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## Abstract

Private providers play a significant role in the provision of health services in Low and Middle Income Countries (LMICs) and the number of private hospitals is increasing rapidly. Within Asia the role of private hospitals in the provision of health services varies considerably. Private hospitals, for example, make up 7% of the total number of hospitals in Vietnam and 50% in Indonesia. The growth of the sector has drawn attention to the many problems that are often associated with this sector and the need for effective regulation if private providers are to contribute to the effective provision of health care. Through regulation state and private hospitals can negotiate their roles and responsibilities, and the state can direct the behaviour of private hospitals.

This paper outlines three main regulatory strategies—command and control, incentives, and self-regulation, providing examples of each approach in Asia, with a focus on the Southern and Eastern regions, namely Southeast Asia, East Asia, South Asia, and the Pacific Islands. Traditionally, command and control regulatory instruments have dominated the regulation of private hospitals in Asia, however, when deciding on which approach is most appropriate it is important to consider the goal of the regulation, the context in which it is to be implemented, as well as the advantages and disadvantages of each approach. This paper concludes that regulation needs to extend beyond command and control to include a full range of mechanisms, including incentives and self-regulatory instruments. Doing so will help address many of the challenges found within individual approaches, in addition to helping address the regulatory challenges particular to many LMICs.

## Introduction

The size of the private sector across Low and Middle Income Countries (LMICs) is increasing, although its role in Asia varies considerably (Tangcharoensathien et al., 2008, Ensor and Palmer, 2009, Hort et al., 2011a, Ahmed et al., 2011). A recent review suggests that countries divide into three groups: 1) countries (including Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, and Thailand) where more than half of services are provided privately at all levels of care; 2) countries (China and Mongolia) where the sector is substantial but where care is primarily confined to specialty services such as dental care ; and 3) countries there the sector provides minimal provision (Fiji, Papua New Guinea, Solomon Islands, Timor-Leste, Tonga, and Vanuatu) (Montagu and Bloom, 2010).

Private providers consist of all actors outside government and include for-profit and non-profit, as well as formal and informal providers, such as clinics or health centres, drug stores, hospitals, traditional healers, and dispensaries (Tangcharoensathien et al., 2008). Growth of the sector has drawn attention to the many problems that are often associated with this sector, which include: low standards of care, poor infrastructure, lack of qualified staff, inadequate or poor equipment, lack of technology, and medical malpractice (Kumaranayake, 1998, Afifi et al., 2003, Kumaranayake, 1997). The ability to regulate the private health sector has not kept up with its growth, and challenges to regulation have included: lack of government institutional capacity, the large size of the sector, lack of resources, and corrupt relationships between the state and private actors (Ensor and Palmer, 2009, Afifi et al., 2003).

While there is a large amount of literature on the regulation of private health providers in LMICs, most of which invariably conclude that regulatory mechanisms or strategies within these countries are weak, there is less literature on the regulation of hospitals as a specific type of private provider. In the past small clinics and drug stores have dominated the sector; while they still represent a significant proportion of the sector, the number of larger facilities, particularly hospitals, is increasing rapidly (Ensor and Palmer, 2009). It is estimated that in India, for example, 93% of all hospitals are in the private sector (RTI International, 2008). While India is something of an outlier, private hospitals play a major role in many other Asian countries. Indonesia, for example, has at least 653 private hospitals, representing 50% of the total in the country (Hort et al., 2011a).

This paper explores the regulation of private hospitals in Asia, with a focus on the Southern and Eastern regions, namely Southeast Asia, East Asia, South Asia, and the Pacific Islands. The paper begins with an introduction to the regulation of private hospitals, followed by a discussion of some of the main regulatory approaches found within the literature, including the main challenges and advantages to each approach. Where possible, examples of regulation of private hospitals in Asia are discussed. The paper concludes with a brief discussion of other regulatory approaches, and asks the question – where do we go from here?

## Methods

Literature was searched which explored the regulation of private hospitals and providers in the Southern and Eastern regions of Asia. Both qualitative and quantitative studies were included. Only papers which explored the role and regulation of private providers in Asian countries were included. The following databases were used: Medline, Web of Science, Global Health, and Google Scholar. A combination of the following search terms was used:

regulation, private hospital, private sector, private provider, health, state intervention, governance, and Asia. Peer-reviewed articles were selected, along with relevant books and grey literature, such as reports. Grey literature was searched using Google's search engine. Reference lists were also searched, looking for additional relevant literature. Only articles published from 1985-2012 were reviewed, in order to ensure that the information included was relatively recent without missing important historical influences. In addition, only English language papers were reviewed. While we recognize that this is a limitation of this review and important information may have been missed, we feel that there was enough English language articles and grey literature with consistent information on the regulation of private providers to warrant this review and provide a strong analytical overview.

### What is Regulation?

Regulation is often defined as the exertion of control over another's or one's own activities. A more detailed definition is that regulation is:

the imposition of external constraints upon the behaviour of an individual or an organization. As such, it is the exercise of authority by some entity over those individuals or organizations, forcing a change from their preferred behaviour. Thus a key element of regulation [...] is that the individual or organization to be regulated must be structurally capable of at least some degree of autonomous or independent decision-making. Otherwise, there is no preferred behaviour to change (Saltman, 2002: 1678).

National governments typically regulate private providers although the function may be delegated to agencies such as professional and provider associations or patients' organizations (Afifi et al., 2003, Saltman, 2002).

### Objectives of Regulation

Market failure in health care, in particular consumer understanding of the need for services and judgement about quality of services combined with a tendency towards oligopolistic behaviour, leads to the need for additional control of providers through regulation. Regulation helps to ensure that private providers not only offer a service that is acceptable to the public, but also meets overall health sector goals (Bennett and Nglende-Banda, 1994, Akhtar, 2011). Through regulation state and private actors can negotiate their roles and responsibilities, and the state can direct the behaviour of private actors (Akhtar, 2011). The four central objectives of regulation are:

1. Control market entry and structure of private hospitals (the quantity of care);
2. Improve and maintain good quality services within private hospitals (the quality of care);
3. Improve efficiency in health service provision within private hospitals (the cost-effectiveness of care); and,
4. Ensure health service provision within private hospitals is provided equitably (access to and cost of care) (Tibandebage et al., 2001, Afifi et al., 2003, Bennett and Nglende-Banda, 1994).

The main purpose of this review is on methods to manage the introduction of new hospitals, as well as control health service provision within existing hospitals to ensure that it is efficient, of good quality, and accessible. Regulation can also exist to encourage the development of hospital services. In countries such as India and China, for example, the government has at different times taken steps to encourage the sector through reductions in import duties on medical equipment, shorter periods for writing off the value of equipment to encourage providers to keep up to date, and more relaxed planning policies to construct higher accounting depreciation, ensuring that private hospital investment and operation is a viable business (see: Qingyun, 2012, *The Times of India*, 2003). Such regulation is not the central focus of this review although some consideration of the use of incentives as a way of encouraging provider growth as well as compliance is provided.

### Common Regulatory Approaches

A number of strategies and their associated regulatory instruments can be implemented to regulate private hospitals. The choice of regulatory strategy used will depend upon the overall objectives of regulation (Akhtar, 2011). In practice a mix of strategies is often used. The three main strategies, described below, are command and control, incentives, and self-regulation.

#### Command and Control Approach

Command and control regulation is the exercise of influence by government through imposing standards, usually backed by sanctions (Baldwin and Cave, 1999). It is the most common approach used by governments in LMICs (Akhtar, 2011). Command and control approaches typically seek to control inputs and the health production process (Tangcharoensathien et al., 2008). Legal or administrative controls are the main way of regulating market entry as well as the distribution, quantity, and quality of health services and products. Through command and control regulation the “force of law is used to prohibit certain forms of conduct or to demand some positive actions or to lay down conditions for entry into a sector” (Baldwin and Cave, 1999: 35). Command and control regulation therefore seeks to achieve either deterrence or compliance from private health care providers (Tangcharoensathien et al., 2008).

The registration and licensing of providers is one of the most common forms of command and control regulation (Ensor and Weinzierl, 2007, Afifi et al., 2003). Licensing of providers is often a compulsory process requiring “universal adherence to minimum standards as a condition of practice” (Ensor and Weinzierl, 2007: 358). Government entities usually administer licensing, which gives health facilities legal permission to practice and includes regular inspections by a regulatory agency (Ensor and Palmer, 2009). Licensing has two main objectives. Firstly, governments need to ensure that only those providers who meet minimum standards, such as hygiene, competency, and ability to deliver specified services, are permitted to enter the market. Secondly, governments need to ensure that hospitals and other health facilities are evenly distributed throughout a country, or are located in the most appropriate locations.

Restrictions or standards are another type of command and control regulatory instrument. These include, for example, health and safety legislation or the legislation of medicine, practice, human resources, and equipment (i.e. volume, quality, price, type), such as

restrictions against dangerous or unethical clinical practice (Akhtar, 2011, Ensor and Weinzierl, 2007, Kumaranayake, 1997). Legal restrictions and controls can be formal, such as laws or administrative decrees, or informal, such as codes of conduct, guidelines, or recommendations (Kumaranayake, 1998). While formal controls are those that require facilities to conform, or face sanctions, informal controls are not binding and therefore do not face the threat of associated sanctions. In addition, sanctions “may require new legislation or be enforced through administrative orders or statutory instruments” (Ensor and Weinzierl, 2007: 358).

Successful command and control regulatory approaches are, however, dependent on a government’s ability to “to formulate satisfactory laws or bureaucratic orders, monitor infringements and enforce sanctions” (Ensor and Weinzierl, 2007: 358), which require a well-resourced regulatory framework (for implementation and monitoring), as well as the existence of a functioning judicial system (for enforcement and sanctioning) (Kumaranayake, 1998). While command and control approaches tend to be the traditional and most common form of regulation in low to middle income countries, the characteristics, or capabilities needed to ensure successful regulation are not guaranteed and the capacity to enforce these regulations is often low (Ensor and Weinzierl, 2007, Kumaranayake, 1997).

A key advantage of command and control regulatory approaches is that they can use the force of the law to impose fixed standards with immediacy in order to ensure health service objectives are met, and to prohibit any activities that go against standards. Command and control approaches therefore allow regulators to outlaw some forms of behaviour completely, and prevent ill-equipped facilities from providing services. There are number of challenges involved in implementing this approach, which include: regulatory capture, legalism, administrative constraints and lack of enforcement, and informational constraints (Baldwin and Cave, 1999).

**Regulatory capture:** Regulatory capture refers to inappropriate influence on a regulatory body by interest groups as a result of relationships between regulators and regulated that become too close (Tangcharoensathien et al., 2008). Consequently, the regulator may represent the interests of the regulated rather than the public. In addition, if a professional body or other regulatory agency is responsible for enforcing regulation, they may be reluctant to act against their own membership or self-interest (Kumaranayake, 1997).

**Legalism:** Command and control approaches may produce very complex and inflexible rules, which may limit competition and enterprise (Baldwin and Cave, 1999).

**Administrative constraints and lack of enforcement:** In resource poor settings the monitoring and enforcement of regulatory controls is often lacking or weak due to limited funding, high administrative costs (on both the regulator and regulated), weak bureaucratic and judiciary systems, and corruption (Ensor and Palmer, 2009, Kumaranayake, 1997, Baldwin and Cave, 1999, Tangcharoensathien et al., 2008, Palmer, 2006). This can lead to a lack of compliance by private providers.

**Informational constraints:** In order to improve existing regulations, monitor the current regulatory controls, and achieve health sector objectives, information about the role and activities performed by private providers needs to be collected. In resource poor settings, reliable and timely data are often limited or unavailable, making it difficult to effectively regulate the sector (Tangcharoensathien et al., 2008, Palmer, 2006).

Despite the above challenges, command and control regulatory approaches are commonly utilized in many low to middle income countries. In Thailand, for example, private hospitals must register and relicense each year with the Medical Registration Division (MRD) of the Ministry of Health (Teerawattananon et al., 2003, Ensor and Palmer, 2009). The MRD regulates through “registration, licensing and renewal requirement, setting rules, standards and monitoring, control of quality and safety, public information and advertising” (Teerawattananon et al., 2003: 325). Sanctions include: reprimand and probation, suspension, and revocation of licenses. The Ministry of Public Health, through the MRD, controls the licensing and renewal of private clinics and hospitals, in accordance with the Medical Premises Act 1998. Criteria for the establishment of new hospitals include mainly structural indicators, and to a lesser extent process indicators. Licensing focuses mainly on physical adequacy such as beds and staffing, and does not include the volume of services through facilities, despite the volume of particular services being seen as a key determinant of quality (Ensor and Palmer, 2009). There are no MRD interventions on the geographical distribution of private facilities. As a result, there is a concentration and oversupply of such facilities in Bangkok and other larger urban centres

Within Indonesia, the licensing and registration of private institutions is not yet widespread (Wang et al., 2009). In addition, there is no institutional or systematic commitment to quality assurance and monitoring, and there are few sanctions or penalties when institutions are found to be working below standard levels. According to the Ministry of Health (MoH) regulation 922/2008, private hospitals are required to have two types of license: an establishment licence (giving permission to construct a facility and issued by the local government), and an operational license (based on the determination of the type of hospital and issued by the MoH) (Hort et al., 2011a). Attainment of an operational license is tied to the number of specialized doctors within a facility, as a result, attracting and retaining specialist doctors is required by many hospitals. Many private hospitals fail to obtain the second type of license because they are unable to maintain the number of specialist doctors required. As a result, the distribution of specialists closely matches the distribution of hospitals. Recently, the Indonesian National Parliament has developed a new hospital law (No. 44/2009), which has provided a stronger framework for the management of hospitals. This law requires the establishment of hospital governing boards, and sets out their responsibilities and functions. Regulatory capacity and the enforcement of sanctions for non-compliers, however, remain weak, and physician ownership of facilities and the management of conflicts of interest are not addressed.

Within Vietnam the government has provided a policy framework for the development of the private sector through setting bed-to-population ratio targets, and the regulation of market entry (Hort et al., 2011b, Montagu and Bloom, 2010). Private providers are officially recognized as part of the Vietnamese health system by the state ordinance on private medical and pharmaceutical practices (Ordinance 26-PL/CTN/1993) (Hort et al., 2011b). Regulation Ordinance 07/2003/PL-UBTVQH11 and Decree 103/2003/ND-CP set out the licensing requirements for private providers. Private hospitals are required to have infrastructure, equipment and staff equivalent to those in district state hospitals, and to have a minimum of 30 inpatient beds. These conditions need to be met in order to receive a licence from the MoH. Licensing requirements also require non-state facilities to obtain establishment permission (a business or investment certificate) from a relevant state body, as well as an operation permit from the MoH. An operation permit covers requirements for the premises and facilities, medical waste disposal, health workforce, as well as requiring the director of the facility to have been practising in the medical sector for a minimum of 36 months.

Private hospitals are also required to treat emergency cases and provide annual reports to the MoH.

Monitoring and compliance of the above regulations within Vietnam, however, has been found to be weak, with private hospitals not complying with the minimum space per bed or medical waste disposal procedures (Hort et al., 2011b). In addition, the decree allowing private hospital operation stipulates that hospitals operate on a not-for-profit basis, however, this has been found not to be the case. There is also no regulation of the type or location of services provided by private hospitals, and few regulatory requirements for private hospitals to contribute to larger social objectives, such as to provide services benefiting public health, or not discriminating against particular patients.

### Incentive Approach

Incentives to influence provider behaviour are an alternative to the legal sanctions applied in the command and control approach (Tangcharoensathien et al., 2008, Baldwin and Cave, 1999). Incentives include financial and non-financial rewards, as well as penalties (Kumaranayake, 1997, Tangcharoensathien et al., 2008). In light of the limited success of legal controls in many LMICs, increased attention has been given to the use of incentives to influence private health care provision (Afifi et al., 2003). The main difference between the command and control and incentive approach is that incentives are voluntary and predispose providers to supply information on their behaviour and actively demonstrate compliance. In general, incentives avoid many of the administrative and political constraints of control-based instruments and are less costly to maintain. A range of financial and non-financial incentives can be used to regulate providers.

Financial incentives involve the use of monetary instruments to persuade or dissuade providers to act in a particular way. The goal of such incentives is to encourage private hospitals to set up in under-served areas, offer certain services, and/or provide services to particular populations (Afifi et al., 2003, Bennett and Nglande-Banda, 1994, Akhtar, 2011). Alternatively, such incentives can be used to dissuade private hospitals from certain activities by, for example, increasing taxation. Incentives are voluntary in that private hospitals are free to forgo the benefits provided by government if they do not wish to pursue the activity (Deber et al., 2004). A variety of financial incentives may be used, including:

**Access to capital:** The provision of capital to finance buildings, equipment and other start-up costs (Afifi et al., 2003).

**Loans:** The provision of low-cost or subsidized loans to private providers (Afifi et al., 2003).

**Taxation:** The provision of tax exemptions or relief, waivers, or income tax contribution deductibles. These can include, for example, exempting medical supplies from customs duties, or providing tax relief to hospitals (Afifi et al., 2003, Bennett and Nglande-Banda, 1994, Akhtar, 2011, Deber et al., 2004).

**Subsidies:** The provision of drugs, dressing, or medical equipment at a low or subsidized cost to private providers (Bennett and Nglande-Banda, 1994). Subsidies can also include the use of vouchers to subsidize payment for services.

**Provider payment:** Provide payments to private providers to induce movement to improve quality, equity, efficiency, consumer satisfaction, or health status (Afifi et al., 2003).



A range of non-financial incentives may also be used to regulate, including:

**Credentials:** The provision of credentials to recognize accomplishment and use for either marketability or status among peers (Afifi et al., 2003).

**Training:** The provision of training in relation to, for example, service provision, management, accounting, auditing, health information systems, or reports management. Training can be both within country or overseas (Afifi et al., 2003, Bennett and Nglan-de-Banda, 1994, Montagu and Bloom, 2010).

**Public-private alliances:** Collaboration between government and professional associations to collect up-to-date information on the private sector, provide government sponsorship of annual listings or directories, or provide speakers and workshops at annual meetings (Afifi et al., 2003).

One main advantage to the use of incentives, compared to control-based instruments, is that they require less bureaucratic support and are less costly to maintain (Afifi et al., 2003). In addition, they involve relatively low levels of regulatory discretion (compared to the command and control approach), since rewards or punishments operate in a mechanical manner once they have been established (Baldwin and Cave, 1999). Such low levels of discretion and the structured mode of implementation limit the possibility for regulatory capture, since constant negotiations, close relations, and information exchanges between regulators and those being regulated are not as common. Within incentive-based schemes, it is up to the provider to decide whether to take part by balancing the advantages and disadvantages of participation.

One challenge to incentive-based mechanisms, however, is that they involve the creation and implementation of complex systems of rules. In addition, in order to ensure providers comply with their obligations, substantial inspection and enforcement might be required. It can also be very difficult to predict the outcome of an incentive on the ground, or indeed whether it will have an effect at all. Regulatory lag is also common with such approaches; it may take a substantial amount of time before any effect of an incentive is known. In addition, such approaches can also be inflexible in their application given their mechanical nature and it may be difficult to tailor such approaches to individual circumstances.

Vietnam has used incentives for investment in private hospitals (Hort et al., 2011b). This has included full exemption from income taxation for the first four years and 50 percent exemption for the following nine years together with the provision of free land. The purpose of such investment is to support the growth of private health providers and encourage the involvement of the private sector in the construction and facilitation of health facilities, as well as to encourage the achievement of bed-to-population targets. The regulations were successful in that the number of private hospitals more than doubled between 2004 and 2008 (from 35 to 82), accounting for 7 percent of all hospitals and 4.4 percent of all hospital beds in 2008. During this time there was also an increase in the number of specialized hospitals (from 17 percent in 2004 to 25 percent in 2008). Vietnam also has experience using voucher payments to subsidize specific services, where 'cash-equivalent' vouchers are used in exchange for services (Montagu and Bloom, 2010).

Although government regulations stipulated the provision of free land for private hospitals in Vietnam, it was found that land is not always provided (Hort et al., 2011b). In addition, it was found that there is no regulation governing the location or type of services to be provided. As a result, the growth of private hospitals within Vietnam was witnessed

predominately in the northern and central regions of the country, and in all regions private hospitals are mainly found within urban areas and in provinces with higher population densities and richer economies.

Within India, incentives to private health providers, including hospitals, include direct and indirect subsidies for private services, facilities, and products (Nair, 2004). Some of the instruments used to encourage private sector participation include: land subsidies, custom duty exemptions, fiscal concessions, and institutional finance at low rates. The promotion of private investments has been directed mainly to tertiary care and a common incentive is the provision of land at subsidized rates. Such incentives are often conditional on the provision of a percentage of free services to the poor, although there is evidence that this condition is often not followed (Nair, 2004). In addition, there is no effective system to monitor the implementation of the conditions attached to subsidies, land is often offered in urban areas as opposed to rural areas, participants are often given inadequate information, a lack of co-ordination between responsible departments exists, and there are inadequate management structures to handle new tasks. As a result, while concessions act as incentives within India, critical equity issues are not being monitored or implemented (Nair, 2004).

### Self-Regulation Approach

Self-regulation is often considered a complementary strategy to both control- and incentive-based regulatory strategies (Afifi et al., 2003). Through self-regulation, medical or professional health associations are required to set the standards for members' behaviour, as well as ensure the standards are met (Afifi et al., 2003, Akhtar, 2011). Self-regulation is "rooted in the belief that government authority to implement regulation can be delegated to the private sector once the roles of each actor and the rules of engagement have been established in a predictable and transparent environment" (Tangcharoensathien et al., 2008: 20). Through self-regulation, peer groups within the industry regulate the behaviour of private health providers and individual practitioners, such as by providing professional codes of ethics, professional development opportunities, and certification (Akhtar, 2011). Self-regulation works through a combination of ethical standards and self-interest since the reputation of compliant providers is tarnished when one provider falls short of established standards and norms. (Tangcharoensathien et al., 2008)

Self-regulation can also help to promote professional ethics and increase quality through government interaction with providers' representative organizations, and the use of non-financial incentives, such as by acting on providers' desire for social recognition and prestige (Tangcharoensathien et al., 2008). The main instruments of self-regulation are accreditation and certification which institute incentives for health care providers to improve quality of care. They are mechanisms which can be used to control and improve the quality of services through oversight by an independent quality control evaluation body (Patouillard et al., 2007). Accreditation and certification systems are often accomplished by delegating authority (in establishing and enforcing standards) to the collaborating professional associations. Accreditation and certification are often used synonymously. The main difference between the two is that certification is often applied to individuals, while accreditation is applied to institutions (Afifi et al., 2003). Accreditation and certification are publicly visible 'seals of approval' of the technical practices of health care providers (both facilities and personnel), based on rational criteria (Afifi et al., 2003: 253). Accreditation and certification therefore allow users to judge a provider's level of technical ability or quality of care.

Accreditation and certification are often financed from fees paid by providers (Ensor and Palmer, 2009). A key reason why facilities will volunteer to pay for accreditation is that it can offer a market advantage, particularly in areas where there are a number of private hospitals for consumers to choose (Ensor and Palmer, 2009). Accreditation and certification can therefore be used by providers to distinguish themselves from other private facilities, in order to influence both users paying for the services, and potential purchasers looking for high quality providers to contract. Self-regulation offers a number of advantages. Firstly, self-regulation provides a good alternative in countries where it is difficult to maintain effective licensing of health care providers, whether due to capacity or financial constraints (Ensor and Palmer, 2009). In addition, as self-regulation is voluntary, those who choose to participate often possess high levels of commitment, particularly to rules and standards set by their peers (Baldwin and Cave, 1999). Other advantages are that it is a low cost approach to regulation for government, the rules and standards set are often seen by facilities as being realistically attainable, there is potential for greater effectiveness in identifying violations and imposing sanctions where necessary, and self-regulatory rules are flexible in that they can be quickly adjusted to changing circumstances.

There are, however, challenges to self-regulation. Self-regulation by professional bodies is prone to regulatory capture by self-interested groups who seek to service the interest of their members as opposed to public interests (Tangcharoensathien et al., 2008). The rules written by self-regulators, for example, may prove self-serving, and can face similar challenges to the rules in command and control approaches (e.g. difficulties in enforcement and legalism) (Baldwin and Cave, 1999). In addition, the public costs of approving self-regulatory rules may be considerable, the procedures employed to establish rules may lack openness, transparency, acceptability, and accountability to the public, self-regulators may be distrusted by the public, and the public may demand that the government take responsibility for the sector, as opposed to allowing self-regulation.

Within Indonesia, hospital accreditation is conducted by KARS, the Komisi Akreditasi Rumah Sakit, or Hospital Accreditation Commission (Wang et al., 2009, Irfianti, 2011). KARS was established by the Ministry of Health and hospital accreditation began in 1996 (Irfianti, 2011). Both public and private hospitals are accredited by KARS. Five categories are examined by the accreditation commission during the accreditation process: management and administration, medical services, emergency services, nursing, and medical records (Wang et al., 2009). Despite benefits of accreditation, in 2011 only 720 (42.4%) of 1699 hospitals have participated in the accreditation process (Irfianti, 2011).

In an evaluation of the accreditation process in Indonesia, the authors found that 84 percent of hospitals agreed that it has helped to improve the quality of hospitals (Irfianti, 2011). It was stated, for example, that the process of applying for accreditation stimulates internal motivation of staff and commitment to self-assessment and subsequent changes. At the same time, the study found that only 61 percent of hospitals thought that accreditation could affect clinical performance, such as by decreasing the number of caesarean sections or a reduction in hospital mortality, and 53 percent of hospitals did not agree that KARS accreditation could increase hospital revenue. According to Irfianti, previous research found no significant relationship between accreditation scores and hospital performance in Indonesia. However, accreditation has been found to affect hospital performance in other countries, such as South Africa. According to Irfianti, one of the main reasons accreditation was perceived to have little effect on clinical performance in Indonesia is because it concentrates on improving the

structure and procedural standards of the hospital, as opposed to clinical processes and outcomes, such as physician behaviour or clinical indicators.

Within Thailand the accreditation process for national-level hospitals began in 1996 as a research and development project (Tangcharoensathien et al., 2008, Sriratanaban, undated). The initial phase of the programme was set up by the Collaboration for Hospital Quality Improvement and Accreditation, a civic organization composed of 40 members from the Ministry of Public Health, professional organizations, government agencies, and individual experts (Sriratanaban, undated). After 1999, this collaboration was transformed into the Institute of Hospital Quality Improvement and Accreditation, an independent agency supervised by the Health System Research Institute. While the programme was slow to start, three years after implementation it was reported that 35 private hospitals had been accredited, in 2004 a total of 86 private hospitals were accredited (Tangcharoensathien et al., 2008), and in 2009 more than 350 hospitals were accredited (Sriratanaban, undated).

The hospital accreditation program within Thailand was seen as more than just a certification or an accreditation programme and was intended to “be a mechanism to encourage total hospital quality improvement in a systematic way and in a proper direction” (Sriratanaban, undated: 5). Within the programme, emphasis is placed on “the principles of self-assessment, quality assurance, customer-focused continuous quality improvement and total quality management”. Accreditation is not meant to just be an external quality audit or inspection of compliance, but is instead meant to encourage hospitals to improve and confirm how well they are doing according to a set of standards. Within Thailand, hospitals are required to pursue accreditation in order to participate in some public health insurance or welfare schemes, and teaching hospitals need to participate within the program if they are to be accredited additionally by health-professional education bodies. Hospital accreditation requirements are the same for both public and private providers and the standards are set for optimal performance, as opposed to minimal requirements for approval. While there is some evidence that hospitals have improved standards of health outcomes and patient satisfaction in attempting to achieve accreditation, accreditation remains voluntary and only a small proportion of the 1,400 hospitals within the country are accredited (Ensor and Palmer, 2009).

#### Other Regulatory Approaches/ Strategies

In addition to the three most common approaches to regulation, a number of other mechanisms are discussed in the literature. It is argued that due to the challenges associated with these three approaches, new approaches to the regulation of private hospitals in LMICs need to be identified and implemented (Akhtar, 2011, Hort et al., 2011b). The following approaches are alternatives that can be used in conjunction with, or instead of, the above approaches.

#### De-centred Regulation

The traditional view of regulation regards it primarily as the function of government (Ensor and Weinzierl, 2007). An assumption of de-centred regulation is that while government initiates regulation, they do not necessarily implement it. De-centred regulation takes the view that the goals of regulation can be more efficiently achieved through the involvement of other actors. For example, while government should be responsible for establishing

regulatory and policy objectives, regulation may be devolved to other agencies or actors outside the government and professional bodies (Akhtar, 2011, Ensor and Weinzierl, 2007).

De-centred regulation therefore “involves a shift away from the state as the sole regulator” (Akhtar, 2011: 9). Regulatory activities are expanded to actors outside of the state, involving a range of activities and mechanisms that have the potential to influence the behaviour of actors. Independent regulatory bodies can be set-up, for example, to license, accredit, and monitor private hospitals (Akhtar, 2011). Through such an approach, challenges associated with conventional strategies, such as regulatory capture, administrative and informational constraints, and lack of capacity to monitor and enforce regulations, can be addressed by devolving regulation to bodies disassociated from government and professional organizations (Akhtar, 2011). It is important to note that such an approach is not without problems. The United Kingdom for example has a history of de-centred regulation, passing the regulation of hospitals and care homes to quasi-autonomous bodies. A number of well-publicised scandals in recent years have alleged that such regulation has sometimes failed to take tough action against low-performing providers.

### Disclosure Regulation

Disclosure regulation requires health care organizations to provide open and transparent information on price, quality, and quantity to consumers, other providers, purchasers, and policy makers (Akhtar, 2011). Disclosure regulation addresses information asymmetry, and as a tool of regulation it is less interventionist than most other mechanisms (Ensor and Weinzierl, 2007, Akhtar, 2011). The aim is to provide information in a transparent and accessible way in order to help consumers with relevant technical information to make informed judgements about which services to use (Ensor and Palmer, 2009).

If successful, disclosure regulation can be the cheapest method of regulation (Ensor and Weinzierl, 2007: 362). Disclosure regulation relies on the availability of information, which can act as both a reward for good providers and a penalty for bad providers. Disclosure can be either on a compulsory or voluntary basis, and it can be promoted or administered by government or an independent or professional body. Through disclosure hospitals can be ranked or scored against each other based on quality, price, availability of services, etc. Through ranking or other scoring systems, reward systems can be developed, such as being allowed to participate in a national insurance scheme, as is witnessed in Egypt. Disclosure regulation can also be used alongside accreditation systems; a list of accredited hospitals, for example, can be published for marketing purposes. Report cards have also been used as a method of providing information to consumers, based on, for example, consumer satisfaction surveys which rank hospitals according to “helpfulness of staff, speed of service and payment of unofficial ‘speed’ money”, as was witnessed in Bangalore (Ensor and Weinzierl, 2007: 362). There is limited information, however, about how much consumers appreciate or utilise such information.

The media can also serve an important regulatory disclosure function. It can, for example, bring to attention incidences of poor practice or performance. Within Thailand, for example, the media was credited with bringing to light regulatory violations on organ transplants, which were followed up by the Medical Council (Ensor and Weinzierl, 2007, Teerawattananon et al., 2003).

## Responsive Regulation

Rather than a separate approach responsive regulation is a way of linking together approaches and regulatory instruments. It operates on the understanding that the effectiveness of regulatory strategies depend on context, regulatory culture and history, and that not all of the strategies above will work in all contexts (Akhtar, 2011). Responsive regulation proposes a pyramid of actions that can be taken by regulators through phased implementation (Akhtar, 2011, Ayres and Braithwaite, 1992). At the base of the pyramid are soft approaches, such as voluntary actions. If these approaches are not effective, regulators can then employ other mechanisms, such as market controls or self-regulation. If actors still do not comply, harder instruments such as enforced self-regulation can be used, followed by command and control mechanisms. At the top of the pyramid are severe actions, such as revoking hospital licenses or banning individuals from practising (Akhtar, 2011). While responsive regulation is argued to be a logical and appealing approach, critics argue that there is little empirical evidence of its effectiveness, it is difficult to test, and most health care regulators do not behave according to the principles of responsive regulation (Akhtar, 2011).

### Regulation of Private Hospitals in Asia – Where do we go from here?

Traditionally, command and control regulatory instruments have dominated the regulation of private hospitals in LMICs, including Asia. When deciding on which approaches are most appropriate it is important to consider the goal of the regulation, the context in which it is to be implemented, as well as the advantages and disadvantages of each approach. Whether a regulatory approach or instrument is likely to work or not will be dependent on the institutions that operate in a given country (Ensor and Palmer, 2009). Some approaches, for example, are likely to be more effective in contexts with appropriate resources and a strong governance framework, while others might prove to be more appropriate for resource-poor settings with weaker governance frameworks. Whatever approach is taken it is important to recognize that information asymmetries between regulators and providers will remain problematic (Bloom et al., 2008). If private providers are unwilling to disclose information, for example, (in relation to quality, price, or medical and financial effects on patients, etc.), due to such things as fear of repercussions or loss of income, regulation will be difficult to carry out (Bloom et al., 2008). If regulation is to be effective, adequate information about provider performance is needed, and systems need to be put in place to collect and monitor this information.

While no regulatory approach is without its challenges, some are more appropriate for LMICs. Command and control regulation, for example, is typically more effective in settings with existing resources and relatively strong governance frameworks capable of proper monitoring and evaluation of health facilities, and the enforcement of regulations. Within the literature, studies that explore the regulation of private facilities within LMICs often conclude that either more regulation is needed, or current regulation strategies need to be improved. It is suggested that regulation needs to extend beyond command and control to include a full range of mechanisms, including incentives and self-regulatory instruments (Akhtar, 2011, Ensor and Weinzierl, 2007, Hort et al., 2011b). Alongside improving the implementation of existing regulations it has therefore also been suggested that countries' current regulatory frameworks be improved by expanding the range of regulatory mechanisms used (Hort et al., 2011b).

Improving existing regulations would involve building the capacity of existing regulators to monitor private facilities effectively and impose sanctions where needed. Expanding the range of regulatory approaches would involve utilizing a variety of regulatory instruments, such as those discussed above. In resource-poor and low capacity settings, self-regulation, incentives, and other regulatory strategies, such as disclosure and de-centred regulation, are viable alternatives to the regulation of private hospitals, as they can help to ensure regulation while relieving over-burdened Ministries.

In order for regulation to be effective it is also likely that more than one form of regulation will need to be implemented simultaneously. For example, while self-regulation may work in some instances (e.g. when the provider has a strong financial incentive to maintain a high level of quality in an attempt to attract international clientele), it may be less effective in others (e.g. ill-equipped facilities providing expensive services to the poor). In these cases stronger forms of regulation, such as the command and control mechanisms discussed above, may be more effective. Regulatory approaches are therefore not mutually exclusive. The use of multiple forms of regulation simultaneously is known as collibration, and can be used in environments where providers' objectives do not reinforce government or societal objectives (Dunsire, 1996; Kirkbride & Letza, 2004). It is the process by which a regulator intervenes in order to tip the balance in favour of government objectives, and may involve conferring privileges to, or handicapping, providers in attempt to work towards these objectives. In essence, it is the manipulation of private providers' actions in attempt to steer them in a direction that meets a common set of goals or objectives (Dunsire, 1996; Kirkbride & Letza, 2004).

Which approaches are most appropriate will be dependent upon the context in which the regulation is to be implemented. Choosing regulatory instruments will require an understanding of current regulatory capacity, provider objectives, alongside where the most impact can be made through regulation (Ensor and Palmer, 2009). In addition, establishing a regulatory system will require a phased approach, which considers both the culture and stage of regulatory development, similar to what is outlined within 'responsive regulation' (Ayres and Braithwaite, 1992, Ensor and Palmer, 2009). Ultimately, expanding beyond command and control mechanisms to use multiple regulatory approaches and instruments will help address many of the challenges found within individual approaches, in addition to helping address the regulatory challenges particular to many LMICs, including Asia.

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