessness.”¹³ Anthropologists have focused on the negative aspects of social life but not because we are all gloomy pessimists. Rather, we have tried to describe the global reality of economic precarity and rising inequalities that seem to increasingly threaten people’s ways of life. This

research is important because it demonstrates that in spite of cultural differences, people around the world struggle with systemic forms of economic exploitation and oppression.¹⁴

At the same time, to understand the world in which we live we need detailed research on pleasure, the good life, well-being, happiness, resistance, and empowerment—especially in contexts of historical disempowerment. Focusing on positive as well as negative responses to medical care, for example, can clarify the effects of health policies and government regimes that claim to improve people's lives. Though uncommon, ethnographies that address the pleasurable aspects of health care explore a wide range of experiences, suggesting that pleasure in medicine is widespread and more meaningful than previously assumed. For example, in analyzing the pleasures of recreational and prescription drug use, Kane Race questions the way a moral injunction against taking drugs for pleasure supports an artificial boundary between licit and illicit drug use (we only have to think about Viagra to see the absurdity of strict divisions between recreational and therapeutic drugs).¹⁵ Some scholars discuss the ambivalent status of medications such as Ritalin and Adderall that produce feelings of pleasure in the body while treating a therapeutic need.¹⁶ Others have examined how medicalized spas and medical tourism blur culturally constructed boundaries between "healing" and "holiday."¹⁷ This research shows that medicine and pleasure are connected in spite of cultural assumptions that they cannot—or should not—coexist. In such cases, therapies that clearly elicit pleasure for users might come under attack or gain an ambiguous standing. In other cases, anthropologists have documented how reproductive technologies, specifically, fetal ultrasounds, can be fun and exciting for parents who delight in seeing their baby and anticipate sharing the scan with others.¹⁸ Farquhar has written about how "eating" traditional Chinese medicine serves as a source of pleasure in its own right.¹⁹ Farquhar and Qicheng Zhang examined how Chinese health promotion practices known as the "life cultivation arts" provide social and political satisfaction for elderly Beijingers who can no longer look to the state for health care.²⁰ Other ethnographic works documenting pleasure in medicine include studies of compassionate interactions with nutrition consultants in Guatemala and private practice IVF doctors in Ecuador, as well as community health workers attempting mosquito control in Nicaragua.²¹ If we were to consider healing arts such as yoga and rituals such as ayahuasca ceremonies, we would see more evidence of people taking pleasure in health seeking.

I propose making pleasure an explicit focus of analysis in medical anthropology. Many forms of medicine elicit pleasure, and documenting these would help us understand how people experience medicine in affective terms. We do not know what we will learn by theorizing about the pleasurable aspects of medicine. Using ethnography to explore what brings people pleasure, we may attain a better understanding of how culture and history shape desires for certain material goods, relationships, and experiences. We may be better able to offer comparative accounts of how people imagine and strive to achieve well-being according to distinct cultural logics. My research found that certain political moments give medicine an outsized significance in society, and studying people's experiences of medicine in these contexts provides unique insights into how people experience radical social change more broadly.

Specifically, I propose focusing on pleasure beyond the positive feelings associated with health care's therapeutic effects. We have all experienced pleasure when a treatment worked as promised: when headache tablets provide relief, surgeries improve bodily function, or physical therapy restores mobility. We are pleased when a doctor resolves problems that trouble us or when a medical encounter boosts our sense of well-being. But medicine also produces positive effects unrelated to the therapy received. We could call these feelings the "surplus effects" of treatment.²² Medicine can evoke a sense of social support, care, and compassion, activate a sense of class mobility, and mark historical improvements in quality of life. In Venezuela under Chávez, government health care affirmed poor people as valued members of society by making it clear that their lives mattered.

Paying more attention to the positive aspects of medicine can revolutionize our understanding of how health care gives meaning to people's lives. In this book I take seriously poor and working-class people's narratives about government health care as a source of pleasure and satisfaction. Many of my interlocutors were not only members of historically marginalized communities, but agents who were actively engaged in forging better lives for themselves. Unraveling the reasons medicine served as a source of pleasure for certain Venezuelans at a particular point in history, this book shows that government health care addressed political and social inequalities by making people feel valued. Theorizing pleasure in this context revealed that people appreciated government medicine as a therapeutic tool and as a technology of social justice.

Defining Pleasure

I use the term “pleasure” because it describes people’s experiences of government health care better than terms like “happiness” or “well-being.”²³ All of these concepts refer to experiences or states of being that are deeply dependent on cultural meanings: what produces pleasure, what counts as happiness, and how people assess well-being vary across cultures and historical time. Yet while happiness and well-being reflect states of being based on a holistic assessment of one’s life, pleasure typically describes responses to discrete, time-limited experiences such as eating a meal, having sex, enjoying an artistic performance, taking a mood-altering drug, or undergoing a religious ritual. And while happiness, well-being, and pleasure all develop in relation to external circumstances, only pleasure refers specifically to an embodied experience of the material world. In this book I focus on the types of pleasure people take in tangible embodied activities related to government health care, things like dancing in a public plaza, hearing a kind word from a government doctor, and filing paperwork to help a neighbor obtain a medical device. These kinds of activities elicited pleasure from participants that was culturally and historically meaningful.

We can observe people enjoying medical encounters in a number of health care settings globally—likely for a variety of reasons—but pleasure in the Barrio Adentro program pointed to important and specific meanings. Venezuelan government health care elicited pleasure among poor and working-class Venezuelans for three distinct reasons. First, increased access to medical services produced material improvements in their biophysical health. This was the most straightforward and expected outcome I observed. Of the hundreds of patients I met, the vast majority volunteered reports of improved physical health that they attributed to expanded government health care. Pragmatically this is what we hope for from health reform: better access to care and improved health as a result. Alongside expressions of pleasure about improved access to medicine, however, I also observed complaints that reforms were incomplete and inconsistent. The same people who praised the new system often called for it to expand and improve. That people hoped for and aspired to even more government health care does not negate the material impact of Barrio Adentro or the positive response it elicited.

Second, government health care produced sensual and social pleasures. Examples of sensual pleasure include treatments that improved one’s bodily experience of the world. Patients described caring government doctors who,

unlike doctors they had encountered before, looked them in the eyes, joked and used pet names with them, and offered compassionate touches or hugs. For many, this kind of care held sensorial and social meaning; patients seemed to cherish doctors who practiced personalized, intimate clinical interactions. Grandparents Club members took pleasure in the exertion, sweating, socializing, and fun of dance therapy classes and field trips. People who became community health workers in Barrio Adentro displayed high spirits when collaborating on a door-to-door census or developing friendships with each other in a government training session. Participating in government health care had positively valued effects on the body and sociality that exceeded the biophysical improvements brought about by medical services. These effects seemed to be valued for their own sake.

The third source of pleasure was political. Patients and health activists expected health programs to do more than cure disease: they saw participation as a means to sociopolitical empowerment. In spite of their problems, government health projects elicited excitement and pleasure because they identified marginalized Venezuelans as bodies that mattered. This finding forms the heart of this book. While any Venezuelan might enjoy experiences of improved biophysical health or the sensual and social pleasures of exercise, only the disenfranchised found government medicine politically empowering. This book aims to explain the meanings of medicine from the vantage point of historically disempowered Venezuelans in particular—poor people, people of color, and women, among others. These groups make up the vast majority of Venezuela's population, which is why this story is so important. If we want to understand how ordinary Venezuelans experienced the Chávez government during this period, we should look at their experiences of Chávez-era health care.

Historically, only certain social groups enjoyed dependable access to biomedical care in Venezuela. Because social inequalities mapped onto unequal access to health care, access to decent biomedicine was associated with wealth, power, privilege, and participation in the formal economy (the latter because only certain kinds of work allowed access to Social Security medical services). My interlocutors took pleasure in the fact that “people like them” (i.e., members of the poor and working classes) could enjoy more reliable access to medical care through Barrio Adentro. Improved access to health care marked increasing social equality. This fact pleased and gratified people from marginalized backgrounds.

Prioritizing community health also meant establishing government clinics in marginalized neighborhoods, which helped resignify those neighborhoods

in positively valued ways. Patients felt that clinics identified historically stigmatized barrios and the people living there as worthy of the state's care while publicly resignifying neighborhoods as capable of promoting health rather than endangering lives through violent crime and lack of services.

Tens of thousands (possibly hundreds of thousands) of Venezuelans participated in community health work for the Barrio Adentro mission. Participation offered volunteers opportunities to help other people and revitalize their communities, both highly valued forms of activism. Being a health promoter evoked pleasure and feelings of satisfaction among people who felt they were heeding the Chávez government's call to play a role in revolutionary democratic political processes. This was the pleasure of belonging to a movement bigger than oneself, being caught up in a revolutionary moment symbolic of broad social changes.

For nearly a century, the Venezuelan state had presented itself as a "magical state"²⁴ that redistributed the nation's oil wealth in the form of development projects for the benefit of all citizens. Political leaders framed citizenship as the shared ownership of oil wealth and cultivated expectations for a wealthy state that would provide for its people. Yet for most poor people and particularly during the 1980s and 1990s, when neoliberal policies were in place, the government failed to live up to its promises. During the heyday of Chávez-era government spending when Barrio Adentro was rapidly expanding, patients felt their concerns were being taken into account not just by medical professionals, but by the state itself, interrupting a history of marginalization with practices that reflected inclusion and belonging.²⁵

Culture and history shape many of the pleasures I identify. A Venezuelan mother might express a strong sense of gratification at receiving free medication for her children due to a history of past deprivations, while somebody who has had access to free health care her entire life might not feel or express gratification for the same benefit. Expressions of pleasure in government health care also reflected the broader political climate of Venezuela at the time. The country was politically divided between people who saw value in Chávez's vision of socialism, which meant empowering the historically disenfranchised majority, and people who did not see value in this vision. People who expressed pleasure in specific aspects of government health programs were often expressing their approval of the government itself (the reverse was often true). If you learned how to read them, expressions of pleasure in health care communicated claims about the rights of citizenship and gratification at being taken into account.

Analyzing why people found health care a source of pleasure challenges reductionistic analyses that assume health care's sole purpose is to address biophysical health concerns. In the case of Barrio Adentro, expressions of pleasure serve as a key to understanding broader cultural, social, and political desires and aspirations among a majority of Venezuelans. Certain aspects of health care beyond medicine prompted pleasure and activated a sense of political belonging. With Barrio Adentro, the location of clinics, how doctors behaved, the freedom to integrate new health programs into existing practices, and participating in community revitalization all produced a meaningful experience of social and political change.

OIL AND EXPECTATIONS IN VENEZUELA

In order to understand why the Barrio Adentro program was pleasurable and politically significant we must understand Venezuela's history, especially how oil wealth shaped people's expectations of their government. A long-standing promise by state officials to share the nation's oil wealth established the notion of a Venezuelan birthright that persisted throughout the twentieth century in spite of numerous government failures to use that wealth for the benefit of the people. While enthusiasm for Barrio Adentro reflected a historical hunger for health care, it also reflected a long history of expecting and desiring state services funded by oil wealth that was perceived as the rightful inheritance of all Venezuelans.

Expectations of Citizenship

Venezuela possesses the largest oil reserves in the world, with nearly 300 billion barrels of proven reserves. It would be hard to overstate the impact of this vast source of wealth on economic, political, and social relations over the past hundred years.²⁶ Politically, oil defined Venezuelan society by allowing successive generations of politicians to promote a model of citizenship in which national belonging meant enjoying a share of the nation's wealth.²⁷

Starting in the 1930s, politicians framed state investment in infrastructure, agriculture, and other economic and social projects as distributing the country's oil wealth to the people. They coined the phrase "sowing the oil" (*sembrando el petróleo*), denoting a political commitment by the state to extract the nation's wealth and distribute it to the population by means of economic and

social development projects. These distinctively Venezuelan ideas of citizenship shaped what people came to expect from the government.

For almost fifty years the Venezuelan state rolled out economic and social development projects bankrolled by oil profits. State interventions to promote social welfare during this period included price controls for basic goods, minimum wage laws, and subsidies for gasoline, public transportation, and utilities. In the field of health care, “sowing the oil” entailed national immunization campaigns and expanding the public hospital system and local medical centers. These initiatives led to notable gains in people’s quality of life, measurable as a steadily falling infant mortality rate, a higher life expectancy, and the eradication of diseases.²⁸ With oil profits flowing, Venezuela enjoyed the highest per capita income in Latin America. This marked wealth, in addition to an uninterrupted period of democratic rule from 1958 on, led many scholars to argue for what became known as “Venezuelan exceptionalism” in Latin America.²⁹ Encouraged by state promises and government interventions, many Venezuelans felt entitled to continued improvements in their living conditions.

Persistent Inequalities

Dazzling wealth and narratives of progress helped hide the fact that people did not share equally in the nation’s prosperity. When the global oil market soared, oil windfalls enabled government spending bonanzas like one in the mid-1970s that alluringly promised to deliver “the Great Venezuela.” But in spite of impressive assets and ambitious development projects, Venezuelans suffered one of the worst levels of income inequality in Latin America.³⁰ This unhappy status quo persisted for decades while entrenched political parties suppressed grassroots and leftist organizations that sought a role in political decision making.³¹ Meanwhile, state interventions never established a comprehensive social welfare system.³² Social programs were circumscribed and unevenly distributed. Health care offers a good example of this problem. Venezuelans faced a byzantine, fragmented system of public and private health care. In 1973, over one hundred government institutions provided public health care, with the main players being the Ministry of Health (MSAS), the Social Security Administration (IVSS), the military (la Sanidad Militar), and the Ministry of Education.³³ Poor and working-class Venezuelans relied on the government for biomedical care, but many people fell through the cracks of the fragmented system.

A 1983 study of a government-run clinic reveals the limitations of poor people's access to biomedicine.³⁴ Located in the *barrio* of Petare in eastern Caracas, El Libertador health center was part of an initiative to bring public services to *barrio* residents during a period of heightened state spending in the 1970s. The doctors were recent graduates of the Universidad Central de Venezuela assigned to complete their obligatory year of service work (physician turnover rates were high). Patients praised the doctors for their earnest and thorough medical exams in spite of the fact that their prestigious medical training did not prepare them to provide basic services in high demand among *barrio* residents, like family planning. The center hired a psychologist, a social worker, and a dentist and organized weekly doctors' visits to remote parts of the *barrio*. Yet major problems plagued the clinic. Administrative failures to deliver supplies meant well-woman exams were cancelled for five months in 1983. The jeeps used for doctors' visits broke down and repair requests went unanswered. Doctors' attempts to help patients receive diagnostic tests and treatments at other public facilities often failed. The clinic was built on the edge of its catchment area, making access difficult for at least half its population. Zoned for an area with 20,000 residents, the clinic had only 3,000 registered patients after more than a year in operation, meaning only 15 percent of *barrio* residents used it.

Social inequalities and poor people's access to services like health care got even worse when oil prices fell. A series of interconnected economic crises unfolded in the 1980s and 1990s; inflation, government corruption scandals, a banking crisis, and massive amounts of capital flight crippled the economy. External debts that the government accumulated during the 1970s oil boom soared to give Venezuela the highest per capita debt in Latin America.³⁵

During this period the country came under foreign pressure to adopt neoliberal austerity measures. Neoliberal ideology assumes the efficiency of free market thinking across a range of human activity and advocates dismantling state welfare systems to make social welfare the responsibility of individuals and private industry.³⁶ Now hegemonic in many parts of the world, including the United States, neoliberalism promotes a model of state and society that undermines the Venezuelan model of state-led intervention for social development.

Venezuelans rejected a model of economic development that denied that national wealth was the people's birthright. In 1989 voters elected a president who explicitly campaigned on an anti-neoliberal platform. Yet he quickly reneged on his promises and accepted an International Monetary Fund

(IMF) loan in exchange for implementing government austerity measures that ended subsidies for things like gasoline and public transportation. The day after the IMF agreement was announced, massive looting and protests broke out across the country, especially in Caracas. State security violently repressed protesters, most of whom were poor, and buried many of its hundreds of victims in a mass grave.³⁷ The event came to be known as the Caracazo and was a turning point in Venezuelan history, marking people's loss of faith in conventional democratic processes to resolve social inequalities.

In the years that followed, the myth that Venezuela's national wealth would promote social progress broke down as economic crises and neoliberal reforms led to a dismantlement of state welfare programs. The government cut public spending, reduced price controls and subsidies, and implemented policies that led to restricted wages and precarious employment.³⁸ Venezuela suffered under neoliberalism much as other Latin American countries that experimented with these policies. Venezuelans saw their standard of living fall dramatically across the 1980s and 1990s. Between 1984 and 1991, poverty rates nearly doubled, from 36 percent to 68 percent.³⁹ In the field of health care government spending fell dramatically with an expectable deterioration in health services.⁴⁰ The state began dismantling national health services by decentralizing them, forcing states and local governments to charge fees for health services due to lack of funding.

Neoliberal policies restricted access to health care during a period of prolonged economic crisis—just when people needed it most. Diseases believed to be eradicated reappeared, and infant mortality rates, which had been dropping steadily in previous decades, started to rise.⁴¹ A 1998 national survey found that 80 percent of people with chronic health problems could not afford their medications. As in other countries that implemented neoliberal reforms, social inequalities became more marked. In Caracas, infant mortality in the poor municipality of Sucre was six times higher than in the adjacent middle-class municipality of Chacao.⁴² Poor and working-class areas grew more socially and spatially segregated from middle-class and wealthy areas in Caracas as fears of crime and a generalized fear of the poor (tied to memories of looting during the Caracazo) led people in wealthier neighborhoods to install exclusionary security measures like walls and guard stations.⁴³

Neoliberal policies were extremely unpopular among Venezuelans. People lost faith in a political system that they now viewed as inefficient, corrupt, and unresponsive to their needs and expectations. A poll taken in 1998 found that “more than 85% of Venezuelans felt cheated out of the benefits of oil

wealth.⁴⁴ The Caracazo, the largest popular protest against neoliberalism in Latin America, heralded the beginning of a decade in which Venezuelan voter abstention was high and “street politics” (*la política de la calle*) dominated as a means of expressing political demands.⁴⁵ Between 1989 (the year of the Caracazo) and 1999 (the year Hugo Chávez became president), students, senior citizens, housewives, medical professionals, street vendors and others staged over seven thousand public protests.⁴⁶

When a political outsider and young military officer named Hugo Chávez led a failed coup attempt in 1992, his critiques of social inequality and promises to end government austerity captured the public imagination. After serving time in prison, he entered formal Venezuelan politics, winning the presidency by a double-digit margin in 1998. Barrio Adentro became one of the largest and most important of his social welfare programs, framed as a state intervention to use oil wealth to improve people’s lives and promote social justice. By funding Barrio Adentro and other social programs with profits from the national oil company PDVSA, and improving people’s quality of life, people felt the government began to actualize the promise implicit in its new motto, Venezuela: Ahora es de todos (Now Venezuela belongs to everyone).

The Promise of Change

With approval ratings of up to 90 percent at the time he took office, Chávez enjoyed an obvious mandate for the systemic changes he promised.⁴⁷ His first major act was to organize a constitutional assembly to transform the legal and philosophical underpinnings of the nation-state. People nationwide elected the constituent assembly and engaged in organized public debates, directly participating in constructing the new constitution.⁴⁸ Venezuelans approved the new document by 72 percent in a popular vote. The 1999 Constitution was socially and politically progressive, emphasizing direct political participation for historically dispossessed social groups, including women, Afro-Venezuelans, and indigenous peoples. The Constitution provided universal guarantees of access to health care, housing, employment, and education (fig. 2). Chávez coined the term “Bolivarian Revolution” (after the liberator of Latin America, Simón Bolívar) to describe the dramatic social changes he sought to implement.

Talk of a revolutionary Venezuela alienated some people, especially members of entrenched elite groups.⁴⁹ Political animosities grew intense and uncivil. In mainstream newspapers and television shows, opposition to



FIGURE 2. Mural of a doctor's visit alongside Article 84 of the 1999 Constitution guaranteeing state-provided health care, 2006. Photo by the author.

Chávez devolved into racist attacks comparing him to a monkey because of his Afro-Venezuelan and indigenous heritage.⁵⁰ Chávez and his supporters derided their most fervent opponents as *escuálidos*, “squalid ones.” The right-wing opposition repeatedly tried to oust him from office via legal and extralegal means. Their efforts included a failed coup attempt in 2002, an oil industry strike in 2003, and a recall referendum in 2004. In facing down these challenges, the government gained more supporters. Chávez won reelection in 2006 with 63 percent of the vote, with a 26 percentage point margin of victory and twice as many votes cast for him compared to 1998.⁵¹

Resisting destabilization and gaining confidence from his reelection, Chávez radicalized his politics. He discussed the country's transformation from capitalism to what he called “twenty-first-century socialism.” He strengthened ties with Cuba and established trade and aid programs to benefit countries in Latin America and the Caribbean. A few years earlier, the government had founded a string of national social programs called *misiones sociales* (social missions) to fulfill constitutional guarantees to health care



FIGURE 3. Construction site for a Barrio Adentro rehabilitation clinic, 2006. The sign reads, “Health is no longer a privilege of the few—it is now the patrimony of the PEOPLE.” Photo by the author.

access, education, and other benefits (fig. 3). Using the language of missions marked them as distinct from other government social programs. The term “missions” invoked Catholic and evangelical Protestant mission work and the concept of a revolutionary mission that imbued government welfare with moral connotations of compassion and social justice. The missions received direct funding from PDVSA, activating long-standing promises to “sow the oil” for the benefit of the people. Between 1998 and 2006 government social spending increased by over 200 percent as officials rolled out new programs across the country.⁵² Using oil profits to fund social programs also reflected a commitment to repay the “social debt” owed to people after the ravages of government austerity. Unlike the idea of “sowing the oil,” the concept of social debt is not unique to Venezuela. Across much of Latin America the idea gained traction as a way to highlight states’ obligation to redress social inequalities that their neoliberal policies inflicted.⁵³

Barrio Adentro

The centerpiece of the Bolivarian Revolution’s efforts to address inequalities and repay the social debt was Barrio Adentro. The Barrio Adentro mission provided universal primary and preventive health care with a focus on underserved communities. As of 2014, this Venezuelan and Cuban government