

Uruguay



Uruguay borders on the west with Argentina and on the north and northeast with Brazil; on the east and south it borders the Atlantic Ocean and the Río de la Plata. It has a land area of 176,215 km² and a topography of low, rolling hills, vast plains, and a fertile coastline. Its climate is temperate. The government is a representative democracy, with executive, legislative, and judicial branches. The capital is Montevideo, and there are 19 administrative departments and 89 municipalities.

Uruguay is an upper-middle-income country that has enjoyed sustained, economic growth. Its gross domestic product (GDP) grew by 36% between 2004 and 2010. Its population is 98% urban, with 18.6% living below the poverty line. The total fertility rate, 1.99 children per woman, is slightly lower than the replacement level.

MAIN ACHIEVEMENTS

HEALTH DETERMINANTS AND INEQUALITIES

Universal educational coverage has been achieved for children aged 4 and 5, with substantial coverage of children aged 3. Secondary education coverage in 2008 was 70%.

Bridging the digital divide in education by facilitating the use of new information technologies is being accomplished through the distribution of free personal computers with Internet access to all schoolchildren. In 2009, 380,000 computers were distributed. Some 220,000 new households have a computer—half of the poorest quintile of the population—and 2,068 schools have been connected to the Internet.

THE ENVIRONMENT AND HUMAN SECURITY

Forests cover 3.7% of the nation's land area; the native forest is protected by the Forestry Law, which prohibits logging.

The National Environment Directorate is building capacity for the environmental management of persistent organic pollutants. The country imports 6,000 tons of pesticide annually. The School of Medicine's Department of Toxicology is a PAHO/WHO Collaborating Center in human environmental toxicology.

Progress has been made in occupational health, manifested in policies to ensure healthy work environments and the creation of joint health and safety commissions. The National Emergency System was established for coordination, prevention, and relief in seasonal disasters.

HEALTH CONDITIONS AND TRENDS

Maternal and child morbidity and communicable disease rates have fallen, leading to an increase in life expectancy. The burden of chronic, noncommunicable diseases has increased. Uruguay has one of the lowest maternal mortality rates in the Region. In 2010, it reported 8.5 maternal deaths per 100,000 live births, with infant mortality standing at 7.7 deaths per 1,000 live births.

Selected basic indicators, Uruguay, 2009–2010.

Indicator	Value
Population 2010 (millions)	3.3
Poverty rate (%) (2010)	18.6
Literacy rate (%) (2009)	98.3
Life expectancy at birth (years) (2009)	76.1
General mortality rate (per 1,000 population) (2009)	9.4
Infant mortality rate (per 1,000 live births) (2010)	7.7
Maternal mortality rate (per 100,000 live births) (2010)	8.5
Physicians per 1,000 population (2009)	2.9
Hospital beds per 1,000 population (2010)	1.2
DPT3 immunization coverage (%) (2010)	95.0
Births attended by trained personnel (%) (2010)	99.9

There were no reports of dengue, leishmaniasis, or Chagas' disease. The immunization program is free, compulsory, and successful; no cases of measles or rubella have been reported. Compulsory vaccination has reduced tetanus. Hepatitis B has been reduced by including the vaccine in the immunization schedule. There have been no reports of human or canine rabies. Hantavirus infection is endemic and predominates in men and rural areas; 18 cases were reported in 2010. Leptospirosis and hydatidosis are endemic, work-related, and focally distributed.

HIV/AIDS prevalence is low and concentrated in sex workers, men who have sex with men, and people confined to institutions. AIDS mortality in 2009 was 5.1 deaths per 100,000. During the influenza A(H1N1) pandemic, the national contingency plan ensured adequate surveillance and care.

In 2009, total mortality was 9.6 deaths per 1,000 population. Chronic, noncommunicable diseases were the main cause of death. The principal causes of death by group were: cardiovascular diseases (30.6%), neoplasms (24.8%), respiratory diseases (9.2%), and external causes (6.6%). The management of heart disease has improved through new diagnostic and treatment methods.

HEALTH POLICIES, THE HEALTH SYSTEM, AND SOCIAL PROTECTION

Health expenditure rose by 23.1% in the period 2004–2008, reaching 7.5% of GDP, while per capita health expenditure grew by 22%. Social protection in health increased under the Integrated National Health System (SNIS), which

Structural Reform of the Health System

In 2008, Uruguay began a structural reform of its health system, designed to move the country toward the adoption of universal health insurance. The reform rests on four pieces of legislation: Law 18131, creating the National Health Fund (FONASA); Law 18161, decentralizing the State Health Services Administration (ASSE); Law 18211, creating the Integrated National Health System (SNIS), charged with organizing and running the public-private health care network; and Law 18335, on the rights and responsibilities of patients and users.

Universality, premiums determined by the subscriber's income, and needs-based services are the core of a reform based on solidarity, with an approach that guarantees respect for rights without restriction.

Separating the Ministry of Health from the main public provider made it possible to differentiate governance from health care delivery functions. The ASSE became a state public enterprise, independent of the Ministry.

Under the new system, service contracts are signed with providers. These contracts promote health services based on primary care and, based on the care priorities set by the Ministry of Health, spell out the guarantees provided under the Comprehensive Health Care Plan and the service goals used in evaluating performance. The management model includes instruments for user participation and input.

expanded coverage to the entire family unit, gradually adding the children and spouses of subscribers. Furthermore, the SNIS coverage became life-long insurance. The fund redistributes financial resources from the population that makes less use of the health services (lower risk) to groups that make more use of them (higher risk).

There is greater equity in expenditure distribution: in 2005, monthly expenditures were US\$ 45 per private

user and only US\$ 14 per public user. In order to rectify this, the public budget was increased from US\$ 190 million annually in 2005 to US\$ 690 million in 2011, resulting in monthly expenditures of US\$ 48 per private user and US\$ 41 monthly per public user. The changes in the health system also gave people greater access to health services by fully or partially eliminating copayments.

Health professionals are concentrated in the major cities. Although the value of a multidisciplinary team is recognized, there is no strategic plan for its organizational and functional integration into the system. In 2010, the Ministry of Health created the Human Resources Division to prioritize the development of human resources for health, with a special focus on education, training, and practice. Initiatives are in place to steer human resources education toward a model based on primary care, which poses a real challenge.

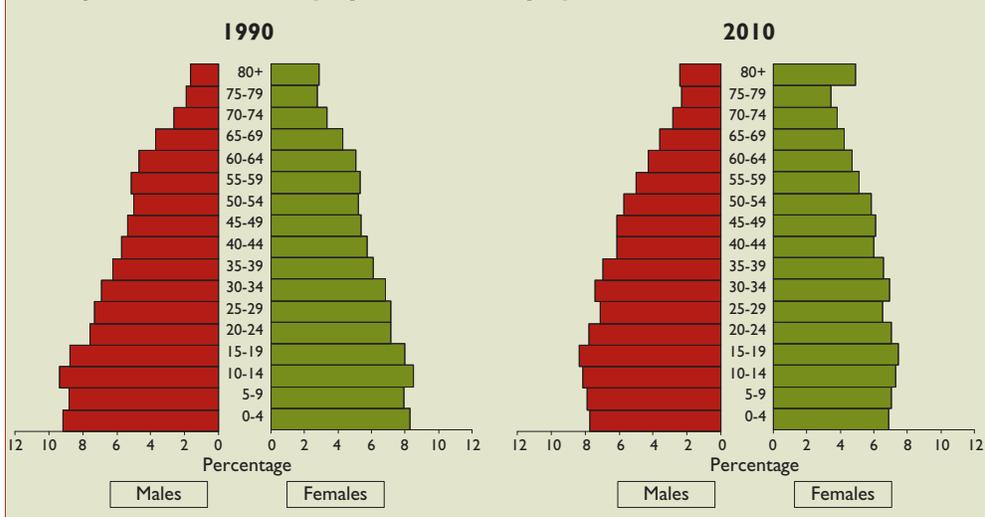
In mental health, national control and surveillance plans have been reformulated, guides issued, and services gradually provided.

Progress has been made in the rational use and correct prescription of medicines, as well as health technology assessment based on cost-effectiveness criteria. Uruguay has 19,791 physicians in the private system and 5,948 in the public system (State Health Services Administration).

As an upper-middle-income country, Uruguay no longer receives international assistance funds. It currently has only two health projects funded with international resources: the Chronic Disease Prevention Project and the recent proposal to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. It has made progress in integrating the surveillance and response systems, as required in the International Health Regulations.

Mechanisms for bilateral information exchange have been set up in border areas, particularly with Brazil.

Population structure, by age and sex, Uruguay, 1990 and 2010.



KNOWLEDGE, TECHNOLOGY, AND INFORMATION

Health science research is conducted at the University of the Republic's School of Medicine and the National Research and Innovation Agency, whose objectives are to promote science and technology development. The country also has a National Strategic Plan on Science, Technology and Innovation.

MAIN CHALLENGES AND PROSPECTS

Although Uruguay has made progress in primary education, its secondary education coverage is insufficient to attain the universal coverage required to achieve the Millennium Development Goals. Gender inequities in working conditions persist, creating gaps in access to a paying job (53.7% of women and 74.4% of men). The average compensation per work hour for women is 10 percentage points lower than it is for men. As for women's empowerment and the promotion of gender equality, despite a certain degree of progress, inequities in opportunities and working conditions persist.

Some 30% of agricultural land has been degraded by erosion, 87% of it in regions devoted to fruit and vegetable cultivation. Air pollution is minimal. Acute pesticide poisoning accounts for 16.5% of medical consultations, 76% of them associated with household pesticides. In agriculture, 36% of health problems are caused by insecticides, one-third of them occupational and accidental in origin.

Every year, some 75 cases of rape are reported—the tip of the iceberg of a hushed-up problem. Domestic violence reports rose by over 20% between 2008 and 2010.

Among people of African descent (10% of the total population), secondary and tertiary school enrollment is lower and poverty levels higher than in the rest of the population; working conditions for this group are also difficult.

The National Road Safety Unit, which regulates and coordinates prevention and control activities, is being strengthened. Traffic accidents are considered a public health problem.

The country has made progress in reducing maternal mortality, but the Millennium Development Goal is still far off. Since 2008, the health system has given priority to the early diagnosis and treatment of syphilis and HIV/AIDS; there is universal access to antiretroviral therapy and 83% coverage. The authorities expect to reduce drug costs, facilitate access by the vulnerable population, and ensure timely diagnosis.

Chronic, noncommunicable diseases are the main cause of disease and death. The National Noncommunicable Disease Risk Factor Survey (2006) found that 30.4% of the population suffered from hypertension, 56.6% were overweight or obese, 29.2% had high cholesterol, and 5.5% had diabetes. Only 2.7% of the population is not exposed to risk factors (56.8% have three or more). There is little monitoring and follow-up of people with hypertension. Some 85% of the

population does not eat enough fruit and vegetables. Smoking prevalence fell to 24% in 2009. Alcohol abuse is more common in men (17.4%) than women (7.9%). Around 35% of the population leads a sedentary lifestyle.

In men, the main causes of cancer mortality are lung cancer (45.32%), prostate cancer (22.13%), and colorectal cancer (11.37%), while in women, they are breast cancer (22.74%), colorectal cancer (12.65%), and lung cancer (6.43%).

In 2010, external causes (traffic accidents, suicides, and homicides) were responsible for 60% of the mortality in adolescents and young people; 8 out of every 10 of the victims were male. The suicide rate has been 17 per 100,000 population for the past five years.

Approximately 210,400 people have a disability. Some 17% of older persons require care to perform their activities of daily living, but only 26% receive it; this is becoming a challenge, given the aging of the population.

The exponential advances and growth of technology pose financial risks in terms of care and financial coverage for catastrophic illness and equitable access to expensive, highly specialized medicines—risks that must be addressed.

Although some health research is conducted, there are gaps in public health knowledge production. It is essential to move forward with the development of a health and management information system capable of shedding light on the national morbidity situation, ensuring that basic data are regularly provided for internal analysis and dissemination to international organizations.

Given Uruguay's current economic development and health situation, major challenges are emerging, such as the aging of the population, the growing population with disabilities, and gender inequity. The high prevalence of chronic, noncommunicable diseases demands a model of care centered on health promotion and disease prevention to reduce or eliminate risk factors and harmful social determinants. This model is being developed and must be consolidated.

The sectoral reform process has enabled Uruguay to reduce the segmentation of its health system to some extent. It must prioritize action to strengthen the network of public providers. As the agency that serves as the model for care and quality, the State Health Services Administration should be at the forefront of the process. Ensuring information systems, adequate staffing, and professional profiles suited to the country's needs is a pressing challenge.