HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

Author:

Ignacio Torres Negreira, Bergstein Abogados

itorresnegreira@bergsteinlaw.com

LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's-eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

Uruguay's healthcare system is founded on the principles of health as a universal human right, a public good, and a responsibility of the state. The system operates as a mixed model, integrating both public and private sectors.

Its financing is managed through the National Health Fund (FONASA), a unified, public, and mandatory fund. FONASA has a hybrid structure, combining contributory components (contributions from households and public/private enterprises) with general state revenues. Through FONASA, financial resources are distributed to public and private providers within the system, using risk-adjusted capitation payments and service provision goals across different levels of care.

In 2024, total health expenditure accounted for approximately 9.19 per cent of GDP.

Public sector

The public healthcare system is led by the Administration of State Health Services (ASSE), the primary public provider, which serves around 1.2 million users. Its funding is primarily derived from FONASA capitation payments.

The Ministry of Public Health (MSP') plays a crucial stewardship role by regulating, supervising and shaping health policies. It ensures equitable access to high-quality services for all citizens and oversees the implementation of preventive programmes, mass vaccination campaigns, and public health initiatives.

Private sector

The private sector operates predominantly through Collective Medical Assistance Institutions (IAMC), which provide health plans financed through FONASA capitation payments supplemented by personal contributions from users.

Additionally, there are fully private healthcare providers, such as clinics and hospitals, which typically cater to individuals with private insurance or those paying out-of-pocket. This sector is characterised by offering specialised and often higher-cost services.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

The National Integrated Health System (SNIS) was established by Law No 18,211 on 13 December 2007, which provides the legal foundation for healthcare financing and reimbursement in Uruguay.

Chapter VII of Law No 18,211 (Articles 55–74) addresses the financing of the SNIS. Specifically, Article 57 creates the National Health Insurance, financed through the FONASA. The National Health Insurance is a public system established in Uruguay with the aim of ensuring universal, equitable, and high-quality access to healthcare services. FONASA itself was created under Article 1 of Law No 18,131 and is funded by contributions from workers, employers, and the State, along with any additional resources that may be allocated (as per Article 60 of Law No 18,211).

Health quota and reimbursement

Comprehensive providers, which are healthcare institutions within the SNIS, receive payments from FONASA in the form of a 'healthcare quota' for each affiliated individual. This quota is designed to reimburse the expected costs associated with their care.

The health quota consists of two key components: (1) capitation payment: adjusted based on the demographic and health risk factors of the affiliated population; and (2) service delivery targets: incentivising compliance with performance and service benchmarks.

The health quota is updated periodically through regulatory decrees. The most recent update was made via Decree No 204/024, dated 29 July 2024.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

The MSP is the central regulatory body responsible for the overall governance of the healthcare system.

The Social Security Bank (BPS) plays a key role in managing the contributions to FONASA.

The National Health Board (JUNASA) operates under the MSP and is tasked with:

1. overseeing the operational aspects of FONASA;
2. setting and reviewing the health quota (capitation payments and service delivery targets) for healthcare providers; and
3. monitoring and evaluating the financial and service performance of public and private providers.

ASSE is the largest public healthcare provider and also plays a key role in the system.

4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

The Covid-19 pandemic had a profound impact on healthcare financing and reimbursement in Uruguay, necessitating significant adaptations to ensure the system's resilience and to meet the unprecedented demands placed on healthcare services.

Healthcare spending increased substantially to cover critical costs, including:

1. Mass vaccination campaigns: procurement, distribution, and administration of vaccines;
2. Expansion of healthcare infrastructure: strengthening intensive care units (ICUs) and increasing hospital capacity; and

3. Acquisition of essential supplies: purchasing personal protective equipment (PPE) and medical materials.

These additional expenditures were funded through general state revenues, the Covid-19 Solidarity Fund ('Fondo Solidario Covid-19'), and international cooperation mechanisms, all while preserving the core structure of the FONASA.

These changes made during the pandemic were made in response to the Covid-19 public health emergency and did not remain as permanent changes to the system. However, the investments made during that period – in both infrastructure and medical equipment – continue to be used beyond the end of the emergency.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

Patients must generally be residents or employed in Uruguay to access the healthcare system through the FONASA.

1. Citizens and residents: all legal residents, regardless of nationality, are eligible for healthcare services under the SNIS.
2. Employees: individuals employed in Uruguay are automatically enrolled in the system and contribute to FONASA.
3. Tourists and non-residents are eligible for emergency medical care but must cover costs privately or through travel insurance.

Access is universal and not restricted by age, gender, or nationality, provided that the person is a legal resident or employee who is contributing to the system.

Healthcare providers, including hospitals, clinics, and suppliers of medical goods, must meet stringent regulatory and quality standards to be accredited by the MSP. Providers must register with the MSP and comply with national guidelines for service delivery or product safety. Only providers integrated into the SNIS can receive reimbursement through FONASA, based on the per capita 'health quota' system.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

Comprehensive health insurance carriers in Uruguay are divided into two categories: those that are part of the SNIS and those that operate outside of it.

Comprehensive insurance within the SNIS

These insurers enter into management agreements with the JUNASA and are required to provide users with comprehensive healthcare programmes approved by the MSP (PIAS). The PIAS is a broad and inclusive benefits scheme that applies equally and is enforceable for all users of the providers under the SNIS. It covers a wide range of medical services, from outpatient consultations at the primary care level to ICU hospitalisations.

The plan ensures access to an extensive list of diagnostic tests and treatments across various medical and surgical specialties, mental health services, all essential medicines, and some high-cost medications. The PIAS is a taxative list, periodically updated through mechanisms developed by the governing health authority. These updates determine which technologies

should be integrated at different stages of comprehensive healthcare, including health promotion and prevention, diagnosis, treatment, rehabilitation and palliative care.

Technologies considered for inclusion in the PIAS encompass a range of categories, including medications, medical procedures, devices, programmes, and care delivery modalities. These regular updates ensure that the PIAS remains aligned with advancements in healthcare and continues to address the evolving needs of the population.

This can be done either through their own resources or by contracting services from other public or private comprehensive or partial providers.

They are primarily financed through the FONASA and may charge co-payment fees (moderating tickets) for medications and medical consultations.

Services or benefits not included in the comprehensive healthcare programmes are provided under freely negotiated agreements between providers and users.

Comprehensive insurance outside the SNIS

These insurers must obtain authorisation from the MSP and are subject to its regulatory oversight.

They operate under a free contracting regime, which allows them to negotiate services and benefits directly with their users. However, they must offer at least the same level of coverage as provided by IAMCs under the SNIS.

Their financing structure includes a minimum FONASA contribution per enrolled user and an additional fee charged directly to the affiliate. Like SNIS-affiliated insurers, they may also collect co-payments for medications and consultations.

It is possible for an insurer to operate within both categories. Non-profit comprehensive health insurance providers, as well as those organised under certain legal forms, may join the SNIS, provided they comply with the relevant regulations. Their incorporation into the SNIS does not preclude them from continuing to operate within the framework of free market contracting.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

The coverage of medical services provided by comprehensive health insurance plans was detailed in Q6.

Both in-person and remote (telemedicine) medical consultations are regulated and priced by the MSP. From a legal and regulatory standpoint, the Uruguayan framework does not establish any significant differences in coverage between in-person medical care and telemedicine services.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

The financing of services provided by hospitals in both inpatient (stationary) and outpatient (ambulatory) settings is integrated into the SNIS as follows:

- Services included in PIAS: If the services are covered under the PIAS, they are financed through the capitation payment that the healthcare institution receives from the FONASA.
- Services outside PIAS: Services not included in the PIAS are financed directly by the affiliated user under a free-market contracting regime.
- Moderator tickets: Institutions can also charge patients for moderator tickets, which cover partial costs of medications and medical consultations.

9. How are the prices of such services determined? How is economic efficiency controlled?

The prices of medical services included in the PIAS are covered by the health quota financed through FONASA. This health quota is regularly updated based on cost proposals submitted by SNIS medical institutions and approved by the MSP (Executive Branch), in collaboration with the National Health Board (JUNASA).

Economic efficiency is monitored through a combination of mechanisms:

1. Capitation and health goals:
    a. Capitation component: This is the primary funding component and is adjusted based on the risk profile of each beneficiary, determined by age and gender.
    b. Health goals component: Approximately 8 per cent of the capitation payment is tied to achieving specific healthcare objectives set by the regulator. This component incentivises providers to meet quality and performance benchmarks.
2. Regular oversight by JUNASA: JUNASA conducts regular evaluations of the capitation payments and moderating fees to ensure proper resource allocation and compliance with performance standards.
3. Inspections and sanctions: The General Directorate of Health Inspection under the MSP enforces compliance with all health regulations. It conducts inspections and initiates sanctioning procedures in cases of non-compliance by healthcare institutions.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

If the services are included in the PIAS, they are financed through the capitation payments received by medical institutions from FONASA.

If the services are not included in the PIAS, they are financed by the affiliated user under a free contracting regime.

Additionally, medical institutions are allowed to charge moderating fees for medications and medical consultations.

This system ensures that essential services are covered under FONASA while providing flexibility for services outside the PIAS framework, maintaining a balance between accessibility and financial sustainability.

11. How are the prices of such services determined? How is economic efficiency controlled?

The financing of the health quota was explained in Q10.

Health institutions are permitted, by regulation, to charge moderating fees and rates, which must be authorised by the Executive Branch, with maximum amounts established for such charges.

These costs are determined by an Executive Decree based on proposals from health institutions and subject to prior approval by the MSP.

The same economic efficiency controls discussed in Q9 apply.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

If pharmaceuticals and medical devices are included in the PIAS, they are financed through the capitation payments received by medical institutions from FONASA.

If the services are not included in the PIAS, they are financed by the affiliated user under a free contracting regime.

Additionally, medical institutions are allowed to charge moderating fees for medications and medical consultations.

The same economic efficiency controls discussed in Q9 apply.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

Health institutions are permitted, by regulation, to charge co-payment fees (moderating tickets) for medications and medical consultations, which must be authorised by the Executive Branch, with maximum amounts established for such charges.

These costs are determined by an Executive Decree based on proposals from health institutions and subject to prior approval by the MSP.

For medications, there is no single standard co-payment; instead, different co-payment rates apply depending on the type of medication.

The same economic efficiency controls discussed in Q9 apply.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

There is relatively low litigation among actors within the SNIS in Uruguay. The processes for determining the health quota, care targets, and co-payment rates involve extensive negotiations among stakeholders, reducing the likelihood of disputes.

The most significant area of litigation arises when users challenge the health system's refusal to cover high-cost or experimental treatments, particularly for rare or life-threatening conditions not included in the PIAS.

These disputes are often resolved through judicial *amparo* claims, where users demand that the MSP or the National Resources Fund (FNR) provide the requested high-cost medication or treatment. Approximately 1,600 *amparo* cases are filed annually, a number that continues to grow. In most cases, the MSP and/or FNR are ordered to supply the requested treatments, reflecting a trend of patient-centred rulings in urgent healthcare matters.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

A primary challenge is ensuring that the health quota accurately reflects the real costs incurred by medical institutions for each patient. Implementing a dynamic health quota that adjusts based on individual patient needs and institutional expenses could be a viable solution. This must be accompanied by stringent oversight and periodic evaluations of medical institutions' expenditures. Additionally, incentives for preventive care could drive better outcomes and improve efficiency.

Moderator fees for medications and consultations remain a critical issue. Adjusting these rates could significantly impact both the financial burden on users and the revenue streams of healthcare providers, necessitating a balanced approach to protect accessibility while ensuring institutional viability.

The increasing demand for the inclusion of high-cost treatments and medications, driven by approximately 2,000 annual legal claims in 2024, poses a financial challenge. Patients often seek the inclusion of these treatments in the PIAS. Addressing this trend will require reforms to the FONASA and alternative financing mechanisms, potentially increasing public healthcare expenditures.

The Covid-19 pandemic accelerated the adoption of telemedicine, which is now in the process of regulatory development. Significant investment in digital health technologies and infrastructure is expected, requiring financial backing from the SNIS and appropriate regulatory oversight to ensure equitable implementation and accessibility.

In summary, the SNIS is built on commendable principles but constantly faces financial sustainability challenges. It is a heavily regulated system under continuous strain, requiring possible reforms to ensure long-term viability. Achieving a balanced approach to financing, controlling costs, expanding access to care, and embracing technological advancements will be critical to its future.