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## *Bolivia's Health Reform: a response to improve access to obstetric care*

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### *Abstract*

This chapter presents a historical overview of the development of a health insurance policy in Bolivia, describing its impact on improving obstetric care. It details the gradual extension of coverage, its legal framework, sources of finance, administrative system, service provision and finally monitoring and evaluation system, all of which gave rise to increased coverage of antenatal consultations and skilled attendant deliveries. It concludes with lessons learnt.

The model for public health insurance in Bolivia has existed for the past 10 years. It was initiated as the “National Insurance Scheme for Maternity and Childhood” with service packages for 32 health issues, continued as the “Basic Health Insurance Scheme”, which expanded to 92 service packages, and since 2002 has been called the “Universal Mother and Child Insurance Scheme” (SUMI<sup>4</sup>), providing service packages for 547 health issues affecting pregnant women from the beginning of pregnancy until 6 months after childbirth and to children from birth to 5 years of age.

SUMI has 3 main sources of financing: municipal, departmental and national. Through a credit agreement, the World Bank established the management and supervision system, including coverage indicators with quarterly monitoring and reports.

The first years after the introduction of the insurance package, 1998 to 2003, saw the greatest coverage increase in antenatal care visits and skilled attendant deliveries; whilst in recent years this growth trend has reached a plateau. This has served to address somewhat the existing geographical and

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<sup>4</sup> Abbreviation from the Spanish: *Seguro Universal Materno Infantil*.

cultural barriers through innovative strategies such as mobile “brigades”, community pharmacies and an intercultural health component that reinforces the use of services in rural areas. Bolivia still requires further innovative approaches to improve maternal health, and universal coverage needs to be considered a political goal to achieve equity in the right to access quality services.

**Keywords:** Health reform, maternal mortality, insurance schemes, outreach strategies

## *Introduction*

The Health Reform process in Bolivia was part of a general package of State Reforms undergone by the country over two decades of democratic government. In this process, the country’s health system has met with a series of new challenges on the road towards achieving the universal right to an equitable and high quality health service that reduces maternal, neonatal and child mortality.

Based on the criterion of “health as an investment”, the country acquired two concessionary credits to finance what was known as the “Health Reform”, which included financing the insurance policy as part of the credit agreements with the International Development Association (*Asociación Internacional de Fomento*). The aim of these agreements is to assist the country in achieving the Millennium Development Goals (MDGs) 4 and 5. Likewise, they promote the policy alignment of all international aid.

This chapter presents a historical summary of how a health insurance policy in Bolivia functions, describing its impact on improving obstetric care. It details the legal framework, sources of finance, administrative system, service provision and finally monitoring and evaluation system which has given rise to increased coverage of indicators such as antenatal care visits and skilled attendant deliveries and shares the lessons learnt.

## *Background*

Bolivia is a landlocked country located at the centre of South America, with one of the highest levels of poverty in Latin America, affecting over half (67.3%) of the population, mostly in rural areas (UDAPE 2006). According

to latest estimates Bolivia has 10,027,643 inhabitants, 35% of whom live in rural areas (INE 2008). The population is culturally diverse; at least 3.6 million are indigenous people, belonging to 36 ethnic groups, mainly Andean Quechua and Aymara speakers from the highlands and valleys and Tupi-Guarani speakers in the lowlands.

National spending on health, as a percentage of the Gross National Product (GNP), increased from 4% in 1995 to 7% in 2002 (Cardenas, 2004). This increase has not been due to a rise in public spending on health over the same period (28% and 23.3%, respectively) but rather to the contribution made by international aid programmes aimed at vaccination coverage and controlling Chagas disease, malaria and tuberculosis, which represents more than 50% of the budget, while the State Treasury contributes no more than 8.2% (OPS 2008).

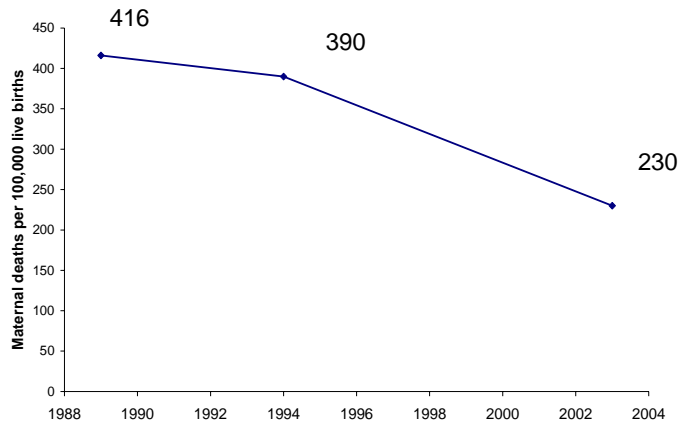
In the past decade, Bolivia has made some remarkable strides in the provision of health services, although healthcare for mothers and newborns still remains inadequate. Over 30% of the Bolivian population has no access to any type of modern medical health services.

There has been a sharp decrease in the maternal mortality ratio. In 1994, the Demographic and Health Survey (INE & MII 1994) recorded 399 deaths per 100,000 live births, with a large differential: ranging from 262 in urban areas to as high as 929 in rural highland areas. This number went down to 230 deaths per 100,000 live births in 2003 (Figure 1). It nevertheless still remains the highest in the Latin American and Caribbean region after Haiti and according to the post-census survey of maternal mortality conducted in 2000 (INE 2003), large urban/rural disparities persist as the maternal death ratio was four times higher in rural areas than in urban zones.

These deaths are mainly related to haemorrhage, infections and abortions (INE & MSD 2003). The major associated factors to these deaths are anaemia, chronic malnutrition, short pregnancy intervals, poor perinatal health care for obstetric complications and women's lack of autonomy to decide on their health problems.

In 1999, the Bolivian government secured a credit from the World Bank to undertake the health reform. Over the ensuing years, the Health Reform Unit developed the technical and financial bases for several Ministry of Health programmes which we describe below.

Figure 1. Maternal mortality in Bolivia



Sources: DHS 1989, 1994 and 2003<sup>5</sup> (INE & IRS/MSI 1990, INE & MII 1994, INE & MSD 2003)

## Methods

A comprehensive literature review was conducted on the most relevant documents with reference to the health reform's legal structure, services offered and financial system. Available external evaluations and administrative reports from the Health Reform Unit were used to document service coverage, implementation problems, equity challenges and the rationale for alternative strategies.

To complete the analysis, five national decision-makers from the Ministry of Health and Sports were interviewed using an in-depth semi-structured questionnaire which focused on information gaps and assessed their perception of the barriers and facilitating factors impacting on the insurance scheme for obstetric care services.

Finally the authors systematized the documentary and interview information, including the major findings from a current external evaluation of the implementation of the national insurance scheme, identifying strengths, opportunities, gaps and challenges to improve obstetric care. This

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<sup>5</sup> The level of MMR reflects the ratio not during the year of the survey but on average 3 years earlier.

was the basis of the summary of lessons learned that may be useful for other countries that are beginning to put in place similar insurance processes.

### *Description of the public health insurance policy*

Inequity and exclusion from basic social services motivated the Bolivian government to implement strategies to improve the status of maternal and child health, launching a national insurance policy in 1996. The aims were to increase coverage, improve the quality of services, improve equity, and increase the efficiency and effectiveness of the health services (Maceira, 2007). Although the insurance policy included maternal and child health, this chapter will concentrate on issues relating to maternal health.

#### THE THREE SUCCESSIVE SCHEMES SINCE 1996

The model for a public health insurance scheme has existed for the past 10 years with subsequent expansions and improvements. It was initiated in 1996 as the “National Insurance Scheme for Maternity and Childhood” (*Seguro Nacional de Maternidad y Niñez*, SNMN)<sup>6</sup> with 32 service packages, providing medical assistance to mothers and children below the age of 5 years. It covered maternity care including caesarean sections for obstetric emergencies and paediatric care for cases of diarrhoea and respiratory infections.

In 1998<sup>7</sup>, this scheme was changed to the “Basic Health Insurance Scheme<sup>8</sup>” (*Seguro Básico de Salud*, SBS) and a complementary indigenous insurance scheme<sup>9</sup>, which together covered service packages for 92 health problems. In addition to the previous scheme, the SBS included obstetric emergency transport, newborn care, child nutrition and development screening, vaccination and care for infectious diseases other than diarrhoea and pneumonia, such as sepsis and meningitis (Böhrt & Holst 2002). For

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<sup>6</sup> D.S. 24303, May 1996, until 1998.

<http://www.derechoteca.com/gacetabolivia/decreto-supremo-24303-de-mayo-1996>

<sup>7</sup> D.S. 25265, December 1998, until 2002.

<http://www.derechoteca.com/gacetabolivia/decreto-supremo-25265-del-31-de-diciembre-1998>

<sup>8</sup> SBS *Seguro Básico de Salud*.

<sup>9</sup> DS 26330, September, 2001. <http://www.derechoteca.com/gacetabolivia/decreto-supremo-26330-de-septiembre-2001>

rural communities lacking health services, the SBS covered the costs of periodic visits by health personnel and it established elements of cross-cultural communication for health staff. Included in the package of services were trained community agents who were provided with credentials and the relevant authorisations (Lugo & Gutiérrez 2002).

On November 1st 2002, the “Universal Mother and Child Insurance Scheme” (*Seguro Universal Materno Infantil*, SUMI) started, covering approximately 500 health problems related to the perinatal period and children from birth to five years. SUMI services were extended on April 1<sup>st</sup> 2006, to incorporate 27 additional sexual and reproductive health service packages, including family planning and cervical cancer screening, protecting women up to 60 years of age.

#### SCOPE OF SUMI

Given the high levels of mother and infant mortality, the country decided to prioritise health services directly addressing these sectors of the population. The SUMI package now covers almost all health conditions related to pregnant women from the beginning of pregnancy until 6 months after childbirth and a very wide range of health conditions and needs of children up to five years. The only health problems excluded are congenital malformations, orthesis, prosthesis, cosmetic surgery, chemotherapy, radiotherapy, transplants and orthodontics.

Technically speaking, SUMI is not an insurance scheme, but rather a package of free services. SUMI is intended to be a universal, comprehensive health care package, which the population can access through all public health services whatever the level, as well as through services provided by the social security system. Clients have to register at first contact and receive a SUMI card which allows them to access any health service throughout the country.

The Catholic Church and NGOs, via their health services, may also be part of the insurance system in accordance with the Supreme Decree 24237. Furthermore, SUMI proposes adaptation of services, when appropriate, to include traditional Bolivian medicine and traditional healing practices appreciated by indigenous and peasant people in Bolivia.

#### LEGAL FRAMEWORK

One of the principal differences between the SNMN, the SBS and SUMI,

was that the former two were supreme decrees signed by the President, while the latter required the promulgation of a law, approved by Congress, which gave it the prerogatives of a state policy. The continuity of a health policy, focused on improving maternal and child health, throughout seven consecutive government regimes is an important achievement. Public health insurance is now a state policy, with an established legal framework and implemented by the public sector, the social security system and some private non-profit and profit making health institutions.

#### FINANCING SUMI

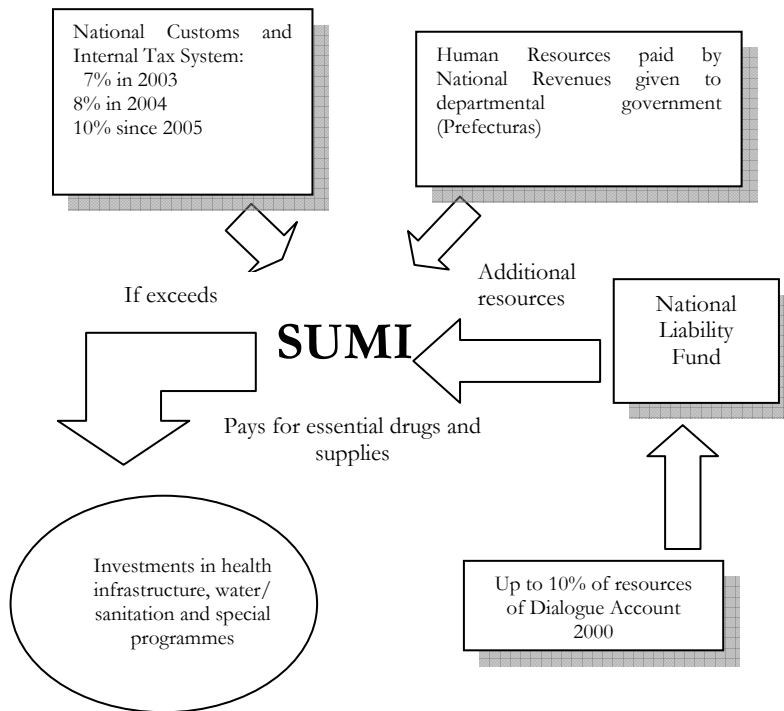
In order to understand the insurance scheme it is necessary to note some of the most relevant laws that support it. Bolivia is divided politically into nine “departments” and 327 “municipalities” (similar to counties in other countries). Municipalities may be as large as a city of 1.8 million or as small as only several hundred inhabitants. At each level, there is a governing structure: municipal, departmental and national government. The laws which regulate SUMI are: (1) the law of popular participation (1994), which transfers national tax funds to municipal governments to administer health and education services; (2) the law of administrative decentralization (1995), which delegates the responsibility for paying health service personnel to departmental governments; (3) the law of national dialogue (2000), which allows the use of national resources, from Highly Indebted Poor Countries (HIPC-II), as a Solidarity Fund for areas of social concern such as health services. While municipal governments, depending on their scale and governing capacity, may raise their own revenues through local taxes, these funds are not used to support SUMI.

SUMI thus has 3 principal sources of financing: municipal, departmental and national. From the total funds received by local governments (municipalities) on a per capita basis from National Income Taxes, 10% is allocated to pay for SUMI services, as well as the health infrastructure and equipment that are municipal assets. Departmental governments have the duty to pay health service personnel.

There are complementary resources available to strengthen SUMI financing derived from the National Solidarity Fund through the Dialogue Law, funded from debt relief. If the municipality has any funds remaining, these are used for social investments: in infrastructure or other activities related to

maternal and child health. For the 2006 period, the municipalities received around 22 million US dollars for the payment of SUMI service packages. This national level policy commitment and dedication to financial support has assured the economic sustainability of SUMI.

**Figure 2. SUMI Financial system**



## MANAGEMENT COMMITTEES

The aim was to create a simple system which would guarantee efficiency. Already at the time of the SNMN and SBS schemes, several reimbursement mechanisms were tested and refined. Basically, these forms and procedures guaranteed that cash or supplies flow back to service providers (Health Centres and Hospitals) after services have been provided. To this end, several forms were created to track patient registrations, monthly summaries, control of expenditures, and finally reimbursement of inputs. In order to cover the payment by one municipality for the services provided to a citizen from its jurisdiction in a centre belonging to another jurisdiction, there is a specific bill for trans-municipal charges.

The measures set out in the SUMI law maintain the national and departmental management units created under previous schemes. However, these management units are now mandatory for the entire national health system, prefectures, municipal governments, the social security system, and all institutions which are subject to these agreements.

It defines administrative authorities in the following way:

- (1) The Technical Coordination Committee (COCOTEC<sup>10</sup>), composed of the Planning Ministry and the Ministry of Health and Sports and the Economic Policy Unit (*Unidad de Política Económica*, UDAPE 2006), in charge of monitoring SUMI.
- (2) The Ministry of Health and Sports, as the National Health Authority, is responsible for establishing rules, regulating, coordinating, supervising and controlling SUMI and how it is applied at all levels of health care.
- (3) The Municipal Governments are directly responsible for implementing SUMI in their jurisdictions, as well as administering the Municipal Health Account (CMS-SUMI<sup>11</sup>) and reimbursing public health centres.

An important change under the SUMI law is the creation of a Local Health Committee (DILOS<sup>12</sup>) as the top authority in local administration in each municipality. This committee is responsible for implementing SUMI, administering the Municipal Health Account and complying with national health policies. It is composed of the mayor of the municipality or his/her

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<sup>10</sup> Comité de Coordinación Técnica.

<sup>11</sup> Cuenta Municipal de Salud - SUMI.

<sup>12</sup> Directorio Local de Salud.

representative, as president of the committee; a representative of the Municipal Vigilance Committee and a representative of the Departmental Health Service (SEDES), set up by the departmental government

#### REIMBURSEMENT PROCEDURES

The flow of funds for payment of services is as follows: (1) the National Treasury opens an account for each municipality and automatically transfers the resources corresponding to its share of national income from taxation (*coparticipación tributaria*); 10% of this sum is transferred to the municipal health account for the SUMI; (2) the health centre which has provided the service sends the administrative bill (FOPO) to the municipality, which reviews it, records it in a database, debits the sum from the municipal account and credits it to the health centre's account. At the same time, the information is dispatched electronically to the Departmental Management Unit where it is consolidated to be sent to the National Management Unit; (3) the National Management Unit identifies and authorizes municipalities to access additional resources from the National Solidarity Fund. This procedure is applicable when the municipality has spent the totality of its funds destined to SUMI. This situation does not often occur, for example, during 2005 only 15% of this fund was used (MSD 2008), particularly for the payment of third level care hospitals.

#### MONITORING SYSTEMS

Monitoring of the SNMN was carried out based on the priority indicators for children under 5 and their mothers, through the National Health Information System (SNIS<sup>13</sup>). Later under the SBS, administrative commitments were established with the aim of following up the seven indicators tracing supply of services and an indicator for the sustainability of financing vaccinations. For SUMI, as part of its credit agreement, the World Bank established management and supervision systems, including eight coverage indicators, with quarterly monitoring and reporting. One indicator was changed, from "coverage of diarrhoea cases" to "early newborn mortality". In the first case, compliance with this indicator did not present a challenge for the country, while in the second the Demographic Health Survey (INE & MSD 2003) proved that newborn mortality was an important

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<sup>13</sup> Sistema Nacional de Información en Salud.

problem, since it represented almost 50% of infant mortality which was at 54 per 1,000 live births.

**Box 1. Eight indicators to monitor mother and child health (MSD 2003)**

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| <ul style="list-style-type: none"><li>✓ Women with 4 antenatal check-ups</li><li>✓ Institutional delivery</li><li>✓ Pentavalent vaccine coverage</li><li>✓ Early newborn mortality in 15 hospitals</li><li>✓ Pneumonia case management coverage</li><li>✓ Iron supplement coverage in children under 5 years</li><li>✓ Number of municipalities with coverage of pentavalent vaccine below 80%</li><li>✓ Sustainability: sufficient funds from the national government to purchase vaccines for the regular expanded program of immunizations</li></ul> |
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Since 2003 under SUMI, an information system has been established, parallel to the national health information system (SNIS). This system electronically tracks service reimbursement forms, by which service provision and financial reimbursement can be opportunely analyzed. This information system and the SNIS are in the process of ensuring mutual compatibility so as to structure a new integrated SNIS which would involve the production, administration and financing of services.

Supervision is in the hands of four external consultants (two auditors and two physicians) who report to the National Management Unit of the SUMI, and who visit those health centres which show reduction in productivity or incongruent data in their information. These visits lead to feedback to the centre and the definition of an action plan. Unfortunately, neither the Departmental Management Unit of the SUMI nor the Departmental Health Service, SEDES, are involved in this supervision. As a result, many recommendations are not followed up.

#### EVALUATION

The monitoring system was complemented by external evaluations carried out by different organizations, which in general agreed that the different types of insurance schemes have had favourable results with respect to the demand for services. However, it is difficult to know if this is only due to the

effect of the insurance scheme or if other social factors influenced this variable. These evaluations identified specific problems in the administration and the quality of services.

Partnerships for Health Reform (PHR) carried out an evaluation of the SNMN in 1998 (Dmytraczenko *et al.* 1998). Other evaluations were carried out on the Basic Health Insurance scheme (Böhrt & Holst 2002, Böhrt & Larrain 2002). The last evaluation was carried out by the Unit of Analysis of Social and Economic Policies (UDAPE 2006) which reports to the Ministry of Development Planning, analyzing the impact of the three insurance systems.

Demographic Health Surveys (DHS), mostly financed by the Health Reform, are planned every four to five years. The information produced allowed the country to measure the progress made towards the Millennium Development Goals, disaggregated by departments and identifying those at greatest risk. At present, the DHS 2008 is at the field work stage, which will measure progress made during previous years.

#### QUALITY MANAGEMENT

Quality assurance systems have been set up to maintain quality of services while increasing coverage. In the second phase of the Health Reform Project (APL II), the Quality Administration Observatory<sup>14</sup> was created, which generates studies and establishes norms for the accreditation and certification of health centres, medical audits and studies of user satisfaction. As the initial step, the Ministry of Health selected 15 hospitals which attended almost 70% of institutional childbirths in the public sector, improved the training of personnel in obstetric and neonatal emergencies, provided equipment and supplies and applied patient and provider bio-safety norms for accreditation, alongside equity assessments for those populations with least access to health.

Among the most important activities carried out by the Quality Administration Observatory was the creation of the Accreditation Commissions in second and third level hospitals and certification for first level health centres. This was accompanied by assessment and equipment of hospitals and first and second level care centres to respond to obstetric and neonatal complications, as well as offering continued staff training on

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<sup>14</sup> Observatorio de Gestión de la Calidad.

standard practices for maternal, neonatal and child care and improvement of infrastructure.

Between 2004 and 2007, of 100 third level hospitals, 34 were accredited and of the 1,000 selected health centres, 300 were certified (MSD 2008). These processes have been supported by the Departmental Health Service, although their implementation has not been homogeneous. Some SEDES have set up teams to support the Accreditation and Certification Commissions, which has led to standardised ways of working, while in others, this activity has been sporadic. Furthermore, the detection of problems in a centre has not always given rise to the necessary decision making and action to correct the problems or follow them up.

#### COMPLEMENTARY STRATEGIES: MOBILE TEAMS, COMMUNITY PHARMACIES AND INTERCULTURAL COMPONENT

Although economic barriers have been mitigated by SUMI, the fundamental challenge continues to be inequities and social exclusion. This is generated by geographic inaccessibility, insufficient human and technical resources, above all in rural areas, and cultural aspects both on the community side and the service provider side. All these phenomena set up barriers to health care access (OPS 2002).

Since 2003, a number of solutions have been proposed and implemented to address geographical and cultural barriers and to make the health service model more inclusive.

The National Programme for the Expansion of Coverage of the SBS and SUMI, EXTENSA, was designed to provide direct basic health services to populations in remote areas of the country. EXTENSA formed multidisciplinary mobile health teams called "Brigades" (doctor, nurse, dentist and assistant). Each one provides services in 40 to 50 communities, which are visited every two months in rounds lasting 20 to 25 days.

In 2006, 59 mobile health brigades reached 202 municipalities and 3,250 communities, covering 411,000 inhabitants, related to more than 500 health centres in the dispersed rural area with the highest poverty index. In the 2007 administrative period more than 1.6 million services were carried out, of which the SUMI covered 59%, displaying a constant increase with reference to the geographical context and the production of services since 2002.

The Community Pharmacy is a strategy for the social inclusion of rural communities with high levels of poverty, guaranteeing prompt access to drugs. It consists of providing a supply of essential drugs to remote communities which do not possess a health centre. This supply is administered by a community health agent elected and supervised by the community. Since the 2005 administrative period, 1,400 Community Pharmacies have been set up in selected communities according to the level of access to health centres; a process which gave rise to the mobilization of more than 4,000 members of the Local Health Committees, who were trained in handling the communal pharmacy and in topics related to health care. With these pharmacies, more than 170,000 inhabitants benefit from prompt and safe access to drugs and essential supplies for resolving basic health problems. Another 1,700 community pharmacies are planned for the 2008 administrative period.

One of the greatest problems of exclusion is the lack of understanding and respect for cultural traditions, which particularly affect rural women. To overcome this barrier, the Health Reform developed an intercultural health component in 2002. 371 health facilities (19% of the entire country) in rural areas are being strengthened with special intercultural training for health service personnel and culturally adapted approaches to attend childbirth, provide care for pregnant women and their families in the maternal homes and make use of traditional herbs in health centres.

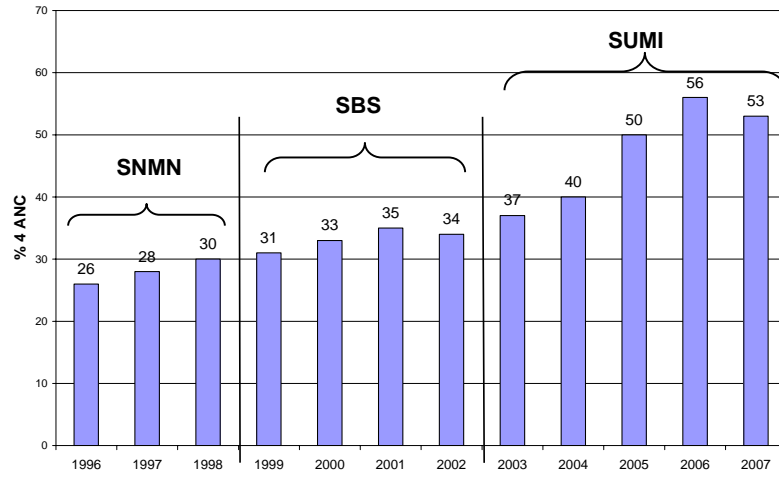
## *Results*

### SERVICE UTILISATION COVERAGE

As stated earlier, the country prioritised eight indicators to measure results within the context of the Millennium Development Goals, establishing annual targets. For the first two years all indicators were met. In the following years, this was not maintained, presenting a different performance level each year. In 2007, four of the projected indicators were met: early neonatal mortality, iron supplementation, coverage of pneumonia cases and immunization financing.

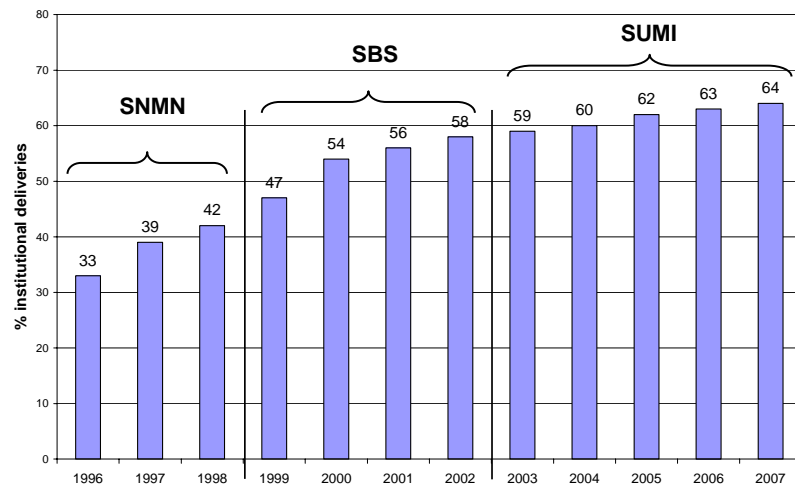
The two indicators selected to measure maternal health, four antenatal checkups (Figure 3) and institutional delivery, are positively correlated with the reduction of maternal and neonatal mortality (Vidal 2003).

Figure 3. Coverage of 4 ANC, 1999-2007, Bolivia



Sources: National Health Information System (SNIS 2008), updated graph from UDAPE report (2006).

Figure 4. Institutional delivery



Sources: National Health Information System (SNIS 2008), updated graph from UDAPE report (2006).

The first years of the insurance scheme - 1996 to 2003 - produced the

greatest increase in coverage of institutional delivery, while in recent years, a plateau has been reached (Figure 4).

#### IMPACT ON MATERNAL HEALTH

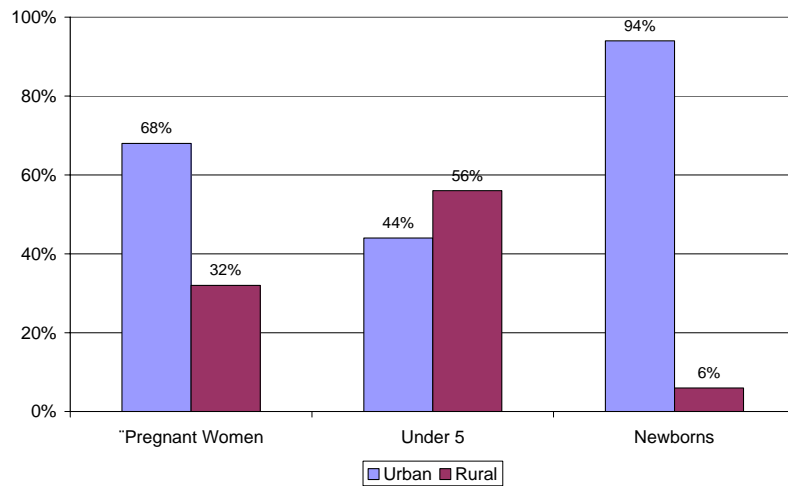
The Bolivian DHS documents the positive changes in maternal indicators. In 1994, the DHS showed that the maternal mortality ratio was of the order of 390 maternal deaths per 100,000 live births, antenatal coverage was 49% and deliveries with skilled attendants 43%. On average, the maternal mortality ratio for 2003 fell to 230 per 100,000 live births, antenatal care was almost 71% and deliveries with skilled attendants stood at about 60%.

#### EQUITY GAPS

All evaluations of SUMI and previous schemes agreed that access to health services had increased, but noted, as one of the crucial issues, that services did not extend to the poorest sectors of the population, and that the rural population was not aware of these insurance services (Narvaez 2002). In the coverage of pregnant women and newborns for the 2004 period, SUMI showed a clear gap between urban and rural areas. In rural areas, only one third of pregnant women completed their 4 antenatal check-ups while this percentage for urban areas was almost 70% (Figure 5). In addition, neonatal coverage (a well baby check-up before one month of life) was only 6% in rural areas, whereas in urban areas it had reached 94%. On the other hand, the coverage for children under 5 (one doctor's visit per year) is 10% higher in rural areas compared to urban areas (56% vs. 44%).

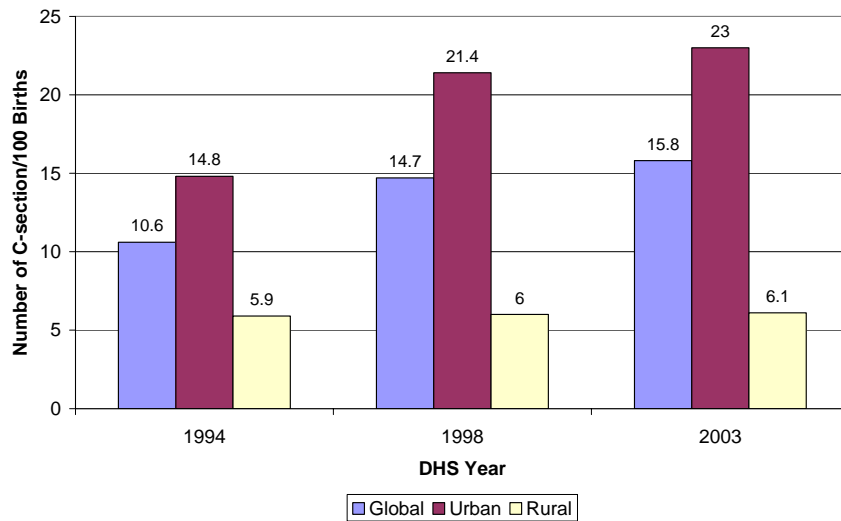
If we look at the C-section rate, which was not one of the 8 monitoring indicators, but which is an excellent indicator of utilisation and accessibility of services, we see that the rate of caesareans has not increased in rural areas since the start of the insurance scheme (Figure 6)

Figure 5. Coverage of 3 services packages: Pregnant women, newborns and children under 5, Bolivia, 2004



Sources : Health Reform Unit, FOPO's 2004

Figure 6. Evolution of urban and rural C-section rate, Bolivia



Sources: DHS 1994 (INE & MSD 1994), DHS 1998 (INE & 1998), DHS 2003 (INE & MSD 2003)

Furthermore, there are still wide disparities between and within regions and departments, especially with respect to disadvantaged groups. For example, in urban areas, antenatal coverage is almost double that of rural areas. The highlands, where most indigenous people live, have the lowest coverage rates (59%) compared to the lowlands with almost 80% coverage and, for those women in the lowest poverty quintile, antenatal care is only 37% (INE & MSD 2003). In addition, skilled birth attendant deliveries in urban areas run to almost 75%; in rural areas this percentage is only 38% and for women in the lowest poverty quintile it is still only around 27%.

The greatest increase in services utilisation took place in third level centres in urban areas, which include general and specialized hospitals. The best facilities are preferred by users as they offer the opportunity of being attended by specialists and have a greater availability of drugs and supplies.

#### QUALITY OF CARE

According to monitoring reports from the Quality Administration Observatory, over the years until 2006, there were deficiencies in the quality of services, such as poor identification of danger signs on the part of health centre personnel, and a lack of basic laboratory tests which could identify early onset of anaemia in pregnant women, urinary tract infections and STDs, and allow them to take prompt decisions. However, hospitals which received accreditation showed a good level of staff knowledge in terms of updated clinical standards, infrastructure, equipment and safety standards. Clinical audits of case histories were satisfactory in the accredited hospitals.

#### SATISFACTION

Users reported a decrease in quality of care, mainly in third level care hospitals. Despite this, during the 1998 evaluation, based on exit interviews, 85% of female users were satisfied with the services (Dmytraczenko *et al.* 1998). This may reflect a general tendency for users to declare satisfaction with the medical care they receive, and a reticence to criticize services especially when the exit interview is done on the premises of the clinic. After this evaluation in 1998, no other comprehensive assessment of client satisfaction has taken place.

#### FINANCIAL SUSTAINABILITY

In the 1998 evaluation the Bolivian scheme was called into question due to

the underestimation of average costs (Dmytraczenko *et al.* 1998). Higher level health facilities faced higher average costs and this needed to be reflected in the chosen levels of reimbursement. This problem persists even today.

The reimbursement per service is the same in urban and rural areas (for example the cost of normal childbirth). However, due to the greater complexity of services offered in urban areas (such as C-sections, neonatal intensive care), urban areas spent twice as much in 2006 as rural areas (US\$ 13,981,775 urban versus US\$ 7,685,678 rural (MSD 2008)).

## *Discussion*

Current evaluations demonstrate that the utilisation of institutional maternal services has increased since the insurance policy was implemented, and this is likely to have contributed to improved maternal indicators, as observed in DHS survey report updates. It is important to recognize that over the course of time, stagnation or a slight downturn in the trends of some indicators can occur. In this case, it may be necessary to identify other outreach strategies in order to guarantee universal coverage.

The main problems of SUMI remain in the area of equity and quality of care. Equity assessments show that the poor, the indigenous and the rural populations still underutilize SUMI. The notable exception being that child health care services are seeing higher coverage in rural areas and this may be related to the success of community-IMCI (Integrated Management of Childhood Illnesses) with intense social mobilization in rural areas, but it could also be explained by a higher use of private providers in urban areas. Another example is the stagnation of the C-section rate in rural areas, which can be explained by the lack of hospital care. Most health centres in rural areas are only equipped and staffed for ambulatory care.

Quality problems are probably due to the coverage increase rate which puts pressure on health service personnel, increasing their daily workload. The disproportionate increase in tertiary level facilities as opposed to primary level ones, must lead us to think about strategies to reinforce the latter and actively support second level hospitals in responding to obstetric and neonatal emergencies.

## *Conclusion and lessons learnt*

SUMI is not perfect. Although more than ten years of implementation seems a long time, the learning process from a public insurance strategy requires constant follow up and contingency strategies to improve services and to achieve the goal of social inclusion. The health sector reform process provides an opportunity to scale up evidence-based effective and feasible maternal essential interventions and set up standards for other organizations.

The fact that a public insurance scheme, such as SUMI, has been adopted as a state policy, guarantees continued commitment, even during political instability or transition, and also financial sustainability. The legal framework and the definition of a shared system of finance have been fundamental in converting SUMI into a state policy. Signing administrative commitments with clear maternal indicators is a practice which allows for improvement in follow-up and decision making by Departmental and National Management Units, Health Network Managers and municipalities to comply with agreed targets.

### **Box 2. Lessons learnt**

1. **Need for bulk purchase of drugs and consumables and for a national purchasing centre:** With respect to the purchase of inputs and medicines, it is advisable for insurance policies to formulate maternal packages according to the level of complexity of the health facility and type of health personnel, and to implement the interventions through bulk purchases between several municipalities or by the Departmental Management Units, so as to reduce costs.
2. **Facilitating delivery of drugs and consumables at providers' level:** With respect to supply, it is necessary to have a supply system, both at national and departmental levels, that will allow health personnel to get drugs and consumables required for obstetric and neonatal emergencies.
3. **Strengthening the management capacity of municipal and health services personnel and systems** should be a priority to resolve bottlenecks. So far, the reimbursement mechanisms are somewhat bureaucratic and slow, endangering the administrative and technical capacity of the health facilities, especially among tertiary level hospitals.
4. **Monitoring progress is essential:** A result driven approach and focus on

accountability would facilitate project implementation and follow up. Therefore, improvement in information systems is required, so as to monitor indicators and assess if the insurance policy is reaching poor populations.

5. **To effectively monitor progress there is a need for standardised indicators:** Compatibility is essential between the information systems of the different insurance schemes with regular health systems, so as to come up with a sole information system. A limited number of maternal indicators focused on target fulfilment is recommended. Close supervision is important to maintain the pace of implementation. Selection of appropriate indicators has also proven to be critical for maintaining the focus on the final results.
6. **Intercultural, gender and inter-generational issues are essential to tackle:** Focus only on the supply side of health reform measures is not sufficient to address the health needs of the poor. The equity gap for low-income households' access to health services still remains. It is crucial that maternal health strategies address client satisfaction and take into account intercultural, gender and inter-generational differences.
7. **Primary stakeholders have to receive support:** The development and consolidation of civil and governmental alliances are needed to sustain and develop insurance policies. Alliances should be established at all levels of society and government, especially with various women's movements.
8. **Strategic action lines to promote community involvement in health services must be developed** to facilitate the participation and empowerment of new civil stakeholders and non-health sectors as local social actors. This could include in particular school teachers, students, and other community members, to promote key family practices, reinforce the link between health services and the community, and stimulate collaboration between sectors, especially between those of health and education, and thus strengthen outreach strategies.

Although interventions to reduce maternal mortality and improve quality of life of women should be given priority, in the framework of the continuum of care, universal coverage of all people has to be a political goal, if we are to achieve equity in the exercising of the right to access quality health services.

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