Series
Health Sector Reform

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Health Sector Reform: The case of Puerto Rico

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CONTENTS

INTRODUCTION

Responding to a request by the health authorities of Puerto Rico, a working party made up of staff from the different divisions of the Pan American Health Organization (PAHO) met over a three-day period with more than 100 people representing the Department of Health, the Health Insurance Administration, a variety of public institutions, and private insurance carriers to analyze the progress made in health reform and to identify and come to an agreement on areas suitable for PAHO technical cooperation to further this reform.

The work accomplished during this meeting facilitated coordination among the divisions and programs at PAHO Headquarters and brought the participants up to date on the health sector reform that had been proposed and implemented—a reform program with characteristics very different from those of other efforts under way in the Region. In particular, the work made it possible to provide an appropriate response to a specific request by one of the Member Governments of the Pan American Health Organization.

One of the recommendations that emerged from the work, specifically for the Program on Organization and Management of Health Systems based on Primary Health Care (HSO), was to prepare a report entitled "Health Sector Reform: The Case of Puerto Rico" to share experiences and document the process, identifying critical areas for change.

The present report was prepared in response to these guidelines. It is based on an exhaustive analysis of the available literature, combined with semistructured interviews with representatives of the institutions involved in the reform process, always seeking the opinions of the pertinent political, technical, administrative, and executive actors.

The report begins with a series of issues and general reflections on the transformation of States and health systems, and an attempt is made to describe the context of the key areas of the Puerto Rican reforms, followed by a discussion of the differences in their implementation and administration.

The background of the reform process and its current status are analyzed, and the report concludes with some specific recommendations that could be utilized to guide eventual changes.

The Division of Health Systems and Services Development and the Program on Organization and Management of Health Systems based on Primary Health Care presents this publication as a contribution to the discussion of the reform processes in the Region.

1. REFLECTIONS ON THE REFORM OF THE STATE AND HEALTH SYSTEMS

It is generally accepted that the role of the State in Latin America has expanded considerably, making it a key protagonist in the societies of these countries. Indicators such as the ratio between public expenditure and gross domestic product (GDP), the share of public investment in the fixed gross investment of the economy, state participation in the job market, and the importance of public enterprises as some of the largest operations in the economies are indicative of this trend[1].

This heavy State intervention stems from structural weaknesses in the economic and social system that once gave no signs of changing in the short term, thus reinforcing state participation.

Given this context, some theoreticians have debated whether the State is obliged to intervene. The majority believe that it should and that the discussion should therefore center on the "how" of the intervention and on whether the State possesses the necessary managerial and administrative capacity.

Studies are available that pinpoint some of the serious problems affecting the State in Latin American that have led to the current reform proposals.

The dichotomy between policy and administration is one of the major problems identified. Policy-making has been separated from administration, a circumstance reflected in both public administration and university education in the Region of the Americas.

Obsolete perceptions are another factor. Traditional managers have believed that defining the orientation of their organizations' work is sufficient to achieve the expected results, without understanding that managerial capacity and a major commitment are required at the middle management and operational levels.

The poverty of strategic thinking in public administration is another major weakness of the State in Latin America. Both the short-term, non-prospective and the long-term visions have prevented the homogeneous development of societies, a factor that has been coupled with the introduction of essentially "logistical" personnel policies in state agencies. Traditional managers in the public sector have forgotten that organizations are "the people who work in them" and have confined themselves to interpreting "human resources administration" as a cold process of recruitment, selection, and remuneration. Human resources development as part of state management has been neglected.

It has also been noted that public administration has pursued a distorted and dependent global technology policy. Technology consumption is a fact of life in our countries. Vast sums of money are spent, for example, on the procurement of equipment and software that fail to produce the anticipated

[1] Kliksberg Berardo, Gerencia pública en tiempos de incertidumbres: Instituto Nacional de Administración Pública, Madrid, 1989.

changes in institutional decision-making, and the authorities, still believing in the myth of "neutral technology," try to incorporate management and organizational models born of different contexts and, hence, unsuitable to the current realities.

We must break away from this outdated paradigm and develop a new one that replaces the prescriptive approach with a heuristic model that properly identifies the sources of state efficiency, assigns a key role to innovation in development, promotes the consolidation of genuine values, and permits the introduction of flexible organizations that promote creativity, effectiveness, and the well-being of the population.

The longstanding debate on the role of the State has been supplanted by a debate on what the orientation of state intervention strategies should be.

Today it is understood that the role of the State is essentially to safeguard the well-being of society and that we must devote ourselves to developing strategies that will permit interventions that are not only reasonable but efficient and effective.

It is also understood that to guarantee the general welfare it is not necessary for the State to act as a direct provider of goods and services and, moreover, that there are areas of development where it is unreasonable for the State to participate directly in management. However, there are a number of strategic areas where the State should retain responsibility, which does not necessarily imply management by its institutions.

What is currently emerging is a State that is essentially a policy-maker and regulator of policy administration--with the actual administration in the hands of private organizations.

Part of the state reform processes is the reform of public health systems.

Health conditions worldwide have undoubtedly improved, a phenomenon that has been most evident in the past 40 years. This improvement has not only had a positive impact on the well-being of population; it has reduced the economic burden represented by workers in poor health and raised the educational level of new generations, which until some years ago were kept out of school by a variety of diseases.

Despite the progress, however, enormous health problems persist, with vast differences in the situation of the developed and the developing countries. In addition to the mortality and morbidity characteristic of underdevelopment, new challenges have emerged, such as acquired immunodeficiency syndrome (AIDS) and the resistance of the malaria parasite to the available drug therapies.

There is no doubt whatsoever that public health systems have played a key role in improving public health in every country in the world. However, these systems also have serious problems that, if unresolved, will slow the rate of progress that has been achieved up to now.

The World Bank Report of 1993[2] highlights four major problems in the world's public health systems.

a) *Poor resource allocation.* The report contends that public funds are squandered on health interventions with limited cost-effectiveness. This means that hospital costs account for 65% of total health care expenditure.

b) *Inequality*. Public health expenditure benefits most those with the highest income. The poor have little access to basic health services, and the care that they receive is usually substandard.

c) *Inefficiency.* Much of the money spent is not properly utilized. Proprietary drugs are favored over generic drugs, health workers are poorly distributed, and hospital beds are underutilized.

d) *Exploding costs.* The biological approach to health care perpetuated over the years contributes to the high operating costs of the health systems, since it promotes highly specialized medicine and high levels of technology consumption.

This report proposes the adoption of three measures that will help to improve the situation.

a) *Promotion of an environment that enables families to improve their own health.* Adopting economic growth policies that benefit the poor, increasing investment in education, and promoting women's rights and improvements in their health status are among the aspects considered important.

b) *Better targeted public expenditure in health.* Reducing spending on tertiary care facilities, the training of specialists, and the promotion of interventions that have little impact on health levels are some areas that should be addressed.

Others aspects that should be considered are: the financing and implementation of public health measures to deal with emerging diseases; the financing and uninterrupted delivery of a basic package of clinical services that meet the demands of the epidemiological conditions in each geographical area; and improvement of state health services management through measures such as administrative and budgetary decentralization and the subcontracting of services.

c) *Promotion of diversity and competition.* Promoting social security or private insurance systems through regulated incentives that foster equity and cost containment; encouraging competition among public and private providers of clinical services and supplies; generating and disseminating information on the performance of service providers, costs, the

[2] World Bank, World Development Report 1993: Investing in Health. Washington, D.C., 1993.

effectiveness of interventions, and the level of accreditation of the facilities and institutions the provide health services.

Within this context, every country in the Region of the Americas has launched a reform of its public health system, basing its actions on two guiding principles: equity and cost containment.

In some cases the strategies utilized involve the consolidation of state participation in public health services administration, with limited participation by the private sector. In others, States promote the privatization of the system as a result of a clear policy in this area or in response to the natural shortcomings of the public system, causing them to steer the population toward the private system.

In light of this situation, the analysis of health sector reform in Puerto Rico enables us to visualize the following:

a) General reform of the State involving educational reform to foster an environment that will enable the family to improve its own health.

b) Reduced public health expenditure by promoting managed care, the financing of activities to deal with emerging diseases such as AIDS, and a basic, guaranteed package of essential clinical services. Also, an improvement in the management of the health services through private sector involvement.

c) The creation of regulated incentives that encourage private insurers to promote both equitable access by the population to health services and cost containment; the promotion of competition among private health service providers; the generation and dissemination of information on provider performance; and the accreditation of facilities and institutions that provide health services, based on the standards already established by private insurers.

These measures all promote diversity and competition.

In this context, the key elements of Puerto Rico's health sector reform are also equity and cost containment.

Two aspects of the Puerto Rican reform process make it substantially different from the reforms in other countries of the Region of the Americas. The first is the indigenous nature of the Puerto Rican reform process, which is the product of independent thought, knowledge, and political decision-making. The second is the active role played today by the private sector in the management and delivery of public health services, which indicates that achieving social equity with broad participation is possible, provided that the State clearly shifts its role from that of service provider to regulator. The absolute responsibility for the health of the population is retained and strengthened, but the administration of that responsibility is delegated to organizations in the private sector.

2. GENERAL OBSERVATIONS ON THE ECONOMIC AND SOCIAL SITUATION

Since 1970 significant economic development has taken place in Puerto Rico within a framework of political stability, democracy, and opening of markets.

The Puerto Rican economy is no longer based on agriculture but manufacturing and service activities. Two-thirds of the population were rural dwellers in 1940; today, two-thirds live in urban areas. Some 45% of the country's work force was engaged in agricultural activities in 1940; by 1990 that percentage had plummeted to 3.7%.

These changes have been accompanied by significant economic growth and social development. In 1948, the GDP per capita was $1,478; by 1994 it had risen to $6,361. This growth in income has been associated with an improvement in the quality of life of Puerto Ricans. In the field of health, for example, there was 1 physician for every 3,763 inhabitants in 1940, while in 1990 the ratio was 1 for every 350 inhabitants.

Life expectancy at birth in 1940 was 46 years; in 1990 it was 75. Infant mortality fell drastically from 109.1 per 1,000 live births in 1940 to 14.3 in 1990.

Education is another area of marked development. In 1950, only 7% of the population over the age of 25 had completed primary education. In 1990 this proportion had risen to 50%. Furthermore, in 1940 31.5% of the population over the age of 10 could read and write in some language. This proportion increased to 90% by 1990.

In contrast to the situation in the 1940s, Puerto Rico's economic growth in the past 15 years has generally been the highest in Latin America,.

It should also be noted that the market economy promoted in Puerto Rico since 1970 has had a severe impact, especially on the younger population. According to official statistics, in 1970 unemployment in the population 16 to19 years of age was 17%; in 1990, it was 54%. For men aged 20 to 29, the figure rose from 7% to 24% in that period, while the figure for women in this same age group rose from 8% to 29%.

In 1995, the inflation rate was 4% and the overall unemployment rate, 14.1%. At the present time, 58% of the population is below the poverty line, with unemployment at 12%.

This situation has been accompanied by social unrest and rising crime, manifested in a general increase in theft and violent deaths. Puerto Rico exhibits the basic characteristics of countries that adopt structural adjustment policies that give special priority to trade liberalization.

Table 1 presents some recent vital statistics for the country, complemented with Graph 1 indicating the demographic structure.

Table 2 shows the employment trend by industry, indicating the growth of the service and manufacturing sector and the decline in agriculture. Graph 2 compares the GDP per capita of Puerto Rico with that of other Latin American nations. Finally, Graph 3 compares the GDP per capita of some U.S. states with that of Puerto Rico. Puerto Rico's has a clear advantage over other countries of the Region of the Americas; not so, however, when compared with the United States.

The causes of death are characteristic of the developed countries, as shown in Table 3.

3. BACKGROUND

Before launching its reforms, Puerto Rico had regionalized public health services organized by levels of care (and still maintains this structure in some areas where the process has not been implemented).

At the primary level, the system had health centers that offered preventive and curative services (outpatient consultations), emergency services, obstetrical services, minor surgery, and home visits. These centers generally covered the area corresponding to a municipio.

Table 1: **Vital Statistics * - Puerto Rico, 1993-1994**

	1994	**1993**
Total Population	3,685,729	3,621,5338
Crude Birth Rate	1.75	1.80
Crude Death Rate	7.7	7.9
Crude Infant Mortality Rate	11.5	13.4
Neonatal Mortality	8.7	9.7
Postneonatal Mortality	2.8	3.7
Fetal Mortality	9.9	11.1

Source: Department of Health, Auxiliary Secretariat of Planning, Evaluation, and Statistics, San Juan, Puerto Rico.

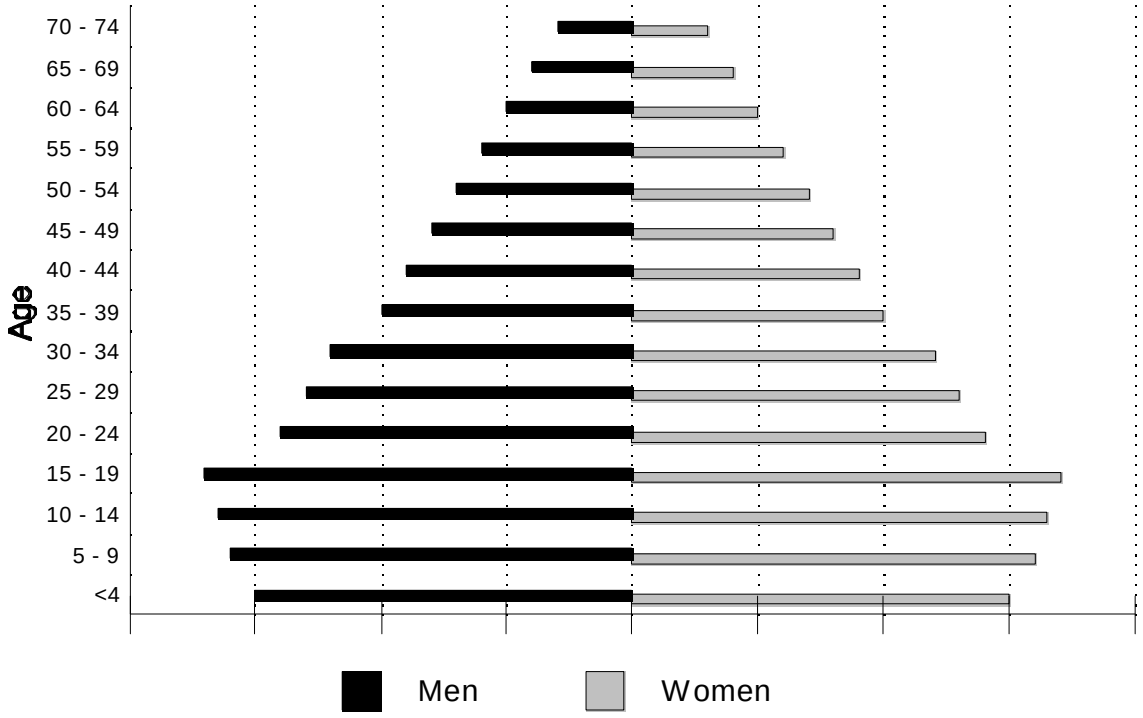
* Rates per 1,000

Table 2: **Employment by Industrial Sector - Puerto Rico, 1950-1990**

Sector	**1950**	**1960**	**1970**	**1980**	**1990**
Agriculture	210,000	131,000	66,000	41,000	35,000
Construction	26,000	50,000	78,000	45,000	56,000
Manufacturing	111,000	91,000	132,000	141,000	158,000
Trade	92,000	98,000	130,000	141,000	190,000
Transportation	30,000	40,000	47,000	48,000	61,000
Services	81,000	78,000	117,000	136,000	213,000
Government	47,000	64,000	107,000	177,000	218,000
Others	5,000	8,000	16,000	23,000	33,000
Total	601,000	558,000	693,000	760,000	971,000

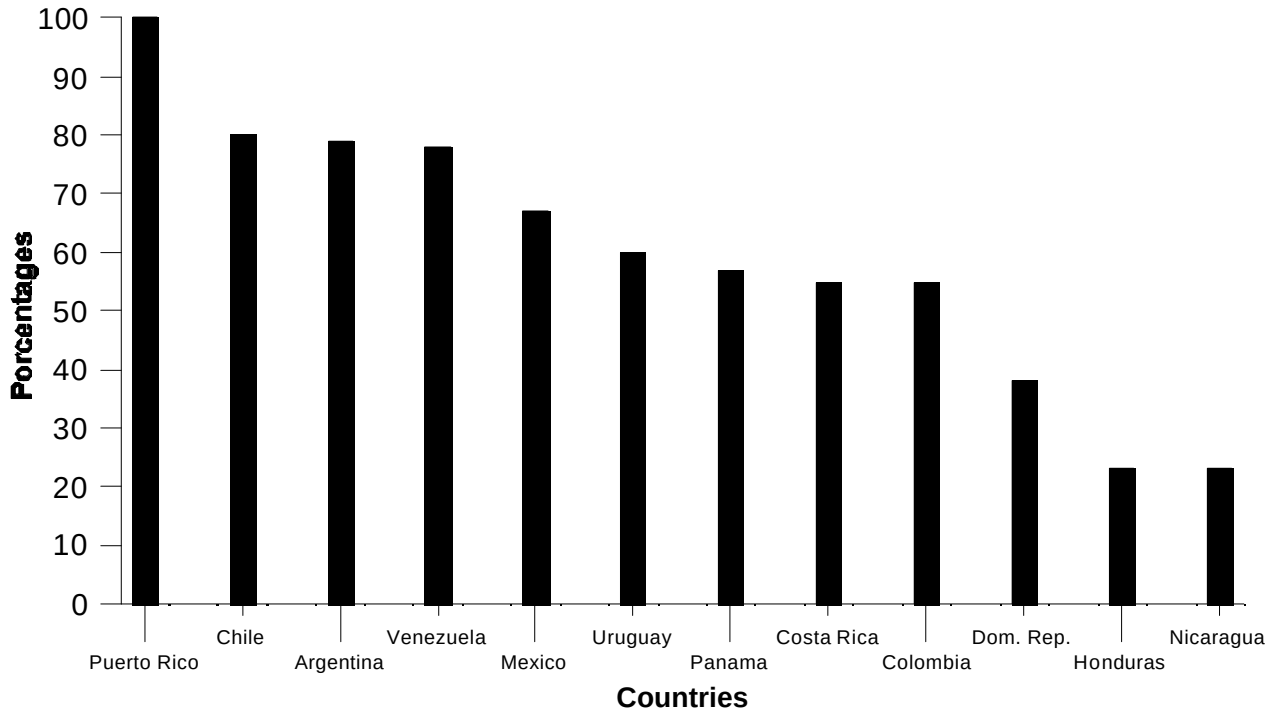
Source: Puerto Rico Department of Labor and Human Resources, Bureau of Labor Statistics. 1990

Graph 1: **Population Distribution by Age and Sex - Puerto Rico, 1990**



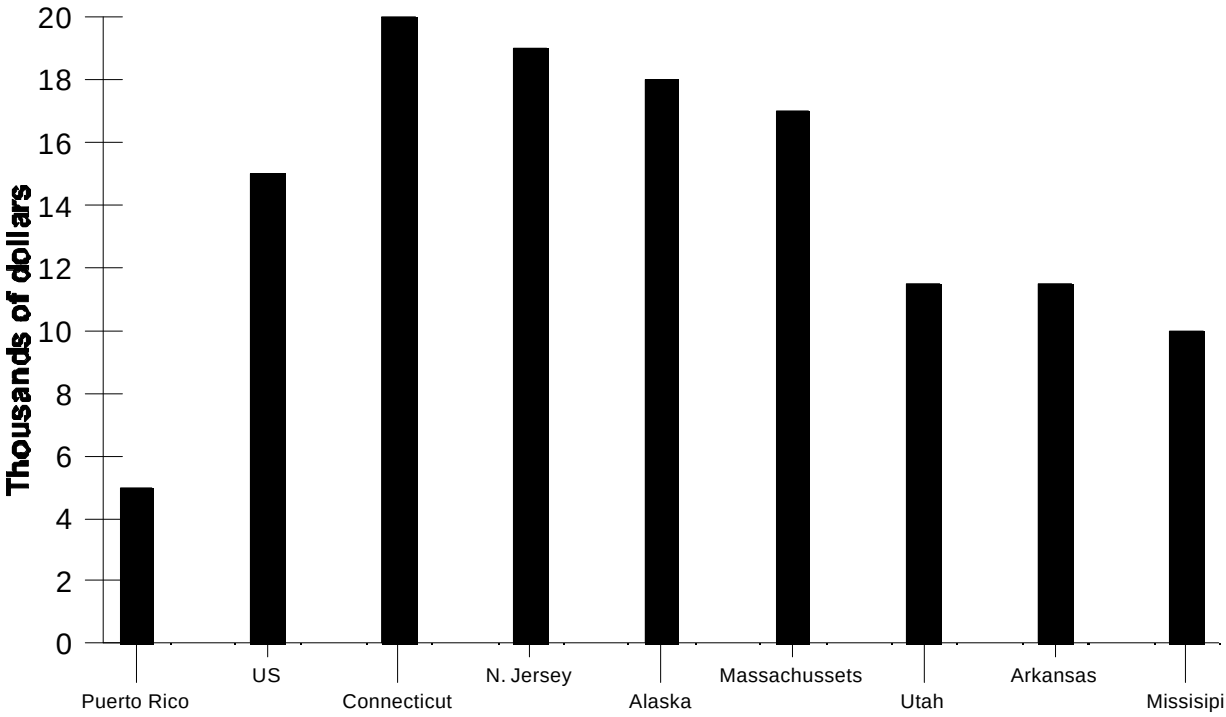
Source: AFASS Office of Health Statistics. Dept. of Health Puerto Rico.

Graph 2: **GDP Per Capita - Comparison of Puerto Rico with Countries of Latin America**



Source: World Bank (1995)

Graph 3: **Income Per Capita in Puerto Rico and the United States - 1990**



Source: Economic Report of the Governor of P.R., 1991 and Statistical Summary of the United States, 1991.

Table 3: **Fifteen Leading Causes of Death - Puerto Rico, 1993-1994**

Order	Causes of death	1994			1993		
		Number	%	Rate	Number	%	Rate
	Total	28,444	100	771.7	28,494	100	786.8
1	Heart disease	5,817	20.4	157.7	5,897	20.7	162.8
2	Malignant neoplasms	4,298	15.1	116.6	4,427	15.5	122.2
3	Diabetes mellitus	1,868	6.6	50.7	1,876	6.6	51.8
4	HIV infection	1,549	5.4	42.0	1,433	5.0	39.6
5	Cerebrovascular disease	1,428	5.0	38.7	1,433	5.1	39.8
6	All accidents	1,313	4.6	35.6	1,236	4.3	34.1
7	Pneumonia and influenza	1,187	4.2	32.2	1,175	4.1	32.4
8	Chronic obstructive pulmonary disease	1,186	4.2	32.2	1,157	4.1	31.9
9	Homicides and legal intervention *	1,017	3.6	27.6	918	3.2	25.3
10	Hypertensive diseases *	916	3.2	24.6	959	3.4	26.5
11	Diseases of the liver and cirrhosis	654	2.3	17.7	772	2.7	21.3
12	Septicemia	504	1.8	13.7	489	1.7	13.5
13	Conditions stemming from the perinatal period	468	1.6	12.7	517	1.8	14.3
14	Nephritis and nephrosis	388	1.4	10.5	423	1.5	11.7
15	Atherosclerosis	243	0.9	6.6	272	1.0	7.5
	Other causes	5,611	19.7	152.2	5,500	19.3	151.3

Source: Department of Health. Auxiliary Secretariat of Planning, Evaluation, and Statistics, Division of Statistics, San Juan, Puerto Rico

* In 1993: Hypertensive diseases were in ninth place, with homicides and legal intervention in 10th.

Also at the primary level, the system had area hospitals with approximately 150 beds and radiology and laboratory services to support more complex diagnoses. The coverage area included several municipalities.

At the secondary level, there were subregional hospitals with 350 beds and more specialized services. The level of coverage was two or more areas. Finally, at the tertiary level, there were regional hospitals with approximately 450 beds and the full complement of clinical specialties and subspecialties, together with the necessary support services for their operation. These hospitals covered two or more health subregions.

According to official statistics 47% of the country's population has access to the public health services. Of this population, 34% receives care financed out of the general state budget and 13% is covered by Medicare. Eleven percent does not receive any type of service, and 42% of the total population uses private physicians. In addition, the figures reveal a significant difference in the quantity and quality of the services provided, with the private health sector clearly at an advantage. They also show higher mortality in the group that receives its care from the public system. A high degree of inequity is also evident in the distribution of human resources, which are concentrated in large urban areas closer to the capital, as seen in Table 4.

Government authorities also note the rather inefficient growth of public expenditure in health, considering it a manifestation of the general state inefficiency.

Table 4: **Providers prior to Health Sector Reform - Puerto Rico, 1996**

Providers	Fajardo	Guayama	Arecibo	Central	Northwest	East	Southwest	Total
Total physicians	110	111	180	105	83	114	61	764
Primary	53	46	65	73	43	32	21	333
Specialists	57	65	115	32	40	82	40	431
Centers	8	7	12	16	6	7	3	59
Pharmacies	9	18	10	16	7	8	4	52
Hospitals	1	51	1	4	1	1	1	10
Laboratories	6	95	11	7	3	2	2	36
Dentists	13	9	15	20	5	8	5	75
Total	147	141	229	168	105	140	75	1.005

Source: Insurance providers

In Puerto Rico total health expenditure in 1990 was $2.5 billion, or 10.9% of GDP. These expenditures can be broken down as follows: $1.1 billion, private health sector; $606 million, Federal Government; $482 million, state government; and $261 million, miscellaneous[3].

A global analysis of the overall development of the State, the government sector, and the health system conducted by the Government shows the following:

a) Between 1960 and 1992 the number of public entities grew by 154%.

b) Employment by economic sector changed markedly between 1950 and 1992, with trade coming to represent 15% to 20%, the agricultural sector declining from 36% to 4%, and the government apparatus expanding from 7% to 29%, making the government the largest employer in the State.

[3] Instituto de Administración y Política de Salud de Puerto Rico. Coordinating Health Care Reform with the U.S. Territories and Possessions: The Case of Puerto Rico. San Juan, Puerto Rico,1996.

c) The consolidated government budget grew by 160% between 1970 and 1990, currently representing 10.9% of GDP, as stated above. Of this figure, $1,500 million (6%) correspond to the private sector, and $1,000 million (4%) to the public sector.

Within this context, a rethinking of the development strategy of the Puerto Rican State has been promoted, based on a more entrepreneurial concept of government and greater effectiveness and efficiency in society through decentralization, privatization, deregulation, less bureacracy, and a reorganization of government programs.

4. THE REFORM OF THE HEALTH SYSTEM

Within the context described in the previous section, the reasons for the reform package promoted by the Government of Puerto Rico are the following:

a) The existence of two separate and unequal health systems: one covering those with the ability to pay through private insurance; and the other covering the rest of the population, the "medically indigent", through the public health services. Private insurance allows subscribers free access to the health services while offering them health service options. Not so the public system.

b) Inefficient use of public resources.

c) Major cost increases in the government health services.

These factors constitute the rationale for the basic principles of health sector reform in Puerto Rico, which are:

a) To eliminate duality and discrimination in medical care.

b) To guarantee access to quality health services by the entire the population.

c) To increase the efficiency and productivity of the health system through mechanisms that foster competition.

d) To improve the quality of the health services.

e) To reorient the government's health intervention strategies toward regulation and control of the personal health care component, as well as health promotion and disease prevention.

The proposed model reorganizes the health system, assigning a steering role to the Department of Health, in the understanding that health is a social good and not just something having to do with direct patient care. It is understood and accepted that health is a universal right, for which the State and civil society are collectively responsible. This means that the Government is the guarantor of the rights and responsibilities of citizens in this matter. In this context, the Department of Health must have the capacity to lead, carry out, and control activities that promote and guarantee the health of the country's population.

In this rethinking of the structure of the system, it is the responsibility of the Department of Health to formulate, organize, and implement the national health policy through planning and mechanisms that foster adequate participation and linkage between health sector institutions and other social actors and that make it possible, moreover, to obtain and properly distribute financial resources.

The functions of the Department of Health are specifically:

a) Formulating and implementing public policy

b) Planning insurance for the medically indigent population and health promotion and protection for the entire population.

c) Regulating the health services, professional practice, and health care facilities.

d) Monitoring and analyzing the health situation.

e) Evaluating and controlling the quality of the services.

f) Implementing the programs for health promotion, environmental health, and other areas.

At the same time, the Government of Puerto Rico has created the Health Insurance Administration of Puerto Rico (ASES) through Law 72 of 7 September 1993. The mission of this agency is to give the people of Puerto Rico access to specialized health services through a managed care model by contracting private health insurance companies and monitoring and evaluating the insurance companies contracted to guarantee free selection and cost-effective, quality services.

Within this frame of reference the basic functions of ASES are the following:

a) To establish a health insurance system that will offer qualified (medically indigent) beneficiaries of the Department of Health access to quality medical and hospital care. Medical indigence is currently defined as a family income of $800 dollars or less, with $190 for each additional household member. The Department of Health certifies those classified as medically indigent by examining their income (the Department has offices throughout the country). This information is transferred to ASES and from there, to the various providers.

b) To negotiate with and contract public and private health/hospitalization insurance carriers under the pertinent legal mechanisms.

c) To establish a fund with state, federal, municipal and other resources to finance insurance for the medically indigent population.

d) To regulate and evaluate model insurance plans to verify that the objectives are being met and to determine whether they should be continued or modified.

e) To establish health insurance benefits under the policy defined by the Department of Health.

f) To develop regulations for health service delivery models that could be use to provide the health services stipulated by law and overseen by the Department of Health.

g) To monitor and evaluate utilization of the models in place.

h) To protect the rights of the health service providers contracted by insurers and the beneficiaries of the services.

i) To adjust the amount of the deductible, copayment, and premiums in accordance with the beneficiaries' income and ability to pay.

j) To monitor and evaluate the management of the private insurance companies contracted.

This system permits the participation of a variety of private insurers, who serve as mediators between ASES and the direct service providers.

Four insurance companies currently share the health services market promoted by the reform process: Blue Cross of Puerto Rico, United Health Care, Triple S, and PCA. These companies contract a variety of direct service providers. Each insurer covers a different area of the country and also operates private managed care models, as indicated below:

Insurer	**Region**	**Model**
Blue Cross PCA and United Health Care	Northeast – Southeast Central – East - Southwest	Staff Model - CSSCA Primary Care Provider
Triple S PCA United Health Care	North-Northwest Central East-Southwest	Independent Practice Association (IPA)
PCA United Health Care	Central East-Southwest	Physician – Hospital Organization (PHO)

Selection of insurance carriers involves the following process:

a) Invitation by ASES to submit proposals.

b) Mandatory meeting: Analysis of preliminary proposals.

c) Evaluation of proposals, conducted at three levels:
- Technical Evaluation Committee (External)
- Administrative Evaluation Committee (ASES)
- ASES Board of Directors

d) Question-and-answer session

e) Selection

f) Negotiation and contracting

As a clear manifestation of public policy, ASES should make sure that insurance carriers do not discriminate against health insurance beneficiaries. Insurers must guarantee that no provider will discriminate against anyone in the population in need of services. Noncompliance by a provider is considered an offense.

In addition, Law 72 creating ASES stipulates that coverage will be broad, barring exclusions for pre-existing conditions, and that there will be no waiting period once a subscriber is issued the insurance.

The origin of the financing is similar to that which existed prior to the reform and consists of funds from the national budget, Medicare, Medicaid, and the deductible paid by beneficiaries. In the current context of transition it has been necessary to finance the process through approximately $300 million in domestic debt. This aspect will be analyzed further on.

5. OPERATION OF THE SYSTEM IN THE CONTEXT OF THE REFORMS

Once an insurance carrier is selected, a fee of $60 per capita is paid to it to cover administrative costs. A $150-$160 payment per family is also made.

The capitation payment made to providers by the insurance companies is minimal, since they receive a fee for administrative costs. Difficulties arose in obtaining information from all insurers on the payments made to providers. From the companies that furnished reliable information, it can be concluded that the capitation and family payment varies from region to region, fluctuating between $44.41 and $45 and $114.11 and $114.28, respectively.

Basic health insurance coverage in the context of the reforms consists of:

- Preventive services
- Hospitalization
- Physicians' services
- Maternity services
- Diagnostic exams
- Clinical laboratory exams
- X-rays
- Ambulatory rehabilitation services
- Emergency services
- Dental services
- Pharmacy services
- Ambulance
- Mental health services (this is offered regardless of whether patients are drugs abusers or alcoholics or are incarcerated).

Special coverage requires preauthorization from the insurer and includes the following services:

- Cardiovascular procedures
- Neurovascular procedures
- Neurosurgical procedures
- Specialized diagnostic exams
- Cancer treatment
- AIDS treatment
- Tuberculosis treatment
- Leprosy treatment
- Dialysis and hemodialysis
- Neonatal intensive care

The basic coverage allows beneficiaries up to 21 visits to a physician a year and gives them the option of up to 30 days of hospitalization and 90 days of outpatient care in the same period. In the area of mental health, beneficiaries have the right to 60 days of hospitalization a year and 30 days when substance abuse is involved.

ASES uses the following criteria to evaluate the performance of insurance carriers:

- Eligibility
- Quality and quantity of services to beneficiaries and providers
- Nature of the coverage
- Submission of requested reports
- Fulfillment of requirements concerning their financial situation
- Characteristics of the standards and norms governing management and care.
- Introduction of innovative management and care initiatives for providers and beneficiaries
- Quality, currentness, timeliness, and cost of the services.
- Regulation and control of fraud and abuse
- Level of access to the services by beneficiaries.
- Complaints and mismanagement
- Capacity in terms of information systems and information processing

The insurers contract different groups of providers, many of them made up of physicians from the public sector and other health workers, and in other cases physicians in private practice. All physicians must be members of some type of legally recognized entity (societies, for example). Annex 1 provides an example of the contracts between insurers and providers.

Part of the capitation payment to the insurance carriers is transferred to the providers, since the insurers collect an administration fee. Some of the companies turn over the full capitation payment, thereby enabling provider groups to administer the resources, contracting hospital and support services. Others split the capitation payment, giving physicians' groups the percentage representing their fees and an appropriate amount allocated to the remainder of the hospital and support services, with the payment broken down into technically defined percentages.

Providers must meet certain criteria for professional accreditation and physical infrastructure. Annex 2 shows the criteria established by one of the insurers. Some of these provider groups, one of which is the University of Ponce School of Medicine, are also engaged in the purchase of the various government facilities. This privatization is taking place along with the implementation of the health insurance system and is the responsibility of the Department of Health of Puerto Rico.

The different provider groups must work under a managed care system. The intent of this approach is to shift the health care model centered on disease—that is, the curative model that provides episodic treatment for specific problems using highly specialized physicians--toward an approach based on health promotion and disease prevention activities, ongoing care, intersectoral and community participation, and teamwork that relies fundamentally on general practitioners.

Primary provider groups are made up of general practitioners, internists, obstetricians, pediatricians, and family physicians.

Some advantages of the managed care model are:

a) Subscribers and their families enjoy preventive medical care through their primary care physician.

b) The primary care physician is the guardian of the family's health.

c) Family records are centralized rather than scattered in different places.

d) Patients receive comprehensive care.

e) Duplication of clinical tests and X-rays and the excessive prescription of drugs are kept under control, with the resulting economic and treatment benefits for subscribers and their families.

f) There is no copayment or deductible for primary clinical laboratory services and x-rays. There is no deductible for hospitalization, except when special coverage is involved.

g) The managed care model offers special coverage when highly specialized and expensive services are required.

h) It rationalizes the general cost of care by requiring entry into the system through the primary level.

Insurers exercise control over providers by periodically monitoring their activities through management information systems and through the control exercised by supervisors who monitor efficiency and ensure that care to clients is not restricted.

To date, the degree of satisfaction found by ASES has been highly satisfactory (see Graph 4).

Figures 1, 2, and 3 show the next areas to be covered by the health sector reform.

Graph 4: **Degree of Satisfaction with the New Government Health Plan**

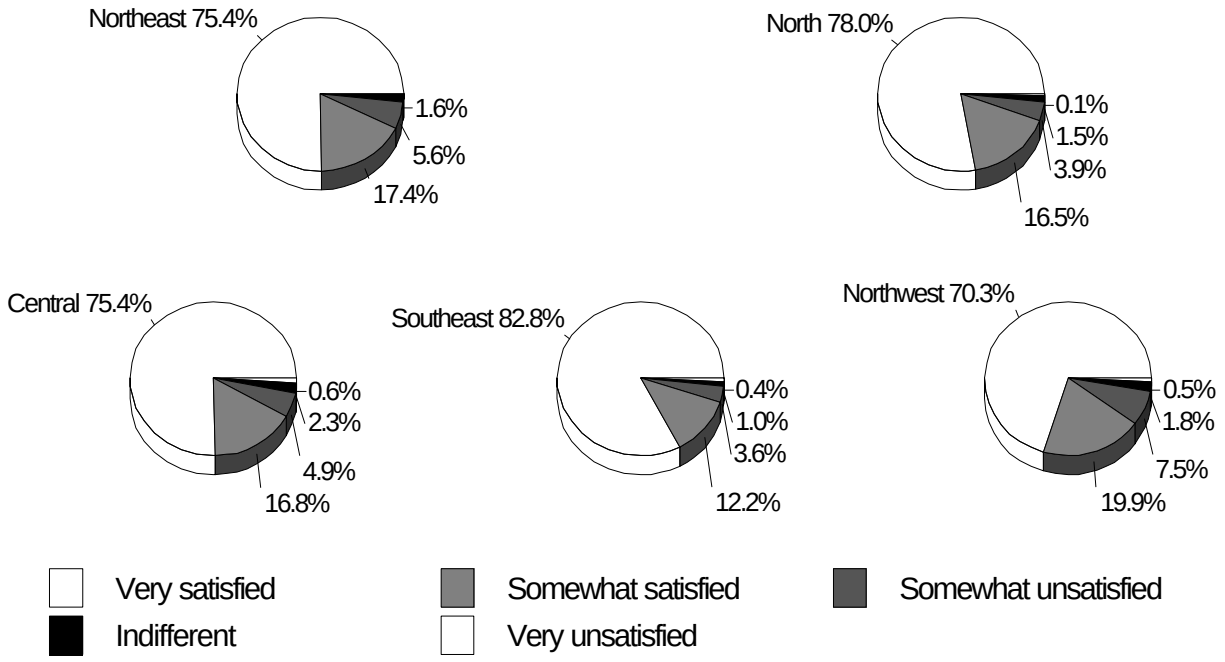
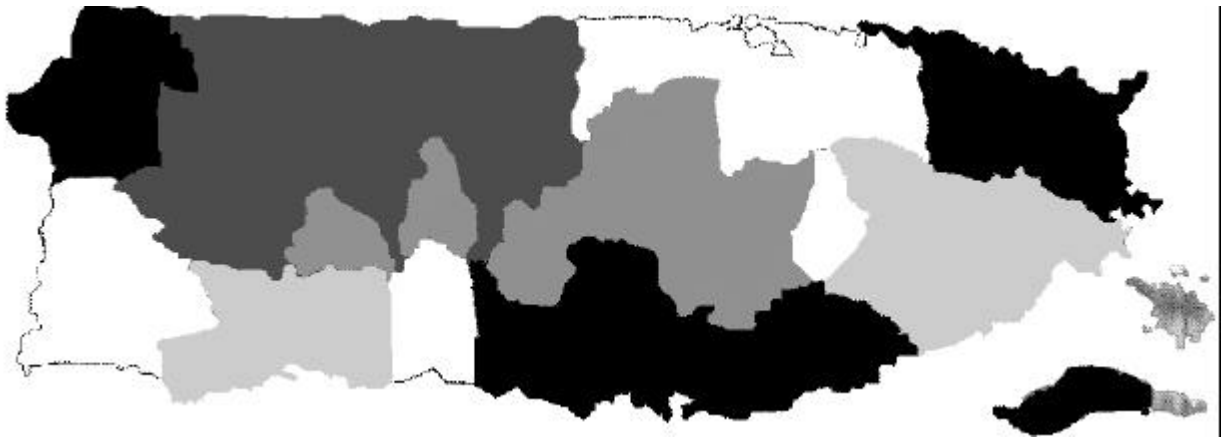


Figure 1: **Health Insurance Administration of Puerto Rico**



Next areas to be implemented:

- Mayaguez, Ponce, Hormigueros, Vega Alta, Cabo Rojo, Dorado, San Germán, Toa Baja, Sabana Grande. Cataño, Bayamón, Guaynabo, Caguas, San Juan, Trujillo Alto, Carolina, Lajas

- Northeastern Area - February 1994 - (Blue Cross) Aguadilla, Aguada, Rincón , Añasco, Moca, Isabela
- Southeastern Area - October 1994 - (Blue Cross); April 1997 - (PCA) J. Díaz, Sta. Isabel, Coamo, Salinas, Guayama, Arroyo, Patillas, Maunabo
- Northwestern Area - May 1996 - (Triple--S) Loiza, Cañovanas, Río Grande, Luquillo, Fajardo, Ceiba

- Northern Area - April 1995 - (Triple--S) Quebradillas, San Sebastián, Las Marías, Maricao, Lares, Arecibo, Florida, Barceloneta, Florida, Morovi, Vega Baja, Uruada

- Central Area - December 1995 - (PCA Corp.) Adjuntas, Jayuya, Villalba, Orocovis, Conozal, Toa Alta, Naranjito, Barranquitas, Comercio, Albonito, Aguas Buenas, Cidra, Cayey

- Southwestern and Eastern Area - August 1996 - (United Health Care) Guanica, Guayanilla Gambo, Yabaco

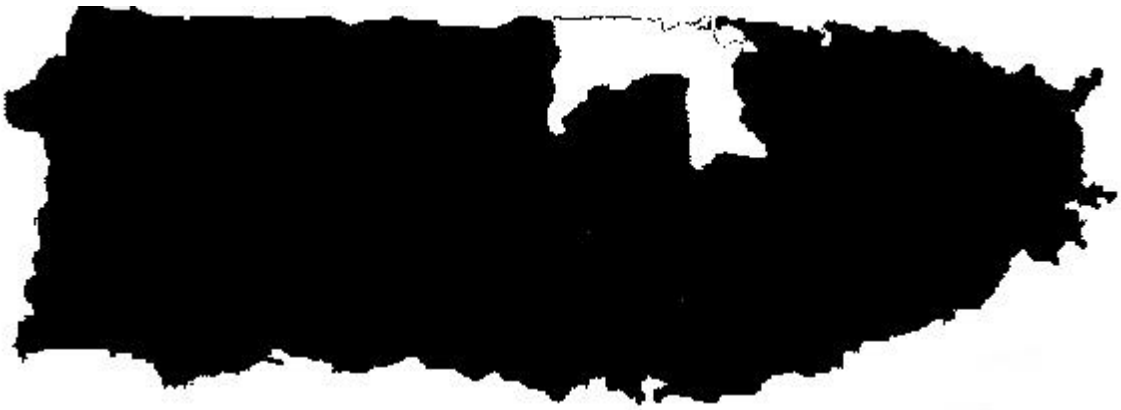
Figure 2: **Health Insurance Administration of Puerto Rico**
Next Municipios to be Included in the Health Reform

ASES 1997

Next municipios to be included in the Health Reform:

- Cabo Rojo
- Hormigueros
- Lajas
- Mayaguez
- Sabana Grande
- San German

Figure 3: **Health Insurance Administration of Puerto Rico**
Next Municipios to be Included in the Health Reform



ASES 1997

Next municipios to be included in the Health Reform:

- Bayamón
- Cataño
- Dorado
- Guaynabo
- Toa Baja
- Vega Alta

6. GENERAL CONCLUSIONS

6.1 Frame of Reference

Opinions vary on the theory and practice of State reform and reform of the public health systems.

The differences concern technical, administrative, legal, and ideological aspects. This means, in popular parlance, that a positive or negative view of a particular reform experience depends on "the eye of the beholder."

For this reason, a clear definition of the guiding principles of the analysis is essential. In other words, the conceptual framework used for the analysis must be mapped out.

In this particular case, it is pertinent to define the following:

a) In countries with deficiencies in their economic and social structure, health care (together with other areas of development) is the responsibility of the State.
In that context, health and education are strategic aspects of development for which the State must assume responsibility. Otherwise, the population is unlikely to gain full access to these services.

b) State responsibility for health does not imply a State obligation to directly administer the health services.
The administration of public health services can be delegated to private entities, but this requires that the regulatory role of state agencies be enhanced.
Essentially, this implies the formulation of clear policies, strategic plans, and standards, together with ongoing evaluation of the technical and administrative operations of direct service providers.

c) Equity, understood as the guarantee that all individuals have access to services that meet their real needs, should be a guiding principle of health system reform in countries with economic and social characteristics similar to ours.

d) The other guiding principle is efficiency, understood as the proper (rational) use of all the resources of the system.
In the context of financial constraints such as those of the Latin American countries, it is essential that limited resources be utilized as efficiently as possible.

e) Recognizing the atmosphere of uncertainty and change in which social organizations operate implies recognizing the need for considerable creativity on the part of managers if they are to address this situation and save their organizations from eventual collapse from an inability to adapt.

6.2 Conclusions

Given these circumstances, the analysis of health system reform in Puerto Rico leads us to the following conclusions:

a) In the context of the sectoral reform promoted in the Hemisphere, the Puerto Rican reform process is peculiar to the country. This is an "indigenous" experience based on the political will and direction of the Puerto Rican authorities and on their knowledge of the island's distinctive technical, administrative, and legal structure.

b) The Reform, grounded in the philosophical precepts and the present enabling administrative and legal provisions, has quickly led to profound and seemingly irreversible social reforms. The State has re-examined its role as a service provider, moving toward a steering role that is essentially regulatory and supervisory in nature. Its concept of health has shifted from a biological and curative perspective to an integrated one in which special importance is attached to health promotion and disease prevention activities. The structure that makes this possible is based on a clear separation of functions between the Department of Health and the Health Insurance Administration (ASES). Under this system the Department of Health is the agency that regulates health in Puerto Rico, formulating policies, plans, and standards and evaluating their application, while conducting health promotion activities; the Health Insurance Administration, in contrast, is the purchaser and supervisor of the health insurance guaranteed by the health card.

   In addition, insurance companies, which traditionally operate from a curative perspective, have re-examined their role, relying on managed care to "rationalize" health service delivery and to conduct health promotion and disease prevention activities. Insurers today have departments of health promotion and surveillance, run by public health experts.

   It is should also be mentioned that these companies have understood that, for them, a key part of the profitability of the Reform lies in distributing the risks derived from their large membership and keeping their subscribers healthy, since it is "more inexpensive to promote health and prevent disease than to cure and rehabilitate."

   Finally, the Reform has transferred control of the system from physicians to users. Physicians have had to organize, exchanging their individualistic clinical behaviors for behaviors that are more entrepreneurial and geared to health promotion. User satisfaction is now the providers' only guarantee of a good income, and for this they have had to redeploy throughout the country, improving access by the population to services that had heretofore been unavailable. This can be seen by contrasting Table Nº 5 with Table Nº 4.

   Medical practice has shifted from a situation dominated by "superspecialists" to one in which generalists (general practitioners, family doctors, obstetricians, and pediatricians) are more common. This implies the need to re-examine human resources education and training at the university level, where the adaptation of curriculum structures has already begun. From this it can be concluded that health sector reform has led to profound social reforms in Puerto Rico.

Table 5: **Providers after the Reform - December, 1996**

Providers	**Fajardo**	**Guayama**	**Arecibo**	**Central**	**Northwest**	**East**	**Southwest**	**Total**
Total physicians	248	340	611	746	251	490	175	2,861
Primary	143	164	333	391	172	358	120	1,681
Specialists	105	176	278	355	79	132	55	1,180
Centers	58	60	32	59	14	7	6	236
Pharmacies	34	52	132	94	45	47	20	424
Hospitals	6	7	8	21	2	6	1	51
Laboratories	28	32	101	60	38	44	22	325
Dentists	61	65	128	131	38	66	20	509
Total	435	556	1,012	1,111	388	660	216	4,406

Source: Insurers

c) There is an undeniable clarity of objectives and harmony of thought in all who are involved in the process. The Department of Health, the Executive Director of ASES, and the Insurance Commision, *inter alia*, have a common and consistent idea of what health reform should be--a consensus difficult to find in other experiences.

d) At the present time, the total cost of the health system has risen, clearly a reasonable phenomenon. The system is in transition, since the Government has not concluded the privatization of facilities and, moreover, has invested significant sums of money to improve care to users in communities where the Reform has not been implemented.
Furthermore, the increased access to health services promoted by the process through more equitable resource redistribution in the country has logically led to wider detection of "hidden" health problems requiring tertiary level services, with the resulting higher costs. This is a also a temporary situation whose duration is difficult to forecast.
Finally, the mediation of insurance carriers implies an increase in the general cost of the system. The government considers the experience of these entities in the administration of health insurance vitally important to the success of the process and, viewed from that perspective, the higher costs are both reasonable and necessary.
In the future, greater managerial capacity among providers may lead to the elimination of mediation by insurance carriers, with a resulting drop in expenditures.

e) The Puerto Rican experience leads to us to conclude that it is possible for the private sector to collaborate with the State in its goal of guaranteeing equity in the health system and that this basically depends on strengthening the regulatory role of the State.

f) The role of universities in the Reform has been limited. Until a short time ago they were devoted to analyzing new scenarios and initiating the adaptation of the curriculum structures of their educational and training programs.

g) The health insurance guaranteed by the Reform provides greater coverage than private insurance, since it does not discriminate against pre-existing conditions.

As a general conclusion we should note that the Puerto Rican reform experience recognizes the State's responsibility for the health of the population, delegates health care administration to private organizations employing innovative schemes, and has established equity and efficiency as its guiding principles.

7. RECOMMENDATIONS

There is no doubt at all that Puerto Rico's health system reform is politically, technically, administratively, and legally consistent. However, we believe it important and appropriate to offer some general recommendations that can be viewed as input for eventual adjustments.

a) The mediation of insurers should be assessed in the medium term. The government's scheme to introduce the administrative experience of these companies during the implementation phase is reasonable, but it is important to mention that several provider groups have been developing their managerial capacity with a view to entering into direct relations with the State in the future.
To this we should add the higher costs of the system produced by this mediation, which could be avoided if it were dispensed with.
However, evaluation of this aspect is essential, since it can be shown that the associated cost increases could be compensated for by the efficient use of resources implied by the reform.

b) Despite the fact that the Department of Health and ASES have moved forward with the definition of evaluation criteria and methodologies, it is crucial that they be supported with the speedy design and implementation of a good management information system.
It is inappropriate to delegate to insurers the task of monitoring the system's impact on the health of the population or on the use of public funds.
"The financial risk can be transferred but not the responsibility for these aspects."
This observation has made it possible to identify providers who have profited substantially from the "sale" of curative services to insurers, while both neglected health promotion and disease prevention. Clearly, responsibility for the equity and efficiency of the system lies with the State.

c) The capitation rate appears high to us. We do not know whether it is because of the costing method employed for the coverage or the bases utilized for the actuarial calculations. We suggest that it be reviewed.
It would also be desirable to establish a policy that standardizes the capitation rate paid to providers, since some insurers break it down (medical care; laboratory, pharmacy, and radiology services; etc.) and others pay the full amount to the primary physicians' group; we feel that this option is better for strengthening the concept of managed care, because it integrates care and centralizes its administration at the local level.

d) We recommend that hospitals not be privatized separately from the facilities in which the primary care groups operate. When this happens, it breaks up the integrated nature of the system and the consolidation of managed care, since hospitals managed as independent corporations cannot control their demand.

e) The monthly issuing of cards should be evaluated in the short term. The culture of demand for services is not very objective in populations accustomed to curative, unrestricted models of health care, a situation that is difficult to change in a short period of time.

f) The financial sustainability of the reform should be evaluated.

This is the aspect that raises the most questions among the various social actors involved, including the press.

As noted in the conclusions section, there is no doubt that the general cost of the system has risen during the initial years of the Reform. However, this increase is undeniably reasonable because of the underlying factors analyzed above.

However, an economic-financial evaluation is recommended to project the duration of the transition phase and to put a number of temporary measures in place that will not produce domestic debt. Raising the tax on nonessential articles such as cigarettes and liquor is one option.

Finally, health sector reform in Puerto Rico has been a highly valuable experience in technical, administrative, legal, political, and philosophical terms—an experience that can be used as a point of reference by other Latin American nations crafting their own reforms and by the Pan American Health Organization in its support for them.

ANNEX A: REQUIREMENTS OF THE CENTERS OF CCSCA

Requirements of the Centers of CCSCA

Center Name _____
Center Number _____
Town _____

	Yes	No	In process	Deadline
Letter of intent to CCSCA Center, with mailing address, telephone number, administrative structure, employer's medical insurance number, and general description of the operation.				
Administrative Structure entails: a. Medical Director b. Administrator c. Coordinator d. Receptionist* e. Secretary* f. Technician responsible for data entry				
Financial audited statements				
Approval from Fire Department				
Approval from Health Department				
Directory of Providers of the Center (See directory attached). In the event of Centers which participate in the reform process, the following is required: a. Speech Therapy b. Audiologist c. Maxillofacial and Oral Surgeon d. Occupational Therapist				
Copy of the contract of providers of services (copy of the medical credentials) a. Referral System “Electronic Payment Cruz Azul”.				
Multidisciplinary health equipment: a. Educator in health b. Dietician and nutritionist c. Psychologist d. Social Worker e. Certified Nurse				
Letter requesting participation in the Pharmaceutical Program (PAID)				
Financial assurance				
Participation in the Program of quality assurance				

	Yes	No	In process	Deadline
Inspection of the facilities of the Center before determining their approval: Ramp and/or any other facilities required for persons with disabilities.				
Computer equipment with the following parameters: - Processor - Pentium 100 MHZ - Hard disk - 1GB - RAM - 24 MB - Monitor - SVGA - Printer - Laser/inkjet - Program - Windows 95				
Telephone line exclusive for modem				
Answering machine				
Once approved, the Center will require the following: a. Banner displaying Centro CCSCA b. Eligibility Program** c. Utilization Program** d. Subscriber rights** e. Law 72**				

* Must have computer knowledge

** Cruz Azul of Puerto Rico will require such equipment once the Center is established.

Cruz Azul of Puerto Rico
Pharmaceutical Department
Form for inclusion, cancellation and/or reactivation
Of Medical Centers in the PAID system

Center Name: _____

Center Address: _____

_____**ZIP CODE:**_____

Center Number: _____

Telephone of the Center: _____

Please indicate with a check mark (✓) action(s) to be taken:

Physicians to be included	**Physicians to be cancelled**	**Physicians to be reactivated**
Last Name	**Name of the Physician**	**License Number**

Effective date:

Program in which physicians will participate (please make a selection)

CCSCA Regular

CCSCA Reform

Golden Dream

Special Groups (Specified groups)

1. _____
2. _____
3. _____

Requested by:

_____
(Print letters)

_____
(Signature)

Rev.11/96

Directory of Contract Providers
Cruz Azul Health Care Center

Center Name

_____

Physical Address

_____

_____

_____

Mailing Address

_____

_____

_____

Telephone and fax

_____

Medical Staff of the Center

Primary Care Phisicians
(General and Family Practice)

1._____

2._____

3._____

4._____

Center Number

_____

Administrator

_____

Contact Person

_____

Employer's Medical Insurance

_____

_____

_____

Address and Telephone

_____

_____

_____

_____