Health sector reforms in comparative perspective – an unending quest … or chasing a chimera

Reformas de saúde em perspectiva comparada - uma questão sem fim .... ou uma busca improvável

James Warner Björkman [1]

Abstract ***Given the problematic nature of attempts to reform national delivery systems for health care, the paper reviews the context and logic of reforms in the health sector. After a background on approaches to building capacity within three generations of public sector reforms, it examines the reforms applied to financing, organizing and delivering health services and suggests strategies for reform that take capacity into account.***

Key words ***Reform, Health care, Public sector, National systems, Strategies***

Resumo ***Considerando a natureza problemática das tentativas de reformar os sistemas nacionais de prestação de serviços em saúde, este documento aborda o contexto e a lógica das reformas do setor. Após um retrospecto das abordagens do aumento de capacitação em três gerações de reformas do setor público, o documento examina as reformas aplicadas ao financiamento, organização e prestação dos serviços de saúde, e sugere estratégias para reformas que levem a capacidade em consideração.***

Palavras-chave ***Reforma, Assistência médica, Setor público, Sistemas nacionais, Estratégias***

[1] Institute of Social Studies. Kortenaerkade 12, 2518AX The Hague. Post Box 29776, 2502LT The Hague, The Netherlands. bjorkman@iss.nl

At its core, reform seeks to modify the way arrangements are currently organized. Re-form seeks to change 'form' and, in so doing, re-arrange the distribution of costs, benefits and valued resources. In the health sector, three issues regularly appear among proposals for reform: cost, access and quality – or, phrased otherwise, reforms in financing (revenue as well as expenditure), reforms in services (who gets what, when, where, how), and reforms in assurance that professionals are delivering competent care. Decades of experience suggest that reform isn't always a good thing but reform, like beauty, is often in the eye of the beholder. Because attempts at reform are inevitable as long as health care delivery systems remain problematic, this essay reviews strategies for reforming the health sector that take capacity into account and describes patterns of reforms applied to the delivery of health services.

Approaches to reform evolved during the past half-century[1]. The 1950s and 1960s were characterized by 'Institution Building', an approach focused on individual organizations. These organizations were modeled on – if not directly transferred from – the developed countries of the world. During these decades many public sector institutions were initiated, including state-owned enterprises with a strong emphasis on state-based delivery of social services. By the late 1960s and early 1970s, the initial emphasis on Institution Building had softened into concern for strengthening institutions that already existed. This shift to 'Institutional Strengthening' sought to provide tools that would improve performance rather than to initiate wholesale change.

The 1960s and 1970s were also the heyday of Development Administration (currently called 'Development Management'), which sought to reach neglected target groups and especially to improve delivery systems in order to reach such targets. Great reliance was placed on the role of government agents, particularly civil servants, for achieving these ends. Development was increasingly focused on people rather than on institutions and, during the decade of the 1980s, the nomenclature shifted again – this time from Development Management/Administration to Human Resource Management. The key sectors to be targeted were education, health and population, and the concept of people-centered development emerged.

During the 1980s Structural Adjustment emerged as a composite of policy reforms that were based on requirements or 'conditionalities' of economic and social changes by the recipients of donor funds. Capacity building broadened to include private as well as associational efforts in addition to government action, and there was greater attention to the international environment as well as national economic behavior. This 'New Institutionalism' – interchangeably called 'Capacity Development' – expressed concern about the sustainability of capacity-building and, in the 1990s, particularly about a paradigm of 'governance' that reunited public administration with political participation. The 1990s were also characterized by a reassessment of technical cooperation and its limitations, plus the emergence of local ownership as a vital factor for development.

Now, in the first decade of the 21st century, the internationally endorsed Millennium Development Goals have become the key driver for change based on results-oriented management and long-term investments. The age of the 'quick fix' is hopefully over, and the recognition of – indeed, the appreciation of – the 'long slog' has begun. Given the spread of information technology, the emphasis today is on knowledge-based networks that emphasize continual learning as well as on synergistic adaptation through increased participation in capacity building.

For several decades, public sector reforms have been premised on the assumption that improving the ability of government to manage its business will lead to improved social and economic progress. The first generation of reforms sought to cut public expenditures and to revive the private sector. Measures included budget cuts, tax reforms, limited privatization, liberalization of prices and, most conspicuously, efforts to downsize the public sector. The latter was almost invariably described as 'bloated' and therefore in need of surgery followed by a strictly enforced diet.

It quickly became evident that the transformation of government would require a long time and that the savings from reduced bureaucratic costs would be insufficient to provide even basic levels of public services. A second generation of public sector reforms then sought to improve the efficiency and effectiveness of government. While the first generation reforms stressed downsizing, contracting and improved control over budgeting and public expenditures, the second generation reforms advocated decentralization to sub-national levels, the creation of semi-autonomous agencies in the central government, and reforms of human resource management (recruitment, selection and training).

More recently the agenda for reform has refocused yet again as a third generation of reforms seeks to improve social outcomes through better service delivery. This strategy emphasizes sector-

Ciência & Saúde Coletiva, 14(3):763-770, 2009

wide approaches, particularly in health and education, in order to produce a coherent program for delivery of services that involves both governmental and non-governmental organizations. While these generations of reforms are overlapping rather than strictly sequential, all reforms have been driven by a combination of external and internal agencies. Multilateral and bilateral aid entails conditionalities that require a (commitment to) change in governmental behavior before money can be transferred. In turn, national planning commissions and ministries of finance require line agencies to adopt reforms that may include a combination of these generations.

Public sector reforms range across a repertoire of policy instruments: streamlined budgets, staff reductions, raised tariffs, contracting out and other forms of privatization. Reform of the health sector has focused on four main options, none of which is mutually exclusive, and all of which may occur at the same time. These are the establishment of autonomous organizations, the introduction of user-fees, contracting out of services, and the enablement and regulation of the private sector.

Most countries share basic goals in health policy: universal (or near-universal) access to health services, equity in sharing the financial burden of illness, and good quality health care. Given the growing share of public money in funding health care, governments have become concerned about efficiency and cost control. Patient satisfaction, patient choice and the autonomy of professionals are important goals too.

National arrangements for financing health care vary widely. On the one hand, the major share of health care funding may be financed by general taxation as in Scandinavia, Italy and the United Kingdom. On the other hand, systems of health insurance are the major source of funds in Germany, France and other continental countries. In all countries, patients pay some proportion of health care costs out of their own pockets through co-payments or deductibles. In most cases, however, governments mitigate the effects of user-fees by exempting certain groups or by setting annual limits on how much families must pay.

Variations in funding and contracting models in health care can be traced to country-specific historical developments but two events in Europe play a crucial role as models for policy. The first was the introduction of mandatory social health insurance for industrial workers and their families in Germany in 1883. Several countries in Europe – and some in Asia and Latin America as well – followed the German example of state-sponsored (but not state-administered) mandatory social insurance to protect the family income of industrial workers against the risks of illness, disability, unemployment and old age. The mandatory membership enforced by social insurance meant that the so-called 'sickness funds' had stable revenue streams and could create wider pools of shared risk. In the 20th century, these nongovernmental funds became core actors in the public policy arena by sharing the responsibility for social policy-making but under ever greater government regulation.

The second major innovation in the funding of health care was the establishment of Britain's National Health Service in 1948. The NHS extended the German insurance model by providing coverage to the entire population with costs paid out of general taxation. Although hospitals were nationalized, family physicians remained independent as practitioners.

During the first half of the 20th century, many European countries followed the German example by implementing separate income protection schemes for certain groups in society (e.g., disability and unemployment benefits for industrial workers). Only after World War II, however, did the full range of modern welfare state programs appear including old age pensions, disability and unemployment benefits, health insurance, sickness pay and child support. In the first decades of post-war reconstruction, there was popular support for this expansion of state-sponsored schemes. Some countries followed the German example of employment-based schemes; others preferred the population-based NHS model.

The spread of the two models was not restricted to Europe. Nations across the world sought to implement similar arrangements to protect the incomes of their populations (or population groups) against the financial risks of illness, disability and old age. By the end of the twentieth century, funding for health care in most countries had become hybridized by adopting elements from both the British and German models. Employment-based arrangements for certain categories of workers were combined with population-wide and tax-based universal schemes.

The 1970s saw a shift from expansion and popular support for welfare state arrangements to reassessment and retrenchment[2]. Economic, demographic and ideological factors contributed to the reshaping of the popular notion of the welfare state from a solution for social problems to that of an economic burden and a cause of economic stagnation[3]. After the oil crises of the 1970s, economic stagflation with persistently high levels of unemploy-

ment meant that state revenues stagnated or declined while public expenditures continued to grow. Moreover, as the end of the post-war baby-boom became visible, demographers realized that they had to revise their earlier demographic projections downwards – and future pension outlays upwards.

In addition, ideological views about the role of the state had gradually changed. On both the left and right of the political spectrum, critics agreed that state powers had become too intrusive in the lives of individuals. Growing discontent over fiscal burdens and disappointing results of public programs, rising consumerism and patient advocacy groups claiming a stronger say in the allocation and organization of health care – all challenged existing arrangements for providing welfare. Governments sought alternative models of governance to reduce the dominant role of the state and decentralize decision making, with more room for individual choice and entrepreneurial ideas[4,5]. Some countries took hesitant steps to introduce market competition in health care by reducing state control over the funding and planning of health care services. They also sought to broaden patients' choice of provider and health plan. Other countries turned to traditional tools of controlling public expenditure by setting strict budgets, reducing the scope of public insurance and increasing direct patient payments.

Factually, despite the rhetoric of increasing the role of the private sector and of 'down-sizing' government, the private sector for the delivery of health care in all countries is already extensive. Indeed, in most countries, the private sector is often larger than the public sector – but, due to ideological blinkers or what we sometimes call 'group think', the private sector has not been acknowledged and therefore not measured, at least in public data sets. Financed primarily by out-of-pocket payments, the private sector in health is largely unregulated. Consequently, instead of 'downsizing' the number of staff – a reform usually applied to the civil service, most reforms found in the health sectors of developing countries emphasize internal reorganization of the public sector – particularly through decentralization and outsourcing.

Health sector reforms have a significant parallel with civil service reforms. In most cases, reforms have been stimulated by economic recession and by severe fiscal problems in the state treasury rather than by an ideologically driven taste for reform. Declining government budgets have adversely affected service delivery, even in those countries which previously had reasonably well performing systems for the public delivery of health services. Pressures for reform of health care, therefore, often emanate from central ministries such finance and planning. In many cases, the Ministries of Health struggle to reinterpret and to respond to policy directives outside of their control. In Colombia strong political leadership plus outside experts from Harvard University forced reforms that integrated the health system with a wider social security network[6]. But 'demand' from the beneficiaries was conspicuously absent.

Economic realities of recession and fiscal crises affect not only the types of policies that are implemented but also reactions to them by the users, beneficiaries and citizens. The stage of raising revenue through the introduction of user-fees in order to supplement government budgetary resources was critical for many governments because of the endemic economic crisis. But the success of the policy, no matter how logical in theory, was constrained by the dwindling capacity of citizens to pay for health care. Furthermore, the administrative cost of collecting user-fees and of monitoring exempted categories of users often exceeds the revenue collected. The initial reform, however well intended, had not considered inevitable transaction costs.

While reforms have been widely espoused in international arenas as well as by technical experts, their implementation has been much more limited. It is difficult to assess the real potential for reforms in the health sector because more time is needed for assessment. Frequently, however, and rather ironically, countries with the most radical reform agenda appear to be those with the least capacity to implement them – or as Caiden and Wildavsky[7] commented caustically some decades ago about planning and budgeting: the smaller the capacity, the greater the ambition, and vice-versa. Perniciously the depth of the economic recession in such contexts requires a radical approach in terms of policy pronouncements, yet reduces ability to implement such a radical agenda.

Other types of capacity constraints have been identified, none of which is unusual. Human resource constraints in terms of the number of skilled staff available, and the motivation of staff to carry out their assigned tasks, are widely prevalent problems. Organizational culture often militates against effective operation of the new modes of government. In organizations that favor hierarchy and command over initiatives and team development, the autonomy formally granted to government entities may not be fully acted upon. While the New Public Management emphasizes the importance of linking performance to rewards, parallel informal systems often undermine the formal reward sys-

Ciência & Saúde Coletiva, 14(3):763-770, 2009

tems. For example, promotions are often made on the basis of patronage and favors in the traditional patrimonial system, rather than on objective assessments of performance. Key systems, such as management information systems, frequently fail to function effectively. Another significant barrier is the lack of incentives for individuals within the health care sector to plan or to monitor their work in terms of the information that is produced. In other words, there is almost no feedback system for self-correcting action.

A further sign of weak capacity is poor coordination among different actors[8,9]. Governments experience great difficulty in translating their broad policy statements into concrete strategies for implementation. As a consequence, there are problems in specifying and then enacting the details of decentralization policies. It is not clear, for example, as to the level of government at which financial rights and responsibilities lie. Likewise, it is not clear which organization should report which data to whom. These are all simple, but disastrous, problems in coordination.

Some of the constraints on capacity are, of course, rooted in the broader public sector rather than only within the Ministry of Health or similar agencies. This is particularly true of human resource management but applies to other systems as well. For example, until recently, all revenues generated from user-fees had to be returned to the national treasury – thus providing little incentive for their collection. Such a disincentive more or less ensured that such fees had zero impact upon the quality of health care. In contrast, when local hospitals are allowed to keep the user-fees that they collect rather than returning them to central coffers, not only do those hospitals have a better record for collection of fees but also they re-invest the surplus in such long-term benefits as higher quality equipment, more reliable stocks of pharmaceuticals and medical supplies, and even lower (or exempted) fees for the truly destitute[10].

Yet another factor influencing capacity that is outside the control of health ministries is the limited extent of private sector development. Limited development or inadequate depth of the private sector in health care hinders the efforts by government to contract out services. More importantly, it implies that government has few local examples of effective management practices in organizations from which to learn. There is a limited reservoir of management skills in the broad economy upon which to draw.

When describing health sector reforms, relevant questions include the types being applied (or at least recommended) and whether they are working in local or even national contexts. When addressing these questions, one has to be aware that generalizations – or their opposite: limited particular examples – tend to caricature reality. The world is vast and diverse so one seeks tangible evidence that health sector reforms are working.

Internal and external pressures for change encouraged national governments to seek solutions and new ideas elsewhere, which stimulated a proliferation of cross-national studies in the field of health policy. Most of those studies consist of descriptive cases and lack a common vocabulary. Terms like 'health reform', 'managed competition' and 'consumer-driven health care' are regularly used but rarely operationalized. While comparative studies aim to analyze processes of health reform across the globe, very few focus conceptually on what they seek to explain.

A common problem is the assumption that policy as stated in law or formal government documents is the same as policy actually implemented. For a variety of reasons, the outcome of reform often differs greatly from the original policy intentions and statements. Faced with public discontent over unintended results, governments feel pressured to adjust their policies.

'Health reform' marks major shifts in decision-making power over the allocation of resources and over financial risks in health care funding, contracting, ownership and administration. Such shifts include the abolition or reinstatement of selective contracting with providers, changes in the authority over capital investments, and expansion or contraction of entitlements of public health insurance as well as restrictions on medical decision-making imposed by practice guidelines. Decision-making power and financial risks can shift from the national level to regional and local governments (or vice-versa) as well as from government control to individual insurers and individual patients and the insured.

Empirical experience with goals and means for health reform indicate potential global convergence on patterns of performance, but countries implement change within their own institutional legacies and within the restraints of existing national institutions and political boundaries. The timing and speed of change of the health reform processes vary as well. In some countries, governments implement major change rapidly. In other countries characterized by strong opposition by organized stateholders, reform efforts are adjusted, delayed or even abandoned.

Any health care system can be described in terms of a country-specific mix of public and pri-

vate funding, contracting and modes of providing services[11,12]. There are five main sources of funding and three dominant models of contracting. The major funding sources are general taxation (general revenues, earmarked taxes and tax expenditure), public and private insurance, direct patient payments (co-payments, coinsurance, deductibles and uninsured services) and voluntary contributions. For some developing countries, external aid can be a major source as well.

Likewise, there are three basic contracting models**.** The 'integrated model' places funding and ownership of services under the same (public or private) responsibility. The best-known example is the original British National Health Service that provides tax-funded health care for all. The 'contracting model' allows governments or other third-party payers (usually administrative agencies for social health insurance but sometimes private health insurers) to negotiate long-term contracts with health care providers. The third model, common in private insurance, is reimbursement where a patient pays the provider and then seeks reimbursement from his insurance agency. Consequently the ownership and management of health services can be public, private (both for-profit and not-for-profit) or a mix of those. Moreover, there are country-specific mixes of formal and informal care, traditional and modern medicine, and medical and related social services.

Combinations of those core elements – funding, contracting (including payment modes) and ownership – determine the allocation of financial risks and decision-making power among the main players in health care. Government ownership and tax-funded services require strong government influence whereas private funding (insurance and direct patient payments) combined with legally independent providers restricts the role of the state even though governments can – and often do – impose rules to protect patients or safeguard the quality of and access to health care.

These terms help to characterize features of health care systems and policy-making but they do not explain the causes or the effects of policy change. In order to understand why countries embark on particular reform paths, one must investigate not only external and internal pressures for change but also structural features of social policy-making that enable politicians and policy entrepreneurs to change the system. Of course, institutional legacies and popular support for existing policy arrangements create powerful barriers to change.

Some of the reforms being proposed for the health sector are Structural Adjustment measures in disguise. They are often complicated and mostly 'top-down'. Other measures call for major changes that are politically unsavory and require strong determination to get underway. Because just getting started is so often such a problem, elaborate plans for implementation tend to remain on the drawing board.

More importantly – and overshadowing the above constraints –the proposed reforms have come to mean 'market oriented' interventions in the health sector. The concept has been promoted by a paradigm of health reforms that parallels and is embedded within the so-called Washington Consensus. It is important to address the underlying assumptions being made about market-oriented reforms because it is contended that a more decisive market orientation within the existing public health sector will bring about increased efficiency. Evidence that market-oriented health care systems are more efficient than public health care systems, however, is absent even in countries such as the US with its market-oriented health care system[13]. Almost twice as many financial resources (approximately 15 per cent of GNP) are required in the US to provide the same type and quality of care available in Western European countries that spend only seven or eight per cent of their GNP – a comparison which indicates that great inefficiencies remain in the most market-oriented health care system in the world.

One major reason for this pattern is that it remains profitable to provide unnecessary care; another is that – in systems where private-for-profit health insurance companies play a major role – transaction costs (administrative and other) are very high, in the order of 20-40 per cent. In the US it is reported that "… private [health] insurers spend around fifteen per cent of their budgets on administration – much of it devoted to keeping the sick off the rolls and, failing that, figuring out ways to avoid paying their medical bills – while Medicare [the federally financed universal health insurance for Americans aged 65 and over] spends two per cent …."[14]. Consequently, even using pure traditional efficiency criteria, evidence from many countries indicates that public health care systems can be not only more equity-oriented but also more efficient than market-oriented health care systems.

However, this observation does not imply that all public health care systems are efficient. The point is that inefficient public health care systems can be made more efficient by improving relevant public policies. A market orientation is not by definition the preferred way out to improve health care for people. Yet reforms intended to strengthen public health policies and public financing of health care

Ciência & Saúde Coletiva, 14(3):763-770, 2009

via taxes are gratuitously dismissed as 'non-viable'. This dismissal is reinforced by the theoretical contention of mainstream health economists that the role of government is 'to adjust the market failures' found in the health sector. The underlying assumption is that a 'perfect market' – one with no failures – will provide the best health care system. But this idealist model implies that demand, as expressed by purchasing power, should ultimately determine the supply and utilization of health care services. It is thus, by definition, impossible for a perfect market to provide health care services according to need – regardless of ability to pay. Only if the groups with the greatest need for care would also be those with the most resources for buying the care they need would the 'market forces' be a possible regulator of access to care.

In reality, the opposite is true. The economically least privileged groups are those experiencing the greatest disease burden, thus having the greatest need for care. Given this reality – and the objective remains to provide health care according to need – we must seek ways to improve the public health care system that caters to the health and nutrition needs of those with less ability to pay. This contention does not exclude a role for a parallel private for-profit health care sector that follows market forces primarily catering to the needs of the most privileged groups, but the consequences of such an 'exit' option must be balanced against the public interest.

Deep structural changes need to be enforced to get reforms in the health sector on a sustainable track. Such a track has to lead to outcomes that ensure minimum care for all citizens. Unfortunately, public hospital care in many countries has become unaffordable to the poor due to steep user fees. Additional hidden costs complicate this situation – 'under the table payments' to doctors being just one type[15,16]. Subsidizing such a system, instead of reforming it, will only channel additional funds to the wrong (non-poor) recipients.

Health sector reforms have been used as crutches to pretend that one is changing the system, but basically staying the course or even regressing. The issue is not whether people should share the costs – because the people always end up paying. The real issue is who is to pay more and who is to pay less or nothing at all. What arrangements would be more effective and sustainable?

Equity-oriented policy measures in the health sector have to be implemented from the central level. Until the equity situation improves, public health services need to be primarily financed by governments (central and local). The financing of health care should move away from regressive fee-for-service schemes and toward prepayment schemes where the whole population – not only the sick – contributes. Direct and indirect progressive taxes constitute the financial base for an efficient, equity-oriented health care system. Government funds can then be used to fund public health services or subsidize social health insurance schemes that will gradually cover the whole population. General tax revenues are a source to obtain financial resources for the health sector. And the use of existing resources (human, material, organizational and financial) should be rationalized to adapt them better to actual needs. This policy will entail reallocating (or even shedding) personnel as well as mobilizing more resources for outreach work. This strategy is linked to medium-term reforms that bring health staff income up to minimum standards of living based on a system of monetary and non-monetary incentives.

Reforms of the public health care sector need not be biased overwhelmingly in the direction of the private sector. The often touted non-service-mindedness of the public sector is not a given. While the public system has many flaws, it also has many strong points. As its core is streamlined and strengthened, ancillary services can be contracted to the private sector – provided there is a fair system of competition in place. The core of a delivery system must ensure equity as the highest priority. This observation brings us full-circle to the old 'political will' issue that is not really an issue of 'will' as such: it is an issue of 'choice', of political choice and subsequent commitment. And being an issue of choice, the responsibility to move towards appropriate reforms remains squarely that of the respective governments.

In 1993 the World Bank acknowledged that 'government policies which promote equity and growth together will therefore be better for health than those that promote growth alone'[17]. Moreover, the better health of the population contributed significantly to further economic growth. Medical interventions are absolutely necessary to deal with the problems of infectious diseases and acute ill health, but greater socio-economic equity is vital to tackle the challenge of health.

The human right to health requires political commitment at all levels to remove global, national and local inequities, including unequal access to health services and medical care. Without such political commitment, the socio-economic conditions that make 'Health for All' realizable do not and cannot exist. Action is needed far beyond health policy because health inequalities are rooted in socio-eco-

nomic structures. Action is needed in all social policies, and it is important to analyze and to understand the roles of various actors influencing the health of the population. It is particularly important to develop a clear conceptual framework of social policies in order to promote health effectively. Such a framework must be adjustable to changes in ideas, investigations or proposed interventions, and must be ensured by political commitment.

In the pursuit of equitable development, modern social paradigms denote new ecological perspectives of disease prevention and protection, enhancement, and promotion of health globally. These paradigms help to formulate viable policies by elaborating and integrating international strategies such as Health for All, Primary Health Care and population planning with national health plans. They resolve conflicts and debates among actors involved in the social policy process at different levels. Through these paradigms, policymakers and professionals, groups and individuals understand the root causes of health problems and identify solutions. Knowledge and awareness of modern paradigms help to ensure social development.

References

1. Whyte A. ***Landscape Analysis of Donor Trends in International Development***. New York: The Rockefeller Foundation; 2004.
2. Timmins N. ***The Five Giants: A Biography of the Welfare State.*** London: Fontana Press; 1995.
3. Wilensky HL. ***Rich Democracies, Political Economy, Public Policy, and Performance.*** Berkeley: University of California Press; 2002.
4. Ranade W, editor. ***Markets and Health Care: A Comparative Analysis.*** New York: Addison Wesley Longman; 1998.
5. Cutler DM. Health Care and the Public Sector. In: Auerbach AJ, Feldstein M, editors. ***Handbook of Public Economics.*** vol 4. Amsterdam: Elsevier; 2002. p. 2143-2243.
6. Bossert TW, Hsiao M, Barrera L, Alarcon M, Leo M, Casares C. Transformation of Ministries of Health in the Era of Health Reform: The Case of Colombia. ***Health Policy and Planning*** 1998; 13: 59-77.
7. Caiden N, Wildavsky A. ***Planning and Budgeting in Poor Countries***. New Brunswick, New Jersey: Transaction Books; 1980.
8. Akukwe Ch. The Need for a Closer Working Relationship between Public Health and Public Administration Professionals. ***PA Times*** 1999; 22(4):3-4.
9. Cooper GA. ***Health Sector Reform: A Study of Contracting of Local Government Primary Health Care Delivery to NGOs in Mumbai (India)*** [unpublished MA thesis]. The Hague: Institute of Social Studies; 1997.
10. Björkman JW, Mathur K. ***Policy, Technocracy and Development: Human Capital Policies in the Netherlands and India***. Delhi: Manohar Publishers; 2002.
11. OECD. ***The Reform of Health Care: A Comparative Analysis of Seven OECD Countries.*** Paris: Organization for Economic Cooperation and Development; 1992.
12. OECD. ***The Reform of Health Care: A Review of Seventeen OECD Countries.*** Paris: Organization for Economic Cooperation and Development; 1994.
13. Marmor TR. Hope and Hyperbole: The Rhetoric and Reality of Managerial Reform in Health Care. ***Journal of Health Services Research and Policy*** 1998; 3:62-64.
14. Hertzberg H. Ghostbusters. ***The New Yorker*** 2007; Oct 1; p. 38.
15. Avetisyan N. ***Provision of Health Care for the Most Vulnerable Groups in Armenia: Implementation in the Government and Armenian Red Cross Society***. [unpublished MA thesis]. The Hague: Institute of Social Studies; 2002.
16. Baru R. ***Private Health Care in India: Social Characteristics and Trends***. New Delhi: Sage Publications; 1999.
17. World Bank. ***World Development Report 1993: Investing in Health***. Washington, D.C.: World Bank; 1993.

Artigo apresentado em 27/11/2008
Aprovado em 02/02/2009