IMPROVING HEALTH SYSTEM EFFICIENCY

URUGUAY

Building up the national integrated health system

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ABBREVIATIONS

AGESIC	Government Agency for Elelctronic Information
ASSE	State Health Services Administration
BPS	Social Security Bank
DISSE	General Directorate of Social Sickness Insurance
FNR	National Resources Fund
FONASA	National Health Fund
HRH	Human Resources for Health
IAMC	Collective Medical Assistance Institution
IMAE	highly specialized medical institutes
JUNASA	National Board of Health
MEF	Ministry of Economy and Finance
MPH	Ministry of Public Health
MTSS	Ministry of Labour and Social Security
PIAS	Comprehensive Health Care Programme
SNIS	National Integrated Health System
SNS	National Health Insurance

1 INTRODUCTION

Uruguay is committed to achieving universal health coverage for its entire population. The path to success relies in part on the health system identifying and resolving any inefficiencies. This would in turn release resources for an expansion of population coverage and available services, improved financial protection for low-income families and, in general, more equitable access to health care.

The health system reform launched in Uruguay in 2005 explicitly prioritizes equity, financial protection and change in the health-care model, and recognizes people's right to health protection. In December 2007, Law 18.211 created the National Integrated Health System (SNIS) and the National Health Insurance (SNS) and set forth as a basic premise, "effectiveness and efficiency in economic and social terms". In relation to the health system, the Law established that "adjustments in the level of health-care premium, the inclusion of new services and the reduction of co-payments shall be made in line with economies resulting from improvements in system efficiency and from the incorporation of new users in the health providers registers".

The policies and regulations designed in the context of the reform have undoubtedly had an impact on system efficiency, as have the resulting actions taken by providers.

The national health system reform indicates changes in the management model, the health-care model, and the financing model. With regards to the financing model, the National Health Insurance scheme and its corresponding National Health Fund entail a new mechanism of payment to health service providers. The mechanism includes a capitation payment adjusted according to the estimated risk of the beneficiaries, and an additional payment linked to the fulfilment of predefined health-care goals. The main changes proposed in the health-care model are an organized network of care levels according to user needs and the complexity of the services based on a primary health care strategy; and a prioritization of first level care. The management model has been mainly reoriented at the macro level, resulting in a new institutional framework with broad social participation, and in the strengthening of the steering role of the Ministry of Public Health (MPH).

1.1 Objectives

This paper analyses the efficiency incentives and the series of policies implemented upon the creation of the SNIS, as well as the observed and expected results following its implementation. The document focuses on three dimensions that have particularly affected efficiency results: institutionality and governance, payment mechanisms to providers, and human resource policies.

The institutional and governance analysis shows the changes in procedures and structures made to regulate, govern, and control the system. For payment mechanisms, the analysis focuses on the modalities used by the National Health Insurance scheme. In the case of human resources, some characteristics of the labour market that impact on the inefficient use of resources, and the policies developed to correct them, are described.

2 THEORETICAL AND CONCEPTUAL FRAMEWORK

2.1 Efficiency in health

In general, the concept of "efficiency" is widely discussed in the economic literature, possibly due to its direct relation with the management of limited resources. Nonetheless, in most studies the concept refers to a better use of resources or inputs in the production of goods and services. In this context, the concepts of technical and allocative efficiency arise. Technical efficiency is centred on maximizing production for a given use of inputs or resources – or minimizing the use of supplies for a given product level – while allocative efficiency refers to an optimal assignation of resources that reflects population preferences or needs.

Here, the discussion on efficiency in health, and specifically from a health system perspective, goes far beyond the idea of minimizing costs and maximising the production of the existing institutions. Producing a greater number of health or medical care services is not a goal in itself for the health system, but an intermediate product or input to achieve the best possible level of health for the population. Therefore, an analysis of efficiency requires a set of health indicators that reflect the results for the entire population.

According to Hollingsworth and Peacock *(1)*, options for measuring this type of results include biometric indicators, such as changes in body mass index for certain population groups; survival indicators such as changes in mortality rates; and quality of life parameters such as disease burden estimates. The empirical problem with this approach, besides the variety of indicators, is that many of them are based on such a wide set of interventions and health policies – and as a consequence, the health system itself – that they may have a negligible impact on health. In other words, is the health system of a given country more efficient because its life expectancy at birth is higher, even if it uses the same resources per capita as another country? Is life expectancy at birth the best indicator of population health? Moreover, is life expectancy at birth the sole result of the health system and the way its institutions operate?

Technical efficiency is defined as health-care interventions that address different pathologies carried out using the lowest possible resources to achieve the desired health improvement. This means applying care procedures based on cost-effectiveness studies. From this standpoint, the health system can assign or