INTRODUCTION

The Oriental Republic of Uruguay borders on the Argentine Republic and the Federative Republic of Brazil. It has a land area of 176,215 square kilometers and a maritime area of 125,057 km². Uruguay is a representative democracy, with elections every five years and separation of powers between the executive, legislative, and judicial branches. It is divided into 19 departments, each governed by a departmental council and an intendant. Law 18.567 (2009) on Political Decentralization and Citizen Participation instituted a third level of government with the creation of 89 municipalities. In national elections in 2009, the left-wing coalition Frente Amplio (Broad Front) was returned to power, and the new Government took office on 1 March 2010 with a parliamentary majority for the period 2010–2014.

The total population of Uruguay was 3,344,938 in 2010, with a population density of 17.8 inhabitants...
per square kilometer. The population was 48.3% male and 51.7% female, for a masculinity ratio of 93.4. The population is overwhelmingly urban (98.1% in 2009, with no difference by sex), with some 40% concentrated in and around the capital of Montevideo. It is an aging population with a spindle-shaped population pyramid. In 2010 children 0–14 years old made up 22.8% of the total population, while the group aged 60 and older made up 17.8%. The group aged 80 and older accounted for 3.7% of the population and was 65.8% female (Figure 1). In 2004, 32.1% of the population lived below the poverty line, declining to 18.6% in 2010. However, poverty rates are higher among children, with 33.8% of children under age 5 still below the poverty line in 2010 in spite of the significant decline in this rate since 2004 (56.4%) (1).

Life expectancy at birth was 76.1 years in 2009, with a difference of 7 years between men (72.56) and women (79.84). The crude birth rate was 14.50 live births per 1,000 population and the crude death rate was 9.39 per 1,000 population. The average annual population growth rate is 0.348, while the total fertility rate is 1.99 children per woman, lower than the population replacement level.

The country has registered sustained growth in its economy in recent years. The gross domestic product (GDP) increased 36% between 2004 and 2010, from US$ 13,167 million to US$ 36,830 million, while annual GDP per capita increased from US$ 4,003 to US$ 11,999. The annual inflation rate was 9.2% in 2008 and 6.9% in 2010. The economically active population in 2010 was 64.2%. The unemployment rate declined from 10.9% in 2006 to 6.8% in 2010; it is higher for women than for men.

**HEALTH DETERMINANTS AND INEQUALITIES**

Universal education has been achieved for children 4 and 5 years old, with significant coverage of 3-year-olds as well. There are several comprehensive services provided through the country’s Equity Plan (2). Secondary education coverage was 70% in 2008, below the benchmark expected in the progress toward universal coverage by 2015. The Ceibal Plan seeks to bridge the digital divide, both between Uruguay and other countries and between different groups of Uruguayans, with a view to providing broader and higher quality access to education and culture. Toward this end, an effort is under way to spread the use of new information technologies by


The population increased 8.4% between 1990 and 2010. In 1990, the population structure displayed a relatively narrow pyramidal shape, with an age structure showing some aging in the population. By 2010, the population structure narrows, showing relative similarity in age groups younger than 55 years and displaying the proportional increase in women older than 80 years; this reflects the relatively low fertility and mortality the country has experienced over the last eight decades.

* Each age group’s percentage represents its proportion of the total for each sex.
providing free laptop computers with Internet access to all schoolchildren. A total of 380,000 computers were delivered in 2009, of which 362,000 were for students and 18,000 for primary school educators. There are 220,000 households that have their first computers—half belong to the poorest quintile of the population—and 2,068 schools have been provided with Internet connections. Steps have been taken to expand these benefits to secondary and technical schools and provide them with 100,000 computers.

The National Institute for Women plays an important role in the empowerment of women and promotion of gender equality, working with civil society organizations that participate actively in shaping the public agenda. Despite some progress, gender inequities are still evident in employment opportunities and working conditions. Female participation in the labor force grew between 1990 and 2009, but only slowly, and there was a gap in access to paid employment (53.7% for women and 74.4% for men in 2009). Women devote more time than men to unpaid work, pointing to the need for a comprehensive system to overcome these inequities. Women’s hourly wages are 10% less than men’s. Women occupy 14% of the seats in Parliament.

Only recently have social policies focused on the living conditions of the population of African descent (300,000 people or approximately 10% of the total population). They face clear disadvantages compared to the rest of the population: their participation in secondary and tertiary education is much lower, their poverty rate is double, and they face unfavorable conditions in the labor market (2, 3).

Uruguay’s favorable terrain and climate make the country a good food producer. The Ministry of Public Health has given priority to addressing inequity and social exclusion with regard to food and nutrition. A significant percentage of children and pregnant adolescents suffer from chronic malnutrition and lack essential nutrients, yet there is also an epidemic of overweight and obesity. Malnutrition is targeted with specific programs at the national level, giving priority to children under age 5 and pregnant women, in coordination with the Ministry of Social Development, the National Food Institute, intendancies, and other ministries. Programs to prevent chronic, noncommunicable diseases are being implemented, including promotion of a healthy diet and active lifestyle, along with periodic health monitoring (4).

THE ENVIRONMENT AND HUMAN SECURITY

Access to Clean Water and Sanitation

The majority of homes (92.3%) have access to potable water through the general network of the State Sanitary Works. The remainder (7.7%) consume water with less quality assurance, although 5.7% obtain it from protected artesian wells. In terms of sanitation coverage, 63.5% of homes are connected to the general sewerage system, while 36.5% use less reliable systems such as leach fields or septic tanks that are prone to cause contamination and other risks, especially in urban areas (5). The Montevideo Sanitation Program (PSU IV) currently under way is expected to provide sanitation to 100% of the capital city’s population.

Solid Waste

Management of solid waste in Uruguay is the responsibility of the departmental intendancies; progress has been made toward greater coverage and modernization as well as notable improvements in the plans for collection and final disposal. The Master Plan for Solid Waste Management in Montevideo and the Metropolitan Area was implemented in 2005.

Deforestation and Soil Degradation

Forest covers 3.7% of the national territory. Native forests are protected by Forestry Law 15.939, which prohibits logging on such lands (6). Forest exploitation has worsened soil degradation. According to the
Ministry of Livestock, Agriculture, and Fisheries, erosion affects 30% of the land used for farming and livestock, 87% of which is used for fruit and vegetable production. Air pollution is not a significant problem.

**Persistent Organic Pollutants**

The National Environmental Directorate oversees a project to build capacity for the environmental management of persistent organic contaminants, intended to increase active supervision and understanding of these compounds.

**Pesticides**

Six thousand tons of pesticides are imported each year. The Department of Toxicology in the School of Medicine of the University of the Republic of Uruguay is a PAHO/WHO Collaborating Center in Human Environmental Toxicology. Emergency response is provided by the Center for Toxicological Information and Advice (Centro de Información y Asesoramiento Toxicológico, CIAT), which functions as the national poison control center. The Ministry of Livestock, Agriculture, and Fisheries registers more than 1,000 commercial products per year, with almost 300 active ingredients. Acute disorders linked to pesticides represent 16.5% of all CIAT consultations. Of these, 76% are associated with pesticides used in the home (rodenticides and insecticides). In agriculture, 36% of the disorders are caused by insecticides, with one-third of these linked to workplace accidents (7).

**The Work Environment and Workers’ Health**

There has been progress in the area of workers’ health, including putting in place policies on healthy workplace environments, establishment of commissions in support of worker health and safety, wage councils, updating the list of occupational diseases (in accordance with the International Labour Organization 2011 recommendations), and more health coverage (8).

**Road Safety**

The National Road Safety Unit was established in the office of the Presidency of the Republic to regulate and coordinate all relevant actions. Motor vehicle crashes are emerging as a public health problem comparable to an epidemic. In 2010, 28,510 people were injured in crashes (5% more than in 2009), with 556 deaths (3.9% more than in 2009); the groups most at risk were men (75% of injuries) and people 15 to 39 years old (50% of injuries).

**Violence**

With regard to gender-based violence, approximately 75 cases of rape are reported each year, but these represent only the tip of the iceberg, as there is widespread silence about this problem. Reports of domestic violence rose from 12,450 in 2008 to 15,277 in 2010, an increase of more than 20%. In 44% of the homicides with female victims in 2010, the woman was the partner or former partner of her attacker (9). Teams on domestic violence and health have been functioning since 2007; the process is promoted by the Program on Violence and Health through the Network against Domestic and Sexual Violence, which by 2009 included 72 teams in public and private institutions. The health services have incorporated routine questions about domestic violence into their clinical histories, followed by counseling (10).

**Disasters**

With regard to emergencies and natural disasters, a National Emergency System was set up in the office of the Presidency of the Republic to provide coordination, prevention, and relief from seasonal disasters, especially river flooding.
**Climate Change**

Uruguay’s small size provides advantages as it seeks to implement climate change action plans. Among these are the strengthening of record-keeping systems, the implementation of specific health surveillance plans, and an energy policy that aims for diversification.

**Food and Nutritional Security**

The main problems related to food and nutritional security are those of excess, including overweight, obesity, and the high prevalence of chronic diseases related to diet. These, however, coexist with problems of nutritional deficiency such as growth retardation (chronic malnutrition) and micronutrient deficiencies (e.g., iron-deficiency anemia). Several programs launched since 2005 to target the populations at risk of nutritional deficiencies are having an increasing impact. They include a joint initiative of the Ministry of Public Health and UNICEF to accredit health centers in Good Infant and Young Child Feeding Practices.

**Food Safety**

There is a low incidence of foodborne diseases, with some 400 cases per year; salmonella infection accounts for 30% of the cases (11). Food safety concerns have brought about increased coordination between private institutions, intendancies, the Uruguay Technological Laboratory, the Ministry of Public Health, and the Ministry of Livestock, Agriculture, and Fisheries. The World Organisation for Animal Health (OIE) has certified the country free from foot-and-mouth disease with vaccination and free from bovine spongiform encephalopathy.

**Health Conditions and Trends**

**Health Problems of Specific Population Groups**

**Maternal and Reproductive Health**

Uruguay has one of the lowest maternal mortality rates in the Region, with 8.48 deaths per 100,000 live births in 2010. However, this is still far above the target of 4 per 100,000 live births established by Millennium Development Goal (MDG)5 for 2015 (12, 13, 14).

Since 2005, several lines of action have been implemented under policies focused on gender and women’s rights: (1) improvement of the quality of care and supervision during pregnancy, childbirth, and the puerperium; (2) free provision of contraceptive methods, including to adolescents; and (3) implementation of Decree 369, intended to reduce injuries resulting from abortions performed in risky conditions (14). In 2009, 77% of women used some contraceptive method (12).

Starting in 2008, priority was given to the early diagnosis and treatment of sexually-transmitted infections, with an emphasis on syphilis and HIV/AIDS. Law 18.426 (2008) on Defense of the Right to Sexual and Reproductive Health prioritizes universal access to sexual and reproductive health services that are comprehensive and interdisciplinary. It does not, however, provide for legal termination of pregnancy.

**Infants and Children (under 5 years old)**

The infant mortality rate in 2010 was 7.7 per 1,000 live births. Policies and programs to improve infant health have shown good results, also helping to lower the under-5 mortality rate. Low-birthweight infants (less than 2,500 grams) accounted for 8.3% of births in 2005–2008 (15). Health policies established under the Equity Plan (2007–2015) and the National Strategy for Children and Adolescents (2010–2030) take into account associations between sectors and make efforts to expand coverage provided by the National Health Insurance program. The continuous improvement of economic, social, and health policies, with an emphasis on prenatal care, early infancy, and marginalized groups, contributes to an encouraging scenario for child health.

**Schoolchildren (6–12 years old)**

An intersectoral technical team from the Ministry of Public Health and the Council on Early and Primary
Education works to implement the strategy of Health-Promoting Schools at the national level.

**Adolescents (13–17 years old)**

A specific program and clinical guidelines on comprehensive care for adolescents were developed and implemented between 2005 and 2010. Special areas for adolescents were set up in public health facilities and adolescent identity cards were introduced within the framework of the Equity Plan (16, 17). In 2009, 31.5% of adolescents between 13 and 17 years of age lived in households below the poverty line. Adolescent pregnancies rose to 26% of the total in public maternity facilities in Montevideo in 2010.

**Adults**

Clinical guidelines for the most prevalent diseases have been prepared. A study on risk factors for chronic, noncommunicable diseases conducted in Uruguay in 2006 showed that barely 2.7% of the adult population had no risk factors, while 56.8% had three or more risk factors (18).

**The Elderly (65 years old and older)**

Regulations, protocols, and guidelines have been adopted for the comprehensive care of older adults in the public and private sectors. They include the regulation in 2007 of Law 17.066 (1998), which establishes categories of residential facilities for older adults. Other measures include protocols for management of the principal geriatric syndromes at the level of primary care (2007); nationwide implementation of the elder adult card as a goal for the National Health Fund (Fondo Nacional de Salud, FONASA); design of priority benefits of the National Integrated Health System (Sistema Nacional Integrado de Salud, SNIS); and publication of a “Guide to Preparing for a Healthy Retirement” (2008). In 2009 regulations were applied to residences that house older adults and to family elder care services, and a “Guide for Home Caregivers” was prepared. Studies conducted in 2006 show that the prevalence of disabilities was 18.3% among people 65 to 74 years of age, and 32.5% in the group aged 75 years or older (19).

**Ethnic or Racial Groups**

Efforts have been made among the population of African descent to combat discrimination against people with HIV/AIDS and to promote the sexual and reproductive rights of women. Attention to groups of South American immigrants is a pending issue.

**The Disabled**

Disability of some kind affects 7.6% of the population, with an estimated 210,400 persons having at least one disability. Among adults over 60 years of age, 17% require assistance in order to carry out basic activities of daily living, but only 26% of those in need receive it (20).

**Mortality**

The Ministry of Public Health generates high-quality information from death certificates. The crude death rate in 2009 was 9.62 per 1,000 population (32,179 deaths) (21).

Chronic, noncommunicable diseases are the leading cause of death in Uruguay. In 2008, 79.45% of deaths were due to four major groups of causes: cardiovascular diseases, neoplasms, diseases of the respiratory system, and external causes (22). The leading cause of cancer mortality among men was lung cancer (45.32%), followed by prostate (22.13%) and colorectal (11.37%) cancers; among women, it was breast cancer (22.74%), followed by colorectal (12.65%) and lung (6.43%) cancers (23).

In 2010 the infant mortality rate was 7.7 per 1,000 live births, with predominance of neonatal mortality (4.02 per 1,000). The leading causes of infant death were perinatal conditions (27%) and congenital malformations (21%) (24). Mortality in children under 5 was 10.9 per 1,000 live births in 2009. The goal established by the MDGs is to reduce under-5 mortality by two-thirds from its
1990 level, that is, to 7.8 per 1,000 live births in 2015; this will require specific actions directed to at-risk and marginalized groups and strategies to eliminate geographic inequities (25). There were 2,383 deaths among adolescents and young adults between 2005 and 2009. Of these deaths, 60% were due to external causes (traffic accidents, suicides, and homicides), and 80% were male (26).

**Morbidity**

**Communicable Diseases**

**Vector-borne Diseases**

There are no cases of indigenous dengue. The *Aedes aegypti* mosquito is found in several departments, especially on the western coast and around the capital. Entomological surveillance in 2010 using the *Aedes aegypti* Infestation Index Rapid Survey found house infestation levels below 3.9% (low to medium risk), thanks to a rigorous prevention plan to control the infestation (27). With respect to Chagas’ disease, in 1997 Uruguay certified interruption of the vector-borne transmission of *Trypanosoma cruzi* by *Triatoma infestans*. Efforts are under way to eliminate focal residual populations of this vector in three departments: Rivera, Tacuarembó, and Colonia (28). There were no reported cases of human or animal leishmaniasis during the reporting period; however, in 2010 the vector *Lutzomyia longipalpis* was detected in Bella Unión (Artigas Department) and Salto Department.

**Vaccine-preventable Diseases**

The free and compulsory immunization program has been successful in reducing incidence of these diseases, maintaining coverage of and access to vaccination, introducing new vaccines, and strengthening the participation of public and private sectors. Since 1987 the Honorary Commission to Fight Tuberculosis and Prevalent Diseases has been responsible for implementing the National Immunization Program, with 95% to 97% vaccination coverage of the target population. There have been no new cases of measles or rubella. Tetanus has been reduced with compulsory vaccinations for children and adults, with a single case in 2009. There has been no diphtheria since 1975. Hepatitis B was controlled by including it in 1999 in the Certified Vaccination Series; in 2010 there were 435 reported cases of non-A hepatitis (B, C, other), for a rate of 13.42 per 100,000 population (29).

**Zoonoses**

There were no reported cases of human or canine rabies between 2006 and 2010. This represents progress toward the goal of achieving certification as free of canine rabies V1 and V2, according to the recommendations of the Tenth and Thirteenth Meetings of the Directors of Rabies Control Programs in Latin America (REDIPRA X and XIII) (30). Hantavirus is endemic and there were 18 cases reported in 2010 (29). It primarily affects men and is related to rural labor and to residence in the rural and periurban areas south of the Río Negro. Leptospirosis is endemic, with epidemic outbreaks. It is predominantly occupational in nature and has a focal distribution, being found mainly in areas of dairy farming and rice cultivation, in socioeconomically marginal areas with precarious infrastructure, and in flood-prone areas. There were 97 cases in 2010, for an incidence of 2.99 per 100,000 population (29). There were 15 cases of brucellosis in 2010, all among meat workers in slaughterhouses (29). Cystic echinococcosis (hydatidosis) is endemic in rural livestock-raising areas, small population centers, and marginal urban settlements. Ultrasound screenings of people living in at-risk areas detected a prevalence of cystic images from 1% to 2%. The control program comes under the Honorary National Zoonosis Commission (Law 17.930 of 2005); its strategic plan calls for taking a comprehensive approach to the human-animal-environment interface and strengthening community participation (31). The plan has the support and technical cooperation of the Subregional Southern Cone Project for Hydatidosis Surveillance and Control.
Neglected Diseases and Other Infections Related to Poverty

In 2002 Uruguay achieved the elimination of leprosy as a public health problem at the national and subnational levels. Remaining cases are concentrated in the northwest of the country; in 2010 there were 11 cases in persons over age 5 (32). With regard to geohelminth infection, the priority areas are informal settlements in urban and periurban areas. An interinstitutional agreement between the intendancy of Montevideo and the School of Medicine between 1999 and 2008 allowed for the screening of 6,205 children from 0 to 3 years of age in day care centers. Prevalence of infection in those screened was 8%; annual incidence was 5.4% in 2000 and 9.8% in 2008 (33).

HIV/AIDS and Other Sexually-transmitted Infections

Actions at the national level maintained a low prevalence of HIV/AIDS (0.42) in the general population for 2008–2009 (34). The epidemic is concentrated in vulnerable groups (sex workers, men who have sex with men, and prison populations); 54.1% of the cases between 2005 and 2010 were in males. Mortality from AIDS was 5.05 per 100,000 population in 2009. In that same year, 75% of new HIV cases were in Montevideo and 25% in the rest of the country. Universal access to antiretroviral therapy has been mandated since 1997, but coverage is estimated at 83% (34). The current challenges are to lower the costs of the medication, to facilitate access of the most vulnerable groups by providing user-friendly services and training for counselors at all levels, and to promote early diagnosis. These challenges will be addressed by the project “Toward Social Inclusion of the Most Vulnerable Populations and Universal Access to Prevention and Integrated Care of HIV/AIDS in Uruguay,” approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria in Round 10. In addition, there will be continued cooperation with the UN Theme Group on HIV/AIDS and with Uruguay’s Commission to Combat HIV/AIDS (Comisión de Lucha contra el Sida, CONASIDA).

Emerging Diseases

During the influenza A(H1N1) pandemic, a national, intersectoral contingency plan allowed for adequate surveillance and treatment of cases. The fact that most patients were cared for at home by community health workers meant that hospitals were not overwhelmed, and there was wide receptivity to vaccination.

A project is currently under way to strengthen epidemiological surveillance of severe acute respiratory infections (SARI).

Chronic, Noncommunicable Diseases

In 2006, the first national Noncommunicable Disease Risk Factors Survey in the adult urban population (25–64 years) revealed hypertension at 30.4% (33.4% in men), overweight or obesity at 56.6% (60.1% in men), and high cholesterol at 29.2% (18).

Cardiovascular Diseases

Cardiovascular diseases are the leading cause of morbidity in the adult and elderly population. Control of coronary disease has improved through the use of new methods of diagnosis and treatment and the installation of fixed and mobile coronary units. The control and monitoring of hypertension is deficient. Hospital admissions for acute myocardial infarction declined by 17%.

Malignant Neoplasms

The National Cancer Registry estimates incidence and trends. The most common cancer in men is prostate cancer (55.7 per 100,000), and in women it is breast cancer (71.3 per 100,000) (35). Neoplasms accounted for 7.8% of hospital discharges from nine private institutions in 2009 (36). The National Oncology Network works in the areas of prevention and treatment. The Oncology Palliative Care Manual for Primary Care was published in 2008.
Diabetes

The Noncommunicable Disease Risk Factors Survey of 2006 revealed a prevalence of high blood glucose of 5.5% (6.2% in men). Work is under way on draft legislation for a national diabetes program comprising prevention, high-quality health services, promotion of healthy lifestyles, and establishment of a national diabetes registry.

Nutritional Diseases

In the population from 24 to 64 years of age, 56.6% are overweight or obese (60.1% of men). Fruit and vegetable consumption is insufficient in 85% of the population. According to UNICEF data, in children up to 24 months old in 2007, the prevalence of growth retardation was 11.3%, underweight was 3.4%, emaciation was 1.9%, and obesity was 8.5%.

Mental Disorders

In the field of mental health, plans have been redesigned for control and monitoring, production of guidelines and indicators, and progressive implementation of benefits. The suicide rate was 17 per 100,000 population between 2006 and 2010.

Other Health Problems

Oral Health

The incorporation of an oral health component in the SNIS was mandated by decree in 2008 and the definition of required benefits for all health providers was included in the Comprehensive Health Care Plan. In 2010, in a population of 4,817 children, 33.9% had caries in permanent teeth and 39.3% in deciduous teeth.

Risk and Protection Factors

Smoking

According to data from the WHO Framework Convention on Tobacco Control, the prevalence of smoking in Uruguay declined from 32% in 2006 to 24% in 2009; this is attributed to the effects of Law 18.256, which aims to control this habit. Occupational exposure to tobacco smoke declined from 36% to 17%.

Alcoholism

Binge drinking is more prevalent in men (17.4%) than in women (7.9%). The highest levels of abuse among men are in 25- to 34-year-olds (23.3%); among women, the highest levels are among 35- to 44-year-olds (8.7%) (16).

Illegal Drugs

The national strategy on illegal drugs is implemented by the National Drug Board, which is responsible for drafting public policy and ensuring individual and collective rights. There is a Comprehensive National Plan to Combat Drug Trafficking and Money Laundering. Health teams have set up a Drug Treatment Network, and have established specialized treatment centers.

Physical Activity

Thirty-five percent of the population has a sedentary lifestyle, while 38% has a high level of physical activity. Women have a greater tendency to be sedentary (40.7%) (15).

Health Policies, the Health System, and Social Protection

Progress is being made toward universal health insurance within the framework of a structural reform initiated in 2008 that promotes changes in management, care, and financing models. Two tools are key to implementing and sustaining these
reforms: the National Integrated Health System (SNIS), as the organizational and functional expression of the public-private network of health services, and the National Health Fund (FONASA), which provides financing of health care through compulsory public insurance. These are accompanied by tax reform and a new social protection scheme that reflects the political decision to promote redistribution of income and social protection for the most vulnerable sectors.

Universality, contributions from beneficiaries according to their income, and the allocation of benefits according to needs are the core criteria of a project based on solidarity and recognition of consistently enforceable rights. The increase in the public budget with an increase in social spending has made it possible to use fiscal resources to complement the contributions of individuals to the social protection system. Priority is given to interventions that benefit children and youth in a context shaped by the biological, social, and intergenerational cycle of poverty and exclusion. In order to confront the social stratification in the system, the reform has promoted interinstitutional cooperation, strengthened leadership, implementation of sectoral policies, and effective fulfillment of the essential public health functions. A political and social dialogue was launched between the various stakeholders involved in the protection and promotion of health, and health financing was integrated in a mandatory public fund, granting regulatory and planning authority to the State.

The Health System’s Stewardship Role

Formation of the SNIS and FONASA made it possible to consolidate the steering role exercised by the Ministry of Public Health and the National Health Board (JUNASA). Performance contracts are signed with public and private providers that regulate their service delivery and guarantee quality of care. These agreements provide for sanctions in cases where providers do not fulfill their obligation to deliver the contracted benefits, in order to ensure that the changes in care and management models are comprehensive and sustained. Monitoring is the responsibility of a dedicated inspection body.

The Ministry of Public Health retains authority with respect to sectoral leadership, definition of essential public health functions, and the regulation, authorization, and accreditation of health services and professionals. JUNASA oversees coverage and financing arrangements and regulates service delivery.

The Social Security Institute (Social Welfare Bank) carries out the administrative and accounting management of FONASA. This process takes advantage of the established capacities for social security coverage of the country and avoids the creation of a cumbersome new bureaucracy to carry out functions that existing agencies with management experience were already performing.

The Health System’s Performance

In March 2010 a decision was made to gradually expand the coverage provided by FONASA and improve the quality of care in a “Second Stage of Health System Reform.” This phase featured the decentralization of the State Health Services Administration (Administración de los Servicios de Salud del Estado, ASSE) and emphasized the role of the National Health Board (JUNASA), which is the agency responsible for management of the system. Its board of directors includes representatives of the Ministry of Public Health, the Social Welfare Bank, the Ministry of Economy and Finance, trade unions, users, and service providers in the public and private sectors. JUNASA signs performance contracts with public and private providers (37); the fundamental clauses promote health services based on primary care, define the explicit guarantees of the Comprehensive Health Care Plan, and set service delivery goals against which to evaluate the performance of providers according to the priorities defined by the Ministry of Public Health. The ASSE also signs performance agreements with its implementing units to ensure improvements in health care.

The management model includes instruments to foster participation and social control by users at
different levels of the health system. In addition to the progress in promoting social participation, there have been advances in reforming and strengthening primary health care. A set of comprehensive and integrated interventions is being implemented by the health services that make up the SNIS, leading to the formation of local networks of institutions. The reform has helped to reduce inequality as measured by the Gini index (from 0.4628 to 0.4526) and has been favorably received overall. Opinion surveys in 2011 found that 65% of the population assessed the reform as “good” or “very good” and only 9% as “bad.”

**Health Legislation**

Between 2005 and 2007, amid intense parliamentary and public debate on the content and scope of the health sector reform, four pieces of legislation were drafted to codify its institutional and legal framework: Law 18.131, which created FONASA; Law 18.161, which provided for decentralization of the ASSE; Law 18.211, which created the SNIS; and Law 18.335, which defined the rights and obligations of patients and users of health services. These instruments establish the competencies, rights, and obligations of all the institutions that make up the health care network, as well as the chronological sequence of the changes, the population groups affected, and the requirements for gradual integration into FONASA, in order to calculate and provide financing for the reform as it develops over time. Law 18.161, on decentralization of the ASSE, removed the principal comprehensive public provider from the Ministry of Public Health, explicitly separating the functions of steering and governance of the system from those of service delivery; previously both were performed by the same institutional and legal entity. The ASSE was transformed into a public corporation, with autonomy from the Ministry of Public Health, a change that formally empowers the ASSE to establish complementary relations and competition with the rest of the services. Law 18.211 is the framework law that creates the SNIS, articulating the various provisions and guidelines that define the structure of the health system as a whole.

The SNIS, which is a political and functional expression of the health sector reform, was conceived and implemented along with tax, educational, and labor reforms. It is an important component of the Equity Plan launched in 2007. As an urgent response to the social emergency affecting the most vulnerable population, steps were taken to create an extensive social protection network that includes conditional cash transfer programs (known as Citizen Income and the New Family Allowance Scheme) whereby beneficiary households are required to fulfill obligations related to health and education. Other elements of the network are allocation of a food card to those with unmet nutritional needs, promotion of employment for youth and women, and universalization of early childhood education and physical education.

**Health Expenditures and Financing**

Health expenditure grew 23.1% between 2004 and 2008, to approximately US$ 2.410 billion in 2008, or 7.5% of GDP. Per capita health expenditure grew 22%. Social protection in health expanded within the framework of the SNIS in two respects: it developed into coverage for the whole nuclear family unit, gradually incorporating the children and spouses of contributors, and it became lifelong insurance. The fund redistributes financial resources from lower-risk population groups with lower use of the health services toward higher-risk groups with more intensive use (risk being associated with age and sex). This eliminates the distortion resulting from adverse selection of users and strengthens intergenerational solidarity. The bonus payment to providers for meeting service delivery goals is 10% of the average “health quota” and is granted when the achievement of health objectives is confirmed (for example, completion of the immunization series in children younger than 12 years).

The distribution of expenditure also advances greater social justice. In 2005, expenditure per user was US$ 45 per month in the private sector and

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US$ 14 per month in the ASSE, a ratio of 3 to 1. To remedy this situation, the budget of the ASSE was increased from US$ 190 million per year in 2005 to US$ 690 million in 2011. The expansion of coverage under FONASA decreased the user population of the ASSE by some 300,000 people. The system allows users free choice of services and the majority opted for private providers, reflecting the widespread assumption that public services are for the poor and are of lower quality. Expenditure per user in 2010 was US$ 48 per month in the private sector and US$ 41 in the ASSE, a ratio of 1.2 to 1.

The changes in the health system also gave the population greater access to services by totally eliminating (or in some cases reducing) copayments. Such payments function as a barrier to access in a model of care that emphasizes prevention and rehabilitation.

**Human Resource Development Policies**

In 2010 the Ministry of Public Health created the Division of Human Resources to give priority attention to the development of the health workforce. It adopted a model with a dual focus on capacity building and management of human resources for health. Initiatives to adapt the training of health personnel to a model based on primary care pose a challenge in a public-private health care system.

The health workforce is unevenly distributed geographically. Although the value of a multidisciplinary team is recognized, there is no strategic plan for the organizational and functional integration of such a team into the system. Fragmentation of service delivery also is a problem that hinders the reorganization of human resources for health. The priority lines of work are the harmonization of pay scales and the resolution of discrepancies, building an information system on human resources for health, development of the nursing profession, and implementation of actions aimed at meeting Regional Goals for Human Resources for Health. The principal components include: (1) the Uruguay node of the Virtual Public Health Campus (the Ministry of Public Health, the ASSE, and the University of the Republic have developed thematic courses on primary care, human resources for health, social determinants of health, local development, and formation of a network of tutors); (2) reform of curricula at the undergraduate and graduate levels in order to adjust to changes in the model of care (with special attention to the consolidation and expansion of the new curriculum for the medical degree), and establishment of a Primary Health Care Institute; (3) capacity building in health system management at the national and departmental levels, and training of Integrated Health Service Delivery Networks; and (4) tailoring the profile of primary health care professionals so they can best fit the requirements of the performance contracts and service delivery goals (ASSE, intendancies, and private sector).

**The Health Services**

Legislation has introduced the possibility of using generic drugs and substituting brands, which requires mechanisms to ensure bioequivalence and bioavailability. Advances have been made in rationalizing use, encouraging appropriate prescription practices, and evaluating health technologies for cost-effectiveness. Capabilities are being developed to promote technology transfer, innovation, and proper management of intellectual property issues. A collaborative action network known as RITTi (Technology Transfer and Innovation for Health in the Americas) brings together different technical cooperation initiatives and agencies with the National Agency for Research and Innovation (Agencia Nacional de Investigación e Innovación, ANII).

The progress and exponential growth of technology in medicine makes it necessary to address the financial risks associated with providing coverage of catastrophic diseases and equitable access to highly specialized and high-cost medicine. Under the reform, the National Resources Fund (Fondo Nacional de Recursos, FNR) is a centralized body that is complementary to, and financially and institutionally independent of, FONASA. It provides
coverage for a large package of highly specialized medical services for diseases that are generally of low prevalence but that require intensive use of technological and financial resources, with a potentially negative impact on providers who respond to these socially significant and sensitive situations. More than 250,000 patients have benefited from 16 techniques in cardiology, traumatology, nephrology, and burn treatment, provided by 27 institutes of highly specialized medicine and 41 hemodialysis centers, mainly in the private sector. The FNR administers strict inclusion protocols with scientific verification of high-cost medicines for the SNIS. Its quality control measures have been accompanied by preventive programs that seek to control risk factors for the covered pathologies. The FNR’s smoking cessation, renal health, and cardiovascular health programs have been effective.

**KNOWLEDGE, TECHNOLOGY, INFORMATION, AND HUMAN RESOURCE MANAGEMENT**

**Scientific Production in Health**

There are gaps in the production of knowledge about public health. Two institutions in Uruguay take the lead in this field: (1) the University of the Republic, whose School of Medicine provides a forum and resources for the generation of knowledge, and (2) the National Agency for Research and Innovation (ANII). An important partner of the university, ANII was set up to design, organize, and administer plans, programs, and instruments aimed at scientific and technological development and the strengthening of capacity for innovation. ANII helps build and coordinate networks of actors involved in the creation and utilization of knowledge in order to strengthen collaboration and optimize the use of available resources. There is also a National Strategic Plan on Science, Technology and Innovation (PENCTI) within the framework of an Interministerial Cabinet for Innovation.

There is very high penetration of telecommunications in Uruguay. In 2010 the Communication Services Regulatory Agency reported that 383,000 consumers had fixed Internet access services and 453,000 had mobile Internet access services. There are 491,000 subscribers to television subscription services (cable or over-the-air), and more than 90% of the population has access to regular television broadcasts. Radio broadcasts reach the entire nation. These communication tools can provide strong support for the dissemination of health information, although their use for this purpose is still limited. Certain websites are well-used sources of information, including those of the University School of Medicine, the Ministry of Public Health, the University School of Nursing, the Virtual Health Library, and the PAHO/WHO Country Office.

There is no national system of information on morbidity, and the provision of basic health data to international organizations is irregular.

**Human Resources**

Beginning in 2009, the Ministry of Public Health compiled a registry of the quantity and types of human resources available in the public and private delivery system, beginning with the First National Census of Human Resources for Health (2008). A census of nursing personnel is planned for 2011 in cooperation with PAHO. The Ministry’s Division of Human Resources has published informative documents, among them Profile of human resources in the health sector in 2008 and Report on human resources for health in 2010. According to the latter report, there are 12,253 nurses employed in the private sector and 7,331 in the ASSE, along with 9,791 physicians in the private sector and 5,948 in the ASSE.

The Division of Human Resources of the SNIS has information on the professional and technical career paths in the health field offered by the University of the Republic.

The regional project of the Ibero-American General Secretariat, working under the leadership of the Ministry of Public Health, has generated regional meetings and studies that assess the impact of the migration of health professionals, especially physicians.
Uruguay has a strong tradition of active participation in international diplomacy, with promotion and defense of multilateralism and of the United Nations system. The 14 resident agencies and funds of the United Nations in Uruguay are participating in the pilot project called “Delivering as One” (“Unidos en la Acción”), which contributes to reform of the United Nations, guided by the United Nations Development Assistance Framework for 2011–2015 and its corresponding Plan of Action. This focuses on four priority areas: productive diversification and international insertion, environmental sustainability, equitable social development, and democratic governance and human rights. Uruguay is the only country of the Americas that is participating in this project. The only significant donors of international resources to the United Nations system in Uruguay, the European Commission and the Spanish Agency for International Development Cooperation, contribute resources to the Coherence Fund, which finances joint projects under Delivering as One.

As an upper-middle-income country with a high human development index, Uruguay is considered by the international financial institutions to have “graduated” from receiving international assistance, and in recent years has been considered a partner in the international development community. The creation of the Uruguayan International Cooperation Agency within the Presidency of the Republic, with responsibility for coordinating international cooperation across sectors, is emblematic of this change.

Two major projects in health are currently supported by international funds: a World Bank credit of US$ 25 million for the Non-Communicable Diseases Prevention Project (2008–2012), and a US$ 7.6 million project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria to be carried out during 2012–2017.

Within the framework of MERCOSUR’s Working Subgroup 11 on health, significant progress has been made in integrating the disease surveillance and response systems of the countries in accordance with the International Health Regulations (2005); the initial effort extends to the Southern Cone, with a view to eventually expanding it throughout South America. In addition, several mechanisms have been established for bilateral exchange of health services in border areas of Uruguay, particularly with Rio Grande do Sul (Brazil), along with South-South cooperation initiatives in training human resources for health.

The recent world economic crisis has had relatively little impact on Uruguay’s dynamic economy. The country has a small population and good social and health indicators. However, there are certain areas of concern that need to be addressed.

One has to do with care for the elderly—in the context of a rapidly aging population—and for people with disabilities. The role of caregiver is typically assigned to women, hindering their integration in the paid workforce. To address this gender inequity, there is an urgent need to set up a national comprehensive care system. Another concern is conditions for the biological and social reproduction of the population, which is more accelerated in the poorer sectors of society. There is a need for interventions in the prenatal period and early infancy, for early stimulation programs, and for strengthening the intersectoral matrix of social protection with a view to reducing inequities and overcoming inequality in the exercise of rights.

The high prevalence of chronic, noncommunicable diseases requires a model of care centered on health promotion and disease prevention in order to reduce or eliminate risk factors and harmful social determinants of health. The development of such a model is in progress and needs further consolidation, with an emphasis on empowerment and education of the population so that they can participate actively in building healthy environments. In recent years the health system reform has emphasized a model of comprehensive and integrated care, with quantitative and qualitative expansion of the Comprehensive Health Care Plan (e.g., to include mental and oral health) and reduction of copayments.
The reform process has been effective in reducing the segmentation of the health system and the fragmentation of services, with encouraging results. Going forward, priority should be given to actions to strengthen the network of public services; the ASSE, as the principal public provider, should spearhead this process and provide a model of quality care. Improving information systems, making adjustments in staffing patterns, and retraining professionals are challenges that must be met. It is important to expand and provide political and technical support for public-private and public-public partnerships.

The changes in health sector financing are oriented to the progressive convergence of the social security contributions to FONASA with contributions from the general tax revenues of the country. This represents a deepening of the national strategy to extend social protection in health in two respects. One is the accelerated expansion of coverage under the SNIS/FONASA, moving in the direction of universal coverage. The other is the increase in solidarity, equity, and sustainability, and in the redistributive function of public health policy. This is implied by the growing share of noncontributory resources in financing of FONASA, the delinking of coverage from the employment and welfare status of the beneficiaries, and the widening of guaranteed access to services of the SNIS.

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