Social protection systems in Latin America and the Caribbean

Plurinational State of Bolivia

Javier Monterrey Arce

ECLAC

Project Document

Social protection systems in Latin America and the Caribbean: Plurinational State of Bolivia

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Economic Commission for Latin America and the Caribbean (ECLAC)

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Contents

Foreword ... 5

I. Introduction: social protection in the Plurinational State of Bolivia ... 7

II. Plurinational State of Bolivia: main economic, poverty and social spending indicators ... 11
- A. Macroeconomic indicators ... 11
- B. Employment indicators ... 12
- C. Poverty and inequality ... 12
- D. Social spending ... 12

III. The structure of the social protection and promotion system: sectoral interventions ... 15
- A. Contributory social protection policies: pension and health insurance ... 15
  - 1. Coverage of social security ... 16
- B. Non-contributory social pensions in the Plurinational State of Bolivia ... 17
- C. Other non-contributory cash transfers in the Plurinational State of Bolivia ... 18
  - 1. The Juancito Pinto Grant ... 18
  - 2. The Juana Azurduy de Padilla Mother-and-Child Grant ... 20
- D. The health sector in the Plurinational State of Bolivia ... 21
  - 1. The SUMI and the SSPAM insurances and the "*Extensa*" programme ... 22
  - 2. Coverage and redistributive impact of the health system ... 23
- E. The education sector in the Plurinational State of Bolivia ... 26
- F. Housing and basic services ... 29

IV. Final remarks ... 31

Bibliography ... 33

Tables

TABLE 1 INCOME INEQUALITY INDICATORS, 2007 ... 12
TABLE 2 SOCIAL SECURITY INDICATORS, 2007 ... 16
TABLE 3 JUANA AZURDUY GRANT PAYMENTS, 2009 ... 20
TABLE 4 HEALTHCARE ATTENTION BY HEALTH INSURANCE COVERAGE, 2007 ... 23
TABLE 5 PUBLIC HEALTHCARE COVERAGE INDICATORS, 2000-2008 ... 25
TABLE 6 HEALTHCARE ATTENTION INDICATORS, 2007 ... 26
TABLE 7 PUBLIC EDUCATION INDICATORS, 2000 AND 2007 ... 26

TABLE 8 EDUCATION ACHIEVEMENT INDICATORS BY ETHNICITY, 2007 27
TABLE 9 NET ENROLMENT RATES BY INCOME QUINTILE, 2007 28
TABLE 10 HOUSING AND BASIC SERVICES INDICATORS, 2007 29

Figures

FIGURE 1 PUBLIC SOCIAL SPENDING, 2000-2006 13
FIGURE 2 COVERAGE OF SOCIAL SECURITY BY INCOME QUINTILES, 2007 17
FIGURE 3 SOCIAL SECURITY AND LABOUR INFORMALITY, 2007 17
FIGURE 4 WHO ARE THE BENEFICIARIES OF DIGNITY GRANT? 2007 18
FIGURE 5 COVERAGE OF THE JUANCITO PINTO GRANT, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007 19
FIGURE 6 COVERAGE OF THE JUANA AZURDUY GRANT, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007 20
FIGURE 7 COVERAGE OF HEALTH SERVICES, 2007 21
FIGURE 8 COVERAGE OF HEALTHCARE INSURANCES BY INCOME QUINTILES, 2007 23
FIGURE 9 COVERAGE OF SUMI, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007 24
FIGURE 10 COVERAGE OF HEALTHCARE ATTENTION AT DELIVERY, BY INCOME DECILE, TYPE OF FACILITY (PUBLIC OR PRIVATE) AND GEOGRAPHICAL AREA, 2007 25
FIGURE 11 COVERAGE OF PUBLIC AND PRIVATE EDUCATION, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007 28

Foreword

Simone Cecchini
Claudia Robles

This report is part of a series of national case studies aimed at disseminating knowledge on the current status of social protection systems in Latin American and Caribbean countries, and at discussing their main challenges in terms of realizing of the economic and social rights of the population and achieving key development goals, such as combating poverty and hunger.

Given that, in 2011, 174 million Latin Americans were living in poverty –73 million of which in extreme poverty– and that the region continues being characterized by an extremely unequal income distribution (ECLAC, 2012), the case studies place particular emphasis on the inclusion of the poor and vulnerable population into social protection systems, as well as on the distributional impact of social protection policies.

Social protection has emerged in recent years as a key concept which seeks to integrate a variety of measures for building fairer and more inclusive societies, and guaranteeing a minimum standard of living for all. While social protection can be geared to meeting the specific needs of certain population groups –including people living in poverty or extreme poverty and highly vulnerable groups such as indigenous peoples–, it must be available to all citizens. In particular, social protection is seen a fundamental mechanism for contributing to the full realization of the economic and social rights of the population, which are laid out in a series of national and international legal instruments, such as the United Nations' 1948 Universal Declaration of Human Rights or the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). These normative instruments recognize the rights to social security, labour, the protection of adequate standards of living for individuals and families, as well as the enjoyment of greater physical and mental health and education.

The responsibility of guaranteeing such rights lies primarily with the State, which has to play a leading role in social protection –for it to be seen as a right and not a privilege–, in collaboration with three other major stakeholders: families, the market, and social and community organizations. Albeit with some differences due to their history and degree of economic development, many Latin American and Caribbean countries are at now the forefront of developing countries' efforts to establish these guarantees, by implementing various types of transfers, including conditional cash transfer programmes and social pensions, and expanding health protection. One of the key challenges

that the countries of the region face, however, is integrating the various initiatives within social protection systems capable of coordinating the different programmes and State institutions responsible for designing, financing, implementing, regulating, monitoring and evaluating programmes, with a view to achieving positive impacts on living conditions (Cecchini and Martínez, 2011).

Social protection is central to social policy but is distinctive in terms of the social problems it addresses. Consequently, it does not cover all the areas of social policy, but rather it is one of its components, together with sectoral policies –such as health, education or housing– and social promotion policies –such as training, labour intermediation, promotion of production, financing and technical assistance to micro- and small enterprises. While sectoral policies are concerned with the delivery of social services that aim at enhancing human development, and promotion policies with capacity building for the improvement of people's autonomous income generation, social protection aims at providing a basic level of economic and social welfare to all members of society. In particular, social protection should ensure a level of welfare sufficient to maintain a minimum quality of life for people's development; facilitate access to social services; and secure decent work (Cecchini and Martínez, 2011).

Accordingly, the national case studies characterize two major components of social protection systems –non-contributory (traditionally known as "social assistance", which can include both universal and targeted measures) and contributory social protection (or "social security"). The case studies also discuss employment policies as well as social sectors such as education, health and housing, as their comprehension is needed to understand the challenges for people's access to those sectors in each country.

Furthermore, the case studies include a brief overview of socio-economic and development trends, with a particular focus on poverty and inequality. At this regard, we wish to note that the statistics presented in the case studies –be they on poverty, inequality, employment or social expenditure– do not necessarily correspond to official data validated by the Economic Commission for Latin America and the Caribbean (ECLAC).

I. Introduction: social protection in the Plurinational State of Bolivia[1]

Poverty affects about 5.5 million people in the Plurinational State of Bolivia. Accordingly, poverty-reduction policies have become extremely relevant in the country during the last decades.

Social protection policies in the Plurinational State of Bolivia, understood as the group of policies aimed to manage risk among vulnerable groups, have undergone relevant transformations from the 1990s onwards. This document analyses the design and coverage of these policies, examining the extent to which they benefit the poorest groups in the population. Special attention is granted to cash transfer programmes, which are the main component of the social protection system in the country. Based on this analysis, it is clear that one of the main challenges ahead for these policies is the appropriate identification of vulnerable groups for a more accurate policy targeting.

A brief summary of the evolution of social protection policies in the Plurinational State of Bolivia shows three main approaches between 1991 and 2009.

Between 1991 and 2001, reforms in the areas of education, health, pensions, and State decentralisation were implemented, as well as the privatisation of State enterprises. These reforms established the bases for an increasing social investment and coverage of education, health and basic sanitation services. Thus, according to the National Statistics Institute (*Instituto Nacional de Estadística,* INE) and based on the Unsatisfied Basic Needs (*Necesidades Básicas Insatisfechas*, NBI) method, between 1992 and 2001, poverty declined from 70.9% to 58.6%. The social protection approach of this period had four main components:

(i) Policies aimed to universalise access to public services, which formed part of the poverty-reduction policies and were a key part of social protection strategies. As part of these policies, the Social Investment Fund (*Fondo de* Inversión *Social*, FIS) was created in 1991, aimed at improving the coverage and quality of health, education and basic sanitation services, prioritising pockets of poverty in rural areas.

(ii) The National Maternal and Child Insurance (*Seguro Nacional de Maternidad y Niñez*) created in 1996 through the Supreme Decree 24303. It provided medical attention to mothers and children under 5, covering 32 services, including delivery attention and emergencies, paediatric

[1] This document is based on the 2009 study "Bolivia: matriz de protección social", unpublished. Data may differ from those published by ECLAC.

attention and respiratory infections. This insurance was replaced by the Basic Health Insurance (*Seguro Básico de Salud*), created in 1998, with a larger coverage of 92 services, including transport due to emergencies, care of the newborn, nutritional vigilance, vaccinations and infant infection diseases treatment.

(iii) The implementation of an individual capitalisation system to finance social security, through the pension reform of 1996 that fully substituted the traditional pay-as-you-go system. The former introduced individual accounts administered by private financial institutions.

(iv) The universal allowance for old age, created in 1997 as part of the pension and capitalisation reform, with the name of Solidarity Allowance (*Bono Solidario,* Bonosol). It consisted of a cash transfer of Bs 1,300 (equivalent to US$ 247) granted to old persons aged 65 and above. Originally, this allowance was financed by the profits obtained from the Common Privatisation Fund (*Fondo Común de Capitalización)*, which was composed by shares of capitalised companies. This allowance changed its amount, name and was even interrupted between 1998 and 2000.

Between 2002 and 2004, the Bolivian Poverty Reduction Strategy (*Estrategia Boliviana de Reducción de la Pobreza*, EBRP) was implemented as the leading tool for social policies in the country. One of its four guidelines was, precisely, increasing security and protection for the poor. Furthermore, in 2004, the Social Protection Network (*Red de Protección Social*, RPS) was created in order to implement programmes and projects for the poorest population, contributing to the coordination and funding of governmental and non-governmental programmes. This social protection arrangement had three main components:

(i) Health insurance for the provision of maternal and infant health services. By the end of 2002, the Universal Maternal and Infant Insurance (*Seguro Universal Materno Infantil,* SUMI) was created substituting the former National Maternal and Child Insurance. The SUMI covered 547 health services for children under 5. It also included reproductive health, family planning and programmes for the early detection of cervical uterine cancer.

(ii) Temporal employment generation through the National Plan for Public Works (*Plan Nacional de Empleo y de Emergencia,* PLANE), implemented between 2001 and 2006 and financed by the international cooperation. PLANE sought to mitigate the impact caused by the declining incomes due to the loss of employment among the poorest population, creating massive employment programmes both in urban and rural areas.

(iii) Social infrastructure to neutralise political tensions through the Poverty-Combat and Social Investment Programme (*Programa contra la Pobreza y Apoyo a la Inversión Social*, PROPAIS). This programme aimed to finance small infrastructure and community equipment projects that provided employment and were located in the poorest municipalities of the country.

Finally, between 2005 and 2009, social protection included the implementation of new cash transfer programmes for vulnerable groups. All transfers are financed by public resources that come from the Direct Tax to Hydrocarbons (*Impuesto Directo a los Hidrocarburos*, IDH), which was created after the nationalisation of hydrocarbons. Three are the main components of social protection during this period:

(i) Implementation of new cash transfers. In October 2006, the Juancito Pinto Grant (*Bono Juancito Pinto*) was first created. This conditional cash transfer aims to foster school retention and is targeted on students of primary education enrolled in public education institutions. Secondly, a universal transfer was implemented, on February 2008, called *Renta Dignidad,* and consisting of a transfer for-life for people aged 60 years and above. A third conditional transfer was set in place in May 2009 under the name of Juana Azurduy de Padilla Mother-and-Child Grant (*Bono Madre Niño-Niña "Juana Azurduy de Padilla"*), which aims to promote the use of maternal and child health services.

(ii) Improvement of the employment conditions of youth working in the urban formal labour market, through the programme "My first decent job" (*Mi primer empleo digno)*. The programme was created in September 2007 and was targeted on youth aged 18 to 24. It provides training over a period

of three months, followed by internships in private companies. In order to promote the permanence in the programme, a grant consisting of Bs 550 (US$ 79) is paid monthly to the beneficiaries. During the internship, the grant is paid by both the company (contributing by 45% of the allowance) and the programme (55% of the allowance).

(iii) Universal access to housing through the Social and Solidarity Housing Plan (*Plan de Vivienda Social y Solidaria)*, created in 2006 by the Supreme Decree 28794. This plan seeks to build housing solutions in areas with greater incidence of extreme poverty. The Plan grants funding for the own construction of dwellings, providing future owners a wage, which is paid during the period of building.

Also, under President Evo Morales (2006-present), the Social Protection Network and Integral Community Development (*Red de Protección Social y Desarrollo Integral Comunitario,* RPS-DIC) was created (Loza, 2007).[2] This is a plan aimed to coordinate social protection policies through investment on human capital development to ameliorate the negative impacts that unforeseen economic events might have upon the incomes and living conditions of the most vulnerable groups, strengthening households' capacities to prevent future risks and poverty. Hence, the RPS-DIC deploys risk management concepts and seeks to break the inter-generational reproduction of poverty. Its main emphasis is on the human capital development of children, youth and mothers, particularly through the improvement of their nutrition, health and education conditions, so as to act upon the structural roots of poverty. Nevertheless, this strategy lacks an explicit identification of what vulnerable groups it will cover and to what extent social protection policies might differ from regular public investment on infrastructure, health and education.

The following section reviews the main economic, poverty and social spending trends followed by the Plurinational State of Bolivia. The third section analyses the main sectoral policies implemented in key areas of social protection, including health, education, social security, housing and sanitation, cash transfers and other risk mitigation policies. Finally, the document closes by discussing the main achievements and challenges of the social protection system in the country.

[2] The Development Planning Ministry (*Ministerio de Planificación del Desarrollo)* designed the *Vida* Plan in order to support social protection policies in the country.

II. Plurinational State of Bolivia: main economic, poverty and social spending indicators

A. Macroeconomic indicators

The Bolivian economy is open and small, with a rather invariable productive structure, mainly based on commodities such as hydrocarbons and minerals.[3] Consequently, the main export products are natural gas, zinc, silver and soya: the total export value of these products represented 70.6% of total exports in 2008.

Since 2000, the Bolivian economy has showed steady growth, with average growth rates of 3% of GDP until 2005, and of 5% between 2006 and 2008. Growth was due to the increase in the international prices of minerals and hydrocarbons and the tax reform of hydrocarbons implemented by the country. Between 2000 and 2008, the value of minerals exports increased by six times, from US$ 260 million to US$ 1,518 million, while the value of hydrocarbons exports increased by 22 times from US $158 million to US$ 3,469 million. This resulted in favourable external and fiscal conditions, with commercial and fiscal surpluses and the accumulation of international reserves. Thus, while in 2000 the commercial deficit was 4% of GDP, in 2008, it reversed to a surplus of 1.3% of GDP.

As part of the tax reform of hydrocarbons, the new Direct Tax to Hydrocarbons (*Impuesto Directo a los Hidrocarburos*, IDH) increased substantially the public sector's resources and became the main source of its financing –particularly, of cash transfer programmes and transfers to sub national governments. In 2008, the IDH collected US$ 949 million, equivalent to 34% of the funding of the non-financial public sector. Thus, while in 2000, the global public deficit was -3.7% of GDP, in 2008, it showed a surplus of 3.2%. Moreover, public spending has doubled between 2000 and 2008. Besides the increased tax base, growth was also explained by higher volumes of gas sold to Brazil and Argentina, in a context of more favourable gas prices and greater dynamism of international trade.

Between 2007 and 2008, the impact of *La Niña* and the rising world food prices led internal prices –particularly of food– to increase significantly. Thus, in 2007, the twelve months-accumulated inflation was 11.7% and in 2008, 11.8%, the triple of the average inflation of the period 2000-2005. As a reaction to this trend, the government suppressed taxes to food imports and banned the export of scarce products (for example, oil).

[3] An input-output analysis shows that since 1990 the productive structure of the country has remained invariable.

B. Employment indicators

Open unemployment in urban areas has been variable. Between 1991 and 2001, the open unemployment rate increased, to later decrease between 2002 and 2007 to a rate of 7.7%. Furthermore, a high percentage of the employed population works in the informal labour market. In urban areas, 71% of the employed population aged 15 and above, works in the informal sector. According to statistics from the Ministry of Labour (*Ministerio de Trabajo*), in 2008, 57% of companies were micro-enterprises and 35%, small enterprises, which explains the relevance of informal labour within small scale economic units. The average nominal wage shows important differences between wages at the public and private sector, according to the Ministry of Labour. In 2006, the average wage of the public sector was 61% of that of the private sector.

C. Poverty and inequality

Despite macroeconomic stability and economic growth in the Plurinational State of Bolivia, income poverty has remained quite stable over the years. In 2007, 5.5 million persons lived in income poverty in the country, equivalent to 55% of the total population. In rural areas, 76% of the population was poor and in urban areas, 45%. More than half of the population (52%) living in poverty was located in urban areas and 48%, in rural areas.

Examining income distribution by area of residence, significant differences emerge: along all income quintiles, in 2007, the population living in urban areas showed greater incomes than the population living in rural areas. Similarly, inequality among the population living in rural areas was considerably higher than among the population living in urban areas (see table 1).

TABLE 1
INCOME INEQUALITY INDICATORS, 2007

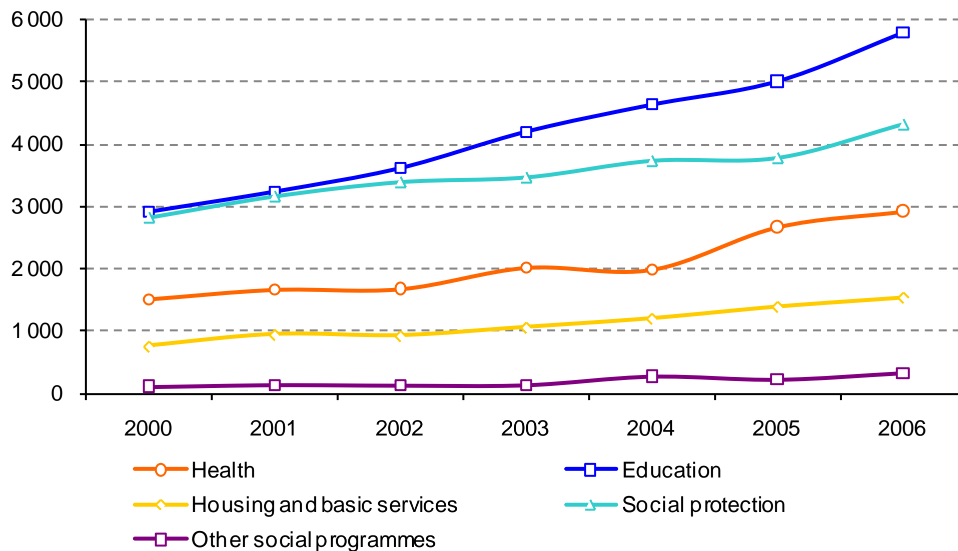
Indicator	Urban	Rural	National
Gini index	0.506	0.599	0.568
Generalised entropy (GE) index			
GE (0)	0.444	0.794	0.684
GE (1)	0.494	0.694	0.622
GE (2)	0.902	1.425	1.175

Source: Own elaboration based on the household survey.

D. Social spending

Between 2000 an 2006, social spending increased, especially on education and health (see figure 1). However, because of the mounting tension and political instability experienced by the country, social spending grew at a slow pace between 2003 and 2005. From 2006 onwards social spending retook its strong growth thanks to the good economic conditions and the inflow of funds to the public sector (see section II.A). In 2006, the main area of social spending was education, which represented 39% of total spending, followed by social protection (29%), whose main component is social security.

FIGURE 1
PUBLIC SOCIAL SPENDING, 2000-2006
(In Bs Million)



Source: Own elaboration.

III. The structure of the social protection and promotion system: sectoral interventions

A. Contributory social protection policies: pension and health insurance

Social security in the Plurinational State of Bolivia does not comprise unemployment insurance, although it includes health insurance and pensions for workers and their dependents. The social security system is composed by the short-term Mandatory Social Insurance (*Seguro Social Obligatorio*, SSO) and the Long-Term Social Insurance (*Seguro Social de Largo Plazo*).

The former deals with health, life and work contingencies, including common illnesses not related with labour activities, maternity and professional risks. It provides medical services (attention for the affiliated members and their families), as well as in kind (medicines, hospital accommodation or supplementary dairy products for pregnant women) and cash transfers (in case of newborns or burial-related expenses). In the case of professional risks, the SSO covers medical attention due to illnesses and accidents at work and the payment of a portion of the taxable wage. In case of illnesses, the worker receives 75% of the salary, and in the case of accidents leading to temporal disability –less than 26 weeks out from work–, 90%.

The Long-Term Social Insurance covers disability, old age and death. It comprises professional risk insurance, in cases were risks are permanent and last for more than 26 weeks. The affiliation to this insurance is mandatory for all workers and voluntary for independent workers.

Since 1996, the pension reform replaced the pay-as-you-go system with an individual capitalisation system administered by private institutions. Under the new system, a clear relation is established between the contributions and the benefits to be received, as the former constitute the main source of financing of individual pensions. The change of system implied evidenced the fiscal burden which resulted from the deficiencies dragged by the former pay-as-you-go system.

As part of the individual capitalisation system, workers' contributions are kept by the employers and deposited into individual accounts that are managed by Private Pension Fund Managers (*Administradoras de Fondos de Pensiones,* AFPs) in Individual Capitalisation Funds (*Fondo de Capitalización Individual*). Workers contribute by 12.5% of their wages: 10% goes to long-term capitalisation; 2% operates as an insurance premium that covers disability or death due to common

causes; and 0.5% is the commission for the AFPs. Additionally, employers make a payment equivalent to 2% of workers' wages in order to finance disability or death insurances related to risks at work.

1. Coverage of social security

According to the World Bank, the Plurinational State of Bolivia is the country with the highest percentage of employed population in the informal sector worldwide. According to data from the 2007 household survey, 69% of the employed population works in the informal sector and is not covered by social security. Although the current individual capitalisation system grants independent workers the possibility of making voluntary contributions, most informal workers do not choose this alternative. Thus, exclusion from social security may be mostly explained due to the different opportunities that citizens have to enter the labour market.

Social security benefits mostly the urban and non-indigenous population (see table 2). Social security coverage is linked to formal employment and depends highly on the level of qualification of the worker. However, even in the case of formal workers, some employers deny them access to social security due to the high costs that compulsory contributions imply. So to avoid this situation, the Ministry of Labour (*Ministerio del Trabajo*) has launched a registry of companies with the full list of their employers and their payment information.

Public health insurance –part of the SSO– covers 17% of the population, including both affiliated members and dependents. It grants general medical attention in social security institutions, besides delivery attention. It has a predominantly urban composition for non-indigenous peoples.

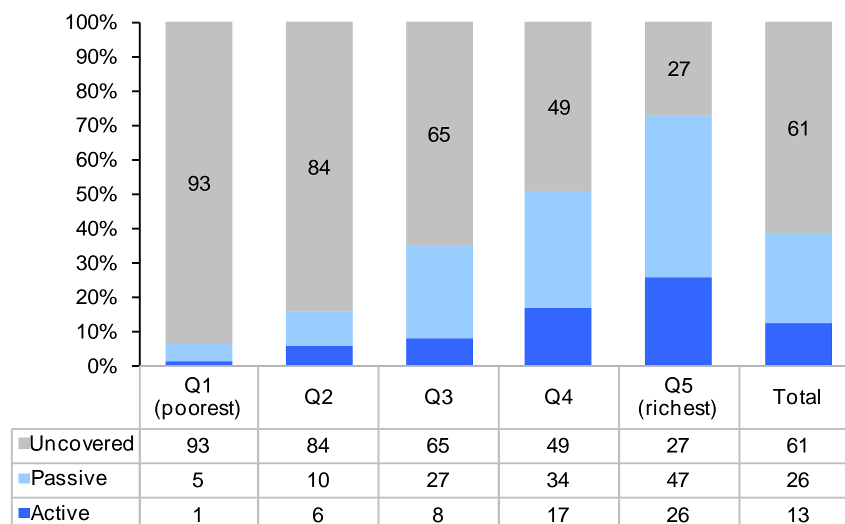
TABLE 2
SOCIAL SECURITY INDICATORS, 2007
(Percentages)

Indicator / Population groups	Urban	Rural	National
Access to public health insurance	23	6	17
Non-indigenous	23	7	20
Indigenous	19	5	10
Coverage of active members	20	3	13
Non-indigenous	22	4	17
Indigenous	11	2	5
Coverage of passive members	41	12	26
Non-indigenous	46	23	41
Indigenous	33	9	17
Persons receiving pension incomes	13	2	8
Non-indigenous	15	3	12
Indigenous	9	2	4

Source: Own elaboration based on household survey data.

Social security is mostly focused on the population belonging to the richest income quintiles (see figure 2). Out of the total employed population aged 15 and above, 69% do not contribute to social security. Moreover, 16% of the employed population in the formal sector is not covered by social security and is excluded due to the evasion committed by employers to social security (see figure 3).

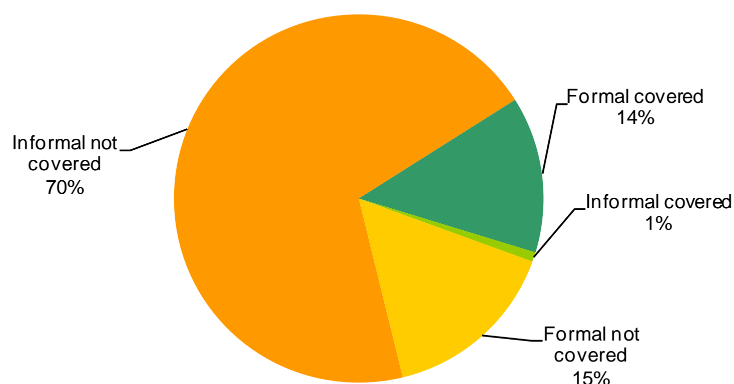
FIGURE 2
COVERAGE OF SOCIAL SECURITY BY INCOME QUINTILES, 2007
(Percentages)



	Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)	Total
Uncovered	93	84	65	49	27	61
Passive	5	10	27	34	47	26
Active	1	6	8	17	26	13

Source: Own elaboration based on the household survey.

FIGURE 3
SOCIAL SECURITY AND LABOUR INFORMALITY, 2007
(Percentages of employed population aged 15 and above)



Source: Own elaboration based on the household survey.

B. Non-contributory social pensions in the Plurinational State of Bolivia

Besides the individual capitalisation system, the new pension system established the payment of a rent for life –called *Bonosol*– for all persons aged 65 and above. This was financed by the utilities obtained by selling public companies' shares, creating the Collective Capitalisation Fund (*Fondo de*

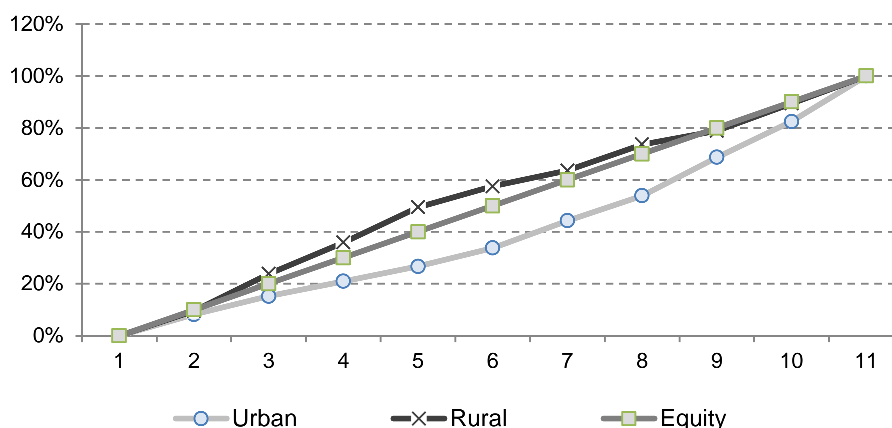
Capitalización Colectivo, FCC). The *Bonosol* had a triple aim: (a) return to the population the value of the shares of the privatised companies; (b) provide a source of income to the elderly, excluded to a large extent from the pay-as-you-go system; and, (c) represent a redistributive instrument.

In February 2008, the Dignity Grant (*Renta Dignidad)* was created to realise integral social security –as established by the Political Constitution of the State (section VII, Chapter V, Social and Economic Rights, Article 67)– through an allowance for life for all Bolivians aged 60 and above. This grant replaced *Bonosol*. Beneficiaries that do not receive a pension, receive Bs. 2,400 per year (Bs. 200 monthly, corresponding to US$ 29). Pensioners receive Bs 1,800 per year (Bs. 150 monthly, US$ 22). Bolivians aged above 60 who receive a salary from the Treasury (*Tesoro General de la Nación*, TGN) do not receive this grant.

The Dignity Grant is financed with resources from the IDH, the profitability of the capitalised companies under the FCC and the TGN. The grant is paid at all authorised finance institutions or at premises set by the armed forces both in rural and urban areas. Beneficiaries living with a disability may place a special request to receive the payment at their homes. Members of the pay-as-you-go system (*Sistema de Reparto,* SENASIR), the Military Corporation for Social Insurance (*Corporación del Seguro Social Militar*, COSSMIL) and AFPs, will be paid the Dignity Grant directly by their institutions.

The Dignity Grant favours mostly poorest groups in rural areas and middle and high-income groups in urban areas (see figure 4).

FIGURE 4
WHO ARE THE BENEFICIARIES OF DIGNITY GRANT? 2007
(Percentages)



Source: Own elaboration, based on the household survey.

C. Other non-contributory cash transfers in the Plurinational State of Bolivia

1. The Juancito Pinto Grant

The Juancito Pinto Grant was first implemented in October 2006 (Supreme Decree 28899). It aims to boost school enrolment, permanence and termination among children in the first five courses of primary education within public schools. In 2007, it was extended to primary school students in the sixth course, and students of special education –for children living with disabilities– and alternative youth education –for students that abandoned studies, are young and aim to retake them– (Supreme

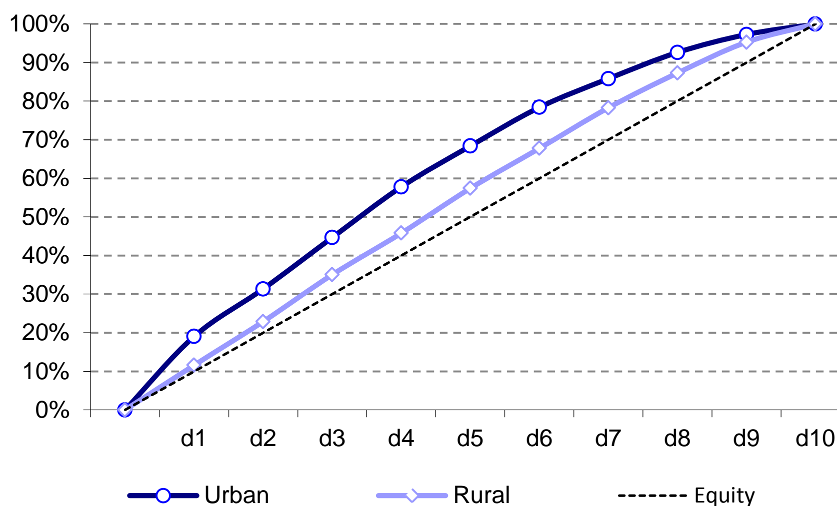
Decree 29321). In 2008, a second extension was passed, covering in full the eight courses of primary school. The payment of the grant is made upon successful control of enrolment and attendance of at least 80% of the school year. The grant consists in an annual cash transfer of Bs. 200 (US$ 29), paid at the beginning and the end of the school year. The financing of this programme comes entirely from the resources collected with the IDH.

In order to pay the grant, the armed forces organise groups that go to the different schools. The Ministry of Education coordinates the timetable of payments with both school directors and the military. Payrolls are created based on the enrolment and attendance registries. Children that abandoned studies do not receive the grant. In order to receive the grant, the children's presence is required, accompanied by parents or tutors with their identification card or the birth certificate of the child. If these documents are not available, the presence of two community witnesses is required.

Between 2000 and 2007, the school dropout rate had decreased. However, the enrolment rate showed a similar trend, indicating that the public education system is not necessarily improving its capacity to keep students throughout the school year. Furthermore, the school dropout rate in secondary school is four percentage points higher than that of primary school. In general, secondary school indicators are not encouraging, leaving in clear that this is a problem insufficiently addressed by the education policy.

In 2008, the grant benefited nearly 1.8 million students, with a fiscal cost of US$ 50 million. The grant's cost has increased by 84% between 2006 and 2008, due to the progressive increase in the beneficiary population rather than to an increase in the enrolment or retention rate. According to the 2007 household survey, the coverage of the grant is 65% of the beneficiary population, implying that 35% of students did not receive it, in spite of accomplishing the requirements. The grant is progressive: it benefits mostly children among the poorest income quintiles and is more pro-poor in urban areas (see figure 5).

FIGURE 5
COVERAGE OF THE JUANCITO PINTO GRANT, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007
(Percentages)



Source: Own elaboration, based on the household survey.

2. The Juana Azurduy de Padilla Mother-and-Child Grant

The Juana Azurduy de Padilla Mother-and-Child Grant was created in May 2009 (Supreme Decree 0066). It has a national coverage and aims to foster the use of health services at pregnancy and delivery, as well as health development controls of children between birth and age 2, at public health centres. Thus, it seeks to promote the demand for health services in order to reduce the high maternal and infant mortality rates. Table 3 summarises the payments of the grant, which excludes women receiving the breastfeeding subsidy (beneficiaries of short-term social security).

TABLE 3
JUANA AZURDUY GRANT PAYMENTS, 2009

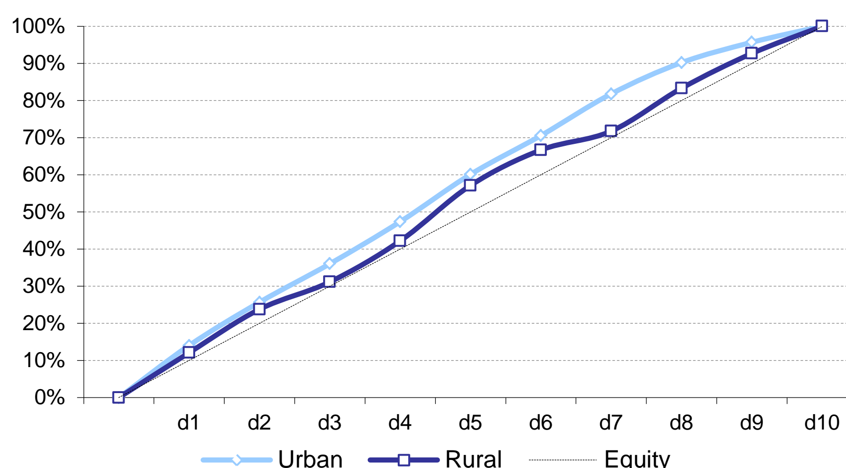
Controls	Quantity	Individual payment (Bs)	Total amount (Bs)	Individual payment (US$)	Total amount (US$)
Prenatal control	4	50	200	7	29
Institutional delivery and post-delivery control	1	120	120	17	17
Controls twice a month	12	125	1 500	18	214
Total			1 820		260

Source: Own elaboration based on the Supreme Decree 0066 (2009).

The grant is mostly financed by the IDH and resources from the international co-operation. It is administered by the Ministry of Health and Sports (*Ministerio de Salud y Deportes*). The Departmental Health Services (*Servicios Departamentales de Salud,* SEDES) provide technical support to the programme. The municipal governments participate in affiliating the beneficiary population and promoting the implementation of the programme. Health networks and mobile teams deliver health attention and verify the accomplishment of the controls. Registration is made with the identity card of the mother, a pregnancy test, if the woman is in the first months of pregnancy, and the birth certificate of the child.

The benefits of the grant are distributed equally among the different income deciles. It is slightly pro-poor, favouring mostly the poorest population in urban areas (see figure 6).

FIGURE 6
COVERAGE OF THE JUANA AZURDUY GRANT, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007
(Percentages)



Source: Own elaboration, based on the household survey.

D. The health sector in the Plurinational State of Bolivia

The National Health System (*Sitema Nacional de Salud*, SNS) is composed by public and private institutions and it is regulated by the Ministry of Health and Sports (*Ministerio de Salud y Deportes*). The system comprises four sub-sectors: public, private, social security and non-governmental organisations. The institutions that form part of the SNS are organised in four levels, depending on the complexity of the services offered:

(i) First-level institutions provide promotion and preventive healthcare services (including traditional health). These are called health centres and are the entrance gate to the system, representing 91.5% of total healthcare institutions. Each of these institutions is linked to higher complexity institutions where patients might be derived, if necessary.

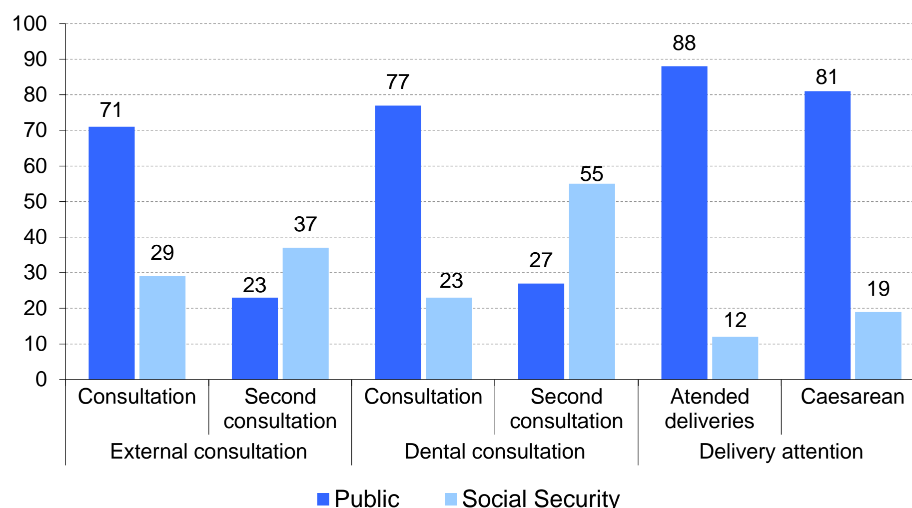
(ii) Second-level institutions provide basic specialities services of general medicine and represent 6.6% of total healthcare institutions.

(iii) Third-level institutions correspond to specialities' hospitals, including infant and maternal hospitals. They represent 1.1% of total institutions.

(iv) Fourth-level institutions are research institutes that do not provide direct attention to patients.

All healthcare institutions provide free maternal (prenatal, delivery and post-delivery), infant (vaccinations and integral attention up to 5 years of age) and old age (integral health attention when aged 60 and above) healthcare services. Both the Maternal Universal Insurance (*Seguro Universal Materno*, SUMI) and the Health Insurance for the Elderly (*Seguro de Salud para el Adulto Mayor*, SSPAM) provide free attention for these groups. Attention provided by other services not considered under the two aforementioned insurances, is offered according to fixed tariffs covering the inputs' costs.

FIGURE 7
COVERAGE OF HEALTH SERVICES, 2007
(Percentages)



Source**:** Own elaboration, based on the household survey.

Short-term social insurance covers almost a third of total external consultations (general medicine or specialities) and a fourth of dental consultations. Among persons covered by social security, a higher proportion returns for a second consultation, which indicates a better follow-up to patients than in the public sub-sector. In turn, in the public sub-sector, only one out of four consultations is a second visit, indicating that most of the attentions are performed in a single visit to

health centres. Social security grants attention to a minor proportion of deliveries (12%) and caesarean surgeries (19%). This may be explained by the fact that short-term social insurance offers less infrastructure than the public sub-system, which has most maternal and infant health specialities' hospitals (see figure 7).

1. The SUMI and the SSPAM insurances and the "*Extensa*" programme

SUMI aims to provide a comprehensive healthcare insurance that covers family planning, prenatal attention, attention at delivery and infant health. It comprises a list of 547 services provided by the public and private sub-sectors, social insurance, churches and NGOs. The beneficiary group is composed by women in fertile age –who may access to family planning services–, pregnant women and children under 5. SUMI is regulated, coordinated, supervised and controlled by the Ministry of Health and Sports, and implemented by the municipal governments who run the Municipal Health Account (*Cuenta Municipal de Salud)*. It is financed by 10% of national and internal taxes, 10% of the National Dialogue Account (*Cuenta del Diálogo Nacional*) (part of the Heavily Indebted Poor Countries, HIPC, initiative) and transfers to departments to afford human resources' costs.

The SSPAM is a comprehensive and free insurance that offers healthcare attention to elders aged 60 and above who lack a health insurance, as stated by Law 3323 passed in January 2006. Beneficiaries are registered at municipal governments' premises. They must confirm their information presenting an identity document (identity card, birth, baptism or military service certificate) once a year to avoid being eliminated from the beneficiaries' list. As part of the registry, beneficiaries must provide an address that defines where they shall seek primary and secondary or tertiary healthcare attention.

The SSPAM provides ambulatory, complementary, dental, hospitalisation services, besides medical treatments and surgery, inputs, medicines, and traditional natural products, by level of attention. However, there is no public information available concerning the quality of the attention provided by this insurance.

Financing for the SSPAM comes from municipal variable resources and from the IDH. Municipal governments must create a specific account for the SSPAM, where they must deposit annually an amount of resources to pay the prime corresponding to the health services provided. The annual value of the prime is Bs 450 (US$ 64) and is disaggregated by level of attention: 19.7% for primary attention; 26.8% for secondary attention and 53.6% for tertiary attention.

All the institutions that form part of the SNS implement the SSPAM, including public, private and short-term social security institutions. In areas where these are not available, attention is provided by churches and NGOs.

Acknowledging the limited coverage of healthcare services in rural areas, "*Extensa*", the National Programme for the Extension of Coverage in Rural Areas (*Programa Nacional para la Extensión de Cobertura en Áreas Rurales*) –which up to 2005 was financed by the Inter-American Development Bank (IDB) and the World Bank and which is currently financed by municipal governments– was created. The programme aims to extend coverage to inaccessible and remote areas through health teams that visit these areas and offer health services. The teams are composed by a doctor, a nurse, a dentist, a technician in endemic diseases and a driver. The beneficiary population is the same than for the SUMI.

Extensa is coordinated by a special unit within the Ministry of Health and Sports. The fieldwork of the health teams is coordinated by the board of directors on local health (DILOS). In 2004, the mobile health teams provided primary healthcare services to 2,500 communities in remote areas; in 2006, it increased to 3,250 communities.

2. Coverage and redistributive impact of the health system

In 2007, the institutional network that comprises the SNS throughout the national territory attended 86% of the total demand for healthcare among the population that had a disease or an accident. Of the 14% of the population that did not attend a healthcare institution, most (9%) is located in rural areas. Furthermore, 16% of the persons that were ill or had an accident attended an institution belonging to social security. Overall, the public sub-sector provides attention to 36% of total demand for healthcare services, disregarding coverage by health insurances (see table 4).

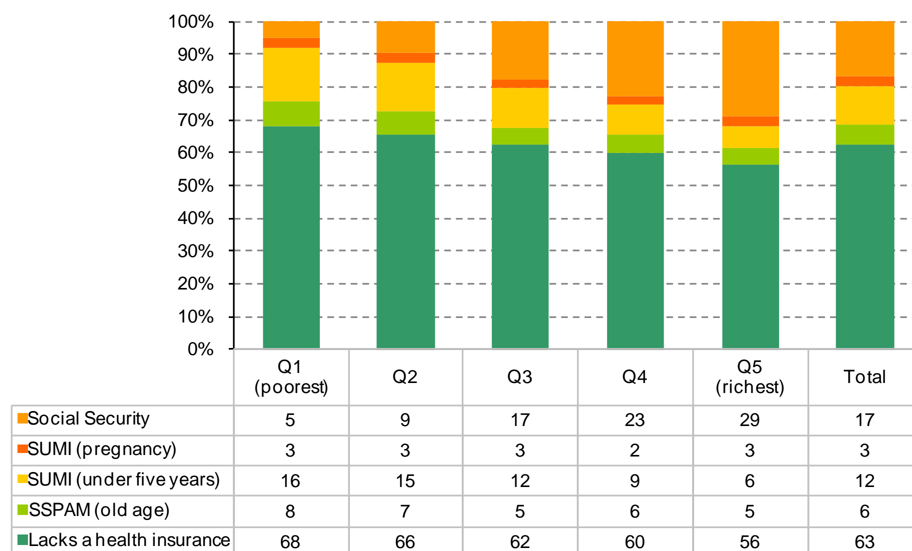
TABLE 4
HEALTHCARE ATTENTION BY HEALTH INSURANCE COVERAGE, 2007
(Percentages)

Institution providing care	Non-insured	Insured	Total
Unattended	17	12	14
Public sub-sector	37	36	36
Social security sub-sector	0	16	8
Private sub-sector	11	9	10
Non institutional	36	26	31

Source: Own elaboration based on household survey data.

According to the 2000 household survey, one of the main reasons for the unattended health demand is the lack of economic means to afford public institutions' tariffs. These represent an obstacle towards achieving universal health access. Both SUMI and SSPAM are important steps to improve access to health; however, these insurances cover a reduced group of the population and leave 63% lacking a health insurance (see figure 8).

FIGURE 8
COVERAGE OF HEALTHCARE INSURANCES BY INCOME QUINTILES, 2007
(Percentages)



	Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)	Total
Social Security	5	9	17	23	29	17
SUMI (pregnancy)	3	3	3	2	3	3
SUMI (under five years)	16	15	12	9	6	12
SSPAM (old age)	8	7	5	6	5	6
Lacks a health insurance	68	66	62	60	56	63

Source: Own elaboration based on household survey data.

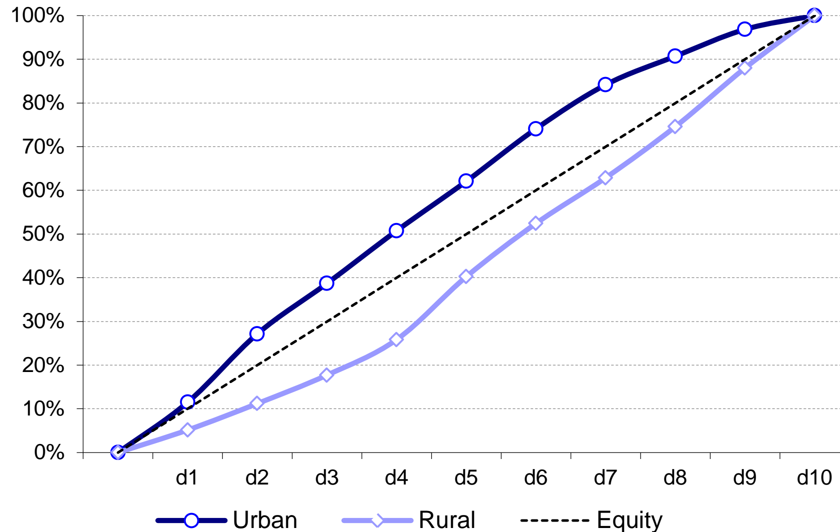
The coverage of social security favours the richest quintiles, as coverage among the poorest income quintiles is quite low. Among all insurances, SSPAM and SUMI are those that favour the poorest population the most. However, according to an evaluation of maternal and child insurances in Bolivia

(UDAPE-UNICEF, 2006), SUMI has not been sufficiently focused on the poorest population; instead, it has benefited mostly the population with sufficient economic means to afford health services' costs.

SUMI has also shown different results by geographical area and income group: in urban areas, it favours mostly the poorest population, and in rural areas, the richest groups (see figure 9). In particular, this is visible with respect to delivery attention at public healthcare institutions, covered by the SUMI (see figure 10).

The quality of infant and maternal health services in major cities and the availability of specialised hospitals, allows pregnant women belonging to all income levels to seek attention under this insurance, at no cost. In rural areas, in turn, non-institutional deliveries are the main birth method, explaining why the SUMI favours mostly non-poor income groups. As a consequence, SUMI reduces the risk of death of children under 1 living in urban areas, but not in rural areas. Still, SUMI reduces the risk of death of children under five living in rural areas, because of the high proportion of paediatric attentions granted there.

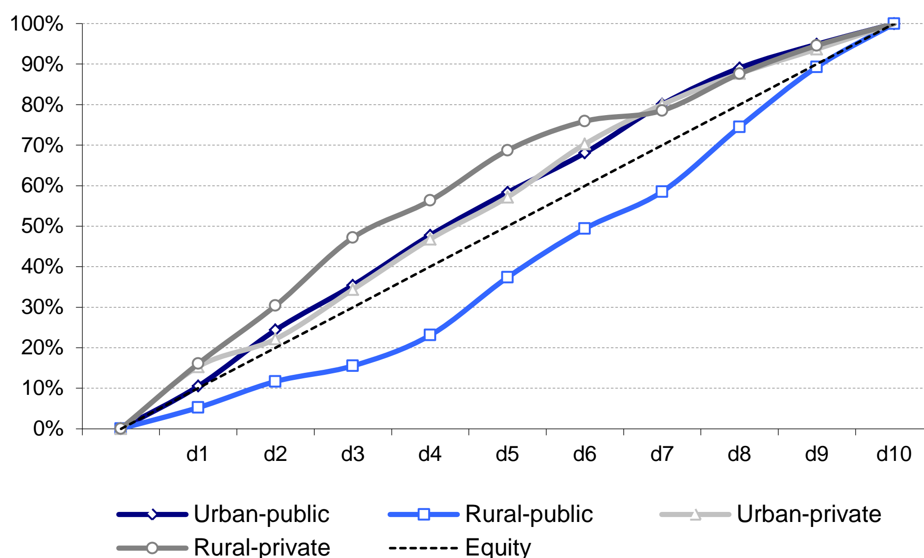
FIGURE 9
COVERAGE OF SUMI, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007
(Percentages)



Source: Own elaboration based on household survey data.

The Plurinational State of Bolivia has high levels of infant and maternal mortality, which can be explained due to a combination of factors, including the lack of appropriate health services and a low demand due to cultural reasons. According to Goldberg and others (2004), 43% of hospitals that form part of the SNS do not have the necessary infrastructure to provide essential obstetric services. Accordingly, services aimed to reduce infant and maternal mortality have constituted a priority of health policy during the last two decades. However, in spite of efforts to extend the supply of prenatal and delivery attention, the coverage of these services is still low (see table 5). According to UDAPE-UNICEF (2006), the main limitations for pregnant women and children under 5 to access health services are the precarious infrastructure of healthcare institutions, the physical distance to the institutions, transport costs and cultural aspects.

FIGURE 10
COVERAGE OF HEALTHCARE ATTENTION AT DELIVERY, BY INCOME DECILE, TYPE OF FACILITY (PUBLIC OR PRIVATE) AND GEOGRAPHICAL AREA, 2007
(Percentages)



Source: Own elaboration based on household survey data.

TABLE 5
PUBLIC HEALTHCARE COVERAGE INDICATORS, 2000-2008
(Percentages)

Indicator	2000	2005	2008 [a]
Coverage of 4th prenatal control	42	50	60
Coverage of institutional delivery	54	52	68
Coverage of the third pentavalent and DPT dose	91	84	90

Source: World Bank (2006) and Ministerio de Salud (2008).
[a] Goal estimated by the Ministry of Health.

Furthermore, no significant changes are observed in widening the coverage of deliveries at institutional healthcare services. Nevertheless, prenatal control coverage has increased. Yet, there is insufficient capacity to provide emergency pregnancy care services (*Cuidados Obstétricos de Emergencia,* COEm), revealing a considerable constraint in the supply of maternal health services that may result in maternal death.[4]

The rural population and indigenous peoples have a higher incidence of illness. This is an indication of a more vulnerable state of health due to worst nutritional conditions and lack of preventive health services (see table 6).

[4] According to Goldberg and others (2006), 56% of specialities' hospitals and 33% of basic hospitals provide full COEm attention.

TABLE 6
HEALTHCARE ATTENTION INDICATORS, 2007
(Percentages)

Indicator / Population group	Urban	Rural	Total
Incidence of illnesses and accidents [a]	15	23	17
Non-indigenous	13	18	15
Indigenous	22	26	25
Attention at delivery in public institutions	81	55	71
Non-indigenous	83	71	80
Indigenous	72	43	54
Coverage of pentavalent vaccine	91	96	94
Non-indigenous	93	99	95
Indigenous	58	93	89
Coverage of polio vaccine	95	100	97
Non-indigenous	97	100	98
Indigenous	58	100	95

Source: Own elaboration based on household survey data.
[a] Incidence is calculated as the quotient between the population that declares having been ill or with an accident, and the total population.

Furthermore, the coverage of the attention at delivery in public healthcare services is also lower among the indigenous and rural population, which has a higher risk of maternal mortality. In particular, indigenous women living in rural areas have twice the probability of dying at delivery than non indigenous women living in urban areas. Also, ethnic inequality is reproduced in the coverage of polio and pentavalent vaccines, which is low among indigenous people living in urban areas.

E. The education sector in the Plurinational State of Bolivia

Between 2000 and 2007, education indicators have shown no significant improvements (see table 7).

TABLE 7
PUBLIC EDUCATION INDICATORS, 2000 AND 2007
(Percentages)

Indicator / level	2000	2007
Gross enrolment rate	77	77
Early education	42	42
Primary education	98	93
Secondary education	52	62
Net enrolment rate	66	66
Early education	33	34
Primary education	87	84
Secondary education	38	47
Dropout rate	7	5
Early education	7	5
Primary education	6	4
Secondary education	10	8
Repetition rate	5	7
Primary education	5	7
Secondary education	9	8

Source: Own estimation based on the Education Information System (*Sistema de Información Educativa,* SIE).

There is a rather restrained access to early education (nurseries) due to the scarce human and physical resources available for this level and the lack of relevance attributed to early education as a determining factor of children's educational performance.

Furthermore, between 2000 and 2007, gross and net enrolment rates in primary education have declined, which means that despite the large number of primary education institutions in the country, there is a group of the population that remains excluded. One of the explanations is that increasing repetition rates is discouraging many students from continuing their studies. Access to secondary education has gradually increased, in spite of rising dropout and repetition rates. This level receives less State attention, and there are no incentives for students to remain or to conclude the education system. Secondary school teachers often work under outdated study plans and conditions, counting with limited pedagogical resources.

Access to education services varies by geographical area of residence and ethnicity. In comparison to the population living in urban areas and non-indigenous people, those living in rural areas and indigenous peoples show a lower access to education, as recorded by three different indicators: illiteracy, completed years of schooling and school attendance (see table 8).

TABLE 8
EDUCATION ACHIEVEMENT INDICATORS BY ETHNICITY, 2007 [a]

Indicator / Population group	2000	2007	Total
Illiteracy rate (%) [b]	4	20	9
Non-indigenous	2	9	3
Indigenous	13	27	21
Completed years of schooling [c]	10	5	9
Non-indigenous	11	7	11
Indigenous	6	4	5
School attendance (%) [d]	65	47	59
Non-indigenous	67	48	63
Indigenous	43	45	45

Source: Own estimation based on the Household Survey.
[a] Belonging to indigenous peoples refers to people that speak an indigenous language as mother tongue.
[b] Population aged 16 and over.
[c] Population aged 19 and above.
[d] Population aged between 6 and 25.

On average, indigenous peoples living in rural areas have four years of schooling, equal to an educational achievement inferior to lower primary education. On the other hand, the urban non-indigenous population has the triple years of schooling, witnessing the enduring ethnic inequalities in the country. Moreover, differences in attendance rates are also an indication of the disadvantaged conditions faced by indigenous peoples and the rural population.

In order to eradicate illiteracy, in 2006, the literacy programme "*Yo Puedo*" was created by the Decree 28675. It benefited 824,101 persons until December 2008. At its conclusion, the country was declared a free territory from illiteracy. In parallel to the programme, solar panels were distributed among rural communities, in order to implement distance learning methodologies (televised classes) in areas with no access to electricity.

Net enrolment rates calculated on the basis of household surveys confirm the lower access to education among the rural population. The enrolment rate of the population in urban areas in primary and secondary education does not show important differences by income quintiles. This is an indication of the wide coverage of the educational offer at these levels. The enrolment rate in higher education grows along income quintiles and access is very low for the population in the poorest income quintile (see table 9).

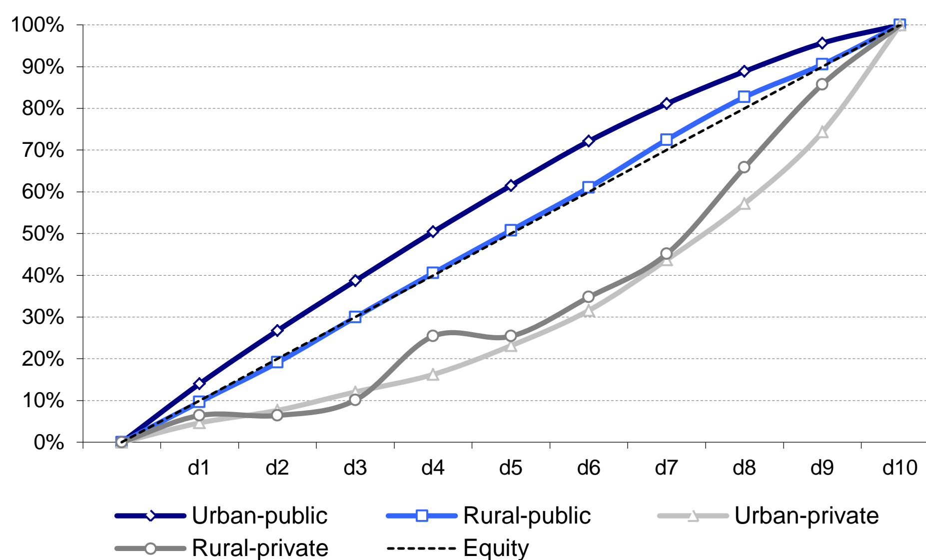
TABLE 9
NET ENROLMENT RATES BY INCOME QUINTILE, 2007

	Quintile I (poorest)	Quintile II	Quintile III	Quintile IV	Quintile V (richest)	Total
National						
Pre-school (4 to 5 years)	21	24	29	32	25	25
Primary (6 to 13 years)	93	91	90	88	90	90
Secondary (14 to 18 years)	56	54	66	65	60	60
Higher (19 to 25 years)	29	25	31	34	45	34
Urban areas						
Pre-school (4 to 5 years)	24	26	26	46	29	29
Primary (6 to 13 years)	92	91	88	89	91	93
Secondary (14 to 18 years)	62	60	71	67	63	59
Higher (19 to 25 years)	38	32	40	43	53	42
Rural areas						
Pre-school (4 to 5 years)	15	21	31	17	19	21
Primary (6 to 13 years)	94	92	92	87	88	91
Secondary (14 to 18 years)	40	40	57	62	57	52
Higher (19 to 25 years)	6	1	4	14	30	15

Source: Own estimation based on household survey data.

As shown in figure 11, public education is pro-poor (57% of the beneficiaries belong to the 50% poorest of the population). On the contrary, the richest population has a greater access to private education. In rural areas, public education benefits equally the whole of the population, due to the predominant public education offer.

FIGURE 11
COVERAGE OF PUBLIC AND PRIVATE EDUCATION, BY INCOME DECILE AND GEOGRAPHICAL AREA, 2007



Source: Own estimation based on household survey data.

F. Housing and basic services

The two main housing problems in the country are the qualitative housing deficit and the low coverage of basic services (see table 10). In rural areas, most households have their own house (85%), but these are built of low-quality materials and lack basic services. In urban areas, a lower proportion of households have their own house (56%), but these are built of better materials and have access to basic services. Furthermore, in rural areas there is a widespread lack of pipes for drinkable water: around a third of rural households have this service. The low population density increases the costs of extending water provision systems through pipes, exposing inhabitants to diseases and infections. However, most households in rural areas have a bathroom with basic sanitation.[5]

To face these problems, during the last decade and a half, much emphasis has been placed on the extension of the coverage of basic services: 53% of public investment was thus focused on programmes for the improvement and extension of drinkable water, sanitation services and electricity networks. Increasing attention is also placed to the improvement of the housing stock. In 2006, the government launched the Social and Solidarity Housing Programme (*Programa de Vivienda Social y Solidaria*) with the purpose of improving access to decent housing through self-construction. However, this has a limited geographical coverage and the houses are built under low quality techniques.

TABLE 10
HOUSING AND BASIC SERVICES INDICATORS, 2007
(Percentages)

Indicator	Urban	Rural	Total
Own house tenancy	56	85	66
Kitchen	78	78	78
Bathroom	84	47	71
Water pipe	95	39	75
Electric energy	98	47	80
Internet	37	7	26
Telephone (fixed)	31	2	21
Telephone (mobile)	78	19	57

Source: Own estimation based on household survey data.

[5] According to the 2001 poverty map (*mapa de pobreza*), between 1992 and 2001, the percentage of the population with inadequate water and sanitation services decreased from 60% to 44% in urban areas and from 98% to 79% in rural areas.

IV. Final remarks

Despite the many social protection policies that have been implemented in recent years in the Plurinational State of Bolivia –many of which are oriented towards protecting the poorest and most vulnerable population–, many challenges remain ahead. In particular, poverty indicators did not evolve substantially between 1999 and 2007,[6] and poverty and inequality are extremely high in rural areas.

Social protection has evolved through three different policy approaches. The most recent, which started in 2005, has two conditional cash transfer programmes (Juancito Pinto Grant and Juana Azurduy Grant) and a universal allowance for the elderly (Dignity Grant) as the main components. These actions have been possible thanks to economic growth and the implementation of a tax reform that has granted the public sector with considerable resources for social investment, mainly through the IDH. However, the social protection plan providing direction to these programmes, the RPS-DIC, lacks a clear definition regarding how social protection is understood and what population groups it covers. Furthermore, the high dependence upon the IDH indicates the fragility of financial sustainability, as a change in the export conditions of gas might put into risk the continuity of social protection policies.

Although the poorest population in both urban and rural areas has access to public education, attention at delivery within public healthcare institutions is mostly provided to the urban population and to the rural population belonging to the richest income quintiles. Socio-economic and geographical differences are particularly evident with respect to access to social security, which covers mostly urban and non-indigenous people, as well as the higher income groups. The SUMI, which should be focused on the poorest population, has not achieved that aim in rural areas, where it benefits mostly higher income groups.

Concerning the two conditional cash transfer programmes, there is no clear indication that the Juancito Pinto Grant has had a significant impact in reducing the school dropout rate, as the allowance it provides is not sufficiently high as to modify the educational decisions of the beneficiaries. This grant is more pro-poor in urban areas. The Juana Azurduy Grant benefits equally all income groups. As with the Juancito Pinto Grant, it is slightly more pro-poor in urban areas. On the contrary, the Dignity Grant is more pro-poor in rural areas, although in urban areas, it favours mostly middle and high income groups.

[6] However, according to household survey data processed by ECLAC, between 2007 and 2009 poverty decreased from 54.0% to 42.4% and extreme poverty from 31.2% to 22.4% (note of the editors).

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This report is part of a series of national case studies aimed at disseminating knowledge on the current status of social protection systems in Latin American and Caribbean countries, and at discussing their main challenges in terms of realizing the economic and social rights of the population and achieving key development goals, such as combating poverty and hunger.

Social protection has emerged in recent years as a key concept which seeks to integrate a variety of measures for building fairer and more inclusive societies, and guaranteeing a minimum standard of living for all. In particular, social protection is seen a fundamental mechanism for contributing to the full realization of the economic and social rights of the population—to social security, labour, the protection of adequate standards of living for individuals and families, as well as the enjoyment of greater physical and mental health and education.

Albeit with some differences due to their history and degree of economic development, many Latin American and Caribbean countries are at now the forefront of efforts to establish these guarantees by implementing various types of transfers, including conditional cash transfer programmes and social pensions, and expanding health protection. One of the key challenges that the countries of the region face, however, is integrating the various initiatives within social protection systems capable of coordinating the different programmes and State institutions responsible for designing, financing, implementing, regulating, monitoring and evaluating programmes, with a view to achieving positive impacts on living conditions.

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