Summary

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Session 4 – Linking social protection schemes with microinsurance

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The design and implementation of an integrated National Health System in Uruguay

PREVIOUS SITUATION:
Health sector was composed by two subsystems non-coordinated. Public sector basically was destined to the indigent, with some specific services like police and military sanities. Private sector was divided in two areas. The predominant sector of IAMC (Collective Health Care Institutions) which comes from Mutuality but also integrated by cooperatives and a minority sector integrated by private hospitals, commercial insurances and doctors in liberal exercise. 60% of IAMC users hired directly in a pre-payed way and the other 40% was financed by the social security. At the end of '90, health sector entered in an economic crisis: several IAMC were conduced to bankrupt and public sector was overflowed.

REFORM PROCESS:
Government that assumed in 2005 drove from the beginning its plan of Health reform and it established a Consultative Groupintegrated by representatives of the State and of civil society. During two years proposals were elaborated, that gave the base of laws for the SNIS implementation.

NATIONAL INTEGRATED HEALTH SYSTEM:
SNIS is National because it includes all inhabitants and its objective is to offer a universal and equal covering. It is integrated because it has public and private providers, and mechanisms of articulation and complementation. Its strategy is Primary Health Care and it privileges health primary assistance, promotion, prevention and rehabilitation.

THE RIGHT TO HEALTH PROTECTION:
The Law that creates the SNIS recognizes that all the inhabitants have the human right to health protection. SYSTEM INTEGRATION: The sole public provider is ASSE, a decentralized entity which manages all medical centers that were in charge of the Public Health Ministry (MSP). The majority private sector is integrated by mutual societies, medical cooperatives and a dependent center of the medical syndicate, and also certain commercial insurances.

BENEFICIARIES:
All the inhabitants are beneficiaries of the SNIS. Nevertheless, in this first stage, the covering through the National Health Insurance (SNS) doesn't include public servants, police and military officers as well as some retired people and people non-include into social security.

BENEFITS GIVE ATTENDANCE IT PRESCRIBES:
The MSP must establish specifically the benefits of being offered by the providers to cover completely the assistance process in the three levels of health care.

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FINANCING:
The SNIS is financed by the SNS, which is managed by the National Health Board (JUNASA), which is integrated by state and private representatives. The SNS is financed by the National Health Fund (FONASA) constituted with contributions of workers, public and private enterprises and the State. The SNS pays the providers an amount integrated by two components: one capita fixed in accordance with the risk of the beneficiaries and one extra pay due to the fulfillment of assistance goals. People non-covered by the SNS continue hiring its attendance trough the mechanism of pre-payment and flat

Key messages:

1. Stand alone microinsurance schemes cannot significantly extend coverage to large numbers
2. Linkages with other institutions can increase the scope of benefits, the financial consolidation, the technical management, the contracting power, etc. of microinsurance schemes
3. Linked schemes are a promising path as shown already by several experiences in Latin America, Asia and Africa
4. Sharing information and knowledge on these experiences is key to develop microinsurance for the poor

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