

Health in Uruguay: Progress and Challenges in the Right to Health Care Three Years after the First Progressive Government

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*Do not guess,
Do not ask.
We will continue in our path
We will build our Program
We will develop our concept of a political force
This is our commitment.*¹

Dr. Tabaré Vázquez
Paso de los Toros – Tacuarembó
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Abstract

Using a social medicine perspective, this article describes the *Frente Amplio* [Broad Front] government strategies for creating a more social, productive, democratic, innovative, and culturally integrated Uruguay. This nation will recognize health as a basic human right, is concerned about the general well being of its population, and understands the need for public health reform.

The present health reform is at the heart of Uruguay's current social, economic and political transformations, changes which have a moral-ethical and social justice dimension. The health proposal calls for substantive transformation, requiring three parallel progressive changes: in health care delivery, in health care management and in health care financing.

The current reform has created a mixed private-public Integrated National Health Care System and an increasingly well funded National Health

Insurance program. The process is new and evolving, transcendent, democratic, and participatory.

Keywords: social medicine, right to health, human rights, reform, Integrated National Health Care System.

Introduction

This article should be read as an attempt to describe and analyze the complex and unfinished transformation taking place in Uruguay's health care system. To speak of "health reform" in this small southern country requires that we visualize a utopia or, as stated by Uruguay's President, Dr. Tabaré Vázquez, "a concrete utopia."

As the founders of social medicine in Latin America have argued historically, any analysis of a given social sector that ignores its historical context and the dominant economic model will be, at the very least, inadequate. Worse, it could very well lead to erroneous conclusions.

If we accept that all analyses are complex and open to debate, then an analysis that considers the historical context, the model of economic development, and the role of various social sectors will inevitably be controversial. Our intention is not to be polemical, but polemics are part and parcel of social reality. They occur between governments and opposing political parties, even among the parties that make up the governing coalition.

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Historical context

This article will examine of the initial steps of a deliberate political change in the way that nation, society, and “man” are understood. Moreover, this is a change supported by over 50% of the country’s citizens.

For 174 years after Uruguay’s independence, the Colorado (Red) Party ruled the country with only two brief interludes of government under the National Party. And then the *Encuentro Progresista Frente Amplio Nueva Mayoría* (now known as the *Frente Amplio*) captured the national government. As of March 1st, 2005, Uruguay is headed by a socialist physician who was President of this coalition of left and center-left parties. This electoral victory was the culmination of a 33 year political struggle.² Thirteen of those years were spent clandestinely, living with political persecution, imprisonment, torture, and forced disappearances.³ The illegitimate civilian-military dictatorship, backed by other countries in the region and the US through the so-called “Plan Condor,”⁴ used “state terrorism” as strategic policy.

The country that welcomed the new *Frente Amplio* government could be summed up as follows: There was a large debt both foreign and social (in terms of unmet social needs). The productive system had been dismantled and the perpetrators of human rights abuses pardoned.

From December 2000 to December 2002, the Uruguayan government’s debt rose from \$9,100 million USD to \$11,400 million USD, representing 120% of the GDP.⁵ By 2004, the debt accumulated in the 25 years preceding the *Frente Amplio* government had grown by 711% (42% of the GDP), from \$1,266 million USD or 16% of the GDP to \$19,979 million USD or 147.5% of the GDP.⁶

The poorest sectors of the population suffered most from the 2000-2004 government’s mismanagement of the economy. But the middle class also experienced massive disruption. The social crisis was evident in the lack of job opportunities, food, clothing, housing, and public health services. Extreme poverty increased from 2.03% in 2001 to 5.99% in 2004, reaching as much as 7.26% in Montevideo, the nation’s capital.⁷ Nationally,

poverty had increased from 27.01% to 40.96% and was as much as 41.54% in Montevideo.⁸

The decade of the 1980s ended with a decline in real wages, which had decreased by 21.16%. This was further exacerbated during the 90s. On average, a 27.1% loss in real wages was seen between the years of 2000 to 2004. More than 90% of the loss in real wages occurred in 2002.

Unemployment reached 19.2% for the September/November quarter of 2002. During 2004, unemployment averaged 13.1%. The intensification of anti-union measures weakened the ability of workers to obtain better working conditions. The strongest unions represented state employees. These factors resulted in a significant social demobilization.⁹

The public educational system underwent a progressive deterioration characterized by lack of resources and a decline in quality of services. While these factors affected the entire system, they particularly impacted the most economically and socially marginalized students. Education was no longer able to reverse the disadvantage caused by poverty and marginality among children and young adults.

A sharp social polarization was evident in a spatial-urban segregation. This was due to the explosive growth in people living on occupied urban spaces (illegal settlements).

For the public health system, the worst years of crisis occurred from 2000 through 2004. The 1999 recession, followed by the 2002 crisis, led to massive withdrawal from the Collective Medical Assistance Institutes which saw their membership drop by about 180,000¹⁰ to 219,000¹¹ between 1999-2003. These individuals were left without medical coverage, and had no choice but to rely on state funded services. However, government cutbacks in public spending had already destabilized public hospitals and other public service centers. The government could no longer provide an effective public health delivery system.

The sharp cuts in public spending were part of an economic model emphasizing excessive deregulation of commercial and financial enterprises. This had been the dominant model in Uruguay since the 70s and was markedly

accentuated in the 90s. This was a development model centered on the financial sector, and it introduced a strong speculative component. The priority was given to fiscal balance, rather than the deteriorating productive sector. With no protections or prior preparation the country was forced to compete in an international market where it was at clear disadvantage. This led to dismantlement of the national productive sector and of the state enterprises and the mortgage of the domestic market. The financial resources arriving from abroad were not used for productive investment, which would have improved the competitive position of the country. On the contrary, they were used to finance the consumption of imported goods, to cover the deficits arising from the country's lack of competitiveness, and to build up reserves that did nothing to stimulate national production. When the bubble burst, these financial resources proved ephemeral.

The Pardon of Human Rights Violators

In 1986, the National Parliament approved the “Ley de la Caducidad de la Pretensión Punitiva del Estado” [*Law allowing for the Expiration State's Right to Punish*]. The first article of this law states:

... the exercise of punitive claims for crimes committed prior to March 1st, 1985 by military and police officials, whether for similar political motives or in connection with carrying out their duties and during actions ordered by their commanders who served during the period de facto, has expired.

This law precluded prosecution for human rights violations. In addition, for “the greater peace of mind of those involved,” it was established that judges would only act if the executive branch specifically authorized them to do so; otherwise, claims would expire within 30 days. The executive branch—and not the justice system—determined which cases were covered by the first article of the law and conducted the necessary investigations needed to verify the truth when denunciations were made to the courts. The Inter-American Commission on Human Rights noted in its 29/92 Report (16 years ago) that the Act violated Article XVIII of the American Declaration of the Rights and Duties of

Man and Articles 1, 8, and 25 of the American Convention on Human Rights, signed by Uruguay.¹²

Program of the Frente Amplio Government¹³

The programmatic guidelines for the *Frente Amplio* government (2005-2010)^{14,15} established various axes for the government's work.¹⁶ These axes would allow the government to develop a comprehensive and coordinated strategy. This was a strategy for real change and not merely for patching things up:

A social Uruguay [is needed] because the greatest wealth of a country is its own people and because the current situation commits any national project to this perspective. ... [A] progressive government that does not confront and dramatically reverse the current social reality of the nation may call itself a government, but it will not be progressive. And we are committed to a progressive government.¹⁷

The social policy of a progressive government should involve the entire state and be democratically woven into the society. It should guarantee the basic needs of the entire population and create conditions that allow for the full development of the individual, based on the following principles: social justice, improvements in the quality of life, decent work, fairness and inclusion, distributive solidarity, participation and decentralization, health for all, the right to education, cultural development, social safety, and affordable housing.

A productive Uruguay, because in the path towards sustainable development, Uruguay must reorganize its economy, improve its government, establish clear rules for the relationship between the State and market economy, reassess the value of work, create jobs, produce, compete, and sell.¹⁸

The priority of *Frente Amplio* was to put the economy at the service of human beings, abandoning the economic conception of humans as mere economic agents whose essence and transcendence are ignored. The economy will need to be reorganized so as to simultaneously achieve productive growth, income redistribution, and stability of economic and social relations.

A progressive economic approach focuses on national employment; promotes economic integration; produces enough to meet the needs of the country and its people; generates the maximum possible value for the country; fosters competition; is sustainable; progresses towards a productive and socially supportive society, with mechanisms for the distribution of wealth, social inclusion and participation; gives the State an active role; carries out comprehensive financial and taxation reform; is aware that the country requires integration into MERCOSUR; seeks to solve the problem of the external debt without falling prey to the rigid conditions set by international institutions; and develops policies promoting innovation in science and technology.

*An innovative Uruguay “promotes technology and stimulates the entrepreneurial capacity of its people as a means of developing its economy ... promoting Uruguay as the authentic “Technological Pole” of MERCOSUR.*¹⁹

From a progressive standpoint, innovation must create fulfilling and skilled jobs, help the country produce more, make businesses more competitive, and create a productive economy. Innovation is not the only ingredient for the development of sustainable production, but it cannot be ignored. There is no development without innovation. These are the basic rights, responsibilities and capacities that Uruguay can and must address.

As a process that requires diverse inputs, innovation must be carried out with determination; it must be managed strategically with the objective of creating a National System of Innovation.

It requires a commitment by the government to develop a series of initiatives grouped into four broad areas. These are: an institutional structure which promotes innovation; a Strategic Innovation Plan based on the scientific and technological knowledge relevant to the current industrial reality; improvements in education at all levels including — but not limited to — that scientific and technological research which is closely related to the demands of society and of the industrial sector in particular; promotion of business investment in innovation that will improve and foster SAMES

(Small and Medium Enterprises) which invest in innovative production.

This progressive government is committed to strengthening the public resources allocated to science, technology, and innovation. Within the short term it has proposed allocating up to 1% of the national GDP to research and development.

A democratic Uruguay: *A democratized society and state “because we believe in society. We do not ignore its complexity or conflicts, nor do we sensationalize them, we aim to manage them in an effort to build a common future for Uruguayan society. [...] It is a matter of conviction and political willingness to recognize each other, to dialogue and come together for a common good. This conviction and political willingness clearly delineate our profound difference from a now-bankrupt form of government that, quite certainly, is not our government ...”*²⁰

The democratizing impulse promoted by the current political movement will have as its essential characteristic the express and clear reclamation of solidarity as an ethic and the development of a new set of progressive principles, aimed at overcoming those values founded in globalization and consumerism.

In this point in time the State will assume the leadership of national development. This will help resolve the increasing social inequalities prevailing in the country. The State will have a direct and active presence in all strategic areas of the economy. Its role as arbitrator and regulator will be developed and strengthened.

The state will promote the democratization of the media and means of communication, both public and private. It will encourage their use to serve the needs of the community; to advance the dissemination of art, sports, science, and technology; to promote national values; and give voice to the various social and political sectors in the country.

Justice is a fundamental principle. It is the responsibility of every democratic government to ensure its vitality and its implementation.

Unlike previous governments, a progressive government must exhaust all means to assure full

compliance with the Article 4 of the Impunity Laws. This article requires the explanation of the disappearances. The government is committed to truth and justice in connection with the crimes against humanity executed before and during the dictatorship. It will make every effort to achieve compliance with the principles outlined in the Constitution and the Law. The progressive government reaffirms its clear position that the requirements of international human rights treaties are of equal value to those of our national laws. In this regard, it will promote the alignment of domestic legislation with that of the international treaties ratified by the country. Until this occurs, it must be clear that actions by the judiciary will not be impeded in any way, as has been done in the past by the traditional political parties. On the contrary, all constitutional powers will be guaranteed to the Judiciary.

State terrorism was strongly condemned by the democratic and progressive forces and this principle will remain the new government's policy with respect to both national and international law. The historical memory of popular struggles and of those involved in those struggles will be reclaimed. It will become an essential part of the people's identity: past, present and future.

The strengthening and consolidation of Uruguay's political and institutional democracy is a significant element in the progressive mission. As part of this process it is necessary that freedom, justice, and active popular participation converge. The transformation of the State must be part of this movement towards genuine democracy. This will occur through radical improvements in the transparency and openness of the governing process; the creation of tools aimed at strengthening horizontal state control; popular (and genuine) participation in the decision making process; and in ongoing monitoring.

The full participation of the country's citizens is an additional guarantee of administrative transparency. It declares a frontal attack on all forms of corruption and demands legislation to address fraudulent behavior and economic crimes. At the same time, it is necessary to promote a better balance between the three branches of government;

in particular the effective economic autonomy of the Judiciary must be assured. This will guarantee technical independence and the provision of human and material resources for the work carried out by the Judiciary and the Administrative, Electoral and Auditor Courts.

Changes in the different Ministries will make them more responsive and efficient when attending to society's needs and demands. Special attention will be given to government agencies that are most closely in touch with everyday life. As such, preference will be given to programs and projects that are collectively coordinated and implemented.

Decentralization at the political and administrative level will be encouraged in order to foster citizen participation at all levels of government, both in the cities and in rural areas. This level of participation requires initiative, an active implementation of policies, and a comptroller of the State's activities at all levels. It requires citizens who are proactive and responsible for the management of this State we are fighting for.

Democratizing the State means reclaiming the place of the Parliament as a forum for critical debate. It is necessary to redefine Uruguay's democracy as the realization of a participatory and representative project.

A Uruguay integrated into its region and the world. *"We do not ignore the complexities in the process of integration, but we assume regional integration as a real strategy for the country. A country with its own development strategy is in a position to participate actively and innovatively in MERCOSUR and from there participate in the international market."*²¹

A progressive government will develop an independent foreign policy, acting in defense of its sovereignty and national interests. It will promote peace and the self-determination of its citizens. It will safeguard human rights, international détente, environmental policies, and relationships between States and peoples governed by international law.

It will recognize the principles of respect for territorial integrity and sovereignty; non-aggression, non-intervention, and non-interference in the internal affairs of others countries for economic,

political, or ideological reasons; equality and mutual benefit.

We will work to reform and strengthen the United Nations and a restructured Security Council. The government will use all means to encourage the democratization of multilateral agencies and the fulfillment of the resolutions of the General Assembly and the International Criminal Courts.

It is time to recapture the initiative and the leading role played by South American countries. Our countries, to the extent that they express the interests of their peoples, are more likely to engage in international solidarity and cooperation and to ensure that economic investments, commercial trade, or scientific-technological progress is in accordance with national and regional interests of its populations.

The integration of Latin America's peoples has been a cardinal, historical objective. Today it is essential for Latin America's development. In this regard, the *Frente Amplio*, while reclaiming the national government, also which pledges to work within MERCOSUR, so that the regional block demands the immediate and complete lifting of the inhuman blockade to which the Cuban government and its people are currently subjected.

The world is at the mercy of an unjust international order. Extreme wealth is concentrated within a small group of powerful nations while poverty increases throughout the rest of the planet. Through its foreign policy, Uruguay's progressive government will try to build a more fair international order by combating the destructive and unjust system that currently conspires against the most basic human rights.

Uruguayan culture, *"because culture provides an indispensable space for dignity, growth, integration and human coexistence in society. Culture is the collective creation of a people's identity; it expresses their shared essential values. Culture is also one of the strongest channels for the international projection of a nation. As such, there is no national plan without a national cultural policy."*²²

If Uruguay's social and productive forces are in a state of emergency, then its cultural wealth is in danger. Currently, Uruguay is experiencing a

scientific and technological revolution unlike any before. Yet there has been no similar evolution in our ways of thinking.

Without dismissing the inevitable debate regarding the role of culture as public service, we nonetheless propose to deepen the role of cultural democracy. It is impossible to exercise the rights of a citizen, either as actor or beneficiary, without an equal access to culture. To speak of cultural wealth means to eradicate cultural exclusivity and elitism and to create "citizens." Consequently, cultural diversity must be valued and promoted. Cultural diversity is central to social inclusion and to the identity, productivity, and sovereignty of a nation. It transcends borders. "Multiculturalism" should be viewed as the key to regional and global integration. Only when people begin to identify themselves as diverse parts of single dynamic unit, with a common past that unites all and drives all to a more successful future, will a regional identity (coexistent with current and tattered national identities) take form.

The state plays a pivotal role in cultural development. It is promoter, spokesperson, regulator and active participant. It is essential and of utmost importance to foster artistic creation and interpretation which can only result from national and regional improvements in educational, science and communication.

Challenges & Opportunities for the Right to Health

*A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations ... [A] State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations ... which are non-derogable.*²³

International jurisprudence is concerned with protecting the right to health through conventions, treaties and covenants, based on fundamental rights. The right to the highest attainable standard of health care was first established in the WHO's Constitution (1946), reaffirmed in the historic Declaration of Alma-Ata in 1978 and again in the People's Health

Charter adopted by the People's Health Movement in 1998.

Frankly speaking, however, national policies on health and the right to health have been only minimally connected to an international legal framework. If we were to briefly sketch the attitudes toward the right to health, we can distinguish four different stages in contemporary Uruguay: The first phase (1985 -1990) begins with the end of the dictatorship and is characterized by a benevolent State, reminiscent of Battlista politics, governing with the philosophy that "the state provides because it is good, not because it should." During the second phase (1990 -1995) of intensifying neo-liberalism the attitude was that "the State does not provide because it should not." A third phase (1995 - 2005) is characterized by a balance between the first and second phases: "the State does not provide because that's not its job and when it does provide, it is good." The fourth (and current) phase is characterized by a public acknowledgement of the right to health as the State's responsibility.

Since 2005, we are faced with a government that recognizes health as a right and a public good. This is a substantive and qualitative change. The state no longer tries to hide behind Article 44 of the Constitution, which makes health a duty and not a right. This reduces the State's role to merely aiding sick individuals in their time of need and caring for the indigent. In the document setting forth the "Background for the Major Programs of the *Frente Amplio* government (2005 – 2010)," the following is written:

*We understand that health is a fundamental human right. We propose the reform of Article 44 of the Constitution which should establish that the State has the duty and responsibility to assist in the health of all inhabitants of the country.*²⁴

We can say, therefore, that "the idea of the State as guarantor of the right to health" is rooted in the militants of the *Frente Amplio* Plenary. At the same time our rather old-fashioned Constitution sets limits on those rights. Despite this situation, no concrete steps have been taking to amend the Constitution. Only the Central Worker's Collective (*Central Única de Trabajadores, PIT-CNT*) has

come out in favor of this reform during its Ninth Congress held in October 2007.²⁵

On the other hand, the most prestigious supporters of the Constitution have argued about possible interpretations of Article 7: "The inhabitants of the Republic are entitled to be protected in their enjoyment of life..." This has been interpreted as suggesting a right to health.²⁶ The heated controversy regarding the Constitution has somewhat obscured Law 13.751, adopted by the General Assembly of the National Parliament in 1969 and which ratifies Uruguay's adhesion to the International Covenant on Economic, Social and Cultural Rights and its Optional Protocol.²⁷

We take the liberty of quoting the concept of the right to health as established in General Comment 14 of the International Covenant:

*The Committee interprets the right to health ... as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as ... access to health-related education and information [...] A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.*²⁸

Uruguay's Health System

The health system is composed of an ensemble of institutions, each with different areas of expertise, objectives, and organizational structures. The whole forms a complex, fragmented, unequal, and uncoordinated system. From a public health point of view, the system lacks a preventive and holistic approach to health, viewing patients as a collection of limbs and organ systems. It is physician-centered, paternalistic, overly biomedical, and provides care that is episodic and erratic.

The health system is divided into public and private sectors. The public sector is composed of the Ministry of Public Health (*Ministerio de Salud Pública MSP*), the Administration of State Health Services (*Administración de Servicios de Salud del Estado (ASSE)*), the Hospital of Specialties (*Hospital de Clínicas, Universidad de la República*), Veteran's Health Services, Police Health Services, the health services of the 19 States (*Depar-*

tamentos), the Bank of Social Welfare (*Banco de Previsión Social*) and the Medical Services of the Autonomous Entities and Decentralized Services (*Servicios Médicos de Entes Autónomos y Servicios Descentralizados*). The private health care sector consists of: Collective Health Care Institutions (*Instituciones de Asistencia Médica Colectiva* (IAMC), private hospitals, private insurers, institutes of highly specialized medicine, preventive medical clinics, diagnostic and treatment facilities, pharmacies and exclusively private care.

The private sector accounts for 75% of health expenditures; spending per user in the (private) IAMCs is two and a half times that of the (public) ASSE. There is a strong correlation between type of coverage, income level, and use of services. The result is a two tier system with *one type of health care for the rich and another for the poor*. The inequalities are even more pronounced when we consider that the population using public health services is generally needier. *The system spends the most on those who need it the least.*

Pre-Reform Uruguayan Health Care System ²⁹			
	Principal Providers	Coverage	Funding
Public Subsystem	ASSE Specialty Hospital	All those not covered by the other systems (48% of the population)	Tax Revenues
Social Security	Collective Medical Care Institutes (IAMC) under contract	Private employees Certain public employees Retirees with low-incomes (20% of the population)	Income-based contributions Tax Revenues
Private subsystem	IAMC	43% of the population (including social security)	Out-of-Pocket Funds from the Social Security System

Health Care Reform

Section 17.930 of the National Budget Law (December 23, 2005) contained the first legal steps designed to reform the national health system.

*The Ministry's budget will include funds for the development of an Integrated National Health System (Sistema Nacional Integrado de Salud, SNIS) and a National Health Insurance (Seguro Nacional de Salud, SNS), wage increases for the lowest paid workers, the strengthening of the primary care infrastructure, the rebuilding of training programs, the restructuring of pay scales, and the decentralization of the ASSE.*³⁰

Article 264 (expanded in 2007) specified that the Integrated National Health System would provide comprehensive care to all people residing in the country, guaranteeing equitable and universal coverage. The system is based on complementary private and public sectors. The overall strategic orientation is towards primary care. The system favors basic health services and fosters health promotion, prevention and rehabilitation.

Article 265 outlines how the National Health Insurance will pay for this health system. A constitutionally valid law will create the National Health Insurance and finance it through a separate Public Fund. Payments into this fund will come from State contributions, public and private enterprises and the users of the Integrated National Health System. Payments to public and private health care providers will be based on risk-adjusted capitation and service provision goals at each level of care.

In 2007, Parliament approved the two key laws that made clear its analysis and understanding of the proposed health care reform. Law 18.131 (May 18th, 2007) established the National Health Fund (FONASA). Law 18.211 (December 5th, 2007) “regulates the right to health protection of all residents of the country” by establishing “the means of access to primary care and the comprehensive benefits of the Integrated National Health System.” The regulatory decree of January 8th, 2008 further elaborated on these laws.³¹

During the new government's first 40 days in office two organizations were formed: the Committee on Bioethics and Comprehensive Health Care Quality (*Comisión de Bioética y Calidad Integral de la Atención de la Salud*, Decrees 610/2005 and 1082/2005), and the Advisory Council for Health Reform (*Consejo Consultivo de Salud Para los Cambios*, decree 133/2005), whose first meeting was on May 4, 2005. Its incorporation envisaged the broadest possible social and institutional participation: the Ministry of Public Health, delegates from throughout the public system, Collective Medical Care Institutes from both Montevideo and the rest of the country, organizations representing both private and public healthcare workers, physician organizations from throughout the country, Uruguay's Orthodontic Associations, organizations representing professional psychologists, the University of the Republic, the States Association, and health care users' organizations.

Throughout 2005 the Advisory Council worked on key aspects of health care reform. It organized itself into three working groups: National Health Insurance, the status of health care workers, and changes to the model of health care delivery. Four separate boards were established to represent the interests of specific groups: the Pharmaceutical Board, the Board of Medical Technologies, the Board of Emergency Services, and the Private Insurance Board. The outcome of this work has been extensively documented and discussed within the Advisory Council. A second discussion phase followed (2005-2006) with the following additional working groups created: definition of the comprehensive benefit package, delineation of the roles of the private and public sectors, and human resources policy.

According to the law, the Integrated National Health System will be guided by several general principles. Health promotion will focus on environmental factors and population lifestyles. Health policy will coordinate various social sectors with an impact on health. Coverage will be universal. Health services will be accessible and sustainable. Service provision will be equitable and continuous. Health care will be prevention-oriented,

holistic and human-centered. Services will be technically competent, up-to-date, and respect the principles of bioethics and the rights of the users. Patients will have a right to make informed decisions about their health. The social participation of workers and health care beneficiaries is encouraged. The system is funded on principles of solidarity. Sufficient resources are allocated for comprehensive care.

The law stipulates that the Integrated National Health System must fulfill the following objectives: achieve the highest attainable standard of population health through comprehensive interventions aimed at individuals and the environmental factors which promote healthy living; encourage the participation of all sectors interested in improving health; implement a comprehensive care model based on a common strategy, well designed health programs, comprehensive interventions, health promotion and disease prevention, early diagnosis, opportune treatment, recovery and rehabilitation of users, including palliative care, promote decentralization of management while setting national norms; encourage coordination between national and state institutions; organize service delivery according to levels of complexity and geographical area; achieve a rational utilization of human resources, materials, finances, and existing public health services; promote continuous professional development of public health human resources via teamwork and interdisciplinary scientific research; encourage the active participation of workers and beneficiaries; establish equitable funding for comprehensive health care.

The Integrated National Health System has to be *a decentralized public agency, under the auspices of the Ministry of Public Health and led by a National Board of Health. All public and private nonprofit health care providers will depend on the National Board of Health* which will establish national health policies, norms, and plans and regulate the hiring of providers. The system will be financed by payments into the National Health Insurance Fund.

The current health reform is at the heart of Uruguay's social, economic and political transformations, changes which also have a moral-ethical and social justice dimension. The health

proposal calls for substantive transformation, requiring three parallel progressive changes: in health care, in health management and in health financing.³²

The change in management was made evident by the previously mentioned Advisory Council and its working groups. Change was evident in the support provided for the development of patient and customer service organizations; in the transfer of responsibilities from the National Public Health Authority to 19 newly formed state health departments; and by the decentralization of the management of the national health care system through the creation of state-level coordinators. The transfer of responsibilities allowed each state to prioritize work based on the needs of specific geographic areas, by defining regions, zones and health areas. Strengthening of health care teams at the primary care level; improvements in management and in service delivery using available resources as well as inter-agency and public-private health care coordination where appropriate were also part of the change. Finally, the change brought democratization, greater transparency in the hiring process using public competitions, etc.

Change in the health care model is evidenced by the recognition of health as a fundamental human right, by the integration of social and environmental factors as determinants of health, and by developing policies that prioritize disease prevention and health promotion. These changes were brought about by the reorientation or the creation of national health priority programs. Priority programs established new national norms and were implemented by all providers in the Integrated National Health Service. Priority programs were created for Child Health, Adolescent Health, Adult Health, Geriatric Health, Women and Gender Health, STDs/HIV/AIDS, Nutrition, Oral Health, Smoking cessation, Disability, Mental Health, Accident and Injury Prevention, Eye health, Diabetes, and Cancer. The Ministry of Public Health also developed projects for Risk Management, created the Healthy Uruguay Project, strengthened the capacity for monitoring health by incorporating a national surveillance network for non-communicable diseases, developed plans for human resources development and set up a

management information structure. It also developed campaigns to combat outbreaks of hepatitis A, incorporated preventive vaccination interventions for seasonal influenza, and prepared emergency plans for the control of dengue fever and avian flu outbreaks.

The financing of health care was changed with the creation of the *National Health Fund* (FONASA) (Law 18.131, May 18th, 2007). The Fund is managed by the Social Welfare Bank and pays for the health care system and the medical needs of its recipients. As established by its regulations, FONASA is funded by mandatory contributions from workers, retirees and businesses; from State and non-state affiliated public contributions; and by a set percentage of the income of the Private Insurance Funds. Contributions are determined as follows: Public, private and corporate institutions contribute 5% of the value of salaries. If the combined contributions of the employee and employer do not cover the cost of providing coverage, the employer is required to make up the difference. Public and private employees pay 6% of their salaries if the salary exceeds 2.5 times the minimum taxable wage (about \$200 USD) and the employee had dependents under 18 or who were elderly and disabled, the rate is 4.5% if the salary exceeded 2.5 times the minimum taxable wage and there are no minors or disabled elderly in the family; and the rate is 3% if the salary is less than 2.5 times the minimum taxable wage irrespective of the family situation. Individuals who work less than 13 days or make less than 1.25 times the minimum taxable wage are not eligible for insurance, although an employer may voluntarily chose to cover them. Life members of the Collective Health Care Institutions with minors or disabled elderly at home pay 3%. If they have no children or disabled elderly at home, they pay nothing.

In the near future, the Integrated National Health System will provide coverage for all workers enrolled in the Social Security System, their domestic partners, their minor children, and disabled parents. Military personnel, police, and government personnel are exempted from the Integrated

National Health System, although the President may decide to include them.

The reform process, at its current stage of development, coexists with certain pre-existing government regulations on health care coverage. Thus, not having medical coverage through National Health Insurance does not mean that the person is left without medical coverage. Integration into National Health Insurance coverage implies the "provision of unique and comprehensive medical services". There is no "package" of benefits. The user chooses his or her health care provider from among those who are part of the system. Providers receive a capitated fee with bonuses for reaching certain quality targets (linked to health promotion and disease prevention). Payment by the user is based on a sliding scale calculated from a percentage of earnings and the family structure and on copayments that depend on the provider.

The Integrated National Health System does not include providers of only limited services. Limited coverage providers filled the majority of posts in health programs set up by unions or community groups. These organizations were "trying to provide some type of health service" for workers (either formal or informal) or for those communities which due to their large size, remoteness, poverty, organizational capacity, and resistance to the dictatorship were not receiving state or market solutions. Many of these services exist today in the form of community-based polyclinics, trade union health services or mutual aid societies. At the height of neo-liberalism in Uruguay, rising prices for basic comprehensive coverage led to the development of different types of incomplete coverage, known as "partial insurance." Medical insurance companies sought to capture the market niche of individuals who could pay, albeit less. Most of these were partial surgical plans and the people who purchased them found that their basic health care needs were not covered. In a similar vein programs were created such as mobile emergency services, prepaid medical or dental services, and to a lesser extent, psychological care. Currently, there are other providers - both limited and comprehensive - who are not yet incorporated to Integrated National Health System. Some public health services exist

only at a primary care level, while others have developed more specialized areas of care, such as the Sanatorium Canzani (created by the Social Welfare Bank), the clinical hospital of the University of the Republic (a comprehensive provider but with relatively little primary care when compared to its specialized services). The system also includes other university health centers that provide social services and community health promotion; as well as the military and police health services.

The next developmental challenge for the National System will be to absorb the plethora of small health care providers found in community centers, union programs, and mutual aid societies. This can be accomplished through their association with the public system including ASSE. This must be accomplished without discriminating against private-limited providers or compromising future public and/or community partnerships. This integration must also include the small mutual aid societies that meet public health regulations and operate according to law, before December 31st, 2010.

While one cannot deny that there has been progress, neither can it be said that the problems of health inequality in Uruguay have been resolved. Both statements are half-truths. The most important stage of the reform has recently begun and the situation is dynamic. The reform is not complete; indeed it has yet to be fully worked out conceptually. This is particularly so given the participation of key stakeholders in health planning. The involvement of beneficiaries and workers in development of health policies, as part of the National Board of Health and of ASSE, marks a turning point. They stop being mere "advisors" and assume a co-leadership role in the reform of the health care system.

Health care reform and a progressive Uruguay

The relationship between the different facets of the new government's programs and its health care reform is both dialectical and real. A full discussion of this relationship is beyond the scope of this text. In order to understand give context to the following statistical analysis the reader must bear in mind that

Uruguay has a population estimated to be 3,334,052 inhabitants (June 2008).³³

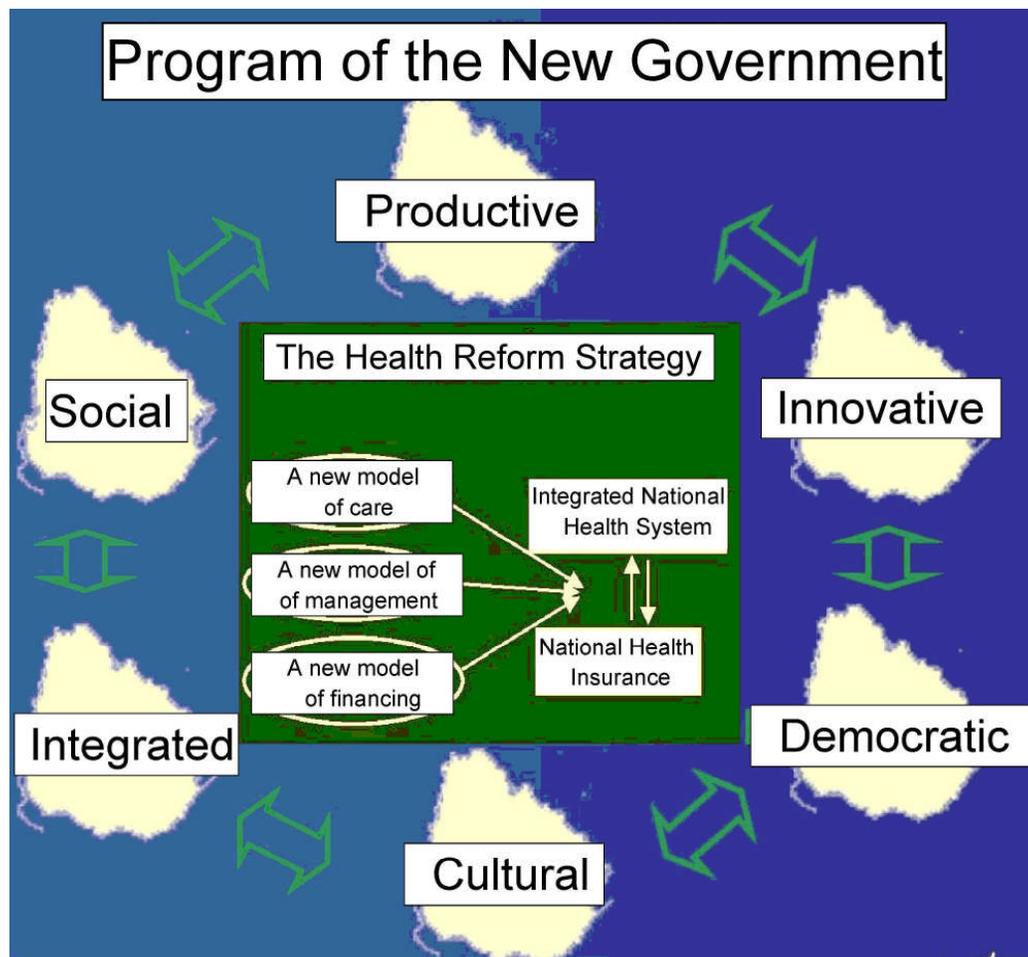
In terms of a "Productive Uruguay" the country's economy has grown, and this growth has been accompanied by increases in employment. Unemployment has fallen by 38.2% to 8.1% (December 2007, comparable to the 8% decrease in 1986). Employment in good jobs grew, as did enrollment in Social Security, a situation which facilitates coverage by the National System. The GNP grew 7% in 2006,³⁴ by 7.25% in 2007 and is projected to increase by 5.25% in 2008. Enrollment in the Social Security system reached one million in July 2005. In February 2007 an additional 13,800 members enrolled³⁵ with an additional increase of 180,000 in October.³⁶ It is currently estimated that more than 1,200,000 people are enrolled in the Social Security system. Not only is this a record figure in the country's history but it also means that *the working population covered by social security grew more than 30% in three years!* Certain sectors of the working class, notably rural and domestic workers, are now covered by the social security system for the first time. The real wage gives evidence of a moderate and sustained recovery. The recovery of real wages is at 17.97%, equivalent to two-thirds of the losses incurred during the previous government (of the red and nationalist coalition).

At the present time the Integrated National Health System seeks to provide coverage for all private workers that contribute to social security, their children under age 18, domestic partners, retirees, and pensioners with low incomes. This means that as of March 24, 2008 a total of 120,000³⁷ workers and 335,000 children under 18 years of age were covered by the Integrated National Health System; an increase of 500,000 new individuals since August 2007. In the words of the Bank of Social Welfare's president, "In the past seven months, the number of people incorporated into the system is equivalent to 70% of all beneficiaries enrolled within the past 34 years."³⁸

Given the growing economy, declining unemployment and real wage increases, it should not be assumed that increasing the workers' contribution to the National System from 3% to 4.5% is a regressive measure. The "Social Uruguay"

tax reform platform declared that "those who earn more will pay more." The reform eliminated 15 taxes (among them the Personal Remuneration Tax, IRP), reduced slightly the sales tax, and combined employer contributions to the social security system (among other measures). A new personal income tax was put into effect in July 2007. This included deductions for contributions to social security and health care; adjustments are planned for 2008-2009 which will increase the number of people who pay reduced taxes or are exempted altogether. This was not merely a name change but a conceptual difference. The IRP applied only to wages and liabilities, while the personal income tax applies to all income (for example, real estate income, bank interests, etc.). It is estimated that 60% of the workers and 82% of retirees will be exempted or pay less in income tax under the new law (the final figures will be available the year following the applied tax reform). The goal of the new system is to redistribute, not to collect more taxes. Nonetheless, increases in economic activity may result in increases in tax collection.

The "Social Uruguay" found organizational expression with the creation of the Ministry of Social Development, which developed the Social Emergency Care Plan (PANES). The first two and a half years were dedicated to transforming conditions of extreme poverty into situations of social inclusion. Up to 400,000 people living in 91,000 households were involved. Between 2006 and 2004 national rates *extreme poverty fell from 5.99% to 2.69%. In the capital of Montevideo, extreme poverty fell from 7.26% to 3.93%.*³⁹ The creation of a chain of programs through PANES helped with many social issues, beginning with assistance with basic skills for employment, adult literacy using the Cuban "I can do it too" program), migrant labor, personal identification related issues, educational support for community teachers and youth classrooms, habitat improvement and establishment of food pantries, assistance with setting up social-cultural producers' cooperatives, micro-credit lending, and many other programs that as a whole, contributed significantly to social inclusion. People recovered their dignity and their hope.



Despite a *national decline of overall poverty between 2004 to 2006 from 40.96% to 33.39% and from 41.54% to 35.75% in Montevideo*⁴⁰ resulting in approximately 184,000 less poor (of whom 80,000 are children) poverty continues to exclude 1 out of 3 Uruguay citizens. As a result, an Equity Plan has been created. This Plan “includes two main sections...: one on structural reforms such as health care, educational and tax reform, but also including equality of rights and opportunities for men and women.” “The second chapter focuses on targeted policies ... which over the long term will reach a broad sector of the population, in particular those who are below the poverty line.”⁴¹

All free social benefits (education for children and adolescents, employment and food assistance) will reach 95% of households living below the poverty line; the plan is to directly accelerate the social inclusion of 900,000 people over the next 2

years. Monetary benefits: 490,000 children will be eligible for a new system of family allowances. Approximately 7,122 pensions will be awarded to elderly individuals; this amounts to a 30% increase in the number of beneficiaries. Employment assistance: 20,000 workers will be employed over the next two years. Educational policy: Child care for children 0 to 3 years will be extended to serve an additional 22,000 children. The Community Teachers’ Program will reach some 30,000 children yearly. It is expected that 20,000 teenagers will re-enroll in the education system or work/study programs. Food Policy: By 2008 92,000 households are expected to benefit from a food debit card for food purchases.

All of the PANES programs involved a social component which offered health prevention services to the heads of households, who are mainly women, and their children. The children were encouraged to

enroll – or return to – the educational system. Gradually, a certificate of fitness to work was introduced and in the last year comprehensive dental care was made available with support from the Faculty of Dentistry, the Mayor of Montevideo, and the Ministry of Public Health. The program worked with the Cuban *Operación Milagros* to successfully provide eye surgeries in Cuba for 2,027 low income persons of low-income. This led to the creation of an “Eye Hospital” equipped through Cuban donations and staffed by Cuban professionals (and provoking a row with the Uruguayan Ophthalmology Society). The Eye Hospital began performing surgeries on February 1st, 2008; there is already a waiting list of more than 3,800 patients from Uruguay’s public sector.⁴²

An “*Uruguay integrated with its region and the world*” included, without doubt, the rapid rebuilding of relations with Cuba and an increased cooperation on health projects. The strengthening of MERCOSUR and its working group SGT11 has resulted in grants from the Japanese government. Grants and low-interest loans from Cooperación Italiana provided resources to upgrade equipment throughout the ASSE care network. Technical cooperation with the Andalucía School of Public Health led it to place its regional headquarters in Montevideo. Joint cooperation between the Bolivarian Republic of Venezuela and Uruguay allows for a professional training of Venezuelans in Uruguay and the reconstruction and modernization of the Specialties Hospital (University Hospital). Joint work between PAHO & UNDP on strategies for productive and healthy communities has resulted in programs like “A Healthy Uruguay.” The impact of these programs is seen in the marked improvement in the public health infrastructure and the creation of continuing medical education programs for public health personnel.

The commitments to “*Innovative Uruguay*” and “*Cultural Uruguay*” can be measured in terms of budgetary allocations. The resources allocated to fomenting innovation in 2008 will be 9 times those allocated in 2004. Allocation of resources for the Ministry of Public Health exceeded \$170 million in USD in 2004 and between \$400 million to \$490 million in USD for 2008. When monetary transfers

to FONASA are included, \$530 million in USD will be spent on health in 2009. The educational budget began at \$430 million or 3.1% of GDP. By 2009 it will have increased to \$1,350 million USD or 4.5% of a considerably larger GDP. That means that *the budget for public health and education will have more than tripled since the inauguration of the new government. In 2005 repayment of public debt accounted for 34% of the GDP; this has now been reduced to 25%*. The strategic guidelines for debt management have been to convert debt with political conditions into sovereign debt; refinance debt over extended periods, thus improving the country’s credit rating; reduce exposure to foreign currency and monetary exchange volatility, and to extend the yields of the national currency. In 2004 spending on social policies in 2004 was 40% of current spending. Currently social spending is 49% of the governmental budget, 9% more than two years ago.⁴³ It is projected to reach 52% in 2009.⁴⁴ Uruguay’s withdrawal from the International Monetary Fund (IMF) was accomplished through early repayments; the IMF debt was completely paid off in November 2006. The IMF debt – which was conditioned on changes in social policies – was replaced with debt from the capital market. As result Uruguay could develop public programs (which the IMF rejected) and save money on interest payments.

As an example of innovation, the CEIBAL Project (*Conectividad Educativa de Informática Básica para el Aprendizaje en Línea*; Basic Computer Skills Educational Connection for Online Learning), seeks to provide computer access, via public school students, to the majority of Uruguayans. The project will give every public school student and teacher an Internet-ready laptop computer. The computers were first distributed in May 2007 in Villa Cardal, a small locale in the municipality of Florida. The government’s goal is to reach to the interior municipalities during 2008 and Montevideo by 2009. Households will be linked up via the Internet thus connecting students, teachers and schools.⁴⁵ By democratizing access to information technology and telecommunications, this project is part of the “*Democratic Uruguay*.” It is an

effort to fashion the “second type of literacy” along democratic lines.

The past three years have seen the first open forums for discussion of topics such education, social security, the proposed tax reforms, etc. *For the first time in history, the meetings of the President and his Ministers have been made public. And for the first time they have taken place in small towns and outside of the capital city.* Democracy implies going to the people, especially those who are the most geographically remote.

Democracy means "truth and justice" with respect to the human rights abuses of the dictatorship and period of *de facto* rule. The pursuit of truth is a human rights policy which strengthens democracy. This is particularly true in a country like Uruguay which suffered grave state-led terrorism. There has been progress in human rights policy including the search for the disappeared both within and outside Uruguay's borders and the recovery of clandestinely buried bodies. The Judiciary has been empowered to investigate and prosecute criminal acts committed by civilians, the military, and the police before the coup, as well as crimes committed for money, such as collecting ransom for missing persons. It is significant that the former dictator Gregorio Alvarez has been arrested and prosecuted for the abduction, illegal transfer, murder, and disappearance of 30 Uruguayan citizens, who were exiled to Argentina in 1978 when he was the Army's commander-in-Chief. And this is not an isolated example.

Full democracy of the State and society will be attained only when “the whole truth is exposed,” no one is left missing among the disappeared, and none of the abducted children remain unaware of their true identity and family. We will have full democracy when those responsible are held accountable and society loses its fear of reprisals because the laws that enshrine impunity are overturned. A society that lives with impunity is not a healthy society. To ensure society's health, *it is necessary to know that truth and justice will be served.*

The proposed program for a "*Democratic Uruguay*" included political decentralization and citizen participation. *The transfer of resources from*

the national government to the states doubled between 2004 and 2007, even when some of those states were governed by opposition parties. Ten districts were governed by the National Party and one by the Red Party. The proposed law on “Reform of the State” includes a thoroughgoing political decentralization, yet one that respects current administrative boundaries. The reform should generate 100 new and autonomous municipal governments that are directly elected by their citizens.

But a *Democratic Uruguay* is most evident in its public health reform. It is seen in the formation of a Committee on Bioethics and Comprehensive Health Care Quality. It is visible in the formation of the Advisory Council for Health Care Reform; the placement of participatory guilds in health centers and throughout the Ministry of Public Health; through the availability of municipal policlinics. Policlinics were conceived as spaces for institutional analysis of the progress of health care programs by organized beneficiaries, health workers and management service teams.⁴⁶

Finally, it is important to stress that the National Board of Health, the maximum authority within the National Health System includes representatives of society (beneficiaries and health care workers), as is also the case with ASSE. If doubt remains about the authenticity of its intent to create a more democratic health care system, Article 12 of the Integrated National Health Care System Act (SNIS) establishes "that to initiate the Integrated National Health System it is mandatory that public and private entities set up review and advisory boards representing their employees and beneficiaries."

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