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Editorial

Health sector regulation – understanding the range of responses from Government

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There has been much mention of the factors behind recent growth of the private health sector in developing countries. Global ideological shifts, pressure from international agencies and ballooning public sector debt have all played their role. We sometimes forget, however, that private provision of medical care preceded the existence of the World Bank by a good few millennia. Perhaps a more pertinent question is why do Governments choose the ways that they do to intervene in health care markets.

Virtually all developing country governments have used some degree of direct state funding or provision of health care as their primary device to eliminate the health access inequities and inefficiencies that existed as a result of purely private access to care. In most countries, these still form the backbone of the health system. Failure of state health care systems to meet all health care needs has become more acute within the last 20 years or so, however, and with it has come rapid growth in the private funding and provision of care. The response of government to the weakening of its primary policy lever, that of direct provision, and the consequent need for it to develop arms-length, regulatory policy instruments, has differed significantly between countries, however. With some imagination, these differences may also be seen as phases in regulatory maturity. Four papers in this edition examine the interface between private health sectors and government in developing countries. The contributors all form part of a European Union funded international research network studying public–private mix issues in health care, PPMNet.

Figure 1 suggests that most developing country health sectors have found themselves in the pre-regulatory stage at some point in the last 50 years. In some, it is because private health care was banned altogether (such as the Former Soviet Union, Tanzania and China), and any form of regulation of the private health sector would thus have been an admission of failure regarding these attempts at eradication. In others, Ministries of Health have simply not had the capacity to prioritize private health sector regulation given other pressing health and social needs. From the paper by Qingyue Meng et al. (2000; pp. 349–356 of this issue), it would appear that much of China is still in this pre-regulatory phase. Unsurprisingly, governments that have previously been most heavily involved in the direct provision of services are generally most lacking in regulating the provision of those services by others. China is probably one such case. The extent of economic liberalization has been so great in China that public sector facilities have acquired many of the characteristics that we think necessitate regulation amongst private providers.

'Paper' regulations probably precede effective regulation of health sectors in most settings. Here legislative efforts are made to regulate private health care provision, but there is often insufficient impetus to carry these regulations through to actual health care delivery. The form of paper regulations is often remarkably similar between countries with widely divergent health sectors, suggesting that legislation often emanates from a common legislative template, rather than a contextual understanding of the private health sector in the country concerned. Many of the so-called 'social' forms of regulation described by Kumaranayake et al. (2000; pp. 357–367 of this issue) seem to fit into this category. One of the first forms of regulation introduced almost universally is conditions of entry for health care professions. For most of sub-Saharan Africa, however, these seem to miss the point that public need is for greater access to care, not better quality of care by an even less accessible, restricted group of practitioners. At least partly because of their lack of contextual fit, much of this paper regulation in developing countries is never enforced. Where patchy implementation does occur, it appears that informal linkages between the regulator and other organs of civil society, such as municipalities or consumer groups, are critical catalysts (Hongoro and Kumaranayake, 2000; pp. 368–377 of this issue).

Finally, three forms of mature regulatory response, where consistent implementation occurs, seem to be prevalent internationally. Ideally, we would like regulation to converge towards the appropriate, targeted form shown on the far left of Figure 1, where government assesses private sector failings and designs interventions to fix specific problems. When the problems disappear, the regulations themselves are removed, or at least wound back. In reality, the other two scenarios are at least as common.

Regulatory capture is particularly prevalent in poorer countries, where governments have little capacity to design regulation themselves, and hence recruit the regulated to draw up the regulatory framework. Factors such as low government salaries and the potential for regulators to gain subsequent

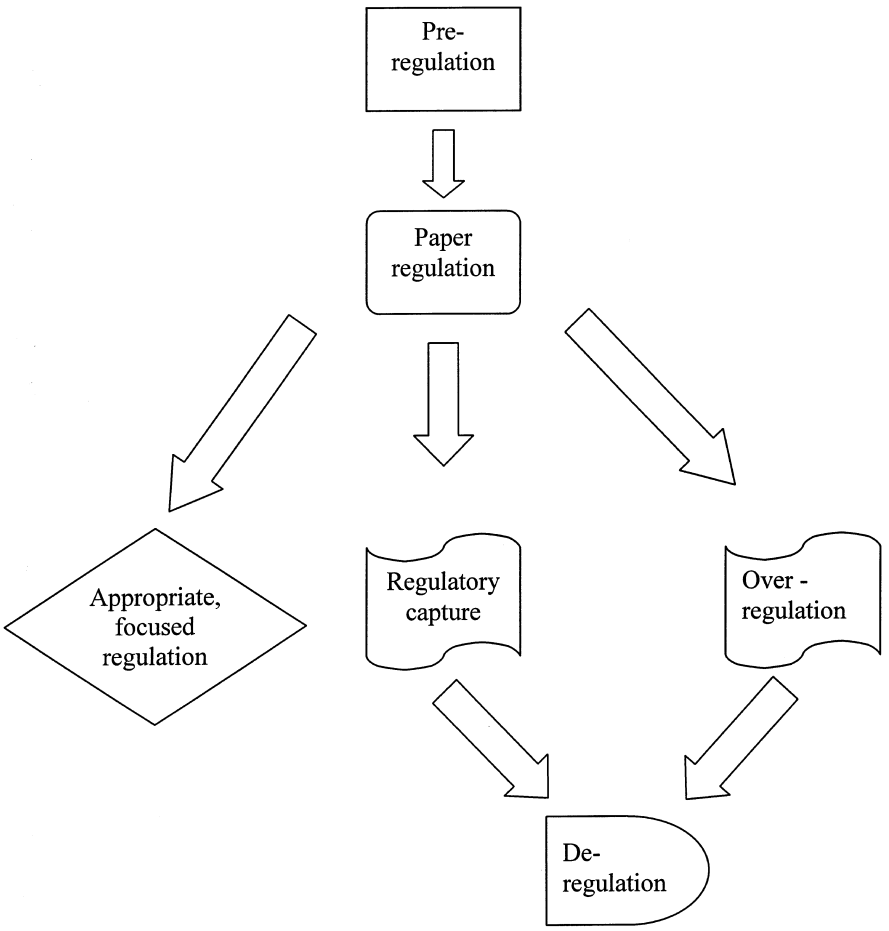

Figure 1. Regulatory metamorphosis in the post-colonial world

employment within the regulated industries also play a role. Regulation of standards of professional practice is impossible without a sizable and influential group of professionals within the regulator, which makes regulatory capture even more likely.

Over-regulation is relatively rare in low-income countries because of weak enforcement mechanisms, but is evident in some middle-income countries with long-established private health care sectors, especially in Latin America. While it is hard to define the threshold beyond which regulation becomes excessive, it would generally include situations where the removal of the regulation would have little or no impact on medical practice except to reduce bureaucratic hurdles. Many accreditation and licensing requirements probably fall into this category. In some instances, the original objective of regulation has long been lost as over-zealous bureaucrats try ever harder to close technical loopholes in the law. South Africa, for example, had a complex set of restrictions on the physical facilities that could be used for medical care. One requirement, designed to inhibit vertical integration, was that a medical consulting room may not share the same building entrance as a pharmacy, laboratory, or other provider of ancillary services. Rather than inhibiting vertical relationships, the main impact of these rules was on architectural style for medical centres, with buildings having multiple external entrances but no internal interconnections.

Given the potential for adverse regulatory outcomes, the call for deregulation, particularly prevalent in the economic liberalization that has occurred within rich countries, is not surprising. Lack of clarity on regulatory objectives may result in losing the desirable outcomes of regulation as well though. The paper by Söderlund and Hansl (2000; pp. 378–385 of this issue) suggests that deregulation of the South African health insurance industry in the late 1980s, while removing much of the unnecessary government involvement in price setting and modes of reimbursement, also had negative impacts on risk pooling and efficiency. The lesson is salutary: excessive, redundant or corrupted regulation may eventually result in the dissolution of appropriate regulations as well. Health sector regulation is an obvious and necessary adjunct to privatization of government health care functions. That said, much more emphasis needs to be placed on making health sector regulations appropriate to the needs of the health service users and the capacity and experience of government.

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