HEALTH SERVICES SYSTEM PROFILE
BOLIVIA
(1st edition, January 2001)
(2nd edition, November 2001) *

PROGRAM OF ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES
DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT
PAN AMERICAN HEALTH ORGANIZATION
EXECUTIVE SUMMARY

Bolivia is a democratic republic with a government consisting of three branches: the Executive, headed by a President elected for a 5-year term; the Legislative, comprised of a Senate and a Chamber of Deputies; and the Judicial power. Under the Administrative Decentralization Act of 1995 (LDA) the country is divided politically into nine departments, each with a departmental executive branch presided over by a Prefect. The nine departments are subdivided into 111 provinces and 315 municipalities--some of the latter are autonomous.

Health activities are included in the General Economic and Social Development Plan (PGDES) and implemented through the Strategic Health Plan (PES) established by the Ministry of Health and Social Welfare (MSPS). The lines of action in the PES are incorporated into the departmental and municipal development plans (PDD and PDM) by coordinating the indicative health planning in the PES with local participatory planning at the municipal level.

The macroeconomic stability and structural reforms introduced in recent years have created an environment conducive to a rise in investments and economic activity. The economic growth of the last decade was based mainly on the performance of capital-intensive sectors such as electricity, transportation, and financial services, which attained growth rates of over 4.5% annually, in contrast to those of other, more labor-intensive sectors such as manufacturing (3.8%) and traditional agriculture (2.5%).

Per capita GDP was US$ 1,026 in 1999, and growth of no more than 2% is expected for the year. In 1998, total public expenditure was 32.1% of GDP and social public expenditure, 15.7%. In 1997, social public expenditure in management increased to 16.5% of GDP.

Of the 8,280,184 inhabitants of Bolivia, 64.8% reside in urban areas. The country has 36 ethnic groups, representing some 3.6 million inhabitants. In 1999, 63% of households were living in poverty, a situation mainly affecting the indigenous population in rural areas. The ratio between the country's highest and lowest income quintiles was 9.5 for the period 1990–1994. During that same period, according to unofficial sources, unemployment was 24%. Estimates of life expectancy at birth in 1999 were 62.2 years overall--60.6 for males and 64 for women. Life expectancy for the period 1990-1995 was 59.33 years, with estimates of 63.6 for the period 2000-2005. Neonatal mortality in Bolivia was 34 per 1,000 live births for the period 1993-1998 (ENDSA 1998). More than half the children who died during the first year of life (67/1,000 LB) did so during the first 28 days. Almost one-third of all deaths before the age of 5 (92) occurs in the neonatal period, a proportion that is similar in both urban and rural areas. Neonatal, infant, and child mortality rates in rural areas are nearly double those in urban areas.

Between 1985 and 1995, neonatal mortality fell by 26.5% and infant mortality by 35.8%, while mortality in children under 5 fell by 41.2%. Measures such as vaccination and well-baby check-ups have made possible these significant declines, especially in children between the ages of 1 month and 5 years.
Measures to reduce mortality in newborns--for example, prenatal check-ups, births attended by trained personnel, and postnatal monitoring--have had less of an impact.

In 1998, diarrhea (25%) and pneumonia (26%) were the most prevalent illnesses in children under 5. The Demographic and Health Survey (ENDSA 98) found that 67% of children under 3 years of age were suffering from some degree of anemia, with chronic malnutrition at 26%.

The health system is made up of three subsystems: public, social security, and private. The Ministry of Health exercises the steering role in the health system at the national level; its role is to regulate, evaluate, oversee, and audit the system within the framework of the Decentralization and Community Involvement Acts. At the departmental level, the departments of health services, responsible to the departmental prefectures, play a role in executing and adapting national policies, consistent with the central level. In the municipalities, local agencies, as decentralized units, are responsible for operational matters and service delivery through the Health Districts, which are responsible for the local network.

The health policy outlined in the Strategic Health Plan (PES) includes four strategic lines of action: technical, intersectoral, social, and legal. The main components of the PES are: universal access, basic health insurance, strengthening of the network of services, family and community health, implementation of the epidemiological shield, the strengthening of basic health programs, and the development of career programs in public health.

Basic Health Insurance is the most important health care policy of the Ministry of Health, and the municipalities contribute to its financing. The management commitments--that is, results-based management measured by the meeting of established goals institutionalized in each department and between departments and the local level--have achieved progress, and modifications for their further development have been suggested, based on the external evaluation conducted by PAHO/WHO.

The National Maternal and Child Insurance and the Basic Health Insurance were evaluated in 1998 and 2000, respectively. The evaluations concluded that they did not reach the poorest population groups; that they were not publicized or well-known, especially in rural areas; that municipal governments were very slow to pay for the services; that the availability of medical supplies was a problem; and that there were disparities in the use of municipal funds.

The management commitments were evaluated in 2001, and the conclusion was that while progress has been made, the indicators must be adjusted and adapted.

In recent years, technical cooperation among countries has intensified. Bolivia has bilateral cooperation relations with a number of partners--in particular, the European Union, the United States of America, Japan, and the Nordic countries. Also relevant is the cooperation of the United Nations system (PAHO, UNICEF, World Food Program, UNFPA, United Nations Volunteers) and other agencies. The multilateral development banks (World Bank and IDB) are contributing through important projects to strengthen the network of services and health care programs. The composition of the cooperation is:
bilateral assistance, 65%; multilateral technical assistance of the United Nations system, 20%; and the development banks, 15%. Foreign nongovernmental organizations provide significant technical and financial cooperation to certain municipalities.
1. CONTEXT

1.1. Political Context. Bolivia is a democratic, representative, and unitary republic, headed by a President. The State is comprised of three branches: the Executive, whose functions are exercised jointly by the President of the Republic and the Ministers of State; the Legislative, which is the National Congress, made up of the Chamber of Deputies and the Senate; and the Judicial, made up of the Supreme Court of Justice, the Superior District Courts, and other tribunals and courts established by law.

The country is divided politically and administratively into nine departments which, under the Administrative Decentralization Act (LDA) of 1995, have a departmental Executive Branch with powers delegated to a Prefect, with oversight by a Departmental Council. The nine departments are subdivided into 111 provinces and 315 municipalities, each with an autonomous, elected municipal government.

The National Planning System was established by Law No. 1178 the Financial Administration and Operational Control System (SAFCO Law) and by Supreme Resolution No. 216779, which regulates national planning. Planning is for 5-year periods and is the responsibility of the Ministry of Sustainable Development and Planning. There are three levels of planning: (i) central, expressed in the General Economic and Social Development Plan (PGDES), an indicative and regulatory guide for the entire nation; (ii) departmental, expressed in the Departmental Development Plans (PDD), and; (iii) local, expressed in the Municipal Development Plans (PDM), which consolidate strategic and participatory planning in the municipalities.

Social policy is laid out in the General Economic and Social Development Plan (PGDES), known officially as "Living Better." The four pillars of the government plan are Dignity, the Institutional Framework, Opportunity, and Equity. The centerpiece of the plan is the Bolivian Anti-Poverty Strategy (EBRP). The National Social Policy Board (CONAPSO, is the entity responsible for coordinating national social and human development policies and has the authority to harmonize activities and propose policies and regulations. Implementation corresponds to four ministries: Labor and Microenterprise; Housing and Basic Services; Health and Social Welfare, and Education, Culture, and Sports.

The Strategic Health Plan (PES) prepared by the Ministry of Health and Social Welfare (MSPS) provide input to the departmental and municipal development plans (PDD and PDM, respectively) through coordination of indicative planning in health proposed in the PES and local participatory planning. Under Supreme Resolution No. 216784, the MSPS, the Departmental Prefectures, and the municipal governments present the Annual Operating Program (POA), which contains the projected health activities for every level.
1.2. Economic Context

The structural reforms introduced in recent years created an adequate environment for increasing investments and promoting greater economic activity. Economic growth in the last decade was based mainly on the performance of capital-intensive sectors such as electrical power generation, transportation, and financial services, which achieved growth rates of more than 4.5% annually, in contrast to the growth of other, more labor-intensive sectors such as manufacturing (3.8%) and traditional agriculture (2.5%). Annual average inflation between 1985 and 1996 was 24.2%. The nonfinancial public sector deficit in 1993 was 6% of GDP, exhibiting a steady downward trend that leveled off at 3.9% in 1997 and 4.6% in 1998.\(^2\)

<table>
<thead>
<tr>
<th>Economic Indicators</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita GDP at constant prices, in US$</td>
<td>811</td>
</tr>
<tr>
<td>Economically active population, in thousands</td>
<td>ND</td>
</tr>
<tr>
<td>Total public expenditure as a percentage of GDP</td>
<td>29.59</td>
</tr>
<tr>
<td>Social public expenditure as a percentage of the GDP</td>
<td>9.27</td>
</tr>
<tr>
<td>Annual inflation rate</td>
<td>ND</td>
</tr>
<tr>
<td>Total health expenditure as a percentage of GDP</td>
<td>ND</td>
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</tbody>
</table>


Technical cooperation between countries has intensified in recent years. Bolivia receives bilateral cooperation from diverse partners--especially the European Union, the United States of America, Japan, and the Nordic countries. There is significant cooperation from the United Nations system (PAHO, UNICEF, World Food Program, UNFPA, United Nations Volunteers) and other organizations. The multilateral development banks (World Bank and IDB) are contributing through important projects to strengthen the network of health services and health care programs. The composition of the cooperation is: bilateral assistance, 65%; multilateral technical assistance from the United Nations system, 20%; and the development banks, 15%. Foreign nongovernmental organizations provide significant technical and financial cooperation to certain municipalities.\(^4\)

1.3. Social Context

According to preliminary data from the last census (2001), the total population in 2001 was 8,280,184 inhabitants, with 64.8% residing in urban areas, and 35.2%, rural areas. The indigenous population is estimated at over 3.6 million and is made up of 36 ethnic groups, with a heavy proportion of original Andean (Quechua-Aymara) and lowland (Tupi-Guarani) cultures, as well as mestizos of Hispanic, Andean, and Amazon origin.
The Human Development Report 1999 lists Bolivia as a nation of intermediate human development, ranking it 112th on the human development index and 99th out of 146 countries on the Gender-related Development Index. In 2000, the rate of open unemployment was 7.84% and visible underemployment, 11.90%.

In 1999, 63% of the population (nearly 5.1 million people) had an income below the poverty line, and 37% had income that did not purchase the basic food basket (extreme poverty). In rural areas, more than 89% of the population lived in poverty and nearly 60%, in extreme poverty. Although the incidence of poverty is higher in rural areas than in urban areas, 52% of the poor are urban dwellers. It has been shown that, in the major cities, there is no significant difference in per capita household income between migrant and nonmigrant families.

According to INE figures issued in November 1999, the ratio between the highest and lowest 20% of the population was 46.4. Figures for the 1990s indicate that in 1990, the poorest 20% of the urban population (first quintile) had 4% of the aggregate income; in 1993, that figure was 3.8%; in 1995, 4%; in 1997, 4.7% in urban areas and 4.4% in rural areas. At the same time, the 20% of the population with the highest income (fifth quintile) in 1990 had 56.4% of the income; in 1993, that figure was 57.4%; in 1995, 56.8%; in 1997, 53.1% in urban areas and 59.3% in rural areas--percentages that remained virtually constant throughout the decade.

According to the figures for 1999, 16.4% of the population was illiterate--less than the 20% estimated in the 1992 census. The education rate is 0.79, and the average number of years of schooling, 3.7. Almost one-third of the country's population is functionally illiterate (20% have never attended school), although this population is concentrated in rural areas and among females.

In the past 5 years, 40% of social expenditure has been allocated to primary education, 22% to health, 11% to services and urban development, 6% to rural development, and the rest to the Pension System. Other institutions that carry out complementary activities in the sector are the Social Investment Fund (FCI) and the current Productive and Social Investment Fund (FPS). They were brought together under the Unified Bureau of Funds (DUF), whose objective is to contribute to the execution of the Dialogue Act, which lays out the basic guidelines for the implementation of the Anti-poverty Strategy (EBRP).

1.4. Demographic and Epidemiological Context

The overall life expectancy estimated for 1999 was 62.2 years--60.6 for males and 64 for females. The difference by sex did not vary from 1990 to 2000, with women living 3.3 years longer.

The country has no data on the structure of mortality by age and cause, or on hospital mortality rates. The last study on total mortality by groups of causes put ill-defined signs and symptoms at 10.8%, communicable diseases at 12.0%, neoplasms at 8.7%, diseases of the circulatory system at
30.3%, disorders stemming from the perinatal period at 5.4%, external causes at 10.7%, and other causes at 22.2%. Some 8,000 and 6,000 tuberculosis cases were diagnosed in 1991 and 2000, respectively. The national incidence rate for tuberculosis was 73.8 per 100,000 population, according to the 2000 report. With regard to leprosy, the country is found in Group 5 of the classification in the Americas, with a prevalence rate of 0.41 per 10,000 population; 47.59% of cases corresponded to the lepromatous form, 36.3% to the tuberculoid form, 10.9% to the dimorphous form, and 5.2% to the indeterminate form. Human rabies remains a public health problem; 83 cases were reported between 1992 and 2000. The last decade has witnessed a marked decline in this disease. From 1991 to 2000, the number of malaria cases rose from 19,031 to 31,468, peaking in 1998 at 74,350, a very high figure. Chagas’ disease is a major public health problem, with the population in 60% of the nation's territory at risk. In 1992, a study yielded a seroprevalence of 40% for the country's total population, with figures as high as 70% in some areas. As a result of the efforts over the past three years, a reduction is anticipated in the vector-borne transmission of the disease. In 1994, the seroprevalence in children under 5 was 11% in urban areas and 70% in rural areas; 75% in schoolchildren, and 45% in military recruits. Blood-borne transmission in 1992 ranged from 6% (Oruro) to 51% (Santa Cruz). The 420,000 clinical cases of Chagas' disease represent estimated losses of 25% of working capacity and 105,000 productive years, and economic losses of Bs. 1,670 per year per person.

One of the principal chronic diseases is diabetes, found in 7.2% of the population in the cities of La Paz, El Alto, Santa Cruz, and Cochabamba. Its prevalence in women is 7.6% and in men, 6.8%. The prevalence at age 45 is 10% and in the 60-64 year age group, 20%. Hypertension has a prevalence of 18.6%, with figures of 21% for males and 16% for females.

The data on violence in 1998 show 504 deaths from homicide, 1,007 from suicide, and 792 from motor vehicle accidents.

The principal causes of death in children under 5 are chronic malnutrition in children under 3, 24%; perinatal causes, 16%; vaccine-preventable diseases, 3%; and other causes, 24%. In 1998, diarrhea (25%) and pneumonia (26%) were the most prevalent illnesses in children under 5. The Demographic and Health Survey (1998) showed that 67% of children under 3 suffer from some degree of anemia and 26% from chronic malnutrition. Neonatal mortality in Bolivia was 34 per 1,000 live births for the period 1993-1998. More than half the children who die in the first year of life (67/1000 LB) do so within the first 28 days. Almost one-third of the total deaths before the age of 5 (1992) occur in the neonatal period, a proportion that is similar in urban and rural areas.

Neonatal, infant, and child mortality rates in rural areas are almost double those of urban areas. Between 1985 and 1995 neonatal mortality fell by 26.5%, infant mortality by 35.8%, and mortality
in children under 5. by 41.2%. Measures such as vaccination and well-baby check-ups have made possible these significant declines, especially in children aged 1 month to 5 years. The measures to reduce mortality in newborns, such as prenatal check-ups, births attended by trained staff, and post-natal check-ups, have had less of an impact.

With respect to emerging and reemerging diseases, there was an outbreak of cholera in 1991, with 206 cases (12 deaths). An explosive epidemic began in 1992, with 23,862 cases. In 1993, 10,290 cases were recorded. This downward trend continued, with the last reported cases in 1998 and none reported in 1999 and 2000. With respect to measles, an outbreak occurred from 1998 to 2000, representing 51% of all the reported cases in the Americas in 1999, with 2,567 confirmed cases. No cases have been reported in the past year. In the past 5 years, 226 cases of yellow fever have been confirmed. Two cases of neonatal tetanus were reported in 2000; in 1989, that figure was 114, falling to 10 in 1998 and 4 in 1999. Four cases of diphtheria occurred in 1999 and 2 in 2000. As for rubella, 420 laboratory-confirmed cases were reported in 2000.

The national incidence rate for HIV/AIDS is 0.62 per 100,000 pop.; between 1985 and 2000 a total of 605 cases were reported. Underreporting is in the order of 30%. Once hundred percent of cases are found in urban settings, 90% of them from the areas of Santa Cruz, Cochabamba, and La Paz. Between 1991 and 1999 the incidence rate for leishmaniasis rose from 21.27 per 100,000 pop. to 30.34. In 2000, the rate was 22.94, or 1,735 reported cases--68% of them in males; 1,458 cases were the cutaneous form (84.04%) and 277 the mucosal form. Plague is confined to an area of La Paz (Apolo). The last outbreak occurred in the period 1996-1997, with 17 cases and 4 deaths.

2. HEALTH SERVICES SYSTEM

2.1 General Organization

Throughout its history the Bolivian health system has been subject to different management models. In 1979, the Government attempted to create a health system made up of the public sector, Social Security, and the private nonprofit and for-profit sector.

The Ministry of Health and Social Welfare (MSPS), whose role is to oversee, regulate, and execute national policies and strategies, heads the public sector. The regional level consists of the prefectures, which are responsible for human resources administration. At the local level, the municipal governments are in charge of administering health facilities.

The Community Involvement and Administrative Decentralization acts have introduced a type of decentralization in which the municipalities are responsible for infrastructure and financing. By the same token, the MSPS and prefectures are responsible for human resources, whose cost is charged to the National Treasury, and where the organized community exercises the social control of
management. This is a complex management model, whose different actors require support in strengthening local management, analyzing and identifying problems, and preparing projects.

The health services network has 40 general hospitals, 30 specialized hospitals, 149 basic hospitals, 986 health centers, and 1,408 health posts; of these 2,613 facilities, 1,995 belong to the public sector, 197 to Social Security, 254 to NGOs, 101 to the Church, and 66 to the private sector. However, low coverage persists in the public subsector (30%).

The social security sector provides coverage for salaried workers organized within the traditional social security financing schemes. These represent 25.8% of the coverage for the population, with very sluggish or negative growth in coverage in recent years. There are eight health funds and two comprehensive insurance plans with a special regime. Social security has 197 health facilities (3.7%) throughout the country. Some 71% (139) of these correspond to the first level of care, 14% (27) to the second, and 16% (31) to the third. Social Security has 2,823 beds, 31% of the country's total hospital beds--13% (360) of them in basic hospitals and 87% (2,463) in the third and fourth level of care.

The private sector includes insurance companies, prepaid medical plans, and nongovernmental organizations. Insurance companies receive funds with which to finance private sector health services. Their main sources of financing are households and businesses, through health insurance premiums. According to the financial reports generated by the Insurance and Reinsurance Authority and the total individual premiums paid, it is estimated that, including households and businesses, the system has approximately 40,000 beneficiaries. It is estimated that, in 1997, this system had around 31,500 beneficiaries.

Nongovernmental organizations play a key role in Bolivia, because of their numbers, their contribution to health service delivery, and the volume of financial resources that they administer. A total of 355 facilities in the country belong to NGOs and the Church (254 and 101, respectively), 97% (344) to the primary care network, 2% (9) to the secondary care network, and 1% (2) to the tertiary care network. This group has 528 in-patient beds (5.7%). The majority of these organizations receive international financing; few operate with domestic resources. Most tend to be located in marginal urban areas, and a small number, particularly those with international financing, in extremely poor municipalities.

Ten percent of the nation's population receives services from these types of providers. The Church provides important services to the community, especially in extremely poor and marginal urban areas. It generally operates with human resources from the State and its own infrastructure, and the financing of services is shared with users. In certain municipalities and communities, the Church is the only service provider. Traditional healers are numerous; many rural or marginal urban
communities have a midwife, healer, or yatiri. The health system is gradually incorporating midwives into local care networks.

2.2 System Resources

Human resources

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</thead>
<tbody>
<tr>
<td>No. of physicians per 10,000 pop.</td>
<td>4.0</td>
<td>3.6</td>
<td>3.4</td>
<td>3.4</td>
<td>5.7</td>
<td>3.1</td>
<td>3.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Total No. of professional nurses per 10,000 pop.</td>
<td>2.0</td>
<td>1.79</td>
<td>1.73</td>
<td>1.72</td>
<td>2.7</td>
<td>1.48</td>
<td>1.43</td>
<td>1.6</td>
</tr>
<tr>
<td>Ratio of dentists per 10,000 pop.</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>0.4</td>
<td>0.4</td>
<td>ND</td>
</tr>
<tr>
<td>Ratio of mid-level laboratory technicians per 10,000 pop.</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>0.6</td>
<td>0.2</td>
<td>ND</td>
</tr>
<tr>
<td>Ratio of pharmacists per 10,000 pop.</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>0.1</td>
<td>0.1</td>
<td>ND</td>
</tr>
<tr>
<td>No. of graduates in public health</td>
<td>25</td>
<td>-</td>
<td>-</td>
<td>45</td>
<td>-</td>
<td>12</td>
<td>ND</td>
<td>ND</td>
</tr>
</tbody>
</table>


During the period 1992-1999, the number of physicians and graduate nurses per 10,000 population declined by 20%. The ratio of general practitioners to specialists for the system as a whole is unavailable.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Physicians</th>
<th>Nurses</th>
<th>Nursing auxiliaries</th>
<th>Other workers</th>
<th>Administrative</th>
<th>General services</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSPS</td>
<td>2,677</td>
<td>1,166</td>
<td>3,871</td>
<td>2,151</td>
<td>2,294</td>
<td>2,209</td>
</tr>
<tr>
<td>Social Security</td>
<td>3,005</td>
<td>1,241</td>
<td>2,248</td>
<td>3,061</td>
<td>1,596</td>
<td>2,046</td>
</tr>
<tr>
<td>Total</td>
<td>5,682</td>
<td>2,407</td>
<td>6,119</td>
<td>5,212</td>
<td>3,890</td>
<td>4,255</td>
</tr>
</tbody>
</table>


In 1992, Bolivia had 2,757 physicians. In 2000, it rose to 5,682, an increase of 106%. Similarly, in 1992 professional nurses numbered 1,379. In 2000, there were 2,407, or a 75% increase.

Drugs and other Health Products

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<tr>
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</thead>
<tbody>
<tr>
<td>Registered pharmaceutical products</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>8,293</td>
</tr>
<tr>
<td>% of brand-name drugs</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>79%</td>
</tr>
<tr>
<td>% of generic drugs</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>21%</td>
</tr>
<tr>
<td>Total drug expenditure</td>
<td>55,895</td>
<td>60,338</td>
<td>71,737</td>
<td>79,035</td>
<td>84,870</td>
<td>103,502</td>
<td>98,497,582</td>
</tr>
<tr>
<td>Per capita drug expenditure</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>10.2</td>
<td>13</td>
<td>12.10</td>
</tr>
<tr>
<td>% public drug expenditure</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>25%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>% expenditure executed for drugs</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>2.12%</td>
</tr>
</tbody>
</table>

The drug market in Bolivia plays a highly significant role in the national economy, it represents 1.15% of GDP. Drug expenditures rose in 1999 to US$ 98,497,582, equivalent to 5% of public sector expenditure, and 18% of Social Security expenditure. Household expenditure on drugs accounted for 77.5% of total drug expenditures in 1999. The drug supply consists of national production, imports, donations, and contraband. Imports account for 70% of the pharmaceutical market; national production, 30%; and contraband, 20%. The drug market consists of 210 companies (laboratories, importers, distributors, etc.), 99 of which offer essential drugs. The Central Office for Drugs and Supplies (CEASS) is the logistical agency of the MSPS responsible for the national procurement and distribution of drugs.

Bolivia has a National Drug Formulary with 245 drugs. Its use is mandatory for both the public and the private sector. Approximately 30% of the population have access to the drugs listed in the Formulary. Some MSPS health programs subsidize the drugs. Drug expenditures consume 65% of the household health budget. Household drug expenditures account for 77.5% of total drug expenditures in the system. There are 8,293 drugs who’s Sanitary Registration is current; of these, 5,518 are marketed and 1,492 are essential drugs (27%). Forty-eight percent of all drugs are imported; 33.5% are nationally manufactured products, and 21% are sold under their generic name. Providers have not had sufficient training with respect to protocols and administrative procedures.

Since 1989 the Ministry of Health of Bolivia has published the following policy documents:

1. Manual of Standards and Procedures 1989-1993, which includes the standards for comprehensive care in the areas of sexual and reproductive health and women, health, and development;
3. 1996: Standards of Care for Women and Newborns in Maternity and Departmental Hospitals, which includes 35 basic protocols; and Bolivian Health Standards for the Care of Women and Newborns at the First and Second Level of Care, whose contents were reviewed, updated, and adapted to the benefits provided by the Basic Health Insurance in 2000;

Private pharmacies and hospitals are required to have a professional pharmacist on staff. In the year 2000, the system had a total of 28,274 units of whole blood and blood components.

**Equipment and Technologies**

Information could not be found on the percentage of defective or out-of-service equipment. Information on the percentage of the operating budget allocated to equipment repair and
maintenance can be found in the 315 municipalities but is not available in a consolidated form. There is no information on the percentage of maintenance staff trained only on-the-job. There is no information on how high-tech devices and/or equipment is distributed, either geographically or between the public and private sector.

### 2.3 Functions of the Health System

**Steering Role:** At the national level, the Ministry of Health exercises the steering role in the health system. Its role is to regulate, evaluate, oversee, and audit within the framework of the Decentralization and Community Involvement Acts. At the departmental level, the health services bureaus, under the departmental prefectures, implement and adapt the national policies in a manner consistent with the central level. In the municipalities, local entities are responsible for operational matters and service delivery through the Health Districts, which are responsible for the local network. The structure of the Health Districts corresponds minimally to the structure used at the municipal level.

The functions of oversight, evaluation, and monitoring of health service delivery through network facilities are performed by the departmental health services through their technical authorities. The district team is responsible for the programmed periodic supervision.

Intersectoral activities and programs are included in the Strategic Health Plan (PES) through four components: Healthy Municipalities; the Intercultural and Gender Approach; Education and Promotion for Health; and mobilization, participation, and monitoring.

In 2001, Bolivia's Health Authority evaluated the 11 essential public health functions established in the performance evaluation instrument promoted by PAHO/WHO. These functions are:

1. Monitoring, evaluation, and analysis of health status;
2. Public health surveillance, research, and control of risks and threats to public health;
3. Health promotion;
4. Social participation in health;
5. Development of policies and institutional capacity for planning and management in health;
6. Strengthening of institutional capacity for regulation and enforcement in public health;
7. Evaluation and promotion of equitable access to necessary health services;
8. Human resources development and training in public health;
9. Quality assurance in personal and population-based health services;
10. Research in public health; and

Bolivia established a National Health Information System (SNIS) 10 years ago. This system provides information on the production of health services and on morbidity subject to program action and surveillance, disaggregated by departmental, district, and municipal health services,
health facilities, subsector, institution, and level of care by year and by month. SNIS publishes information on 2,780 health facilities, posting it on the Internet with a 3 to 4-week lag.

The Training and Professional Accreditation Unit of the MSPS establishes priorities for training. The Policies and Strategies for Developing Human Resources for Health have been published. The Ministry of Education, Culture, and Sports, in conjunction with the Executive Board of the Universidad Boliviana, reached a consensus on a Draft Law for the Creation of a National Accreditation Commission for Higher Education (CONAES) to establish evaluation and accreditation processes in the country. The objective is to upgrade the quality of professional education and training programs offered at Bolivia's public and private universities. The National Hospital Accreditation Commission made up of the Ministry of Health, the National Health Fund, the Medical and Nursing School, the Organization of Private Clinics, and NGOs, has accredited a number of hospitals. There are accreditation standards for the third level of care, and a manual on the accreditation of health services is being prepared for the first level. There is no information on agencies devoted to health technology assessment.

**Financing and Expenditure**

The State Comptroller's Office prepares the information on the financing of health expenditure. This information is considered reliable and timely.


<table>
<thead>
<tr>
<th>Health Sector Financing, 1995-1998 (in thousands of current US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PUBLIC SECTOR</strong></td>
</tr>
<tr>
<td>GOVT.</td>
</tr>
<tr>
<td>BUS.</td>
</tr>
<tr>
<td>HOUSE-</td>
</tr>
<tr>
<td>HOLD</td>
</tr>
<tr>
<td>EXT.</td>
</tr>
<tr>
<td>COOP.</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Source: Based on information in Cárdenas, Marina: *Cuentas Nacionales de Financiamiento y Gasto en Salud, Bolivia, 2000*. (preliminary data).

The most important financing entity in the public sector is the government; in the social security system, businesses/institutions; and in the private sector, households.
The ratio of public health expenditure to total public expenditure rose by 24% in the period 1995-1998. Moreover, during the period in question, total per capita health expenditure increased from US$40 to $53.

The table on national health expenditure by source of health sector financing shows that from 1995 to 1998, total expenditure in the health sector increased by 43% in current terms. Expenditure in the public sector was invariably higher than in the private sector, ranging from 57.4% in 1995 to 59.7% in 1998. Social Security showed the highest expenditure during this period, with figures of 37.4% to 42.7% of the total, or 64% increase for the period. This is followed by household expenditure for private services, accounting for 28.4% of the total in 1995 and 30.7% in 1998, or a 55% increase. Expenditures financed with international cooperation exhibited a 12% decline, its contribution to total expenditure falling from 10.2% in 1995 to 6.3% in 1998. Furthermore, health sector expenditure as a percentage of GDP was roughly 4.5% to 5.0% for the period.
The table on health sector expenditure by item of expenditure shows that the most significant item is “personal services.” Nevertheless, the inadequacy of the information available to desegregate the data by item of expenditure is reflected in the high percentage found in the category “Other.” There is no reliable information on the allocation of private health expenditure. Public expenditure at the first level of care is 7%. There is no available data on the secondary and tertiary levels.

**Insurance**

It is expected that reliable information on coverage and service delivery modalities in the public sector will be available through the National Health Information System (SNIS). This system already has data from the different health insurance plans and some NGOs, with whom it has agreements; the data must still be processed, however. In reference to the 1999 data from SNIS on new consultations by individuals 5 years of age and over, the public sector achieved coverage of 50%, the Health Funds 31%, NGOs 18%, and the private sector 1%. There is no information on the percentage of the population without effective coverage, or on what have traditionally been the main differences between the benefits guaranteed by the Ministry of Health and those of Social Security to their beneficiaries. The Social Security standardized the health benefits for all its members.

In July 1996, through Supreme Decree 24303, the Government of Bolivia established the *National Maternal and Child Insurance*, which offers a series of free services for pregnant women, newborns, and children under 5. The basic objective was to increase coverage in these populations,
with a view to reducing maternal and neonatal mortality rates.

On 31 December 1998, the National Government promulgated Supreme Decree No. 25265, creating *Basic Health Insurance* as a public service offering universal access to essential culturally appropriate, quality health benefits. Some benefits were added under the *National Maternal and Child Insurance* to target children under 5 and women of reproductive age. Equally, coverage was extended to the general population in endemic areas.

The Basic Health Insurance provides 92 benefits in the areas of health promotion, disease prevention, and cure. One of them is the detection of maternal syphilis, included as the Subprogram for the Elimination of Maternal and Congenital Syphilis by Ministerial Resolution No. 365 of August 1998. These activities are designed to reduce mortality in newborns, children, and mothers.

### 2.4 Delivery of Services

**Population-based Health Services:** The priority programs target vulnerable groups (primarily children under 5, women of reproductive age, and adolescents). They are executed through health promotion and disease prevention activities carried out by nursing auxiliaries and health promoters at the first level of care and educational campaigns at the community and institutional level. There are programs for the prevention of tuberculosis, rabies, and Chagas’ disease, for which the coverage is not quantified. One of the programs for early detection of pathologies is the Program for the Prevention of Cervical Cancer, whose impact has not been assessed.

Since 1996, immunization coverage has fallen due to the institutional weaknesses of the Expanded Program on Immunization. Action at the local level has also suffered due to a lack of support from regional authorities. The information on coverage is not reliable. However, the data on management commitments for the year 2000 show 89% DPT3 coverage in children under 1 year. The percentage of coverage with respect to the first prenatal check-up increased from 44.9% to 52.5% between 1989 and 1994, reaching 69% in 1998. Coverage in urban areas is over 81%, while in rural areas it is under 53%. In the departmental capitals, it is 83.8%, while in municipalities with a high degree of marginalization, it is 33%. The percentage of coverage decreases as the age of the mother and birth order increase. It is higher in the *llanos* (78.9%) than in the valley (70.5%) and the altiplano regions (60.7%). The department with the highest coverage is Santa Cruz (81.6%), and the one with the lowest, La Paz (58.9%).

The most influential variable is the mother’s level of education. Among women with no schooling, the percentage is 39.4, while among those with a high school education, it is 91.9%. These data refer to the three years prior to the ENDSA 98. For the first prenatal check-up, the SNIS databank indicates coverage of 73.9% in 1996, 85.44% in 1997, and 89.57% in 1998. The average is 83%,
14% higher than the figure provided by the ENDSA 98. Based on information from the SNIS database, we see that the percentage of women with four or more prenatal check-ups was 36.8% by the year 2000. The percentages range from 18% in the rural area of the Department of La Paz to 77% in the rural area of Santa Cruz. The percentage of institutional births rose from 42.3% in 1994 to 55.9% in 1998. The sharp increase between the last two studies is due basically to the free birthing care provided through the National Maternal and Child Insurance since 1996.

**Personal Health Care Services.** The current National Health Information System was designed in 1990 and went into operation in 1991. Standardized reporting was instituted at the national level in the form of the Monthly Health Activities Report (IMAS), the Monthly Epidemiological Surveillance Report (IMVE), and an annual Basic Model of Care. The primary care records connected with the Single Clinical History were also standardized. Today, there are sections for use at different stages of life--for example, the Basic Perinatal Clinical History, the Perinatal Card, the partogram, the Child Health Card (includes developmental and vaccination history), and the Referral and Counter-referral slip, with instructions for filling them out. There are also model reports, namely: IMAS, IMVE, the extra Quarterly Report, and Report on the 10 Principal Causes of Morbidity and Mortality.  

The sector where the SNIS has the least information coverage is the private sector. It is estimated that only 50% to 60% of facilities in the sector are registered and reports to the SNIS. A total of 66 health facilities send information to the SNIS. In the last decade, a sizable number of facilities operated by NGOs and the Church appeared, mainly in urban areas. Furthermore, the supply of services in the private sector has risen markedly in recent years. Although official figures are unavailable, this situation has clearly given users greater choice among providers.

**For the Primary Care Level.** There is no information on the coverage of the different networks of public and private health service providers. Primary care services do not have computerized information systems; data processing is done manually, and systems at the district level are only 40% computerized.

The five leading causes for consultations are: diseases of the respiratory tract, infectious intestinal diseases, diseases of the musculoskeletal system, skin, genitalia, and the buccal cavity. Nursing auxiliaries deliver primary health care, providing outpatient consultations for prevalent pathologies and house calls during weekly visits to communities.
Production of Services. Year 1999

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NUMBER</th>
<th>RATE PER 1,000 POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations and check-ups with physicians</td>
<td>7,368,826</td>
<td>906</td>
</tr>
<tr>
<td>Consultations and check-ups with non-physicians</td>
<td>4,434,707</td>
<td>545</td>
</tr>
<tr>
<td>Consultations and check-ups with a dentist</td>
<td>994,667</td>
<td>122</td>
</tr>
<tr>
<td>Emergency consultations</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>2,723,154</td>
<td>335</td>
</tr>
<tr>
<td>X-rays</td>
<td>1.826*</td>
<td>0.85*</td>
</tr>
</tbody>
</table>


For the Secondary Level of Care. No information is currently available on the coverage provided by the different public and private networks of health service providers. One hundred percent of hospitals at the third level and a very small percentage at the second level have more than 50 beds and computerized information systems for the administrative and clinical management. There is no information on the degree to which the data is used for clinical management.

Production of Services. Year 1999

<table>
<thead>
<tr>
<th>Indicator</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of discharges</td>
<td>358,982</td>
<td></td>
</tr>
<tr>
<td>Occupancy rate</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>Average days of stay</td>
<td>3.9 days/ person</td>
<td></td>
</tr>
</tbody>
</table>

Source: SNIS 1999. MPSSP Bolivia. * Includes information from maternity facilities.

There is no information on the five leading causes of hospital discharge for the principal networks of providers, or on waiting lists or the amount of time it takes to be seen.

Quality

Technical quality: There is no information on the percentage of facilities with quality assurance programs or ethics committees and/or committees to oversee professional behavior established and functioning. Caesarean sections account for 18.1% of all deliveries. At the second level, this figure was 18%, and at the third level, 28% in 1999. There is no information on the hospital infection rate. Hospital ethics committees are currently being set up, and rules have been created for their operation. The percentage of patients who are issued a discharge report is unknown. There is no information on the percentage of autopsies performed out of total hospital deaths, or on the percentage of audited maternal or infant deaths.

Perceived quality: There is no information on the percentage of facilities with programs in place to make them more patient-friendly. Programs with specific user-orientation procedures are being developed throughout the system and have been implemented in 100% of first-level facilities in the public sector and NGOs; there is no information in this respect for the other types of facilities.
There is no information on the percentage of facilities that conduct user satisfaction studies or surveys; however, the information on Basic Health Insurance and the care it provides to users is deficient. The information sources cited most often have been health workers and television. Since the advent of the National Maternal and Child Insurance and Basic Health Insurance, users have seen an improvement in the quality of care provided to the point where they recommend the insurance services to other people, a finding that coincides with those of all the previous studies. This favorable attitude is related to fact that the services are free, the wait is acceptable, and maternal and/or neonatal complications are often satisfactorily resolved.

Still, a considerable percentage of users pay to enroll in the Basic Health Insurance, which, added to the payments for sonograms, laboratory tests, and drugs, leaves no doubt that the Basic Health Insurance is not free. However, it remains the cheapest alternative to private care for the population. There is no information on the percentage of facilities with arbitration committees (or their equivalent). However, the recently organized National Ethics and Bioethics Committee is supporting their operations in each Department.

3. MONITORING AND EVALUATION OF SECTORAL REFORM

3.1 Monitoring the Dynamic

The Health Sector Reform process has its origins in a series of events—in particular, the promotion of management, administration, and decentralization, the creation of Districts, the improvement of the health services infrastructure between 1989 and 1993, and the subsequent establishment of maternal and child, and old age insurance. In the 1960s, what was then the Unionized Medical Federation of Bolivia called for universal access by the population to free health facilities as a social right; this demand was taken up by the Medical School of Bolivia, which called this proposal the Unified Health System. Toward the end of the 1970s, a National Health System was set up for the first time that was neither a monopoly nor hegemonic, based on a model of care organized around subsectors. In the late 1980s, the EMSO/World Bank put together a proposal for a transformation in health, whose objectives included the creation of departmental governments in charge of health.

The Community Involvement Act launched the debate on health sector reform with the argument that “Bolivia requires substantive reform of its national health system, because with the current system it cannot address its cumulative social deficit, repair the damage, or create permanent effective mechanisms to meet the needs of its population, keeping pace with the changes that have taken place in the country and serving as a catalyst for development.” This proposal was grounded in the need for implementing a system of universal health insurance that would guarantee a basic package of care for all Bolivians.
Since 1994, the Government has been implementing reforms such as the Community Involvement and Administrative Decentralization Acts, which redefine the competencies of Executive Branch and municipal government authorities in the health sector. Nevertheless, the decentralization of the health sector has followed a structure based on health districts instead of the municipal sphere.

The purpose of the Strategic Health Plan (PES) is: “To construct a Bolivian health system with universal access, based on primary care delivered through family and community medicine, the epidemiological shield, basic insurance, short-term social security, the promotion of healthy municipalities, and career paths in public health, with social participation and control, as part of a reform process that the authorities intend will culminate with the Health Act, turning sectoral policies really and truly into State policies.” Recently, the reorganization of the MSPS placed the Reform Unit of the project financed by the World Bank under the General Bureau of Health Services.

The National Maternal and Child Insurance and the Basic Health Insurance--or package of benefits for children under 5 and women covering a certain number of contingencies--were evaluated in 1998 and 2000, respectively. The evaluations concluded that: (i) These programs did not reach the poorest population groups; (ii) They were not publicized or well-known, especially in rural areas, (iii) Municipal governments were very slow in paying for the benefits; (iv) Timely procurement of medical supplies was a problem; (v) There was a disparity in the use of municipal funds: while some municipalities were not utilizing the coparticipation funds at all, others were overutilizing them.

The management commitments were evaluated in 2001, and it was found that progress has been made in achieving the results, but that the indicators need to be modified and adapted.

**Monitoring the Contents**

**Legal Framework:** In the context of the Community Involvement and Administrative Decentralization Acts, Supreme Decree 24237 created the Decentralized Participatory Public Health System, strengthening activities in the areas of monitoring, surveillance, and evaluation of health policy implementation, the general strategies of the national programs, and the special projects.

Since the start of the current administration, the health sector has been part of the Equity pillar, and sectoral reform has accordingly been considered within the framework of an intersectoral approach and the anti-poverty struggle. Until now, sectoral reform has been implemented through Supreme Decrees. The purpose of the *Bill on Universal Health Insurance*, to be debated in the upcoming legislative sessions, is to guarantee the right to health through Basic Health Insurance, which will cover the country's entire population. To this end, an integrated, decentralized, and participatory Bolivian Health System would be created. This bill is before the National Senate for discussion and
passage as the Law of the Republic. However, its passage is unlikely before the change in administration, and a national strategy may be required for political, social, and technical negotiation in stages with the country's various opinion sectors.\textsuperscript{22}

\textbf{Right to Health Care and Insurance}: Both the Constitution and the Supreme Decrees recognize the right of citizens to health protection. Article 3 of Supreme Decree 25265 defines basic Health Insurance as follows: “Access to Basic Health Insurance is a right guaranteed by the State and is free to all users. All the country's inhabitants are protected by the Basic Health Insurance, within the limits of the benefits established in this decree.”

\textbf{Steering Role and Separation of Functions}: The MSPS is working on improving the operating capacity of the SEDES as a strategy for strengthening the steering role of the health authorities. New regulatory institutions that affect the sector have not been created. According to the performance evaluation of the essential public health functions (FESP) in Bolivia, conducted with the evaluation instrument promoted by PAHO/WHO in 2001, the best results were obtained in the functions \textit{Social Participation in Health} and \textit{Development of Policies and Institutional Capacity for Planning and Management in Health}. The lowest performance was found in the functions \textit{Research in Public Health} and \textit{Evaluation and Promotion of Equitable Access to Necessary Health Services}.\textsuperscript{23}

Historically, Bolivia has not had an integrated health system. Instead, there has been tremendous fragmentation and a clear lack of coordination within and among the three subsectors. The current Administration plans to construct a Bolivian health system based on universal insurance; however, it has not made a separation of the steering role, insurance, health service delivery, and evaluation an objective.

Action has been taken to ensure that information systems periodically issue relevant reports that will enable the authorities to set priorities, make decisions, and allocate resources at the different decision-making levels. This is because sectoral reform is supposed to be based on the best available information and the continuous evaluation of processes and outcomes. Furthermore, the authorities are aware of the limitations of the SNIS in terms of the timeliness and reliability of its information and the need for improvement.

The National Maternal and Child Insurance and the Basic Health Insurance have introduced and strengthened popular participation mechanisms with respect to health planning and management, particularly at the local and district levels, as well as mechanisms to promote accountability at all levels of the system. The central and departmental levels have introduced the monitoring of management commitments to detect high-risk municipalities, basing their findings on the degree to which the established goals have been met.
Decentralization Modalities: The administrative levels of the health services system, the functions of each, and the relations among them are being reviewed and modified by Decree, principally in the prefectures and municipalities. Such proposals are consistent with the LDA, the LPP, and the regulatory Decrees. The health services (infrastructure and equipment) have been transferred to the municipalities, which have been allocated coparticipation funds for maintenance, equipment, and construction projects, in keeping with local needs. There is still little deconcentration within the main public health facilities, which means that there is no quantifiable evidence. In 2000, autonomous hospital management was introduced. Management contracts were established for the administration of some health districts, with autonomous delegation to the nonprofit private sector; however, mechanisms have not been set up to regulate these processes.

Social Participation and Control: The participation of the organized community in consensus-building entities has increased. Surveillance committees and original peoples who once were excluded from the decision-making process are now involved in the discussion of health problems. The Strategic Health Plan, through "Health with Identity with an Intercultural and Gender Approach in Health," also addresses the specific problem. The authority of the Surveillance Committee derives from the Community Involvement Act and the regulatory Decrees; however, its activities have not gone forward for lack of economic resources and training. There is no information on whether such entities and mechanisms are beginning to obtain a degree of formal legal status. As a result of the national dialogue on establishing the Bolivian Anti-Poverty Strategy, discussions and debates on problems and potential solutions were held at the municipal level; this process was adopted by the local governments. Social control mechanisms are currently being discussed, especially now that the execution of social and productive projects will be arranged for and carried out by municipal governments. The Unified Bureau of Funds (DUF) administers the resources.

Financing and Expenditure: There is no information on whether the information systems on financing and expenditure are being upgraded to make them reliable and comparable among territorial units and/or facilities. At present, administrative instruments to modify the distribution of public expenditure have not been developed. However, with the resource allocation process and, primarily, the Regulatory Decree on SEDES, the health services can reinvest the resources generated by cost recovery in their own activities; this implies the need for financial information systems, which do exist.

Supply of Services and Models of Care: As a result of the decentralization of the health system, new actors have become involved (mainly in the municipalities and prefectures), who have increased the supply of public health services. Thus, the first level of care represents some 80% to
90% of the system's response capacity. Action is currently being taken to improve coordination among institutions at the different levels of the system to strengthen the network of services. Pilot projects have been under way since 1999 for the organization of decentralized networks of providers with public/private coordination. Adequate information on the results is not yet available. 

Management Model: The institution of the Management-by-Results Model has been established and supported through the signing of management commitments in each department; the departments, in turn, attempt to make these same commitments with the local level. A recent evaluation by PAHO/WHO indicates that this process is under way, with the respective monitoring of 15 results indicators for established goals and 10 process indicators to measure improvements in the quality of care, institutional strengthening, and decentralization. Public facilities have begun third party purchasing and sales of services. There is no information on whether business, self-management, or other criteria are being applied in the organization of public health facilities, or whether health facilities or services have been or are going to be privatized.

Human Resources: Changes have been made in the forms of professional practice, introducing a multidisciplinary orientation, since the model of care establishes that “universal access” will be “guaranteed through primary health care, with family medicine as the point of entry to the Bolivian Health system.” The strategies for health workers are the regulation of training processes in the health system and the establishment of a career program in public health. Training courses on the management of priority programs and the administration of the SNIS are being offered annually for executives working in medicine, nursing, and dentistry, with special emphasis on aspects of management. There is no information on whether certification mechanisms for health workers are being created or updated, or on the establishment of performance incentives. The Ministry of Health and Social Welfare has proposed the establishment of the career program in public health to achieve stability with respect to staffing in the health services and improve the quality of human resources.

Quality and Health Technology Assessment: There is no information on mechanisms for assessing health technologies before they are introduced and/or during their use. The Bolivian Institute of Nuclear Science and Technology (IBTEN), with the support of PAHO/WHO, has carried out a research project on Evaluation of the Quality of Diagnostic Imaging Services, in which seven health centers participated. The evaluation covered quality control in imaging and technical procedures for three pathologies: breast cancer, tuberculosis, and lower and cervical back pain. A total of 260 x-ray units are registered in the country, 185 in the departmental capitals, and 75 in the provinces. This number does not represent all the equipment in the country, which is estimated at 400 units. With regard to dental x-ray equipment, 76 units are registered, 54 of them in the departmental capitals and 22 in the provinces; however, estimates put the total number of dental x-ray units at 600.
3.2 Evaluation of Results

The studies in progress found in “Health Care for Mothers and Newborns within the Health Reform Component in Bolivia”, ”Evaluation of Basic Health Insurance,” and “Evaluation of Management Commitments 2000,” lead us to conclude the following about health policies for mothers and newborns:

Users. The information on Basic Health Insurance and the care offered to users is poor. The information sources most often cited have been health workers and television. As a result of the National Maternal and Child Insurance and Basic Health Insurance, users have noted an increase in the quality of care provided, to the point of recommending utilization of the insurance services to other people, a finding that coincides with those of all previous studies. This is related to the fact that the services are free, the wait is considered reasonable, and maternal and neonatal complications are favorably resolved. A substantial portion of users pay to enroll in the Basic Health Insurance, which, added to the payment for sonograms, laboratory tests, and drugs, makes it clear to users that the Basic Health Insurance is not free. However, notwithstanding, it remains the most accessible alternative to private care for the population.

Provider satisfaction. There is general acceptance of the Basic Health Insurance on the part of providers, although some changes have been proposed, especially with regard to the dosage of drugs included in the protocols and, to a lesser extent, the type of drugs to be used for managing complications. According to providers, some of the shortcomings of the Basic Health Insurance are the poor information offered to users about services covered by the insurance and the lack of human resources to tend to the large number of users.

Coverage. The reports on the results of the management commitments indicate that coverage by the Basic Health Insurance increased from 33% in 1996 to 52% in 2000; and immunization coverage with DPT3, from 70% in 1996 to 89% in 2000. Similarly, the municipalities at risk because of low coverage fell from 62% in 1996 to 23% in 2000. The coverage for women with respect to family planning counseling rose from 12% to 25% between 1996 and 2000, representing one of the principal achievements.


Access. The Basic Health Insurance has reduced economic inaccessibility. However, cultural–and, especially, geographical–barriers persist, as well as others related to response capacity, particularly in rural areas. A number of initiatives are under way to reduce linguistic and cultural barriers;
however, they are but a very few. There are no studies in the public sector on how long patients must wait for surgical procedures or consultations. There is no evidence with regard to the effectiveness and quality of the Basic Insurance and its impact in terms of reducing gaps for ethnic groups or disadvantaged population.

*Technical quality.* Medical audits are being conducted, but the results have not been published. No teams have been organized or strengthened to implement programs for preventive and/or corrective maintenance. There is no information on hospitals with quality committees up and running. Very few hospitals have a hospital infection committee, and discharge reports are not given to patients when they leave a facility. There is no response for the other headings based on reports, data, or evidence of improvement. There is no entity to monitor the sectoral reform process itself.

*Community involvement.* It is popular participation, more than the health sector, which has promoted community involvement. However, a project known as "Health with Identity," based on the participation or inclusion of indigenous and original peoples, is under discussion with a view to enrolling these groups in the Basic Health Insurance.
* The second edition of the Profile was discussed by a group of 10 professionals and senior decision-makers from the General Bureau of Health Services, the General Bureau of Disease Prevention and Control, the General Directorate for Environmental and Occupational Health and Health Promotion, and the Program Chiefs of the Ministry of Health and Social Welfare, as well as NGOs working in health, Save the Children, International Action for Health (A.I.S. Bolivia), the Center for Research, Education, and Service (C.I.E.S.), the PROCOSI Network, the Departmental Medical College of La Paz, the University of San Andrés Medical School (UMSA), and PAHO/WHO. The PAHO/WHO Representative Office in Bolivia was responsible for the technical coordination of the national group. Dr. Guillermo Seoane of John Snow, Inc. Mother Care Bolivia was commissioned to perform the external review. Responsibility for the final review and decisions and editing corresponded to the Program on Organization and Management of Health Systems and Services of the Division of Health Systems and Services Development, PAHO/WHO.

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