BOLIVIA'S REFORM TO IMPROVE MATERNAL AND CHILD MORTALITY

by

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Abstract

In the mid 90’s, the government of Bolivia collaborated with the World Bank and others to design a health sector reform with the principal goal of reducing the country’s high infant and maternal mortality rates, the second highest in Latin America. In the first phase of the reform, beginning in 1996, an earmarked amount of central government revenues devolved to municipalities was set aside to finance the drugs and supplies necessary to deliver 26 maternal and child interventions, by any health care provider, without any patient contribution. During the second phase of the reform, beginning in 1999, the benefits were expanded to 90 interventions and the earmarked revenues were doubled. Evaluations show that intermediary goals of the reform, such as higher prenatal coverage, increased assisted delivery, and higher coverage of acute respiratory infection and diarrheic disease in children less than five years old, are being accomplished. Key features of the reform making this possible include (i) modifying the financing and payment mechanisms of priority services within the public health sector; (ii) introducing performance agreements with specific output and process targets, and (iii) continuity through different political periods. Major challenges include reducing the equity gap in access to services between high and low income households and resolving the bottlenecks generated by the country’s fragmented decentralization.

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**Introduction**

In 1996, the Government of Bolivia (GOB) launched a health reform strategy with a principal goal of reducing maternal and infant mortality. The reform was motivated by maternal and child mortality rates that were higher in Bolivia than other countries in the region as well as large disparities between urban and rural groups, and more specifically among indigenous peoples representing more than half of the country’s population. For example, the national rate of maternal mortality was about 390 per 100,000 live births (DHS 1994), more than double the average of countries in the region. Variations in maternal mortality ranged from 20 to 600 per 100,000 live births, depending on the income quintile. Despite government efforts to expand access to health care, utilization of formal health services remained low, especially among the rural poor.

To spearhead efforts to improve these unsatisfactory health outcomes, the government launched the Seguro Nacional de Maternidad y Niñez (SNMN) – or National Insurance for Mothers and Children – in the framework of a broader program to decentralize public financing to municipal governments. Two major policy changes at national level made the SNMN initiative possible. First, in April, 1994, the government passed a wide-ranging Law of Popular Participation, which entitled municipalities to 20% of all government revenues and transferred the ownership of health and education facilities (as well as the responsibility over their maintenance and further investments) to municipal governments. Second, in July 1995, the government passed the Law of Administrative Decentralization, creating an intermediate government entity between the municipal and national governments called “Prefectura”, serving as the Ministry of Health’s proxy for policy-making at the regional and local levels and responsible for managing and allocating health personnel to facilities.

Thus, the two laws created a radically different context for health care by placing both financial resources and physical infrastructure in the hands of local government. With respect to improving health, municipalities would now be expected to make use of the funds earmarked for services to improve health status outcomes and better reach the poor. The fundamental goals were to reduce by 50% the number of deaths among otherwise healthy women due to events of pregnancy and labor, and to cut in half the number of deaths in children under five due to pneumonia or diarrhea.

This paper focuses on the design, implementation, and impact of the Maternal and Child Health Insurance through two phases – from inception in 1996 to 1999 (Phase 1), to revision and expansion from 1999 onwards (Phase 2). Our analysis makes use of the ‘Flagship Framework’ -- as developed by the World Bank Institute and Harvard School of Public Health – which emphasizes the importance of change along five dimensions (or “control knobs”), namely: financing, remuneration of providers, organizational change, behavior change, and regulation.
Pre-Reform Background

In the mid-90’s Bolivia had approximately 7.5 million people, with a per capita income of about $900 per year. The leading causes of maternal mortality were hemorrhage (39%), eclampsia (21%), abortion (10%) and infections (4%). The leading causes of under 5 mortality were diarrhea (36%), pneumonias (20%), perinatal (16%), and immunopreventable diseases (3%).

In 1995, total expenditures on health were in the vicinity of $40 per capita, representing 4.8% of GDP. Financing of the health sector relied on general revenues from taxes (28%), social health insurance (37%), and out-of-pocket payments (35%). In view of deteriorating economic conditions during the 1980’s and underfinancing of health services by government, user fees had become increasingly prevalent in public facilities.

The organizational structure of public finance and provision was a top-down, centralized approach to providing health care, with the design and delivery of services being mostly public, with the social insurance administration tending to its own defined membership, and a small private sector operating largely in urban areas. Coverage of the population was estimated to be 35% by the public network, 25% by the social insurance, 5% by the private institutions and 10% by NGOs. By some estimates, 25% of the population, principally rural, was not effectively covered by any subsector of health services (public, NGO or private), implying that centrally funded public services were not effectively reaching the poor (with an estimated 70% of the population living under the poverty level).

Many international donors and local organizations were playing a role with specific health targets like usage of antenatal care, however most worked outside the system, mainly through NGOs, with little integration to the government’s service delivery mechanisms.

PHASE I of the National Maternity and Child Insurance (SNMN)

Phase I of SNMN can be characterized by three distinguishing features. First, it was coupled with (and indeed made possible by) a devolution of public financing for health from central government to municipalities. Second, expectations of improved effectiveness of public spending on maternal and infant mortality were tied to expectations that municipalities would play a more decisive role in getting “value-for-

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\(^2\) This part of the paper has benefitted by presentations at the annual Flagship Course, convened in Washington DC by the World Bank Institute in 1998 and 1999 by Dr. Fernando Lavadez (General Manager of Health Services and Director of the Health Reform Project, Bolivia), and others.
money” from the additional public financing that came under their control. Third, the devolved public funds would be used by municipalities to pay for priority services needed by women and children, thus removing the constraint of user charges on demand and access.

In these respects, SNMN is not really an insurance program – as it’s name would suggest – but a reallocation and “targeting” of public funds to improve the health outcomes of an important population subgroup. Having said this, designers of SNMN felt there was not sufficient administrative capacity to apply “means testing” to determine who was poor, and therefore deserved free services, thus opening the door to anyone who came forward to make use of the services. Moreover, there was agreement among the planners of SNMN that “universality” would be a better understood and politically acceptable concept, especially among the indigenous communities.

Nor did Phase 1 of SNMN qualify as a “big bang” approach given the budgetary constraints and limited public resources available, the enormity of the problems faced by providers to improve and extend service, as well as the needs and demands of households in poor areas. Rather, it included a rather modest, affordable set of health interventions, it made use of the existing network of facilities, and it relied on self-targeting of people wanting the services (on a politically acceptable, universal basis), rather than more complicated and often disputed targeting of population subgroups in distinct geographical areas.

More specifically, Phase 1 of the SNMN can be described in terms of the five Flagship “control knobs” as follows.

**Financing (96-98)**

As part of it’s overall decentralization plan, beginning in 1994, 20% of central government tax revenue was distributed – on a per capita basis – to the country’s 311 recognized municipal governments, giving them control over the use of these funds within their territorial jurisdiction. This enabled poor rural municipalities to access funds directly for the first time, and proved to be a progressive allocation of public tax revenues, thus reducing equity gaps in the allocation of resources in the country.

Eighty-five percent of the national revenues allocated to each municipality had to be spent on what was termed “investment purposes”. And starting in 1996, with the launch of SNMN, 3.2% of those investment monies were earmarked to health and deposited in special Municipal Health Accounts, from which each municipality could draw to pay participating providers.

**Payment of Providers (96-98)**

The payment mechanism was based on a fee-for-service retroactive reimbursement from municipal governments (Municipal Health Accounts) to health facilities. A pre-set payment schedule was established to reimburse providers for 26 interventions. Among
the 26 interventions, those specific to maternity included prenatal care, preeclampsia, eclampsia, vaginal delivery with neonatal care, Cesarean section delivery with neonatal care, postpartum sepsis and postpartum hemorrhage. Neonatal services included asphyxia, pneumonia, and sepsis. Services for children under five years of age included acute respiratory illnesses and diarrhea.

The Payment schedule covered the cost of drugs, supplies, hospitalizations, and laboratory exams. For government owned facilities this was viewed as being appropriate because, under the Popular Participation Law, together with the Administrative Decentralization Law (described earlier), the costs of maintaining and operating public facilities were treated as fixed costs, covered by municipalities. Similarly, because of low productivity and excess capacity in the MOH clinics, the human resource costs were also considered fixed and paid for by the Ministry of Health, through the Prefectures.

Providers serving the social security network were also expected to deliver SNMN services for “free” to the population, at the pre-set reimbursement rates. In the case of non-public providers, however, the partial reimbursement rates entailed subsidization of human resources costs. As a result, many of them (for example, the NGO provider PROSALUD) chose not to participate as SNMN provider.

Reimbursement was made effective, in arrears, at the end of each month. Each facility would record the number of services delivered each month and then send this information to the Health District, which would then consolidate the information for the entire service network and send it on to the corresponding municipality. The municipalities would then reimburse the facilities, either directly or by district. This system of reimbursement in arrears was chosen on account of the weak administrative capacity of most of the country’s municipalities.

As expected, the fee-for-service payment mechanism created an incentive among providers to register the services they delivered to patients. And, insofar as new clients were served, the payment mechanisms enabled public expenditures to “follow the patient” (by actually paying per service rendered) rather than going only to inputs, as in the past, without any clear indication the inputs were actually benefiting patients.

**Organization (96-98)**

No direct change was launched by the decentralization reforms or by SNMN arrangements. Facilities providing the 26 interventions included MOH facilities at all levels of the service delivery network, some social security hospitals and a small number of private non-for-profit organizations. Private for-profit providers did not participate.

**Regulation (96-98)**

The MOH and SNMN administration set the reimbursement fees and monitored and evaluated performance on 5-8 health utilization criteria. However, there were no performance agreements with explicit, accountable criteria in Phase I of SNMN.
**Behavior Modification (96-98)**

At the beginning of the reform some resources were invested in an information campaign to convey the importance of using maternal and child health services and their availability free of charge. This included public announcements on radio and TV, and in informal community discussions.

**Impact of Phase I**

An evaluation of Phase 1 covering 31 health facilities in 12 municipalities, representing the 3 geographic zones of Bolivia, was undertaken from February to July, 1998. At the time of this evaluation, no information was available on mortality outcomes. Results were thus based on changes in inputs and intermediary performance criteria. Indeed, the absence of baseline data on desired outcomes – prior to the interventions – mean that the impact of the SNMN cannot be rigorously ascertained.

These results for Phase I suggest the following:

- As conveyed in Table 1, there was a considerable increase in institutionalized deliveries in the public network and among social insurance and NGO providers, as well as increased utilization of health facilities for antenatal care, diarrheic disease and acute respiratory infection. The data in Table 1 report growth in utilization during the 18 month period following implementation of SNMN, compared with utilization 18 months prior to SNMN. The last column in Table 1 conveys that utilization of the same services fell among private providers, where user fees remained in place. This suggests that there was a shift in demand from the private to the public sector.

<table>
<thead>
<tr>
<th>Service</th>
<th>Public Facility</th>
<th>Social Security</th>
<th>NGO</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal visits</td>
<td>39</td>
<td>16</td>
<td>94</td>
<td>-50</td>
</tr>
<tr>
<td>Other outpatients</td>
<td>29</td>
<td>34</td>
<td>61</td>
<td>-56</td>
</tr>
<tr>
<td>Total births</td>
<td>50</td>
<td>43</td>
<td>28</td>
<td>-37</td>
</tr>
<tr>
<td>Other inpatients</td>
<td>26</td>
<td>18</td>
<td>47</td>
<td>-29</td>
</tr>
</tbody>
</table>

Source: PHR, 1999, see footnote 3.

- As conveyed in Table 2, women with a “low” socio-economic background were making greater use of the services than better off women. Moreover, women

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who had not previously used services, for example delivering at home, were increasingly making use of services for the first time. The evaluators further suggested that the increased coverage was higher in those regions where utilization had been lowest, thus providing a possible equity benefit across regions.

Table 2: Percent Change in Utilization by Socio-Economic Level

<table>
<thead>
<tr>
<th>Service</th>
<th>Low Socio-econ Level</th>
<th>Middle Socio-econ Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>Prenatal</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>Other outpatient</td>
<td>74</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: PHR, 1999, see footnote 3.

- Even without incentives to human resources and an increased burden of their work load, 85% of users interviewed by the evaluators expressed satisfaction with the services received.

As would be expected, Phase I of SNMN encountered many implementation problems, especially pertaining to reimbursement of providers of SNMN services. Indeed, part of the function of Phase I was to yield lessons and insights for the refinement and development of a later, Phase II. Lessons learned include:

- Reimbursement rates for providers of SNMN services were, in general, underestimated by MOH, especially for medications and supplies. And some services that should have been reimbursed considering their impact on preventing mortality, such as oxygen for the newborn, were not included.

- The reimbursement fees were fixed for each service independently from the cost structure or level of complexity of the facility in which they were provided (i.e. the same amount was reimbursed for a delivery whether it occurred in a health post or in a hospital, public or NGO). Different cost structures are particularly relevant to NGO providers who must pay recurrent costs, for workers for instance, from revenues and cannot rely on MOH budgetary allocations, thus undercutting broader participation of providers in the SNMN.

- While the availability of drugs improved in most facilities, as a result of SNMN payments, drug provision issues remained due to (i) reimbursement delays and (ii) non-compliance with MOH intervention protocols resulting in actual costs that were higher than those covered by the reimbursement schedule.

- Although the mechanism of reimbursement was relatively simple, the institutions did not have the culture, personnel skills and management capacity to liaise effectively with the MOH, as a purchaser/payer. Overall, managerial capacity was low, affecting not only the flow of resources but accountability.
• In the absence of fees, users frequented higher level facilities relatively more than primary level facilities, even when the latter would have been more cost-effective and efficient in providing services.

• Only 70% of users interviewed knew the benefits of the SNMN, showing the need for more information to the public.

• Funds earmarked for reimbursement of SNMN services were not fully utilized, perhaps due to the newness of the program and correspondingly low service demand, lack of information among beneficiaries of their entitlement to free services, lack of preparation and capacity among public providers, and insufficient reimbursement rates for non-public providers.

More recently, data from the 1998 DHS permitted an analysis of the impact of the SNMN on health outcomes. Findings show that indeed, there was a 10% drop in infant mortality from 75 deaths per 1,000 live births in 1994 to 67 in 1998. This was accompanied by an overall increase in the utilization of services, as measured by the SNMN evaluation. However, the DHS 1998 also shows that the improvements in outcomes were somewhat larger among richer households than poorer households with negative results on equity. While the infant mortality decreased by 27% for the richest income quintile (from 38 to 26 per 1,000 l.b.), it decreased by only 5% for the poorest (from 115 to 107 per 1,000 l.b.).

Phase II: SNMN evolves into Basic Health Insurance (BHI)

By 1999, SNMN became more fully integrated within the government’s overall health reform strategy, and the “National Maternity and Child Insurance” (SNMN) was expanded to become the “Basic Health Insurance” (BHI). The reformers established that maternal and infant mortality and morbidity were still the main health problems to be tackled. However, they decided to also include other health priorities under the umbrella of the public health insurance, such as TB and other vector transmitted diseases, which had previously been addressed by vertically-financed public health programs.

Based on the priorities and the evaluation of Phase I, the government introduced several important changes to strengthen the Basic Health Insurance (BHI) to reduce maternal and childhood mortality. The reformers doubled the financing, expanded the benefit package, revised reimbursement schedules, and introduced performance agreements between the

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different levels of the Ministry of Health’s decentralized system. In addition, vector control programs were put into place to complement treatment schedules now included in the insurance (for example in the case of malaria). As was the case during Phase I, the program offered universal access to all Bolivians demanding services from BHI. Overall, the temptation and political pressure to begin a completely new strategy were neutralized by the reformers with technical and economical arguments, and the changes introduced essentially represented a continuation and improvement in terms of the benefit package and the financing strategy. Again, we briefly summarize the main changes introduced with the BHI in terms of the five Flagship “control knobs”.

**Financing (99 onwards)**

The 3.2% share of local government revenue earmarked for the SNMN during Phase I was now doubled to 6.4%. The practice of depositing these funds into an earmarked municipal account for reimbursement of BHI services was continued in view of the perceived importance of involving municipal governments and separating the financing of BHI services from other uses, or management by any one individual. This arrangement is depicted in Figure 1.

![Figure 1: BHI Financing and Payment](image)

The increase in financing to 6.4% was justified by an expansion of the plan of benefits from 26 interventions in Phase I to a broader package of 90 cost-effective interventions during Phase II. The expanded interventions focused not only on the main causes of maternal and under 5 mortality, but also on the main causes of morbidity from endemic diseases in the general population. With this expansion, the government’s main public health strategies and programs were all integrated into the benefit package. Some of these services, however, continued to be financed by resources from the central level, in many
cases with donor support (e.g. family planning inputs, drugs for treating TB and sexually transmitted diseases, vaccines, etc.).

**Organization (99 onwards)**

Phase II did not change the way in which the providers were organized but, rather, introduced new “contractual” arrangements to assure better performance in the delivery of services and related health outcomes. These arrangements were in the form of performance agreements – setting targets on both process and output indicators – between the Ministry of Health and its decentralized regional institutions at the Prefecture level (not the municipalities). In turn, most of the country’s 9 regional health agencies signed performance agreements with their health districts (corresponding to the local health service networks).

The exercise of setting targets on priority indicators related to maternal and child mortality and other endemic diseases helped focus the activity of the health sector from inputs towards results. However, an important weakness of the system was the lack of clear incentives for the different MOH levels to reach the targets. Some progress in this area was achieved through public evaluation of the regions on their health performance, and a one time recognition of the best-performing region with a US$10,000 prize in medical equipment. However, no changes were introduced at the local service delivery level, which is the level actually responsible for producing the results.

Another change was the inclusion of several of the MOH’s various centrally-financed public health programmes and strategies into the BHI. These included the Expanded Program of Immunisations, the Sexual and Reproductive Health Program, and Malaria and TB programs. In addition, the MOH developed BHI medical care guidelines that were consistent with Integrated Management of Childhood Illnesses (IMCI), and the Maternal Neonatal Package (MNP) strategies. This resulted in greater integration and coherence of the national strategy and goals and helped bring donor agendas and efforts into closer alignment with the government’s reform.

**Payment (99 onwards)**

Providers continued to be reimbursed by “fee-for-service”, with levels of reimbursement still based on the direct cost of drugs and supplies, as well as the average cost of a day of hospitalization – all using MOH protocols or expenditure levels. However, to give health facilities incentives to increase the demand for some key services, incentives were introduced on top of the cost of selected services. For example, the fee for institutionalized deliveries now included an additional 40%, which could be used freely by the facility.

**Regulation (99 onwards)**

The changes introduced with BHI, including the mandatory requirement that public or social insurance institutions deliver the services included under the BHI free of charge for
the targeted population, were passed through a *Supreme Decree*. This was considered a weakness by some of the reformers who wished to see the insurance supported by a National Law.

**Behavior (99 onwards)**

The introduction of performance agreements and associated monitoring and evaluation aimed to change the culture of accountability and focus the effort of the whole public provider network, starting with the regional administrations, to accomplish the BHI goals.

It should be noted, however, that municipalities needed persuasion to accept participating in the BHI, since this implied earmarking twice as many resources as previously (thus losing control over these municipal funds). Political pressure was rallied to mobilize local leaders who resisted the program, including extensive consultations and briefings with MOH personal. Another strategy to get municipalities on board was to establish a strategic alliance with UNICEF in view of its strong “field presence” in Bolivia and commitments to improving maternal and child mortality. This strategy succeeded in getting an initial 100 municipal governments to sign the agreement to participate in the BHI. And by 2000, all of the country’s 314 municipalities had entered into signed agreements to participate in the BHI insurance scheme.

**Evaluation of Phase II**

Results to date suggest that the deepening of the reforms led to a further increase in coverage of priority maternal and child services. Between 1998 and 2002, there was an increase in coverage of institutional deliveries (from 42% to 54%), fourth antenatal consultations (26% to 36%), pneumonias (69% to 100%) and diarrhoeas (29% to 43%) in children under 5 years (see Graphs 1 and 2). The BHI undoubtedly played a central role in this, as evidenced by an analysis of the determinants of health services. For example, knowledge that the public health insurance provides free services increases the probability of women receiving skilled birth attendance by 16 percent. Similarly, it increases the probability that children under five years receive care for acute diarrhoeal diseases and for acute respiratory infections by 8 percent and by 4 percent, respectively.

Despite these results, however, in recent years, the rate of increase in coverage has been tapering off, and even decreasing for some key indicators. Furthermore, the equity gap remains, despite the fact that the reforms reached not only the urban and rich, but also the poor, rural and indigenous municipalities. In 2001, the coverage of skilled birth

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Graph 1

Coverage of Skilled Birth Attendance and Antenatal Care
1994-2002

Graph 2

Coverage of DPT3, Pneumonias and Acute Diarrheal Diseases.
1994-2002

Source: MOH, National Health Information Service (SNIS) (www.sns.gov.bo)

attendance was 89 percent for the richest fifth of the population, while it reached only 25 percent for the poorest. Finally, despite the introduction of the public health insurance, households remain an important source of financing for the sector, with out-of-pocket expenditures contributing 30 percent of national health spending.

Discussion

The reforms described above, in the form of Phase I and Phase II, suggest a number of positive conclusions. In terms of health system outcomes, the Bolivian reforms appear to be making progress on all three “core outcome” variables identified by WHO in its WDR 2000 report, as well as in the Flagship Diagnostic Framework. In the Flagship Framework, those core outcomes are improvements in “health status”, “financial risk protection” and “responsiveness to clients”.

First, the Bolivian reforms appear to be improving utilization of services that can reasonably be expected to lower maternal and childhood mortality rates. Looking at a wider time frame, from 1994 to 2002, deliveries attended by trained personnel more than doubled, from 25 to 54%. Similarly, attended pneumonia cases among children under 5 rose from 26 to 100%, and attended acute diarrhoeal diseases rose from 18 to 43%. And while vaccination rates of children under 1 year with the third dose of DPT dropped to as low as 71% in 1996, it recovered with the reforms and reached 98% by 2002.

Second, by allocating and earmarking public funds for health to municipalities on a per capita basis, and collaborating with donors to channel resources to national health programmes through the BHI, the Bolivian reforms appear to be contributing positively to financial risk protection of poorest households. This is reinforced through the reimbursement of cost-effective health services that tend to impact most on conditions affecting poor households, whereas access to needed services was limited in the past for economic considerations.
Third, through the use of explicit performance agreements with set output and process targets, the reforms have sought to improve accountability and responsiveness to clients, which entail improving accessibility and quality of services. In addition, the fee-for-service payment mechanisms gave providers incentives to provide more services to clients, free of charge. The shift from budgetary allotments to cover costs of inputs, to reimbursement for services rendered to clients, signals that resources are actually “following clients” in a more direct manner.

In the framework of the Flagship five “control knobs”, the Bolivian reforms have centered on financing and payment, with some more modest changes in terms of organization, regulation and behavior. First, changes in financing have been innovative and have taken advantage of the country’s decentralization process. These resulted in an increase of public funding earmarked for reimbursement of cost-effective services at the municipal level. Second, providers are being reimbursed at levels the “system” can afford, with built-in incentives to motivate providers to seek more clients for priority services in terms of decreasing maternal and child mortality. Third, the existing organizational structure has been used to roll out the program of services, with extensive consultation with various players – municipalities, district offices, and providers – to try to get them on board.

In terms of the “organizational” control knob, however, much remains to be done. While the adoption of performance agreements helped to build in accountability and the basis of a culture of results-orientation and monitoring and evaluation, no complementary changes were introduced into the organizational structure of the sector to align incentives and resources with responsibilities. A key bottleneck relates to the management of human resources. These are currently under regional authority, while the ownership of health facilities and the responsibility for health outcomes lie at the municipal level.

Another key challenge is reducing the equity gap in access to health services between the rich and the poor, and the indigenous and non indigenous populations (see Graph 3). Recently, the MOH launched a program using itinerant health brigades and indigenous community health agents to reach out to isolated rural communities. Furthermore, using funds from the HIPC debt-relief initiative, a fund was established to bring an additional 2000 physicians, nurses, auxiliary nurses and other professionals into the system of public health providers, with priority given to rural areas.

In addition to this increased supply of health providers in rural areas, complementary actions focusing on “behavior” will probably be necessary to successfully reduce the equity gap. These include focusing on the cultural barriers to care that divide the indigenous and non indigenous world. More specifically, institutional providers need to be sensitized to the cultural practices of indigenous communities and the services modified accordingly. In this respect, the MOH is working on the dissemination of a
Pregnant Women’s Rights Charter, which entitles pregnant women to certain rights such as giving birth in the position they chose (indigenous women usually prefer giving birth in a squatting position) and receiving the placenta (which according to cultural practices has to be buried). This entails important behavior changes on the part of the providers, as well as the users.

Finally, the Bolivian reforms provide an illustration of an incremental reform, with modest beginnings, that have progressively become more comprehensive and inclusive. In the process of moving from Phase I to II, as described in this paper, there has been much room for “learning while doing” and discussion of options. And instead of abandoning Phase I to accommodate new political agendas, the government has built on Phase I, showing consistency of commitment in Phase II. This has put the government in a good position to feature the “Basic Health Insurance” initiative as a core strategy in it’s recent Poverty Reduction Strategy and to tap HIPC debt relief funds to help assure BHI achieves it’s goals. Since early 2003, the government has started the third phase of