UHC 2030

Evaluation of Universal Health Coverage

Consultation with Civil Society
Uruguay 2022

Date: July 22nd 2022

Lead organization: CIET

Number of participants: 7

Provide description of make up for the focus group: patients, migrants, different geographical areas of the country, transplant recipients, patient rights advocates, older adults

Methodology: Focus Group (meeting by Zoom)

Facilitator: Diego Rodriguez, CIET

Note Takers: Lucia Turcatti y Maria José Alcoba, ciet.uy@gmail.com

Number of breakout rooms: 1

Notable quotes for each question: all the participants expressed themselves in all the questions, so the answers include the participation of all those who were present.

“SISTEMA NACIONAL INTEGRADO DE SALUD”[1]

The Uruguayan health system is based on the notion of health as a universal human right, a public good and the responsibility of the State. Total health spending in the country represented 10.5% of the Gross Domestic Product (GDP) in 2019.

The National Integrated Health System (SNIS) was created by Law 18,211 (December 2007) and integrates public and private providers. Its financing is through the National Health Fund (FONASA), a unique, public and mandatory fund. It has a mixed constitution, with a contributory component (households and companies) and a General State Revenue component.

The SNIS ensures universal coverage through 42 eligible comprehensive health providers, which provide a broad set of benefits -the Comprehensive Health Care Plan (Plan Integral de Atención a la Salud - PIAS)- that is the same for everyone.

The Ministry of Public Health (MSP) is responsible for directing the system, defines health policies and regulates the care provided by providers based on priorities determined by the demo-epidemiological situation.

The National Health Board (Junta Nacional de Salud - JUNASA) administers the National Health Insurance (SNS), which is financed by FONASA, and ensures compliance with the guiding principles of the health system. It is a collectively managed board made up of seven members: four representing the Executive Branch -two from the MSP, one from the Ministry of Economy and Finance and one from the Social Security Bank (BPS)- one representing health providers, one representing workers and another by users of the health system.

[1]PAHO Document: Funcionamiento del sistema de salud en Uruguay. Año 2021.

Model of attention

Law 18.211 established that the SNIS should be organized "in networks by levels of care according to the needs of the users and the complexity of the benefits" and that it implement the strategy of primary health care (Atención Primaria en Salud - APS), prioritizing the first level of care (Primer nivel de Atención - PNA).

The PNA comprises a network of care units that provide timely attention to the demand and other health needs of the population through interdisciplinary teams: "a systematized set of sectorial activities aimed at the person, the family, the community and the environment aimed at satisfying basic health needs and improving quality of life with adequate resolution" (Law 18,211).

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

1. Does your government have an intersectoral coordination agency/mechanism/government department that promotes universal health coverage? If so, how well is this mechanism or department working?

An intersectoral coordination area is or was JUNASA where all the actors were present, including the Users' Movements, mainly associated with public health care institutions (ASSE). In this space, at least the concerns and claims were made.

But in this new administration they made a reform and it practically does not work, which has led to a lack of interaction between the different actors linked to health. JUNASA is part of the System, it is part of the Law, but it does not work.

2. If your organization is primarily engaged in health promotion, have you collaborated with other government ministries or departments, other than MOH, in your health promotion efforts? How have those joints been?

The organizations taking part at the meeting did not mention collaborating with other Ministries

3 a. Which groups of people do you identify in the country that struggle to access health services? Which are their main access barriers?

3 b. Taking into account the needs of the groups identified above, which are the specific health services that are sub-prioritized?

OLDER ADULTS: Older adults state that one of the main difficulties in accessing adequate health care is economics. They are the ones who consume most medicines, but in many cases they cannot access all they need, due to economic difficulties.

PUBLIC CARE USERS: There are also differences depending on whether you are a user of private mutual insurance companies or of the public care service. It is more difficult to access medicines in public care than in private care.

PEOPLE WITH MENTAL HEALTH PROBLEMS: Suicides have increased, mainly in young people, and no response is in sight

PEOPLE WITH ADDICTIONS: Lack of continuity in care. There is no answer to be able to provide them with effective care. It also coincides with the fact that there is a lack of medicines in the health system, which harms the continuity to follow a treatment. And those who do not have access to medicines later end up in mental institutions and that harms the user much more and the health institution, which often does not have adequate places to provide quality care to the user.

PEOPLE WHO NEED ACCESS TO HIGH-COST MEDICATION OR HIGH-COST TREATMENTS: There are people who need very expensive drugs or treatments to continue living and the health system does not provide them within its basic benefits.

MIGRANTS: There are problems of access and accessibility to health services for this population. "Access" refers to regulatory issues, to legal impediments. “Accessibility” refers to how a person obtains access to the health care they need, once they are already affiliated with a health care institution.

Although the Law guarantees access in a very avant-garde way, the problem is the later compliance with the Law. There is when you see a lack of programs, strategies, tools, that is, everything that allows implementing what the law guarantees.

So, in terms of the migrant population, in terms of access there are hardly any problems, the only problem is the voluntary interruption of pregnancy for migrant and foreign women who have resided in the country for less than a year, because the Law is clear in this issue and establishes an additional requirement that indicates that women must prove one year of residence in the country. But it is the only "legal" impediment.

The main problem for this population is not “access” but rather “accessibility”, that is, how do we take these people so that they can access these treatments or medications, or simply join ASSE to be able to access a general practitioner.

Access at first was not so problematic. But now the situation is also a little more complex because the migrants who arrive are in a worse situation than those of years ago. Mainly due to the situation in their countries of origin and that leads them to arrive with a deteriorated state of health.

The ideal and correct thing would be for the Government to provide accompaniment and advice to these people. There are advisory issues for migrants that are "no health issues", such as knowing what procedures and how to do them to obtain a residence and ID document in the country, in order to later be able to access health care.

It is necessary to implement strategies and tools to comply with the law.

TRANSGENDER PEOPLE: access to the health system is difficult for them due to the discrimination they suffer. Some trans people do not have their identity changed in their ID and when they are called to an office, the institution calls them by the name that appears and not by their identity change. The health system is quite discriminatory and conservative when it comes to dissident populations, as well as the Afro population and the population with disabilities. These situations lead them not going to the doctor.

PEOPLE WHO LIVE GEOGRAPHICALLY AWAY FROM THE COUNTRY'S CAPITAL: There is a lack of health professionals and specialists in the north of the country. It is a situation that has not been solved for more than 20 years.

Now there isan idea of trying to decentralize education and that health professionals and medical specialties can be trained in the interior of the country, with the aim that they can also stay to provide care in those areas, closer to their place of origin and residence.

There are Departments (States) of the Interior that do not have medical specialists care and most of them are concentrated in Montevideo. People from these departments must go to the capital or to other departments to be treated, where in addition there is a cost of travel, the problem is also added if they have to stay more than one day.

The lack of money makes it even more difficult to move to get care.

There are not enough care centers to serve the most remote populations, mainly those who do not live in the capitals of the departments.

PEOPLE WITH VISION PROBLEMS: The “miracle operation” (free eye operation), which mainly affects older adults, was discontinued.

With the pandemic, polyclinics have been closed and have not been opened again.

PATIENTS WITH DIFFERENT PATHOLOGIES: There are difficulties in accessing quality care, depending on the type of pathology suffered. Mainly there are difficulties in "rare" diseases because in this case they are difficult to diagnose. But also not only these diseases have problems of lack of control and monitoring, also for example in oncology.

4. Do you think that the UHC laws/policies/strategies that exist in your country are being properly implemented?

The laws of the health system are long-standing and sometimes it is due to a specific case that we get to know them.

Every law has its shortcomings and its advantages. It is important to keep reminding the government and the institutions, because the fact that the Law exists does not mean that they know it.

It is also necessary to evaluate the laws and see if they are consistent with the current historical and social reality, because every law responds to a reality of the moment it was created.

It is important to know the laws and be able to accompany them with scientific evidence to give them value.

The government does not know all the laws and sometimes you have to keep reminding them. The regulation is perceived as quite complete, regardless of whether we like it or not. There is no lack of health regulations and it is quite extensive.

It can be considered that the Law in Uruguay guarantees access in a very avant-garde way, but the problem is that later that Law is complied with. And that is when you see a lack of programs, strategies, tools, that is, everything that allows to implement what the law guarantees.

Of course, the Law does not cover everything, especially when it comes to high-cost treatments or medications. In this type of case we finish in the legal, judicial sphere, through Recurso de Amparo (legal resource).

When there is a large number of appeals for the same claim, it is only then that the MoH and the National Resources Fund consider the inclusion in the list of some of the medications and/or treatments that have been winning in court for years.

This happens because it is difficult for both the government and the health care institutions to provide treatments that are not within the “legal” coverage, that is, those that are not included in the PIAS.

Therefore, there are situations that are linked to issues of "humanity" of the institution whether or not to give these treatments, because there are life-threatening situations, which many times cannot wait for the case to be legally resolved first and then provide the attention.

What the Law says, surely we all know. But the truth is that until the problems are exposed publicly, things are not begin solved.

5. Are you aware of any accountability or monitoring mechanism for universal health coverage in your country? If yes, please explain your answer.

In fact, there is no accountability mechanism. There are even many aspects that are not transparent in how they are resolved.

The controls by the government on the mutualists (private health services) do not work. For example, they are given money by FONASA but then they are not controlled in how they invest it in, they can invest it in building a parking lot for cars or for anything, and nothing happens. It is money that should be used to improve the quality of health care, as it is in the Law.

6 a. Do you think that health services in your country are of good quality? Can you elaborate and give examples?

6 b. Which health services and which communities/population groups experience gaps in quality?

LOSS OF QUALITY: Although health services have always had their shortcomings, lately quality care has been lost and care has been dehumanized.

The communities that suffer from gaps in care are those already detailed in question 3.

MULTI-EMPLOYMENT: One of the causes of the problems of quality of care is the multi-employment that health personnel have in order to have an economic income that allows them to sustain their lives. Being able to avoid these situations would improve the quality in terms of contact time and dedication to each patient.

MEDICATIONS: In many cases there is even difficulty in accessing the medications that are covered by the PIAS, mainly in public health services. But there is also a lot of medication that is not included in the basic benefits and is particularly difficult to access when they are expensive and are necessary for the person to continue living.

MENTAL HEALTH: A response from the health system to people with mental health problems is not visualized. In recent times there has been an increase in suicides and no actions seem to be take to prevent these situations.

PEOPLE-CENTERED MEDICINE: People-centered medicine is not being carried out, but rather centered on diseases. Medicine is organized in relation to the doctor and is a "hospital-centric" or "sanatorium-centric" medicine.

We are facing an organizational problem on how this kind of "cure, accompany, guide" services is organized, which today are carried out all within a hospital, but there is no containment or service once the patient leaves the hospital. .

TRANSFER: When people live far from health institutions or when they have economic problems to maintain themselves, being able to travel to be treated becomes a barrier to actually accessing care in the health system.

EXTRA HEALTH ADVICE: for some populations in particular, such as migrants, many times in order to access care in the health system they need advice on other situations that must be resolved beforehand in order to access the system, such as procedures for obtain residency.

POLYCLINICS AND SPECIFIC TREATMENTS: In recent times, polyclinics have been closed and have not been reopened, in addition to ceasing to provide some treatments for specific populations, such as vision problems. A problem that mainly affects older adults and who previously could have free eye surgery, now this care service is not provided.

RARE DISEASES: they have problems of lack of control and monitoring, including other types of diseases such as oncology.

7. Where do you think your government should invest more to achieve UHC?

• Facilitate access to health centers (mainly transportation) for the population that lives far from them.

• Avoid multi-employment of health personnel. Increase their dedication in an only health center, improving their salaries.

• Increase the time that each doctor can dedicate in the consultation to each patient.

• Provide support services and outpatient care.

• Provide accommodation for companions of people who must undergo prolonged treatment or whose recovery from health problems requires several days of hospitalization. Mainly those who live far from care centers.

• Provide high-cost medicines and treatments for people who cannot access them. Even this could mean less expense for the Ministry of Public Health, given that it mostly ends up paying when legal actions are carried out and in that instance the cost of the medicine is much more expensive, in addition to the time spent by all parties to resolve the issue in court.

• Update availability and incorporate latest generation drugs.

• Provide advice on extra-health issues that patients need in order to be treated.

• Increase the amount allocated to public health care, given that the money allocated to this care has not increased

8 a. At national level: are there opportunities for people, civil society organizations and the private sector in your country to participate in planning, budgeting, monitoring and evaluation of the health sector?

If so, what are those opportunities and are they effective and efficient for the participation of civil society, in particular, of the most vulnerable and marginalized populations and communities?

8 b. At community level: Are communities involved in planning, budgeting, and accountability processes for health at the local level?

If so, how are they engaged?

Decision makers do not take civil society into account, unless legal actions are initiated or the problem is spread in the press.

The participation of civil society is a continuous request to decision makers and in particular to the Ministry of Public Health. It is done from different organizations linked to different sectors with their specific problems or organizations that bring together more than one health problem.

Civil society in many cases acts as support and accompaniment for patients when they require extra-hospital care. They have also played a fundamental role so that some populations could access medicines or treatments, and at the level of health policies, they have managed to get the authorities to finally implement policies or enforce them in accordance with current regulations.

There are even regulations that establish areas of participation and coordination in which civil society must participate, but it has been systematically ignored.

The organizations, in addition to raising the health problems that need to be addressed, have also proposed solutions, and even carry out actions on a voluntary basis to cover aspects that the government is ignoring.

9 a. Can you identify some of the main challenges for women and girls in their access to health services?

9 b. What types of health services are most difficult for women and girls to access?

9 c. What are the main challenges in accessing health care services for people who are not binary?

The group only highlighted in particular the problem of access to care for migrant women who have lived in the country for less than a year, in the case of voluntary interruption of pregnancy, because the Law establishes this additional requirement of accrediting one year of residence in the country for an abortion.

10 a. How has the primary health care system been affected by the current COVID-19 pandemic?

10 b. How do you think primary health care can evolve/improve to be better prepared for future pandemics and other health emergencies?

Due to the pandemic, the first level of care was suspended for a long time and then it was by telephone, and the level of care that existed before the pandemic has not yet returned. During COVID 19, it was not possible to go to the health centers for consultations.

In the case of transplant patients, it is highlighted that during the pandemic medical societies have been close to these patients, "the transplant center has always been in contact with them" through calls. This was achieved as a result of civil society intervention.

Given the relevance of comorbidities, the registry of patients and their conditions or diseases must be improved and unified, in addition to systematizing and being able to use electronic medical records

11. Are there any other elements of UHC and the distribution of health services in your country that were not covered in today's discussion?

It is necessary to allocate more money in the prevention of those diseases that can be prevented, which would imply less spending by the government on health care when the person is already suffering from the disease.

It is also necessary a greater commitment and participation in dialogue instances by other government sectors that may have interference in the quality and capacity of attention, such as the Ministry of Economy.