

Transformations of public healthcare services in Puerto Rico from 1993 until 2010

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Abstract: Background. Existing studies that analyze the Puerto Rico Health Reform of 1993 are virtually inexistent; they tell us little about the transformations of the public healthcare services in during the period and none of them achieve a complete assessment of the reform. **Methods.** Using case study methodology and administrative data from the Puerto Rico Government, an assessment and analysis of the health reform is achieved for the 1993-2010 period. **Results.** The analysis of the structure of the health sector and health related expenditures, show that the government has not contained the health expenditures, there is still a dual healthcare system in the island and that the government continues to provide health services and contracts health professionals. **Conclusions.** Taking into consideration that none of the objectives of the Puerto Rico Health Reform were met, there is sufficient evidence to conclude that these Health Reform was a failure.

Key words: health reform, Puerto Rico, public policy evaluation, public health

During the decade of 1990's most of the governments of the world put in place health and healthcare reforms. This was partly in response to a document published by the World Bank titled "Financing Health Services in Developing Countries: An Agenda for Reform". The island of Puerto Rico affected by two currents of influence, from the U.S. by the Clinton Health Reform¹ and from the Latin America as countries such as Brazil, Peru and Honduras inserted in the health reform wave that was covering the world². With the election of Dr. Pedro Rosselló González on 1992 as Governor of Puerto Rico, a Health Reform was in order as it was one of the biggest campaign promises presented by him and his political organization.

The Structure and Organization of the Regional Healthcare System on 1993

Ever since 1953 until 1993 the Public Healthcare of Puerto Rico was developed around the ideas and recommendation of Dr. John B. Grant which included the establishment of a four level healthcare sector³. These four levels were strategically located through the island. On the first level the people of Puerto Rico would find immediate Diagnostics and Treatment Centers on each municipality (county equivalent), these centers provide primary healthcare services for conditions such as preventive medicine, and follow up for persons with conditions such as hypertension, diabetes and asthma. Given their ideal location the government included prenatal care and health services for healthy children. If the services required were not available on this first level, they acted as referral centers for the secondary level.

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This secondary level was comprised of five Area Hospitals spread across the health regions of the island. The location of these centers was in central points of regions thus close to the towns in each region. They served as support centers for those conditions that could not be treated in the first level. These facilities provide services that included internal medicine, pediatric health, simple surgeries and gynecological and obstetric medicine. The system was organized in a way that if the services required other kind of attention the patient was referred to the third level which provided tertiary healthcare.

The tertiary level was comprised of 6 Regional Hospitals and 2 Sub-Regional Hospitals which provided patients with more complex clinical conditions which required specialized professionals and high level diagnostics technology. The services of this level included much more complex surgical processes than the ones found in the secondary level.

At the top of this health sector organization was the supra tertiary level consisting of the Puerto Rico Medical Center, which was conceived as a “Supreme Court of Health for Puerto Rico”⁴. This Medical Center was composed of the University Pediatric Hospital; University Adult Hospital; Industrial Hospital, managed by the State Insurance Fund; the Cardiovascular Center for Puerto Rico and the Caribbean; the Oncologic Hospital, managed by the Puerto Rican League against Cancer; and was the seat for the Medical Sciences Campus of the University of Puerto Rico. This level provided much more complex and specialized services than the other three levels of the public health system, which included physiatrists, neurologists, geriatrists and psychiatrists.

Up until that moment, facilities in the first three levels were managed by the Health Facilities and Services Administration of Puerto Rico (AFASS, Spanish acronym). For the Medical Center, the Medical Services Administration (ASEM, Spanish acronym) was established in 1945 to manage all the issues related to this medical complex.

After the Regional System was established several Health Reform initiatives were implemented in Puerto Rico, especially by the administrations of Rafael Hernández Colón (governor from 1973 until 1977 and reelected in 1985 until 1993) and Carlos Romero Barceló (governor from 1977 until 1985). At the end of his first administration Hernández-Colón raised the access to healthcare to law level which is still the public policy that still guides all health sector initiatives. This Law 11 of June 23, 1976 has three principal premises that the government has the responsibility of giving access to health services to the population, that primary and preventive health services must be the priority in the Health System of Puerto Rico and that the government has the responsibility of ensuring that the private sector can be an ally in the fight against health situations of the population. In this law, the government acknowledges for the first time that there is a need for the government to employ the tools available in the private sector to take care of the health of the population⁵. On his part Romero-Barceló presented his project “Democratization of Health” which removed the short term hospitalizations from the Diagnostics and Treatment (primary level) and consolidated all of them in the Area Hospitals (secondary level). This law also allowed private companies to administer these secondary level facilities. During his last term in office, Hernández-Colón administration

approved the Law to Regulate the Contracts between the Government and Private Interests for the administration and operation of Public Health Facilities, which allowed transfer of management of hospitals and centers in favor of private companies. This last law would be the tool for the privatization process of the Puerto Rico Health Reform of 1993. None of these reforms had any lasting effect, with respect to the composition and structure of the public health sector. From the initial “privatization project” only one institution could keep managing a public hospital, mainly because they got more money than needed, proportionally speaking, with the population they served⁶.

One of the campaign promises of Dr. Rosselló was to implement a health reform that would give health insurance to the poor and underserved in the island. Dr. Rosselló was no novice at Health Policy and Health Reforms; he had previous training as a Public Health Professional from the Medical Sciences Campus of the University of Puerto Rico and as Health Commissioner of San Juan (capitol of Puerto Rico). In San Juan he implemented a comprehensive health reform known as “Alliance for Health”, which ensured services to the population of that city with mobile health units, seven Diagnostic and Treatment Centers, a long term care clinic, one Emergency Room and one county hospital⁷ totally independent from the one managed by AFASS.

Health Reform Project

On August, 1993 the majority delegation in the Senate presented the Senate Project 400, which later became Law 7 of 1993. The project proposed the new Health Reform for Puerto Rico and a new public corporation called Puerto Rico Health Insurance Administration (PRHIA), which was based in three objectives:

1. Containment of the health related public expenditures;
2. Eliminating the dual system of healthcare services; and
3. Transforming the role of the government from one of a healthcare services provider to one of a health insurance provider, especially for the poor and underserved and regulator of the health services on the island.

For the second objective it must be noted that the regional system was becoming a real burden on the government’s budget, and because of the rising costs in medical technology, the solution proposed by the Reform was the total privatization of the system. From now on, Puerto Rico would aim to have only a private healthcare sector, which the proposers of the reform considered to have better service quality and more resources⁸. The policy drafters and supporters argued that with the inclusion of the free market forces, the health sector would grow and prices would be lower. With the Health Reform the insurance model would be the one known as managed care⁹. The AFASS resources would then, and were¹⁰, transferred to the Department of Health for future administration and for continuation of the privatization process.

Considering the importance of the Puerto Rico Health Reform of 1993, it is incredible that only three documents effectively assess it, but these documents never assess of the

goals of the reform. The objective of this article is to present an evaluation of the Health Reform at the light of the objectives that lead to its drafting and approval.

Reactions from concerned and affected sectors

The Puerto Rico Senate and House of Representatives received public opinions from diverse sectors which include official statements by government officials, private entrepreneurs, scholars, politicians and lawyers. As could be expected, the government officials from the island's Department of Health, Department of Justice and the Comptroller presented opinions that supported the Health Reform. This dynamic, in which department secretaries do not oppose the directions of their political leader, can be traced back to the official rule to the administration of former governor Roberto Sanchez-Vilella¹¹, where he stated that when agency secretaries had public appearances they would be speaking in favor of the public policy of the government and under no circumstances were they allowed to speak against it. However, the public statements made by remaining deponents provide some insights into the virtues and deficiencies of the Health Reform. This section has the objective of pointing out the warnings presented by those who opposed the way the Health Reform was established, principally because of the existence of more efficient ways to achieve a healthier Puerto Rico¹².

The Puerto Rico Medical Association presented a public statement regarding the project to create PRHIA. They had a long story of opposing projects that could provide access health for the poor and underserved. This opposition dated back to 1973 when they successfully defeated the Universal Healthcare Insurance project that was presented by the government. On this occasion, they also presented opposition to this health reform. They presented opposition on two areas public policy and PRHIA creation. The Medical Association wanted the government to include a physician in the Board of Directors of PRHIA and pointed out that the board's members commissioned the decision making process to a set of interests who had conflicting ideas as to what was the best for the population's health. They warn that the new structure could end up creating the same bureaucracy that existed in the Department of Health and the AFASS. This bureaucracy could become the biggest obstacle that a citizen could have to obtain health services. The most innovative recommendation was to privatize the hospitals in favor of Medicine Schools, so they could become a source of clinical practices for students and a place to work for the physicians of the country. This recommendation was ignored, and 18 years later Puerto Rico does not have enough clinical practices to suffice the demand from students. To make things worse, these limitations have presented a serious threat to the Medicine Schools of the island.

The president of the Puerto Rico Nursing Board presented the opposition of this body regarding the proposed Health Reform. Nurse Carmen Bigas, President of the Puerto Rico Nursing Board, stated that the health reform was redundant policy because the focus on preventive care was public policy since 1979, as it was presented before. She warned that without a study on costs and clear legislation about the new public policy the government could end up spending more and having more people fall ill. She proceeded to critique the way in which the more than 100,000 people with health related professions

were excluded from the project and it only focused on medical and hospital services, a point in common with the Puerto Rico Medical Association. The professionals that were left out included but were not limited to Counselors, Social Workers, Psychologists, and Nutritionists. Bigas recommended focusing the energies on a Total Health System Reform. She expressed that the reform left out essential services to the population, specially for the poor and underserved that include home health, dental health and mental health; the reform excluded vital services to the population even the school health and the role of the public health nurse in the island. Lastly, she warned that before giving the health sector to the private sector, it would be ideal to do a pilot project and then draft legislation to establish the guidelines to the process. The physicians and nurses agreed that the country deserved a Total Health Sector Reform.

At that moment, the government had a public service structure called General Council of Health which was presided by Dr. Rita Osorio to ensure that the new public policy in health would not be fought by this organism, the governor asked for the resignation of all the members of the Board of Trustees of the council and replaced the structure with a new Health Reform Institute. Dr. Rita Osorio presented supporting statements to the Puerto Rico Health Reform, particularly with regard to the idea of making health services the same for those with acquisitive power and those who were certified as poor and underserved. The board of the General Council of Health opposed the way the government was replacing the General Council of Health with the Health Reform Institute, to a great degree the functions of PRHIA were the same as the ones delegated on the General Council of Health, which left the future of the council in question. They also mentioned that the Health Reform should be tied to specific criteria focused on availability, access, an integrated system, cost-effectiveness and cost-efficiency.

Some mayors of the municipalities of the island expressed their concerns as to the impact the health reform would have on municipal finances. They opposed the project if in the future it would become a financial burden to their municipal governments. An energetic mayor of San Juan (capitol city) also encouraged the government to stop the unequal treatment to the people of San Juan, who were beneficiaries of the San Juan Health System described previously.

On the part of Health Insurance companies, the record includes a letter sent by Miguel Vazquez Deynes, who was President of SSS-Health Insurance Company. On his communication he expressed his opposition to the idea of the private insurance that companies provided to subsidize the insurance provided by the government. This technique, known as “cost-shifting”, should not be considered as a possibility in the case of the approval of the Puerto Rico Health Reform. This meant the government would have to be able to pay for what they were doing, instead of relying on the companies to provide the service. From the private sector, the company Caribbean Hospital Inc., a company with a history of being a participant of privatizing efforts in the health sector, presented their opinion approving the health reform specially the privatizing process which to their opinion would bring more and better health services to the people of Puerto Rico. Additionally, a law firm participated in the process; they recommended

PRHIA to be under the Puerto Rico Health Department to make the functions more constitutionally compliant.

Considering the amount of input, presented by these persons the most suiting statement regarding the law process is the one made by Dr. Estela S. Estape “change is a process of growth and learning. It’s not easy to achieve, and it takes time for a change to be accepted, no matter where you stand on the issue”¹³. This paper intends to present insights into this process of change, a process that was, for some, condemned to failure since the beginning. In spite of the amount of valuable input presented by either supporters or detractors of the proposed Health Reform of Puerto Rico of 1993, the law that creates PRHIA was approved without any substantial changes. History would prove that some of the warnings expressed by the professionals that objected the reform would become the reality of the island 20 years into this health reform.

Results

Privatization process and elimination of the dual system

The objective of eliminating the dual system was going to be achieved by privatizing the public healthcare system to private companies. This privatization process was executed from 1994 until 2002; from 2003 onward the Government approved a law to stop and prohibit every privatization process.

Table 1 Municipal Diagnostics and Treatment Centers status as of 2010					
Public		Private	330 Center	Special Agreement	Closed
Municipality	Administrator	Municipality	Municipality	Municipality	Municipality
Adjuntas	Health Department	Aibonito	Barceloneta	Culebra	Aguada
Añasco	Municipality	Arroyo	Camuy	Dorado	Aguas Buenas
Canóvanas	Public University	Barranquitas	Ciales	Florida	
Cataño	Municipality	Cabo Rojo	Lares	Luquillo	
Cayey	Municipality	Ceiba	Loíza	Lajas	
Coamo	Health Department	Cidra	Morovis	Maricao	
Comerio	Municipality	Corozal	Quebradillas	Rincón	
Guánica	Municipality	Gurabo		Vega Alta	
Guayanilla	Municipality	Hatillo		Vega Baja	
Isabela	Municipality	Hormigueros			
Jayuya	Municipality	Juana Díaz			
Juncos	Municipality	Las Marías			
Maunabo	Municipality	Naranjito			
Naguabo	Health Department	Orocovis			
Patillas	Health Department	Peñuelas			
Río Grande	Municipality	Salinas			
Sabana Grande	Municipality	San Germán			
Santa Isabel	Health Department	San Lorenzo			
Toa Alta	Municipality	San Sebastian			
Toa Baja	Municipality	Utuado			
Trujillo Alto	Municipality	Villalba			
Vieques	Health Department				
Yabucoa	Health Department				

Source: Data about the Health Facilities Report, Department of Health (Unpublished Report)

Table 1 presents how the primary care facilities that used to be in total control of the government are administered in 2010. Considering that the privatization process was going to eliminate the dual system by merging the public and the private sector, it was expected that after 18 years no public sector existed, it would be transformed into a bigger and robust private sector in which market forces would lower prices and increase availability. Up until 2010, the government directly controls 23 facilities, and operated 9 facilities under special partnerships with private companies. The privatization process also opened the doors to the phenomenon of Municipalization in which each municipality controls services normally managed by central governments. This is the case of 65% of the facilities that are still controlled by either by the Department of Health of Puerto Rico, the University of a Municipality Government.

This process also allowed non for profit organizations such as the ones that operate 330 Health Centers to acquire facilities. It has also lead to the end of services in two municipalities. This table allows concluding that the government is still a direct provider of services after 18 years; thus the dual system still exists. In some cases such as Trujillo Alto, Aguas Buenas, Maunabo and Río Grande, the facilities were privatized and later reacquired by the government.

Availability of hospital beds around the island

The Puerto Rico Department of Health data regarding hospital bed availability in the privatized centers allows concluding a shrink on the availability of beds on these facilities.

Table 2: Availability of Hospital Beds in Privatized Centers from 1993 until 2010			
Facility	Beds in 1993	Beds in 2010	Net Change
Aguadilla Hospital	230	153	-97
Yauco Hospital	186	105	-81
Manatí Hospital	250	250	0
Guayama Hospital	161	115	-46
Fajardo Hospital	180	166	-14
Humacao Hospital	250	0	-250
Mayagüez Regional Hospital	199	157	-42
Ponce Regional Hospital	427	355	-72
Arecibo Regional Hospital	138	138	0
Bayamón Regional Hospital	401	101	-300
Caguas Regional Hospital	373	149	-224
San Juan Regional Hospital	450	224	-226
Carolina Regional Hospital	250	217	-33
Total Beds	3495	2130	-1,365
Source: Hospital and Other Health Facilities Report for 2010, Department of Health			

Table 2 shows that from the privatized facilities there is not a substantial change in the amount of facilities but the number of hospital beds in these facilities dropped by 39%. That is why most of the services in the island have been turned from required hospitalization for recovery to ambulatory or with minimum stay at the hospital facility. The limited scope of Table 2 can be complimented by calculating the Hospital Bed Rate by 1,000 persons; on 1993 these rate was 3.74 the figure for 2010 is of 2.66 which points in the direction that Puerto Rico experienced a reduction on the availability of hospital

beds. Comparing this figures with the ones considered acceptable in the European Union which is 9.7 per 1,000 persons¹⁴ the case of Puerto Rico in 1993 was bad and it worsen with the implementation of the Healthcare Reform. In the case of the rest of the world some countries like Japan, Germany and Czech Republic have a Hospital Bed Rate over 7 beds per 1,000 persons. Countries with similar indicators or near the numbers for Puerto Rico include Canada and Norway, two countries who have established strong preventive health systems, which are not comparable with the healthcare system of Puerto Rico. An analysis done during 2010¹⁵ presented results on the stability of the Puerto Rico Health Sector, since 1999 until the present days the size of the health services sector is virtually the same.

To counter the reduction on the size of the health sector of the island and the scarcity of health services for the poor and underserved the government approved Law 3 of 2003, in which the government prohibited the Puerto Rico Health Department selling, giving away or separating health facilities to private companies. With this the objective of eliminating the dual system of health would seem unreachable.

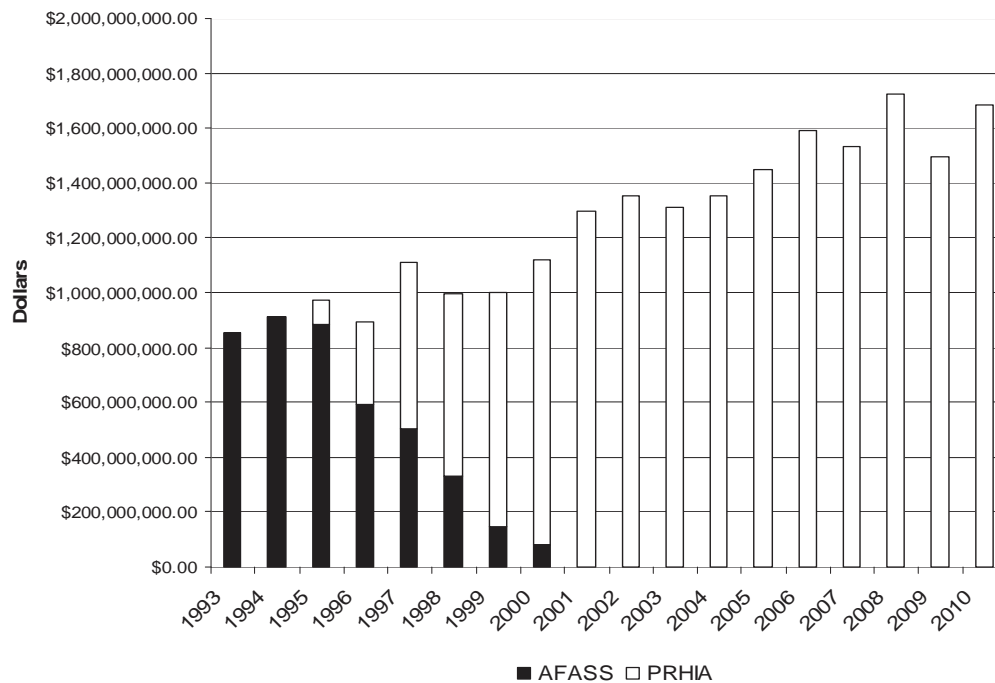
Public Expenditures in Healthcare Services

As discussed before the Health Reform major driving force was the need to contain the public expenditures. This objective can be assessed by observing the trend in the aggregated expenditures, health expenditures as proportion of the Gross Domestic Product (GDP) and the individual allocation of resources. The international trends present growing proportional expenditures around the world from 21 out of the 22 more advanced economies have experienced an increase in public expenditures in the health area from 1980 until 2008. The case of emerging economies also experienced an increase in health related expenditures, but in a lower proportion than their advanced counterparts¹⁶.

Aggregated Health Government Expenditures

Logically the assignment of resources for AFASS started decreasing as more regions were added to the public health insurance program. But Figure 1 presents how the trend in government health related expenditures has increased during the last 18 years. This result allows concluding that the cost containment objective of the Health Reform was not achieved.

Figure 1 Aggregate Government Expenditures for Health



Understanding the demographic characteristics of the population of Puerto Rico as a country that is aging¹⁷ and the research on the cost of the insurance coverage for the Health Reform of Puerto Rico¹⁸ which points to a strong and significant positive relation between these two variables the costs of the public health insurance are more likely continue increasing.

Health expenditures as proportion of the gross domestic product and gross national product

The aggregate expenditures in Puerto Rico do show an increasing trend; however this must be also evaluated as a proportion of the Gross Domestic Product (GDP) and Gross National Product (GNP) of the island, to have a clearer idea of the trend. The figures regarding the GDP of the island could lead to erroneous conclusions, because of the gap between the GPD and the GNP of the island. This gap is mainly produced by the repatriation of profit by multinational companies that operate in the island¹⁹. That is why Figure 2 presents both trends, which are very similar.

Figure 2 Health Expenditures as Proportion of GDP and GNP

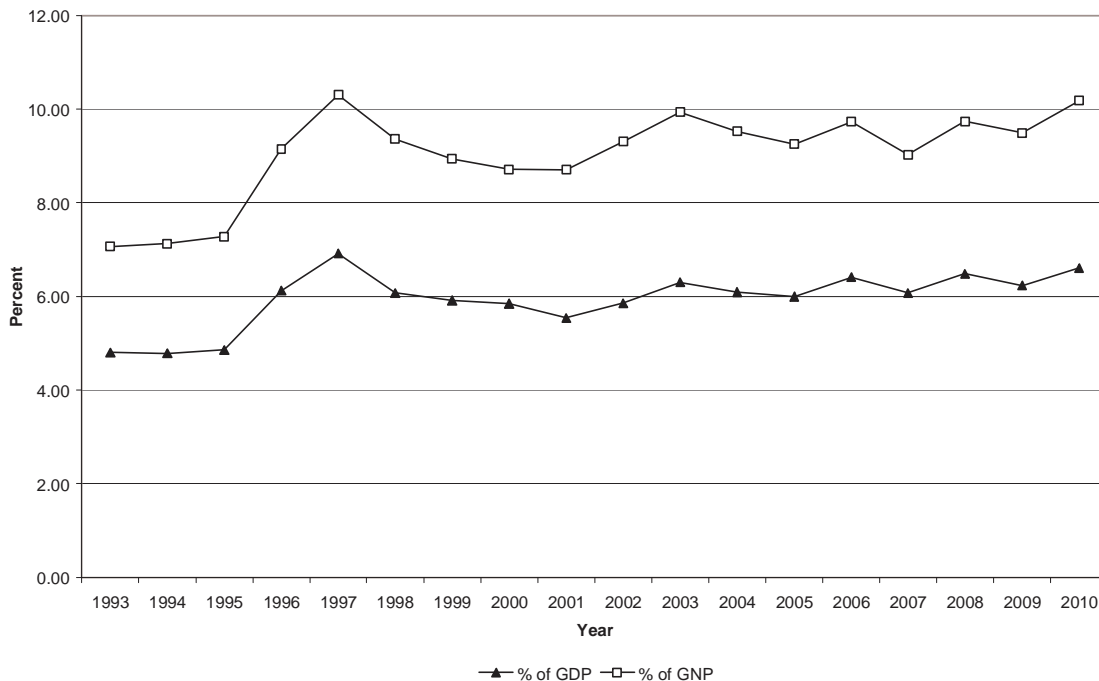


Figure 2 presents how the both the health expenditures represent a higher proportion of both the GDP and GNP for Puerto Rico for the 1993 -2010 period. Considering the conditions mentioned previously, the GNP presents a much clearer situation for Puerto Rico. The trend of health expenditures proportionally speaking to the GNP presents that the island health related expenses are over 10%. Which means Health represents at least ten percent of the economic activity in the island.

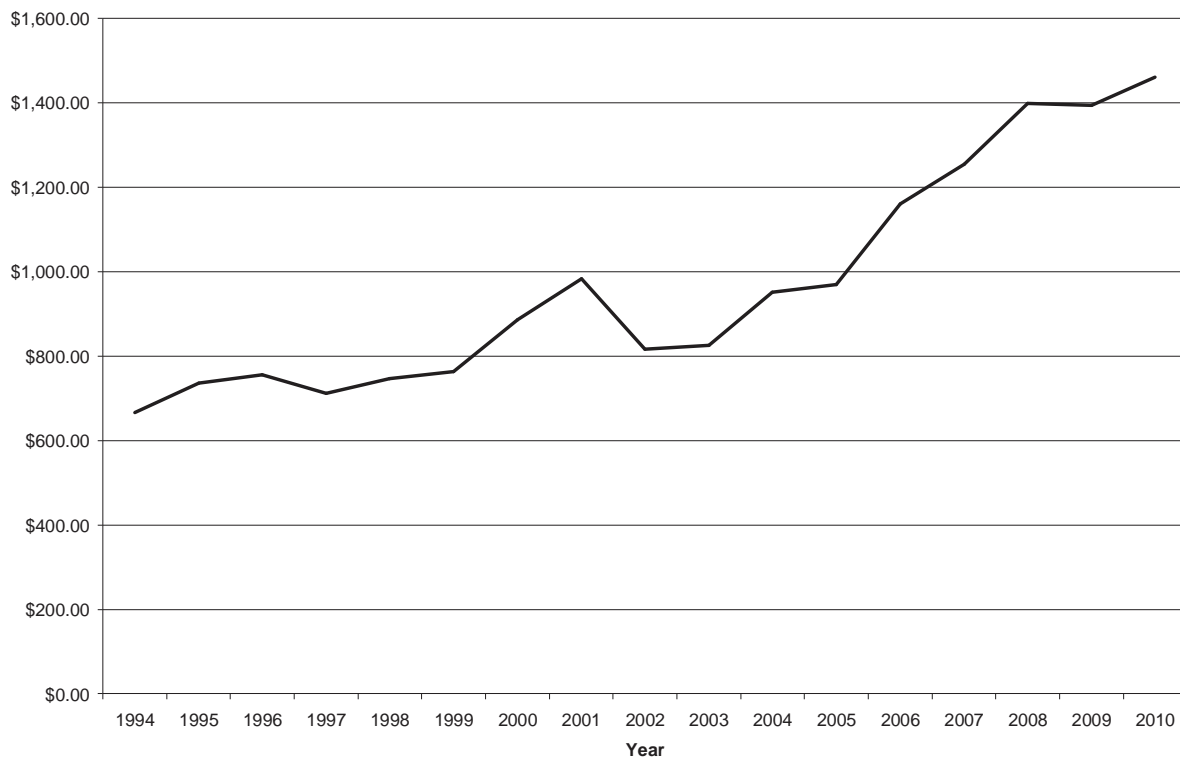
The trend on the proportion of health expenses with regards to the GDP and GNP are fairly similar to the ones found in the United States. It is precisely because of the political and social relation that Puerto Rico has with the US that it is expected the island is subject to the first world trends, but particularly of the US.

According to the International Monetary Fund, for the moment in which the reform was being proposed the trends of the First World and Developing World pointed to a probable increase in the health related expenditures, thus the objective of the reform was an anachronism at the moment.

Individual Resource Allocation

Figure 3 presents the trend of individual benefits from 1994 until 2010 the yearly allocation per person has increased in a 119.22%. The costs could not be contained the average increase for this category is of 7% per year.

Figure 3 Estimated Individual Allocation for Beneficiaries



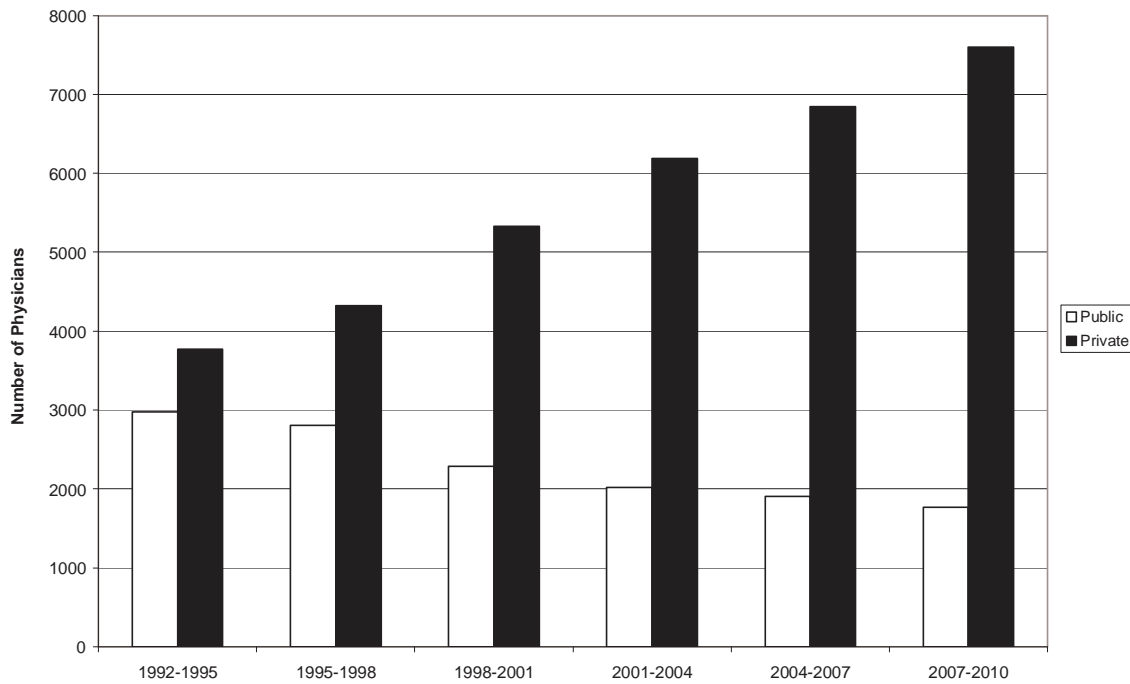
— Source: Estimated Using the Trends in Premiums by Region by Year Database, Puerto Rico Health Insurance Agency

On the cost containment issue has been prey of the development of new medical technology and inflation a fact recognized in the island²⁰ and even in national and international discussions²¹ in both cases it has been recognized that the development of new technology increases prices significantly. An analysis of the OECD Health Data shows that from the great cases of health reforms in the world only Singapore achieved constant health costs containment; the ones that did not achieve this include Germany, Great Britain and the United States of America²².

Employees who provide direct services to the population

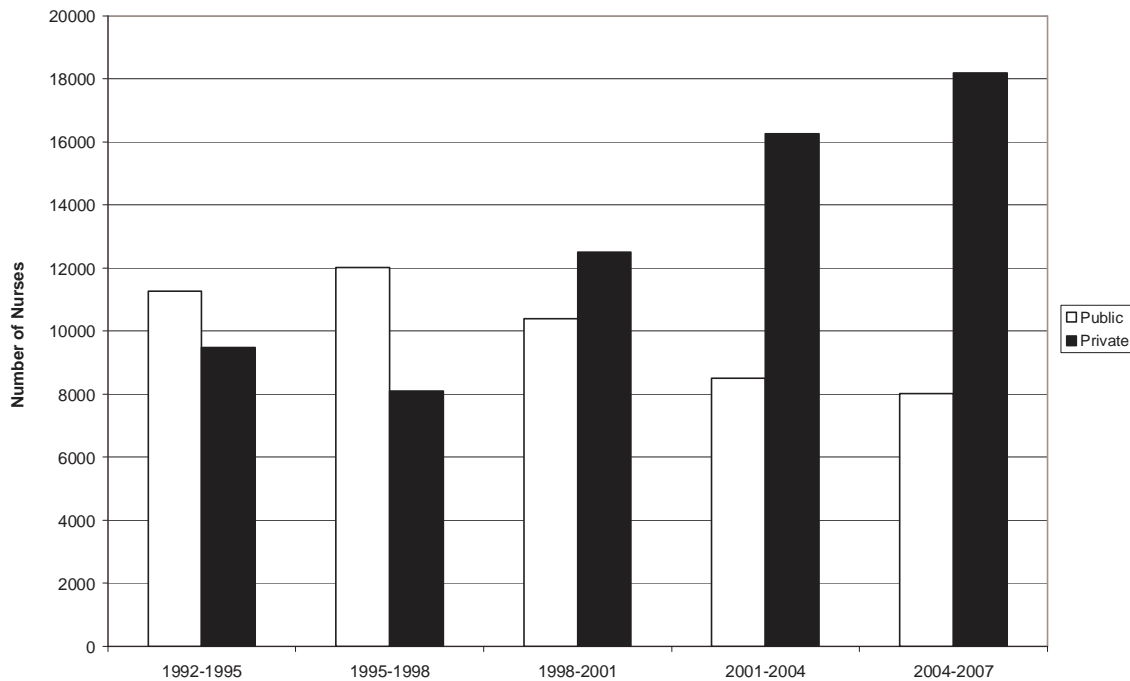
The objective of transforming the role of the government from a direct provider of services to one of an insurer can be assessed by presenting data on the public hiring of professionals who provide direct services to the public in this case physicians and nurses.

Figure 4 Physicians in the Public and Private Sector



Source: Health Professionals Register 1992-1995, 1995-1998, 1998-2001, 2001-2004, 2004-2007, 2007-2010.

Figure 5 Nurses in the Public and Private Sector



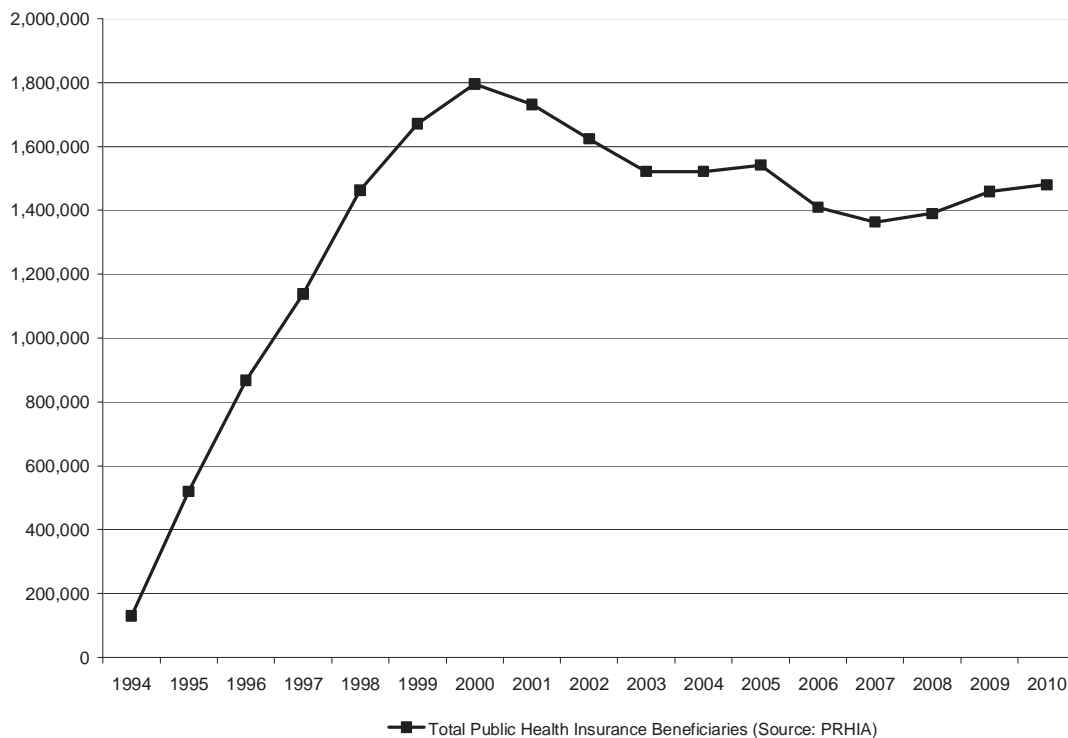
Source: Health Professionals Register 1992-1995, 1995-1998, 1998-2001, 2001-2004, 2004-2007

From Figures 4 and 5 it can be appreciated that there is still a substantial number of physicians and nurses being hired by the public sector. It seems that from 1995-1998 the dismissal process of physicians triggered a small substitution effect in which more nurses were hired; this process has been widely studied. Some research points to the conclusion that nurses working as substituted can provide high quality care as doctors at lower cost²³. The figures allow concluding that the government is still hiring professionals that provide direct service to the population. For the 2004-2007 the government contracted more nurses than it did back in the initial years of the health reform.

Provide Health Insurance to the Poor and Underserved

Related to the third objective of the reform, which consisted of transforming the role of the government from a direct service provider to one of insurer, Figure 6 presents the trend on the provision of Health Insurance to the population of the island. From 1994 until 2000, the government started to include regions to the new health insurance. On 1999, the ruling party lost the election and with it a revision to the eligibility rules was done, eliminating the benefit to almost 100,000. After that revision it can be appreciated that the number of beneficiaries has continued reducing. It is the perception of the investigator that the reduction of the total population experiences by the island and massive migration from poor and middle class persons are the cause of this descending trend.

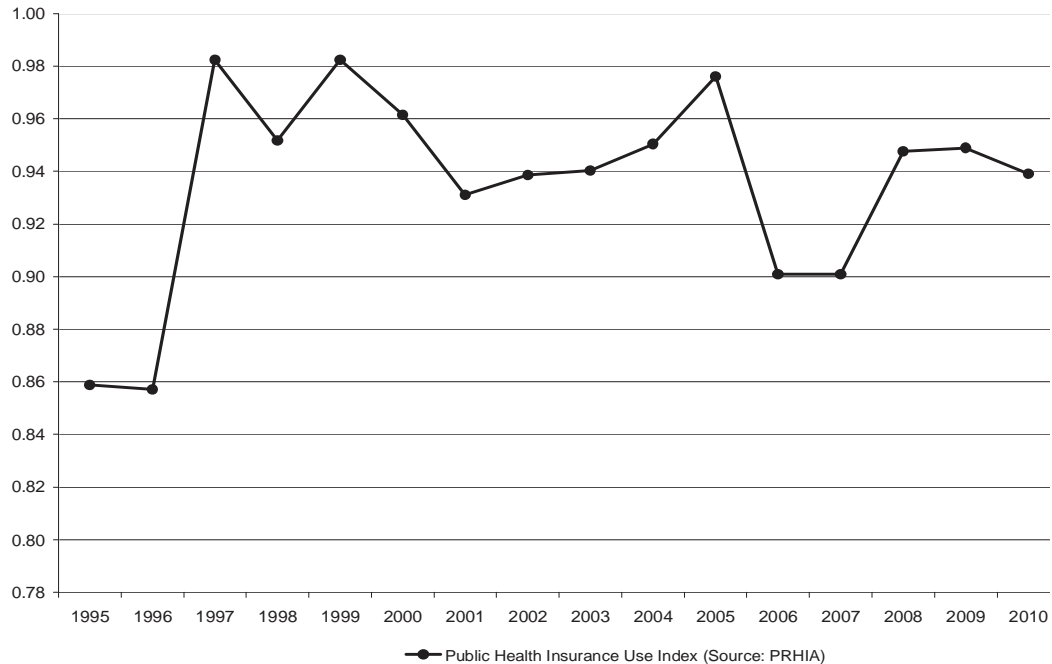
Figure 6 – Public Healthcare Insurance Beneficiaries



As in the previous section the total number of beneficiaries could mislead the conclusion so an Index of Use was developed to see how many of the eligible were obtaining the service. The results presented in Figure 7, presents this Index of Use, it can be

appreciated that this index has remained over the 85% and in some cases has approached to the 99% which proves that the government has at some extent achieve this objective, however as it was discussed before the government still provides direct service in health center and continues hiring professionals who provide direct service to the population.

Figure 7 – Index of Use for the Health Insurance



Insights into the 2010-2013 Reform Process (es)

Although it is outside of the scope of this paper there are some details worth mentioning related to the Puerto Rico Health Reform of 2010 and the current situation of the health policy of the island. After 18 years of the approval of the Health Reform the public opinion started to turn against it. The problems ranged from poor access to health specialists, long waiting periods for referrals and a perception that the health provider and health insurance companies interest were over the well-being of the beneficiaries' interest. The government, this time under the leadership of Luis G. Fortuño approved a second reform called Integral Model of Health (MISalud, Spanish acronym). Less than a year after the approval of the MISalud Reform the system started collapsing and the Governmental Development Bank started to oversee all operations of PRHIA

As a result of the elections of 2012, Alejandro García Padilla was elected Governor of Puerto Rico. One of the biggest policy measures that are expected from his administration is a new Health Reform with which persons have would have universal access to health services. A project to materialize this universal access has yet to be presented and brought to public discussion by the new government administration.

Discussion

This results of this investigation present contradicting evidence from the ones presented in the Chapter 5 of the annual report to the governor published by the Puerto Rico Planning Board on 1995 and endorsed by the Board's President, Planner Norma E. Burgos Andujar²⁴. The results also contradict the conclusions of Dr. Luis Raúl Rivero²⁵ on the timid success of the healthcare reform. Of course, this is doing an assessment of the objectives of the reform; probably a survey on the public health insurance program participants could provide insights into the individual experiences. The research of Marie S. Reyes-González²⁶ indicates "not everything is negative; the reform also has positive aspects from which the one that highlights is the access to a broader medical, dentists and hospital net and the fact that persons now have a health insurance". This success presented by Reyes-Gonzalez could be challenged using the results of the research done by the Commission for the Evaluation of the Health System of the Commonwealth of Puerto Rico²⁷ in which alarming evidence of the abandonment of preventive care. These results include that in diabetic population only 14% got a deep eye test, 16% of them were monitored for nephropathy, 33% had an hemoglobin test to make things worse 82% of this population had poor control of sugar levels. On the general population the indicators are not different, only 54% of the population at risk had a mammography, only 47% of the women got a PAPS test, 60% of asthmatics were managing their condition with inappropriate medication and 88% of the population did not get a chlamydia test. In terms of oral health 48% of the population did not visit the dentist.

Up to this date recently elected Governor Alejandro Garcia Padilla is debating if the resources of the Healthcare Reform could be invested efficiently by establishing a universal access healthcare structure in the island.

It is clear that the Puerto Rico Healthcare Reform of 1993 and the subsequent transformation of it to MiSalud provides enough information and experiences with which Puerto Rico could establish an effective health reform to benefit more persons including those who remain uninsured known as the "floating population"²⁸.

Multiple health reform systems can be proposed to improve the health of the people of Puerto Rico. The most effective will be one that is integrated through all levels, in which improving the conditions of the people are the principal objective and one in which health education and prevention become central point for the healthcare of the all Puerto Ricans. Considering that health and education are the two main pillars of development processes; the Puerto Rico Government should establish a public policy in which these two areas play an important role in the future of the country in which development is achievable. Through this research it has been proved that it is impossible to eliminate the government participation in the development and performance of the modern health systems. The research also points to a limit in which the private sector can act as the provider of healthcare services and administrator of the development of the health system of the country. 20 years after the implementation of the Health Reform the island still has a dual healthcare system which is far from eliminating the access barriers and eliminating disparities in the access to healthcare services on it, the main disparity determinant is the

distinction of the health insurance as either public provided or privately acquired. The constant deficiencies of the actual healthcare sector highlights the problem of scarcity and rationalization of the health services for the beneficiaries of the Health Insurances, provided by the government through PRHIA. The breach between those who have a private health insurance and those who are public health insurance beneficiaries does not seem to close nor reduce. It seems that after 20 years the government is in position of reevaluating the role of the government in the health sector by numerous reasons including: 1) that it is a significant source of health services for the population, 2) finances services directly or indirectly, 3) it is the regulating agent for all health related issues and has the duty of educating the country on preventive and curative health, 4) has the duty of collecting health related data for the development of technology and 5) other functions on planning the future of the health service sector of the island.

When and if a new system is proposed it should be on that is integral, considering all health services issues and actor, even including the providers of services and health related professionals. It should be the result of the input of all health and health sector components points of view as broadly defined as possible so that the new reform is a democratic expression of the needs of the people and a scientifically informed one.

References

- 1 Maldonado NI. On health in Puerto Rico. University of Puerto Rico Press, 2008.
- 2 Infante A, De la Matta I, López-Acuña D. Reform of Health Systems in Latin America and the Caribbean: situation and trends. *Pan-American Journal of Public Health*. 2000;8(1/2):13-20.
- 3 Arbona G, Ramirez De Arellano A. Regionalization of health services: The Puerto Rican Experience. International Epidemiological Association and World Health Organization. Oxford University Press. Toronto, NY 1978.
- 4 Arbona G. Memories: professional journey of the architect of public health in Puerto Rico. University of Puerto Rico Press, 2007.
- 5 Law 11 of June 23, 1976 – Integral Reform of the Health Services of Puerto Rico Act.
- 6 Public Statement by Ileana M. Colon-Caro, CPA, Comptroller of Puerto Rico to the Government Reforms Commission of the Senate of Puerto Rico, 1993.
- 7 Rosselló-González PJ, González AR. Alliance for Health: a new perspective for the health of Puerto Ricans. San Juan, Puerto Rico 1992.
- 8 Delgado, AEL. Assessing the quality of health care, the first step for reform. *Salud Uninorte*. 2000; 26(1):143-154.

-
- 9 Izquiero-Mora LA. The metamorphosis of Health Services: from rural clinics to pre-managed care. San Juan, Puerto Rico. 1995.
 - 10 Act 187 of 1998, approved on August 1998, To repeal Act No. 26 of November 13, 1975, as amended, known as the “Health Facilities and Services Administration of Puerto Rico”, in order to dissolve the juridical entity thus created and consolidate its powers and faculties with the Department of Health.
 - 11 Sánchez-Vilella R. Function and action of the Executive Branch. La Fortaleza. 1965
 - 12 Official Record of the Legislative Services of Puerto Rico regarding La7 of 1993 which established the Puerto Rico Health Reform. 1993.
 - 13 Estapé ES. Health Care Reform in Puerto Rico: Introduction. Journal of Allied Health. 2000 Jan; 29(1):5.
 - 14 Jakubowski E. Healthcare Systems in the European Union: A comparative Study. Directorate General for Research, Working Paper, Public Health and Consumer Protection Series, SACO 101 EN. 1998 Nov.
 - 15 Santos-Lozada AR. Transformations of public healthcare services in Puerto Rico from 1993 until 2010. Master of Arts Thesis, Economics Department, University of Puerto Rico, Rio Piedras Campus.
 - 16 Clements B. Global Trends in Public Health Spending and Outlook. Fiscal Affairs Department, International Monetary Fund, 2011 Jun 21.
 - 17 Figueroa-Ramirez R, Rodriguez-Figueroa J, Rivera-Negron R. Puerto Rico 2000-2010: More than te Census. Demographic Assistance Group, San Juan, PR. 2012.
 - 18 Bruguera-Fabre A. The costs of the Puerto Rico Health Reform: a Regional Analysis. Bulletin of the Economists Association of Puerto Rico, 3(1). 2008.
 - 19 Curet-Cuevas E. “Political Economy of Puerto Rico: 1950 to 2000”. San Juan, PR 2003.
 - 20 Certified Public Accountant Board of Puerto Rico. Recommendations to the Puerto Rico Health System, 2009.
 - 21 Newhouse JP. An iconoclastic view of healthcare cost containment. Generations. 1996 Summer; 20(1):61.
 - 22 Schreyögg J, Meng-Kin L. Health-Care Reforms in Singapore-Twenty Years of Medical Savings Accounts. CESifo-DICE Report. 2004, Apr.

-
- 23 Laurant M, Reeved D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care (Review). The Cochrane Collaboration.
 - 24 Economic Report to the Governor. Office of the Director, Puerto Rico Planning Board, 1995.
 - 25 Rivero LR. A study of the 1993 Healthcare Reform in Puerto Rico. Master in Public Health Thesis, Biomedical Sciences School, University of Texas at Galveston.
 - 26 Reyes-González MS. Development and Analysis of the Puerto Rico Health Insurance Agency (PRHIA). Master Thesis for the Public Administration School, University of Puerto Rico, Río Piedras.
 - 27 Commission to Evaluate the Health System of the Commonwealth of Puerto Rico. Evaluation of the Health System of Puerto Rico. Towards an integral development of the Puerto Rico Health System: citizens with public health conscience and a health system with inter sectorial, holistic, emancipating with foundations in the right of the human to health. Presented by Dr. Jorge Sánchez to the Governor Aníbal S. Acevedo Vila.
 - 28 The Money is available, a new and universal health insurance for Puerto Rico. Life Quality, El Nuevo Día, 18 Jan 2013.