
URUGUAY
PROFILE OF HEALTH SERVICES SYSTEM

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

EXECUTIVE SUMMARY

Uruguay is a unitary, democratic state with a national government and 19 departmental governments.

According to the 1996 Census, the total population of the country was 3,163,763 (90.8% urban). In 1997, the per capita gross national product (GNP) was US\$ 6,114; public spending represented 32.2% of the GDP and social public spending, 22.5%.

The unemployment rate was 10.5% in 1998. Despite a downward trend since 1996, unemployment began to rise in 1999 as a result of the economic and financial crisis in Brazil. In 1997, 6% of households in urban Uruguay were below the poverty line and 2% were below the extreme poverty line. The national illiteracy rate in the population 10 years and older was 3.1%. The average years of study in the population 12 years and older, excluding preschool, was 8 years.

The health system in Uruguay consists of a public and a private sector. The institutions in the public sector are the Ministry of Public Health (MPH), which provides its services through the State Health Services Administration (ASSE); the Social Welfare Fund; the University of the Republic; the armed forces and police health services; the municipal governments; and other public and autonomous entities. The private system is made up of collective health care institutions (CHCI)--roughly 50 prepaid insurance institutions that provide comprehensive care; private medical care institutions (called partial health insurance institutions); highly specialized medical institutes (HSMI), which are public or private enterprises that perform some of the 15 high-tech and/or costly procedures paid for through the Public Resources Fund; and private sanatoriums, clinics, and physician's offices, together with residences and nursing homes for the elderly. The various public and private institutions purchase services from and sell services to each other, thus creating strong ties among these public and private actors.

In 1997, roughly 12,000 physicians and 2,400 university-trained nurses were actively working.

The health sector as a whole is financed as follows: 42% through the payment of premiums to CHCI and partial-insurance institutions; 25% through the sale of services; and 23% through general taxes.

The principal expenditures of the health sector as a whole are: 46% for wages, 25% for the purchase of supplies; 17% for drugs; and 3% for investments.

In 1996, 33.7% of the population was covered by the MPH; 46.6% by the CHCI; 4.2% by the armed forces health services; 1.8% by the police health services; and 1.2% by others. Furthermore, 11.7% of the population had no coverage, and the status of the remaining 0.9% is unknown.

In ASSE facilities, the consultation rate per 1,000 population is 3,768, whereas in CHCI it is 5,854. The average length of hospital stays in the former is 15 days and in the latter, 4.5 days. In MPH hospitals, 15% of births are by cesarean section, versus some 30% to 40% in CHCI hospitals.

In Uruguay there is no process aimed at reforming the health sector as a whole. However, there is a series of projects basically directed toward strengthening both the managerial capacity and delivery of services of the MPH and the actions in certain priority programs. These projects are part of an overall government

policy to modernize the State and strengthen the social sectors and are financed almost entirely through World Bank and IDB loans.

1. CONTEXT

Political Context: Uruguay is a unitary, democratic state, with a national government and 19 departmental governments, all of which are elected every five years through compulsory voting by secret ballot, with every vote of equal weight.

The national government is made up of the Executive, Legislative, and Judicial Branches. The departmental governments consist of a governor and a departmental board (with 31 members or alderman). The governors make up a National Congress of Governors, which coordinates local policies.

The Social Cabinet coordinates actions in this area. It is composed of the Ministers of Public Health, Education, and Culture; Labor and Social Security; and Housing and Environment; and the Planning and Budget Office of the Office of the President of the Republic.

The Constitution of the Republic stipulates that, within the first six months of its term, the Executive Branch must submit the national budget for its term in office (five years) to the legislature. That budget establishes the government's principal development guidelines. Every year, the Executive Branch submits an accounting to the legislature on budget execution for that fiscal year. The general health policy is included in the five-year budget. In the last five-year period (1995-1999), priority was given to reducing infant mortality. There are no other national or subnational mechanisms for development planning and management, social policy implementation, or the inclusion of health policy in government programs.

Although no official document lays out the principal political and/or social problems affecting the health situation or performance of the health services, these problems are thought to include the age structure of the population (12.8% of the total population is 65 or older), the high cost of health care, and the centralization of the MPH.

Economic Context:

Principal Economic and Social Sector Indicators

INDICATOR	YEAR						
	1991	1992	1993	1994	1995	1996	1997
Per capita gross national product in constant prices, in US\$ (1)	3,211	3,763	4,353	4,086	5,608	5,899	6,114
Total public expenditure, as a percentage of GDP	30	N/A	N/A	N/A	31.4	N/A	32.2
Public social expenditure, as a percentage of GDP (2)	18.7	N/A	N/A	N/A	23.6	N/A	22.5
Total health expenditure, as a percentage of GDP	8.04	8.26	N/A	9.81	9.98	N/A	N/A

Source: 1. - ECLAC. Statistical Yearbook for Latin America and the Caribbean. Santiago, Chile 1998. 2. - ECLAC. *Social Panorama of Latin America*. Santiago, Chile. several years.

Contribution to the GDP by Economic Sector in Percentages, 1997

(At producers' prices, in constant 1983 prices)

Agriculture, livestock, and fishing	11.69
Mines and quarries	0.24
Manufacturing industries	20.48
Construction	2.85

Businesses, restaurants, and hotels	14.56
Transport and communications	9.98
Electricity, gas, and water	3.86
Banking, finance, and business services	21.1
Community, social, and personal services	15.24

Source: Uruguay, Central Bank of Uruguay. Statistical Bulletin, 1998.

In the last five-year period (1995-1999) strong support has been received from the World Bank and the IDB in the form of loans to the social sectors, including the MPH. According to the MPH investment balance for 1997, the implementation of these projects, financed with foreign debt, totaled US\$10,983,826 (Source: General Accounting Office of the Nation).

Social Context: According to the 1996 National Census, Uruguay had a population of 3,163,763, with an urban population of 90.8%.

In 1995, Uruguay had a human development index (HDI) of 0.885, ranking 38th on the HDI Index and 14th according to the classification that subtracts the HDI classification from real per capita GDP. The country ranks 54th on the Gender-related Development Index¹.

Unemployment was 10.5% in 1998. Declining between 1996 and 1998, the trend was reversed in early 1999 as a result of the crisis in Brazil. There are no official figures on informal employment.

For urban Uruguay (92% of the population), the trend in the percentage of households under the poverty line has been as follows: 12% (1990), 8% (1992), 6% (1994), and 6% (1997), and that of households under the extreme poverty line: 2% (1990), 1% (1994), and 1% (1997). Uruguay has no indigenous population.

The ratio between the income of the upper and lower 20% of population for 1997 was 3.75 and has remained stable for the past three years (1994-96), ranging from 3.80 to 3.70.

The illiteracy rate in the population 10 years of age or older is 3.1% for the country as a whole (3.6% in men and 2.6% in women). The average years of schooling in the population 12 and older, excluding preschool, is 8 years.

2. HEALTH SERVICES SYSTEM

General Organization: The health system is made up of the public and private subsystems.

The institutions in the public sector are: (i) the Ministry of Public Health (MPH); (ii) the Social Welfare Fund (SWF); (iii) the University of the Republic; (iv) the armed forces and police health services; (v) the municipal governments; and (vi) other public and autonomous entities.

The MPH provides services through the State Health Services Administration (ASSE). The MPH-ASSE has roughly 65 health facilities, which are classified by level of complexity as multipurpose clinics, health centers, and hospitals (A, B, C, and specialized). There is a total of 6,200 beds for acute care and 2,300 for long-term mental health care throughout the country. For each of the 18 departments in the interior of

the country there is a departmental hospital that serves as a referral hospital for other ASSE facilities in that department. Although most departmental hospitals have a support committee to collaborate on administering financial resources (in September 1998 approval was given for paid positions on that committee to afford the hospitals greater decentralization), the ASSE remains highly centralized.

The MPH's principal source of financing is taxes (around 95% of the total budget) from the five-year budget, and 5% from nonbudgetary resources obtained from the sale of services). The MPH has some 12,000 staff members throughout the country. Under the law of 10 November 1987 creating the ASSE, more complex benefits can be purchased from private providers. In the interior of the country, the purchase and sale of services between the ASSE and the private sector is common.

The Social Welfare Fund is an autonomous State entity provided for in the 1968 Constitution currently in force. Its task is to coordinate state social welfare services and organize social security. The SWF acts both as an intermediary, receiving worker and employer contributions and contracting collective health care institutions, and as a direct provider of health services to both pregnant women and children. All workers with one or more employers who enter or return to private work in the private sector have the right to health insurance provided through those institutions and contracted by the SWF. Self-employed persons with no more than one dependent and the collaborating spouses of self-employed rural workers with only one dependent are entitled to this as well. Furthermore, the Fund, as a direct provider of health services, covers: care for workers during pregnancy and childbirth, as well as ordinary pediatric care up to age 6; dental and orthodontic care and social welfare up to age 9; and health care up to age 13 (or no age limit) for persons with birth defects. It owns one hospital and 6 maternal and child centers in Montevideo. In other parts of the country, the Fund contracts services to the MPH or collective health care institutions (CHCI). The principal source of financing is employee and employer premiums (approximately 90% of the total financing); it also receives funds from the government's five-year budget (10%). The University of the Republic, through the University Hospital (with up to 650 beds), provides care in almost every medical specialty. It is a public, general service for patients with acute conditions. Its functions are teaching, research, and health service delivery. Its organization is determined by the University's Central Board of Directors, as proposed by the Board of the School of Medicine. The Hospital's principal source of financing is taxes, through the government's five-year budget. It has all levels of complexity and is the only hospital that belongs to the University of the Republic. It was supposed to be a national referral center but, due to a lack of financial resources, it is in crisis and has suspended some services. According to the information available, it currently does not sell services. For four years, through an IDB loan, the possible conversion of the Hospital has been analyzed to include a new model of care, the medical curriculum, the placement of the Hospital under the University, etc.

The armed forces health services, a unit of the Ministry of Defense, has a 450-bed central hospital. The police health services, under the Ministry of the Interior, has a 70-bed hospital. Their principal source of

financing is taxes, through the government's five-year budget. Both institutions cover active and retired personnel, pensioners, and their family members. In the interior of the country, they provide their services through the MPH, through agreements that have been in place for decades.

The municipal governments provide outpatient care to the general population and represent the Executive Branch locally. Among their other functions, the governments serve as the health police, without prejudice to the functions of the MPH. The law creating the ASSE (Art. 275) empowers the Administration to transfer administration of the use of ASSE health facilities to the departmental governments through an agreement, although this type of transfer has yet to occur. Municipal government health services provide care at only the first level of complexity. The principal source of financing is taxes, through the five-year budgets of the municipal governments.

There is no entity that coordinates all public health institutions. The various public health institutions have purchase and sale agreements for services throughout the country. There are also agreements for the direct purchase and sale of services between the MPH and the medical cooperatives in the interior.

The private system is comprised of private service providers, including: (i) collective health care institutions (CHCI); (ii) private health care institutions (the so-called partial health insurance institutions), which are roughly 68 for-profit companies that provide a specific type of care (for example: emergency, dental, multipurpose clinics, etc.); (iii) highly specialized medical institutes (HSMI) (public or private companies that perform some of the 15 procedures funded through the Public Resources Fund); and (iv) private sanatoriums, clinics, and physician's offices, together with residences and nursing homes for the elderly.

Collective health care institutions (CHCI) are private organizations that offer prepaid insurance with comprehensive coverage. Almost 50% of the country's population belongs to a CHCI. These institutions can adopt any of the following three legal forms (Law 15,181 of 21 August 1981): (a) care associations, which are based on the principles of solidarity and, through mutual insurance, provide health care to their beneficiaries (known as mutual aid associations, they first appeared in the country almost a century and a half ago); (b) professional cooperatives, which provide medical care to their members and beneficiaries, in which the equity is contributed by the professionals of the cooperative; and (c) nonprofit health services, created and financed by private or semi-public enterprises to provide health care to company staff and their families. Of the 50 CHCI in the country, 7 are mutual assistance associations. Most of the remaining 43 are professional cooperatives. A few institutions created prior to the 1981 Law were not legally converted to one of the three forms indicated above.

The CHCI are independent organizations that compete with one another. The State, through the MPH, the Ministry of Finance, and the Ministry of Labor, exercises some legal and technical control over them; however they do have a high degree of autonomy. The greatest constraint to that autonomy is that the

State sets a price ceiling on monthly premiums. The CHCI are scattered throughout the country, with at least one in every department.

Their principal source of financing is premiums (75% of their total revenue in 1998). Premiums are either: (i) paid by individuals; (ii) paid through a collective agreement; or (iii) paid by social security. Other sources are member copayments for the use of services (11%) and revenues from the sale of services, and other sources (14%).

Most CHCI are grouped into second-level associations (Medical Federation of the Interior (FEMI), Union of Mutual Assistance Associations of Uruguay (UMU), and the CHCI Plenary). The CHCI's involvement with the public sector takes place, in particular, through the purchase and sale of services. There is also coordination in areas related to health promotion and disease prevention through ad hoc commissions.

In the past decade, CHCIs continued to be the dominant model in Uruguay; however there is a growing trend toward the emergence of "private medical care" institutions, which are commercial health insurance companies. Some attempt to sign up people who cannot afford a CHCI and do not wish to be covered by the MPH. Others target high-income persons who would like more benefits than those provided by a CHCI. A third group is made up of so-called mobile emergency medical services, which provide a service that complements that of the CHCI.

System Resources

Human Resources:

Type of Resource	Year							
	1990	1991	1992	1993	1994	1995	1996	1997
Total physicians ¹	9,788	10,217	10,608	11,021	11,241	11,470	11,815	11,964
Total nurses	1,710	1,774	1,851	2,047	2,139	2,126	2,277	2,369
Total mid-level laboratory technicians	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
No. graduates with post-graduate degrees in public health	3	4	0	1	3	1	1	2
Ratio of physicians per 10,000 pop.	30.9	32.3	33.5	34.8	35.5	36.3	37.3	37.8
Ratio of professional nurses per 10,000 population	5.4	5.6	5.8	6.5	6.8	7.0	7.2	7.5

Source: 1 University Professionals Retirement Fund of Uruguay.

Human Resources in the 5 Principal MPH Hospitals, 1998

Institution	Type of Resource					
	Physicians	Nurses	Nursing auxiliaries	Other workers	Administrative personnel	General services
H. Pereira Rossell (Maternity and Pediatrics)	448	57	535	373	211	226
H. Maciel (for acute patients; Montevideo)	335	42	265	165	93	108
H. Pasteur (for acute patients; Montevideo)	271	39	245	141	130	97
H. Departmental of Paysandú (for acute patients)	156	12	179	103	54	108

Institution	Type of Resource					
	Physicians	Nurses	Nursing auxiliaries	Other workers	Administrative personnel	General services
H. Departamental de Salto (for acute patients)	128	26	159	73	61	153
Total	1,338	176	1,383	855	549	692

Source: MPH-ASSE

No substantial changes to the quantity and distribution of human resources are expected in the immediate future.

Drugs and Other Health Inputs: All drugs marketed in Uruguay must be registered consecutively with the MPH. An estimated 4,000 medicines are marketed in the country.

In 1971, the MPH prepared an essential drugs list (EDL) in response to WHO requirements. Use of the list is compulsory for all units of the MPH-ASSE. There is a standing EDL committee that decides on which drugs to include or remove. When last reviewed (1998), the EDL included approximately 300 drugs, listed by generic name. Every private institution has its own list, which generally is more extensive than the EDL.

In 1992, a system was launched to dispense drugs in single doses in a sector of both a public and a private hospital. At present, implementation of the system has been expanded but is not widespread. There are no figures on the percentage of hospitals with this system.

Since 1996, the MPH has been promoting the preparation of protocols for implementation in both the public and private sectors. It started with protocols for surgery, then moved on to internal medicine, pediatrics, and gynecology and obstetrics. Workshops to test them were held in 1999, with the participation of important professionals from the area and private sector institutions. For the next stage, a pilot study will be conducted in two public and two private institutions.

Current regulations stipulate that a pharmacist must be responsible for the technical management of private pharmacies and MPH-ASSE hospital pharmacies.

In 1997, 115,490 blood donations were reported.² The sale of blood and blood products is prohibited by law.

Equipment and Technology: There is no national inventory of equipment in either the public or private sectors. Furthermore, there are no data available on the average age of hospital buildings or that summarize other characteristics. Many of the buildings in the public sector date back to the 1920s, while many in the private sector were built in the 1950s. Although from 1987 to 1990 the MPH had a technology unit that analyzed equipment import requests (in terms of the effectiveness of the technology and the country's needs), it no longer exists.

Several high-tech or costly procedures (lithotripsy, kidney dialysis, heart surgery, hip or knee replacement, serious burns, etc.) are financed through the Public Resources Fund (created in 1979) and performed by

highly specialized medical institutes, which may be public or private. In Uruguay, 100% of the population is covered; therefore there are no problems of economic or geographic access to these procedures.

Functions of the Health Services System

Steering Role: The MPH was established in 1934. Its Organic Law (which is still in effect) and subsequent decrees by the Executive Branch stipulate that it is the agency responsible for setting standards, regulating and controlling the health sector, developing programs for prevention, and administering its health services. There is no single authority that regulates and oversees the entire health system, nor are the essential public health functions clearly defined. The financing of the public sector is set forth in each five-year budget. Oversight and control are exercised through the accounting that the Executive Branch is obliged to present annually, and through the comptroller of the government accounting office.

There are regulations governing the private sector, both the CHCI and partial-insurance plans, that determine what benefits they are to provide, as well as aspects of investments, minimum operating requirements, etc. However, CHCI are more heavily regulated than partial-insurance institutions. For example, CHCI prices or premiums are regulated by the Ministry of Economy and Finance, which is not the case for partial-insurance plans.

The MPH Quality Control Division receives and processes complaints from users of private sector facilities. It conducts the pertinent investigations and proposes the necessary corrective measures or sanctions. The oversight mechanism for the delivery of public sector services is not centralized and is in the hands of each institution.

There are several examples of intersectoral actions and/or programs. In 1990, the MPH identified 12 priority health problems, which have currently been reformulated as 15 (cardiovascular health, breast and lung cancer, traffic accidents, infant mortality, Chagas, oral health, etc.). All these programs conduct intersectoral activities, including those coordinated between public and private health institutions, since their main activities are geared toward health education. There are fewer actions related strictly to institutional health service providers, and they are aimed at improving referral and back-referral systems (for example, screening schoolchildren with a vision or hearing pathology, bringing drivers with alcohol on their breath to health services, or breast cancer referrals, etc.).

The MPH has a reliable, timely information system on mortality; however, the data on morbidity is scattered and incomplete. With respect to the operation of health services, the MPH has the National Information System (SINADI), which has data from the CHCI on coverage, the number of services delivered, economic and financial management, and some variables related to the physical resources of private health institutions in the country; however it does not have information on human resources. An information system on the production, performance, and cost of State Health Service Administration facilities (MPH-ASSE) has also been in operation for a decade. The information available is rarely

utilized either at the central level of the MPH or by private institutions or MPH facilities, for lack of an adequate institutional culture. However, efforts to improve management have been made in recent years.

The Human Resources Department of the MPH plays a more administrative role, rather than formulating human resources policy. The School of Medicine of the University of the Republic, founded 150 years ago, is the only institution that trains physicians, nurses, nutritionists, and miscellaneous technicians (laboratory, medical records, anatomic pathology, etc.). In the past decade there was a proliferation of private schools for nursing auxiliaries, especially in the interior of the country. All such institutions must meet a series of criteria and can then accredit the skills of the professionals trained. To be able to practice, all health professionals must be registered with the MPH, which authorizes them to work in the country. There are no professional associations, except for one being established in the nursing profession that still lacks legal status. The MPH and other institutions (fire departments, municipal governments, etc.) authorize facilities, but there is no accreditation system.

There is no agency devoted to health technology assessment.

*Financing and Expenditure*³: There is no single, systematic information process on the financing of the country's health expenditure. There are isolated experiences in this area, and the last publication of such information was issued in 1996 by the MPH, with financing from the World Bank.⁴

Structure of Health Sector Financing, Uruguay 1995 (% of total financing)

INSTITUTION	SOURCE OF FINANCING						TOTAL
	Taxes	Fees	Personal withholdings	Premiums	Income	Other	
<i>Public sector:</i>							
Ministry of Public Health	1.71				0.07		1.78
State Health Services Administration	14.37				0.60		14.97
Armed forces health services	1.5		0.30		0.02		1.87
Police health services	1.01		0.27				1.28
Hospital de Clínicas (Univ. of the Republic)	1.50				0.08		1.58
Social Welfare Fund	0.23		2.03				2.25
State Insurance Fund		1.33					1.33
A.N.C.A.P. (State oil company)		0.55					0.55
A.N.P. (State port authority)		0.04					0.04
Municipal Government of Montevideo	0.41						0.41
Honorary Commission to Combat Cancer	0.14				0.02		0.16
Honorary Commission for Cardiovascular Health	0.01				0.0002		0.01
Honorary Commission for the Tuberculosis Campaign	0.24					0.04	0.29
Honorary Commission to Combat Hydatidosis					0.05		0.05
Treasury Contribution to the Public Resources Fund	2.03						2.03
PUB. SECTOR SUBTOTAL	23.19	1.92	2.60	0.00	0.83	0.04	28.59
<i>Private sector:</i>							

INSTITUTION	SOURCE OF FINANCING						
	Taxes	Fees	Personal withholdings	Premiums	Income	Other	TOTAL
Collective health care institutions		5.95		38.21		5.46	49.62
Private sector contribution to the Public Resources Fund				3.87			3.87
Partial-insurance plans: Mobile emergency medical services		5.85					5.85
Partial-insurance plans: Medical and surgical		0.43					0.43
Partial-insurance plans: Dental		2.52					2.52
External pharmacies		6.44					6.44
Nursing homes and residences for the elderly		0.36					0.36
Notary fund			0.36				0.36
Exclusive private care		1.96					1.96
PRIV. SECTOR SUBTOTAL	0.00	23.52	0.36	42.08	0.00	5.46	71.41
TOTAL	23.19	25.44	2.95	42.08	0.83	5.50	100.00

Source: Uruguay, Project for Institutional Strengthening of the Health Sector, Ministry of Public Health, International Bank for Reconstruction and Development. *El gasto en salud en el Uruguay, años 1994 y 1995*. MPH-FISS: Montevideo, September 1996. Pages 76 and 77.

The three principal mechanisms through which families make their contributions to institutional health service providers (whether public or private) are: (a) voluntary prepayment of premiums (42%); (b) the purchase of goods and services, including drugs (25%); and (c) taxes (23%).

In the private sector, members overwhelmingly prepay their premiums (59%). The second most common source of financing is the purchase goods or services by the population (33%), the cost of which is essentially paid to the partial-insurance plans, external pharmacies, nursing homes, and exclusively private care, and payment for requests for goods and services by members of mutual assistance associations. These two modalities account for the financing of 92% of the private sector.

The principal component of health financing, CHCI membership premiums, experienced appreciable real growth in the period 1988 to 1996. In that period, basic monthly premiums rose 68% throughout the country (56% in Montevideo, 100% in the rest of the country). There is no direct public financing for the private sector, however social security administers employer and worker contributions and pays for insurance in the private sector. There is no tax relief for subscribing to private health insurance. There is no information on nonreimbursable donations or loans, although they are not thought to be significant. With regard to reimbursable loans, reference was made above to loans from the World Bank and the IDB. The status of data on spending is the same as that on financing.

HEALTH EXPENDITURE, URUGUAY 1995 (% of the total)

HEALTH SECTORS	NATURE OF THE EXPENDITURE					
	Personal withholdings	Drugs	Materials and others	Investments	Outsourcing	TOTAL
Public sector	36.6	12.0	41.0	2.8	7.7	100.0
Private sector	49.4	18.6	18.4	3.4	10.2	100.0
TOTAL	45.7	16.7	24.9	3.3	9.5	100.0

Source: Uruguay, Project for Institutional Strengthening of the Health Sector, Ministry of Public Health, International Bank for Reconstruction and Development. *El gasto en salud en el Uruguay, años 1994 y 1995*. MPH-FISS: Montevideo, September 1996. Pages 13 and 14.

National per capita health expenditure in 1995 (the last year available) totaled NUr\$3,576 (approximately US\$400). In 1995, 71.41% of total health expenditure corresponded to the private sector, 16.76% to the MPH-ASSE, and 11.86% to other public institutions. There are no data from the immediate past to estimate trends. There is also no information available on public health expenditure by level of care.

In a 1994 study,⁵ no important differences were found between the percentage of health expenditure in total household expenditure in Montevideo (11%) and the rest of the country (9%). However, there were when considering per capita expenditure, which in Montevideo (US\$286) was double that of the rest of the country (US\$145). Spending was similar for high-income households in Montevideo and the interior, but low-income households in the interior spent less than those in Montevideo. In Montevideo, the rich spent 10 times more than the poor, and in the interior they spent 19 times more.

Insurance: The timely reliable data the MPH has on coverage is for collective health care institutions. There are no data for the rest of the private sector. There is an estimate for MPH coverage, based on the number of health service cards issued; however, it is not very reliable. The military and police health services have a closed population. There are no timely, reliable data for the municipal governments and other public institutions. A 1997 decree issued by the Executive Branch established the Single Formal Coverage Registry (RUCAF), requiring public and private institutions at the national and departmental level that provide any type of health care coverage, whether partial or comprehensive, to submit a complete list of their members or users to RUCAF. This system is not yet operational.

In 1996, 33.7% of the population was covered by the MPH; 46.6% by CHCI; 4.2% by military health services; 1.8% by police health services; and 1.2% by others; 11.7% of the population had no coverage, and the status of the remaining 0.9% is unknown.⁶

Under Article 44 of the Constitution, the State will provide services for disease prevention and health care free of charge only to the indigent or those who lack sufficient resources. The MPH issues four types of health care cards: (i) the free health care card for people whose income is not more than two and a half times the national minimum wage, who are not charged for the services rendered; (ii) the subsidized health care card, which has two categories: those who must pay 30% of the fees and those who must pay 60%, depending on their income level; (iii) the maternal and child health care card, for pregnant women and mothers up to 6 months after delivery and children under 1 year of age, who receive free care; and

(iv) the card for free lifelong care, which includes pensioners over 65 and pensioners under 65 on disability.

Workers in the private sector must join a collective health care institution (CHCI) within 10 working days of their entry into or return to work through the Social Welfare Fund, which is co-paid by workers and employers.

There is a National Information System (SINADI), centralized in the MPH, to which all CHCI must report their number of members and capital expenditure, among other data.

The Public Resources Fund began to function in 1981 and fully finances some 15 highly specialized or costly procedures: heart surgery, pacemaker insertion, chronic hemodialysis, hip and knee replacement, etc. The Fund's principal sources of financing are contributions from the State to cover care for persons with an MPH health care card and from the collective health care institutions to cover care for their members (who contribute approximately 10% of mutual assistance premiums to the Fund).

In addition to the total or comprehensive care, private enterprises (some 64 throughout the country) that offer partial health insurance for emergencies, outpatient care, dentistry, etc. This partial insurance system has been in place since the 1950s but was recently expanded in the 1980s; 30%-35% of the country's population belongs to these plans, as it is common to have dual coverage by this system and the total coverage system.

The greatest difference between health care in a MPH service and a CHCI is the accommodations: the MPH has rooms that hold up to 25 patients, while CHCI typically have semi-private rooms with two beds. The technology and human resources in both services are very similar.

All private sector workers who contribute to Social Security have the same type of benefits through the CHCI. There is no specific definition of a basic package of benefits or plan. Until 1989, the MPH determined semiannually which benefits would not be included in CHCI benefits. In that year, the criterion was modified, and it was decided that a ministerial resolution would be required to add any benefits.

Service Delivery:

Health Services for the Population. Several public institutions engage in activities to promote healthy habits and protect against risks. Principal among them is the MPH, which has a Health Promotion Division. The main priority programs to reduce infant mortality, cardiovascular disease, breast and lung cancer, AIDS, substance abuse and addiction, traffic accidents, poor oral health, etc. fall under that Division. Its activities are geared toward health education for at-risk groups, but its exact coverage is not known. The programs work in a coordinated manner with public and private, primary and secondary educational institutions. Some indicators in certain programs show progress, although not exclusively because of these activities. For example, the infant mortality rate in 1990 was 20.0 per 1,000 and, in 1996, 17.5 per 1,000; the DMFT Index at age 12 was 4.2 in 1990 and in 1998 was estimated at 2.3 (due to the

introduction of fluoridated salt for domestic use); and the annual incidence of HIV in the country has plateaued. However, the indicators for chronic noncommunicable diseases have still not shown significant improvement.

The percentage of vaccinations in children under 1 year of age for 1996 were: three doses of the polio vaccine, 88%; three doses of the DPT vaccine, 88%; the MMR vaccine (measles, mumps, rubella), 84%; BCG, 99%; and the meningococcal vaccines A+C, 90%. Prenatal care and delivery coverage by trained personnel are 98% and 99%, respectively.

Health Services Geared toward the Individual:

For Both Levels of Care:

The data provided by the different management information systems (SINADI for most of the private sector --CHCI--, and PRORRECO for the MPH-ASSE) are considered to be timely and reliable. The problem lies in the managerial capacity of the human resources in both sectors, which generally do not make adequate use of such information.

There has been no change in the past decade in the ability of users to choose between different health care providers: workers in the private sector may freely choose from among the different private health care institutions; workers in the public sector also have that choice, except for some groups with their own services (armed forces, police); the unemployed are treated in the MPH; and retirees, depending on their ability to pay, in the MPH or various private sector institutions.

For the primary care level¹: The percentages of total coverage, by institution, for the entire country are: 33% for the MPH; 47% for the CHCI; and 6% for the armed forces and police health services; while 12% have no formal coverage. It is interesting to note that almost half of the population covered by the MPH consists of children and adolescents (47% are under the age of 20) and almost half the population receiving care in CHCIs is between the ages of 15 and 49.

In general, the use of computer systems is widespread in both public and private health centers. The development of computerized networks is determined by each institution. There is still no network linking the computerized information systems of the various institutions.

Production Indicators, 1998

	NUMBER	RATE PER 1,000 POPULATION
Consultations and check-ups by medical professionals. Ministry of Public Health		
-ASSE (total) (1998)	4,898,343	3,768
-CHCI (total) (1998)	8,780,805	5,854
Consultations and check-ups by nonmedical professionals	N/A	N/A
Consultations and check-ups by dentists	N/A	N/A
Emergency consultations		
- CHCI (1998)	1,135.035	757
Laboratory tests	N/A	N/A

Source: PRORRECO, MPH-ASSE and the National Information System, MPH-CHCI = collective health care institutions

Information on the five most frequent causes of consultation is not available.

All the collective health care institutions (CHCI) offer house calls. In recent years, a home hospitalization system has been developed in CHCI.

For the Secondary Level of Care:

Institutional coverage was already noted above and refers specifically to the secondary level, since there are no data broken down by level of care. MPH-ASSE hospitals have the following information systems: the Production, Performance, and Costs System (PRORRECO), the Accounting System (CONTA), a pharmacy management system (in most hospitals), and some have a program for human resources.

There is no data on the degree to which the information is used for clinical management (for example, to increase the efficiency of wards and operating rooms and reduce unnecessary exploratory surgery or waiting time).

	INDICATOR		
	Total no. of discharges	Occupancy index	Average length of stay (in days)
MPH-ASSE (1998)	145,224		
In Montevideo		95%	15
In the rest of the country		60%	7
Collective health care institutions (1998)	154,867	N/A	4.5

The five most frequent causes of hospital discharge were not available for the principal networks of providers.

Quality:

Technical Quality:

There are no quality programs in MPH-ASSE facilities; however some experiments with this are under way in the private sector. In 1997, a partial-coverage health care company (emergency services) won the first national quality award out of all the companies in the country in the various sectors.

The only Ethics Committee in the sector is that of the Medical Union of Uruguay, which is largely geared toward addressing malpractice suits against Union members.

Cesarean Sections, by Institution and Geographical Location, Uruguay 1995
(% of total deliveries)⁷

	MPH	CHCI
Montevideo	16	41
Interior	13	30

Roughly 38% of deliveries in the country are in the Department of Montevideo. Interior (the other 18 departments in the country).

In November 1997, it was decreed that each public or private health care facility in Uruguay must have a committee to control nosocomial (hospital) infections, as part of its administrative structure, with a one-year deadline for its implementation.⁸ As yet there is no data on how many institutions have an operational hospital infections program or committee at the national level. Of the 25 private health care facilities in the interior of the country, 14 set up a hospital infections committee about three years ago.⁹ Some public hospitals have a nosocomial infections committee, depending on the level of interest of their directors.

There are no data on the percentage of autopsies out of total hospital deaths, although the level is estimated to be very low. Autopsies are compulsory in the case of violent deaths. There are no figures on the percentage of maternal or child deaths audited.

Perceived Quality:

Since 1996, a Baby-Friendly Hospital accreditation system has been in development. To date, the main maternity hospitals in the country, both public and private, have been accredited.

By Executive decree (June, 1992) the Standards for Medical Conduct and Patients' Rights were established. This decree also created the Association of Health System Users (AdUSS), which has its headquarters in the MPH and basically works to support users in processing complaints to the Ministry.

In 1999, a survey system was launched to evaluate user satisfaction in four MPH hospitals. This practice is expected to continue.

In the private sector, especially in larger institutions, user satisfaction is frequently evaluated. However, the data have not been disseminated and are for internal use in each institution.

There is no information on the percentage of facilities with established, operating arbitration commissions (or their equivalent).

3. MONITORING AND EVALUATION OF SECTORAL REFORM

Monitoring of the Process

Monitoring of the Dynamics: Uruguay has no process to reform the health sector in its entirety. There is a set of projects aimed at strengthening both the managerial capacity and service delivery of the MPH and the activities of certain priority programs. Such projects are part of an overall government policy to

modernize the State and strengthen the social sectors, begun in 1995 and financed almost completely by loans from the World Bank and the IDB.

This process is directed at general level by the Office of the President of the Republic and the Planning and Budget Office, and within each sector by the appropriate Ministry. In the health sector, the projects are concentrated in the public sector and almost entirely in the MPH. The Minister exercises the steering role for projects within the MPH, with advisory services from the International Cooperation unit of the MPH, the three General Bureaus, and the IDB and World Bank project chiefs. Since their start (1995), there have been several adjustments to the projects and changes in personnel. There have been missions from the banks to evaluate project monitoring; however use of their reports is restricted.

Monitoring of the Contents

Legal Framework: There are no plans to propose amendments to the Constitution or the basic legislation governing the health sector. The State reform process has reaffirmed the two substantive roles of the MPH set forth in the 1967 Constitution and the Organic Law of the MPH (1934): to provide care free of charge to the indigent or those without sufficient resources and to promote health and reduce risk factors in the entire population.

Right to Health Care and Insurance: The Constitution stipulates that the State will legislate in the area of public health, that each individual must protect his/her health and seek care when ill, and that the State will provide free care only to the indigent.

There is no specific program to increase coverage. The possibility of granting CHCI coverage to children (the age is still to be determined) currently covered by the MPH-ASSE or SWF is being studied.

Between 1995 and 1997 there was an attempt by the Minister of Public Health at the time to establish a basic package of benefits for the country's entire population, however this was not achieved. Nonetheless, this is being proposed by one of the more influential groups in one of the political parties in the current national elections.

Steering Role: Strengthening of the steering role of the MPH has been on the agenda for more than a decade in the various departments of the MPH. However, there have been no structural changes or new regulatory institutions created that affect the sector. No action to modify the information systems has been taken.

Separation of Functions: There are no plans to reorganize the regulatory, financing, insurance, and delivery of health services functions. No institution has been created that is responsible for policy formulation, financing, coverage, and delivery of services.

Decentralization Modalities: In 1995, a political agreement was not reached to promulgate a proposed law in the Parliament to make MPH-ASSE hospitals more autonomous. However, the MPH continues to promote the decentralization of its facilities through a project financed by the World Bank that creates

public hospitals with decentralized management. It aims to strengthen the managerial staff in hospitals--four in particular (Las Piedras, Maldonado, Salto, and Tacuarembó).

Social Participation and Control: There are support committees in some ASSE hospitals and district health commissions in municipal government health centers (in the outskirts of the cities). Social participation is not on the agenda.

Financing and Expenditure: The MPH, through the ASSE, has been utilizing the PRORRECO program (production, performance, and costs) for over a decade in almost all its hospitals. The reliability of the program varies from hospital to hospital. The MPH is studying the new version of WINSIG to update its current system. The CHCI must and do provide certain information on expenditures and investments to the National Information System (SINADI) of the MPH.

There still is no national accounts program. However, the feasibility of initiating a project to this end, to be financed by the World Bank, is being studied. No measures are being introduced that substantially modify the structure or composition of health expenditure and the financing thereof.

Service Delivery: There are currently no projects aimed at significantly modifying the supply of first- and second-level services. The number of public and private service providers has not increased. Since 1990, the MPH has identified 12 priority health problems, which are still targeted in its policy, and determined the populations at risk for certain pathologies.¹⁰

Management Model: No substantial changes to the health care models or the relationship between the actors are being proposed. Attempts are being made to further the implementation of management commitments among MPH-ASSE hospitals. Both MPH and SWF public health facilities outsource some services, such as cleaning, security, and certain types of equipment and facilities maintenance. They also purchase services for the (high-tech and/or costly) procedures financed by the Public Resources Fund, many of which are provided by private companies. Public health facilities do not operate as decentralized public companies; the system is still quite centralized. No public facilities have been turned over to private management.

Human Resources: Although not within a framework of sectoral reform, the creation of a National Public Health Institute is under way, which would be directed by the University of the Republic and the MPH. Its duties would be education, research, continuing education, and advisory services in different areas. For 10 years, filling budgeted public administration positions has been prohibited by law (a State reform policy). There have been no other significant changes in the recruitment, supervision, and dismissal of human resources in both the public and private sectors.

For years, there have been different incentive systems for MPH-ASSE personnel, which there are no proposals to change substantially. Each private health institution has its own incentives systems. No changes have been made in the forms of professional practice with a multidisciplinary orientation.

Quality and Health Technology Assessment: No accreditation mechanism as such currently exists. Different alternatives are being analyzed, but for now there is nothing concrete.

Evaluation of Results

No studies can show that any changes that have occurred in the country in terms of equity, effectiveness, quality, efficiency, financial sustainability, and community participation are due either totally or partially to sector reform.

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