URUGUAY

Capital: Montevideo
Area: 177,410 km²
Population. 3,080,000 (1990)
Population density: 17.3/km²
Urban population: 89%
Per-capita GDP in USD: 2,470 (1988) (a)
Life expectancy at birth: 72.2 years (b)
Infant mortality rate: 20.3‰ live births (1988) (c)
Illiteracy: 4% (d)
Population under poverty line: 22.1% (e)
Human Development Index 1992: 0.880 (29th) (f)[1]

Equity and productive change in the Southern Cone Common Market (MERCOSUR)

The Eastern Republic of Uruguay has historically had one of the highest levels of economic and social development and equity in Latin America. Uruguay is therefore among "high human development" countries, according to the United Nations' Human Development Index (HDI), and in 1991 it held the 32nd and in 1992 the 29th highest rankings in the world, in both years the highest in Latin America. The crisis the country has experienced in the past two decades caused significant setbacks in some social indicators and revenue distribution, however.

The country's population, which is slightly more than 3 million inhabitants, is very unevenly distributed: three-quarters of its people live in urban centers, and 43% in only one city, Montevideo. The Uruguayan population, which for the most part is descended from European immigrants, is fairly homogeneous, although a few ethnic features of Guarani origin remain in the rural population. In Montevideo there are some ethnic groups (Judaic, Armenian, and black) which maintain distinct cultural identities. The last group has several thousand members who are

very poor The middle class is large and constitutes a little over a third of the population

Despite its small population, Uruguay cannot offer job opportunities to everyone in its active population. Although Uruguay has traditionally received European immigrants, residents began to emigrate in the 1960s. As a comparison, the country's migration rate of 8% was twice that of other countries with heavy emigration like Haiti and El Salvador. One of the factors that reinforced the migration trend was the exile of thousands of Uruguayans after the 1973 military coup. More than 342,000 persons, or over 10% of the country's population, including large numbers of educated people, emigrated between 1963 and 1985.

In 1984, Uruguay joined the democratizing wave sweeping Latin America in the preceding decade. The 1984 elections put behind 11 years of authoritarian rule, violation of human rights,[2] and application of liberal economic policies oriented toward exportation and liberalization, which had had profound negative effects on Uruguayan society. The adjustment was inequitable, wages fell by about 50% of their real value between 1973 and 1983, unemployment grew to 16% of the work force, and in 1984 poverty affected 20% of the Montevideo population. All this occurred in a country which, in the decades preceding the military regime, had had one of the highest living standards in Latin America. In summary, the employment and income situation in 1984 was worse than what it had been in the three previous decades. Further, democracy inherited difficult social conditions, an external debt which in 1988 was $6,050 million, and whose payment weighed heavily—and continues to do so—on the country's economy inasmuch as it consumed 6% of the gross domestic product (GDP).

From 1985 to 1988, the country experienced an economic revival, due in part to a favorable international context. Gross national income grew by 29% and the GDP by 17% in those three years. Inflation was high, but not out of control as in Argentina and Brazil, and was 80% to 90% yearly in 1988 and 1989. Unemployment dropped and wages increased. This revival was short-lived and inadequate, however: in 1989, the Government, pressed by the external debt and faced with strong macroeconomic imbalances, signed agreements with international financing agencies which strongly affected the population. The new administration extended the adjustment policies. In 1990, the first year of the Lacalle administration, wages dropped by 15% and inflation grew. In short, between 1981 and 1989, the per-capita GDP reflected a cumulative drop of 9.8%.

In 1991, the country signed agreements with Argentina, Brazil, and Paraguay to establish the Southern Cone Common Market (MERCOSUR) in 1994 and 1995. Economic integration will lead to extensive readjustments and changes in the country's economy, since its weaker productive structure will have to compete with its three economically more powerful neighboring countries. The future looks uncertain for the business, labor, and political sectors, as well as for the whole of Uruguayan society. The potential improvement or worsening of the well being of Uruguayans will depend largely on the form and consequences of the regional integration process. MERCOSUR thus represents the biggest challenge Uruguay will have to face in the years to come.

The employment situation and labor market

Uruguay has one of the lowest rates of demographic growth in Latin America. In 1975-1985 it was barely 1% annually. Nevertheless, the economically active population (EAP) grew considerably—60% of the population old enough to work—even though this level plateaued in 1985 in Montevideo. This was the result of more women entering the labor market.

The Uruguayan labor market is subject to much legal control and inspection, and has a much higher proportion of wage earners than in the other countries of the region (72% in Montevideo and 68.4% in the rest of the country), features that give it a high degree of "formalization." Since the mid-1960s, however, there has been a slow but noticeable increase in the number of

informal and self-employed workers, with a related decrease in public sector workers.

From the mid-1960s to the mid-1980s there was also improvement in the primary education level of the work force The proportion of the EAP that had not completed primary schooling dropped from 23% to 13% of the total in that period. In parallel with this, the percentage of the EAP with more than nine years of study, the basic cycle of approved middle education, rose from 20% to 38% of the total. This trend has been more noticeable during the democratic period. There is a considerable discrepancy between the instruction provided by the educational system and the requirements of the labor market, however.

The improvements in educational levels did not match parallel improvements in work opportunities. In fact, the Uruguayan labor market is characterized by its lack of dynamism. Between 1966 and 1986 it barely achieved an annual growth rate of 1%. This implies a strong imbalance between worker supply and demand. Many workers, especially younger ones, thus see the job expectations that the general educational system has given them frustrated. A solution to this discontent is often migration abroad.

The acute recession of 1982-1984 brought the highest open unemployment rate (16%) in the decade, in 1983. A slow employment recovery began in 1985. It is estimated that 105,000 jobs were created in 1984-1989, despite the fact that the economic revival slowed, starting in 1987. This figure equals 17% of employed people in 1984. Starting in 1991, unemployment rose again, stabilizing at about 10% of the EAP. Unemployment did not affect all working groups equally but was concentrated among youth and women who were not heads of households. Unemployment affected half the youth under 25 years of age, whereas women's unemployment was twice that of men.

Underemployment—estimated at around 7%—affects a large segment of the EAP; most are in that situation because they work less than 30 hours a week.

Prevalence of poverty and social policies

Uruguay is one of the few Latin American countries with a high level of equity in income distribution. Under the military regime, however, poverty increased and income became more concentrated, both the result of the strong drop in real wages. From the beginning of the 1970s to 1984, the proportion of wages in national income decreased from 40% to 27%.[3] In 1985, with the restoration of democracy, the situation seemed to improve. In 1987, however, the poorest 20% of the population were receiving 6% of the total family income, whereas the richest 20% were receiving 44% of the total income.[4] Between 1970 and 1984, the number of poor families in Montevideo doubled. The situation improved, starting in 1985, when real wages and employment levels rose. From 1987 on this improvement reached the lowest strata as well as self-employed workers, while informal workers also recovered some buying power.

Between 1983 and 1989 the segment of the Montevideo population living in poverty fell from 19.3% to 13.1%, affecting 14.4% and 9.2% of households, respectively. As noted above, economic revival reduced so-called "new poverty" (households impoverished by the reduction of wages' buying power), but not "chronic poverty," which tends to remain constant despite economic improvements. In urban inland areas where this situation is most common, the "poor" population dropped from 29.5% to 19.3% of the total population, affecting 23.4% and 13.6% of households, respectively.[5]

Other methods of measuring poverty, based on unmet basic needs instead of income, which use poor quality housing and/or overcrowding, lack of potable water and toilet facilities in the home, and lack of access to schools and health services as indicators, estimated that in 1985, 22% of households were critically lacking in the above areas. Households with unmet basic needs (UBN) were concentrated in urban marginal and

more particularly in rural inland areas. According to these estimates, 40% of rural households, or 36.5% of households in municipalities with less than 2,000 inhabitants, 24.8% of households in municipalities with between 2,000 and 15,000 inhabitants, 17.7% of households in municipalities with more than 15,000 inhabitants, and 14.6% of households in Montevideo had some unmet basic needs.[6]

According to the 1985 household survey, the "poverty map" shows considerable regional disparities. At one extreme was Montevideo, with the smallest number of households (14.6%) with UBN. At the other were the central, northern, and northeastern departments, which had the greatest shortfalls: Treinta y Tres, 30%; Durazno, 30.2%; Salto, 31.9%; Tacuarembó, 37.4%; Cerro Largo, 39.8%; Rivera, 39.7%; and Artigas, 40.4%.[7]

For the most part, urban poverty affects laborers (two-thirds of the total), police and military families (18%), and self-employed workers (12%). Families with the least means (20%) also had more than 40% of the population younger than 14 years, which indicates that a high number of the country's youth and children suffer from severe nutrition, health, and education deficiencies. Some fetal malnutrition has been observed in this group. Thus, more than half of children less than five years old in poor families suffer from malnutrition-related conditions such as low weight and height for their ages.[8]

Social policies in Uruguay were developed early but began to decline in recent decades, especially those related to housing and social security, in a context of crisis which gave priority to solving the country's macroeconomic imbalances rather than to the welfare of its people. Social policy decisions thus tended not to have priority in the political agenda and to be scattered among various agencies and ministries. Lack of resources impeded their scope, and their effectiveness diminished noticeably.

The democratic revival brought about renewed emphasis on the social environment through policies aimed at the population groups most deprived of nutrition, maternal and child health care, housing, and other areas. Among these outreach agencies were the Centers for Care of Children and Families (CAIF), supported by public agencies with the participation of the United Nations Children's Fund (UNICEF). The institutional model has not been redefined, however, and policy fragmentation and the lack of an overall design still persist.

Public spending on social security, education, and health amount to 50% of the state's costs and 16% of the GDP, including local entities and autonomous social security agencies. Two-thirds of expenditures pertain to social security (13% of the GDP).[9] "Direct social expenditure"[10] is 6% of GDP and "human expenditure" is 4%, and so, though Uruguay is a country with "high human development," it ranks among countries with "average human expenditure." Because Uruguay is a country with a high per-capita GDP, this percentage is one of the highest in the continent in absolute terms, however.

Social security is, consequently, the most important pillar of social policy. It is financed by workers' and employers' payments, and increasingly by state contributions. It covers risks of disability, death, unemployment, illness, work accidents, and retirement pensions, and permits disbursements to families for maternity and other situations. Pension fund payments, or "pension checks," which have high population coverage, make up more than 80% of the disbursements. The social security system is composed of the Social Insurance Bank (BPS), the police and military pension fund banks, and the State Insurance Bank, in addition to various mutual benefit funds affiliated with the state.

The number of beneficiaries has been increasing since the 1960s, when pension disbursements began to include various working-age groups and families of dead retirees. The proportion of the population receiving some kind of financial compensation rose from 9% in 1955 to 25% in the mid-1980s. This expansion of benefits created growing pressure on public expenditures, which was checked by reducing the average value of the pensions and transfers received.[11] In 1989, the large amount of $736 million (28.6% of the state's expenditure and 9.2% of the GDP) was

allocated to maintain the system. The system's deficit, which in 1983 equalled 4.3% of the GDP, was one of the highest in Latin America.[12] However, 73% of pensions were less than $100 monthly, an amount that makes survival difficult.

Twenty percent of the country's 765,057 pension fund subscribers received pensions in 1989, though more than half of the retirees were under 60 years of age. In 1990, however, the number of persons over 60 years of age was only 510,000. The mismatch in these figures reflects the generosity with which pensions have been granted and the existence of multiple pension fund subscribers, whose number is difficult to reckon.

The system is now the focus of a national debate. Its viability is being questioned since it is so costly in public funding and in the long run does not solve many of the problems which justified its existence. Specific criticisms are directed at the smallness of pensions, the poor coverage of certain population groups, and the lack of progressivity in the system. In 1989, the wealthiest 20% of the population received 30% of pensions, whereas the poorest 20% received only 12.4%. Social security reform in fact poses a problem that is difficult to solve politically. The way in which this reform will be implemented will determine possible improvements in its efficiency, egalitarian nature, and effectiveness in providing well-being to Uruguayans.

The health situation, nutrition, and environmental sanitation

The health sector in Uruguay has three subsectors: public (Ministry of Public Health), with 8,948 beds; mixed, or mutual benefit fund, with 2,345 beds, and private, with 1,436 beds [13] The Ministry of Public Health is almost completely financed by its paying services, while the mixed, or mutual benefit fund, sector depends on family and state contributions. The private sector is relatively small and also includes voluntary bodies such as the Red Cross and Procardias.

The mixed sector serves the greatest number of consumers (more than half of the population), even though there are marked differences between the capital, Montevideo, and the rest of the country. In Montevideo, 69% of the population is covered by mutual benefit insurance, 17.3% by public health, and 8.5% by other, mostly private services. Approximately 5.1% lack coverage In rural areas, public health is of greater importance, however, since it protects 41.5% of the population, compared with 43.1% covered by mutual funds, 12% by other services, and 3.4% who are not covered at all.[14]

The state's participation in health expenditures is not major (around a quarter of the total), in contrast to education and other social expenditures. Health expenditures are distributed in a relatively progressive manner, since 20% of families with lesser resources receive 37% of total health allocations. This is due to the fact that public health mostly covers lower-income groups

Uruguay has one of the highest per-capita rates of health human resources in Latin America. In 1986 there were 31.9 physicians and dentists and 3.4 registered nurses for every 10,000 inhabitants. It has been noted that these ratios may indicate a surplus of personnel, associated with some underutilization of human resources. There is, moreover, a major imbalance between medical and auxiliary workers, with a high concentration of physicians in the capital (one physician per 192 persons).

Among the problems facing the health system are its almost exclusive reliance on curative rather than preventive medicine, poor coordination among the various services, uneven financing, and inefficient administration. One of the indicators of deterioration in the system is the low wages of its personnel, which have resulted in many vacancies and, at the same time, the extensive practice of multiple jobs, a paucity of university-trained nurses, and poor quality of services. The beginning of democracy saw the introduction of measures to rationalize services, such as the creation of the state's Health Services Administration, which enabled the Ministry to concentrate on health policy. There is still a need to modernize hospitals' infrastructures and equipment, raise wages, and put major emphasis on preventive

medicine. One of the most pressing health policy needs is the financial improvement of several mutual funds, whose situation is critical.

Child mortality dropped notably in 1978-1988 after almost two decades of relative stagnation. Whereas in 1978 it was 43.8‰ live births, it dropped to 20.3‰ live births in 1988,[15] though other sources place the rate at 23.8‰ live births.[16] The decrease in mortality was achieved through the Ministry of Public Health's campaigns against diarrheal diseases and respiratory infections. This proportion varies considerably according to the various social and economic strata. It was 13‰ in the middle and upper classes, and 40‰ among the poor served by public health.[17]

The four leading causes of death in the Uruguayan population in 1986 were diseases of the circulatory system (40.1%), malignant tumors (23.2%), diabetes mellitus (2.1%), and respiratory diseases such as bronchitis, emphysema, and asthma (1.2%). These death causes, as well as high life expectancy at birth (more than 72 years), are usually seen in countries with a high level of development and urbanization. Maternal mortality was 4‰ live births in 1986.[18]

Special mention should be made of the health situation of elderly persons. It is estimated that, though they represent only 16% of the population, persons over 60 years of age account for more than a third of the country's medical consultations, consume 34% of all medicines, and incur 41% of the country's pharmaceutical expenses. The same group is also responsible for 25% of all hospitalizations, with an average stay longer than that of the rest of the population, which highlights the importance of geriatric medicine in Uruguay.[19]

Dental health is one of the most critical challenges facing the Uruguayan health system. Tooth decay affects 98% of the population, and there are well-known deficiencies in prevention programs. Sexually transmitted diseases (STD) are grossly underreported and increased during the second half of the decade. Chagas' disease can still be found in the country's northern rural areas. Hepatitis A is more frequent and endemic in areas with poor sanitary conditions. From 1983 to mid-1992, 278 cases of AIDS and 139 deaths were reported, which represents an intermediate situation in the region, though the trend is upward.[20]

There is no general information on the nutritional status of the Uruguayan population. Some recent, if partial, studies show that although it has been satisfactory in recent decades, there are differences in the nutritional status of children according to their social class and residential area. Significant deficiencies are seen in the poorest segments and in rural and marginal urban areas. Of pregnant women under 21 years of age who sought care in the public health sector serving persons with limited or no means, 54.1% were underweight in 1988. The proportion was 33.5% in women over 21 years of age. In 1988, 8% of infants were born with low birth weight (less than 2.5 kilograms) and 10% had an inadequate weight (2.5-3 kilograms).[21] The nutritional census conducted of all first-graders in the country in 1987 indicated that 80.3% were of normal height, compared with 84% of children in developed countries. The census showed a close correlation between schools in areas having homes with UBN and the greatest nutritional deficiencies.[22] Child mortality caused by vitamin and nutritional deficiencies was only 3.7% in 1988, however, according to data from the Ministry of Public Health.[23] Students and mothers and children are the targets of the state's nutritional programs. The Ministry of Public Health, through its maternal and child program, distributes food to groups at risk. The school dining room program of the Schoolchildren Development Commissions covered 125,000 children in 1988.

In the area of environmental health, 26% of households lacked running water and 27% lacked flush toilets at mid-decade. Public sanitation networks covered 47% of households (53% in urban and only 4% in rural areas). In rural areas, only 10% of households were connected to general water networks.[24] Pollution of waterways is common. In 1988, Montevideo's shore was contaminated with coliform bacteria, which led the Ministry to recommend that offshore bathing be avoided. Solid waste disposal is the responsi-

bility of departmental authorities. The method used is sanitary landfilling, but a chemical plant has been put in operation in Montevideo.

Over 200 pesticides, forbidden in many countries and considered dangerous to health by international organizations, are routinely used in Uruguay. They cause serious environmental deterioration and health problems like poisonings and cancer, whose magnitude it is difficult to estimate. Studies at the Faculty of Medicine have shown that persons exposed to pesticides have elevated concentrations of chlorinated residues in blood and maternal milk Other studies, sponsored by the Organization of American States (OAS) in 1980 and 1986 to measure the level of pollution in the Plata River, showed that the concentration levels of aldrin, dieldrin, and DDT (all chlorine derivatives) were in all cases higher than those established by the World Health Organization (WHO). Very high concentrations of agricultural poisons were also found in eastern milk-producing and rice-growing regions. Uruguayan agricultural products were often rejected by other countries because they contained toxic pesticide residues prohibited by industrialized countries. An example is lindane, which is much used in farming, industrial and household fumigation, and even as a pharmaceutical preparation for human consumption, despite its demonstrated adverse effects on health and its carcinogenic potential.[25]

Housing and basic services

During the past two decades, some improvement has been observed in dwellings in ownership by occupants, quality of construction, and available space and services. In the mid-1980s, 57% of the population owned the homes in which they lived and 93.6% of dwellings had at least masonry walls. It is estimated that only 1% of dwellings (even those located in marginal urban or rural areas, particularly in the suburbs of Montevideo) were shacks or were built of waste materials. 8.6% of households were overcrowded.[26]

The proportion of inadequate dwellings (21%) is much larger in rural areas.[27] They are also those that most lack basic services. The low proportion of rural dwellings with access to water and sanitary facilities has already been noted. The same situation prevails with respect to electricity, since the proportion of dwellings connected to networks in 1985 was 85% nationally and 92% in urban areas, but only 36% in rural areas

The education situation

Preprimary education coverage grew by 47% during the last decade, though it covers only a sixth of the children who begin primary school, and that mostly in Montevideo and the highest socioeconomic strata. This situation is worrisome inasmuch as this imbalance in availability makes the disadvantages of poor children worse and causes problems for poor mothers in carrying out income-producing activities.

Primary schooling covers all school-age children, one sixth of whom enroll in private schools. The unequal distribution of schools in the country has led to serious overcrowding problems in some schools and underutilization in others in terms of low instructional quality and benefits therefrom. There are high repetition and school dropout rates among the poorest segments of the population.

Secondary education is organized into two cycles. a preuniversity cycle and a technical and vocational cycle. The latter has serious problems in adapting to the requirements of the labor market, which has led to a proliferation of private non-formal education methods. As are primary schools, secondary schooling is affected by the "deprofessionalization" of teaching because of low wages and educators' multiple jobs

Higher education faces a problem of large numbers of students because of the great increase in enrollment (as many as 60,000 students) and budget deficits hindering it. The extreme rigidity of the university system and its maladaptation to the labor market have already been noted. As with secondary education, university education

needs comprehensive academic and administrative reform.

The situation of women

Since the beginning of the 1980s, Uruguay has shared with Argentina and Panama the highest rates of female activity in Latin America. The proportion of female participation in the labor force is also higher in Montevideo (45% of the EAP are women) than in other cities in the region (33% in Buenos Aires, 41% in São Paulo). This high rate results from various factors, such as male migration, the greater industrial proportion of the EAP, and especially the deterioration in real wages, which forced many women to seek employment to supplement their families' incomes. The economic crisis has thus brought about an increase in the participation of women in the work force. Women work mostly in factories and services, in the latter in occupations considered "female" such as domestic service, teaching, nursing, and trade. Women's wages are much lower than men's in the same occupations. In 1986, for example, the average wage of women was 19,000 new pesos, as against 36,000 for men.[28] Since 61% of working women also have home responsibilities, the "double work day" is very common.

Low preschool education coverage impedes the entry of low-income women into the work force. Only 22% of children of working mothers below the poverty line are cared for by nursery schools or child centers, most of the rest being left to the care of other family members.[29]

Unemployment affects women—and particularly young women— to a greater extent than men, with rates twice the national average. In 1988, the unemployment rate of women under the age of 24 was almost 30% in Montevideo and 24% elsewhere in the country, as against 8.9% nationally.[30] These figures are probably related to relatively low hiring of women with children.

As for work force education, the differences between men and women are very small, except in nonuniversity technical and vocational training, in which women represent only one-third of the total, and in studies traditionally reserved for women like primary school teaching, where 85% of teachers are women.

Children born out of wedlock are beginning to be an increasingly important problem. Twenty-six percent of children are born out of wedlock, 23% in Montevideo and 29.6% in the rest of the country. This occurs mostly among adolescents and less educated women. Of the babies born out of wedlock, 77% are born to women under 15 years of age and 47% to 15- to 19-year-old women. Moreover, three of every four deliveries by uneducated women and 58% of those by women with incomplete primary education have these characteristics. In fact, there is a high proportion of single mothers, which largely reflects paternal irresponsibility, limited access to family planning, and the need to provide more education in this area. Many children cannot, therefore, be supported as the law requires. Directly related to this situation, 14% of households with children are headed by women, and such households are often poor.

Although there are no data on abortion since it is officially illegal, conservative estimates indicate that the number of abortions is at least as great as of births.[31]

Violence against women, both in and outside the home, is a serious threat to the female population. Violence at home, which in some instances degenerates into murder (some studies in the 1980s showed that in 20% of homicides, the victim was one of the partners),[32] reflects the prevailing traditional concept of patriarchal marriage. The existing reporting system, as well as the previous one, have not provided safety mechanisms to ensure that women who report abuses will not suffer further attacks. This has been a serious impediment to preventing violence against women. Moreover, some courts and police departments legitimize marital violence to a certain extent, and sexist features persist in the Penal Code.

The situation of children and youth

Because of Uruguay's demographic characteristics, the proportion of youths under the age of 14 is relatively low and is decreasing. According to 1985 census data, this age group represents 27% of the population. The incidence of poverty in the group is nevertheless greater than its proportion of the total population. According to data from UNICEF and the United Nations Economic Commission for Latin America and the Caribbean (ECLAC), children under 13 years of age represent approximately 40% of the country's population with UBN (42% in Montevideo). It is well known that poverty in Uruguay mostly affects families with heads of household who are under the age of 30 and have children. In other words, almost half of Uruguayan children are born and live in poor, overcrowded homes lacking basic services and having problems surviving.[33] According to the 1985 census, some 3,700 children between the ages of 12 and 13 and 92,168 children between the ages of 14 and 19 worked in the economy's "visible" sector.

The National Children's Institute, formerly the Children's Council, is the agency responsible for youth at risk, those who are abandoned or delinquent, and others. In 1986, 25.4% of the Institute's entrants were due to mothers' work, 22.6% to financial inadequacy, 11.3% to delinquency, 10% to behavioral maladjustment, and 5.5% to maternal abandonment. The Institute provided care to 2,519 institutionalized and 1,061 noninstitutionalized youth in 1987. Since 1989 the Institute has been implementing preventive programs for street and poor youth in an effort to reverse prevailing institutional strategies. The need to deal with the causes and not the effects of the situation has been pointed out, taking into account the fact that 48% of entries are caused by financial difficulty or mothers' work.[34]

Unemployment particularly affects young people and, as already noted, young women. The youth affected include not only the poor who cannot find employment because of their lack of training, but also those who are better trained but are seeking jobs for the first time and come from higher social strata.

The situation of the elderly

The country's "mature" demographic profile is determined by its low birth and death rates, long life expectancy, and migratory movements, and is characterized by the gradual aging of its population. In the early 1960s, 9.8% of the population was older than 60. This proportion rose to 15.7% in 1985 and represented 462,700 persons, 326,000 of whom were more than 65 years of age. Projections for 1990 and 2025 are 16.5% and 18.4%, respectively.

Elderly people are mostly found in urban areas, and especially Montevideo. Around 13.4% of them live alone, as opposed to 1.6% of the rest of the population. Most people living alone (70%) are women, as the National Health Survey revealed. To these must be added people institutionalized in asylums or homes. Loneliness and isolation are now the main problems of the elderly, and are at the root of psychological disturbances which often result in other health problems.

There are more elderly people in low-income groups because of small pensions. It has been noted that passage from active life to old age often leads to poverty As noted above, most old-age pensions do not support retirees and force them to seek family assistance. In this context, it is significant that various agreements between the Government and international financing agencies were made public in May 1989 which stipulated a reduction in pensions. Following an intense campaign, retired persons' associations succeeded by plebiscite in obtaining a constitutional reform under which pensions would be readjusted in the same proportion as the wages of public officials

Despite the importance of this group and the specific nature of its problems, there is neither a policy nor an agency governing this area. Although families have traditionally been responsible for the care of their elderly, development and urbanization are dissolving this practice which,

combined with the considerations above, increasingly translates into abandonment of and loneliness among the elderly.

Present practices are based on institutionalization of the elderly, whether for health, social, or family reasons. Aside from the options of institutionalization, remaining in the family, or living alone, there are no "intermediate services" to respond to the distinct needs of this age group. In Montevideo alone, it is estimated that there are about 300 (mostly profit-making) "health houses" or homes, of which only 140 are properly registered or negotiating their registration. The others are "clandestine" in nature and often operate without meeting acceptable medical, sanitary, and housing standards Prevailing regulations and the ability of public authorities to supervise such institutions are notoriously inadequate

The impact of international cooperation

Because of its developmental levels, assistance and cooperation agencies do not consider Uruguay a priority country, as a result of which, despite the lack of consolidated data, it may be said that it has not obtained significant external assistance. Starting with the restoration of democracy in 1984, however, several programs of varied nature and sources were established. Their sponsorship was bilateral, as by the Agency for International Development (USAID), or multilateral, as by the United Nations Development Program (UNDP), Inter-American Development Bank (IDB), International Labor Organization (ILO), and UNICEF. Most of them were technical assistance programs aimed at strengthening social programs.