
URUGUAY

GENERAL SITUATION AND TRENDS

Socioeconomic, Political, and Demographic Overview

Uruguay, known officially as the Eastern Republic of Uruguay, has the smallest land area (176,215 km²) of any country in South America. The country's economy is based on agriculture, especially livestock. There are no appreciable mining resources, and industry is based on the processing of farming and livestock products. Since the creation of the Southern Common Market (MERCOSUR), the tertiary (service) sector has gained importance. Uruguay has a population of slightly more than 3 million people, 51.6% of them women. Of the total population, 89.1% reside in urban areas and 42.2% in Montevideo Department.

Uruguay is a representative democracy, with voting for national and municipal authorities in elections every five years. The Executive Branch is made up of a president and 12 ministers, and the Legislative Branch consists of 30 senators, the Vice President of the Republic, and 99 representatives. The Judicial Branch's highest body is the Supreme Court of Justice. Administratively, the country is divided into 19 departments. Departmental and municipal governments have little autonomy from the central government but can levy or eliminate certain types of taxes and do have responsibilities in health care. The department with the smallest area is Montevideo, but it has the most inhabitants. Uruguay is not divided into regions. When departmental data are analyzed, the tendency is to consider, on the one hand data from Montevideo, and on the other hand, data on the "interior," that is, the 18 other departments. The most notable recent political event was approval of a reform of the National Constitution through a plebiscite in December 1996.

The reform of the social security system, approved by law at the end of 1995, allows private companies to operate in the pensions and retirement market. These companies are called Pension Fund Administrators.

In 1995, the Government initiated earnest efforts toward educational reform, aimed at strengthening the public education system—but not the private system—in all four of its areas: primary, secondary, technical, and professional education, as well as teacher training and upgrading. One of the main objectives is to extend preschool education to all children aged 4 and 5, which began in 1997.

In 1995, some 700,000 students were enrolled in public and private primary, secondary, and technical and professional schools (excluding universities). Of these, 166,500 were secondary and technical/professional students in the public system.

Economic and Social Situation

The most noteworthy economic event was the creation of MERCOSUR in mid-1993, fully implementing the agreement signed between Argentina, Brazil, Paraguay, and Uruguay. MERCOSUR permits the free movement of goods and services among these countries and equalizes the tariffs on various products for third-party countries.

The growth in the gross domestic product (GDP) was 6.8% in 1994; 2.4% in 1995, and 4.9% in 1996. For 1997, an increase in the GDP of 3% was expected. Between 1985 and 1990 inflation ranged from 60% to 80% per year. In 1991, it reached 82%, then fell to 24% in 1996. The Economics Institute of the University of the Republic estimated that inflation would be 20% in 1997, and the Government expected that it would range from 14% to 17%. The budget deficit was 1.7% of the GDP in 1996. Up to 1991, the balance of trade was positive but became negative in 1992. In 1996, the negative balance was US\$ 925.6 million.

Between 1984 and 1996, the purchasing power of wages grew at an annual rate of 2.3% (3.2% in the private sector and 1.3% in the public sector), while the purchasing power of retirees and pensioners grew at an annual rate of 5.5%. From

1992 to March 1997 the national minimum wage (in current dollars) did not vary significantly. It was US\$ 89.6 per month in 1992, US\$ 87.7 in 1994, US\$ 92.4 in 1996, and US\$ 90.5 in March 1997. In 1990, 8.5% of the economically active population was unemployed. In 1995 the figure was 10.3% and in 1996, 11.9%. It was estimated that unemployment in 1997 would be around 11%.

In *Social Panorama of Latin America 1996*, the Economic Commission for Latin America and the Caribbean points out that economic growth and lower inflation played a significant role in reducing urban poverty in Uruguay, which fell from 12% in 1991 to 6% in 1994.

The overall reduction in unmet basic needs throughout the country in the 1984–1994 period was approximately 40%. This reduction may be related to housing programs, expansion of the drinking water supply, and development of the health services in the urban areas of the interior. Among the residents of Montevideo, the percentage of people with unmet basic needs decreased from 14.7% in 1984 to 9.1% in 1994. In urban areas of the interior it fell from 28.9% in 1984 to 17.3% in 1994. A breakdown of unmet basic needs by age indicates that children under 15 have the highest rate of unmet basic needs.

In the urban areas of the interior, 3.5% of the dwellings are not supplied with drinking water, and 2.2% have no adequate waste disposal system. In 1996, in Montevideo, 98.8% of all dwellings had piped drinking water.

Population

According to the May 1996 National Census, Uruguay had a population of 3,163,763. The census showed a decrease in the rural population, continuing the trend found in previous censuses. The average annual population growth rate during the 1985–1996 period was 0.6%. The crude birth rate during 1990–1995 was 17.6 live births per 1,000 population. In the same period, the general fertility rate was 70.6 live births for every 1,000 women aged 15 to 49 years. The total fertility rate was 2.33 children per woman. The crude net reproduction rate was 1.14 daughters for every woman aged 15 to 49 years.

In 1995, the crude death rate was 10.0 per 1,000 population, and life expectancy at birth was 73.3 years overall, 69.3 years for men and 77.4 years for women. The population is clearly aging, with a large proportion in the advanced age group and low, declining percentages in the infant and juvenile populations. In 1996, 25.1% of the inhabitants were under 15 years of age, 62.1% were aged 15 to 64, and 12.8% were 65 or older. The annual growth rate of the group aged 65 and older is four times higher than the average for the country.

The literacy rate in 1996 was 95.7%. There has been a steady increase in the average years of schooling among the adult population aged 15 and older. There are nine years of

compulsory education—six years of primary school and three years of secondary school.

Mortality and Morbidity

In Uruguay, 100% of deaths are recorded, and all death certificates are completed by a physician. In 1995, there were 31,700 deaths in the country. Of that total, 4% were children under 5 and 70.6% were people 65 and older.

Of the total deaths in 1996, 6.8% were “ill-defined symptoms, signs, and conditions.” The total death rate of 8 per 1,000 in the 1950s has risen slowly since then, reaching 9.9 per 1,000 in 1995. The trend in proportional mortality by age has gone down in all groups except those aged 65 and older. Proportional mortality in this group increased by 70.6% between 1980 and 1995.

The infant mortality rate for the entire country was 19.6 per 1,000 in 1995 and 17.5 per 1,000 in 1996. Almost all births (99%) occur in a hospital, and 100% are certified by a physician or university-trained midwife. Underreporting of births is very low, 2.3%. Unreported births tend to be detected later through various mechanisms.

There are no reliable data on morbidity from the most prevalent diseases. However, the Ministry of Public Health routinely collects certain morbidity data, almost exclusively from outpatient visits and only for the population using the Ministry's services. There is underreporting of this information and the data that are collected are not processed on a regular basis. With the exception of the mandatory disease reporting system, the country has no information system for collecting morbidity data from all its various institutions.

In 1996, the Ministry of Public Health, in collaboration with the IDB, conducted a study of losses from disability-adjusted life years (DALY) attributable to different causes. The results were consistent with what was already known, that is, that noncommunicable diseases are much more significant in Uruguay and produce the greatest loss of DALY, far ahead of communicable diseases and external causes (homicides and accidental injuries).

SPECIFIC HEALTH PROBLEMS

Analysis by Population Group

Infant Health (under Age 5)

In 1996, there were 58,928 births in Uruguay, and 1,033 children under the age of 1 died, for an infant mortality rate of 17.5 per 1,000 live births. Neonatal mortality was 9.6 per 1,000 and postneonatal mortality, 7.9 per 1,000. Of total

deaths in children under 1 year, 48% occurred in public health services, 31% in private facilities, and 17% at home.

In 1996, the leading causes of death in children under 1 year were birth defects (3.3 per 1,000 live births), hyaline membrane disease (1.8 per 1,000), acute respiratory infections and pneumonias (1.4 per 1,000), and prematurity, neonatal sepsis, and meconial aspiration syndrome (each with a mortality of 1.1 per 1,000).

The leading causes of hospitalization for children under 1 year in the hospitals of the Ministry of Public Health in the interior of the country were acute respiratory infections (28%) and intestinal infections (17%). There is no information on the private sector, although it is thought that the situation is similar. In the infant population aged 1 to 4 years, the three leading causes of death in 1995 were accidents and injuries (16.1 per 100,000 live births), malignant neoplasms (10.2 per 100,000), and birth defects (6.3 per 100,000).

Health of Primary-School Children (Ages 5 to 9)

In 1995, 41% of the deaths in children aged 5 to 9 came from three causes: accidents (with mortality of 12.8 per 100,000), malignant neoplasms (3.5 per 100,000), and birth defects (2.7 per 100,000). In the group from 5 to 14 years, injuries in general were the leading cause of hospitalization (15%), and acute respiratory infections were the second cause (10%).

Health of Adolescents (Ages 10 to 14)

In 1995, accidents remained the leading cause of mortality in the group from 10 to 14 years. In fact, 60.5% of all deaths from accidents of all types among all age groups occurred in the 10–14 age group. Malignant neoplasms were the second cause of mortality in the 10–14 age group, and diseases of the circulatory system were third.

Health of Adults (Ages 15 to 64)

Of the 31,700 deaths that occurred in Uruguay in 1995, 23.0% were in the group aged 25 to 64. As with the 10–14 age group, the leading causes of death of those between 15 and 34 were accidents and injuries. Between the ages of 35 and 64, malignant neoplasms (breast cancer in women and lung cancer in men) were the leading cause of death, followed by cardiovascular disease.

The maternal mortality rate was 2.1 per 10,000 in 1994, when 12 maternal deaths were reported in the entire country. It is believed that there is significant underreporting of maternal mortality, but the true extent is unknown.

In the adult population, 34% of the hospitalizations in Ministry of Public Health facilities are for normal childbirths. Other major reasons for hospitalization are complications during pregnancy, childbirth, and puerperium (16%); injuries and poisonings (7%); and mental disorders (3%).

Health of the Elderly (Age 65 and Older)

The proportion of deaths that occur at age 65 or older is rising, particularly among women. The leading cause of mortality is cardiovascular diseases, and the second is tumors. Among cardiovascular diseases, ischemic heart disease ranks first in the group aged 65 to 79, and cerebrovascular disease among those 80 and older. The second cause of death in this group is malignant neoplasms, most frequently of the trachea, bronchia, and lungs among people aged 65 to 79, and of the rectum and colon for persons 80 and older.

One problem that the Ministry of Public Health considers a priority among the elderly is social isolation, particularly among women who live alone.

Analysis by Type of Disease or Health Impairment

Communicable Diseases

Vector-Borne Diseases. Cases of malaria, dengue, plague, schistosomiasis, and yellow fever do not occur in the country. *Aedes aegypti* was eradicated from Uruguay in 1958. However, in 1997 uninfected larvae of this mosquito were found in areas bordering on Argentina. There is evidence that the spread of Chagas' disease was halted in Uruguay in 1997.

Vaccine-Preventable Diseases. Cases of poliomyelitis, neonatal tetanus, and diphtheria have not been reported for more than 15 years. Eleven cases of whooping cough were reported in 1994, 69 cases in 1995, and 17 cases in 1996. Twelve measles cases were reported in 1994, 5 in 1995, and only 1 in 1996. There were two cases of nonneonatal tetanus in 1994, two cases in 1995, and one case in 1996.

In 1996, vaccination coverage for tuberculosis prevention with BCG in children under 1 year was 98%. Coverage for diphtheria, whooping cough, and tetanus with three doses of DTP vaccine was 89%; for poliomyelitis, with three doses of live oral polio vaccine was 89%; and for measles, mumps, and rubella with the MMR vaccine was 85%.

Cholera and Other Intestinal Infectious Diseases. The cholera epidemic that began in 1991 in the Americas did not spread to Uruguay, where no cases have been recorded during this decade. As a cause of mortality in children under 1 year,

acute diarrhea ranked eighth in 1995, with a rate of 0.4 per 100,000 live births. In 1996, 3,565 cases of viral hepatitis and one case of typhoid fever were reported.

Chronic Communicable Diseases. Mortality from tuberculosis was 2.8 per 100,000 in 1986 and 2.2 in 1995. The incidence of tuberculosis in all its forms was 19.3 per 100,000 in 1995. Continuing to decrease, leprosy has ceased to be a priority health problem. Prevalence in 1996 was 3.8 per 100,000 population.

Acute Respiratory Infections. Acute respiratory infections ranked sixth as a cause of mortality in children under 1 year in 1995, with a rate of 5.6 per 100,000 live births.

Rabies and Other Zoonoses. In the past 10 years, there have been no reports of human or canine rabies. The rate of surgical prevalence of hydatidosis (the number of people undergoing surgery for hydatid cyst in relation to the total population) was 12.4 per 100,000 population in 1993, falling to 10.5 in 1994 and 9.4 in 1995.

AIDS and Syphilis. From 1983 through 31 January 1997, 851 cases of AIDS were reported. In 1993, 103 cases were reported, 119 in 1994, 127 in 1995, and 156 in 1996. In January 1997, 11 cases were reported. The fatality rate has been 56% for the 851 reported AIDS cases. Approximately 60% of the HIV-positive and AIDS patients use Ministry of Public Health facilities. From 1983 to 31 January 1997, 2,153 people were reported with HIV-positive serology. In 1993, 239 seropositives were reported, 242 in 1994, 257 in 1995, and 309 in 1996. During the month of January 1997, 23 cases were reported. The last sentinel study of HIV, conducted in late 1996, showed a prevalence of 0.2% in the general population, which means that there are about 6,300 people infected in the country. A 1995 study had found an estimated prevalence of 0.24%.

AIDS continues to occur primarily among men; in 1996 there were 4.6 male patients for every woman. Sexual transmission predominates (68.7%), far outranking blood-borne transmission through intravenous drug abuse (26.9%). There are no seropositive cases attributable to blood transfusion. Mother-to-child transmission, however, is rising, moving from 2.6% of the total cumulative cases as of 1992 to 4.3% of the total cases as of 31 January 1997.

In 1996, 879 cases of syphilis were reported.

Noncommunicable Diseases and Other Health-Related Problems.

Nutritional Diseases and Diseases of Metabolism. Fat consumption has always been very high in Uruguay. An

FAO/WHO report indicated that in 1993 fats accounted for 32% of total caloric intake.

The 1994–1995 Household Spending and Income Survey confirmed that as earnings increase, so does the percentage of calories consumed in the form of fats. In the poorest households, 24% of the total calories consumed come from fats, while in the wealthiest households the percentage is 34%. Daily dietary cholesterol intake is also very high and also increases with income. Fish consumption is very low and also increases with income, but is very limited at all income levels.

Fruit and vegetable consumption is limited but rising. According to the Household Spending and Income Survey, average daily consumption of fiber is 23 g in the interior and 24 g in Montevideo. The poorest 10% of the households in Montevideo consume a daily average of 18.7 g of fiber, while the wealthiest 10% of households consume an average of 28 g.

There is a high prevalence of obesity in some sectors of society. For example, 9% of the children treated in the private-sector collective health care institutions were obese, while the percentage was only 3% for children treated by the public sector. In a representative sample of 4,000 adults in the city of Montevideo, overweight or obesity—defined by the body mass index—was found in 47% of men and 58% of women. There was a strong statistical correlation between obesity and low socioeconomic status in women. In men, however, the correlation was inverse and less pronounced.

According to a ministerial report submitted in 1997, 28% of the 5,543 children under 5 cared for in Ministry of Public Health facilities between 1994 and 1997 showed retarded growth, as determined by their height-for-age.

Endemic goiter and blindness due to vitamin A deficiency are not public health problems in Uruguay. Table salt has been iodized since 1963.

The prevalence of diabetes in the country is estimated at 7.6% in men over 18 years of age and 10.0% in women in the same age group. Diabetes ranks fifth as the cause of death, with a rate of 20.2 per 100,000 population.

According to a study conducted in October 1996, 50.5% of children under 1 month of age are not exclusively breast-fed. The rate of exclusive breast-feeding is 37.5% in infants under 4 months. For children aged 6 to 9 months the rate of appropriate supplementary feeding is 30%.

Cardiovascular Diseases. For 40 years, cardiovascular diseases have been the leading causes of death in Uruguay, accounting for 30% of total deaths in 1996. Mortality from cardiovascular diseases, at 357 per 100,000 in 1995, has remained relatively stable in recent years. Each year some 400 deaths are attributed to hypertension, about 3,700 to ischemic heart disease, and 3,500 to cerebrovascular disease. Of the total deaths from cardiovascular disease, 80% occur in people aged 60 and older. Ischemic heart disease and cerebrovascu-

lar disease together account for more than 63% of deaths from cardiovascular diseases.

In recent studies (1991–1993, 1995), hypertension was among the primary causes for medical visits. In a survey conducted in Montevideo, hypertension was found in 20% of the adult population. Among the general population in the cities of Rivera and Tacuarembó, the prevalence of hypertension was 24%, with a 15% prevalence for borderline hypertension. In two research studies on workers being issued health cards in Montevideo and San José, the percentages of hypertensives were 7% and 10%, respectively.

Malignant Neoplasms. In 1995, 7,029 people in Uruguay died from tumors of all types. The mortality was 221.9 per 100,000 population, and higher in men (263.7 per 100,000) than in women (182.2 per 100,000). Cancer ranked second as a cause of mortality, accounting for 22.3% of deaths. As in previous years, in 1995 lung cancer was the leading cause of cancer death in males, followed by cancer of the prostate, rectum and colon, stomach, and esophagus. In women, breast cancer continued to rank first, followed by cancer of the rectum and colon, stomach, uterus and cervix, and pancreas.

Accidents and Violence. In 1995, accidents and injuries together were the third leading cause of death, with 7.1% of all deaths. The corresponding mortality was 70.3 per 100,000, which indicates an increase in recent years (in 1991 the figure was 45.2 per 100,000). A possible reason for this increase is the growth in the number of automobiles in the country, which almost tripled between 1991 and 1996.

Accidents in general and traffic accidents in particular are the leading cause of death in people under 30. Accidents account for 28% of deaths in children aged 1 to 4 and 50% of deaths in the 15 to 19 group.

Reporting of all traffic accidents that cause some type of physical injury and require taking the injured to an emergency service began in November 1995. In December 1996, the Registry of Injured Persons, part of the Ministry of Public Health, was operating in most of the country's departments. According to the data from the Registry, 56% of those injured in traffic accidents were between the ages of 15 and 39.

In March 1997, Breathalyzer tests for alcohol and blood alcohol tests began to be administered to drivers in Montevideo and along various national highways. By law, those who refuse to submit to a Breathalyzer test are regarded as probably intoxicated and are sent to the appropriate court. Maximum tolerance levels are 0.8 mg of ethanol per 100 ml for drivers in general and 0 mg for those who work as drivers.

Behavioral Disorders. In a survey conducted in 1995 to study the prevalence of smoking in Uruguay, almost 22% of a representative sample of people over the age of 13 in urban

areas throughout the country admitted to being regular smokers. The prevalence of smoking was higher in Montevideo (23.6%) than in the interior (20.2%), and higher among men (2.2 male smokers for every woman), with most smokers belonging to the group aged 30 to 39. Male smokers differ significantly from female smokers. Most men who smoke have a basic level of education, do manual labor, receive low pay, and work long hours. Among women, smokers more frequently have an average or higher level of education, are engaged in intellectual pursuits, and have high incomes.

There are no good data on alcoholism. Mortality from cirrhosis of the liver rose from 8.5 per 100,000 in the 1986–1991 period to 11.0 per 100,000 in 1995, and affects men much more than women.

Mortality from mental disorders increased significantly between 1984 and 1995, from 7.2 to 24.8 per 100,000.

Oral Health. There was a countrywide decline in the DMFT (decayed, missing, filled teeth) Index from 4.1 in 1991 to 2.5 in 1996 among children under age 12. The sale of fluoridated salt began in 1991. Of the salt sold for household use in 1996, 60% was fluoridated.

Emerging and Re-emerging Diseases. In February 1997, the first case of hantavirus was diagnosed in Uruguay. It was confirmed by laboratory tests, and the patient survived. In 1996, 382 cases of meningitis were reported in the country.

RESPONSE OF THE HEALTH SYSTEM

National Health Plans and Policies

The Constitution of the Republic establishes that the State will legislate on all issues related to health and public hygiene, seeking the physical, moral, and social betterment of all the country's inhabitants. All residents have the duty to protect their own health, as well as to seek care when ill. The Constitution also says that the State will provide measures for prevention and will give care free of cost only to the indigent or those who lack sufficient resources. In 1934, the Organic Public Health Law created the Ministry of Public Health and established its commitments to public health, health care, monitoring health, and the setting of standards.

The Ministry of Public Health is the agency responsible for setting standards and regulating the health sector, developing preventive programs, and administering its healthcare services. In recent years, there has been a continuity in Ministry policies concerning the decentralization of services—began in 1987 and accelerated in 1995—the targeting of actions to priority problems, and the maintenance of moderate state control over the private sector.

The Government is engaged in the reform of social policy, with the goal of improving public administration, increasing productivity, readjusting services, and refining spending. Reform of the public sector to gradually phase out nonessential state services is considered a priority. This has been reflected in a Ministry policy of increasing its effectiveness and efficiency, while still ensuring universal and equitable access to health services of acceptable quality and efficiency. A gradual reduction in its activities in the direct delivery of services is proposed through the transfer to third parties of all functions considered nonessential and by redistributing responsibilities and resources through a decentralized model for the administration of the health services.

In 1995 the Government signed two loans, one with the World Bank to finance the Project for Institutional Strengthening of the Health Sector, and the other with the IDB to finance the Strengthening the Social Area project.

As part of the first project and based on a legislative strategy approved by the World Bank, two draft decrees have been prepared. One would create a legal framework to operate public hospitals with decentralized management, and the other would implement a Single Registry of Formal Healthcare Coverage, under the General Health Bureau of the Ministry of Public Health. This registry would make it possible to gather the necessary information on medical coverage for all residents of the country, thus detecting cases of dual coverage—very frequent in Uruguay—and identifying where this harms the State Health Services Administration (ASSE) if the bill for services received is not paid by the appropriate institution.

In recent years, there has been a tendency to separate two normative roles in health care administration, that of regulation and that of oversight. Beginning in 1987 with the creation of ASSE as an autonomous agency within the Ministry of Public Health, the two functions began to be differentiated. The project transforming ASSE into a decentralized service is moving in the same direction. Also, departmental health directors were created beginning in 1995; they have functions similar to those of the Director-General of Health, but they work only in their own departments.

Created in 1979, the Public Resources Fund (PRF) is a public entity, not a Government one. Its aims are to collect and administer the resources necessary to pay for the services of highly specialized medical facilities. It pays for highly complex and costly procedures, and the country's entire population is covered. The PRF finances heart surgery, pacemaker insertion, hip prostheses, chronic hemodialysis, transplants, the treatment of serious burns and, as of 1992, chronic peritoneal dialysis on an outpatient basis, knee prostheses, and lithotresis. The list of treatments covered by the PRF can be expanded, reduced, or modified through a resolution of an Honorary Administrative Commission. The sources to finance the PRF are varied, but its basic sources are contribu-

tions from the State to care for users of Ministry services and contributions from the private-sector collective health care institutions to cover care for their members, who are generally people with average or high incomes.

Health Sector Reform

The strategy for carrying out health sector reform is based on the reassessment of primary care, improved coordination between the public and private sectors, modernization of the health information system, strengthening of the central ministerial level, and decentralization of Ministry of Public Health hospitals.

Now under study is the creation of a national health sector information system. Its development requires the selection of data, the production of information appropriate to the new model of care, and the implementation of a communications network linking all public and private institutions in the health sector.

Strengthening the central ministerial level means improving the government's capabilities in managing the system; formulating health plans and programs; setting technical, administrative, and financing standards; coordinating the activities of public and private agencies; and supervising, auditing, and evaluating compliance with policies and plans.

Decentralization of the management of Ministry hospitals began in 1987 with the creation of ASSE, the public agency responsible for administering Ministry hospital facilities.

In 1995 the Government sent to Parliament a draft proposal for a five-year budget, one of whose articles provided for the decentralization of ASSE. The article was not approved, perhaps due to pressure from the private sector in the country's interior, which perceived the ASSE as a potential competitor.

The Ministry has continued to promote decentralization, especially with the proposal to create public hospitals with decentralized management. The goals of that project—financed by the World Bank—are to improve the management and administration of health facilities, increase efficiency in the allocation and management of sectoral resources, promote functional coordination with the private sector, and effectively use the existing hospital infrastructure.

The creation of public hospitals with decentralized management is intended to improve the response capability of the health services, ensuring recognized levels of quality management, and to formulate a new management model for public hospitals, based on measurement of their processes and outcomes, and centered on the costs and quality of services. Each hospital should prepare a budget defining the hospital product, its management processes, and costs, thus making it possible to evaluate the services provided in terms of efficiency and technical effectiveness. The goal is also to map out a specific

legal framework for managing the hospitals and to introduce the concepts of managerial and administrative responsibility in the utilization of resources and the attainment of results.

In the process of transforming the public hospital into a decentralized management hospital, the State must guarantee the population's access to health services and assume the role of regulating the system. This implies the establishment of alternative intervention modalities in the market to help ensure more equitable access to health services for the population, with a resulting redistribution of income.

The health sector reform strategy includes the Medical Center Project. The general objective of this project—financed by an IDB loan for US\$ 80 million—is “to help adapt the health system to the specific situation of the country.” The specific objectives of the Project include upgrading training and redefining the role of the University Hospital in the national network of health institutions.

Significant among the obstacles to sectoral reform and decentralization is the country's centralist culture and the vested interests of powerful groups.

Organization of the Health Sector

Institutional Organization

The public health system consists of services under the Ministry, provided through ASSE; the University of the Republic, through the teaching hospital (*Hospital de Clínicas*); the health care services of the municipal governments; the armed forces health services; the police health services; and the medical services of other public and autonomous entities. The ASSE provides health services to lower-income persons. It has 65 health facilities throughout the country, with 8,553 beds located in hospitals for patients with acute or chronic conditions (some 2,300 for chronic patients). The university teaching hospital has 700 beds and provides tertiary care to users of Ministry services for free and to the rest of the population for a fee.

The armed forces health services cover approximately 220,000 people and have a 447-bed hospital. Police health services have a 70-bed hospital and cover some 120,000 people.

The Social Welfare Fund covers care for pregnancy and childbirth for pregnant workers or workers' spouses, as well as pediatric care up to age 6. It has its own hospital and several maternal and child centers in Montevideo and in Canelones Department. In the interior, the Fund contracts for services with the Ministry of Public Health or the private-sector collective health care institutions.

The State Insurance Fund has a 160-bed hospital in Montevideo and contracts for services with third parties in the interior. It covers occupational diseases and work-related acci-

dents for workers covered by the Department of Social Health Insurance.

The country's municipal governments provide outpatient health services to the general population.

The autonomous entities and decentralized services are state and semipublic agencies. They offer highly diverse medical services, from hospitalization to payment of private insurance premiums, at the beneficiary's option.

The private health sector consists of 53 collective health care institutions (CHCI), 68 partial-insurance health plans, several highly specialized medical institutes, private physician's offices that charge fees for services, private nursing homes, and some foreign insurance companies.

Of all the public and private health institutions, the most important in terms of coverage are the CHCIs. They serve approximately 55% of the population. Public coverage through ASSE is approximately 28%, and military and police health insurance cover approximately 10%. Although the precise figure is unknown, it is estimated that the partial-insurance plans cover a significant portion of the population. It is estimated that insurance plans registered with the Ministry of Public Health provide coverage to some 800,000 people. These plans cover certain types of medical, surgical, emergency, and dental care.

The CHCIs are private nonprofit organizations that provide services through prepaid health insurance. There are three types: mutual assistance associations, which are based on the principles of cooperation and use a system of mutual insurance to provide medical care to their members; professional cooperatives providing medical care to their members and associates, in which corporate capital is contributed by the respective professionals; and health services created and financed by private companies or quasi-governmental entities to provide nonprofit medical care to personnel and family members.

The CHCIs are independent institutions that compete with each other. The State exercises some legal and technical control over them, but they have a high degree of autonomy. In 1983, it was decreed that each CHCI must have at least 10,000 members; the largest one has 280,000 members. There are three types of affiliation with a CHCI: collective state affiliation through the social security system, collective affiliation paid for by private companies, and individual affiliation, generally for relatives of persons affiliated in one of those first two ways.

Some 35 CHCIs are physicians' cooperatives located in the country's interior and affiliated with each other through an association called the Medical Federation of the Interior.

Workers in private companies subscribe to a compulsory health plan through the Department of Social Health Insurance. The plan affiliates them with the CHCI of their choice and provides total health coverage for themselves, but none for their dependents. In the event of unemployment, the health insurance plan covers the period in which the worker is covered by unemployment insurance, up to six months.

There are four national honorary commissions. They are public, not state, entities and are financed with percentages of different taxes (on alcohol, tobacco, etc.) and rates. They are made up of representatives from public and private institutions, including trade associations and nongovernmental organizations. The primary duty of the Honorary Commission to Combat Tuberculosis and Prevalent Illnesses is to deal with tuberculosis throughout the country and to be responsible for all vaccination activities in the country and the selective detection of congenital hypothyroidism. The three other honorary commissions deal with cardiovascular health, the struggle against cancer, and the struggle against hydatidosis.

Health Legislation

In 1987, the State Health Services Administration (ASSE) was created by law as an autonomous agency of the Ministry of Public Health. ASSE has the authority to transfer the administration or use of health facilities to the departmental governments and may reach agreement with the CHCIs to use their facilities some of the time.

The National Resources Fund was created in 1979 and became fully operational in 1981. It is directed by an Administrative Honorary Commission advised by several technical commissions.

A law regulating the creation of the CHCIs was promulgated in 1981, and the decree regulating investments in CHCI health services was issued in 1983. In 1989, an ordinance established the regulations governing partial-insurance health plans.

When the 1967 Constitution was adopted, the Social Welfare Fund was created and given the task of "coordinating state social welfare services and organizing social security." The Fund centralizes the administration of disability insurance and also administers old-age pensions.

In 1979, maximum centralization in the administration of social security was reached when a General Social Security Administration was created as an agency of the Ministry of Labor and Social Security. It absorbed the activities of the Social Welfare Fund and incorporated into its operations the administration of health insurance plans, family insurance, and maternity and unemployment insurance. In 1986, the General Social Security Administration was eliminated and its functions were taken over by the Fund, which was reestablished.

The State reform currently under way reaffirms two essential duties for the Ministry of Public Health. One is prevention programs and free care to the indigent and other poor persons. The other is health promotion through the control and reduction of risk factors for disease, together with improvements in the quality, timeliness, effectiveness, and efficiency of health care for the entire population.

Health Services and Resources

Organization of Services for Care of the Population

Disease Prevention and Control. For a number of years, the Ministry of Public Health has given top priority to the following problems: morbidity and mortality from traffic accidents; cardiovascular diseases; substance abuse and addictions; infant mortality and poorly monitored pregnancy and childbirth; AIDS; breast cancer; lung cancer; oral health; social isolation of the elderly; Chagas' disease; hydatidosis; violence, especially domestic violence; and disabilities stemming from eye diseases (amblyopia in children and cataracts in the elderly) and from hearing disorders.

In 1995, the Ministry created the Health Promotion Bureau, which includes the Department of Health Education. There is also a National Drug Board, which reports directly to the Office of the President and includes several public agencies.

Uruguay is not subject to major natural disasters except for some flooding in winter and fires in summer. For special situations like these, the National Emergency Committee meets. The Committee is comprised of several public agencies and reports directly to the Office of the President.

Epidemiological Surveillance Systems. Uruguay has a single epidemiological surveillance system, which is directed and coordinated by the Epidemiological Monitoring Department of the Ministry of Public Health. Its objective is to make timely recommendations to the authorities on short-, medium-, and long-term measures to prevent or control diseases subject to surveillance or other unusual or epidemic health situations.

The regular reporting sources are persons who are required to report, basically physicians or the technical administrators of health institutions. Sentinel posts are voluntary reporting services specifically selected because they have a large number of users and a ready willingness to report. Reportable diseases include foodborne diseases.

The National Blood Bank, an agency of the Ministry, regulates, supervises, and controls all the country's blood banks. Donation is voluntary and uncompensated. A strict preliminary screening of donors is performed, through questioning and then serology for HIV, syphilis, hepatitis B, and Chagas' disease. Transfusions must be requested by a physician, who is in most cases a specialist in hemotherapy.

Drinking Water and Sanitation Services. According to the 1985 census, 7.4% of the population was not supplied with drinking water, and the percentage of the population with critical sanitation deficiencies was 8.5%. There are no recent data available, but according to reports from the State Sanitation Works the drinking water system has been extended in recent years in both Montevideo and the interior.

The water in the network has good sanitary treatment controls, and its supply is the exclusive responsibility of Sanitation Works, which is also in charge of controlling surface waters and beaches and informing the population about the level of *Escherichia coli* contamination.

Public sewerage services reach 43% of the country's population and 51% of the urban population. In Montevideo, coverage is close to 80%. When the expansion of this service is completed—financed with an IDB loan—more than 95% of households will be reached.

Solid Waste Management Services. Households in Uruguay generate an estimated 2,000 tons of solid waste per day, and treatment varies from department to department. Generally speaking, there is a notable lack of an effective methodology for final disposal. Also, there are shortcomings in their handling and disposal of hospital, pathogenic, and toxic waste.

Prevention and Control of Air Pollution. The country's favorable atmospheric conditions significantly reduce the amount of air pollution. This is indicated by data from measurements of suspended particulates and sulfur dioxide. Air pollution sometimes occurs in industrialized urban areas as a result of petroleum refining, cement manufacturing, and the burning of fossil fuels.

Food Safety and Control. From 1993 through May 1997, 26 outbreaks of food poisoning reported to the Epidemiological Monitoring Department of the Ministry of Public Health have been laboratory-confirmed. Bacterial agents were the most frequent cause (89%), with foods of animal origin the most implicated (73%) and homes the most frequent location of the outbreak (46%).

Food Assistance Programs. For over 20 years, the Ministry of Public Health has had a supplementary food program to combat malnutrition and low birthweight in the population covered by ASSE, specifically at-risk children and pregnant women. This program has been strengthened by other food assistance programs that are operated by other agencies linked to the Government and by nongovernmental organizations and that are intended not only for pregnant women and children but for older adults as well.

Organization and Operation of Personal Health Care Services

Basically, the physical infrastructure in both the public and private health sectors has not changed significantly in recent decades, although facilities have been remodeled and expanded. In Canelones and Las Piedras—both in metropolitan

Montevideo—two new hospitals have been built and will soon start operating.

As part of World Bank and IDB technical cooperation projects, the resizing of the health care network is being studied. In Montevideo, there are a large number of hospital beds, with a high occupancy rate and a high average hospitalization rates. In the interior, hospitalization levels are adequate, but the occupancy rate is about 50%. If the average hospitalization period in the private sector were applied to the number of hospitalizations done by the public sector, half the current number of beds would be enough. This indicates the need to reconsider not only the number of facilities, but basically the operations within each facility.

The private sector requires authorization from the Ministry of Public Health to build new hospitals and import equipment valued at over US\$ 20,000. In the mid-1980s, the Ministry opened a Medical Technology Unit that analyzed private sector requests to import technology. The Technology Unit considered not just the technical standpoint, but also the technology's effectiveness and the country's needs. However, once equipment was authorized, since there was no regulation of the fee being charged to use it, monopoly or oligopoly situations were created that were hard to manage. This led interest groups to exert pressure and evade regulation, importing equipment and reducing prices as a result of competition. However, the control only affected the private sector. In the public sector, equipment was acquired with nothing more than a request from the director of an institution, depending on the availability of funds, without planning based on the population's needs or on establishing levels of care. Currently, the budget and infrastructure are inadequate and there is no maintenance program. The country has no national inventory of public or private equipment. There are no data on the availability of replacement parts or staff training.

It is estimated that the private health sector, consisting of the CHCIs and the private sanatoriums, has some 3,500 beds for the hospitalization of acute patients throughout the country. The CHCIs administer a total of 2,800 beds, 1,800 of which are in Montevideo. The private sanatoriums—5 in Montevideo and 34 in the interior—have some 700 beds.

According to 1996 data, CHCI members annually average 5.5 medical consultations, 1.21 hospital stays, and 4.95 days of hospitalization. The average hospital stay is 4.2 days, and 37% of births are by cesarean section. Members receive an average of 10.9 prescriptions per year and 1.9 prescriptions per visit. Of all CHCI members, 16% are over 64 years of age.

Inputs for Health

The supply of drugs in the country is adequate, in both the public and private sectors. Since 1971, the Ministry of Public

Health has periodically published a list of essential drugs (the latest in 1996), with their international generic names.

Pharmaceutical spending accounts for 15% to 20% of all health sector spending. Purchasing is done through public bidding or negotiation with laboratories. The drugs that are marketed must be registered with the Ministry's Office for the Control of Drugs and Related Products, which assesses quality and other characteristics, under the supervision of the Ministry's Quality Control Laboratory.

Drugs are provided at no cost to those with a health care card from the Ministry.

Vaccinations are administered through the Ministry's Expanded Program on Immunization (EPI), in both public and private sector vaccination units. The management of the EPI is the responsibility of the Ministry's Epidemiology Department. In both the public and private vaccination units, vaccines are free, and all people receive care. The vaccines included in the EPI (for tuberculosis, diphtheria, tetanus, whooping cough, poliomyelitis, measles, rubella, and mumps) are required by law. In addition, vaccination is provided against *Haemophilus influenzae* B. Health workers at risk from contact with patients and patients undergoing chronic dialysis are vaccinated against hepatitis B.

Human Resources

The number of physicians, dentists, pharmacists, and nursing assistants is adequate for the population. There are 11,928 physicians (3.7 per 1,000 population) and 4,069 dentists (1.3 per 1,000 population). In contrast, there are not enough professional nurses, as there are only 2,230 (0.7 per 1,000 population).

Health sector education is not planned. Admission to health training is open to anyone who meets the requirements, without admissions quotas. However, in recent decades concern in this area has been growing, and medical associations are promoting the regulation of admissions to the School of Medicine. The number of physicians and their distribution by specialty is being considered. It is believed that there is overspecialization based on technology, and a lack of health services managers and administrators, as well as such public health specialists as epidemiologists and health economists.

Research and Technology

In Uruguay, very little research is conducted, especially in the area of health systems and technology. Epidemiological research, however, is somewhat more developed and its findings do guide policies to resolve specific problems. In other

areas, there is only an awareness of the problem and specific research on some subjects. In addition, the training of health professionals in research concepts and methodology is inadequate. In this respect, the education of health workers is very heterogeneous. In the area of technology, research is not conducted before technology is incorporated nor is there any subsequent evaluation of the results of technologies. The limitations are basically the lack of training and an absence of firm policies requiring research findings for decision-making.

Expenditures and Sectoral Financing

Health expenditures in 1995 were US\$ 1,781 million, or US\$ 564 per person. As a percentage of GDP, total health expenditures have been growing. The share was 6.2% in 1982, 8.3% in 1992, and 10.0% in 1995.

Of total health expenditures in 1995, 28.6% were in the public sector and 71.4% were in the private sector. For some time, spending by the public sector has remained at about 30%, but moving downward, while the private sector has accounted for slightly more than 70% of spending, with that proportion increasing.

The largest portion of spending in 1995 was for the CHCIs, with 49.6%. The State Health Services Administration accounted for 15.1%; spending in pharmacies outside of hospitals was 6.4%; partial health insurance plans accounted for 5.9%, and the contribution from CHCIs (through a surcharge on the fees prepaid by their members) to the Public Resources Fund was 3.9%. The share of spending in the other health entities was small, just 1% to 2% each.

The expenditures for the four public Honorary Commissions (to Combat Cancer, for Cardiovascular Health, to Combat Hydatidosis, and the Tuberculosis Campaign) represented only 0.5% of health expenditures in 1995, amounting to about US\$ 9 million.

Of all expenditures, in both the public and private sectors, 45.7% went to pay for personnel costs, 24.9% to materials and other items, 16.7% to drugs, 9.5% to contract third parties, and 3.2% to investment.

In 1995, considering the public and private sectors together, 42.1% of health funding came from the monthly fees paid by CHCI members, 25.4% from direct payments by users, 23.3% from general taxes, 3% from withholdings on employee compensation is allocated to health insurance and other social security agencies, 0.8% from extrabudgetary resources of institutions in the public sector, and 5.5% from insurance premiums such as those for mobile emergency medical services and from direct private spending.

In the public sector, financing for health sector expenditures in 1995 came basically from taxes, which financed 81.1% of spending; 9.1% from withholding on wages; 6.7%

from the sale of services; and 2.9% from the extrabudgetary resources of institutions in the public sector.

In the private sector, 59% of financing came from mutual fees, 33% from income from the sale of services, 0.5% from withholding on wages, and 7.5% from such other sources as partial-insurance health plans, exclusive private care, and nursing homes for the elderly.

External Technical and Financial Cooperation

In 1995, a joint IDB/Government of Uruguay project was announced under the program known as Strengthening the Social Sector. With a budget of US\$ 42.5 million—US\$ 12.5

million contributed by the Government and US\$ 30 million financed by an IDB loan—it will carry out infrastructure and reform projects in education, health, labor, justice, nutrition, and social information. The health objectives include initiating public sector reform, improving institutional efficiency, adapting the supply of health services to the epidemiological profile and needs of the population, expanding coverage, and improving the quality of basic services.

There is another project to strengthen the decentralized management of hospitals, financed by the World Bank.

According to studies conducted by the Economics and Health Commission of the Medical Union of Uruguay, the amount of international assistance received comes to approximately 0.1% of health expenditures.