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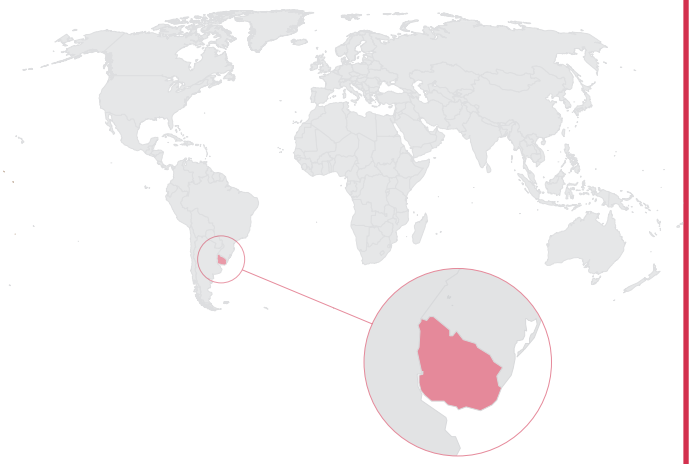
Social Policy Country Briefs

Uruguay



Guillermo Fuentes

The Health Care System in Uruguay

Global Dynamics of Social Policy CRC 1342

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Content

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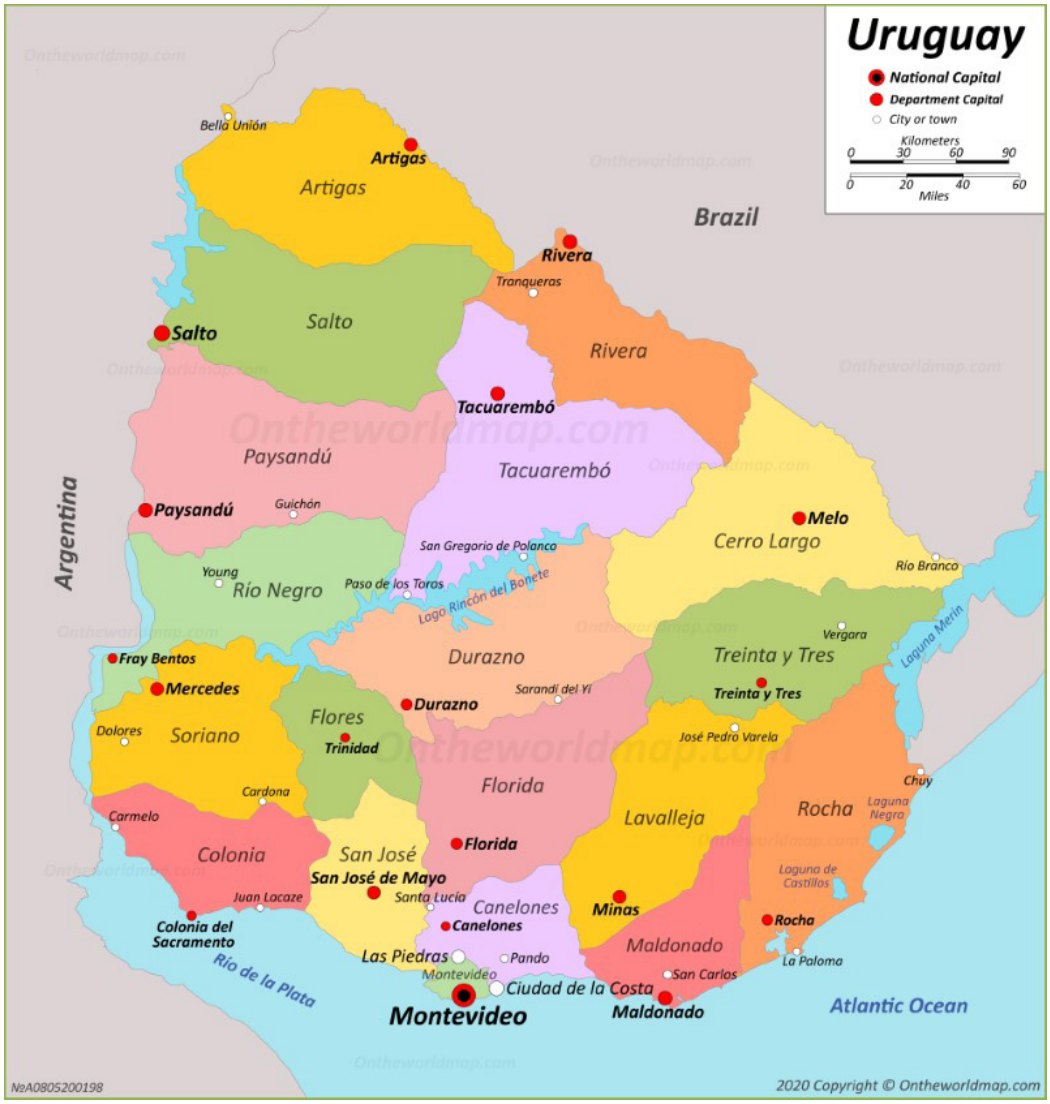
1. Country overview (latest data available)



Source: https://ontheworldmap.com/uruguay/ (Accessed February 9, 2024)

- Sub-Region: South America
- Capital: Montevideo
- Official Language: Spanish
- Population size: 3.422.794 in 2022
- Share of rural population: 4 % in 2022
- GDP: 71.18 billion US $ in 2022
- Income group: High Income
- Gini Index: 40.8 in 2021
- Colonial period: Previously an area of interest of Portugal and Spain, Spain established its position as colonial power in the second half of the 18th century. Shortly after gaining independence from Spain in 1811, Portugal annexed Uruguay as a Brazilian province in 1821. A revolt in 1825 led to Uruguay being internationally recognized as independent state in 1828.

Source: World Bank 2021, 2022; Encyclopedia Britannica 2024

2. Selected health indicators

Indicator	Country	Global Average
Male life expectancy	72 (2021)	69 (2021)
Female life expectancy	79 (2021)	74 (2021)
Under-5 mortality rate	6 (2021)	38 (2021)
Maternal mortality rate	19 (2020)	223 (2020)
HIV prevalence	0,6 (2021)	0,7 (2021)
Tuberculosis prevalence	32 (2021)	134 (2021)

Source: World Bank

3. Legal beginning of the system

Name and type of legal act	Act 2.408 creation of the National Hygiene Council
Date the law was passed	1895
Date of *de jure* implementation	1895
Brief summary of content	This new body was the first institutional effort to organize the public provision that was being created, with hospitals throughout the territory, and at the same time begin to regulate a series of community arrangements with a mutual nature, created by different groups of immigrants. It implies a centralization of the health policy.
Socio-political context of introduction	The main drivers were the need to regulate and guarantee minimum levels of quality in the attention by private providers, and to rationalize the State expansion in terms of infrastructure and health coverage of low and middle income groups.

4. Characteristics of the system at introduction

a. Organisational structure

By the end of nineteenth century, the incipient system was highly centralized. Although there were Councils at the subnational levels, their autonomy was virtually inexistent (Fuentes 2013).

At a regional level, municipalities were responsible to manage public hospitals, but the resource allocations, and the administrative procedures to do so, were determined at the national level (SMU 2002).

b. Coverage

Although Uruguay achieved fairly broad coverage of its health care services early in the 20th century, the truth is that in terms of equity in access to care, it had flaws from the beginning, due among other things to the inharmonious coexistence of three models of care: public, private and social security (Moreira &Setaro, 2002). This was due to the fact that, unlike what happened with the rest of the public services in the country, where the State played a fundamental role as a promoter and articulator of the provision; in health matters, it was civil society, and more precisely the immigrant groups, who initiated the provision of health services.

This is how, since the end of the 19th century, the first mutual aid societies appeared that dealt with the health care of these groups of immigrants – Spanish, Italian, British – and later expanded their coverage to the rest of the population. Since the formation of Uruguay as an independent country in the mid-19th century, a series of efforts can be identified by civil society to cover its health care needs – fundamentally the sectors with greater economic resources. Thus, "*...the first mutual organizations are appearing, based on the prepaid and non-profit system. (These) would be administered cooperatively, the associates elected their own authorities, which were in charge of contracting medical services for the associates.*" (MSP, 2009). Until that moment, while the territory

was dominated by the Spanish empire, the main forms of care for the population came from direct hiring of private physicians or charity provided by religious institutions.

With the creation of the "Asociación Española Primera de SocorrosMutuos" (First Spanish Association of Mutual Aid) in 1853, mutualism began to be the form of organization for the provision of the most important health services in Uruguay throughout the 20th century. This fact remains a particularity of the Uruguayan case, since there are not many configurations of this type in international experience - Catalonia and Israel are probably similar examples in this sense.

Among the main characteristics of the development of these initiatives, the new institutions were originally intended to serve specific groups, essentially discriminated against due to their belonging to a certain group of immigrants such as the Spanish in the aforementioned institution, or enabled by their membership in a union organization. Without attempting to be exhaustive, one can name the "SociedadFrancesa de Socorros" (French Relief Society) in 1854, the "SociedadItaliana"(Italian Society) in 1862, the "Círculo Napolitano"(Neapolitan Circle) in 1880, or the "Círculo de ObrerosCatólicos" (Catholic Workers' Circle) in 1885 (MSP, 2009).

Table 1. Health coverage in 1908 (SMU, 2002)

Percentage of population covered by government schemes	85,6%
Percentage of population covered by social insurance schemes	4,3%
Percentage of population covered by private schemes	10,1%
Percentage of population uncovered	-

Since 1910, with the 3.724 law (National Public Assistance Act)health coverage in Uruguay is formally universal, because it establishes that anyone who cannot afford the costs of private medical attention must be covered by State providers. The law established the conditions that a person should fulfil in order to receive free charge attention, which basically are the demonstration of lack of income (Fuentes 2013).

c. Provision

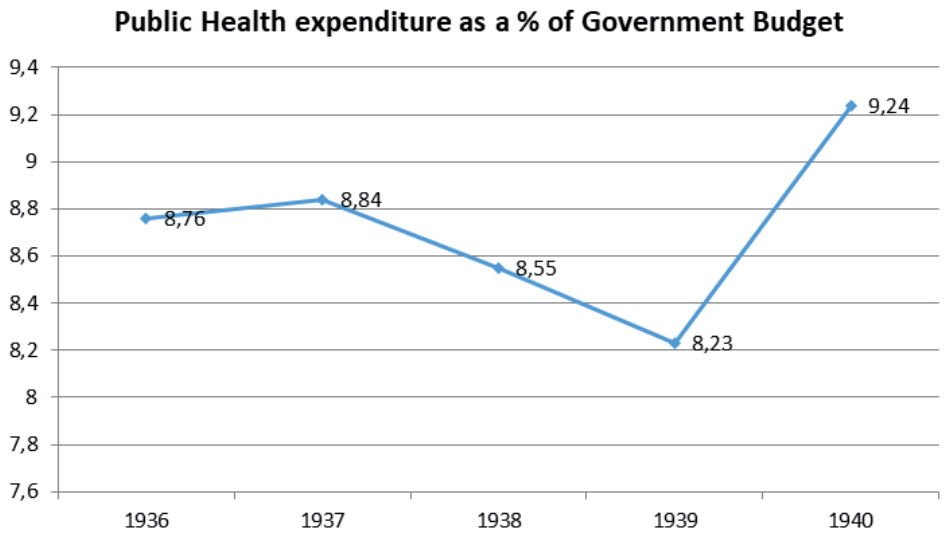
Indicator	Value	Source
Physicians (per 10.000 people). 1938 first data available	7,6	Acción Sindical (1939)
Hospital beds in Montevideo (per 1.000 people). 1921	11,8	Becerro de Bengoa (1922)

Since health care providers offers an integral attention, both inpatient and outpatient care are carried out by the same actors. Nevertheless, the system has been built on the prominence of inpatient care, where the hospital is the centre of the system. Primary care and prevention clinics exist mostly in the public sector, with clinics around the whole territory (Setaro 2010). This configuration led to very high levels of hospitalization, which led to increased system costs. This issue was denounced by some analysts of the time who compared the situation of Montevideo, where 367,000 people lived and in 1921 had 4,261 people hospitalized, compared to European cities with a similar population such as Edinburgh (341,035 people and 1,771 hospitalizations), Rotterdam (377,273 and 910). or Dusseldorf (257,695 and 700) (Becerro de Bengoa, 1922).

In terms of service package, in general it included hospital care, surgical interventions, and some medications and tests free of charge. In the public sector, all the services and medicines are included in the package, while in the private sector people have to pay a co-payment in order to get access to some studies or treatments. On average, the service package in Uruguay is very comprehensive taking into account the needs of the society. In addition to this package, since 1981 Uruguay has the *Fondo Nacional de Recursos* (National Resources Fund) which works as a reinsurance for comprehensive providers, for services of greater complexity and cost. Thus, the FNR´s competence is to provide universal financial coverage for highly complex procedures, high-priced devices and high-priced medication to all people living in the country with health coverage. Examples of this procedures or treatments are dialysis, high cost cancer medicines or hip implants (FernándezGaleano et al 2015).

d. Financing

Although there is not much information regarding the sources of health financing, as was the case in most countries in the region, most of it was made up of direct out-of-pocket payments. At the time when the health system began to be consolidated, the Uruguayan State was still fragile in terms of its tax collection capabilities. Because the people who received care from the mutual societies contributed directly, and due to the lack of regulation, there are no records of these movements. The next graph shows the earliest available data of public health expenditure as a percentage of total government budget.



Source: https://cienciassociales.edu.uy/servicios/unidad-de-metodos-y-acceso-a-datos/series-historia-economica/

e. Regulation

Given the importance of the mutual organizations as a result of their strong development, the State slowly began to assume certain social responsibility in the field of health. In 1889, the Charity and Public Benevolence Commission ("Comisión de Caridad y Beneficencia Pública") was created through a law that placed the Commission under the Ministry of Government, with the aim of managing existing hospitals. Up to that point, there were four charity hospitals: in Montevideo, Paysandú, Salto, and Tacuarembó, which were originally run by religious organizations, but since that moment began to be managed by the State. The organization's task was to "... *administer charity hospitals, for which a specific fund is allocated, sustained through taxes on gambling.*" (MSP, 2009). However, it never fulfilled this role, and it even excluded those centres dedicated exclusively to the care of military personnel. Thus, another characteristic structural feature of the Uruguayan healthcare system emerges here: the separation of civilian and military health.

In the subsequent years, on the one hand, the State began to establish a coverage network in the territory by opening public hospitals in the interior of the country. On the other hand, it started to develop effective regulatory and leadership activities for the entire health sector, among other things, through the 1895 Law 2.408, which created the *Consejo Nacional de Higiene* (National Hygiene Council) (MSP, 2009). This Council had a Departmental Council under its hierarchical dependence for each region in the country. A factor present in this institutional configuration, which has also been characteristic not only of the health sector but of the Uruguayan Public Administration in general, is the centralization of management. The truth is that departmental councils had no autonomy regarding the Council installed in the capital (SMU, 2002).

The integration of this Council - 16 honorary members - provides a fundamental element for advancing the understanding of the power and pressure capacity of the various actors involved in any reform process in this sector. Although these Council members belonged to various State institutions, the effective decision-making capacity was in the hands of the seven titular members, who were all professional doctors (MSP, 2009).

Thus, at the historical moment when State intervention in health matters was proposed, political authorities had at least two tasks: on the one hand, the regulation or control of existing mutual societies to ensure certain minimums in

the quality of care; on the other hand, there was the challenge of initiating a process of expanding health coverage to the broad sectors of the population that were outside the existing scheme, particularly the middle class and the more deprived sectors, as higher-income classes already had private care. Moreover, these actions also coincided with the rapid process of secularization that the Uruguayan state underwent compared to the rest of the region. Thus, by 1906, all crucifixes had been removed from hospitals, replaced by the national coat of arms (Piotti, 1998a).

5. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Public Assistance Act
Date the law was passed	1910
Date of *de jure* implementation	1910
Brief summary of content	This Act established for the first time that it was the responsibility of the State to ensure medical care for those who did not have enough resources to purchase health service in the market. National Public Assistance was created – dependent on the Executive Branch through its relationship with the Ministry of the Interior – and in the same regulation, the conditionality to be declared "indigent" were also introduced, which those people who aspired to receive free assistance had to demonstrate. Thus, with the abandonment of charity as the main care mechanism, the effective secularism of the country's health service slowly took place.
Socio-political context of introduction	This law was approved in a political context of great reformism in social matters, from which the State began to build the foundations for greater intervention in the economic and social life of the country, thus leading the development process.

b. Major reform II

Name and type of legal act	Law-Decree 10.384
Date the law was passed	1943
Date of *de jure* implementation	1943
Brief summary of content	The main goal was to regulate the private medical assistance. Basically, it institutionalized the different institutional arrangements already in place (both profit and non-profit organizations). In addition to this differentiation, the normative/law established basic rights for beneficiaries that had to be guaranteed by all providers, but the regulation did not include issues related to quality of care.
Population coverage	From this regulation, mutualism as a sector began to grow, because its institutionalization enabled the different corporations to begin a process of signing agreements that guaranteed coverage for their members, within the framework of the salary councils. Mutual organizations covered around 204.000 people by 1935 (SMU, 1939) and that number arose to 398.052 by 1952 (Setaro, 2013). By Mutualism we can understand a cooperative movement to form mutual aid societies in industry, agriculture, insurance, banking, etc. In a broad sense, recognition of the reciprocal interdependence and the tendency to mutual aid manifest in any form of collectivism (Pratt Fairchild, 1949 in Kruse, 1994). Salary Councils are tripartite integration bodies that, through the mechanism of social dialogue, establish minimum salaries, categories and other benefits. Likewise, they function as a conciliation and mediation body for collective conflicts.
Socio-political context of introduction	The approval of this regulation was preceded by other attempts to establish greater regulation in the activity of health providers, which had been rejected at the parliamentary level, due to strong opposition from the medical union and the mutual companies themselves (Fuentes 2013). This opposition from doctors also continued after the approval of the rule, because it institutionalized a configuration of providers that had been built without any type of prior planning. At the same time, the regulation did not make substantial progress in improving the management of these companies (SMU 2002). Around 1943, which is when this law was approved, the Salary Councils were also created, along with Family Allowances, in response to the living conditions of workers and their families. Therefore, this period is considered the founding moment of the welfare regime in the country, with a Bismarckian or corporate logic (Antía et al2017).

c. Major reform III

Name and type of legal act	Law 18.211. Creation of the Sistema Nacional Integrado de Salud (SNIS) (National Integrated Health Care System)
Date the law was passed	December 2007
Date of *de jure* implementation	January 2008
Brief summary of content	The main policy goals were increase formal coverage, reduce out-of-pocket expenses, strengthen the role of the State as a regulator but also as a provider (not only for poor people). There were also second order goals, related to start a process of decentralization, which includes the separation of the main public provider (ASSE) from the Ministry of Public Health, and the introduction of social participation in relevant system management positions (Fuentes, 2013).
Population coverage	Health coverage is universal by default, because the State has the constitutional responsibility to take care of those who cannot afford the cost of attention. With the reform, the Fondo Nacional de Salud - FONASA (National Health Fund) was created. It consists of a fund of contributions from workers, companies and the State, proportional to income. This contribution guarantees formal coverage to the worker and his family, who can choose a health provider (public or private non-profit). The only corporate groups that maintain specific coverage are the military, police and municipal employees (Fuentes, 2013).
Available benefits	Any provider who receives transfers from FONASA has to guarantee a service package called PIAS[1] (Plan Integral de Atención a la Salud- Comprehensive Health Care Plan). PIAS include hospital care, outpatient services, and tickets for medicines, among other things.
Socio-political context of introduction	The creation of the SNIS was promoted by the first centre-left government in the country's history, led by FrenteAmplio, who won the elections of 2004 with parliamentary majority. The economic crisis of 2002 consolidated a structural crisis within the health system that had been brewing since at least the 1980s. The diagnosis that a reform of the system was necessary had consensus among the different political and union actors (Borgia 2008). The FrenteAmplio strategy involved a formulation with broad participation of different actors, which determined an incremental change that strengthened the historically built Bismarckian logic.

6. Description of currenthealth care system

a. Organisational structure

The system is highly centralized, despite some attempts to change it. The 2007 reform created Departmental Health Boards at the subnational level, but the hierarchical control exercised by the Ministry of Health is very strong, so Boards have little autonomy. Public provider, ASSE, is the only provider of the system who has infrastructure throughout the whole territory, with hospitals and polyclinics in every city in the country. In return, private providers cover one region or city.

In terms of organization of the system, despite the aim to build a system that reduces health inequalities, the implementation reinforces the previous segmentation. In that sense, Uruguay has three separate sub systems, clearly separated according to income: most of rich people and a part of the upper-middle class pay for private for-profit insurances. Middle income people, salaried workers and their families tend to use Mutualistas (private non-profit providers), while poor people and workers of the informal sector are covered by public institutions.

b. Coverage

Percentage of population covered by government schemes (2023)	39,09
Percentage of population covered by social insurance schemes (2023)	57,75
Percentage of population covered by private schemes (2023)	3,16
Percentage of population uncovered	-

1 https://www.gub.uy/ministerio-salud-publica/institucional/normativa/ordenanza-n-289018-catalogo-prestaciones-pias

c. Provision

Indicator	Value	Source
Physicians (per 1.000 people). 2017	4,9	World Health Data
Nurses and Midwives (per 1.000 people). 2019	7,2	World Health Data
% of hospital beds in private sector for moderate and intensive care. 2020	53,01	Ministry of Health
Hospital beds (per 1.000 people). 2017	2,4	World Health Data

Service package is defined by PIAS, and includes hospital care, outpatient services, dental care, mental care, medical emergencies at home, surgeries, radiotherapy, etc. Based on comparative perspective with other countries of the region, PIAS constitutes a very comprehensive package, which is reinforced by the existence of the National Resource Fund that was mentioned before. It acts as a backup fund with universal coverage.

d. Financing

Indicator	Value	Source
Total expenditure for health as a % of GDP. 2021	9,19	Ministry of Public Health
Public share of financing sources of total health expenditure. 2021	74,0	Ministry of Public Health
Social security contributions as a % of total health expenditure. 2021	48,0	Ministry of Public Health
Out-of-pocket share of financing sources of total health expenditure. 2021	15,3	Ministry of Public Health

Source: https://www.gub.uy/ministerio-salud-publica/comunicacion/noticias/cuentas-nacionales-salud

e. Regulation of dominant system

Private non-profit subsystem (Mutualistas) constitutes the dominant system. Since the reform, the Ministry of Public Health consolidated as the regulator of the system through the creation of a new institution: the *Junta Nacional de Salud* (National Health Board) which is integrated by representatives of the Executive Power (Ministry of Health, Ministry of Economy), private providers, non-medical unions, and user's movements. The main task of the new board is regulating the system (Rodríguez Araújo & Toledo 2010). In order to do so, the management instrument that would regulate the relationship between providers and the State is the contract. From this contract, the evaluation indicators of the activity of these companies will be explicit, as well as the mechanisms and criteria for payment of the "health fees" determined by the authorities. Likewise, the contract will establish the conditions under which the different providers must provide the control body with the information necessary for the exercise of its tasks. This regulation includes issues related to human resources, quality of attention, infrastructure or the incorporation of new procedures (Setaro 2010).

The Ministry of Public Health defines and update which services are included in the benefit package, as it was established in the Decree 46/008: "*according to scientific evidence, the demographic and epidemiological reality of the population, as well as the cost study.*"

7. Co-existing systems

Aside from the mutual system, the other significant scheme is the public one, that covers more than a third of the entire population, and that is majoritarian in rural areas. As it was informed before, public sector has the mandate to cover those people in worst economic situation. Instead of receiving fees according to age and gender, the public provider (ASSE) receives transfers from the national budget. In this case, the regulation is not by contract.

Instead, it follows logic of command and control with preeminence of political logic. The third part of the system is the private for profit subsystem, which is concentrated in the upper classes (Fuentes & Rodríguez Araújo, 2021).

8. Role of global and religious actors

Uruguayan State had an early process of secularization during the beginning of the 20th Century, and that includes the removal of all religious references from public hospitals. Since then, religious organizations were also removed from the management of public hospitals, and only remained in charge of some mutual providers like the *Círculo Obrero Católico* (Catholic Workers Circle).

In terms of global actors, they do not play a significant role in terms of financing healthcare, but without a doubt, the Pan-American Health Organization (PAHO) play a role by leading some debates related to public health campaigns like vaccination or prevention of non-communicable diseases such as hypertension.

From another point of view, the main characteristics of the new system are aligned to the principles Universal Health promoted by PAHO (Fuentes, 2015).

9. List of additional relevant legal acts

Name and type of legal act	Brief description
Law 18.131 (18/05/2007)	Creation of the National Health Fund (FONASA).
Law 18.161 (29/06/2007)	Creation of the Administración de Servicios de Salud del Estado (ASSE) as a decentralized organization. ASSE is the main public provider.
Law 18.335 (03/09/2008)	Rights and Obligations of Patients and Users of Health Services.

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