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TRIP REPORT

BASICS

REVIEW OF GOVERNMENTAL INTERVENTIONS AFFECTING THE EXPANSION OF THE PRIVATE SECTOR IN DEVELOPING COUNTRIES

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TABLE OF CONTENTS

I. INTRODUCTION 1

II. OVERVIEW OF THE PRIVATE SECTOR 2
Definition 2

III. FACTORS AFFECTING THE DEVELOPMENT OF PRIVATE HEALTH CARE PROVISION IN DEVELOPING COUNTRIES 3
3.1 Demand-side Determinants 3
3.2 Supply-side Determinants 5

IV. GOVERNMENT INTERVENTIONS 7
4.2 Incentives/Tax and Subsidy 8
4.3 Insurance and Cost-Sharing Mechanisms 9
4.4 Information 10
4.5 Interventions in Factor or Input Markets 10
4.6 Public Financing 11
4.7 Licensing and Regulation: 12

I. INTRODUCTION

A growing recognition of the size, scope and diversity of private sector in health service financing and provision has resulted in increasing policy attention on both the potential of the private sector to support the attainment of public health goals and the role played by private providers in national health systems.

In response to these developments and in keeping with broader ideological trends towards democracy, pluralism and greater private sector involvement, many countries have adopted policies changing the relative roles of public and private sectors in health care. These policies are ones through which public goals can be pursued by making better use of the private sector and by reducing unnecessary and inappropriate burdens on the public sector [4].

Most developing countries have implicitly accepted the need for a mixed supply [1]. Attitudes toward the private sector have changed remarkably to the extent that private sector is increasingly seen as a partner [2]. The question of how to engender closer public/private collaboration in health service provision and financing in support of improving health outcomes has received heightened attention. Concepts such as sharing public resources with private providers and determining areas in which the public and private sectors have a comparative advantage in both financing and production of services must be taken into account [6].

Although the role of government in financing health care is of continuing importance, government has been seen less and less as the principal provider of services, while the significance of its policy making and its capacity to regulate and coordinate diverse health agencies have increasingly been recognized [2]. On the other hand, as the private sector becomes increasingly involved in the financing and provision of health care, the government has been subjected to increasing challenges on both efficiency and equity grounds [6].

Government has a clear role in ensuring equity of access to health care, as well as a safe and appropriate health service provision for the population. The main concern for public policy is to encourage private sector involvement without adversely affecting the existing public sector health delivery system [6]. Government must have mechanisms through which to liaise with private health care providers [3]. This interaction between the two sectors may be carried out through a number of features of the existing economic and health care system such as the regulation and licensing of private providers; taxes and subsidies and the incentives these create for providers and users of private health care; purchasing of privately financed services; direct public financing and provision of health services; interventions in input markets; provision of information; and coordination.

There are situations when the government has no other way but to intervene in the health sector if the attainment of equity goals are to be accomplished. Market failure (problems with adverse selection and moral hazard) is viewed as one of the most important reasons for public interventions in the health sector. The characteristics of health care are such that a pure market

solution is likely to be inequitable and inefficient [20]. Whereas the state aims towards equitable service provision, the private for-profit sector is driven by the desire to maximize profits which create strong incentives to avoid dealing with, for example, high cost cases [3].

Many interventions within the scope of public health can be guaranteed only by the government [21]. Such is the of the public goods, i.e., the benefits of one person's consumption of health care extend beyond the individual and benefit the entire public, such as water and sanitation services and vector control. There are also goods with significant positive externalities, such as communicable disease control and merit goods, that is, those goods which are believed to be intrinsically good, such as preventive care and early detection of disease. If left to the market, such services might be provided at a level below that which is socially optimal[3].

Another reason for government involvement in the health sector is the consumers lack of information about appropriate treatment(s) and its cost. Instead, consumers rely on health workers to make decisions on their behalf. The latter may over-provide care in order to generate higher levels of income. Problems of imperfect information also arise in the insurance market; those insured may be encouraged to consume services which they do not need. This is costly to both the individual and society and may compete with objectives of the state, such as increasing access to care[3].

Finally, given that the state has a responsibility to ensure that health services are available to all the population, the government is left with the responsibility to finance with public funds those who cannot afford paying for their care[21].

II. OVERVIEW OF THE PRIVATE SECTOR

Definition

Private sector is the term used to signify those organizations and individuals working outside the direct control of the state[2]. It encompasses all those organizations and individuals tl.. are involved directly or indirectly in the production, financing, delivery, and distribution of health services and ancillary goods and services[6].

However, as is the case in most developing countries, the distinction between the public and private health sectors is blurred due to the fact that many public providers also provide services privately, outside of normal working hours[11].

The private sector is usually divided in two groups: the for-profit and the not-for-profit subsectors [29]. The not-for profit subsector includes international non-governmental organizations (NGOs), national voluntary associations, religious missions and community self-help groups. On the supply side, the for-profit subsector consists of a variety of providers, such as physicians in private practice, traditional healers, clinics, hospitals; and product retailers, such as pharmacies,

drugstores, dispensaries; and product manufacturers and distributors. On the demand side, there are individual consumers, HMOs, insurers, and/or third-party payers.

Efforts to delimit the private health care sector should clearly distinguish between public and private financing and provision of health care. This distinction is needed because it will bear out very different implications for the incentives faced by providers and users, and hence, different policy implications[4].

Increasingly, governments are experimenting with health care systems, mixing public and private elements[2]. For example: services may be publicly provided and privately financed (i.e., charging of user fee in the public health system; private beds in public hospitals), or privately provided and publicly financed (e.g., social insurance financing; services contracted to private providers).

III. FACTORS AFFECTING THE DEVELOPMENT OF PRIVATE HEALTH CARE PROVISION IN DEVELOPING COUNTRIES

To develop informed policies towards the private health sector requires an understanding of the factors that influence its development. These factors can be divided on the basis of whether they determine the demand for or supply of private health services. There are other factors internal to the provider that will affect its performance, including the organization's or individual provider's objectives, as well as its management structure and culture[3].

3.1 Demand-side Determinants

The key factors that influence the demand of private health services include income, price, quality, private and social insurance, transport infrastructure, nature of the medical referral system, demographic and epidemiological factors, educational and cultural issues, health seeking behavior, and previous historical experience.

The demand for private services is derived from the overall demand for health services; the decision to seek care comes first, followed by the choice, if any, of provider(s). Evidence suggest that choices between provider type (public or private) are based on factors such as expect benefit, price, opportunity cost, availability, quality[1].

There is evidence that health care demand and income are closely linked, and because private health care is deemed more efficient, and supposed to be of a better quality, the demand for private care can be expected to increase with real income [6].

Price is another important determinant of both the overall demand for health care and the choice of provider. The choice of provider is influenced by the differences in price between comparable alternatives. Private provision will be greater where public sector prices are higher relative to private prices [1].

In addition to price, quality (cleaner and friendlier environment, better drug supply) as perceived by the user, rather than quality as a technical standard (poorly understood by users), is one of the most important determinants of patients' choice of provider and willingness to pay[15]. The role of deficient drug supply in deterring utilization has frequently been emphasized[15].

Risk-sharing payment mechanisms, such as insurance, can be a major determinant of private health care development. Because of the element of catastrophic risk in medical markets and the related problems consumers have paying for care, the development of instruments on the demand side of the market to finance the consumption of medical services will have a major impact on the level of demand for private services[28]. The major influence of insurance and similar arrangements on the demand side is to reduce the effective price faced by the consumer. In so doing, it increases choice of provider and may lead to increasing consumption.

Private insurance provided directly by employers is the most common form of insurance around the world[1]. In Chile, the development of a private system of financing and administration of health care benefits (ISAPRES) to which workers can make compulsory contributions as an alternative to the public system, has had a positive impact on the development of private sector services[24].

The potential for private insurance to substantially increase the level of private provision is limited in poorer countries because it usually is restricted to the formal employment sector, high income individuals, and specific areas, such as cities[1]. In Senegal, the government's policy of requiring large companies to provide their own clinics has promoted the growth of employer-based services, while on the other hand, it has also reduced the demand for private for-profit services [5].

Social insurance that is compulsorily required under legislation offers greater opportunities to achieve wider coverage [1]. In Latin America, more than 50 percent of all people are covered by social security health services[29]. Many of the social security organizations in developing countries have a significant degree of public subsidy. This is the case in Colombia where the Social Security System is divided in a regime financed by payroll-deductions from the higher income population group and a subsidized regime for the poor[25]. In contrast, in many of sub-Saharan African countries, current social health insurance arrangements cover only those people in the formal sector. In these countries, there is a danger that social health insurance skews resources towards the relatively wealthy portion of the population[2].

The impact of social insurance on the private sector depends critically on whether reimbursement of private providers is permitted[1]. In many developing countries, social insurance not only insures, but provides care in their own facilities as well.

For the last decade, some countries have sought to expand the role of the private sector in financing health care through the introduction of user fees for public services. Charging users for certain public services may lead to a greater demand for private health care services[illegible] In addition, user fee policy aims of improving the public service quality may lead to an increase in

price competition with private providers. User fees may also pave the way for options, such as health insurance[7].

The development of roads and transport services, especially for rural inhabitants, will increase the access to health care facilities, and thus increase the size of the potential market for private providers.

The structure of the medical referral system will also influence demand, which may be supply-induced demand due to the patients' lack of information[10]. That in turn can influence the growth and composition of private provision. In the Thai health card system, holders can only use government facilities and must follow established patterns of referral[27]. In Malawi, on the other hand, the government is exploring ways to cross-refer patients between public and private facilities[17].

Demographic and epidemiological factors which affect individual health status and demand are not seen as causing major impacts on the private provision of care[1]. However, the epidemiological transition, the decline of infectious and parasitic diseases and a rise in chronic, degenerative, or accident-related diseases currently taking place in many developing countries, has profound implications for health policies in the next few decades. It has been suggested that in addition to increasing efficiency, governments will have to focus on efforts at promoting health and preventing disease before the demand for services for the "new diseases" absorbs the available health resources[23].

Cultural and behavioral factors can also influence demand for private services as it is assumed that increased levels of education are associated with increased demands for higher quality medical care and more modern treatments. Moreover, previous exposure to and familiarity with modern medical services may also lead to a greater and more differentiated demand for medical services, and may lead to an increased demand for private medical services, promoting competition and better services [5].

Health seeking behavior may also be associated with increased demand for private services in the sense that people given the provision of widely accessible health services may become accustomed to frequently requesting medical services when ill, and thus as part of an increased demand for health services, the scope for private sector activity may also increase.

3.2 Supply-side Determinants

The supply of private provision will be determined, in part, by the demand for services. It will reflect the influence of economic, social, political and regulatory factors on the availability and price of inputs (capital, labor, physical plant, and technology).

The supply of private health care will also be influenced by the impact of insurance mechanisms, the nature of competition in the market for health services, and the regulatory framework within which minimal standards for the provision of health services are laid down.

Labor inputs are a critical resource in the provision of medical care. Labor supply to the private sector in developing countries will reflect the effects of education and training of health personnel, emigration and immigration, and competition with the public sector [1]. In most developing countries, the government has a near-monopoly in the training of health professionals.

Public policy regarding health personnel has a major impact on the availability of personnel to the private sector. In Kenya, nurses and clinical officers are allowed to establish medical practices [11]. In most developing countries, low wages in the public sector have driven medical professionals out of public service and into the private sector.

In many developing countries, imported personnel are an important source of labor. This is the case in much of Sub-Saharan Africa, where missions and other NGOs employ a significant number of imported personnel[1]. In contrast, emigration of health personnel may act as a constraint to the development of the private sector. In South Africa, the political situation of the anti-apartheid regime, as well as the attraction of higher incomes overseas, has led to the emigration of many (foreign and domestic) doctors over the last decade[18].

Capital can be an important determinant of the supply of private medical services and in funding insurance schemes. The importance of capital varies with the level of complexity and organization of the medical facility[2]. In the Philippines, inadequate or expensive capital may be partially responsible for the proliferation of the small single-proprietor hospitals in the private sector[28]. Private providers are constrained by the large capital outlays needed for establishing facilities and financing technology and equipment, running day-to-day operations, stocking and maintaining an adequate supply of drugs, and paying malpractice insurance premiums[5]. The lack of financial institutions specializing in health sector financing may also be a major constraint to private sector development[26].

The availability of financing, which is clearly a policy measure, along with growth in demand will positively affect private sector investments in health care in developing countries. There are also factors which will have a negative effect on private investment including: fiscal deficits, the volatility of inflation, and exchange rates[6].

Government's high taxes on imported drugs and equipment have restricted private sector development in many developing countries. Import restrictions affect the entry of inputs of the health care industry into the country. In the Philippines, importation of medical equipment and supplies and pharmaceuticals are subjected to a set of tariffs and duties[28]. In contrast, in Thailand, exemption of import duties for high-cost medical technologies has contributed to the accumulation of technology in the private sector (this oversupply of technology encourages abuse)[27].

Insurance can have a significant impact on the supply, organization, composition and costs of private health care provision[1]. Insurance is also a major determinant of investments in new technology and equipment by the private sector. Providers will respond to the changes in incentives that insurance creates. The incentive effects on providers are determined by the patterns of reimbursement. Clearly, supply of reimbursables over other items will tend to increase, which may lead to an over-provision of those items. For example: the reimbursement rules of the Philippines' Medicare system are shown to be responsible for the proliferation of smaller primary care hospitals in the country [28].

IV. GOVERNMENT INTERVENTIONS

Governments can indirectly influence the development of private health services by their impact on the general social and economic environment; directly by intervention(s)in the health sector. There are a number of interventions or policies through which the public sector can directly influence both the demand for and supply of private health care services.

Policy tools available to the government include: incentives/taxes and subsidies; public provision of health services; public financing of health services; provision of public information to alter existing patterns of demand; licensing and regulatory approaches; interventions in factor or input markets; and coordination.

4.1 Public Provision of Health Services

Macroeconomic factors are the major determinants of the demand for health care. However, the government can influence the demand for private services by direct involvement on the supply side of the market through public production of health services. This will influence the demand for private provision via the mechanism of public-private sector competition. It is expected that this competition will foster greater efficiency and better quality of care[6]. Within a country the geographical distribution of publicly provided services may also influence the provision of private services[1].

The fact that both sectors are competing for similar types of resources may lead to situations where one sector may suffer at the expense of the other. In the Philippines, for example, the competition from government services for paying patients is viewed as a constraint to the growth of the private sector[28]. To limit the negative impact of government services on the private sector, government could eliminate subsidies to higher income groups who use the public sector, thus providing these groups an incentive to use the private sector[29].

It has been recommended that to promote efficiency in the provision of health services, governments in developing countries should concentrate their efforts in encouraging the private sector only in areas in which the private sector has a competitive advantage in relation to the

public sector[6]. For example, services with high "merit good" components ought to be targeted to the public sector, whereas most curative services can be left to the private sector.

4.2 Incentives/Tax and Subsidy

Governments' actions may involve a variety of non-monetary and monetary incentives, in the form of tax and subsidies. These incentives could be used to encourage the private sector either to collaborate with the public sector or could be directed at supporting the development of the private sector[2]. Incentives could also be used to promote efficiency in the provision of health services.

Taxes and subsidies work by altering the cost for the consumers and producers, through which changes in their consumption or production decisions are induced[4]. There are direct subsidies, such as a direct payment of insurance premium for low income households or other changes in the price, and indirect subsidies which act through other systems, e.g., the tax system.

Incentives or subsidies can be offered to consumers to increase their use of private providers [5]. Instead of targeting subsidies to the facilities, subsidies could be provided to households, allowing consumers a choice of providers. In countries where personal income tax payments are significant, it may be possible to increase the demand for private services by making medical expenditures tax deductible[1].

The intent for tax incentives or subsidies to providers could be to increase the production of health services or to lower costs [4]. For example, private provision could be encouraged by exempting certain medical supplies from customs duties, offering tax relief to private providers who locate in under-served areas, subsidizing medical education, and by exempting not-for-profit organizations who steer not-for-profit providers into areas where the government is unable to provide services [2]. Government subsidies can also be given to reduce the cost of insurance to both employee and employer, thus, increasing the demand for health insurance.

An alternative way in which governments could provide certain incentives to the private sector is through the use of the payment mechanisms. Different forms of payment have different incentives inherent in them. The most common payment mechanism is that of fee-for-service; the inherent incentive in this mechanism is for the provider to over-provide services. Contrary to this mechanism, capitation-based payments offer the provider an incentive to reduce services delivered [2]. Instead, many developing countries prefer salaried methods of payment which do not provide enough incentives for the physicians to put in the required amount of effort, and omit effective penalties for neglecting patients's needs[6].

The complexity of interactions between the public and private sector means that a subsidy in the public sector may indirectly affect the private sector. The existence of free services in the public sector constitutes an explicit consumer subsidy in the public sector, the objective of which is to increase consumption of health services. But as this has an effect on the choices made by

consumers about which providers to consult, there is ultimately an effect on private providers also [4].

Similarly, since a subsidy is a financial tool, decreasing or eliminating a subsidy involves transferring the source of financing from the public to the private sector[4]. At the same time, the existence of a subsidy may make investment opportunities more profitable, thereby attracting more private resources [4].

4.3 Insurance and Cost-Sharing Mechanisms

In many middle-income countries or urban areas in some low-income countries, the major intervention or development that will alter the nature and extent of demand for medical care will be insurance. Insurance will expand both the demand for and the supply of private services. Government approaches with respect to insurance provision include the decision whether or not to introduce social insurance, taxes and subsidies, as well as regulation and legislation.

The potential success of implementation of social health insurance schemes will depend on targeting such issues as equity, administrative capacity and the extent whether health insurance is able to raise revenues. Schemes are likely to be particularly inequitable in financing if government contributes to the premiums instead of shifting its own funding to focus more resources on uninsured workers and reaching out rural areas[2].

Health insurance, regardless of the type of scheme adopted, brings a considerable administrative burden in terms of design details, implementation of schemes, and regular monitoring[2]. To carry out those tasks, an adequate management and administrative capacity should be in place. Financial skills and information systems should be developed to ensure access to a defined package of benefits, and to ensure that payments do not outstrip revenues. Cost-containment measures should be taken to prevent imbalances between contributions and payouts. Mechanisms to collect premiums should be developed in countries where the income tax system does not cover the majority of the population[2]. Finally, the development of insurance schemes will require that the socio-political and legal environments of the countries undergo a major change[6].

User fees for public health care services is another device used to promote the private sector in the financing of services. Although, improving quality must be a primary objective of fee policy, in most situations the raising of revenue is likely to be the major objective of the user fee policy. Income from fees has been demonstrated to represent a modest percentage of total government expenditures for health; however, it may be a substantial percentage of expenditures at the lower levels of the system and individual health facilities. Very small expenditures for maintenance, emergency purchase of drugs, or spare parts may make a major difference to the quality of service [2].

Several countries aim at improving efficiency with their user fee system by creating incentives through the price structure for patients to use the most appropriate levels of care[15].

There are many issues to be considered regarding the implementation of fee systems. Administrative capacity is considered to be a crucial factor for the success of the policy. Other important factors include the decentralization of the administration of the fee revenues and the retention of fee income at the health facility in order to improve services. There is evidence of reduced utilization of health services among poorer groups after the introduction or increase in the level of user charges. Currently, possible suggested policies to counter the problem of regressivity are price discrimination and exemptions mechanisms[7].

4.4 Information

By providing patients with information, it is possible to change their health seeking behavior and thus, demand patterns. At the same time, by shifting demand between providers, consumers may affect provider behavior[3].

Direct intervention through the provision of information about the cost and quality of services in the private sector is one way to increase the role of the consumer in health services[4]. A possible mechanism for informing consumers in many developing countries is the mass media, which can be used to increase knowledge about corruption and inefficiency in both the public and private sectors. In Bombay, India, the media is playing a key role in exposing medical negligence and medico-legal cases[19]. In Chile, part of the success in the implementation of pension reforms in the country is attributed to the popular support created by an active public relations campaign to sell the new concept to the public [22].

Another mechanism for informing consumers is to work through community organizations. Such organizations represent the interests and needs of the community and assist consumers in exercising their purchasing power by providing information about different providers[3]. Governments can encourage the development of community organizations through financial and/or technical support.

The traditional health practitioners are an important source of health education messages [5]. A few governments are trying to find ways to integrate traditional practitioners into preventive care programs [14]. In Malawi, the upcoming Herbalist Association will allow for new channels of communication with the government. The Association will play a role in enabling cooperation between the herbalists and the government in referrals and policy. In addition, it will function as a forum for the dissemination of ideas [17].

4.5 Interventions in Factor or Input Markets

The government can influence the availability and cost of inputs to health care, such as medical personnel, drugs, and equipment through several public policies, including direct provision; economic incentives and disincentives, in the form of taxes, fees, and subsidies; and administrative actions, such as regulation and licensing [11].

Governments can also address problems in the distribution of doctors geographically or across facilities or specialties by targeting subsidies to private doctors working in underserved areas. In some countries, private physicians are encouraged to locate in underserved areas in such ways as subsidized loans for the establishment of their practice, and transfer or sale of infrastructure to private physicians[4]. Governments can also set incentive payments, or the provision of free supplies may be used to encourage private providers to offer preventive services[3].

A different approach is to foster appropriate sharing of public resources between the public and private sector through sharing physicians and other medical staff time between the public and private sector. In developing countries, many public physicians work "after-hours" in the private sector to supplement their income. The practice of moonlighting is encouraged by a few governments, such as Kenya [26]. In other countries, such as Senegal, moonlighting is illegal and is seen as a major constraint to the growth of private sector in that country[5].

One favorable outcome of these arrangements is that public sector physicians have their incomes raised by their private practice, which greatly leverages their government salaries. The negative side is that physicians have incentives to self-refer patients to their private practice and the quality of public services may suffer due to the "after-hours" work of physicians[6].

Another form of sharing of public resources commonly observed is the private sector's use of hospital beds, operating rooms, and other types of capital. Such is the case in Malawi where the government permits active medical personnel in its facilities to set up private surgeries[17]. In Papua New Guinea, private practitioners are allowed to use the government hospital for their practice[16].

Technology, equipment, and supplies are inputs usually imported. Their import can be encouraged through the use of preferential import quotas, preferential access to rationed foreign currency, and exemptions from import duties.

4.6 Public Financing

Governments may choose to help finance health care directly by providing investment funds or indirectly, through subsidies, tax policy, credit controls, and access to limited foreign exchange. These financial incentives, in addition to expanded third party payment mechanisms, are seen as important factors influencing the growth and organization of private delivery systems[29].

Governments can also influence the private sector through direct public financing of privately provided services or goods. In a number of developing countries, contracting is particularly common for the non-clinical components of health services, such as laboratory and equipment maintenance, catering, and security services[2].

Contracting of clinical services is emerging in many developing countries, such as the contracting of private hospitals to provide services for non-private patients in South Africa[9]. Other countries

have established "private pay" beds within government facilities[2]. In Latin America and Asia, the public sector contracts for clinical care provided by a range of public and private providers[13].

Contracting with non-governmental, not-for-profit agencies may have potential in developing countries. In some parts of India it is reported that in return for a subsidy, NGO hospitals operate an exemption mechanism for patients identified as poor[9]. The payment of block grants to NGOs or other organizations for operating costs, a situation commonly found in many African countries, might be considered contracting[9]. In Kenya, the Mission/NGO facilities function as district referral hospitals in those districts where government district hospitals do not exist[12].

Some of the advantages of contracting include: public financing ensures that risks and uncertainties are shared; resource allocation decisions remain in the hands of public institutions; and the introduction of competition which is seen as a means of promoting productive efficiency by ensuring that inefficient providers are not awarded contracts[9]. In addition, contracting permits the public sector to take advantage of the assumed efficiency of private sector production, and allows for public-sector financing in areas traditionally not considered profitable by the private sector (such as contracting private providers for services such as immunization)[6].

Despite all its advantages, the contracting of clinical services may not be feasible in most developing countries at present[9]. Public sector purchasers in many developing countries are unlikely to have either the managerial skills or the requisite information for the design, negotiation, implementation, and/or monitoring of efficient contracts[13]. Furthermore, in many developing countries, the small number of potential contractors may not allow the emergence of competition in the contracting process, which will compromise the system's efficiency[13].

4.7 Licensing and Regulation:

The objective of most regulations is to alter the behavior of agents in order to eliminate market failure, or to otherwise alter the market outcome so that it is closer to some social optimum[4]. Regulation(s) can be exercised by public or private bodies whose acts of control will seek to influence the price of services, labor, capital, and quantity and quality of services. Regulation is essential in order to protect both the consumer and the bona fide private providers[2]. Two features distinguish regulation from other forms of policy intervention: first, it works through legal or administrative channels; and second, regulations are coercive in nature[4].

It has been suggested that conventional regulatory actions by the state often fail because they focus on constraining only the outputs of the health care system. This approach is insensitive to the pattern of incentives produced by the system, and their impact on regulatory effectiveness. An example of this is the powerful and contrary incentives that an open-ended reimbursement system may offer to both regulators and those regulated[6].

Regulatory structures should be designed to match specific conditions within a country; and to avoid unnecessary cost, regulatory mechanisms should be as simple to operate as possible[2].

Effective regulation depends on the existence of sufficient administrative resources to develop and then implement regulations affecting the private sector. Monitoring is crucial to both the implementation of incentive mechanisms and regulatory control[3]. In addition, there must be a legal framework in which compliance and cooperation can be assured[1]. Although most countries have licensing requirements and a legal framework for regulation, these are not enforced or checked effectively[2]. Lack of funding and resources may also prove a substantial obstacle to successful regulation[3].

Furthermore, effective regulation of the private sector and incentive setting will depend on adequate information about the private sector and its internal dynamics. In many developing countries, little information about the private sector and its activities is available[3]. At the most basic level, there needs to be a list of all private providers so that the government and other regulatory bodies know whom they are regulating[3]. This type of list is often achieved through the compulsory registration of providers.

Price of care can be regulated by directly fixing fee levels for private providers or by regulating provider payments through third parties. The latter is the easiest approach when the government or other statutory bodies have control over the financing mechanism, usually through social insurance or legislation affecting private insurance.

Governments can control private insurance through the regulation of insurance reimbursement rates or premium structures to achieve broader social goals. Payment mechanisms can be used to control the output of individual providers by limiting practice size (as in the capitation system) or by creating appropriate incentives to reduce overtreatment or excessive prescribing.

The quantity, distribution and location of private services can be controlled through the regulation of the establishment of private facilities. The first stage of regulation is the licensing and registration of the facility. Several countries have attempted to influence the location of private providers as a way of improving the integration of private providers into the national health care system[3]. Location of facilities could be controlled in order to ensure an even and equitable distribution of health facilities as well[4].

Licensing and regulation are probably most importance in the case of quality. This can be of great relevance to the standards of technical quality when providers face considerable incentives to improve consumer-perceived quality[1]. In regulating technical quality, the structural and process-oriented aspects of quality are the easiest to deal with (i.e., basic service configurations, minimum facilities required to operate as a clinic or hospital). Quality in terms of clinical outcomes is much more difficult to assess and regulate.

As the private sector expands in middle-income countries, there is a need to shift from structure-oriented regulation to the more sophisticated practice-oriented regulation through quality assurance programs[3]. Quality assurance mechanisms need to be in place before insurance is introduced in a country to guarantee access to a good quality of care to potential consumers[2].

Opportunities for training, both overseas and locally, are important incentives for raising the quality of private providers' work[2]. Less formal training initiatives, such as inviting private sector participation at Ministry of Health conferences, may also improve skills and generate incentives for appropriate practice, while also serving to keep private providers in touch with Ministry of Health treatment guidelines and policy[3].

The government can make positive, as opposed to strict regulatory, contributions to improving the quality of care from public and private sectors by developing and encouraging the use of standardized treatment protocols, medical record keeping, and medical accounting practices[29].

Regulatory controls could be established with the objective of increasing the efficiency and effectiveness with which the health system operates. Controls could include: technology regulation, as in the case of large institutions where the acquisition of equipment and new technology can be controlled through a process of assessment and licensing; labor market issues, such as number of years of public service which must be provided by publicly-trained practitioners; rules relating to the use of the health system, for example, requiring that patients seeing specialists are referred by general practitioners; reporting communicable diseases; and epidemiological monitoring information[4].

Professional organizations often act as regulatory agents for the members of the profession. They are responsible for monitoring medical standards, licensing medical personnel, and controlling the quality of individual practitioners. Professional organizations are generally run by members of the profession. In most developing countries professional organizations tend to take a passive role in setting minimum standards, and simply react to complaints brought to them[3].

The effectiveness of such self-regulating arrangements vary considerably. The professional body's objectives are likely to differ from those of the government[3]; their objectives may be too similar to those of the providers they are supposed to be regulating and as a result, may not protect the interests of the consumer. It may be necessary to back-up the regulatory authority of medical and other professional councils with a governmental regulatory body[2]. Alternatively, professional organizations could adopt a more active role: they could establish regulatory review bodies, institute medical audit techniques, or introduce accreditation schemes[3].

Finally, it is been observed that the strongest incentive to coordinate and regulate lie at the local level. Regulatory capacity requires a considerable degree of decentralization and local responsibility and authority[3]. Although the allocation and utilization of resources may improve with decentralization, decentralized systems may suffer from a lack of central guidelines. A careful balance needs to be achieved between central guidance and local initiative[2].

APPENDICES

APPENDIX A

TABLES

TABLE 1
GOVERNMENT INTERVENTIONS ON DEMAND SIDE DETERMINANTS

DEMAND SIDE	GOVERNMENT INTERVENTION	COUNTRY EXPERIENCES
SOCIAL HEALTH INSURANCE	MECHANISMS TO COLLECT PREMIUM IMPROVE ADMINISTRATIVE AND MANAGEMENT CAPACITY MONITORING MECHANISMS INFORMATION SYSTEMS COST-CONTAINMENT MEASURES REIMBURSEMENT RULES/PAYMENT MECHANISMS SUBSIDIES FOR THE POOR BENEFICIARY BASE REGULATIONS	Subsidized regime for the poor: COLOMBIA Medicare: PHILIPPINES Capitation-basis payment: THAILAND Reimbursement, rules and proliferation of small hospitals: PHILIPPINES

DEMAND SIDE	GOVERNMENT INTERVENTIONS	COUNTRY EXPERIENCES
PRIVATE HEALTH INSURANCE	PROMOTING PRIVATE INSURANCE INSURANCE INDUSTRY REGULATION EMPLOYMENT-RELATED COVERAGE LAWS TAX TREATMENT OF PREMIUMS TAX DEDUCTION FOR CORPORATE OWN-PROVISION OF SERVICES DIRECT SUBSIDIES TO EMPLOYEES, EMPLOYERS OR INSURANCE COMPANIES	Large companies requirements for direct delivery of care: SENEGAL, PHILIPPINES ISAPRES: CHILE
INDIVIDUAL DEMAND AND FINANCING (USER FEE FOR PUBLIC SERVICES)	MALPRACTICE LAWS IMPROVE ADMINISTRATIVE AND MANAGEMENT CAPACITY EXEMPTION MECHANISMS DECENTRALIZATION OF THE SYSTEM SUBSIDIES FOR LOW-INCOME INDIVIDUALS	User fee: KENYA, NIGERIA, GUINEA, BURUNDI
PUBLIC PROV. OF SERVICES	PUBLIC SECTOR COMPETITION	ALMOST ALL COUNTRIES

DEMAND SIDE	GOVERNMENT INTERVENTIONS	COUNTRY EXPERIENCES
PUBLIC FINANCING	CONTRACTS FOR GOODS AND SERVICES FUNDING OF INSURANCE SCHEMES IMPROVE INFORMATION AND MANAGERIAL SKILLS MONITORING MECHANISMS	NGOs facilities as district referral hospitals: KENYA NGOs hospitals operates exemption mechanisms for poor patients: INDIA Contracts private hospitals to provide for non-private patients: S.AFRICA Contracting non-clinical services: INDIA, INDONESIA, MALAYSIA
INFORMATIO N	ASSIST DEVELOPMENT OF COMMUNITY ORGANIZATIONS HEALTH EDUCATION MASS MEDIA	Healer as source of health education messages: MEXICO, ZIMBABWE Use of media to expose medical negligence: INDIA Public relations campaigns: CHILE
TRANSPORT	DEVELOPMENT OF TRANSPORT	

TABLE 2
GOVERNMENT INTERVENTIONS ON SUPPLY SIDE DETERMINANTS

SUPPLY SIDE	GOVERNMENT INTERVENTION	COUNTRY EXPERIENCES
LABOR	TRAINING AND LICENSING EMPLOYMENT AND STAFFING REGULATIONS SUBSIDIES TO EDUCATION PUBLIC-FINANCED MEDICAL EDUCATION SUBSIDIES FOR DOCTORS WORKING IN UNDERSERVED AREAS ALLOW USE OF PUBLIC FACILITIES FOR PRIVATE PRACTICE ASSIST PROFESSIONAL SOCIETIES TO DEVELOP IN-SERVICE TRAINING PROGRAMS FOR PRIVATE SECTOR PERSONNEL SECONDMENT OF HEALTH PERSONNEL TO NOT-FOR-PROFIT ORGANIZATIONS MOONLIGHTING BY GOVERNMENT PHYSICIANS	Legal private practice by gov. physicians: INDIA, INDONESIA, MEXICO Tax relief for insurers in rural areas: MALAYSIA Public personnel performing private surgeries in public facilities: MALAWI Private practitioners use of public facilities: PAPUA NEW GUINEA Moonlighting by gov. physicians: BRAZIL, IVORY COAST, NIGERIA, KENYA THAILAND, SRI LANKA

SUPPLY SIDE	GOVERNMENT INTERVENTION	COUNTRY EXPERIENCES
EQUIPMENT AND SUPPLIES	TECHNOLOGY REGULATIONS IMPORT DUTY EXEMPTIONS FOR MEDICAL SUPPLIES	Duty free for high-tech equipments: THAILAND
PUBLIC FINANCING (FINANCIAL CAPITAL)	PROVISION OF INVESTMENT FUNDS SUBSIDIES AND TAX POLICIES CREDIT CONTROLS MANAGEMENT OF DIRECT FOREIGN INVESTMENT	Subsidies to private health care services: COLOMBIA Tax reliefs for not-for-profit hospitals: NIGERIA, INDONESIA Tax relief for traditional practitioner: ZIMBABWE Tax exemptions for private hospitals constructions: THAILAND
PHYSICAL PLANT	FACILITY LICENSING REQUIREMENTS LOCATION RESTRICTIONS	Licensed facilities: ALMOST ALL COUNTRIES Subsidies to private sector located in undeserved areas: COLOMBIA

SUPPLY SIDE	GOVERNMENT INTERVENTION	COUNTRY EXPERIENCES
MEDICAL CARE AND SERVICE QUALITY	SUBSIDIES FOR PRIVATE SERVICES PROVIDING PREVENTIVE SERVICES TAX EXEMPTIONS FOR NOT-FOR PROFIT ORGANIZATIONS QUALITY ASSURANCE MECHANISMS RULES REGARDING THE REFERRAL SYSTEM REPORTING COMMUNICABLE DISEASES AND EPIDEMIOLOGICAL MONITORING INFORMATION	Free vaccines to private providers: INDIA, INDONESIA, NIGERIA Distribution of condoms through the private sector: INDIA, NIGERIA, ZIMBABWE Immunizations, family planning, treatment of many communicable diseases: ZAMBIA, KENYA
INFRASTRUCTURE	TRANSPORT, ELECTRICITY, WATER SYSTEMS AND COMMUNICATION	

APPENDIX B

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