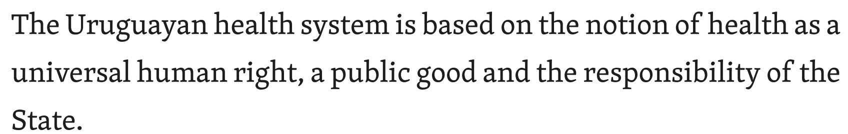
Functioning of the health system in Uruguay

Principles, financing, management, and care model

PAHO Pan American Health Organization World Health Organization REGIONAL OFFICE FOR THE Americas



The Uruguayan health system is based on the notion of health as a universal human right, a public good and the responsibility of the State.

Total health spending in the country represented 10.5% of the Gross Domestic Product (GDP) in 2019.

The National Integrated Health System (SNIS - for its acronym in Spanish-) was created by Law 18,211 (December 2007) and integrates public and private providers.

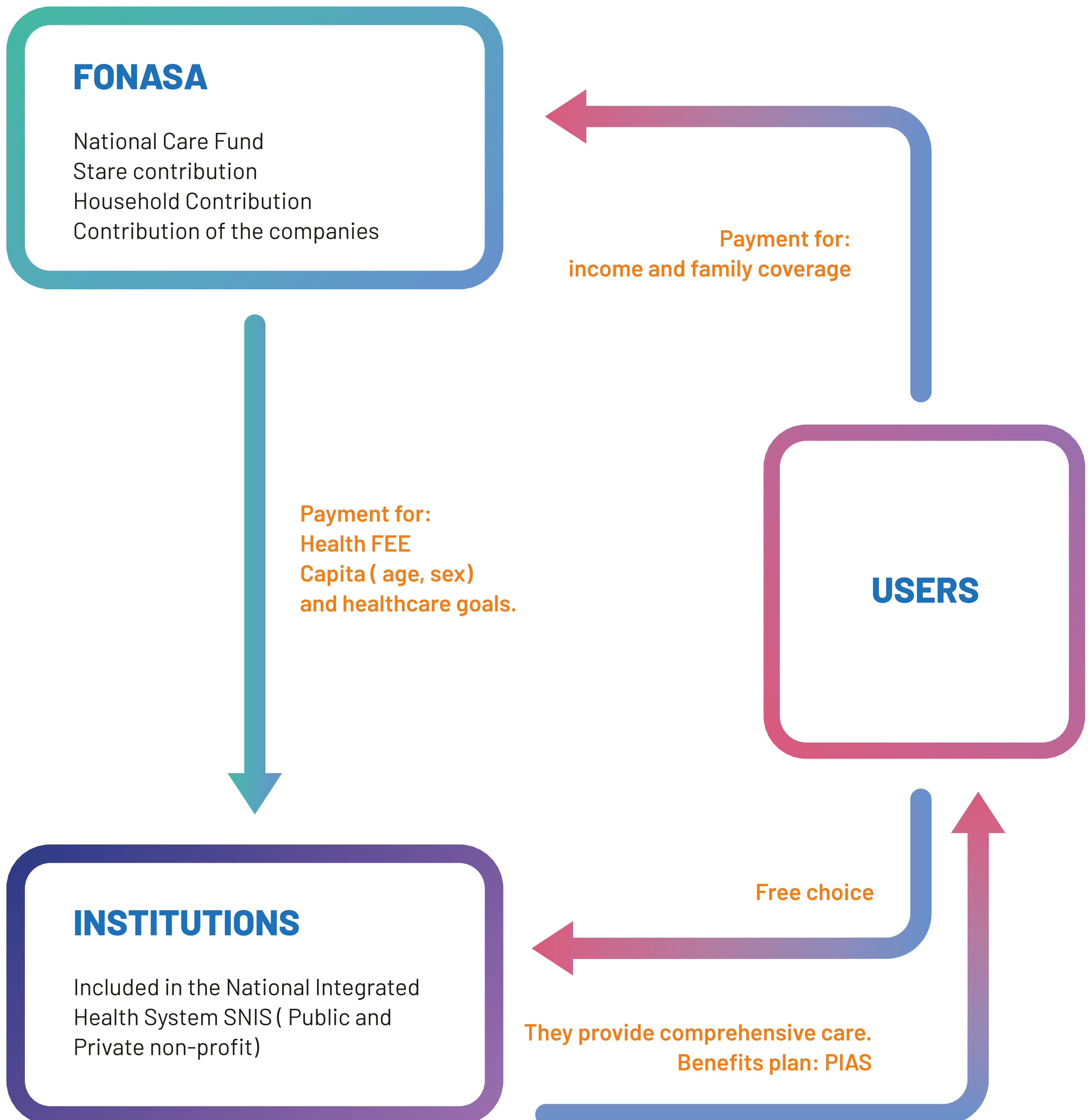
It is funded through the National Health Fund (FONASA - for its acronym in Spanish), a unique, public, and mandatory fund. It has a mixed constitution, with a contributory component (employers and employees) and a component of General State Revenue.

The SNIS ensures universal coverage through 42 eligible comprehensive health providers, who provide a broad set of benefits - the Comprehensive Health Care Plan (PIAS - for its acronym in Spanish-) - which is the same for all.

The Ministry of Public Health (MSP - for its acronym in Spanish-) is responsible for the stewardship and leadership of the system, defines health policies and regulates the care given by providers based on priorities determined by the demo-epidemiological situation.

In 2016, the MSP defined for the first time National Health Objectives, with a horizon towards 2020, as a strategy to prioritize health problems of the population to be addressed and also serves as an articulating element of intersectorality, the allocation of resources and international cooperation. Currently, the MSP authorities are adjusting the health objectives and will define new goals by 2030.

Schematic operation of the Health system



Users of the National Integrated Health System

3.500.000
total population.

2.500.000
people enrolled through social security (FONASA).

1.000.000
people covered by the main public provider (ASSE) without being covered by social security.

> **About 2.545.680 people have rights acquired by social security (National Health Insurance) and contribute to the National Health Fund (FONASA).**

This group includes:
* **Active formal workers and their dependents:**
- dependent children under 18 years of age and of legal age with disabilities
- spouse or common-law partner (voluntary)
* **Retired people**

> **About 1.000.000 people who do not contribute to FONASA are covered by State Health Services Administration (ASSE - for its acronym in Spanish-).** Their coverage is financed through General Revenues and they have access to the same benefits plan (PIAS).

* Approximate data based on the estimate of the National Institute of Statistics as of June 30, 2021 and the MSP of July 2021.

How are health providers linked to the SNIS?

Management model

Each of the 42 health care providers signs a management contract with the National Health Board (JUNASA - for its acronym in Spanish-) that obliges them, as integral providers, to provide the complete benefits plan (PIAS) in adherence to the regulator's guidelines. This contract may be reviewed periodically.

The National Health Board (JUNASA) administers the National Health Insurance (SNS- for its acronym in Spanish-), which is financed by FONASA, and ensures compliance with the guiding principles of the health system. It is a participative stewardship organism made up of seven members: four representing the Executive Power - two from the MSP, one from the Ministry of Economy and Finance and one from the Social Security Bank (BPS- for its acronym in Spanish-) - one representative of health care providers, one for health workers and one representative of the users of the health system.

BPS is responsible for the administrative accounting management; it collects employer and employees' contributions and pays health care providers, if authorized by JUNASA, which has the potential to block payment if the institution does not comply with all requirements. required by its management contract and current regulations.

¿How are health providers and population linked?

Free choice

People who contribute to FONASA can choose their integral health provider, joining one of the 41 private integral providers or the public provider, which is the State Health Services Administration (ASSE).

About 480.000 people who contribute to FONASA have chosen ASSE, which makes it the largest provider in the SNIS. Unlike the private ones, ASSE does not charge user fees (orders and tickets).

The free choice of health provider occurs within a framework of regulated mobility: when choosing a health institution, FONASA affiliates must remain in it for two years, except for some exceptional situations. This facilitates the continuity of care and, at the same time, allows providers to foresee the resources they will have to have to serve the population they provide care to.

The possibility of choosing between private providers and ASSE has contributed to reducing the segmentation of the system based on the socioeconomic insertion of the population and its ability to pay.

Comprehensive Health Care Plan (PIAS)

It is a wide and integral benefits plan, unique to all users of all SNIS providers. It includes from outpatient consultation at the first level of care, to the hospitalization in ICU, ensuring a wide list of diagnostic studies and treatments linked to the different medical and surgical specialties, mental health care, all essential medications and some high-priced medications.

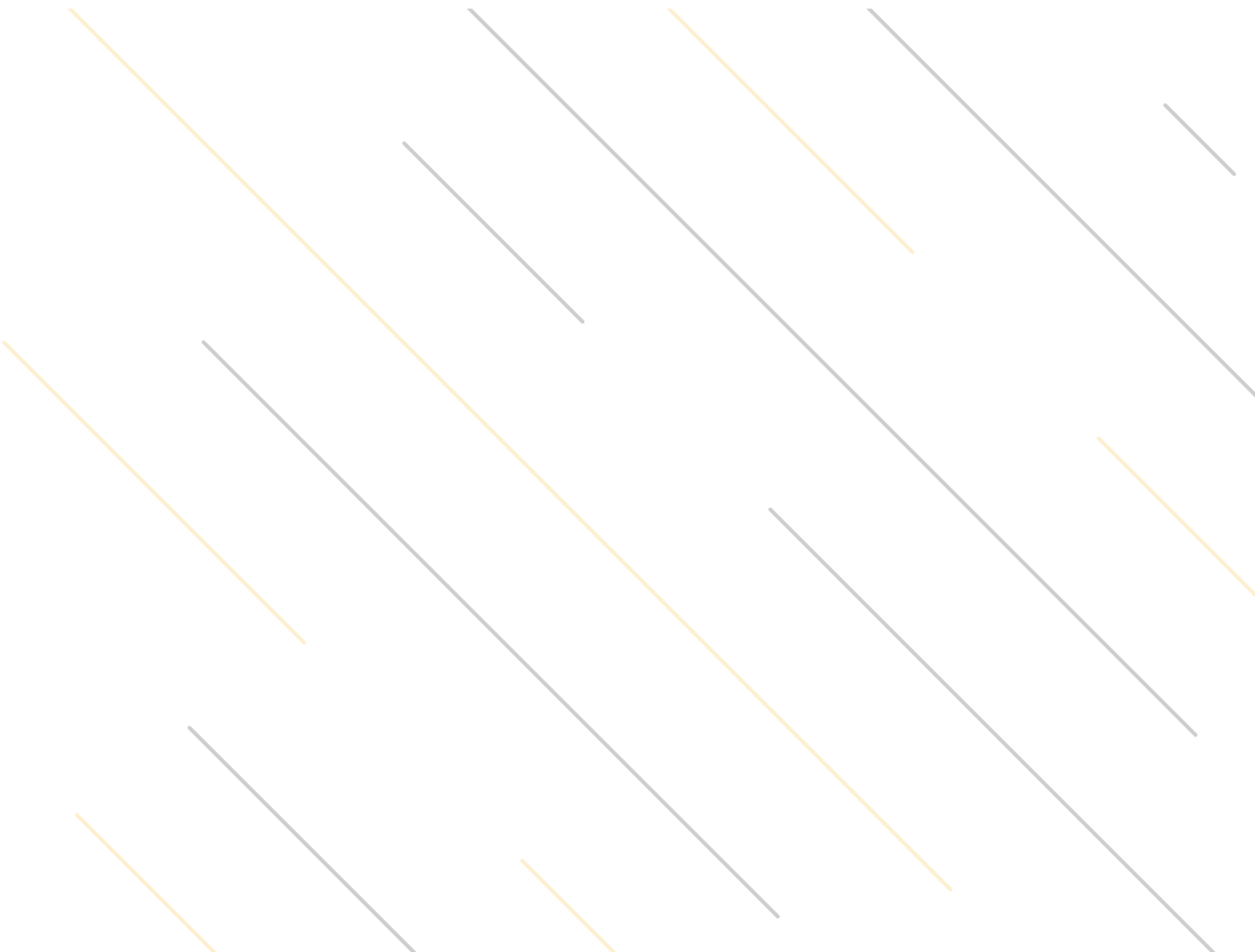
The PIAS is a taxative list that is periodically updated through mechanisms developed by the governing organism to discern which technologies should be integrated into the different stages of comprehensive care (promotion and prevention, diagnosis, treatment, rehabilitation, and palliative care). These technologies include medications, procedures, devices, programs, and modalities of care.

The health technology assessment and the decision of their incorporation into PIAS have so far been carried out by groups that operate in different general directions of the MSP. Prioritization criteria and available scientific evidence are applied to ensure that the technologies to be incorporated are safe, and more effective and

more efficient than those already in PIAS.
In 2020, the Health Technology Assessment Agency was created by law- a legal entity under public-private law that is linked to the Executive Power through the MSP - which will assume some of these functions.

- The benefits of the priority programs, the care modalities, procedures, medicines, and devices of low and medium complexity, as well as some of high complexity, are provided by comprehensive health providers and financed by FONASA.

- Very complex diagnostic and therapeutic procedures -provided by Institutes of Highly Specialized Medicine (IMAE -for its acronym in Spanish-), high-priced medicines and some special programs, are financed by the National Resources Fund (FNR).



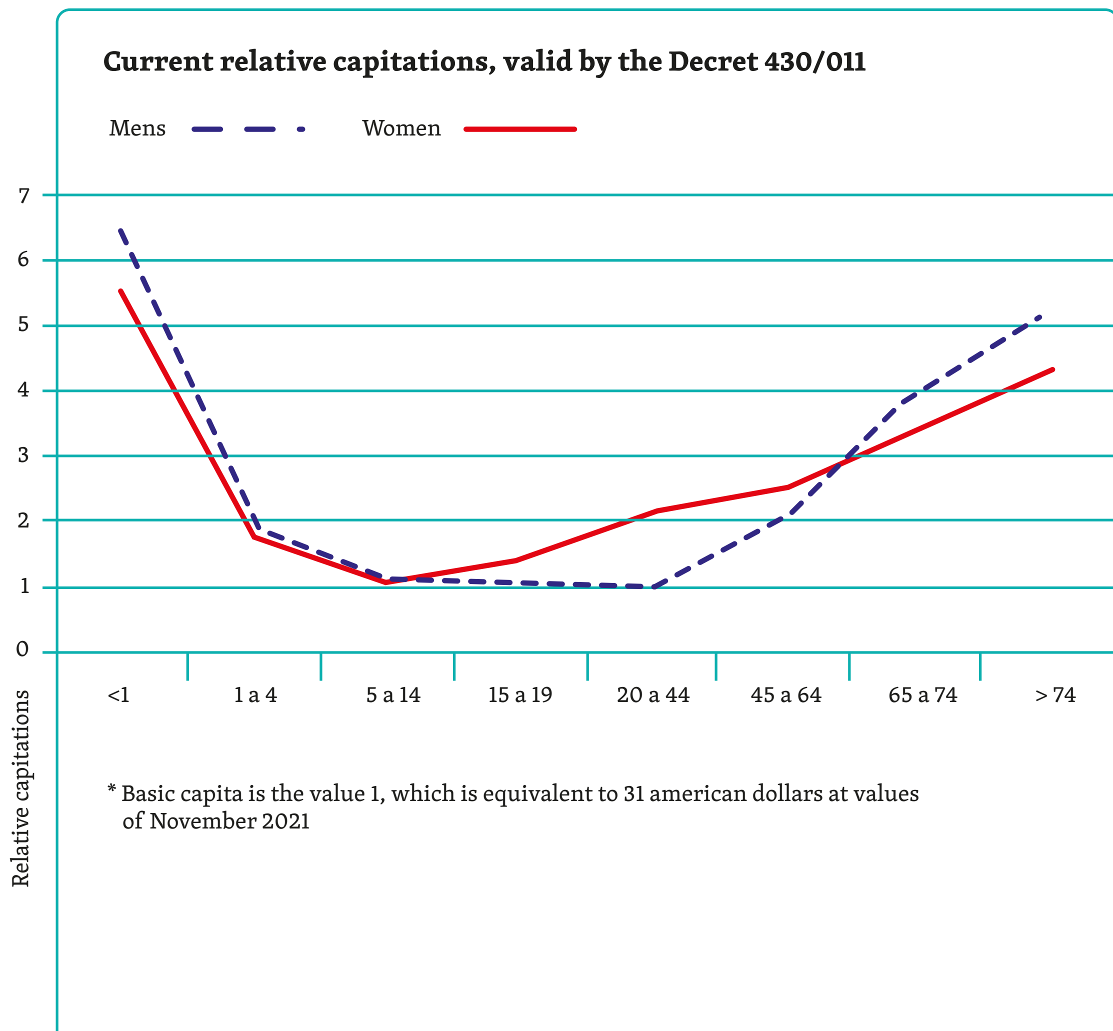
How is the health system financed? Financing model

Providers' payment mechanisms

Integral SNIS providers receive from FONASA a "health fee" for each member that reimburses them for the expected costs derived from their care.

The health fee has two components: the capitation payment and the performance based payment according to healthcare goals.

The capitation is the main component and is adjusted according to the risk associated with each beneficiary, which is determined based on age and sex. In this way, it seeks to respond to expected expenditures according to sex and age. For example, the capita is higher during the first year of life, as well as in advanced stages, and it is higher in women of reproductive age compared to men of a similar age group.



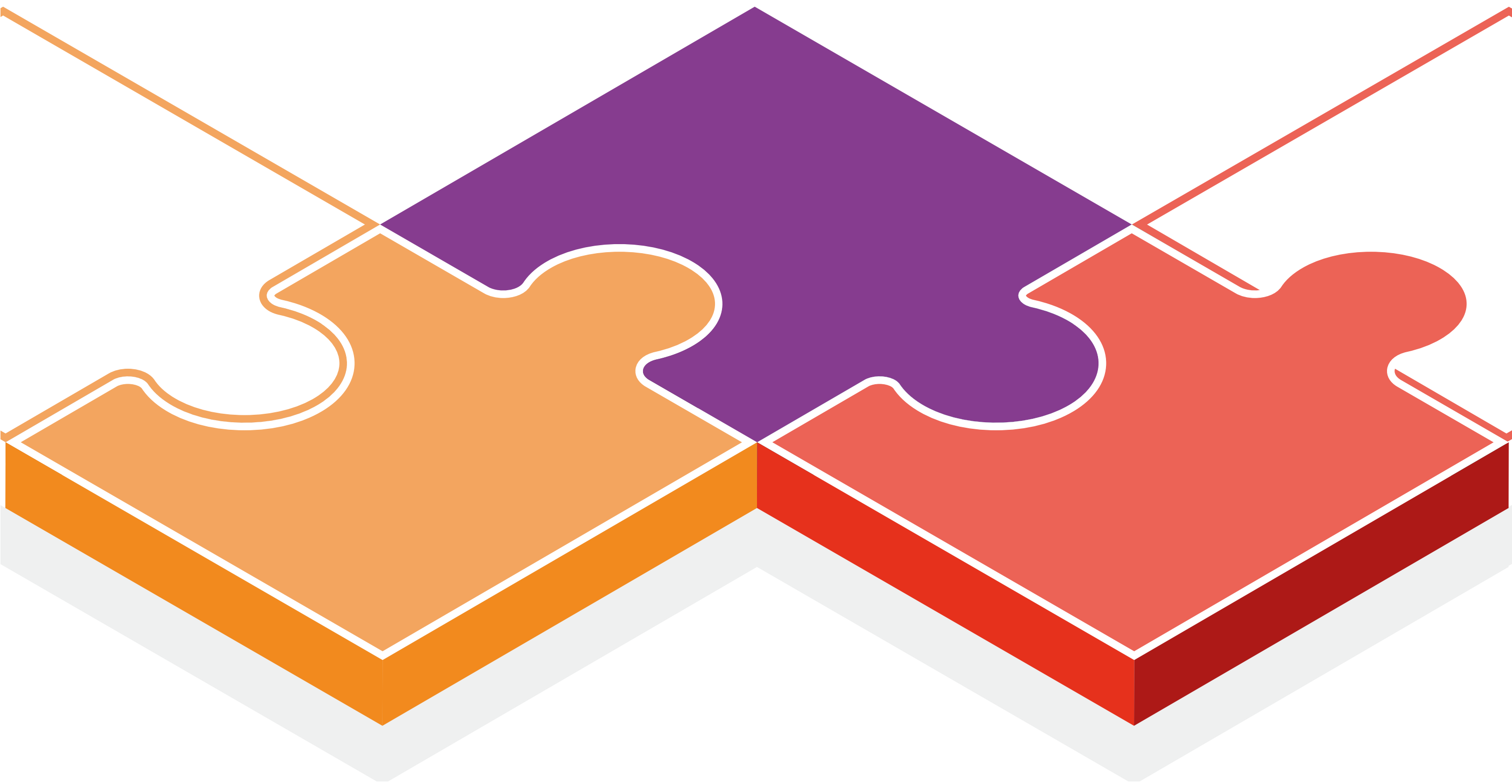
This payment mechanism avoids the risk of refusal by private institutions to enroll people who, due to their pathologies or their age, would mean higher costs (cream skimming). This provides universal coverage by preventing exclusions.

The performance based payment according to healthcare goals represents approximately 8% of the health fee for each affiliate and is an incentive that JUNASA pays to the integral provider if it achieves certain health care goals defined by the regulator. Examples include service provision goals related to maternal and child health, to the hiring and training of human resources, to the fulfillment of health objectives, as well as the recovery of face-to-face care and the mitigation of the delay in scheduled surgeries in the post-pandemic.

The payment of the health fee, through the two components, is one of the outstanding characteristics of the Uruguayan health system, because it makes it very powerful in terms of ensuring health coverage regardless of expected individual costs, while giving the health authority a great stewardship power.

The payment mechanism for the fulfillment of healthcare goals allows the regulator to involve providers in critical issues for the health of the population; it is a way of facilitating the institutions' commitment to health priorities.

How is FONASA funded?



State Contribution

Arises from General Revenue and completes the payment of the total amount of health fees that is not covered by contributions; it currently represents 24%[1] of total FONASA expenditure.

Employers

Public and private (5% of nominal wages).

Formal workers

They contribute a percentage of their salary. Those who receive salaries below 2.5 Bases of Benefits and Contributions (around 270 dollars) contribute a rate of 3% of their nominal salary for their affiliation and their family. Those who have salaries above this limit contribute 4.5% for their coverage; 6% if they have children or dependents, and 8% if they extend the benefit to children and spouses.

1 - Gustavo Rak "11 years of the National Health Insurance", in Advances in consolidation of the National Integrated Health System.

Pooled funds

Funds with various contribution channels allow health systems to have a greater chance of withstanding the financial accounting stress of providing health care with a broad benefit plan and face “catastrophic” expenditures that can compromise sustainability. Uruguay has two pooled funds: FONASA and the National Resources Fund (FNR).

The FNR was created in 1980 and covers highly complex services. It is financed mainly from a percentage of FONASA’s employees’ contributions, and to a lesser extent from a fraction of individual affiliations to private institutions and is completed with the contribution of General revenue. In 2015, the FNR introduced the collection of co-payments for assisted human reproduction treatments (the beneficiaries contribute according to their ability to pay and in relation to the number of attempts); the collection of co-payments is also applied to some services that have to be provided abroad, but represented a marginal proportion of 0.8% in 2019[2] .

Public spending on health

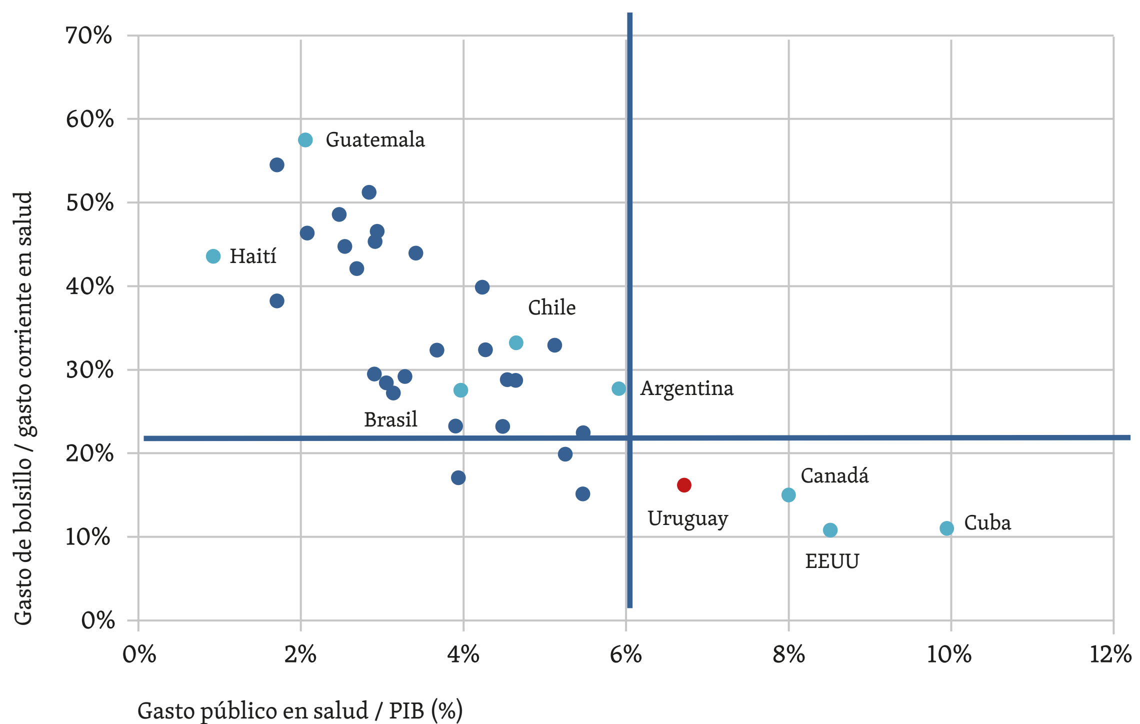
PAHO promotes as a regional strategy that public spending on health is at least 6% of Gross Domestic Product (GDP) to ensure that the financing of the system is made with public spending and does not depend on the contribution of out-of-pocket spending by families. In Uruguay, public spending on health represents 6.93% of GDP.

PAHO recommends that out-of-pocket expenditure do not exceed 20% of total health expenditure, because these disbursements are not related to people's ability to pay and, as they are made at the time of accessing to the services, they can represent a barrier to access. In Uruguay, the main expenditure includes direct payments (products or private consultations) and moderating rates (orders and tickets); since the beginning of the reform, out-of-pocket spending fell from 23% to 15%, according to data from the 2019 MSP.

2 - National Health Accounts 2018-2019, Ministry of Public Health.

The combination of high public spending and low out-of-pocket payments places Uruguay among the few countries in the region that present values within the thresholds recommended by PAHO of 6% of GDP for public spending on health and 20% for out-of-pocket expenses on health, within health spending.

Public spending on health as a percentage of GDP and out-of-pocket spending as a percentage of total health spending in the Americas 2018.



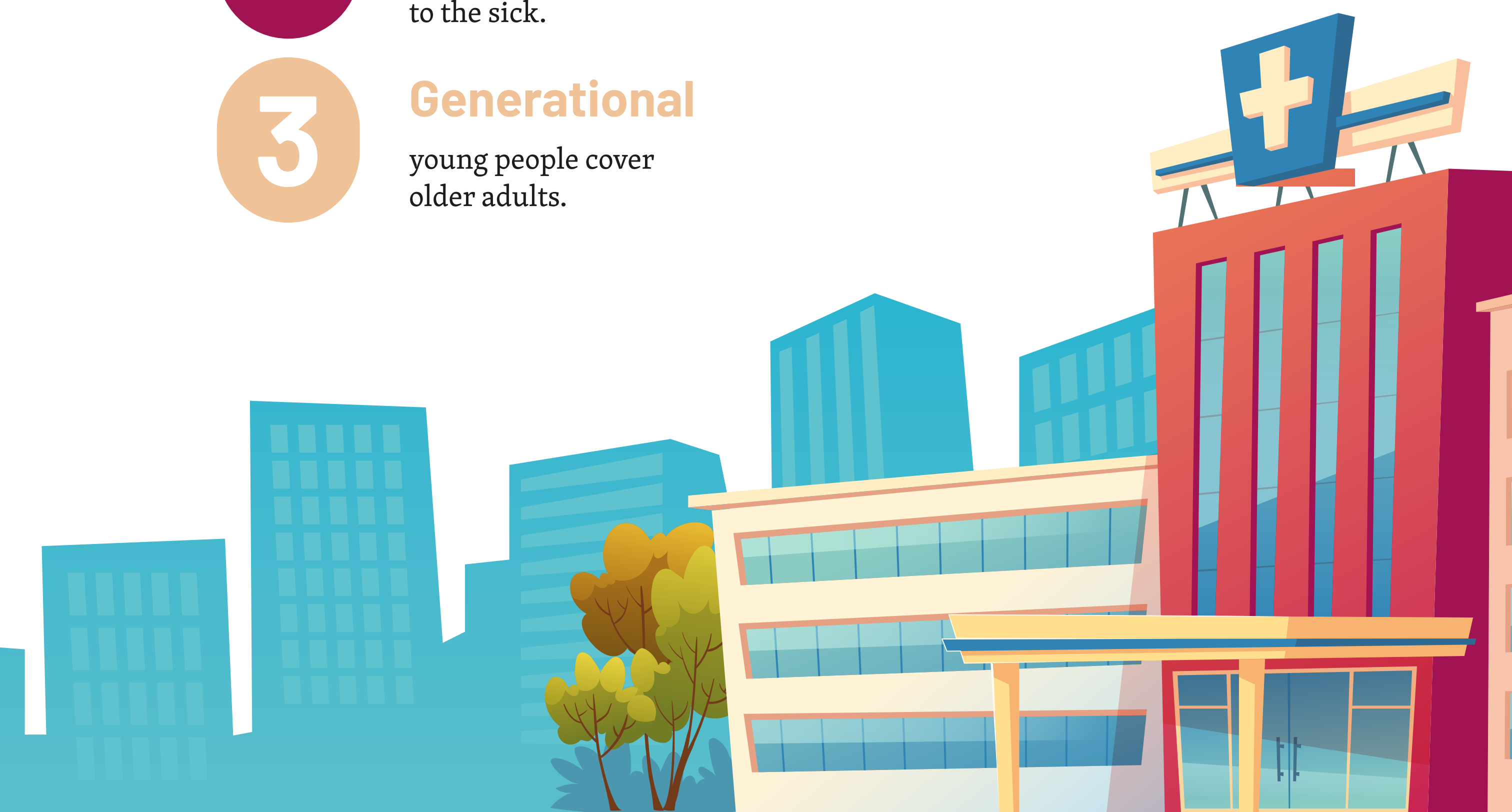
Source: Health Economics, MSP, based on the Global Health Expenditures Database.

The health system is mixed and supportive

SNIS financing is mixed, because FONASA has a very relevant contributory component and a non-contributory component, which contributes General Revenue.
In addition, it is mixed because the State finances the care of people who do not contribute to social security (about 1.000.000) who have ASSE coverage and who receive, at no cost, the same benefit plan as those affiliated with FONASA.
The fact that workers contribute a proportion of their salary makes the system supportive, because those with better salaries make a greater contribution that make it possible to cover the benefits of workers and retirees with lower incomes.

The Uruguayan health system follows the logic of solidarity on three levels:

1. **Economic**
   those with higher incomes cover those with lower incomes.
2. **Health**
   the healthy contribute to the sick.
3. **Generational**
   young people cover older adults.



The provision of health care is also mixed because it is public and private.

In addition to ASSE and the 41 private ones, the system includes other comprehensive public providers, such as Police Health and Military Health, which, although they are not part of the National Health Insurance, provide the same benefits plan that FONASA affiliates receive and under the same care guidelines. They also have mixed financing, with contributions from police and military officials and a supplement from General Revenues.

The SNIS includes other non-comprehensive providers that provide certain sets of benefits to specific populations, which are financed with their own resources, not linked to FONASA:

- Public: Hospital del Banco de Seguros del Estado (which provides coverage for pathologies and occupational accidents), BPS services (for example, the National Reference Center for Congenital Defects and Rare Diseases, CRENADECER), first-level services of the departmental governments and Hospital de Clínicas of the public university Universidad de la República.

- Private: mobile medical emergency services, partial providers, laboratories.

Since 2007, the provision of health services has been separated from the governance and regulation of the health system, as established by Law No. 18,161, which decentralized ASSE from the MSP. It allows the regulatory organism to be empowered to control all providers, but not to get involved in their management.

Model of care

Law 18,211 established the SNIS to be organized "in networks by levels of care according to the needs of the users and the complexity of the services" and that it implements the primary health care (PHC -) strategy, prioritizing the first level of care (PNA).
The PNA comprises a network of healthcare units that provides timely care to the demand and other health needs of the population through interdisciplinary teams. As defined by Law 18.211, it ensures "a systematized set of sectoral activities aimed at the person, the family, the community and the environment, aimed at satisfying basic health needs and improving the quality of life with adequate resolution."

The PNA is the gateway to the system and the privileged institutional setting for developing the PHC strategy, which works intersectorally to influence the social determinants of health, such as access to drinking water, sufficient and healthy food, prevention of gender violence and harmful habits.

PAHO recently reaffirmed PHC through the document of the High-Level Commission formed in 2018, 40 years after the Alma-Ata International Conference on PHC. A resolutive PNA is one that when it cannot resolve, refers people through integrated networks to second and third levels of care, with an adequate referral and counter referral that allows continuity of care.

Uruguay has developed a model of care that offers in the PNA the services linked to the programmatic areas prioritized by the MSP, avoiding vertical programs. The PNA and the networks that include other levels of complexity attend to the care demand such as reproductive health, pregnancy control, HIV, cancer, respiratory and cardiovascular diseases, up to palliative care.

PAHO argues that health systems work better with a logic of integrated health services delivery networks (-RISS for its acronym in Spanish-), which includes a critical attribute of having a defined population and territory, in charge of healthcare units. This organization has not been generalized in the Uruguayan health system. The greatest advances have been made by ASSE, which has services in 19 nationally based primary care networks, which coordinate with secondary and tertiary level hospitals and specialized centers. The private sector has made disparate efforts to strengthen its PNA structures, generating a greater presence in the territory stimulated by the regulatory framework of the reform. Advances in this regard have generated more efficient, timely and better-quality care.

Challenges persist because having a "membership register" is not the same as having a "population in charge"; health providers, and therefore their health teams, still do not have a known list of people linked to each of their healthcare units.

Digital health

Uruguay has an important development of digital health and has advanced in a national electronic medical record (HCEN - for its acronym in Spanish-) with the leadership of the Agency for Electronic Government and Information and Knowledge Society (AGESIC -by its acronym in Spanish-).

In April 2020, during the COVID-19 pandemic, Law 19.869 was approved, which establishes the general guidelines for the implementation and development of telemedicine as part of the health services provisions, that is still in process of regulation.
This law promotes telemedicine as a resource that facilitates better access for the entire population to the health system, by breaking down geographical barriers, allowing optimization of healthcare resources and increasing resolution, with a perspective of inclusion and respect for human rights.

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