CHAPTER 7

Establishing Social Equity: Bolivia, Ecuador, and Peru

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Poverty and inequality are two of the most persistent challenges in developing countries, increasingly proving that concerns for social justice, economic growth, and sustainable development are indivisible and require simultaneous and holistic attention. The high inequality in the Andean states[1] is especially challenging because it is reinforced not only by income disparities, but also by ethnic and cultural diversity and geographic obstacles that prevent a high proportion of the population from actively influencing social, economic, or political processes. This is apparent from the especially high incidence of poverty among indigenous populations, most of whom reside in rural and mountainous areas. In Peru, 59 percent of Quechua and Amazonic groups and 57 percent of Aymara people are in the bottom income quintile, compared with only 29 percent of nonindigenous people (Vásquez 2007).[2] In Ecuador, poverty among indigenous people reaches 80.2 percent, compared with 57.9 among nonindigenous groups. In Bolivia, 73.9 percent of indigenous people and 52.5 percent of nonindigenous people live in poverty (Hall and Patrinos 2006).

Vulnerable populations in the Andean subregion are defined not only by their lower income and lack of access to a market economy, but also by their restricted access to basic services such as good-quality education, health care, and information on adequate nutrition. Over the last half-century, the Andean states have achieved tangible results in expanding public services and granting basic opportunities to more citizens. For instance, illiteracy in Ecuador decreased from 44.2 percent to 9.0 percent

between 1950 and 2001[3]; less than 3 percent of Peruvian youth aged 5–24 were illiterate in 2005, compared with 22 percent of the older generations[4]; and in Bolivia, 67 percent of mothers today receive medical attention at delivery, compared with only 47 percent 10 years ago (UNDP 1998, 2007). Still, serious disparities in access and in the quality of basic services remain in those three states, and they contribute to perpetuating the inequality and poverty traps there.

Since the mid-20th century, the following three major stages in social policy (roughly comparable across the three states) can be discerned in Bolivia, Ecuador, and Peru:

1. an expansion of the public service sector in the 1970s and early 1980s that led to creation of major social security institutions and succeeded in insuring most formally employed citizens [5]
2. a retreat of public funds from social services during the structural adjustment period in the late-1980s and early 1990s resulting from the belief that economic growth and market forces would be sufficient to eliminate persistent inequalities
3. a proliferation of targeted and conditional cash transfer programs, initiated since the late 1990s, emphasizing universal opportunities for basic education, health care, adequate housing, and nutrition; and aiming to provide those opportunities to the most vulnerable groups, regardless of formal affiliation with the institutions of social security.

The notion of social policy based on fundamental rights and explicit entitlements relatively similar to the Chilean health model of 2004 (Regime of Explicit Guarantees in Health) has gathered strength in social policy analysis throughout Latin America. Instead of seeking to define "vulnerable groups" and target their access to basic services, the social guarantees approach tested in Chile seeks to define basic universal entitlements and to eliminate obstacles that could prevent *any* group from receiving them. So far, none of the Andean states has adopted explicitly rights-based or social guarantees programs. However, the progressive attention on economic, social, and cultural rights in legislation, policy strategies, and concrete programs in those countries gives reason to believe that a rights-based model may have grounds in the Andean context. Budget constraints as well as contrasting governance approaches—of the Ministry of Social Development on one hand and the Finance Ministry and financial institutions on the other—are some of the primary challenges to reaching a social contract

and gaining approval of policies based on rights principles. This chapter examines primary and secondary education and selected health policy experiences in Bolivia, Ecuador, and Peru to illustrate the progress made toward defining and meeting universal entitlements in these policy areas, and it highlights ways in which a social guarantees focus may help improve the effectiveness of these programs. The chapter uses the social guarantees and subguarantees concept (see chapter 2) as a framework for analysis.

A fundamental principle of the social guarantees framework is that entitlements to basic services and the mechanisms put in place to fulfill them should be defined clearly; reflected in the country's legal, institutional, and policy frameworks; and protected over the long term by relevant budget arrangements. Another key feature of this framework is that it envisions mechanisms not only for access to and quality of services, but also for their affordability and opportunity for redress, among other factors, making sure that people encounter no obstacles to receiving the defined services.

Since the ratifications of the countries' constitutions in the 1990s and, more recently, ratification of the 2008 Constitution of Ecuador and approval of a new Constitution in Bolivia in January 2009, the normative frameworks in the three countries have become increasingly explicit in acknowledging social and economic rights for all citizens, including language of both "rights" and "guarantees" in the social and economic realm. The constitutions establish, for instance, that primary and secondary education is obligatory and free of charge. (In Bolivia, only primary education was obligatory prior to the 2009 Constitution.) The provision of bilingual education is stipulated in all three constitutions, as is the responsibility of the state to monitor and supervise educational quality.

Traditional medicine also is respected in the three states. The new Constitution of Bolivia has advanced significantly with regard to the use of traditional medical services, declaring that the state will promote respect for and research into traditional medicine, will register natural medicaments, and will regulate the quality of traditional medical practices (art. 42). The duties of the state regarding health—at least according to the Constitution—are generally less clear than those in education and they pertain mostly to promoting a healthy lifestyle and awareness-raising on public health issues. Concrete entitlements to medical care, as an expression of the right to health, are not specified in the constitutions of any of the three states. More explicit language on the state's responsibility regarding health rights has been added recently: the 2008 National Constitution of Ecuador declares that the state will "guarantee this right . . . through permanent,

opportune, and non-discriminatory access to integral health services and services in reproductive health" (art. 32); and the Bolivian Constitution of 2009 guarantees access of citizens to all needed medications, prioritizing the use of generic ones (art. 41).

Apart from constitutional entitlements, the effective fulfillment of rights relies on the existence of coherent supporting legislation that elaborates in detail the services, standards, and division of responsibilities related to their provision. The purpose of this is to clarify the role of all respective stakeholders—state agencies, the private sector, civil and community institutions—allowing citizens to seek accountability from the respective institution when entitlements are being denied. In this respect, the Andean subregion can benefit greatly from a social guarantees framework. Progressive reforms in the constitution or in national policy strategies often are not followed up with effective supporting norms and mechanisms, nor are those reforms always allotted sufficient budgets. Legal commitments related to bilingual education, for example, rely almost exclusively on international aid, and they lack a steady and adequate source of funding. As a result, the advances made on the high policy level do not reach their full potential impact in the lives of poor people.

Overall, the protection and fulfillment of economic and social rights in the Andean states and throughout the Americas still lag behind those of civil and political rights. Civil and political freedoms—such as universal suffrage, the right to identity, and indigenous groups' rights to consult with and/or be represented directly in political decisions—largely have been achieved; but disparities in education, health, and housing persist. The realization of economic, social, and cultural rights in the Andean subregion has been addressed mainly with regard to the protection of cultural identity—for example, the right to receive education in one's native language or to practice or seek health care in traditional medicine. In this manner, states in the region generally have ensured that economic, social, and cultural rights will be *respected*. To ensure that these rights are not only respected but in fact *fulfilled* would require a more proactive approach by policy makers and society as a whole. The existence of coherent legislation on social and economic entitlements, and clear institutional responsibilities in all stages of service delivery, are key steps in this direction.

Another essential feature of a rights-based social policy is that policy priorities are determined as a result of a balanced dialogue within a society. The rights-based approach implies obligations both on the state and on its citizens; hence, citizens' engagement in determining entitlements,

implementing and monitoring programs to fulfill them, and raising awareness about them is an absolute prerequisite for the success of this policy approach.

The notions of national dialogue and consultations with diverse social groups are not new in the Andean states. In Peru during the early 2000s, President Alejandro Toledo broke new ground by opening up dialogue on a renewed social agenda to government, civil society, the private sector, and international donor agencies. That dialogue resulted in the 2002 signing of the National Accords aimed at improving equity and social justice; and it led to creation of a long-term Roundtable for Poverty Reduction, responsible for maintaining dialogue on the social agenda and protecting the neutrality and transparency of new social programs. Some civil society organizations already are being instrumental in raising awareness of and monitoring health and nutrition rights, education rights, and children's rights. Nevertheless, the National Accords do not grant citizens' organizations regular participation and voice in decision making.

Similarly in Ecuador, civil society groups—such as the Observatory for the Rights of Children and Adolescents, the Fiscal Policy Observatory, and the Social Contract for Education—have taken on planning and monitoring functions regarding social services, setting up concrete indicators on children's education and health rights, and informing the public on their performance.

In Bolivia, the Participation Act of 1994, the National Dialogue process of 2000, and the subsequent legal Act of 2001, based on municipal and regional discussions, have redefined social policy planning procedures and established a "social control mechanism" whereby citizens carry out participatory planning to prioritize spending in their municipalities (MacLean-Abaroa 2001). The Dialogue Act (which resulted from the National Dialogue process) also identified at the national level policy priorities related to social and economic rights and established concrete mechanisms to address them—for example, the Universal Maternal and Child Insurance (UMCI) system, which will be discussed in more detail below.

In summary, participatory practices and civil participation have advanced markedly over the past decade, setting a possible foundation for the success of rights-based policies in the Andean subregion. Nevertheless, to achieve a balanced dialogue at the national, municipal, or neighborhood level, all citizens need to possess adequate information. Raising awareness on rights and entitlements among the most vulnerable groups and in the most remote

locations in the Andean states is a remaining challenge that civil society, the private sector, and other nongovernmental groups ideally would help the state overcome. Currently, a number of donor-driven projects in the region are focusing precisely on local mechanisms for raising awareness of social standards (for example, nutrition and quality of basic education).

Finally, a successful rights-based policy requires a stable fiscal commitment to reflect the legal, institutional, and policy advances in the social agenda. Until 2005, public spending in health and education as a percent of GDP in the three states discussed here was among the lowest in the world.[6] Spending on education as a percent of GDP even declined in Peru and Ecuador between 1991 and 2005.[7] That decline has been reversed in the last couple of years, but it is too soon to assess how stable this recent trend will remain over the long run. In 2006, after a consultation with various representatives of the public/civil society, the government of Ecuador approved a regular annual increase in the education budget that amounted to 0.5 percent of GDP until the budget allocation reaches a proportion of 6.0 percent. The same consultation approved a mandatory increase of 0.5 percent of GDP for the health sector until the allocation reaches 4.0 percent (García, Larrea, and Enríquez 2007; UNESCO 2007). The 2008 Constitution of Ecuador declares health, education, and justice to be priority sectors in terms of state expenditure (art. 286), for which consistent funding should be guaranteed. In Bolivia, the government's commitment to the funding of public services is expressed in its commitment to the Millennium Development Goals and beyond—to an expanded set of objectives defined in Bolivia's National Development Plan—and it is those objectives that determine minimum spending. Thus, in all three states there is a pronounced commitment on the part of the government to the adequate financing of social policy. Yet, even if a fiscal agreement is reached on the national level, states still face the challenging possibility that finance authorities ultimately may not allocate the money to complete the budget for the agreed goals.

Redistribution of resources is necessary in most cases to make the social guarantees approach feasible and affordable. To be fully aware of the challenges before implementing rights-based social policy in any state, regardless of its level of development, one needs to look not only into the absolute and relative social budget allocations and the quality of the economic and social management, but also into the overall patterns of resource distribution in the state. In Ecuador, for example, part of the debate over social spending in recent years was concerned with the difference between allocations for public service, which benefit primarily the poor and the middle

classes (5.7 percent of GDP in 2005, with 1.8 percent of GDP going to basic education and 1.2 percent going to health), and allocations for universal subsidies in electricity, gas, gasoline, and diesel (7.0 percent of GDP), which benefit mostly the middle and wealthy classes (García, Larrea, and Enríquez 2007). In Peru, the discussion was focused on the leaks and insufficient coverage of the social programs, which revealed that the very poor were not necessarily the main program beneficiaries.

Uneven tax systems, along with limited capacity for tax collection, also have been cited as a reason behind persistent inequality in Latin America. Low revenue collection is characteristic of the region, owing largely to macroeconomic crises, high inflation, and sustained political opposition. It has been claimed that taxing high-income classes directly is difficult in the region, mainly because a large fraction of the state's income comes from capital and high taxation may cause capital flight. Some progressive tax reforms to benefit the poor have been introduced in the region—such as the tax on bank debits to replace income taxes in Ecuador—but these initiatives are scarce (see Justino and Acharya [2003]).

Even in the context of limited public resources, governments have demonstrated some positive examples of effective prioritization and protection of defined entitlements in social policy. Bolivia's recent program of maternal and infant health care is one example. During the 1990s, health policy allocations in Bolivia rose steadily, based on the expectation that the government would collect increasingly higher revenues from the private sector to sustain the enlarged social spending. In practice, a series of external shocks after 1999 hampered the country's economic growth, leading the public sector into substantial fiscal deficit.[8] Because social spending could not be lowered easily, given the widespread poverty in the country, it was necessary to define priorities in spending. Thus the UMCI was born. The context in which this program arose is comparable in many ways to that in Bolivia's neighboring states.

Political instability throughout the Andean subregion historically has undermined the sustainability of social policies. To be successful, any current or future initiative toward a more equitable social contract needs to consider, to the extent possible, measures that allow for the progressive improvement of programs, institutions, and financial agreements, while protecting them from being discontinued or reversed.

The following sections employ a social guarantees framework of analysis to (1) illustrate the progress that Bolivia, Ecuador, and Peru have achieved toward the fulfillment of selected entitlements in education and health; and

(2) highlight areas in which the policies and programs in question can be improved to better protect citizens' rights to education and health.

Universal Entitlements in Basic Education

Rights-based principles can be identified clearly in Bolivia's, Ecuador's, and Peru's education policies. All three states constitutionally have declared the right to universal and free education (12 years in Bolivia,[9] 10 years in Ecuador, and 12 years in Peru), and the states assume responsibility for making education during those periods accessible to all. The Ecuador Constitution of 2008 states that education is free and obligatory until the end of high school (*bachillerato*) or an equivalent level, that public education is free until the university level inclusive, and that bilingual education should be provided. It also declares the responsibility of the state to guarantee—according to the principles of social, territorial, and regional equity—that all people have access to the public education system. Bolivia's Constitution prior to 2009 declared only primary education as free and obligatory, although the period of primary education formally was extended from 5 years to 8 years. According to the new Bolivian Constitution (2009), education is obligatory up to the secondary (*bachillerato*) level and free of charge up to the tertiary level (art. 81). In Peru, the Constitution of 1993 states that education is obligatory and free at the preschool (*inicial*), primary, and secondary levels; and that access to university education at public institutions for anyone who demonstrates sufficient academic ability should not be impeded for financial reasons. It also declares the state's responsibility to regulate and supervise quality in the education sector.

Opportunities for access to basic education have been augmented significantly since the mid-20th century. The infrastructure and enrollment rates for primary and secondary education have grown in rural and urban areas alike; and bilingual education programs now are operating, albeit with very limited resources, throughout the region. Decentralization and participatory approaches to the delivery of education also have increased, drawing parents' associations and local nongovernmental organizations (NGOs) into the decision-making process. Nevertheless, important challenges remain, namely in maintaining the quality of basic education and in bringing bilingual programs up to par with Hispanic education. First, the lower priority placed on quality and quality monitoring makes it difficult for policy makers fully to assess the outcomes of educational reforms.

Creating and enforcing clear quality standards need to go hand in hand with efforts to raise enrollment and prevent children from dropping out of school early. Second, serious disparities remain between bilingual education and Hispanic education in terms of access, quality, financial protection, and overall spending, thus putting indigenous groups at a disadvantage.

Through some basic questions and answers, table 7.1 highlights the basic education areas of progress and lag according to a universal, rights-based perspective. It uses the concept of social guarantees and subguarantees to assess whether mechanisms have been put in place to address a number of essential aspects of educational delivery—access, quality, financial protection (affordability), redress, continuous revision, and civil participation.

Although expanded, access to education remains limited particularly for low-income groups and students in rural areas, who face stronger financial constraints and longer commutes. Even if the opportunities for enrollment are provided, dropout rates remain high. In Bolivia in 2005, only about 77.8 percent of children completed the mandatory 8 years (Barja and Leyton 2007, p. 27). In Ecuador, it was reported that approximately 10.6 percent of school-age children work and study at the same time, and that 16.0 percent only work and do not attend school.[10] Adult illiteracy rates on the national scale are 13 percent in Bolivia, 12 percent in Peru, and 9 percent in Ecuador (UNDP 2007). There are virtually no mechanisms within the education system to ensure the continuous provision of basic education that takes into account financial, geographic, or other barriers to access, so a high disparity exists between enrollment and completion. Access is limited, particularly for indigenous groups, despite the long-term existence of bilingual education systems. In Peru, where national-level school completion rates are the highest of the three states (94 percent for primary and 88 percent for secondary school), no more than 10 percent of indigenous children gain access to bilingual education. Bilingual education there is provided only up to the primary level, and it is very limited in both resources and outcomes. In Ecuador, access to bilingual education is limited to 66 percent at the elementary level, and to 86 percent in primary and 22 percent in secondary grades. The fact that a number of indigenous children have no birth certificates further complicates their access to school (García, Larrea, and Enríquez 2007, p. 55).

Despite the fact that basic education at the levels described above is guaranteed free of charge, students must contribute financially to attend school. In Ecuador until April 2007, an annual enrollment fee of $25 was in place, and registration costs were covered for only 63 percent of students.

Table 7.1. The Social Guarantees Matrix for Basic Education Programs in Bolivia, Ecuador, and Peru

Subguarantee	Bolivia	Ecuador	Peru
Access			
Are the beneficiaries and services clearly defined?	Yes—universal, free, and mandatory primary and secondary education (12 years, ages 6–18; extended in January 2009, under the new Constitution, from 8 years of primary education only).	Yes—universal, free, and mandatory elementary, primary, and secondary education (10 years, ages 6–15)	Yes—universal, free, and mandatory preschool, primary, and secondary education (12 years, ages 4–16)
Are there institutional procedures for monitoring access?	No. By law, the Ministry of Education is responsible.	Yes. Monitoring for bilingual education is realized through the National System of Nationalities and Peoples of Ecuador.	No concrete mechanism exists. By law, parents' associations are responsible.
Are there legal or institutional mechanisms that ensure nondiscrimination in access to services?	Bilingual programs are available for indigenous people.	Bilingual programs are available.	A bilingual and intercultural program is available for indigenous people.
Are services guaranteed for the amount of time needed?	Yes. The Bono Juancito Pinto cash transfer, given out at the end of the school year, has been introduced to prevent students from dropping out.	No	Yes, but dropout rates are high, especially among rural girls and indigenous people.
Is there a maximum waiting period for receiving a service?	No	No	No
If the service is unavailable within the prescribed waiting period, what is a guaranteed alternative (in the same time period)?	None. When the problem is age or a physical restriction, alternative education helps complete or complement.	None	None. Alternative education programs exist for adults, but they are not a replacement for timely education.

Quality			
Are there clear quality standards?	No	Yes, as defined in the curricular reform of 1996.	No. They currently are being developed by the Ministry of Education.
Are programs being evaluated on a regular basis?	No	No	No regular mechanism is established. The Ministry of Education conducted evaluations in 1996, 1998, 2001, and 2004.
Are standards and evaluation results communicated effectively to the public?	No	No	No, but the results of teachers' evaluations have been published by the press since 2008.
Financial protection			
Do beneficiaries need to contribute to the cost of service?	They need not contribute to tuition. They incur related costs (such as transportation, books) that are not covered by the government. The government provides school breakfast.	No	Yes, they contribute about one third of the cost: transportation, uniforms, and some school materials as well as parents' association fees.
Are services accessible to beneficiaries who cannot contribute to the cost?	They are believed to be through supplementary programs (school breakfast, family cash transfers). However, costs for transportation, books, uniforms, or other supplies are not covered.	Access is limited because of related costs—transportation, lack of school infrastructure or resources to hire teachers (especially in bilingual programs).	Yes, financial assistance is available.
Is this information communicated effectively to the public?	All laws and norms regarding the education sector are public.	No	Parents' associations and the Ombudsman are responsible. The consistency of information varies across communities.

(*continued*)

Table 7.1. The Social Guarantees Matrix for Basic Education Programs in Bolivia, Ecuador, and Peru (*continued*)

Subguarantee	Bolivia	Ecuador	Peru
Redress and enforcement			
Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?	Yes. SD 25273 of January 1999 specifies the channels.	Yes, though some are difficult to access and others do not operate throughout the country.	Mechanisms to make claims/seek redress are available through parents' associations and the Ombudsman.
Continuous revision and participation			
Are there mechanisms that allow for continuous improvement of services?	No, not at the national level.	The Children's Rights Index has been applied since 2003 by the Observatory for the Rights of Children and Adolescents.	Programs exist to this end, but there is no guaranteed mechanism.
Do civil, parent, or community organizations have a concrete role in the design, implementation, and monitoring of the program?	Yes. A network of local, departmental, and national councils is the primary decision maker in education delivery.	The Observatory for the Rights of Children and Adolescents has produced a report every three years since 2002; the Social Contract for Education; national, regional, and local indigenous organizations.	Yes. Parents' associations and different NGO networks have roles.
Which law or institution guarantees citizens' involvement?	SD 25273 of January 1999.	National Council for Children and Adolescents and its executive secretariat, created in 2004.	Law 28628 regulates the participation of parents' associations.

Source: Authors' compilation.
Note: NGO = nongovernmental organization; SD = Supreme Decree.

In Peru, students and their families are expected to cover approximately one third of educational expenses. Partial financial protection mechanisms have been introduced to curb the high dropout rates. Family cash transfers conditional on school attendance, such as the Juntos program in Peru and Bono Juancito Pinto in Bolivia, have been popular measures of financial protection throughout the region. These conditional benefits contain additional incentives to attend school, and they strengthen the monitoring of attendance; but it is unclear whether they actually reduce attendance barriers for children. School feeding programs, introduced in Bolivia and Peru, and distribution of textbooks and uniforms have been other methods of financial protection, showing good results if applied consistently across communities.[11] The new national Constitution of Bolivia declares that support for students at all education levels will be made available through financial aid, feeding programs, clothing, transportation, and school materials as well as through merit-based scholarships (art. 82). The relevant policies, programs, and budget channels need to be established to fulfill and monitor this guarantee. Overall, the three states have demonstrated both willingness and flexibility in introducing programs to lower financial constraints for basic education. All of these financial protection programs, however, operate as separate forms of assistance that do not effectively ensure the affordability of basic education for all. They address some related costs (such as food and clothing), but not others (such as transportation). Rural youth still exhibit higher dropout rates and lower secondary school enrollment rates, largely because of transportation costs. In Peru, 48.9 percent of rural youth are able to go to secondary school, compared with 76.2 percent of urban youth (Ramirez 2004). A consistent mechanism for financial protection with adequate attention to secondary as well as primary education has been proposed by civil society in Peru, but it is yet to be developed and approved by the government (Vásquez and Monge 2007).

Some discrepancies in educational spending also have been observed. For example, only 35 percent of Ecuador's education spending in 1999 reached the poorest two quintiles. In addition, annual spending in the bilingual education system ($154/student in 2006) was considerably lower than that in Hispanic education ($300/student in 2006) (García, Larrea, and Enríquez 2007, p. 33). Spending in bilingual education increased by 30 percent in 2007, but there is still a large gap. Peru, despite impressive enrollment statistics, exhibits low education spending for the region, 90 percent of which is channeled toward payroll. In Bolivia, the fact that

only primary education is guaranteed makes for a significant discrepancy between primary and secondary education spending. Primary education spending grew from $201.4 million to $263.6 million between 2000 and 2004, whereas spending in secondary education in 2004 was only $74.5 million (Barja and Leyton 2007, p. 25).

Perhaps the greatest challenge to the delivery of education from a rights perspective is the lack of consistent attention to quality. Although mechanisms to expand access and citizens' participation have improved consistently in recent decades, none of the three countries yet counts with a regular mechanism to measure and improve quality. On one hand, this results in low learning levels on a national scale. In a country with very high enrollment rates, such as Peru, a 2004 evaluation showed that fewer than 24 percent of students exhibited satisfactory language skills and fewer than 5 percent had sufficient math skills, thus leading to the conclusion that Peruvians are "very well schooled but very poorly educated" (Guigale, Fretes-Cibils, and Newman 2006, p. 21). On the other hand, weak attention to universal quality contributes to deepening the gaps between high- and low-income classes, rural and urban areas, and indigenous and nonindigenous students. In all three countries, a policy pattern of decentralizing education transferred greater monitoring responsibility onto community groups and parents' associations. Because low-income, rural, and indigenous groups generally lack access and possess less information on what constitutes "good-quality" education, they are not as likely to demand improvements.

To prevent disparities in quality and to raise the quality of basic education nationwide, governments may consider establishing clear national standards and a monitoring system. These can be applied at the local level with the help of parents and community associations. Such a unified monitoring system is still incipient in each of the three states. An educational quality measurement system was created in Bolivia in 1995 and subsequently abolished in 2004. Currently, the Constitution of 2009 indicates that monitoring, measurement, evaluation, and accreditation of educational quality will be managed by a technical government entity independent of the Ministry of Education (art. 89). In addition, an ad hoc national educational conference can be called every 5 years to provide orientation to education policy. In Ecuador, a national testing system, *Aprendo*, was used in 1996, 1997, and 2000; and a different one was used in 2001. A consensual curricular reform was approved in 1996, establishing goals for teachers and students; but there is no mechanism for monitoring it. Peru's

General Law on Education states that norms and standards for each level of the education system should be established, but the country does not count with a unified quality standard. Instead, the Ministry of Education gives education centers the autonomy to disseminate indicators, criteria, and other instruments to measure learning, but it does not *oblige* them to do so. A National System for Evaluation, Accreditation, and Certification of the Quality of Education was conceived in Peru to serve as a comprehensive mechanism for regulating quality, but at the time of writing it is not operational.

The lack of information on quality standards and the lack of established financial protection channels have impeded the ability of students and parents to claim entitlements to basic education. Formal mechanisms of redress in the three states exist on the regional and national levels; however, they are not always linked to concrete entitlements, and the information and incentives for using them are scarce. In Ecuador, a Constitutional Tribunal and an Ombudsman are available but are hard to access. Councils and cantonal boards for the protection of the rights of children and adolescents may serve as redress and enforcement institutions, but they are available only in Quito and Cuenca. Community councils for the protection of children and adolescents are being created. In Peru, the primary mechanisms for redress are the parents' associations and the Ombudsman (created in 1993, with offices in each region). Parents' associations give citizens ample right to pursue grievances, but they have not been very effective in addressing quality concerns. That ineffectiveness is mostly because they lack information about quality standards; however, it also is reinforced by the scarcity of resources and the low availability of teachers in more remote locations. In addition, the students who face greatest risk of dropping out often are not ones whose parents actively participate in parents' associations, so those bodies are an insufficient channel to guarantee access and nondiscrimination.

Channels for civil participation are developing progressively in the Andean states and already have shown results in education reforms. Civil society organizations and the Catholic Church, for instance, played a key role in the Bolivian educational reform of 1994 that called for greater gender equity and for modernization of the administrative system and the curriculum, among other improvements. In this process, NGOs filled a gap between the government and the population. Currently, networks of local, departmental, and national councils comprising civic and public representatives continue to exist in Bolivia and heavily are involved in decision

making in the education sector. Their role is codified within the country's Popular Participation Law. Bolivia's new Constitution formally recognizes and guarantees social, community, and parental participation (art. 83). In Ecuador, the Observatory for the Rights of Children and Adolescents and the citizen movement Social Contract for Education provide much-needed feedback on the state of basic education services. The former entity monitors basic education as part of a composite Children's Rights Index that measures nine rights on a 0–10-point scale (where 10 means full respect for rights). In 2007, Ecuador scored 4.3 on this scale (UNICEF 2007, p. 9). The participation of parents' associations in Peru is established by law (No. 28628), but there is room for improvement in their effectiveness, as noted above. Different networks of NGOs also are active at the local level.

Thus, the analysis from a rights-based perspective, using the matrix of guarantees and subguarantees in five basic areas, enables one to identify important advances in basic education policy, as well as aspects that still fall short of realizing citizens' entitlements to which states have committed themselves. It demonstrates a marked increase in access in contrast to a lack of clear quality standards and quality supervision. And the analysis brings attention to the lack of consistent financial protection mechanisms to prevent children from low-income groups, rural areas, and indigenous populations from dropping out of school early.[12] When such mechanisms are established, information channels and local-level institutions—now existing only in some areas—may enable citizens to claim and redress their entitlements. On the national level, Bolivia, Ecuador, and Peru have developed elaborate and concrete legislation that highlights entitlements related to basic education and delegates specific institutional responsibility for their realization. However, weak institutional capacity at the local level and low or disproportionate financing of education programs continue to favor higher-income, urban, and nonindigenous groups and to compromise the universal rights-based commitments established by law.

Universal Entitlements in Health Care

In the 1980s, the Pan-American Health Organization established health as a fundamental right of every human being (PAHO 1989; Hilburg Catter 2003). Unlike the right to education, however, the interpretation of the right to health is less well defined in the Andean subregion and in the

Americas as a whole. Constitutionally, each of the three states discussed in this chapter recognizes every human being's right to a healthy life. In Ecuador the 2008 Constitution also speaks of free access to medical care (without guaranteeing concrete services) and of the state's duty to monitor health services.

In Ecuador, the Constitution guarantees the promotion and protection of health for all people (meaning potable water, decent housing, developing nutritional security, and the like); it further declares that public health care services will be universal and free of charge at all levels of attention (diagnostic, treatment, medications, and rehabilitation [art. 362]), and that emergency care may not be denied for any reason (art. 365). In the Bolivian Constitution, with its amendments of 2005, the duties of the state regarding health care were framed in the context of social security. The state assumed an obligation to "protect the human capital and health of the population and ensure that the livelihoods of persons with disability are protected" (art. 158). The new Bolivian Constitution of 2009 is more explicit in declaring that "the state in all its levels will protect the right to health by promoting public policies directed to the. . .free access of the population to health services" (art. 35) and will "guarantee access to universal health insurance" (art. 36). It prioritizes the promotion and prevention services (art. 37). The Peruvian Constitution of 1993, which establishes the right of each person "to maintain a healthy life free of discrimination," limits the duties of the state to health promotion, leaving treatment, recovery, and rehabilitation services the individual responsibility of citizens.

More explicit language on the right to health can be seen, however, in national laws and policy strategies in the health sector that are updated regularly in an increasingly participatory manner. The General Law on Health in Peru and the strategy of its Ministry of Health are examples of that. However, national strategies and the legislation regulating the major institutions in the sector are too general to be considered an effective rights-based policy.

It is only in the last decade that a normative framework on health programs with concrete and universal entitlements and institutional obligations has become effective in the subregion. Three such programs will be discussed here—Universal Maternal and Child Insurance in Bolivia,[13] the Free Maternal and Child Health Care Program in Ecuador,[14] and the Integral Health Insurance (IHI) system in Peru.[15] These programs set an example for policy instruments through which specific entitlements may be fulfilled, even though challenges of legal, policy, and institutional

coordination prevent them from fully realizing their stated objectives. Making these programs sustainable is essential to securing their ability to protect established health entitlements.

Despite the lack of clarity on its normative duties, the state is still the largest provider of health services in Bolivia, Ecuador, and Peru when measured by the percentage of public health infrastructure. In Peru as of 2005, the Ministry of Health owned 96.5 percent of all health posts (small health centers), 62.3 percent of health centers, and 32.2 percent of hospitals in the country. All three states have undertaken some degree of decentralization of health services, giving more financial and management independence to regional health authorities and municipalities. Even so, health care remains primarily concentrated in major urban centers—for example, in Peru, 48 percent of all physicians are based in Lima (Vásquez 2007, p. 28). This centralized infrastructure and concentration of professionals in urban centers is another major challenge to realizing universal health programs.

In the last 10 years, creative initiatives involving local and international NGOs have emerged in the three states. They have contributed strongly to overcoming geographic and socioeconomic barriers and to raising awareness of medical and nutrition entitlements in urban and rural communities alike. In Peru, ForoSalud (Foro de la Sociedad Civil en Salud; Network of Health NGOs) has partnered with CARE-Peru to train a number of women volunteers in the most remote areas to monitor nutrition and health standards within their communities and to be involved in demanding better health services. Governments also have taken steps to encourage citizen participation by decentralizing health authority to the municipal level and engaging communities in determining policy priorities. Thus, the social control mechanisms in Bolivian municipalities (National Dialogue Law) and the local committees for health administration in Peru were established. The latter provides a good example of community leaders playing an active role in local health management. Peruvian Law 27657 (art. 3) states that the local committees "constitute a contract between the government and the population for a shared provision of basic health services."

Financial constraints and an inadequate distribution of health spending across population groups are additional serious impediments to a rights-based approach to health policy in the region. In Peru, the poorest quintile of the population absorbs 7 percent of all health spending (public and private), whereas the richest quintile absorbs 44 percent (Vásquez, Cortéz, and Riesco 2000). This disparity results in large part from the fact

that higher-income groups use more (and more expensive) health services. With respect to public spending only, the state supports 32 percent of the expenditures of the poorest quintile and 40 percent of those of the richest quintile; but even with this difference, the amount of public funds allocated to the richest quintile is approximately nine times higher than the amount spent on the poorest one.

The analysis of the selected health programs shows that resource constraints often are *not* a significant cause of programs' suboptimal performance. Bolivia's UMCI is financed by the National Treasury and by 10 percent tax transfers from municipalities. When funds do not suffice, the municipalities may request additional funding from a special account set up during the 2000 National Dialogue process. In 2003, only 47 of Bolivia's 314 municipalities (and 28, as of 2004) requested additional financing, and most of the municipalities enjoyed positive balances. Contrasting these figures with the fact that 28.7 percent of mothers and 42.6 percent of children did not have access to UMCI during that period proves that the availability of funding cannot compensate for other barriers in the program's design and implementation (Bolivia, Ministry of Health and Sports 2005, p. 5). In 2006, the public sector in Bolivia had an overall fiscal surplus of 4.6 percent (Bolivia Information Forum 2007), which motivated some district governments to propose even more ambitious health insurance schemes within their districts than the one provided by the national government. Expanded insurance programs in Peru can be considered in districts that enjoy higher tax revenues from the mining industry, but these resources generally have been invested in infrastructure.

The consistent funding of these health programs has been ensured through special measures in all three states, as shown above for Bolivia's UMCI. The Free Maternity and Infant Health Care Program in Ecuador is financed through the Ecuadorean Solidarity Fund and 3 percent of tax revenues from such consumer goods as cigarettes and alcohol (García, Larrea, and Enríquez 2007, p. 21). Funding for Peru's IHI system is guaranteed, and an Intangible Fund for Health Solidarity was created specifically to facilitate excluded groups gaining access to health services.

Table 7.2 and the analysis that follows employ the social guarantees framework to demonstrate the extent to which the selected programs in Bolivia, Ecuador, and Peru succeed in protecting entitlements to health. From the perspective of rights, they represent some of the most progressive health policies within each state. Nevertheless, they give unequal attention to some of the key features of a rights-based policy—they emphasize access

Table 7.2. The Social Guarantees Matrix for Selected Health Programs in Bolivia, Ecuador, and Peru

Subguarantee	Bolivia (UMCI)	Ecuador (FMCHC)	Peru (IHI)
Access			
Are the beneficiaries and services clearly defined?	Yes, both are defined by law.	Yes, both are defined by law.	Yes, defined by law for a list of services giving priority to maternal and infant care. IHI does not include rehabilitation services.
Are there institutional procedures for monitoring access?	No	Yes	No
Are there legal or institutional mechanisms that ensure nondiscrimination in access to services?	Yes, for indigenous people.	No	None are clearly specified.
Are services guaranteed for the amount of time needed?	Yes, clearly specified.	Not applicable	Yes, for some services, such as hospitalization.
Is there a maximum waiting period for receiving a service?	No	No	For tertiary-level (specialized) hospital services, the maximum waiting period is 18 days. (SD 006-2005-SA, Art. 3).
If the service is unavailable within the prescribed waiting period, what is a guaranteed alternative (in the same time period)?	None is guaranteed.	None is guaranteed.	None is guaranteed.
Quality			
Are there clear quality standards?	No, the law only mentions recommendations on quality.	Yes, quality standards are based on international standards.	No
Are programs being evaluated on a regular basis?	No	Not at the national level.	No, despite existing institutions (Food and Nutrition Program for High-Risk Families, National Institute of Health).

Are standards and evaluation results communicated effectively to the public?	No	No	No
Financial protection			
Do beneficiaries need to contribute to the cost of service?	No	Not by law, but in practice many do contribute.	Yes, though by law the service should be subsidized for the poorest people.
Are services accessible to beneficiaries who cannot contribute to the cost?	Yes	Access is limited for many women.	There is no clear information.
Is this information communicated effectively to the public?	No	No	Some information is communicated through NGOs.
Redress and enforcement			
Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?	Yes, at both local and national levels.	Yes, but not in all provinces and municipalities.	No, there are no clearly specified mechanisms.
Continuous revision and participation			
Are there mechanisms that allow for the continuous improvement of services?	Yes, but the mechanisms are not functioning.	No regular mechanisms are available.	None is guaranteed on the national level.
Do civil, parent, and community organizations have a concrete role in the design, implementation, and monitoring of the program?	Yes, they have a role in design and implementation, but not a significant role in monitoring.	Not concretely, though there are designated mechanisms.	The NGO ForoSalud
Which law or institution guarantees citizens' involvement?	Popular Participation Law.	Users' Committees of the Law on Free Maternity and Infant Health Care.	General Law on Health 26842.

Source: Authors' compilation.
Note: FMCHC = Free Maternal and Child Health Care Program; IHI = Integral Health Insurance; NGO = nongovernmental organization; UMCI = Universal Maternal and Child Insurance.

and financial protection while lagging behind in the protection of quality, citizens' participation, and citizens' ability to claim and redress services.

The three programs discussed in this section incorporate a progressive design if analyzed from a rights-based perspective. First, they provide services to clearly identified groups with regard to universally established health standards. Second, they describe a set of minimum and well-defined medical benefits required by those groups. Third, they are entrenched in specific laws and regulations that guarantee equitable and nondiscriminatory provision and financing. Last but not least, their legal framework establishes mechanisms of continuous revision and redress. In practice, however, they fall short of achieving their goals of universal access and quality, and do not enable citizens to easily demand the services to which they are entitled through these programs.

The Bolivian UMCI defines a list of 585 benefits to be provided free of charge to all mothers from the gestation period until 6 months after childbirth and to all children up to 5 years of age. The services are to be provided in a decentralized manner, with the budget and administrative procedures necessary to complete them defined within each district and municipality. These benefits are obligatory and granted in all health establishments. Since January 2007, new benefits have been added to the program, including preventive health tests for women, and the program was extended to all women under 21 years of age. In 2004 it was estimated that 28.7 percent of mothers and 42.6 percent of children did not have access to UMCI (Bolivia, National Institute of Statistics 2005).

The IHI[16] system in Peru ensures free health care for people in extreme poverty. As of December 2008, a total of 10,358,793 Peruvian citizens were affiliated with the system that covers maternal, child, and other essential health services, representing a 48.3 percent increase from December 2007. Currently, the program operates in all 25 regions of the country with the objective of covering all settlements where 65 percent or more of residents live in poverty or extreme poverty. For the rest of the settlements, it aims to apply a user identification system that estimates the payment capacity of each registered person (Peru, Ministry of Health).[17] Although the government publishes extensive statistics on the program's coverage,[18] it does not specifically monitor the percentage of that population who is eligible but does not access the program's services. Breaches in access nevertheless can be inferred from the differences in some statistics.

The Free Maternal and Child Health Care Program in Ecuador defines 54 benefits that include services during pregnancy, natal and postnatal

care, family planning, detection of cancer and HIV/AIDS, and so forth. However, it excludes treatment of sexually transmitted diseases and some common childhood pathologies, even ones that require hospitalization.

The large degree of informality—that is, lack of formal insurance—in the Andean subregion calls for more creative methods to ensure universal access. This is especially noted in Bolivia where a large part of the population does not have health insurance or seeks care in the informal sector. According to the Bolivian Household Survey for 2003–04, 76 percent of people who got sick or had an accident searched for medical attention and 24 percent did not. Out of the former group, 54.3 percent did so in the formal health care system, and the remaining 45.7 percent received attention in the informal sector. From those who did not seek medical care, 40.9 percent pointed out a lack of money as the main reason; 30.1 percent considered that their condition was not serious enough to warrant attention; and 29.0 percent alluded to other reasons, including distance from a medical center, bad quality of service, and lack of insurance (Bolivia, National Institute of Statistics 2005).

Breaches of access to the three programs often result from cultural or language barriers or geographic obstacles affecting indigenous people and other ethnic minorities, such as Afro-Peruvians or Afro-Ecuadoreans. Rather than launching separate programs targeted to the needs of indigenous or rural populations, governments can make the existing universal health programs more inclusive by asking these questions: Which groups will face the greatest barriers or discrimination to access services? and What instruments can be put in place to facilitate their access? This aspect has been addressed only partially in the three health programs analyzed here. Protocols of attention to indigenous and Afro-Ecuadorean communities were not included in the maternity and child health program, contributing to the exclusion of these groups from services.

Universal access to the three programs also is heavily compromised by nonexistent or ineffective public information mechanisms. The 2005–06 Life Conditions poll in Ecuador revealed that only 34 percent of women knew of their entitlements under the maternity and infant health program (García, Larrea, and Enríquez 2007, p. 24). Peru's National Communication Policy on Health (1994) and subsequent creation of the Institutes for Health Education (2003) have taken some steps to address the issue of scarce public information.[19] Even more effective have been donor and civil society efforts in training local women as educators in health and nutrition (see Cotlear [2006] and DFID/CARE-Peru [2006]).

Given that these programs offer a set of universal and free services, they did not envision complex financial protection mechanisms—such as levels of contribution depending on income or contribution ceilings. This puts rural and marginalized groups at a disadvantage. Even though formally they do not need to pay for the services, they often incur related transportation costs or fees. A 2004 Ecuador survey showed that 28.0 percent of pregnant women had to pay for medical services during delivery and pre-/postnatal care, and 26.1 percent had to pay for supplies in public health centers (CEPAR 2005, p. 33). A more differentiated system of financial protection within the program would help even out access to the program for all income groups.

One of the greatest weaknesses, common to all three programs, is the lack of embedded mechanisms to ensure quality. Instead, quality assurance for the programs derives from general health system norms[20] or from sporadic initiatives outside of the program or outside of the health sector (driven by donors or civil society) that aim to upgrade quality.[21] Of even more concern is the fact that health professionals show very little awareness on issues of quality, management, and enforcement of standards. In a 2000 demographic and health survey by Peru's Instituto Nacional de Estadística e Informática, about 45 percent of respondents did not know about or did not take into consideration existing management and enforcement mechanisms. More than 30 percent considered nontransparent contracting and supply practices in the health centers to be frequent or very frequent. Moreover, 22 percent of the physicians interviewed reported they were not willing to take any measures if it were discovered that medical supplies were procured in a dubious manner; 25 percent were indifferent on the transparency of staff selection (Alcazar and Andrade 2000).

With regard to opportunities for redress, only the UMCI in Bolivia contains structured procedures consistent with the decentralized nature of the program. At the local level, any citizen is entitled to bring claims and allegations before his or her local health directorate. The latter registers the claim or allegation and sends it to the network manager, who has a maximum of 10 days to initiate appropriate investigations and deliver a report that includes corrective recommendations. The local health directorate is responsible for acting on these recommendations and communicating its actions to the claimant. A fraud and control system under the Ministry of Health was developed to monitor the functioning of the redress framework. However, it is impossible to assess how effective this mechanism is because statistics on the number of registered claims by type

and their corrective recommendations are not available publicly. In Ecuador and Peru, various civil and governmental organizations—such as the users' committees in Ecuador and both Infosalud and ForoSalud in Peru have the potential to act as agencies of redress. That is not their explicit mandate, however, and they contribute more to raising public information on health entitlements and mobilizing collective demand for service improvement. Two cases of judicial redress based on articles 3 and 7 of the Constitution were recorded in Peru: two people demanding access to HIV medication and a group of women, supported by civil society groups, demanding access to contraception drugs.

The Popular Participation Law in Bolivia enabled sizable community participation in designing and implementing the UMCI program. Social networks, composed of grassroots organizations and civil society representatives, were created with well-outlined functions to (1) exert social control so that the beneficiaries of UMCI receive quality services and denounce all cases of mistreatment and discrimination before the local health directorates; (2) identify and help overcome the barriers that keep people from accessing UMCI services; (3) participate in all negotiations within the local health directorates and in their planning process; and (4) promote social mobilization in support of the health sector. Furthermore, the social networks have the responsibility to develop continuous and well-articulated social management within the health system to guarantee the exercise of the right to health. As mentioned above, no statistics or evaluation is available to document how well the social networks ensure program accountability. The new Constitution of Bolivia indicates that the state will regulate quality through medical reviews that evaluate personnel, infrastructure, and equipment; will sanction malpractice; and will guarantee organized participation of citizens in making decisions about the health system (arts. 39 and 40).

In Peru, the Local Committees for Health Administration provide some good examples of community participation in health administration (for example, in the construction of new health infrastructure). Where local committees have been implemented, it has resulted in a more responsive and accountable service delivery model (World Bank 1999, p. 31). This model, however, is not active in all parts of the country. A consultation mechanism was created to collect indigenous people's perspectives on health priorities and health policy methods.[22] In summary, Peru exhibits a lot of positive promotion of citizen participation, but the mechanisms are not functioning in a coordinated manner, and that undermines their potential to provide feedback and directly influence specific state programs.

Similarly, with regard to revision and improvement mechanisms in the three states, a number of channels exist and possess the necessary powers to influence health authorities. But they are not always linked to concrete policies and programs with the explicit mandate to monitor and improve them, and often are operating in limited geographic areas.[23] The Ombudsman (*Defensor del Pueblo*) in Bolivia shows one positive example. In its 2005 report, the Ombudsman acknowledged that some services essential to women's health are not included in the UMCI (Bolivia, Defensor del Pueblo 2005). It showed that many conceiving-age women are at risk because of the lack of measures to prevent uterine cancer. The Ombudsman tracked down an old regulation that extended the program's coverage to some additional services, including annual Pap tests for all women. Linking monitoring mechanisms and agencies to a regular process of revising policies and programs would result in more efficient interventions in the health sector.

The analysis above enables us to draw two fundamental conclusions regarding the programs' potential to fulfill established health entitlements and promote a rights-based approach: First, the analysis from a social guarantees perspective illustrates that sole attention to free and universal access, without considerations for quality and other important indicators, compromises the overall effectiveness of the programs. Universal design has helped expand coverage and eliminate some usual breaches of access. At the same time, insufficient attention to quality standards and their monitoring, and to mechanisms of redress, are not addressed. The list of entitlements/benefits generally is provided free of charge on a universal basis rather than through differentiated financial protection mechanisms. A majority of patients still incur personal expenses because of related costs or insufficient resources/supplies at their medical centers.

Second, the analysis suggests that the institutional potential for rights-based policies in Bolivia, Ecuador, and Peru is much stronger than what can be inferred if one looks strictly at the agencies formally associated with the three programs. A broader look at agents and activities in the health sector reveals a variety of creative approaches by civil society, community organizations, donor institutions, and Ombudsman offices that contribute—each in its own way—to reducing gaps in access, information, quality, or other areas. Taking advantage of this existing potential and linking it directly to the implementation and monitoring of policies and programs can result in a more coordinated and effective framework to fulfill health entitlements.

Conclusion

An analysis from the perspective of social guarantees highlights some essential lessons for increasing equity and inclusion through social policy. On a broader scale, it shows the importance of giving equal and adequate weight to the four basic domains of policy planning—legal, institutional, instrumental/programmatic, and financial.[24] When legal commitments are made but resources are not allocated to complete them or a sustainable institutional structure is not established to fulfill them, state commitments have no potential to influence inclusion. This seemingly self-evident statement is especially important when rights of vulnerable groups are at stake—low-income groups, ethnic minorities, or others—given their low potential for mobilization and weak representation in decision-making channels. Even though indigenous groups, women, youth, people with disabilities, and other marginalized populations now have more channels to express their views than they had in the past, and there are more state institutions and civil organizations to represent them at national and local levels, the relative influence of these channels on universal policy design and resource allocation remains weak. Thus, most bilingual education programs in the region consistently are underfunded, regardless of constitutional commitments to provide bilingual options in basic education. To respond to the needs of vulnerable groups in practice as well as in law, governments' commitments need to be reflected in all policy domains—legal, institutional, programmatic, and financial. This point can be strengthened by establishing ongoing mechanisms to incorporate civil feedback in policy making instead of or in addition to one-time nationwide consultations.

With regard to the planning of concrete programs, the social guarantees and subguarantees perspective demonstrates the value of a holistic vision in service delivery. In both education and health programs, the analysis reveals that progressive attention has been given to expanding coverage and access while quality norms and their monitoring consistently have been neglected. Beyond the access/quality disparity, which already has been acknowledged and well documented in social policy literature of the region, the subguarantees analysis points to a number of areas that affect program performance but are not given explicit consideration. These areas include mechanisms of financial protection (that is, the need to look at all related costs and the affordability of the services for all citizen groups) and accessible and affordable channels for redress, among others. Considering these aspects in program design is equally important as considering access

and quality. School dropout rates, for instance, largely are the result of households' inability to afford related costs (food, uniforms, textbooks, and transportation), and the same is true for basic health services. In addition, the social guarantees analysis shows that progress in subguarantee areas (access, quality, and financial protection) is strongly interrelated. One cannot establish an effective mechanism for redress if quality or financial protection standards on the basis of which beneficiaries may claim services do not exist. Nor can continuous revision be realized if there are no norms on which to base an evaluation. Certainly, the list of subguarantees can be expanded and made more precise. The analysis in this chapter has included some of the most essential components.

This chapter has highlighted the need for policy planning that gives as much consideration to the process of service delivery as it does to broad targets. National strategies and policies in basic services largely are driven and shaped by such targets—for example, reducing the incidence of malaria by 40 percent and of tuberculosis by 30 percent and establishing an autonomous social security system by 2011, in the case of Peru; reducing infant mortality to 30 per 1,000 live births between 2003 and 2015, in the case of Bolivia. On one hand, such broad national commitments in the framework of the Millennium Development Goals have stimulated the expansion of coverage to protect vulnerable populations and to sustain budgetary commitments for related programs. On the other hand, if taken as an ultimate goal of social policy, these broad commitments also should motivate governments to look beyond targets and ensure sustainable policy designs. More sustainable designs would address a range of criteria, including but not limited to universal access, quality, financial protection, redress, and regular revision. In other words, achieving targets and improving the process and effectiveness of policies should go hand in hand.

The social guarantees framework suggests one route toward such inclusive and sustainable social policy design. The content of citizens' entitlements or benefits as well as the concrete mechanisms for their delivery are to be developed, discussed, and approved within each society's unique context.

Notes

1. According to the United Nations Development Programme's 2007/08 Human Development Index (UNDP 2007), Bolivia, Ecuador, and Peru have Gini coefficients of 0.60, 0.54, and 0.52, respectively.

2. According to Peru's 2007 population census, the indigenous population is only 14.82 percent, measured by the number of people whose mother tongue is indigenous.
3. Figures are according to Ecuador's Population and Housing Census, series 1950–2001, produced by the Integrated System of Social Indicators.
4. These figures were published by Peru's Ministry of Education, Office of Education Statistics, in 2005.
5. During this period, health and education infrastructure was extended to most remote areas, and access to these services increased radically.
6. Public expenditures on health as a percent of GDP in 2004 were 1.9, 2.2, and 4.1 for Peru, Ecuador, and Bolivia, respectively, according to the 2007/08 *Human Development Report* (UNDP 2007).
7. It declined from 2.8 percent to 2.4 percent of GDP in Peru, and from 2.5 percent to 1.0 percent in Ecuador. In Bolivia, it rose from 2.4 to 6.4 percent (UNDP 2007).
8. The fiscal situation in Bolivia improved significantly after 2004.
9. Prior to January 2009, the Bolivian Constitution considered only primary education (8 years) to be mandatory.
10. The figures are from Ecuador's National Institute for Statistics and Census. The Center for Development and Self-Management (DyA–Ecuador), a leading NGO that seeks to improve quality and coverage of health and education services and to influence public policy, gives a worse picture—69.9 percent work and study simultaneously, 15.0 percent exclusively work, and 13.3 percent only study (cited in García, Larrea, and Enríquez [2007, p. 38]).
11. A program begun in Peru in 2008 has committed to delivering laptop computers (one per child) in rural areas.
12. A new proposal that tries to provide a monetary subsidy to rural girls and adolescents as well as indigenous children in Peru has been suggested by Vásquez and Monge (2008; also see Vásquez [2008]).
13. The program's normative basis is Law 2426, in force since January 2003.
14. Its normative basis is Law 14, October 2005.
15. Its normative basis is found in the General Law on Health (modified through Law 27604), Ministerial Resolution 725-2005/MINSA, Supreme Decree 004-2007-SA.
16. Information about the system is available at http://www.sis.gob.pe/a_quien_antec.html [accessed March 12, 2009].
17. Information is available at http://www.sis.gob.pe/a_estad_cuadr.html [accessed March 31, 2009].
18. Coverage statistics are available at http://www.sis.gob.pe/estad_indic_070723_ 2.htm [accessed March 17, 2009].
19. By 2006 the Institutes for Health Education had grown to 699 educational centers, 300,000 students, and 13,308 trained educators; currently, there are

more than 762 accredited centers and 585,381 students (Peru, Ministry of Health [2006], cited in Vásquez [2007, p. 49]).

20. For example, Peru's Law on the Ministry of Health (Law 27657, art. 8) states that "all health establishments and health services should be appropriate from a scientific and medical point of view and should be of good quality."
21. These initiatives include the Ombudsmen, the Observatory for the Rights of Children and Adolescents in Ecuador, and the programs Coverage with Quality and Project 2000 in Peru.
22. The mechanism for consultation was created through an agreement (a ministerial resolution) between the Ministry of Health and the Interethnic Association for the Development of the Peruvian Selva.
23. For example, Peru's Support to Modernize the Health Sector program is active only in Apurimac, Ayacucho, and Huancavelica.
24. See chapter 2 for a more detailed discussion of the policy domains and the social guarantees model.

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