3 The state and the private sector in health policy

Overview

This chapter introduces you to two of the most important actors in health policy – the state and the private for-profit sector – although in some situations other actors can play influential roles. The chapter traces the changing roles of these two sectors in health policy and thereby provides the context to understanding the content and processes of contemporary health policy making.

Learning objectives

After working through this chapter, you will be better able to:

- **understand why the state is at the centre of health policy analysis**
- **describe and account for the changing role of the state in the past few decades, and what this has implied for the state's role in health**
- **identify a range of private sector organizations with an interest in health policy**
- **explain how the private sector increasingly influences health policy**

Key terms

Company Generic term for a business which may be run as a sole proprietorship, partnership or corporation.

Corporation An association of stockholders which is regarded as a 'person' under most national laws. Ownership is marked by ease of transferability and the limited liability of stockholders.

Decentralization The transfer of authority and responsibilities from central government to local levels, which are thereby strengthened.

Industry Groups of firms closely related and in competition due to use of similar technology of production or high level of substitutability of products.

Multinational corporation Firm which controls operations in more than one country, even if it does not own them but controls through a franchise.

New public management An approach to government involving the application of private sector management techniques.

Private sector That part of the economy which is not under direct government control.

Privatization Sale of publicly owned property to the private sector.

Regulation Government intervention enforcing rules and standards.

Transnational corporation Firm which owns branch companies in more than one country.

Introduction

This chapter concerns the changing role of the state in health policy. The state is typically a central focus of policy analysis, this is in part the result of its omnipresence and, in part, because it does more than any other body to decide what policies should be adopted and implemented. Policy decisions of governments extend deeply into people's lives from the relatively trivial to the life-changing. Depending on where you live, the state may, for example:

- regulate the number of children you have (China)
- decide whether or not divorcees are allowed a second child (allowed in Shanghai but not in the rest of China)
- prohibit private medical practice (Cuba)
- determine the age at which sex-change therapy is allowed (presently 13 years in Australia)
- determine whether or not emergency contraception is available over-the-counter (not available in the USA but available in the UK)

The state may also:

- subject persons of different race, ethnicity, or religion to different laws
- imprison suspected terrorists indefinitely without charge (France) or suspend protections of Geneva Conventions for enemy combatants (USA).

For much of the twentieth century the state has played a dominant role in the economies of most countries: airlines were owned and operated by the state as were other utilities such as railways, water, electricity, and telephones. Many governments presided over command and control economies in the context of rigid five-year development plans. In many newly independent countries, the government also became the major employer. For example, in Tanzania the government's workforce grew from 27 per cent of those formally employed in 1962 to over 66 per cent in 1974 (Perkins and Roemer 1991). By the 1980s things began to change; states were rolled back and the private sector was encouraged to enter fields that were once the preserve of the state – including health care. This shift has had implications both for the content of health policy as well as the actors participating in the health policy process.

In this chapter, you will chart the changes to the roles of the state and market. The activities of different branches of government in the policy process are explored in greater detail in Chapter 4. The chapter begins by exploring state involvement in health and presents arguments which justify its prominent role. You will then learn why disillusion with the state has grown over the past two decades and why this has given impetus to a world-wide movement of health sector reform. The emergence of the private for-profit sector in health services is highlighted and three ways that it increasingly affects health policy are illustrated.

The role of the state in health systems

By the early 1980s, the state had assumed a leading place in health care finance and in service delivery in most countries. In addition, it played the central role in allocating resources among competing health priorities and in regulating a range of activities which impinge upon health. To take just one example, think of the role that states might play with respect to the regulation of health care service delivery. Mills and Ranson (2005) have identified the following regulatory mechanisms which have been applied in low and middle income countries.

To regulate the quantity and distribution of services, the state has:

- licensed providers (in all countries) and facilities (increasingly common for hospitals)
- placed controls on the number and size of medical schools (common), controlled the number of doctors practising in certain areas, and limited the introduction of high technology (being considered in Thailand and Malaysia)
- provided incentives to practise in rural areas (many countries for doctors)

To regulate prices of services, governments have:

- negotiated salary scales (Zimbabwe, Argentina)
- set charges (South Africa)
- negotiated reimbursement rates (many social insurance schemes)

To regulate quality of health services, governments have:

- licensed practitioners
- registered facilities
- controlled the nature of services provided
- required providers to establish complaints procedures
- required provision of information for monitoring quality
- controlled training curricula
- set requirements for continuing education
- introduced accreditation of facilities

In addition to the finance, provision and regulation of health services, most states have assumed a range of public health functions, for example, they:

- ensure safe water and food purity
- establish quarantine and border control measures to stop the spread of infectious diseases
- regulate roads and workplaces to reduce the threat of injuries
- legislate, aimed at curbing environmental and noise pollution
- set standards for food labelling, the level of lead in petrol, and tar and nicotine in cigarettes
- regulate and license industries as well as force them to adopt different technologies on public health grounds
- add chlorine to drinking water

You could likely add to the above list which is meant to illustrate the state's deep and wide involvement in health at the beginning of the twenty-first century. This raises the question of how such growth has been justified.

Activity 3.1

The following reviews the rationale for the involvement of the state in health. While reading through the section, makes notes as to the main reasons for the state involvement in the health systems.

Economists have focused on market failure as the principal reason for a pronounced role for the state in health care finance and provision. Efficient markets depend on a number of conditions. These are often not met because of specific characteristics of health and health services. First, the optimal amount of health services will not always be produced or consumed because the externalities (costs and benefits) are not taken into consideration by consumers or producers. For example, childhood immunization rates in the UK are decreasing because parents' decisions relate to the perceived costs and benefits of protecting their children as opposed to the benefits of protection of others by reducing the pool of susceptible children. Second, the market will fail to provide many so-called 'public goods' because of the lack of incentives to do so. Public goods are those that are 'non-rival' in consumption (consumption by one person does not affect consumption of the same good by others) and 'non-excludable' (it is not possible to prevent a consumer from benefiting – by making them pay), for example, control of mosquito breeding or producing knowledge through research. Third, monopoly power may lead to overcharging. Monopolies could be established by the medical profession, the drug industry or a hospital in a given catchment area. However, some economists argue that the lack of efficient health care markets provide relatively weak justification for state delivery of health services (except in relation to public and preventive health services) as these could be dealt with through regulation.

Another argument in favour of a strong state role hinges around information asymmetry between consumer and providers. Consumers are at a disadvantage and private providers are in an unusually strong position to take advantage of this imbalance through profit seeking and over-treatment. Another characteristic of the market is that the need for health care is uncertain and often costly. This provides an argument in favour of insurance. However, experience suggests that private insurance markets do not work well in health. Both of these reasons provide compelling support for state involvement.

Yet it is rather unlikely that these economic arguments can account for the prominent role of the state in health. If any theoretical or philosophical principle were invoked, it would likely be related to equity and the concern that some individuals will be too poor to afford health care and require the support and protection of the state. This touches on the wider debate on the ethical underpinnings of a health care system. There are those who argue that health services should be treated similarly to other goods and services for which access depends on ability and willingness to pay. Others argue that access to health care is a right of all citizens, irrespective of their income or wealth.

In practice, the role of the state in health service finance and provision has varied significantly between countries, depending on whether or not private markets have developed for insurers and for providers and whether or not the state has taken responsibility for providing for the whole population (e.g. India and Zambia) or catered more for the poor (e.g. Mexico and Thailand). Nonetheless, what was uni-

form across all countries was an expansion of the role of the state in health during the twentieth century, with the state assuming the central and primary responsibility for health services and thereby taking the centre stage for health policy making.

Feedback

The main justifications for state involvement are:

- market failure
- information asymmetry between consumer and provider
- need for care uncertain and often costly
- to achieve social equity of access to care

The critique of the state

Considerable disaffection with the expanded role of the state took place during the 1980s and led to a reassessment of its appropriate role in the health sector. This happened in the context of a global economic recession, mounting government indebtedness, and spiralling public expenditure. Conservative governments came to power in the USA and the UK which questioned what they saw as bloated and inefficient public sectors presiding over important areas of the economy. Reforms were introduced which involved liberalizing trade, selling off publicly owned industries, deregulating utilities and private industry, and curbing public expenditure. Tapping into widespread dissatisfaction with state administrations generally, which were often viewed as distant, undemocratic, unresponsive, unaccountable and even corrupt, the idea of rolling back the state spread to other high income countries and later to middle and low income countries as well. International financial institutions, such as the World Bank and the International Monetary Fund, pressured governments to reduce their deficits, and control public expenditure by implementing what were termed 'structural adjustment programmes'. In return for targeted loans and grants, governments promised to reform their economies principally by privatization and by reducing the involvement and responsibility of the state, particularly in service provision.

The decade was marked by a global turn in favour of the market, with a concomitant scepticism about the merits of pursuing social solidarity through government action. The collapse of the Soviet Union further discredited the notion of centrally planned, state-controlled economies. Anti-state, pro-market philosophy was promoted around the world by international agencies and private foundations. They, often rightly, claimed that the public sector too often provided patronage instead of service, employment rather than goods and services, and used office to secure political support. As proof, they pointed to poorly performing, costly and overstaffed bureaucracies, providing inadequate service in disintegrating facilities.

These trends were reflected in the health sector and led to a movement for health sector reform (Roberts et al. 2004). The state was widely regarded as having failed to provide services for everyone, despite rising levels of expenditure. Political pressures had resulted in public finance of health services which were not cost-effective while more cost-effective services were not widely provided. The political demands of the economic elite and the self-interest of urban-based bureaucrats resulted in a

disproportionate allocation of resources to urban tertiary facilities at the expense of basic services for the bulk of the population. Poor management decreased their efficiency and resulted in problems such as lack of continuous drug supplies. In many low income countries, inadequate finance meant poor equipment, poorly paid staff, leading to poor quality care. Public providers were often absent from their posts (sometimes attending illegal private practice), poorly motivated, seen as unresponsive, and charging patients illicit fees for services that governments proclaimed were freely available to all. Those people who required publicly financed services most often failed to access them while those who were politically connected were able to capture this state subsidy. Many, including the poor in the poorest countries, were in practice relying heavily on the private sector – often facing catastrophic payments to do so.

Reinvention of government and health sector reform

Given the widespread problems experienced in the sector, it is not surprising that the idea of reform was seized upon so readily. Yet the means for reform were greatly influenced by the prevailing ideology of the appropriate role for the state and the delivery of public health services. The state was to be slimmed down, health provision was to be made more efficient by introducing competition and decentralizing decision making, and the private sector was to be afforded a much larger role (Harding 2003).

Prevailing neo-liberal economic thinking was brought to bear to understand the root causes of the malaise in the health sector and greatly influenced prescriptions on the appropriate role for the state. Two theories stand out: public choice and property rights. *Public choice*, discussed in Chapter 2, deals with the nature of decision making in government. It argues that politicians and bureaucrats behave like other participants in the political system in that they pursue their own interests. Consequently, politicians can be expected to promote policies which will maximize their chances of re-election while bureaucrats can be expected to attempt to maximize their budgets because budget size affects bureaucrats' rewards either in terms of salary, status or opportunities to engage in corruption. As a result of these perverse incentives, the public sector is deemed to be wasteful and not concerned with efficiency or equity. *Property rights* theorists explained poor public sector performance through the absence of property rights. They argue that in the private sector, owners of property rights, whether owners of firms or shareholders, have strong incentives to maximize efficiency of resource use as the returns to investment depend upon efficiency. In contrast, such pressure does not arise in the public sector; staff may perform poorly at no cost to themselves, resulting in a poorly performing systems overall. They have few reasons to do well because they cannot benefit personally from goal performance, unlike in a business. Both theories draw attention to the incentives which motivate state officials and how these influence the policies that they pursue.

These beliefs gave rise to proposals to curb the state – to radically contain public expenditure – but also to introduce 'new public management' in those areas of the health sector which were not privatized. It was new in the sense that it sought to expose public services to market pressures by establishing internal markets within the public sector. Internal markets were established by forcing public providers

(e.g., general practitioner groups) to compete for contracts from public purchasers, contracting out service provision by competitive tendering (for hospital catering and cleaning services, for example) and devolving significant decision making to organizations, particularly hospitals, and to lower levels of government. These reforms involved the creation of purchasing agencies and the introduction of contractual relationships within the public sector.

In addition to reforms within public administration, new mechanisms to finance health care were put on the policy agenda (such as out-of-pocket fees for service use), restrictions on private providers were lifted, diversity of ownership in the health sector was promoted, and efforts were made to improve the accountability of providers to consumers, patients and communities.

Decentralization, another popular reform, aimed to transfer the balance of power within the state. In one form, functions held by the Ministry of Health (MOH) were transferred to newly established executive agencies which assumed management responsibility at the national level (for example, in Ghana and Zambia). The MOH could then focus its efforts on policy and oversight. In other cases, authority was transferred to district or local levels. Decentralization can also involve providing autonomy to hospitals by giving them control over their budgets. Decentralization distributes power from the MOH to other organizations.

Although the state has been slimmed down in many countries in the course of such reforms, it is almost universally agreed that the state ought to (and often does) retain a variety of functions. On the one hand, governments need to 'steward' the sector. Stewardship involves safeguarding population health by developing policy, setting and enforcing standards, rationing and setting priorities for resource allocation, establishing a regulatory framework, and monitoring the behaviour of providers. On the other hand, governments need to 'enable' – whether that is enabling the private sector or ensuring the fair financing of service provision through tax or mandatory insurance in high income countries and targeting public expenditure towards the poor in low income countries.

The World Bank was highly influential in promoting these reforms in low income countries, both through policy advice and through conditions attached to lending programmes. While these reforms have been nothing short of revolutionary in their intent, they have had mixed results on the ground. Although most governments have embraced reform, at least rhetorically, few have managed successfully to implement them. Implementation has also sometimes resulted in unanticipated consequences. While user fees for public services were introduced primarily to raise resources, they have not been very successful in this regard but have often had a negative impact on the use of essential services. Arrangements to protect the poor from charges have been difficult to administer. In China, reforms have resulted in fewer people being covered by health insurance. While 71 per cent of the population had some form of health insurance in 1981 (including 48 per cent of the rural population), by 1993 the level had fallen to 21 per cent, with 7 per cent coverage of the rural population (WHO 1999).

Activity 3.2

Make a list of health reforms which have been discussed or introduced during the past decade in your country. See if you can find reference to each of the reforms listed above, and if possible others, using Table 3.1. Depending on your general knowledge of health sector reform in your country, you may need to do some research. If you live in a low or middle income country, one approach to gathering the information would be to consult the World Bank's website where you can search for analytic or project lending reports (staff appraisal reports) for your country. If you live in a high income country, you can consult the European Observatory on Health Systems and Policies (www.euro.who.int/observatory) which covers a number of countries outside of Europe as well.

Table 3.1 Health reform checklist

Health reform	*Yes*	*No*
Liberalizing laws on the private providers		
Introducing user fees and strategies to exempt poor		
Introducing community-based insurance		
Introducing social health insurance		
Creation of purchasing agencies		
Introduction of contractual relationships and management agreements		
Decentralization of health service		
Decentralization of hospital management		
Encouraging competition and diversity of ownership		

Feedback

It is not likely that you ticked 'yes' to all reforms, as the content of reforms differed across countries. Nevertheless, it is likely that you identified a number of them, as virtually no health system has remained untouched by these sorts of reform.

The reform movement highlights the power of ideas and ideology in policy change. Yet reforms have provoked significant resistance. Some opposition has been based on philosophical and ideological grounds. Many have questioned the lack of evidence upon which reforms were based as well as the imposition of 'blueprints' without due consideration of national and local context (Lee et al. 2002). Yet reforms were more often resisted on the basis of the costs that they imposed on the incomes and interests of those actors who had benefited from the prevailing system. Consequently, successive rounds of reforms have rolled out unevenly across countries, with considerable evidence of limited progress and poor results, leaving the agenda largely unfinished in many countries (Roberts et al. 2004). Part of the failure of reform programmes rested on the disproportionate emphasis placed on the technical content of reform at the expense of the politics of the reform process.

Yet reforms continue to be announced. In 2004, for example, Russian President Vladimir Putin's government drafted a bill aimed at reforming its 'bloated' health bureaucracy by sacking approximately half (300,000) of its doctors and health workers in the next few years (Osborn 2004).

The for-profit sector and health policy

The assault on the state in the 1980s and 1990s provided an opportunity for the private for-profit sector in health. While the private sector was already active in many countries in terms of health service delivery, it was usually overlooked in relation to health policy and regulation. This is surprising because it is difficult to identify health policies in which the private sector does not have an interest or play some role. But what exactly is the for-profit sector and how is it involved in health policy? The following provides a brief overview of the types of private sector actors in health and differentiates the three main ways that the private sector is involved in health policy.

What is the private sector?

The private for-profit (or commercial) sector is characterized by its market orientation. It encompasses organizations that seek to make profits for their owners. Profit, or a return on investment, is the central defining feature of the commercial sector. Many firms pursue additional objectives related, for example, to social, environmental or employee concerns but these are, of necessity, secondary and supportive of the primary objective which concerns profit. In the absence of profit, and a return to shareholders, firms cease to exist.

For-profit organizations vary considerably. The sector consists of firms which may be large or small, domestic or multinational. In the health sector there are single doctor's surgeries and large group practices, pharmacies, generic drug manufacturers and major pharmaceutical companies, medical equipment suppliers, and private hospitals and nursing homes.

When thinking about the role of the commercial sector in health policy, it is often useful to broaden the scope of analysis and include organizations that are registered as not-for-profit in their legal status. These may have charitable status but are established to support the interests of a commercial firm or industry. These may include business associations or trade federations. For example, both PhRMA (American Pharmaceutical Manufacturers Association) and BIO, the biotechnology industry organization, are engaged in the health policy process.

A wide range of industry-funded think tanks, 'scientific' organizations, advocacy groups (such as patient groups) and even public relations firms working for industry are actors engaged in the health policy arena. For example, the tobacco company Philip Morris established the Institute of Regulatory Policy as a vehicle to lobby the US federal government and delay the publication of a report by the Environmental Protection Agency on environmental tobacco smoke (Muggli et al. 2004). The International Life Sciences Institute (ILSI) was established in 1978. The Institute's first President envisioned it as a mini-World Health Organisation. It describes itself as a 'Global Partnership for a Safer, Healthier World' which employs strategic alliances to bring scientific solutions to important public health issues, particularly in areas such as diet, tobacco and alcohol. While it is at pains to present itself as a scientific body, its first President served simultaneously as a Vice-President of the Coca-Cola Company and it is predominantly funded by the food industry. It has gone to great lengths to conceal the commercial sponsorship of its research and publications and present itself as scholarly and independent (James 2002).

Industry also organizes and supports patient groups to influence health policy decisions of governments. For example, 'Action for Access' was set up by Biogen in 1999 to get the UK National Health Service to provide interferon beta for multiple sclerosis patients (Boseley 1999). In some health policy debates, public relations firms play important roles. Firms are employed to put across industry views, through the media or other means, as disinterested third parties. In 2002, the five leading health care public relations firms in the USA earned over US$300 million for planning pre-launch media coverage of new drugs, cultivating prescribers, publishing medical journals and supporting patient groups with the aim of influencing health care policy and practice (Burton and Rowell 2003).

Looser groups supported by industry can also be influential in the health policy process. ARISE, Associates for Research into the Science of Enjoyment, promotes the pleasures of smoking, alcohol, caffeine and chocolate. With support from companies such as British American Tobacco, Coca-Cola, Philip Morris, RJR, Rothmans, Miller Beer and Kraft, it publishes articles that promote and advocate consumer freedom in relation to those substances and deride the necessity of public regulation. One publication called *Bureaucracy against Life: The Politicisation of Personal Choice* attacks the European Community for restriction of individual choice in connection to 'the alleged dangers associated with alcohol, tobacco, caffeine and an increasing range of foods' as paternalistic.

Activity 3.3

Look at the business section of a major national or international newspaper. Find examples of each of the types of commercial organizations listed above with a linkage to a health issue (either due to the goods or services they manufacture, promote, distribute, sell or regulate). Provide one or two examples of each category of commercial entity, the health issue in which they have an interest, what they manufacture, distribute, sell, or promote, and the relationship of these goods or services to health (either positive or negative). Also, see if you can find any references to less formal commercial organizations – this may be more difficult. You may need to collect newspapers for a few days to get an example of each type of organization.

The types of organization to consider are:

- Small firm
- MNC or TNC
- Business association
- Professional association
- Think tank
- Patients' group
- Commercial scientific network
- Public relations firm
- Loose network

Feedback

It should be evident that a wide range of organizations and groups associated with the private sector are interested and involved in health policy in your country. It may also be evident from the news clippings that these organizations vary tremendously in relation to their size (by staff, sales or market capitalization – value on the stock exchange), organizational form, and interest in particular health policies.

What makes the private sector a powerful actor in health policy?

Power is the ability to achieve a desired result. Resources often confer power and, on that basis, the power of some industries and firms may be obvious to you. Of the top 100 'economies' in the world 49 are countries, but 51 are firms when measured by market capitalization. Figure 3.1 compares the market capital of ten of the largest companies in the world, ten leading pharmaceutical firms, with the gross national income of those low income countries for which there was data in 2003 – note how the firms dwarf the size of the collective economies of the poorest countries. The revenue of the top 50 pharmaceutical firms amounted to US$466 billion in 2003 which had increased from US$296 billion just two years earlier (Sellers 2004). Contrast the magnitude of corporate sales with the annual budget of WHO: it is a paltry US$1 billion and has remained stagnant for over a decade.

Firms provide governments with tax revenues, some are major employers in the economy, and governments gain influence in international affairs on the coat tails of their large corporations and are therefore interested in their success. In many sectors, firms have specialist knowledge which governments rely on in making policy and regulations. For these reasons, small and large businesses are often important actors in policy debates.

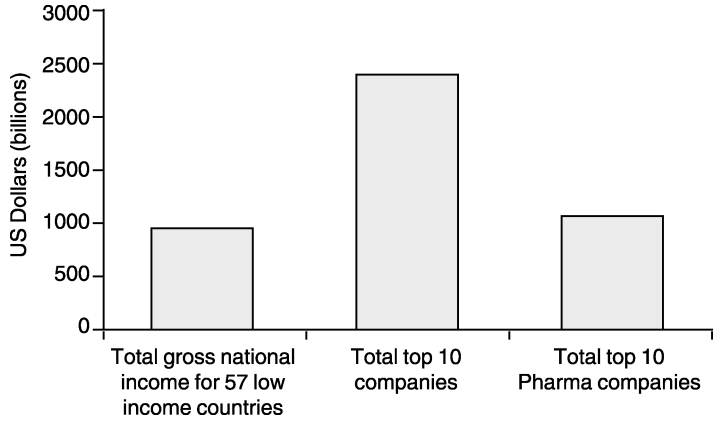

Figure 3.1 Market capitalization of largest companies compared with gross national incomes of 57 low income countries, 2003

Sources: World Bank (2005) and Bureau Van Dijk (2005)

How is the private sector involved in health policy?

In Chapter 1 a distinction between public and private policy was made. You learned that the private sector develops policy related to health – whether it is a firm setting down rules for its staff (e.g., on sick leave) or an industry federation establishing policies for its members (e.g., in relation to environmental pollution). This is one way that the private sector is involved in health policy, through self-regulation. You will now explore private health policy making in further detail as well as two additional mechanisms through which the private sector is involved in health policy. One of these is likely to be obvious to you after having completed Table 3.1, namely, the private sector's involvement in public policy making. In addition, a new form of engagement, referred to as 'co-regulation', provides a middle ground between self-regulation and public policy.

Self-regulation

Self-regulation concerns efforts by private companies to establish their own rules and policies for operating within a specific domain. For example, rules governing how to design, categorize, produce and handle particular goods and services are routinely adopted by groups of companies and industries.

One can distinguish between two types of self-regulation. First are those efforts which attempt to regulate what might be termed private 'market' standards and, second, the regulation of 'social standards'. In the case of market standards, aspects of products, process and business practice are subject to self-regulation for the purpose of facilitating commerce. Common standards support business by reducing transaction costs, ensuring compatibility, and creating fair competition for all firms in the market. There are thousands of examples of self-regulation from codes of conduct on advertising (which, for example, might restrict advertising of unhealthy products to children) to standards governing voltages within medical equipment to standards on electronic medical claims.

Self-regulation through social standards is generally undertaken in response to concerns raised by consumers, shareholders, or due to the threat of impending public regulation which may be more onerous. Initiatives include corporate social responsibility, voluntary codes and reporting initiatives, and some corporate philanthropic programmes. These initiatives sometimes govern social issues that are already subject to (often ineffective) statutory regulation.

Company and industry-wide codes of conduct represent one increasingly prominent form of self-regulation through social standards. Currently voluntary codes cover a variety of corporate practices that are important determinants of health. Depending on your line of work, you may be aware of voluntary codes which cover such aspects as occupational health and safety, wages and hours, minimum age of work and forced labour. The promise and perils of codes are set out below to allow you to judge whether or not they are good substitutes for public policy.

It is relatively easy to understand why firms and industries adopt voluntary codes governing social issues. First, by doing so, firms are often able to generate public relations material and improve their corporate image. Second, early adoption of a code can differentiate a firm from a competitor and thereby increase its market

share. Third, adoption of codes in response to consumer or shareholder demand permits firms to demonstrate that they listen and can boost sales and investment. Depending on the issue, codes can be used to stave off consumer boycotts and also public regulation. As you can see, there is a market logic to codes.

Codes can also be good for society. The introduction of a standard by one firm or a group of firms can compel other firms to adopt similar standards so as to prevent the loss of market share. By pulling up the laggards, leading firms can ratchet up standards across an industry. Second, in some contexts compliance with voluntary codes may be more effective than compliance with statutory regulation. The theory is that companies adopt codes so as to gain market share and comply with them so as not to lose the confidence of their consumers/shareholders. Codes are also promoted as curbing government expenditure on public regulation.

At first glance codes appear to represent a win-win situation but closer inspection reveals some weaknesses in this form of private policy making. One analyst concludes that 'corporate codes of conduct are treated with disdain and largely dismissed by knowledgeable and influential opinion leaders among various stakeholder groups, as well as by outside analysts and the public-at-large' (Sethi 1999).

Activity 3.4

Based on your general knowledge of codes, take the following test to see if you can deduce why Sethi made such pessimistic remarks:

1 Do codes typically:
   a) enunciate general principles; or
   b) provide specific standards (i.e., quantifiable and measurable indicators)?

2 Do codes typically:
   a) focus on concerns of consumers in high income countries (e.g., child labour, or pesticide residue on organic fruit); or
   b) concerns of local employees (e.g., right to collective bargaining, pesticide exposure)?

3 Is code compliance likely to be:
   a) linked to internal reward structures in the company (are there incentives to ensure that the code is implemented?; or
   b) divorced from reward structure, operating procedures, or corporate culture?

4 Do companies typically make public:
   a) the process by which they seek to comply with the code and the findings related to the code; or
   b) only those aspects of the findings which are favourable?

5 Is reporting of code implementation typically:
   a) subject to external scrutiny; or
   b) handled internally by the company?

Feedback

While there are undoubtedly exceptions to the rule, Sethi (1999) concludes that codes typically comprise lofty statements of intent, are largely responsive to consumer pressure and therefore highlight issues in consumer-sensitive industries (e.g. clothing) while ignoring many others, and that companies tend to lack the means to communicate compliance with the code in reliable and believable ways. The correct answers are all 'b'.

A review of voluntary codes of pharmaceutical marketing concluded that they lacked transparency and public accountability because consumers were not involved in monitoring and enforcement, they omitted major areas of concern, and lacked timely and effective sanctions (Lexchin and Kawachi 1996). Similarly, a former Executive Director of WHO argues that self-regulation in the case of tobacco manufacturing and smoke-free policies 'failed miserably' (Yach 2004).

Another problematic aspect of voluntary codes relates to their reliance on company 'commitment' to stakeholders. Undertaking to voluntarily uphold a particular principle is qualitatively distinct from being held accountable under law to ensuring specific rights, for example, of those affected by company operations. As a consequence, patchwork self-regulation results in 'enclave' social policy which governs select issues and groups of workers at a specific point in their working lives (e.g. only those workers in a specific plant and only while they hold their jobs). Some fear that these self-regulatory efforts will erode societal commitment to universal rights and entitlements.

In summary, an increasing number of self-regulatory mechanisms are being adopted by the business community in areas which affect health. Private actors are involved in policy formulation, adoption and implementation, often without reference to state actors. While private policy may promote health, it may also have negative impacts. Consequently, the need for public regulation remains – and unsurprisingly, the private sector has a stake in public policy – a topic now addressed.

The private sector and public policy

In the following chapters you will learn more about how the government makes and implements public policy – here examples are provided to illustrate the involvement of the private sector in the process. The private sector is often affected by public policy and, as a result, may attempt to influence the content of such policy. The private sector wields influence in a number of ways. Firms will often provide finance to political parties and to political campaigns in the hope that once those parties and politicians are in office they will be more responsive to demands that firms may make in the policy process.

Private organizations will also lobby for or against particular policies. Influence can also be wielded through corporate participation in government committees and working groups. Moreover, corporate executives also compete for public office, and, if successful, may take positions in line with business interests.

Co-regulation

Co-regulation presents a 'third way' between statutory regulation and self-regulation. It may be viewed as public sector involvement in business self-regulation. The idea is that public and private sectors will negotiate on an agreed set of policy or regulatory objectives. Subsequently, the private sector will take responsibility for implementation of the provisions. Monitoring compliance may remain a public responsibility or may be contracted out to a third party – sometimes an interested non-governmental watchdog. Co-regulatory initiatives often involve public, private and civil society actors working in partnership.

Co-regulation is relatively new, with limited experience at the national and regional levels. For example, in the UK, the Advertising Standards Authority has a range of sanctions against misleading advertisements which is backed up by statutory regulations of the Office of Fair Trading which can secure a High Court injunction to prevent a company publishing the same or similar advertisements. In other words, the statutory backing gives the self-regulatory code teeth. The European Union is also experimenting with co-regulation particularly with respect to the Internet, journalism and e-commerce.

Summary

In this chapter you have learned why the state is considered the most important actor in policy making. While it is important to understand the role of the state in policy making, an analysis focused entirely on the state is no longer sufficient. This is because the role of the state has changed and the private sector now features more prominently in health policy making – either independently or in association with the state.

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