Competition Commission of Pakistan
Creating a level Playing Field

Competition Assessment of the Private Healthcare Sector in Pakistan

July 2013

COMPETITION COMMISSION OF PAKISTAN

This study assesses the level of competition in the private healthcare sector of Pakistan using secondary data and a new survey commissioned by the Competition Commission of Pakistan.

DISCLAIMER

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Table of Contents

List of Figures:

List of Tables:

Acronyms

BHU	Basic Health Unit
CAF	Competition Assessment Framework
CCP	Competition Commission of Pakistan
CEO	Chief Executive Officer
DFID	Department for International Development, UK
DHQ	District Head Quarter
ECC	Economic Coordination Committee
JCAHO	Joint Commission on Accreditation of Health Care Organizations
MCH	Maternal and Child Health
MOH	Ministry of Health
NCT	National Council for Tibb
NHA	National Health Accounts
NHPU	National Health Policy Unit
OECD	Organisation for Economic Co-operation and Development
OPD	Out-patient Department
PMDC	Pakistan Medical & Dental Council
PNC	Pakistan Nursing Council
RHC	Rural Health Centre
RHC	Rural Health Centre
SDS	Service Delivery Survey
THQ	Tehsil Head Quarter
THQ	Tehsil Head Quarter

Foreword

To better understand the functioning of markets and identify competition vulnerabilities, the Competition Commission of Pakistan (CCP) regularly conducts competition assessments. The studies conducted thus far include important sectors of the economy, covering both industry and services such as fertilizer, polyester staple fiber, sugar, cooking oil, banking, aviation, etc. These assessments examine competition issues and government interventions that may distort incentives; information asymmetries and anti-competitive practices prevailing in the sectors.

Access to adequate and quality healthcare services is not only a basic human need, it also affects the quality of workforce. Thus, it has far-reaching implications for the productivity and competitiveness of the economy. For several reasons, the public sector healthcare services could not cater to the growing demand. This resulted into an expansion of the private sector healthcare services. This is not a Pakistan-specific situation, because healthcare has emerged as one of the largest business sectors globally as well. Despite its growing significance, little is known about the working of the private healthcare market in Pakistan.

This study is a competition assessment of the 'Private Healthcare Sector'. The aim of the research is to provide valuable information about performance of private healthcare sector with respect to cost and customers' satisfaction. This Report also focuses on a wide range of competition issues comprising market dominance, deceptive marketing, tying practices, market entry, etc. It also sheds light on the regulation of the sector in Pakistan and in other countries. The weaknesses in the policies and processes have been identified along with recommendations to enhance competition.

Though, the immediate beneficiary of this report is the CCP but owing to the fact that the healthcare governance is in the transition phase and a structure is evolving in the provinces, this report will provide useful insights to the policy makers, including both the legislative and the executive branches. The recommendations offered in the report, particularly to introduce quality/standards and reduce information gaps, need special attention of the policy makers.

For this report, the consumer perception survey was designed and conducted by a team consisting of Mr. Abrar Hafeez of Consumers Rights Commission of Pakistan and Ms. Rizwana Shabbir from the Institute of Social and Policy Sciences, Islamabad. The report was finalized by Ms. Kishwar Khan Director, CCP, under the supervision of Mr. Mueen Batlay, Member, Competition Policy and Research Department of the CCP. The CCP gratefully acknowledges the contribution of several stakeholders who volunteered to share their views.

Dr. Joseph Wilson
Chairman

Executive Summary

1. In Pakistan, private health care accounts for double the services offered by the public sector. There is a general perception that the rapid growth of the private sector has not generated efficient outcomes for consumers, particularly in terms of quality, cost and other relevant indicators. This is often attributed to the pursuit of pure self-interest by the market players. Against this background, the Economic Coordination Committee (ECC) of the Cabinet referred the matter to the Competition Commission of Pakistan (CCP) to review the cost of healthcare sector.

2. According to the economics of competition, the cost at which a particular service is provided to the consumers depends, among other factors, on the level of competition prevailing in the 'relevant' market. Competition forces enterprises to enhance efficiency, reduce cost and offer better service. Taking a holistic view, in addition to evaluating the cost of private healthcare, CCP considered it imperative to evaluate the presumptions regarding prevalence of anti-competitive practices in the private healthcare sector.

3. This study is based on internationally acknowledged analytical frameworks for competition assessment. These frameworks provide operational guidelines to assess the degree of competition and identify competition vulnerabilities in specific sectors. Using these analytical tools, this report presents an objective analysis of the market that is supported by empirical evidence. The report also covers a critical review of the policies and regulations relating to the sector. To formulate meaningful recommendations, a comprehensive survey was conducted, involving service providers, users and regulators.

4. The supply side of the private healthcare sector, i.e. profit-based healthcare enterprises, primarily consists of clinics run by individual registered medical practitioners (for medical consultation/ check-up) and hospitals/ medical complexes that offer a wide range of services (consultation, specialized/ general/ surgical treatment, etc.). The demand side is quite diverse, consisting of buyers belonging to various income groups.

5. We observed that the growth of the private healthcare sector is not a Pakistan-specific phenomenon. In fact, healthcare has emerged world over as one of the largest business sectors, with global revenues estimated at US$ 2.8 trillion. The healthcare markets in the neighboring countries of China and India manifest the same phenomenon.

6. In Pakistan, the sustained expansion of the private healthcare market corresponds to a surge in the demand for these services, which, in turn, is a function of an increasing population and the existing demand-supply gap,

besides a failing public healthcare sector. This study finds that the market for medical consultation and general treatment is relatively less concentrated. A large number of suppliers and buyers interact in this domain. However, the supply side of specialized treatment (cancer, kidney/ liver transplant, heart diseases, radiology, etc.) displays a higher degree of concentration. Profits are contingent upon a number of factors, including the nature, quality and diversity of services provided by the private health care facilities. The survey reveals that a majority (60%) of patients are satisfied with the services they receive from the private sector.

7. We observed that specific standards for cost determination for healthcare services have not been developed. No regulatory mechanisms are in place which set quality standards relative to cost. As a result, procedures for determination of the cost of services are largely arbitrary. The main variables that influence cost are the experience and reputation of the consultant, the number and proclaimed quality of services being offered, the area of operation of the facility, the availability of qualified consultants on the roll of the healthcare facility and the availability of diagnostic equipment. The sector is prone to information asymmetries. Generally, a health facility's advertisement campaign covers its cost-side marketing issues, such as the level of experience/reputation of consultants, modern medical equipment & techniques, etc. However, other objective information is not disclosed to the buyers. Therefore, over-treatment and unnecessary medical tests have become a common practice, an average consumer is not in a position to detect or prevent such practices. Regulators were of the view that there is a visible rise in the cost of services, but expressed their inability to check it owing to the lack of any provision in the law.

8. We are of the view that health sector governance plays a key role in the provision of equitable healthcare services. Considering that access to healthcare is a constitutionally guaranteed right, the population cannot be left completely dependent on the private sector. Citizens' wellbeing calls for presence of appropriate regulatory and administrative mechanisms. The National Health Policy, the key building block for the legal and policy framework on health, does not articulate a 'standards' framework for private healthcare. This has led to an absence of appropriate regulation at the federal as well as provincial tiers of the government. The role of health regulatory agencies at the district level also remains visibly weak vis-à-vis the private healthcare market.

9. To improve the state of competition and hence to reduce the cost of healthcare, the study recommends revisiting the national health governance paradigm. The study finds that a regulatory mechanism that oversees activities such as the authorization to set up a private healthcare facility, setting up of quality standards, and output based value of services is non-existent. To improve the situation, it is necessary that the national policies specify objectives and actions focusing on institutional reforms and maintenance of quality standards in the provision of healthcare services.

10. To ensure availability of quality services at a reasonable cost, this report recommends that the statutory role of PMDC be revised and broadened to include the authority to issue licenses for the establishment and operation of private healthcare facilities. From a competition regulator's perspective, this would help reduce instances of deceptive marketing practices in the healthcare sector.

11. Competition, as well as choices available to the consumer, can be enhanced by increasing transparency about market participants. This can be done by reducing information asymmetries, and making it easy to access necessary information. It shall alter the behavior of service providers and that of users. For this purpose, the Report recommends PMDC to maintain a centralized database containing information on healthcare facilities, particularly their quality. Once in place, this database would need to be updated at regular intervals and made accessible to consumers at large. The presence of such an autonomous information repository shall facilitate consumers in making more informed choices.

12. Based on the survey findings and information gathered from a range of stakeholders, we are of the view that setting up of a 'standards' framework will contribute in the promotion of competition in the private healthcare market.

13. The report points towards the possibility of certain anti-competitive practices, and recommends the CCP to take appropriate actions.

SECTION 1 – INTRODUCTION

1.1 Setting the Context

In Pakistan, private healthcare services have increased considerably. We observe that issues relating to the accessibility and quality of services provided by the public health sector have led to a steady and robust growth of the private health sector over the years. Beset with problems like structural fragmentation, inefficiencies, and resource scarcity, the non-functionality of the public health sector has created a large demand supply gap, leading to the emergence and growth of the private health sector.[1] Even where the government's health facilities are easily accessible, people prefer to use private hospitals and clinics. According to an estimate, the average Pakistani household spends 5.2% of its total monthly household expenditure on healthcare – the poor bearing a heavier burden of medical costs than the rich.[2] The health expenditure of households in 2009-10 amounted to Rupees 273 billion, which is about 70% of total health expenditures.[3]

The emerging private health sector is not a Pakistan-specific phenomenon. Internationally, it has emerged as one of the largest business sectors with global revenues estimated at US$ 2.8 trillion.[4] Healthcare markets in neighboring China and India show similar trends.[5] However, the growth of private healthcare in Pakistan seeks special attention because of two reasons: Firstly, the extent of the growth of the private sector in Pakistan is comparatively higher than other countries. Presently, the private sector is providing twice the health-care services relative to the public sector.[6] Secondly, there is an absence of a policy and regulatory framework to steer the private sector.

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[1] See Heartfile, Transparency International, Pakistan Health Policy Forum & Department of Health NWFP, *Pakistan's Health Sector: Doest Corruption Lurk?* 2008; Nishtar. S. *Choked Pipes: Reforming Pakistan's Mixed Health System*, 2010; and Nishtar, S., *Health Systems in Pakistan*, 2006.
[2] Ibid. Nishtar, S., 2006
[3] According to Pakistan Bureau of Statistics, the share of Punjab in Pakistan's total out-of-pocket health spending is 56%, followed by Sindh 24% and KP 13.7%. The share of Balochistan is the lowest at 5%.
[4] Confederation of Indian Industry: http://www.cii.in
[5] In India, for instance, the healthcare revenue is about $ 30 billion constituting 5% of GDP.
[6] Government of Pakistan, Federal Bureau of Statistics, *National Health Accounts*, 2005-2006.

The concern about the private sector's failure in provision of efficient services calls for serious attention in the backdrop of Pakistan's poor health indicators. Though, there has been a noticeable improvement in some health indicators over the years, Pakistan ranks poorly on most indicators. Life expectancy in Pakistan remains lower than many in its peer group, while infant and maternal mortality rates are amongst the highest. Pakistan's health indicators have remained poor despite several reforms in healthcare delivery systems and targeted public health programs. High incidence of preventable communicable diseases, malnutrition, and infant and maternal mortality, is a challenge for the health management system of the country. Infant mortality rates (65.1 per 1000 persons) and maternal mortality rates (350 per 100,000 live births) are among the highest in the world.[7] Malaria, tuberculosis, diarrhea, measles and tetanus continue to pose serious threats to the health of millions of Pakistanis. The poor health condition of the population is a major constraint in human capital formation. It has adverse effects on economic growth and the country's global competitiveness. Poor public health has been found to be one of the 15 most problematic factors that hamper growth of business in Pakistan.[8]

These poor health indicators may be attributed to problems in the provision of public health services. The public sector's performance has suffered owing to low budgetary allocations. Public expenditure on health, as a percentage of gross domestic product (GDP), is one of the lowest in the world. It has declined from 0.58 per cent in 2000-01 to 0.56 per cent in 2008-09, and currently stands at 0.54 per cent.[9] As a result, growth in the number of healthcare facilities has not matched population growth. Services offered enjoy minimal confidence of the population due to their poor quality, resulting in their underutilization. For example, in 2004-05, of total cases of pre and post natal consultations surveyed, only 38 per cent occurred at a government health facility.[10]

[7]Government of Pakistan, Ministry of Finance, Economic Survey of Pakistan, Islamabad, 2009-10.
[8]Competitiveness Support Fund, *The State of Pakistan's Competitiveness Report 2009*, Islamabad, 2009.
[9] Government of Pakistan, Ministry of Finance, Economic Survey of Pakistan, Islamabad, 2008-09 & 2009-10.
[10] Government of Pakistan, Federal Bureau of Statistics, *Pakistan Social and Living Measurement Standards 2004-5*, Islamabad, 2006.

A number of research studies have examined the role of private healthcare providers, but only a few have taken into account the implications of a lax regulatory framework, and the changing dynamics of the healthcare market. Zaidi's[11] research (1988) can be regarded as a pioneering effort to study the evolution and key issues of private health facilities. A majority of the research work focuses on deficiencies in the public health sector. The studies by Rehana *et.al*[12] (1995) and Toor & Butt[13] (2005) focus on determinants of health expenditure in Pakistan. In addition to examining the socio-economic determinants of health expenditure, Rehana also highlights the rising trend of medical professionals turning to private practice. However, the studies which deal with the state of private healthcare do so in passing. Islam[14] (2002) highlights the structural fragmentation of the healthcare system and stresses an increased role of the private sector with an emphasis on public-private partnerships. The study suggests that the private sector needs to initiate social insurance schemes for health services emulating examples of Thailand, Philippines and Bangladesh. Akram and Khan[15] (2007) review public healthcare systems and public spending patterns on health. Their work focuses on three areas including access, quality and mainstreaming of private healthcare. Nishtar (2010)[16] in her leading work on Pakistan's health system, documents the issues in health governance. To strengthen the regulatory role of the government, she suggests mainstreaming of private healthcare and institutional reform.

All the above mentioned studies address a wide range of issues, yet none of them cover aspects relating to competition in private healthcare facilities, their efficiency and subsequent effects on consumers. Nevertheless, the existing literature assisted in developing a useful understanding of the private healthcare market and commonly raised issues.

[11] S. Akbar Zaidi, The Political Economy of Health Care in Pakistan, Vanguard; Lahore 1988.
[12] Rehana Siddiqui, Usman Afridi, and Rashida Haq, *Determinants of Expenditure on Health in Pakistan*, in The Pakistan Development Review, Vol34, N04, 1995 pp. 959-970.
[13] Toor, I. A., and M. S. Butt, 2005 *Determinants of Health Expenditure in Pakistan*, in Pakistan Economic and Social Review 43:1, 133–150.
[14] A. Islam, *Health Sector Reform in Pakistan: Future Directions*, Journal of Pakistan Medical Association, Vol: 70, No: 4 April, 2002.
[15] Muhammad Akram & Faheem Jehangir Khan, *Health Care Services and Government Spending in Pakistan*, Pakistan Institute of Development Economics, PIDE Working Papers32, 2007.
[16] Sania Nishtar, *Choked Pipes*, Oxford University Press, Karachi, 2010.

It is worth noting that effective competition is central to the operation of markets. It sets incentives for innovation and enhancing productivity.[17] In the case of Pakistan's healthcare sector, its growth has run in parallel with trends such as high costs, non-accreditation, and absence of appropriate regulation. Concerns have been raised regarding abuse of dominance and tying of unrelated services. Prevalence of such practices is not only contrary to the principles of a competitive market, but also results in impeding growth. In this context, the Economic Coordination Committee (ECC) of the Cabinet requested the Competition Commission of Pakistan (CCP) to review the cost of healthcare sector and to submit a comprehensive report to the ECC.[18] The CCP submitted a preliminary report to the ECC wherein it was mentioned that due to non-availability of reliable data, the cost of private healthcare could not be reviewed appropriately. The CCP highlighted the need for understanding relevant aspects in a systematic and analytical manner. In order to fill the research gap, the CCP undertook the present study with the purpose of analyzing competition issues and the prevalence of anti-competitive practices. The objectives of the study are listed in the following section.

1.2 Objectives of the Study

Realizing the need for generating empirical evidence on the state of competition, and formulate suitable recommendations to improve competition, it was necessary to conduct an independent assessment of private healthcare.

Within this context, the study attempts to attain the following major objectives:

i. Thorough scrutiny of concerns regarding the rising cost of private healthcare services and consumers' access to quality services.

ii. Evaluation of the prevailing presumptions regarding anti-competitive practices in the private healthcare market.

[17] Nick Godfrey, *Why is competition important for growth & poverty reduction*, Section 3.1, OECD Global Forum on International Investment March 28, 2008.

[18] This was dropped from the ECC's agenda when health became a provincial subject after approval of the Eighteenth Amendment in the Constitution of Pakistan on April 8, 2010.

iii. Analysis of the market structure, and the role of various stakeholders in the provision of services.

iv. Review of relevant regulations and policies with reference to their adequacy and effectiveness in promoting efficiency, transparency and competition.

v. Formulation of a set of recommendations on the basis of identified issues for improving market outcomes.

1.3 Framework of Analysis

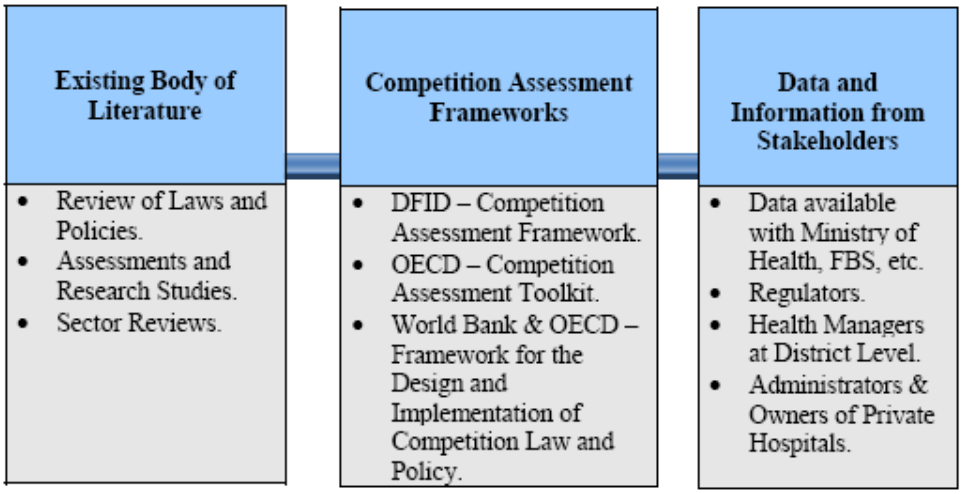
In Pakistan, the growth of private healthcare has raised a number of concerns regarding inadequacies of the regulatory framework governing private healthcare facilities, and the likelihood of anti-competitive practices. These concerns merit a comprehensive evaluation and analysis of the state of competition in private healthcare.

Against this background, the present assessment draws on two key sources: first, the existing body of work undertaken on the private health sector in Pakistan; and second, the competition assessment frameworks developed by international organizations. Though the existing literature does not cover competition concerns, nevertheless it deepens the understanding regarding commonly raised issues, policy barriers, regulatory challenges and the conduct of private healthcare providers. We have used the competition assessment frameworks to assess market structure, identify entry barriers, vested interests, and to map out signs of anti-competitive conduct. Views and information collected from stakeholders ranging from consumers, regulators, health managers in public departments and owners of private hospitals have assisted in our analysis. As summarized in Figure 1.2, the following instruments were used to conduct this competition assessment:

i. OECD's *Toolkit* that focuses on the evaluation of government policies and regulations. It helped to identify policy barriers and chalk out policy guidelines.[19]

[19] Organisation for Economic Co-Operation and Development, *Competition Assessment Toolkit*, Paris Cedex 16, France, 2007.

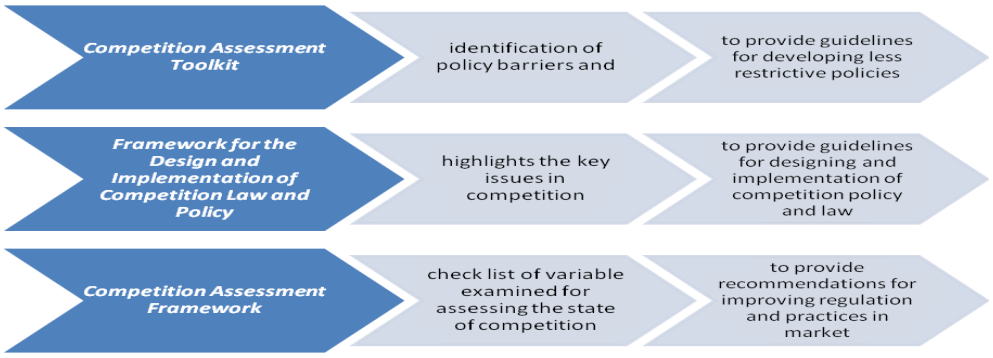
Figure 1.1: Framework of Analysis



ii. OECD-World Bank's *Framework for the Design and Implementation of Competition Law and Policy* was used to highlight key issues concerning competition.[20]

iii. DFID's *Competition Assessment Framework* that provides an elaborate checklist of variables was used for assessing the state of competition in the private healthcare sector.[21]

Figure 1.2: Use of Competition Assessment Tools and Frameworks



[20] This has been developed jointly by the Business Environment Group of the World Bank and Directorate for Financial, Fiscal, and Enterprise Affairs. *A Framework for the Design and Implementation of Competition Law and Policy*, OECD Publishing, Paris, 1998.

[21] Department for International Development (DFID), *Competition Assessment Framework: An Operational Guide for identifying barriers to Competition in Developing Countries*, PRD 114, 2008.

Keeping with the objectives of this study, we used two broad sets of parameters. The first set accounts for the structure of the private healthcare market. It includes profiling of the sector and identifying key players with their respective roles. It also delineates the regulatory framework governing private healthcare facilities. The second set of parameters deals with the functional aspects of the private healthcare market. These required us to examine the prevalence of anti-competitive practices (both horizontal and vertical) and the possibility of unequal enforcement of laws. Strategic entry barriers, resulting either from the actions of market players or those arising from government policy or regulations were also analyzed.

1.4 Methodology

The evaluation methodology included a comprehensive review and analysis of available data, research efforts undertaken by the government, research institutes and independent researchers.[22] In addition to this, key informant interviews were conducted through a specially designed 'service delivery survey'. The purpose of the survey was to get feedback from both the supply and demand side stakeholders, i.e. hospital/clinic owners and consumers of private healthcare services (patients and their attendants).

As explained earlier, minimal information on the private health sector, especially in the context of competition was available. To meet the specific objectives of the present assessment, a number of tools were designed and implemented. These included a structured questionnaire for a Service Delivery Survey (SDS)[23] and an open-ended questionnaire for Key Informant Interviews.[24]

The SDS helped us collect valuable empirical evidence relevant to the scope of the present study, i.e. the cost of private healthcare, the behavior of market players and the prevalence of anti-competitive practices. 503 respondents (patients and their attendants) were interviewed to get information about their experiences at private health facilities. About 80% of the respondents were from urban areas. The gender composition of

[22] The data available with Federal Bureau of Statistics, Health Management Information System of Ministry of Health, and Pakistan Medical and Dental Council (PMDC) were reviewed and analyzed. List of works/studies/researches consulted is attached as Annex-V.
[23] Detailed note on coverage and profile of respondents is contained in Annex- I.
[24] Sample SDS form and key informant questionnaires can be seen at Annex-II.

respondents was 74% male and 26% female. The respondents included patients getting treatment (consultation or admitted) and attendants with the patients present at private health facilities. The respondents represented diverse income groups. The survey was conducted through a questionnaire designed to collect both quantitative and qualitative data. In order to substantiate the findings of the SDS, 20 key informant interviews were conducted with major stakeholders.[25] For this purpose, separate questionnaires were designed for entrepreneurs and officials of regulatory bodies. The respondents included CEOs of hospitals/clinics and members of regulatory authorities, such as the Ministry of Health (MOH), Pakistan Medical and Dental Council (PMDC), and provincial health departments.

1.5 Sample and Profile of Respondents

A detailed survey was specifically designed and conducted in the urban and rural areas of Rawalpindi and Islamabad. 503 patients and attendants were interviewed to get information about experience regarding private health institutions. About 80% of the respondents were from urban areas and 20% represented rural areas. 73.60% of the respondents were male and 26.40% were female. In urban areas, 72% respondents were male and 28% were female, while in rural areas 80% were male and 20% were female.

Table 1.1: Respondents - Gender and Area-wise Distribution (%)

Area	Male	Female	Total
Urban	57.60	22.40	80.00
Rural	16.00	4.00	20.00
Total	73.60	26.40	100.00

Age composition of the respondents is shown in the following table. Most of the respondents i.e. 27% fall in the age group of 31-40 years; about 23% of the respondents were in the age group 26-30 years while 20% were in the age group 18-25 years.

Table 1.2: Percentage Distribution of Respondents by Age Group

Age Group	Urban	Rural	Total
18-25 years	17.00	3.40	20.40
26-30 years	18.00	4.60	22.60

[25] The information was collected on the basis of responses as well as focused discussion on the key parameters listed in the questionnaires. List of interviewees is given in Annex III.

31-40 years	20.60	6.80	27.40
41-50 years	15.20	2.80	18.00
51-60 years	7.20	1.80	9.00
61 years or above	2.00	0.60	2.60
Total	80.00	20.00	100

1.6 Limitations of the Study

The study provides a broad analysis on aspects of competition in the private health sector, especially focusing on Islamabad and Rawalpindi. The study is somewhat limited in its scope, as it focuses on competition among private healthcare facilities in specific localities.

In this study, private healthcare refers to for-profit private sector institutions which cater to the needs of different income groups. Not-for-profit or charitable health institutions remain outside the scope of this study. The determination of the relevant market is the basic element for dilating upon the competition assessment of any sector. The 'relevant market' is defined in Section 2(k) of the Competition Act, 2010.[26] Accordingly, the relevant market must be determined with reference to the product as well as geographic market. The interchangeability and substitutability aspect of the products or service must also be dilated upon. Considering this, it can be argued that the services provided by large allopathic private hospitals can not be substituted with those of homeopathic or one room clinic. Similarly, the services provided by homeopathic and unani hakeems are not interchangeable in many aspects to the services provided by medical units having surgery and transplant facilities. For the purposes of this Report, we have narrowed down the 'relevant market' to include only the private hospitals and clinics. Therefore, the Report does not cover the healthcares provided by hakeems and unani, etc.

[26] According to the Act, the "relevant market" means the market which shall be determined by the Commission with reference to a product market and a geographic market and a product market comprises all those products or services which are regarded as interchangeable or substitutable by the consumers by reason of the products' characteristics, prices and intended uses. A geographic market comprises the area in which the undertakings concerned are involved in the supply of products or services and in which the conditions of competition are sufficiently homogeneous and which can be distinguished from neighboring geographic areas because, in particular, the conditions of competition are appreciably different in those' areas.

Finally, the study presents a competition analysis within the private healthcare sector, but does not directly compare it with public healthcare.

1.7 Scheme of the Study

This study is divided into six chapters. After the introduction, the second chapter explores key features of public and private healthcare. In addition to discussing functional dimensions, the section evaluates the nature and structure of the private health sector.

The third section deliberates upon the regulatory mechanism including the relevant policies, laws and regulations. Moreover, the role of governing bodies and institutions is elaborated along with their implications for competition in the sector.

The fourth section addresses the private sector's efficiency and costs of private healthcare, based on the survey findings.

Section five provides an analysis of the state of competition in private healthcare. It addresses issues regarding the consumers' freedom to choose, entry barriers, anti-competitive conduct, and the effect of competition on the cost and efficiency of the private healthcare market. The final section provides an overview of the major challenges and issues, which is followed by recommendations for improvement.

Section 2 – Health Sector Overview

To better understand the business environment within which the private health sector operates, it is essential to review the mechanism of health service provision. The healthcare system consists of several streams of services (*allopathic, homeopathic, unani, vedic, etc*.). However, for the purpose of this study, Pakistan's health sector is categorized into two broad categories, i.e. public and private. A review of the overall healthcare system is covered in the paragraphs that follow.

2.1 Public Health Sector

The public health delivery system functions as an integrated health complex that is administratively managed at the district level. Health service delivery is primarily a provincial matter, while the federal government plays a supportive and coordinating role. The Federal Ministry of Health is mandated with policy making, coordination, technical assistance, training and seeking foreign assistance. It also has a number of vertical public health programs, such as programmers for immunization, family planning & primary healthcare, the National Tuberculosis Control Program, the National Aids Control Program, etc. Though these are funded by the Federal Government, their implementation is carried out at the provincial and district levels. In 2005-06, the health facilities at the federal level included 7 hospitals, 39 dispensaries, 1 tuberculosis (TB) clinic, 4 Maternal and Child Health (MCH) Centres, 3 Rural Health Centres (RHCs), and 14 Basic Health Units (BHUs).[27] In 2010-11, the number of hospitals and MCH increased to 12 and 5, respectively. There is considerable addition in the number of dispensaries that increased to 75.[28]

[27] Government of Pakistan, Federal Bureau of Statistics, *National Health Accounts*, 2005-2006.

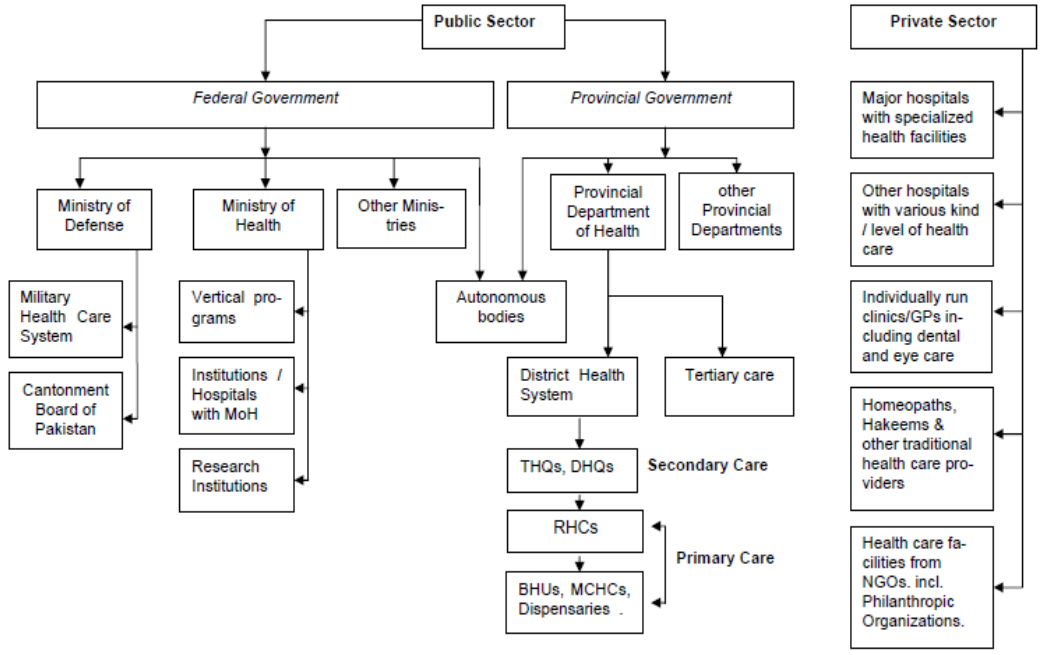
[28] '*Year Book- 2011*', Federal Bureau of Statistics, available at: http://www.statpak.gov.pk/fbs/sites/default/files/other/yearbook2011/Health/10-1.pdf

At the provincial level, healthcare provision is divided into primary, secondary and tertiary healthcare categories. Primary healthcare is implemented through BHUs, RHCs, MCHCs and Dispensaries. A BHU caters to a population of 10,000 to 15,000. 5 - 10 BHUs are attached to an RHC. An RHC mainly provides preventive and health promotion services such as maternal and child health services, immunization, diarrheal disease control, malaria control, child spacing, mental health, school health services, prevention & control of locally endemic diseases, and provision of essential drugs. RHCs cater to a population of 25,000 to 50,000. They also provide preventive and health promotion services. In addition, RHCs also provide curative services for common illnesses. MCHCs are part of the integrated health system focusing on the maternal and child health.[29]

Secondary healthcare includes first and second level referral facilities providing acute, ambulatory and inpatient care provided through Tehsil Headquarter Hospitals (THQs), and District Headquarter Hospitals (DHQs). Primary and secondary healthcare constitutes the District Health System. A typical THQ caters to a population of 100,000 to 300,000 while a DHQ serves a population of 1-2 million. Tertiary health care is provided through major hospitals with specialized facilities which are under the administrative jurisdiction of the provinces.[30] Figure 2.1 provides an overview of the healthcare system in the country. At the Federal level the Ministry of Health was devolved to the provinces on June 30, 2011. However, it was re-established in 2013.

[29] For details see *'Health System Profile of Pakistan'* Regional Health System Observatory, WHO, 2007. Available at: http://gis.emro.who.int/HealthSystemObservatory/PDF/Pakistan/Full%20Profile.pdf
[30] *Ibid*.

Figure 2.1: Overview of the Healthcare System of Pakistan[31]



2.2 Private Health Sector

The private health sector includes profit based healthcare enterprises and non-profit health facilities run by philanthropic organizations (mostly NGOs) that are outside the domain of the public sector. It comprises a number of private healthcare facilities operating in the market, which vary from one-person clinics to multi-specialty medium OPD facilities and to hospitals with in-patient facilities. The market also comprises hakeems / tabibs, lady health visitors, midwives, nurses, paramedical staff and unqualified health professionals who provide health services at facilities such as maternity homes, clinics, diagnostic health facilities and pharmacies. A fair degree of overlap or duplicity exists between public and private sectors as it is a routine practice for a public sector medical practitioner to offer his/her services in the public sector as well as run his/her own private clinic. The private health sector service delivery mechanism is, therefore, multifaceted and is characterized by numerous types of health service providers, varying ownership patterns and different types of medical treatments. They can be loosely categorized as follows:

[31] *Ibid.*

a) Hospitals with specialized health services.

b) Hospitals with tertiary healthcare.

c) Small & medium sized hospitals with variable quality/level of services.

d) Sole proprietorship or individually run private clinics/general practitioners including dental and eye care.

e) Partnership-based or mutually run private clinics.

f) Trusts and companies incorporated under the Companies Ordinance.

g) Homeopaths, hakeems, tabibs and other traditional health providers.

h) Healthcare facilities operated by NGOs including the philanthropic organizations.

i) Ambulatory healthcare services.

The organizational models of the majority of private sector hospitals are sole-proprietorship or partnership-based, as there are no constraints involved in establishing a private health clinic other than the investment capability of the owner. The financial constraints faced by the owner and the cost of medical technology determine the cost and quality of services provided. An absence of appropriate regulation is a crucial factor in this regard, which is discussed in detail in subsequent sections of the study.

Table 2.1: Number of Public and Private Health Facilities by Type[32]

Type	Public Sector	Private Sector
Tertiary care hospitals	56	8
DHQs	116	-
Small & Medium sized hospitals	850	692
BHUs	5290	-
RHCs	552	-
Total No. of available beds	98,684	20,000
Total private health-care institutions		73,650
Partnership based private clinics	-	1271
Sole proprietorship private clinics	-	71,106
Trusts hospitals/operated by NGOs	-	581
Maternity care centers	907	-
Tuberculosis clinics	289	-

[32] *Ibid.*

The National Health Accounts data in Table 2.2 shows that the private health sector has emerged as a major healthcare service provider, especially for secondary and tertiary level health services.[33]

Table 2.2: Types of Healthcare Expenditures

Type	**2005-06*** (Rs in million)	**2007-08** (Rs in million)	**Percentage change**
Federal Govt.	23,816	27,664	16
Provincial Govt.	19,007	27,757	46
District/Tehsil Govt.	14,215	23,547	66
Social Security Funds	2,839**	3,259	15
Autonomous Bodies/Corporation	1,450***	1,725	19
Private health insurance	285**	523	84
Private households' OOP payment	177,010**	220,508	25
Local NGO's	15,919***	19,023	19
Official donor agencies	3,565	9,626	170
Total health expenditures	**258,106****	**333,632**	29^

Notes:

*Current prices, **Revised, ***Estimated
^According to the NHA, the inflation adjusted change was 8%.

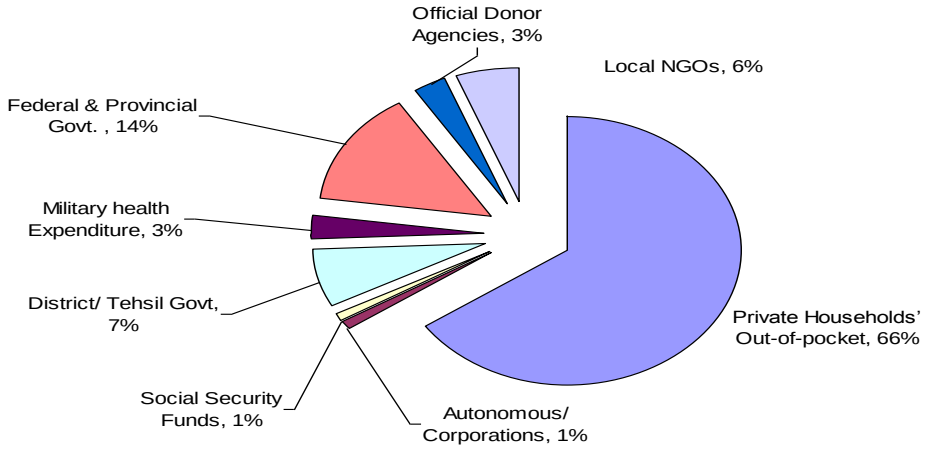
Source: NHA, 2007-08, Pakistan Bureau of Statistics[34]

Figure 2.2 shows the shares of various financing agents in the total health expenditure.

Figure 2.2: Healthcare Financing in Pakistan: 2007-08

[33] NHA 2005-06 and 2007-08. For detailed information on healthcare expenditure from 1996 to 2005, see: http://www.who.int/nha/country/PAK.pdf

[34] National Health Accounts, 2007-08. Available at: http://www.pbs.gov.pk/sites/default/files/national_accounts/national%20health%20accounts/National_Health_Account_2007-08.pdf



Source: NHA, 2007-08, Pakistan Bureau of Statistics[35]

2.2.1 Salient Features of the Private Health Sector Market

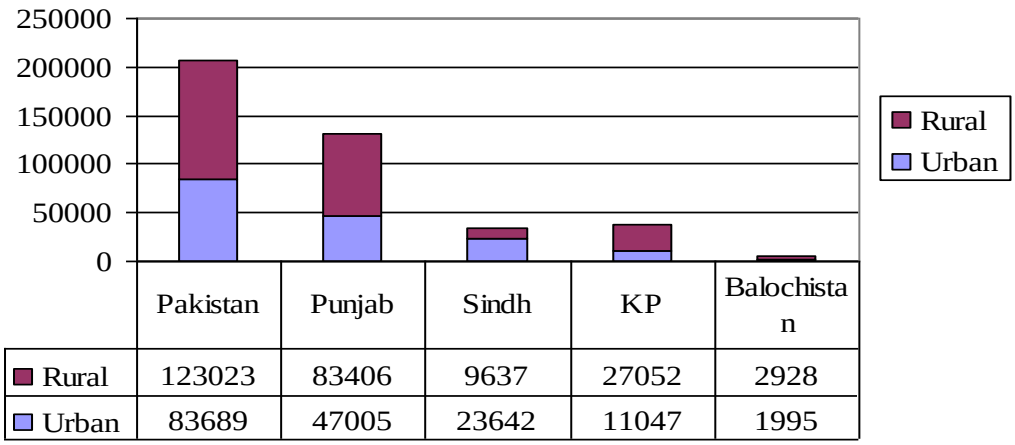
The private health sector is a major healthcare service provider, especially for the secondary and tertiary level services in Pakistan. This section examines the structure of the private health sector market, revealing the nature and roles of market actors like healthcare buyers & suppliers. The analysis shall also help assess the respective market power of buyers and sellers of private health services.

2.2.1.1. ***Market Structure:*** As explained above, private health sector's supply side generally consists of clinics with individual registered medical practitioners (mainly related with medical consultation/check-up) and hospitals which offer a wide range of services (consultation, general, surgical or specialized treatment, etc.). The demand side consists of a diverse range of buyers belonging to various income groups.

The market for private healthcare services is unevenly distributed across four provinces, with Punjab having the highest number of private service providers. The urban/rural comparison shows that more private services are available in the rural areas as compared to urban areas, both at the national and provincial levels.

Figure 2.3: Private Healthcare Providers: 2009-10

[35] *Ibid.*



	Pakistan	Punjab	Sindh	KP	Balochistan
Rural	123023	83406	9637	27052	2928
Urban	83689	47005	23642	11047	1995

2.2.1.2.***Market Shares:*** From Table 2.3, it appears that the share of 'Out-patient services' is comparatively higher than the 'Hospitals' and 'Laboratories and diagnostics'. The NHA estimated that there were 125 big hospitals and 4255 small hospitals in Pakistan in 2009-10. The number of small and big hospitals is the highest in Punjab, followed by Sindh, KPK and Balochistan.

Table 2.3: Area Distribution of Private Healthcare Services by Type & Size: 2009-10

(Numbers)

Area	Hospitals			Outpatient Service Providers	Laboratory & Diagnostic Service Provides	Total
	Big ≥50 beds	Small <50 beds	Total			
Pakistan	125	4255	4380	196843	5489	206712
Punjab	66	2610	2676	125171	2564	130411
Sindh	46	1018	1064	30742	1473	33279
KPK	11	568	579	36205	1315	38099
Balochistan	2	59	61	4725	137	4923

In any sector, the relative market power of different actors can be assessed through analyzing their respective market shares. Increased market power confers an incumbent market player or a group of market players with the ability to exploit its position through practices that limit a competitive environment. We observe that market shares for basic medical consultation

and general treatment are dynamic because a large number of suppliers operate in various segments at the same time. However, the supply of specialized treatment, such as cancer, kidney/liver transplant, heart diseases, radiology, etc., generally shows stable market shares with an expanding demand. Looking at this potential as an opportunity, brisk entry by new health service enterprises has been witnessed during the last few years.

2.2.1.3. ***Market Entry*:** There has been significant growth in the supply and demand for private health services. Representatives of regulatory bodies as well as the executives of healthcare enterprises substantiated the fact that there are no visible entry barriers in the private health market.[36] This also suggests prevalence of low intensity of predatory response from incumbent health service providers to the new entrants. This market characteristic supports our initial findings of low market concentration in the private health market, thus reducing the chances of abuse of dominance. National level data covered in the following Table shows that the share of private sector is more than 70% in the total health consultations in the country:[37]

Table 2.4: Private Sector Health Consultations (%)

	Total	**Urban**	**Rural**
Pakistan	70.71	77.5	67.2
Punjab	73.64	74.6	73.2
Sindh	77.92	85.8	69.1
KPK	49.92	50.1	49.8
Balochistan	57.0	71.9	50.5

Source: Pakistan Social and Living Standards Measurement Survey, 2010-11

[36] Key informant Interviews: DG Health, MoH, Islamabad and Dr. Zaheer, CEO, Shifa International Hospital Ltd., Islamabad.
[37] Pakistan Social and Living Standards Measurement Survey 2010-11.

A review of the key features of the private health care market shows expansion and new entry in the sector, along with a surge in the demand. There is no evidence of a predatory response towards new entrants by existing service providers.

Section 3 - Regulation of Private Health Sector: Review of International and National Regulatory Frameworks

As discussed in the foregoing sections, regulatory control in the private healthcare aims to control market entry, price and quality of products and services. A review of international practice informs that all developed, and a majority of the developing countries have some form of regulatory control over private health care providers.[38] We observe that the low and middle income countries tend to have weak legislation on private health providers, and there is generally poor demand for the regulation of the private health sector. The review also reveals that direct regulation of price is not common in developing countries due to a lack of reliable information on the private sector's costs. Most of the existing regulatory instruments are input oriented, such as registration of health facilities and licensing.

3.1 Regulatory Control: Cross Country Evidence

In the paragraphs that follow, we will look into various modes of regulations adopted by some countries to regulate the private sector healthcare provision.

3.1.1 The Regulatory Regime in India

The private health sector in India comprises general practitioners, nursing homes and hospitals. The medical professional has to be registered with the Medical Council, which is a statutory body that sets the standard of medical practice, disciplines the professionals, monitors their activities and checks any malpractices. The doctors who decide to set up their own clinics, hospitals, nursing homes, polyclinics, etc. have to register with the respective local body. At present the private health sector in India is regulated under two different authorities:

[38] Controls are also exercised on the production and distribution of drugs and medicines.

3.1.1.1 ***The Medical Council:*** The Medical Council of India and the respective State Councils have to regulate medical education and professional practice. Presently, beyond providing recognition to medical colleges, the Medical Council does not concern itself with the practitioner, unless some complaint is made and a prima facie case established. The national body at present concerns itself with only recognizing and de-recognizing medical colleges, whereas the state bodies function only as registrars for issuing a license for practicing medicine.

3.1.1.2 ***The Local Bodies*** (Municipalities, Zilla Parishads, Panchayat, Samitis, etc.) have the authority to provide a license to set up a nursing home or hospital, and regulate its functions. However, besides providing the certificate to set up a hospital or nursing home, the local bodies do not perform any other function, in spite of provision in the Act.

3.1.2 The Regulatory Regime in Bangladesh

In the case of Bangladesh, the 1982 Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance (No. IV), 1982, defines the main elements of the regulatory framework regarding the private provision of healthcare services. This Ordinance specifies that no person shall establish a private clinic without a license from the Ministry of Health and Family Welfare. The stipulated conditions are predominantly input-based, with no mention or scope for monitoring the actual quality of clinical care provided. The Directorate of Health Services of the Ministry of Health and Family Welfare is responsible for overseeing private health services.

3.1.3 The Regulatory Regime: The Case of United States

Self-regulation is rooted in the belief that governmental 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.

Accreditation of healthcare facilities and hospitals in particular has long been the norm in high-income countries. The U.S. Joint Commission on Accreditation of Hospitals was established in 1950, and in 1988 it was renamed the Joint Commission on Accreditation of Health Care Organizations (JCAHO). It is the first and largest accreditation program in the world, and is often cited as the prototype of self-regulated accreditation systems in the health care industry. As a model of self-regulation, the processes of defining and monitoring standards remain independent, and participation by hospitals is voluntary. However, several federal and state regulations follow the JCAHO standards, and allocation of public funds and other government decisions have become increasingly tied to accreditation. As a result, JCAHO accreditation has become an effective part of the public regulatory system.

3.2 Regulation of the Health Sector in Pakistan: Review of Health Laws, Policies and Regulations

Health governance plays a key role in ensuring provision of equitable healthcare. Moreover, access to healthcare is a constitutionally guaranteed right. The requirements of health and well-being necessitate presence of appropriate regulatory and legislative mechanisms. Regulation of private health facilities by the government is pertinent in ensuring access of consumers to quality and efficient healthcare services. Ideally, a regulatory framework should cover the authorization for establishment of private health facilities, establishment of minimum standards and oversight of the provision of standardized services. The present state of competition in the private healthcare market highlights a weak regulatory framework to meet these governance objectives. The following sub sections present a review of existing laws, policies and institutions for the regulation of private healthcare.

3.2.1 Legal and Policy Framework

Until recently, the Ministry of Health has remained responsible for the formation of policy guidelines at the federal level. The role of provincial tiers includes formulation of policy for their respective territories, implementation and monitoring of the policy objectives. The policy objectives at the national or provincial level are based only on the

provision of primary healthcare to the masses. There is no defined strategy for equitable provision of health services. There exist huge regulatory gaps regarding the cost and quality of private healthcare, such as a lack of effective regulation involving quality-based criteria of setting up new health enterprises. More importantly, relevant laws and regulations do not address business malpractices in the private healthcare market.

3.2.2 Key Institutions and Instruments

In order to identify gaps in various regulatory instruments, this section will cover an overview of various laws and regulations at the national level. The key legal and policy instruments examined include:

1. National Health Policy 2009
2. Pakistan Medical and Dental Council Ordinance 1962
3. Medical and Dental Degrees Ordinance 1982
4. Control of Narcotic Substances Act 1997
5. Drug Regulatory Act 2006
6. Drug Rules 1986
7. Drugs Act 1976
8. Pharmacy Act 1967
9. Allopathic System Ordinance 1962
10. Allopathic System (Prevention of Misuse) Ordinance 1962
11. Unani, Ayurvedic and Homeopathic Systems of Medicine Rules of 1965
12. Pakistan Nursing Council Act (1952, 1973).

3.2.2.1. National Health Policy

National Health Policy 2009 is a document that identifies objectives of health governance in Pakistan. Significantly, the document identifies an unregulated private health sector as a major issue and challenge for health policy makers:

> *"lack of effective implementation of regulations particularly in a large unregulated private sector are some of the factors having an adverse impact on the performance of the health sector"*[39]

While necessitating the adoption of appropriate health technologies for the delivery of quality services, the document highlights the requirement for

[39] Government of Pakistan, Ministry of Health, *National Health Policy* 2009, p.06

regulations for effective implementation of the same in the private health sector.[40] Despite identifying the challenge of regulation of the mushrooming unregulated private health sector, the policy fails to identify any course of action to achieve the stated objectives. There is a need to understand the importance of the private health sector and the manner in which it can be used to address health issues in Pakistan. NHP needs to provide a set of cogent policy actions, such as proposing quality standards for the health enterprise as well as the services they offer.

As an important strategic component for the implementation of the National Health Policy 2001, a National Health Policy Unit (NHPU) was also established. The mandate of NHPU included evaluation of the private health sector and its expansion in terms of infrastructure, human resources and finances. The evaluation was aimed at the preparation of a regulatory framework for the private sector. It was envisaged that a study shall be commissioned for this purpose. However, the study has yet to be completed.[41]

3.2.2.2. Pakistan Medical and Dental Council (PMDC)

The PMDC is a statutory regulatory and registration authority for medical and dental education practitioners. This organization was constituted under the Pakistan Medical and Dental Council Ordinance, 1962. The key objective to establish PMDC was to safeguard public interest, by establishing uniform minimum standards for basic and higher qualifications in medicine and dentistry throughout Pakistan.[42] To ensure that medical and dental institutions in the country follow the regulations of the council, it inspects the colleges periodically. Colleges recognized by the Council, are inspected after every five years to ensure

[40] *Ibid*. pp13-14
[41] Health system profile: Pakistan, Regional Health System Observatory, available at: http://gis.emro.who.int/HealthSystemObservatory/PDF/Pakistan/Governance%20and%20oversight.pdf
[42] The composition of the Council includes members from the National Assembly, representatives of provincial governments, universities, registered medical practitioners, members nominated by the Federal Government, of whom at least one is a member of the Armed Forces Medical Services, registered dentists, teaching staff from medical and dental institutions, a member from the legal profession, nominated by the Chief Justice of Pakistan; and the Director General of Health, Government of Pakistan Ex-Officio. The members of the Council from amongst its members elect the president and vice president. PMDC website available at: http://www.pmdc.org.pk/AboutUs/tabid/72/Default.aspx

maintenance of standards on the basis of which recognition was granted. For private healthcare providers, the Council also prescribes the code of medical ethics for the registered medical practitioners in order to ensure ethical practices and prevention of professional negligence.[43] Though, the Council can take cognizance of individual practitioners when a complaint is lodged against them, no formal procedure for oversight or provision of remedy is available for the consumer against malpractice by private health facilities. There are no regulatory requirements ensuring quality standards while setting up a private healthcare enterprise, so any medical practitioner registered with the PMDC can start a healthcare business. The situation calls for a revision of the role of PMDC, with reference to its licensing and monitoring mandate.[44]

3.2.2.3. Pakistan Nursing Council Act (1952, 1973)[45]

The Pakistan Nursing Council was set up as an autonomous regulatory body, constituted under the Pakistan Nursing Council Act of 1952. It is empowered to register (license) nurses, lady health visitors, midwives and graduates of public health schools and to issue diplomas. The PNC also inspects schools of nursing, midwifery and public health. In addition to playing a key regulatory role regarding nursing education and training, PNC also issues licenses to practice. The Council is mandated to ensure standards of education and practice. The Council also prescribes penalties for fraudulent registration by intention of pretense, and has the authority to remove the person from practice for professional misconduct.

3.2.2.4. Unani, Ayurvedic and Homeopathic Systems of Medicine Rules of 1965

This traditional form of medicine has been accepted and integrated into the national health system in Pakistan. The Unani, Ayurvedic and Homeopathic System of Medicine Rules of 1965 govern the education and practice of alternate

[43] *Ibid.*
[44] PMDC would of course require a capacity – both in terms of human and financial resources - commensurate with the assigned task.
[45] Health Systems Profile- Pakistan Regional Health Systems Observatory- EMRO 49.

medicine in Pakistan. There is a National Council for Tibb and the Ministry of Health, through this Council, oversees the qualification of practitioners. Pakistan's unani teaching institutions are recognized by the Government, and are under the direct control of the NCT, which is responsible for maintaining standards of education in recognized teaching institutions, revising/modifying syllabi, and conducting annual examinations.

3.3 Provincial Health Sector

At the provincial level, the control and administration of the health system has three tiers: the department, the secretariat and the directorate. The Minister for Health is in charge of the health department in the province. He/she submits important cases to the chief minister/governor and keeps them informed of significant developments. Secretary, Health has the overall charge and is responsible for implementation of national policies at the provincial level. The Directorate General of Health Services liaises with all district health offices in the province.

3.3.1. ***Regulation of Health Sector at District Level:*** At the division level, the Director, Health Services, assisted by an Additional Director, Health Services, heads the divisional health management team. This team is responsible for the supervision of secondary care at DHQ and THQ Hospitals, through medical superintendents, and primary healthcare through district health officers. A District Health Officer (DHO) heads the district's health management. He/she is assisted by a number of officers, including a District Superintendent-Vaccination (DSV); District Sanitary Inspector (DSI); Communicable Disease Control Officer (CDCO); District Inspector Health Centers (DIHC); District Drug Inspector; Assistant Entomologist (AE); and a Deputy District Health Officer (DDHO) at Tehsil Headquarters. This team is responsible for supervising primary healthcare, including outreach services and the National Program for Family Planning and Primary Health Care.

3.3.2. ***Regulation of Health Sector: Post 18th Amendment Scenario:*** Prior to the enactment of 18th Constitutional Amendment Act, 2010, the Health Sector was already in the

provincial domain.[46] However, at the federal level, the MoH was performing the policy formulation role. The MoH was devolved as a result of the constitutional changes, and the scenario in the context of regulation of the private health facilities at the policy level needs attention of provincial policy makers.

3.4. Present Regulatory Framework: Issues & Gaps

The lack of appropriate regulations and implementation infrastructure makes it easier for the private sector to indulge in anticompetitive practices, such as deceptive marketing. The inferior standard of medical practice by quacks, '*atai'* and unqualified doctors are instances of deception.[47] In addition to this, the prevalence of low quality and high cost of services is also observed.[48] We find that the government bodies have weak authority, poor procedures and inadequate capacity for regulation of quality of private healthcare. In this regard, we have identified the following key challenges:

i. The National Health Policy fails to articulate a 'standards' framework for the private healthcare sector in Pakistan.
ii. The National Health Policy is deficient in providing clear directions for specific policy action as well as institutional actions for the maintenance of quality standards of healthcare services, to be provided to masses by both the public and private health sectors.
iii. The statutory role of the PMDC leaves a vacuum for the authority to issue licenses for the establishment and operation of private healthcare facility.

[46] There are certain legislations at the provincial level, for instance North-West Frontier Province Medical and Health-Institutions and Regulation of Health-Care Services Ordinance, 2002, and the Punjab Healthcare Commission Act 2010. It is worth noting that the Act covers grading of healthcare facilities. However, the Commission has yet to start functioning; therefore it will take time to evaluate its usefulness.
[47] See for instance, http://globalgeopolitics.net/wordpress/2011/02/28/pakistan-injecting-disease-with-medicine/
[48] Another related issue is that of substandard and spurious pharmaceuticals, according to a study by Sania Nishtar (The Gateway Paper; *Health Systems in Pakistan- a way forwards*, Pakistan Health Policy Forum and Heart file, Islamabad 2006, pp:128), counterfeit medicines constitute between 40 and 50 per cent of total supply in Pakistan. This view is shared by others also, see: http://www.dailytimes.com.pk/default.asp?page=2006%5C03%5C09%5Cstory_9-3-2006_pg7_60.

iv. The role of health regulatory agencies at the provincial as well as district level is visibly weak vis-à-vis the private healthcare market.[49]

v. There is a need to make the institutional governance within the health sector more responsive towards consumer concerns regarding exploitation. For this purpose, separate guidelines need to be formulated for sole proprietors and corporate entities.

In the past, two of the four provincial governments— KPK and Balochistan - initiated regulation in the health sector by establishing health regulatory authorities, but both authorities did not perform their mandated roles effectively.[50] With devolution of the Ministry of Health to the provinces, the above mentioned gaps will need to be addressed by the provinces. Despite an increasing role for the provincial governments, health experts identified certain areas where federal government has to perform necessary functions at the national level. These include the development of national health policy, trade in health, health information, health research, health regulation and international commitments.[51]

[49] During the interview, a district health officer stated that, in case, the district health authorities have to take an action against a private facility, they prefer to take along the *Drug Inspector*. His presence is to threaten them of fine and closure of their pharmacies, as the provincial and district health authorities have "no teeth to bite". This statement is clearly indicative of the absence of a resolute framework for regulation of the private market.

[50] Op. cit., Nishtar, S. 2010.

[51] http://www.heartfile.org/pdf/HEALTH_18AM_FINAL.pdf

Section 4 – The Cost & Efficiency of the Private Health Sector

In Pakistan, the majority of the population (more than 70%) makes 'out of pocket' expenditures on healthcare in a system where public and private services are available in parallel. Private healthcare has a majority share in terms of expenditure. The high cost of private healthcare services is one of the most frequently raised concerns. Increased competition generally tends to bring down or stabilize the prices of goods and services, in addition to improving quality. With growth in private healthcare services, it was expected that the cost and quality of services would also respond to the dynamics of competition. Contrary to this perception, the trend in fees for services, as well as, the prices of linked facilities have shown an increase.

In this section, we use empirical evidence gathered through field surveys and interview with key stakeholders, to look into the cost of private healthcare services. The study aims to ascertain if the services being offered justify the prices being charged, and how these prices affect consumers' choice. Finally, the effect of increased competition on the cost of services will be explored.

4.1 Cost Determination and Increase in Fee

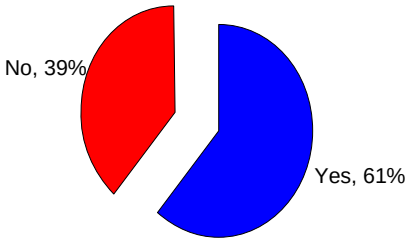
It is important to determine the mechanism through which private healthcare providers, consultant clinics and hospitals determine price to be charged for an assortment of services they offer, such as consultation, procedures, nursing, pre and post-operative care, medicine, diagnostics, etc. In a competitive market, the prices of goods and services are determined through balancing supply and demand.

The private healthcare market in Pakistan seems to be operating without any standards for cost determination. No regulatory mechanisms are in place that can determine certain set of quality standards relative to their cost. Procedures for determination of the cost of services are largely arbitrary. The main variables that influence cost are the experience and the reputation of the doctor, the number and claimed quality of services being offered, the area of operation of the facility, the availability of qualified

doctors associated with the healthcare facility as well as available diagnostic equipment. During the course of the survey, it was found that private health enterprises use deceptive marketing tactics and inadequate information to exploit consumers to attain their business objectives. The sector is prone to crucial information asymmetries. Generally, a health facility's advertisement campaigns cover cost side marketing issues, such as the level of experience/repute of consultants, availability of equipment & techniques, and associated services. However, important information is often kept hidden from the buyers. The most prominent exploitation of buyer's lack of information is over-treatment, unnecessary medical tests, etc., which is found to be a common practice.

In this context, the first presumption to be tested was whether private health care providers are frequently unnecessarily increasing their fees. A vast majority of the patients and their attendants (61%) agreed that the private healthcare bills rise frequently. This view is supported by the NHA results that show a high incidence of 'medicare' inflation. [52] The private health service providers, when inquired about this perception, were of the view that quality health services are not cheap and that costs increase on account of inflation. On the other hand, regulators were of the view that there is a visible rise in the cost of services, but expressed their inability to check it, owing to the lack of any provision in the law to tackle such increases in cost.

Figure 4.1: Is the fee of private hospitals increasing frequently?



[52] NHA provides deflated estimates on the basis of Consumer Price Index computed for 29 health products e.g. as doctors' fee, laboratory tests, etc., categorized as 'Medicare'. CPI for 'Medicare' for 2009-10 and 2007-08 was 157.02 and 132.23, respectively, resulting in a price increase of about 19% within two years.

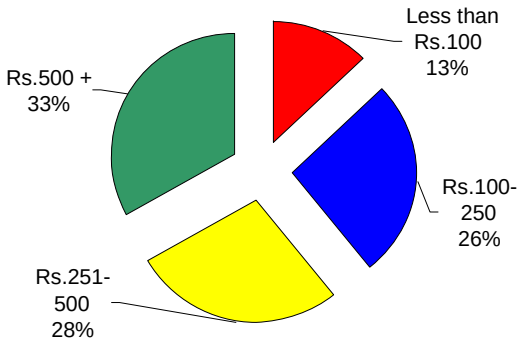
4.2 Cost of Different Types of Private Health Care Facilities

There are multiple categories of healthcare service providers. Some doctors operate in their private clinics, while some private enterprises have a number of consultants on their roll. In certain cases, registration fees are charged, in addition to consultation fees; these are dealt separately in this Section.

4.2.1. ***Consultation Fees:*** Varying quality of private health services are available, depending upon the geographical area and field of expertise. The results show that a majority of patients (69%) pay a consultation fee in the range of Rs. 250 to 500. Cheaper service, ranging from Rs. 100 to Rs. 250 is also available. Of the total respondents from urban areas, a majority (68%) reported paying consultation fees in the range of Rs. 250 to 500, while the remaining reported paying Rs. 1000. The cost of service is lower in the rural areas; a majority of the respondents (70%) reported paying fees between Rs. 100 and Rs. 250. Price setting seems to follow the 'ability to pay' principle.

4.2.2. ***Registration Fee:*** In addition to the doctor's fee, a number of private healthcare providers also charge a registration fee. Most of the owners and managers of private healthcare facilities denied that such a fee was being charged. However, a sizeable proportion of the respondents (40%) claimed to have paid a registration fee in addition to the consultant's fee. The following chart shows the fees paid as reported by respondents.

Figure 4.2: Amount of Registration Fee



4.3 Quality of Services vis-à-vis the Cost of the Services

As discussed earlier, effective competition tends to ensure consumers' access to high quality services and products. Though the quality of private sector services is often questioned but our survey shows majority of the respondents (75%) being fairly satisfied with the quality of services, for the cost incurred. This indicates an improved quality of services being available to the consumers in the market.

Table 4.1: Consumers' Satisfaction and Quality of Service (%)

Level of Satisfaction	Quality of Services					
	very unsatisfactory	Unsatisfactory	Undecided	Satisfactory	very Satisfactory	Total
Highly unsatisfactory	0.20	0.40	0.80	1.80	0.40	3.60
Unsatisfactory	0.40		1.40	2.80	1.00	5.60
Undecided	0.40		1.40	10.20	3.20	15.20
Satisfactory	0.20		0.80	44.40	15.80	61.20
Highly Satisfactory			0.20	3.80	10.40	14.40
Total	1.20	0.40	4.60	63.00	30.80	100

4.4 Effect of Cost on Consumer Choice

Theory suggests that a rise in the cost tends to decrease the demand and consumption of services. At the same time, consumers of that service look for alternative options to fulfill their demand. However, we have observed that more consumers make their decision on the basis of the quality of service rather than the cost of the service. Still, about 17% of the total respondents cited cost of the available services as one of the key factors for their choice. This suggests that the demand for healthcare is relatively inelastic.

4.5 Effect of Competition on the Cost and Efficiency of Services

4.5.1 ***Effect on Cost:*** The present state of competition in the private healthcare sector seems to have a negligible impact on the cost of services. Most of the respondents interviewed (78%) were of the view that costs have not decreased. According to managers of private healthcare enterprises, cost has not decreased due to a lack of

competition between health facilities. Provision of quality healthcare services can be termed as a stand-alone initiative. The effects on cost may become visible when facilities providing the same quality increase in number, thus reducing the supply-demand gap.

4.5.2 ***Effect on Efficiency:*** Competition, in general, tends to increase efficiency of a market. Therefore, there will be a positive effect on efficiency if intense competition prevails among private healthcare enterprises. During the survey, a majority of the respondents (61%) agreed that expansion in private healthcare has resulted in more efficient services.

Section 5 - State of Competition in the Private Health Sector

As elaborated earlier, the private health sector has grown rapidly over the last few decades for a variety of reasons. Besides other expected outcomes of this growth, it was presumed to spur a competitive environment, resulting in the availability of cost-effective and efficient services to consumers. However, consumers are of the view that growth of the private health sector has fallen short of providing low cost services to consumers. This perception is coupled with indications of anti-competitive practices in the private healthcare market. As discussed in the forgoing section, an increase in competition seems to have failed to reduce the cost of services, though efficiency of the sector appears to have increased. These findings suggest the need for an analysis of the state of competition on the basis of empirical evidence generated from the service delivery survey and key informant interviews. Such an analysis shall help identify reasons for the lack of reduction in costs, and possible occurrence of anti-competitive practices.

5.1 Competition in a Growing Market: Availability, Choice & Freedom to Shift

Private healthcare witnessed a significant upward shift with the entry of a large number of enterprises, but the sector has yet to meet the ever-growing demand for quality health services. The increasing number of private healthcare providers has led to the emergence of a relatively more competitive environment.

5.1.1. ***Growth in the Market:*** The rapid growth of private health facilities is well established by the available statistics.[53] Around 77% of the population has access to healthcare services from the private health sector, and only 23% use services from the public sector in Pakistan. There were 965 hospitals operating in the public health sector in 2006-2007, with the exception of RHUs/BHUs. At the same time, there were 1,271 partnership-based private clinics, 1,252 private limited companies and 71,108 sole proprietorship clinics in the private health sector.[54] The expansion of private healthcare was substantiated by respondents of

[53] See for instance: http://www.statpak.gov.pk/fbs/content/pakistan-social-and-living-standards-measurement-survey-pslm-2010-11-provincial-district-0

[54] National Health Accounts 2005-06.

the service delivery survey, as they indicated (90%) that the number of private health facilities has increased considerably.

5.1.2. ***Choice Factor:*** Enhanced choice is an outcome of an increased number of suppliers of the same service. Availability of choices of the same quality and corresponding costs stimulate competition. The increase in the number of health service providers in the private health sector has resulted in the availability of options to consumers.

5.1.2.1. Availability of Choice: The patients and their attendants were inquired about the availability of other medical facilities in the private sector, from which they are able to choose. The results indicate availability of multiple options. 84% of the respondents reported having a choice of different healthcare facilities.

Table 5.1: Availability of Choice (Percentage)

Area	Yes	No	Total
Urban	68.74	12.42	81.16
Rural	14.91	3.93	18.84
Total	83.64	16.36	100

5.1.2.2. Quantum of the Availability of Choice: The availability of multiple choices was also quantified. The results indicate that in urban as well as in rural areas, 37% of the respondents reported having at least one additional option, 42% reported having 2 or more choices, and 16% reported having three or more options. The results are indicative of not only the growth, but also the availability of choice to consumers. Consumers select a specific clinic or hospital with knowledge of the other options available in the area.

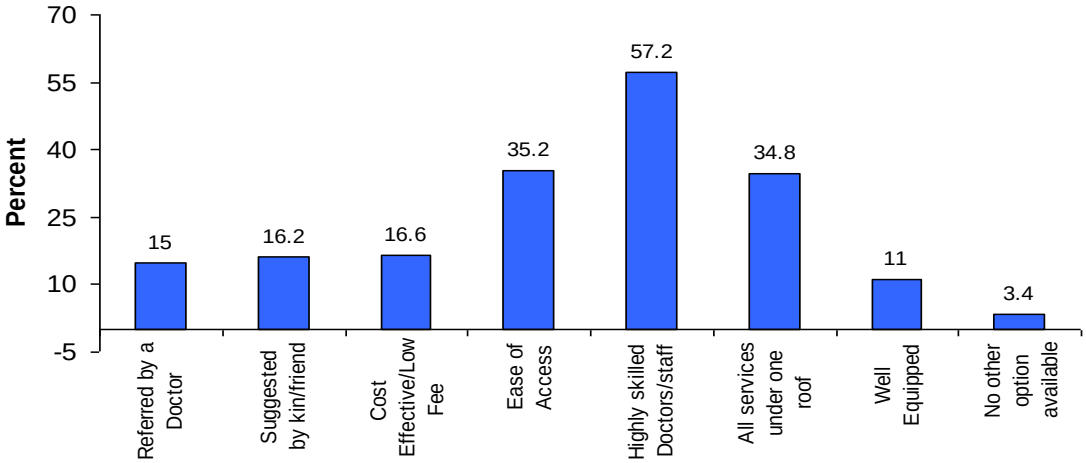
Table 5.2: Quantum of Choice (Percentage)

No. of hospital/Clinics	Urban	Rural	Total
1	27.72	9.65	37.38
2	34.65	7.18	41.83
3	15.59	0.74	16.34
4	3.71	0.25	3.96
5	0.50		0.50
Total	82.18	17.82	100

5.1.2.3. Choice Determinants: The study tried to identify and quantify the determinants of choice. What factors assist a consumer in choosing a particular hospital or clinic? From a list of reasons, respondents identified key reasons for choosing a particular hospital or a clinic. The foremost reasons cited include the skill of doctors, the ease of access and the availability of all necessary services at one location. More than half of the respondents (57%) reported selection of a particular health facility because of the availability of a skillful health professional. Ease of access to a specific health facility was another decisive factor, as 35% of the respondents mentioned this to be the main reason for their choice. The availability of all services at one location was an important reason for a sizeable proportion of respondents. Rather surprisingly, the cost of service remained a less important determinant of choice, as only 17% of the respondents identified it as being an important reason.

Our evaluation of the growth of the private health sector indicates that there are multiple choices available to the consumers but their decision making is largely influenced through marketing practices of the suppliers of health services. Choice is largely thwarted by the non-availability of objective information on the quality and cost of health services.

Figure 5.1: Choice Determinants for the Selection of Hospital



5.1.2.4. *Competition and Provision of Quality Services:* Consumers are major beneficiaries in competitive markets; they get benefits in the form of better services at relatively controlled costs. The present evaluation undertook efficiency analysis of the services provided by the private sector on the basis of consumer satisfaction and perception. The results indicate that a majority of the consumers are satisfied with the quality of services being provided by private healthcare enterprises. 76% of the respondents expressed an overall satisfaction with the quality of services. The efficiency indicators selected for the present survey included: the quality of treatment, availability of doctors, availability of support staff, attitude of doctor/staff, the condition of medical equipment, hygiene conditions, waiting room set-up, toilets and sanitation.

We found that the majority of the respondents were satisfied with all indicators. Table 5.3 depicts the relevant figures for these indicators.

Table 5.3: Quality of Service and Level of Satisfaction of Consumers (%)

Indicators	very unsatisfactory	Un satisfactory	Undecided	Satisfactory	Very Satisfactory	Total
Quality of Treatment	1.2	0.4	4.6	63	30.8	100
Availability of Doctors	1.2	0.8	5	66.4	26.6	100
Availability of supporting staff	1.8	2.4	8.4	67.8	19.6	100
Attitude of Doctor	0.6	0.6	2.2	58	38.6	100
Attitude of Staff	0.6	2.8	11.6	62.2	22.8	100
Condition of Medical Equipment	6.2	2.6	13.4	58.8	19	100
Medical Check-up Fee	3.6	5.6	15.2	61.2	14.4	100
Hygiene Conditions	1.4	2.4	11.4	69	15.8	100
Waiting Room Set-Up	1.2	4.4	14.2	66	14.2	100
Bath rooms Sanitation	10.4	3.6	17.4	59.2	9.4	100
Overall Satisfaction	0.8	0.4	6	76.2	16.6	100

5.2 Supplier Behaviour: Competition Concerns

As reported in the survey, there have been positive effects of growth in private health care. Despite this, the perceptions regarding anti-competitive behavior persist. The absence of objective regulation, as discussed in the report, accentuates the apprehensions

of consumers. Previous sections dealt with the changing features of the private healthcare market, such as a substantial increase in the number of private health providers and its corresponding effects on the quality and cost of private healthcare. The following section focuses on horizontal and vertical competition issues.

5.2.1. ***Anti-Competitive Conduct***: Multiple practices constitute anti-competitive conduct, such as abuse of dominance, cartelization and deceptive marketing.

5.2.1.1 *Abuse of Dominance and High Profitability*: Rapid expansion in private healthcare has resulted in the proliferation of private health clinics and hospitals. The perception of dominance and its subsequent abuse may be based upon market segmentation. In the private healthcare sector, the market is segmented based on socio-economic stratification, as well as areas of professional expertise. Prevalence of such a situation may allow facilities to dictate their terms, an issue that is explored in more detail later. In this study, we also looked into the health market with respect to the dominance of healthcare enterprises. In urban areas, there are a large number of private hospitals; hence establishing dominance is not straightforward for any particular hospital. Market shares are relatively unstable, as there is constant flux in the demand and supply of healthcare services. None of the regulators, consumers or hospital managers and owners complained about the existence of dominance. Private hospitals seem to have a large presence, yet these are unable to dominate the market. As a commercial practice, they attempt to maximize profits in several ways, some of which may attract the provisions of Competition Act, such as tying.[55]

There is a perception of high incidence of profitability in the private healthcare sector, and this partly explains the high rate of entry in the market. However, profitability for entities operating in the market remains on the higher side. Executives and doctors of different healthcare enterprises were of the view that there are large profit margins if quality is compromised. They suggest that if quality is assured, then profit margins shrink drastically. Profitability, on the one

[55] For details, see Section 5.4.

hand, directly corresponds to the quality and improvement of services. On the other hand, it reflects the failure of the market to coincide with the constantly increasing demand. As is evident from results of the survey, (Section 6.2) a majority of the consumers have acknowledged an improvement in the quality and efficiency of private health care services. The increasing profits are contingent upon a number of factors including: a failing public sector, the quality and diversity of services provided by private healthcare facilities, and improvement in the quality of diagnostics. From the perspective of competition law, high profits are not an anticompetitive concern. Nevertheless, excessive pricing, if proved to be a result of the abuse of a dominant position, is anticompetitive. Survey results indicate that high profitability is encouraging competition by promoting entry into the private health market. The financials of the health enterprises were not accessible to the survey teams; however for one of the hospitals that is functioning as a listed company, the profits after tax increased from 11.4 million in 2007 to 258.6 million in 2011.[56] Therefore, it is suggested to conduct an in-depth analysis to determine if the high profitability is a result of excessive pricing.

5.2.1.2 *Cartelization:* A significant number of consumers appear to be apprehensive regarding the formation of cartels by private healthcare facilities. However, during the course of the study, no such association of private hospitals was found to be operating. The Pakistan Medical Association (PMA) was found to play a negligible role in influencing the private health care suppliers. Some of the key informants, mostly representatives of regulatory bodies, are of the view that there seems to be collaboration in the consultation fee structure in sole-proprietorship clinics that provide specialist consultancy. Based on the incidence of this practice that varies from one facility to another, these views could not be confirmed. For instance, consultation fee of a dermatologist is around Rs. 1500 in Islamabad[57], whereas the service of similar quality is available at lower rates in Rawalpindi and surrounding districts.

[56] For details, see http://www.shifa.com.pk/finst/
[57] www.doctorfinder.pk/fee-analysis.aspx

From the competition law perspective, it needs mention here that the general and specialist associations can provide a forum to relevant professionals to collude. It could not be ascertained if the healthcare related associations are actually involved in anti-competitive practices, as is the case for several other sectors.[58] Nevertheless, it is advisable for the competition watchdog to be cautious about their role and activities. In the healthcare sector, besides PMA, some other associations are:[59]

- Pakistan Dental Association
- Pakistan Pediatric Association
- Pakistan Orthopaedic Association
- Pakistan Association of Plastic Surgeons
- Association of Pediatric Surgeons of Pakistan
- Pakistan Association of Urological Surgeon

The membership of these associations varies largely according to the strength of the profession.[60] According to the aims and objectives, these associations generally bring together relevant professionals for mutual interest, and to promote awareness and publicize specialized information.[61]

5.3 Barriers to Entry:

Market competition is affected by a number of barriers that include natural, strategic and regulatory barriers. The most relevant in the context of private healthcare sector are regulatory and policy barriers.

[58] The Competition Commission of Pakistan has identified anti-competitive conduct of several other associations in the sectors of banking, cement, sugar, poultry, jute, etc.

[59] The specialist professionals have also organized themselves in the form of societies, for instance in the fields of rheumatology, haematology, ophthalmological, gastroentology, physiology, surgery, cardiovascular & thoracic surgery. Pakistan Pediatric Association is also registered as a society under the Societies Registration Act, 1860.

[60] We found that over ninety per cent of the dentists in Pakistan are members of the Dental Association, which comes out to be about nine thousand. The Plastic Surgeons Association and the Association of Pediatric Surgeons have 53 and 165 members, respectively.

[61] For instance, the Pediatric Association is a body of all child specialists of Pakistan; it publishes material about the relevant field, available at: http://www.ppa.org.pk/PPJ.aspx. The Association of Pediatric Surgeons has its own journal, available at: http://www.apsp.edu.pk/journal.htm. Similarly other associations also have their journals and periodic publications.

5.3.1 *Regulatory Barriers to Entry*: Regulatory oversight, such as authorization to establish a private healthcare facility, setting of quality standards or output-based value of services does not exist. Instead of creating any barriers, lack of an appropriate regulatory framework tends to facilitate practices that are detrimental to consumers at large. There is a perception that it is not difficult to set up a private healthcare facility. The same was corroborated by the regulators as well as owners and managers of private health facilities.[62] Key informant interviews reveal that in order to establish a clinic or a hospital of any scale, an individual has to be a registered medical practitioner. The only other constraint involved is one's financial capacity.[63]

5.3.2. *Existence of State Owned Enterprises*: The presence of a large state-owned enterprise at times tends to distort competition. But in the case of health sector, the non-functional public sector has facilitated the growth of private healthcare. The findings of the survey confirm this fact, 76% of the respondents were of the view that private health care facilities are more efficient than the public ones.[64]

5.4 Deceptive Marketing & Incidence of Tying:

Anti-competitive practices, contrary to competitive norms, require evidence-based analysis. In view of the limited scope of the present study, it was not feasible to track and identify all such practices, especially deceptive marketing in the form of quackery. Major practices that were observed during the course of evaluation are discussed below:

5.4.1. *Charging of Registration Fees along with Consultation Fee*: A number of private hospitals in urban as well as rural areas charge an extra sum as registration fee. Of the total patients interviewed, 40% had to pay a registration fee prior to medical checkup. For those who paid, registration charges ranged from Rs 100 to Rs 1000.

[62] Key informant interview with Dr Shahid Pervaiz, DDHO Rawlapindi.
[63] Key informant Interview with Dr. Akhtar Butt, owner Akhtar Health Clinic.
[64] 'Pakistan Social and Living Standards Measurement Survey, 2010-11', covers information for the treatment of diarrhea and pre and post natal treatment from public and private sector. It shows that in areas where public sector hospitals are in better shape, say in Rawalpindi and Islamabad, the public sector outperforms the private sector. Otherwise, private sector has a substantial share even in the rural areas of KPK and Baluchistan, See table 3.3 of the above referred document. Available at: http://www.statpak.gov.pk/fbs/content/pakistan-social-and-living-standards-measurement-survey-pslm-2010-11-provincial-district-0

Table 5.4: Registration Fee in Private Hospitals and Clinics (%)

Area	less than Rs.100	Rs.100-250	Rs. 251-500	Rs.500 +	Total
Urban	9.50	19.25	30.00	41.25	100
Rural	27.00	54.00	18.00	1.00	100
Total	13.00	26.20	27.60	33.20	100

It was found that registration was not directly related to the healthcare service provided, as it involved maintaining some basic information about the patient. This is a cause of concern, as some service providers were found to charge fee as high as Rs 500.

5.4.2. *Purchase of Medicine from In-house or a specific pharmacy:* The sale of medicine is a major source of income in the health sector. It was observed that private enterprises use a number of ways to ensure that they extract benefits of this through tying. Patients complain of doctors' prescribing a brand of drug that is only available at specific pharmacies or medical outlets. Complaints regarding referral to a specific medical store and mandatory purchase from in-house pharmacies are common. The availability of a pharmacy within the premises of a hospital or clinic is a common mechanism to make patients buy medicines from there. While investigating medicine prices at such stores, the prices were found to be higher relative to the open market. During the survey, 24% of the respondents said they were forced to buy medicines from in-house medicine outlets.

5.4.3. *Diagnostics from Specific Laboratories:* Another area of concern related to tying that requires attention is diagnostics. 25% of the respondents informed that they were required to get medical tests from in-house or specific laboratories. It was found that certain hospitals refuse to entertain results from any laboratory other than their own.[65] They deal with this issue by professing that they will not compromise on the quality of laboratory tests. However, views expressed during key informant interviews show that the main purpose of such a requirement is revenue generation from tying of products.

[65] Key Informant Interview, Assistant Registrar PMDC, Dr. Ahmad Nadeem Akbar.

Section 6 - Conclusions and Recommendations

1. Recent years have seen a phenomenal growth in private healthcare. Private health clinics and hospitals operate across all socio-economic settings. Considering the importance of healthcare for the population at large, besides its economic implications for overall productivity and competitiveness, the CCP conducted a comprehensive competition assessment of private healthcare. This study is based on internationally acknowledged analytical tools and frameworks for competition assessment, such as the DFID's Competition Assessment Framework and the OECD Competition Assessment Toolkit. These structures provide operational guidelines for assessing the degree of competition and identifying competition vulnerabilities in specific sectors of the economy. For this assessment, pilot and detailed surveys were conducted in May and June 2010, in the urban and rural areas of Rawalpindi and Islamabad. Based on the survey findings and information gathered from a range of stakeholders, recommendations have been developed to improve competition in the sector.
2. According to the Constitution of Pakistan, the State has the primary responsibility to ensure provision of healthcare to citizens. However, owing to a number of reasons, the government has failed to meet this responsibility. The private sector has filled this gap left by a failing public healthcare system. As a result, private healthcare providers enjoy a substantial share of the health market.

3. We note a number of positive outcomes arising due to the growth of private sector, particularly the availability of choices and the improved quality of services, as reported by respondents of our survey. It remains crucial for the government to facilitate the private health sector, as well as encourage new entrants in the market. There is a need to offer incentives for entrepreneurs willing to establish healthcare facilities in peripheral and rural areas.

4. This study informs that the market for basic medical consultation and general treatment is not concentrated, as a number of suppliers operate in this domain. However, the supply of specialized treatment such as cancer, kidney/liver

transplant, heart diseases, radiology etc. has a high market concentration. The results indicate that the market shares of different suppliers of consultation and general treatment are prone to fluctuations.

5. 61% of the respondents agreed with the notion of a rise in fees. The private health service providers attribute this increase mainly to rising inflation. Regulators also shared the view about rising costs, but expressed their inability to check it, owing to a lack of any provision in the law.

6. Consultation fees were found to depend on the quality of services, the geographical area and the field of expertise. The fees as well as variety of services were considerably lower in rural areas.

7. Most of the healthcare providers denied charging a registration fee in addition to consultants' fee, but 40% of our survey respondents claimed to have paid registration fees.

8. Competition tends to ensure consumers' access to quality services and products. In the survey, consumers also tend to agree that the quality of services has improved. We have observed that rather than the cost, consumers make choices on the basis of the quality of service. This suggests that the demand for healthcare is relatively inelastic.

9. The present state of competition in private healthcare had a negligible impact on the cost of services. We are of the view that the effect on cost may become visible when facilities providing the same quality increase in number, thus reducing the supply-demand gap.

10. Competition tends to increase the efficiency of a market. During the survey, a majority of the respondents (61%) agreed that expansion in the private health sector has resulted in more efficient services.

11. The profitability in private healthcare was found to be on the higher side. It reflects two aspects: firstly, profitability directly corresponds to quality and

improvement of services. Secondly, it reflects the failure of supply to catch up with the constantly increasing demand. From the perspective of competition law, high profits are not an anticompetitive concern. Nevertheless, excessive pricing, if proved to be a result of an abuse of a dominant position, is anticompetitive. We suggest an in-depth analysis to determine if the high profitability is due to excessive pricing. Our survey results indicate that high profitability is encouraging competition by promoting entry in the private health market. As a commercial practice, the health enterprises adopt several ways to maximize profits; some of these may attract Competition Act, such as tying.

12. A significant number of consumers appear to be apprehensive about some sort of collusion by private healthcare facilities. However, during the course of the study, we did not find any such association of private hospitals or proprietors.

13. Private health sector has grown rapidly over the last few decades for a variety of reasons. Besides other expected outcomes of this growth, it was presumed to spur a competitive environment, resulting in the availability of cost-effective and efficient services to consumers. However, consumers are of the view that growth of the private health sector has fallen short of providing low-cost services to them. These concerns led to an analysis of the present state of competition on the basis of empirical evidence generated from a service delivery survey and key informant interviews. After a detailed study, we are of the view that an increased role of private entities in such a crucial sector needs to be monitored, properly targeted and carefully regulated.

14. We found two key challenges to promote competition and to achieve outcomes favorable to consumers. An objective regulatory mechanism is almost nonexistent in the private healthcare sector. Consequently, tasks such as the authorization to establish a private healthcare facility, existence of quality standards, and an output-based assessment of services is also absent.

15. The health sector is prone to information asymmetries, as consumers lack the knowledge of their disease, its diagnosis as well as its treatment.

Adherence to a holistic approach is essential, to tackle these challenges. The following specific recommendations, based on the findings in this study, highlight the pillars of such an approach:

Recommendations

We understand that the following recommendations, for a review of the regulatory regime with regard to private healthcare, will ensure better outcomes for the consumers.

1. Revisiting health policy regulation

From a competition standpoint, increased regulation of markets is generally considered an unhealthy restraint on market forces. However, in certain instances, especially in sectors prone to market failures, appropriate regulatory mechanisms can improve outcomes by setting rules of the game and guiding behavior. Therefore, the policy makers need to revisit health policy with reference to role of the private sector. The private health sector needs to be viewed as an important tool in bridging the vast gap in the demand and supply of health services. It is in the environment of a failing public health care system and lack of regulation that the private health sector evolved in the first place. Thus advocating for regulation of the private health sector becomes questionable. It remains for the government to ensure that such a regulatory mechanism be introduced that does not constrain the growth of the private health sector, but in fact aids its operations and promotes competition. The private health sector needs to be looked at as a solution to the problem, rather than the problem.

a) Formulation and maintenance of quality standards

The organizational model of a majority of private sector facilities is sole-proprietorship or partnership-based.[66] There are no constraints involved in establishing a private health clinic except investment capability of the owner. The present situation necessitates stipulation of quality and professional standards for establishment of private healthcare facilities. This is also necessary to check the deceptive marketing practices of quacks and unqualified doctors.

b) Authority to license medical facilities

The statutory role of the PMDC is suggested to be revised for inclusion of the authority to issue licensed authorization for establishment and operation of private healthcare facilities. Separate guidelines need to be formulated for sole proprietors and corporate entities. Competence and impartiality of the PMDC's Board and staff will need to be ensured.

c) Guidelines for prevention of tying practices

The survey conducted for this study found some incidence of tying with regards to registration fee, tests from specific laboratories and referral to in-house pharmacies. Mostly, this is done on the purview of ensuring quality. However, guidelines need to be established for adherence to certain standards and for expanding consumers' choice.

2. Filling the information Gap – A National Healthcare Information System

The health care sector is prone to information asymmetries. Suppliers of services may extract premiums owing to the fact that patients are ill-informed about medical treatment and costs. Since no treatment can be 100% effective, a doctor's efforts and expertise remain unverifiable. One of the significant findings of the study is the absence of a comprehensive and well managed information and data

[66] At the national level, the highest percentage of private healthcare providers work as sole-proprietorship (76%) or partnership-based (7.1%). Despite a low share of only 1.2%, the category of 'Private limited company' incurs the highest expenditure of Rs16, 657 million (44% of total) followed by "individual proprietorship" at Rs 8,960 million (24%).

system that could provide updated and detailed statistics regarding private healthcare facilities. Therefore, availability of objective information on the quality and cost of services is a pre-requisite for a competitive and well-functioning healthcare market.

In the present setup, we suggest PMDC be mandated with maintaining a centralized data base of all the healthcare enterprises at the federal as well as provincial level. The data base maintained shall need to be updated at regular intervals. Access to consumers through an appropriate mechanism shall also need to be ensured. Cognizance of the fact that a health facility's history shall be in public domain will align incentives for doctors to exert maximum effort and compete on the basis of objective criteria.

We recommend that a separate database with specific proprietary information should also be maintained, with limited access, for the purposes of regulation and enforcement.

Establishment of an autonomous information regime, assessing and reporting upon the cost and quality of available health facilities, can facilitate consumers in making informed choices. It will also help establish a competitive environment in the private healthcare market.

3. Recommendation for further research

During the course of this study, it was observed that there exists a nexus between private health providers and pharmaceutical production and distribution sector. Gifts and other incentives by companies affect the prescription practices of doctors.[67] As the examination of pharmaceutical sector and the dynamics of its relations with other market actors were beyond the scope of the present study, it is suggested that comprehensive research be commissioned to look into the anti-competition aspect of this nexus. Also, there were indications that the doctors take commission from the labs

[67] For instances relating to Pakistan and other countries, see the work of the Network for Consumer Protection available at: http://www.thenetwork.org.pk/

for each patient they refer to a particular lab. Although, data was not available on this aspect, but it is obvious that such a practice affects competition among various labs. The proposed research study should also cover this feature of the doctors' relations with the labs. We also suggest looking into the profitability of private hospitals to determine if the high profits are accruing because of excessive pricing.

4. An active role to be played by civil society

There is an ongoing debate on moving towards self regulation from the approach of regulatory control by the government in the health sector. However, self regulation highlights a number of deficiencies in the context of competition, such as regulatory capture and weak legal oversight and enforcement. Therefore, engaging the private sector to assume a greater role should take into account the challenging prerequisite of increased government capacity to regulate well, including command and control. Civil society and consumer protection organizations can play a significant role to ensure that public voices are heard and policy actions are taken accordingly.

5. Actions recommended to the CCP

i. There are several associations in the healthcare sector, these general and specialist associations can provide a forum to relevant professionals to collude on fees, charges, etc. Therefore, their role and activities should be monitored for anti-competition conduct.

ii. The CCP should undertake advocacy and investigative action to determine and eradicate tying and deceptive marketing practices as per Competition Act.

iii. The excessive pricing issue highlighted in this report should also be examined to ascertain abuse of dominance.

iv. To promote competition in the sector, the CCP may consider issuing a policy note to the concerned quarters, to revisit health policy regulation in the light of recommendations of this Report.

Annexure I - Questionnaire for Private Health Sector Service Delivery Survey

Section I: Identification *(To be filled by enumerator)*

A1	Enumerator code			A2	City Name		A3	Locality	

Section II: General

Q-1	Full name (Optional)					
Q-2	Gender		1	Male	2	Female
Q-3	Age of Respondent (attendant)					
	1	18-25 years	2	26-30 years	3	31-40 years
	4	41-50 years	5	51-60 years	6	61 years or above

Section III: Competition Assessment of Private Health Facilities through Service Delivery Mechanism

(a) Product Choice& Decision Making

Q-4	**On what grounds, you have made decision about this particular hospital?**					
	1	Referred by a Doctor	**2**	Suggested by kin/friend	**3**	Cost Effective/Low Fee
	4	Ease of Access	**5**	Highly skilled Doctors/staff	**6**	All services under one roof
	7	Quality of infrastructure	**8**	No other option available	**9**	Any other please specify: ……..

Q-5	**Have you made your decision from wider range of choice?**			
	1	Yes	**2**	No
Q-6	**Kindly tell the names of some hospitals over which you have preferred this particular hospital?**			
	1		**2**		**3**	
	4		**5**		**6**	

(b) Service Quality, Infrastructure and satisfaction level:

Q-7: How much satisfied you are with the following facilities of your Hospital?

SCORE						
Indicators	**Satisfaction Level**					
	Very Satisfactory	Satisfactory	Undecided	Unsatisfactory	Very Unsatisfactory	No Response
Quality of Treatment	5	4	3	2	1	66
Availability of Doctors	5	4	3	2	1	66
Availability of supporting staff	5	4	3	2	1	66
Doctor/Staff Attitude	5	4	3	2	1	66
Condition of Medical Equipment	5	4	3	2	1	66
Medical Check-up Fee	5	4	3	2	1	66
Hygiene Conditions	5	4	3	2	1	66
Waiting Room Set-Up	5	4	3	2	1	66
Bath rooms Sanitation	5	4	3	2	1	66
Overall Satisfaction	5	4	3	2	1	66

(c) Fee Structure, Service Provision & Regulation

Q-8	**Have you chosen this Hospital on the basis of low consultation fee structure?**			
	1	Yes	**2**	No
Q-9	**Were you required or asked to pay the registration fee before going for the medical Examination?**			
	1	Yes	**2**	No
Q-10	**What is the average Registration fee of the Private Hospitals?**			
	1	<100 Rs	**2**	100-250 Rs
	3	251-500 Rs	**4**	500-above Rs

Q-11	**Are you compelled to purchase the medications from the Pharmacy established in side the Hospital?**			
	1	Yes	**2**	No
Q-12	**Are you compelled or forced to have the medical tests from a specific Medical Laboratory?**			
	1	Yes	**2**	No
Q-13	**Kindly tell the average consultation fee in this private Health-Care Institute?**			
	1	100-250 Rs	**2**	251-500 Rs
	3	501-1000 Rs	**4**	1001-1500 Rs
Q-14	**Is the Consultation fee of private hospitals rising frequently?**			
	1	Yes	**2**	No
Q-15	**If the Consultation fee increases, can you change/shift the Hospital compromising your satisfaction level?**			
	1	Yes	**2**	No
Q-16	**Does the health facility administration charge you any kind of exit fee when you are shifting to new health facility?**			
	1	Yes	**2**	No
Q-17	**Do you agree that the Consultation fee structure of private Hospitals justifies the services provided there?**			
	1	Yes	**2**	No
Q-18	**Do you agree that public Health-Care institutes are less efficient than private ones?**			
	1	Yes	**2**	No

Annexure II - Questionnaire for Executive of a Private Health-care Facility

1. Kindly tell us, the names of some major private health-care service provider in this city besides you?

2. Have you observed any major/significant shift in the market share of certain private health-care service provider?

3. Has there been extensive entry by new service providers in health-care business during recent past?

4. If so, can you tell us some reason for this increased market entry?

5. Do you agree that a high profit margin is one of the major causes for this trend?

6. Do you think that new health-service providers succeeded in making their mark in private health-care market?

7. Can you tell us some specific challenges and obstacles faced by your organization upon entry in the health care business?

8. Do you agree that new entrant has to face a lot of obstacles to start its business in highly concentrated market of private Health-care service providers rather than a less concentrated market place like residential area?

9. Are there any barriers like access, technology and supply of medical inputs faced by new entrant in private health-care service market?

10. If so, how do they affect the new entrant in the market?

11. Can you name any regulatory barriers which make entry in private health-care business difficult or restricted?

12. Do you agree that there are no limits to the number of health-care service provider permitted to enter the health-care service market, keeping in view the regulatory framework?

13. However, is private health sector subject to any regulations or policies that are costly or that frequently change?

14. If so, which government organization is responsible for administering them?

15. Do you think that health-care firms in this market suffer from unequal application of laws or regulations?

16. Is private health-care sector restricted to charge specific price for a particular health service due to any regulation?

17. Do the suppliers of medical equipment (surgical & pharmaceutical firms) have high bargaining power for their services provided to the health-care facility?

18. Are there any health service providers which dominate the private heath sector in this city by controlling prices of their services?

19. Do you think that major health care service providers have aggressive behavior towards new entrant of equal market footings (equal investment, infrastructure & scope of services)?

20. Do prices or profits in this private health sector appear to be higher than those prevalent in similar market (service market) in the country?

21. Is there any practice of price discrimination (charging different prices to different consumers) by health service providers?

22. Do the health service suppliers require that the service buyers also purchase a different service other than requested? (consultation + lab tests from a specific laboratory)

23. Does advertising in the health market concentrate on brand awareness, service and product features rather than on price?

24. Are there any regulatory captures by private health-care service provider?

25. Do you think that there are cartels in the health sector? If so, do they coordinate their prices?

26. Do you think that professional association like PMA has any influence on the registered medical practitioners in the private health-care sector?

27. Do any professional associations (PMA) of doctors/nursing/staff appear to have a role in setting or influencing the prices of final services being offered by the private health-care service providers?

28. Do you think that lack of infrastructure in some geographical areas appear to give incumbent health service provider a monopoly status?

29. Do you think that the private health-care providers have to face some kind of competition with the state owned health care facilities?

Questionnaire for Key Member of a Health-care Regulatory Authority

1. What is the regulatory mechanism of private health sector in Pakistan?

2. Kindly tell us; what are the major pre-requisites, in regulatory perspective, for setting up private health-care facility in Pakistan?

3. Is the private health sector subject to any regulations or policies that are costly or that frequently change?

4. If there is any such restriction, which organization is responsible for administering them?

5. Are there any regulatory barriers for a new market player to enter in the private health-care sector?

6. Is there any such regulation which makes entry for a new health-care service provider more difficult?

7. Are there any limits to the no. of firms permitted to enter the private health-care sector?

8. Is the private health sector regulated to charge specific price for a particular health service?

9. Do you agree that there is little/no regulation of private health sector for the protection of the rights of health service buyers especially in terms of cost of private health-care?

10. Do you think that current regulatory actions distort the competition in the private health-care sector?

11. Kindly tell us, are there any regulation to check the unethical practices by the health-care firms?

12. Have you ever listened or dealt with the case of abuse of dominance by large health care firms against small market players?

13. What are the regulations regarding the abuse of dominance by large private health-care firm?

14. Do you agree that there are unequal applications of laws or regulations on small or relatively new market players?

15. Do you think that there are certain cartels in the private health sector and they coordinate their prices of health services being offered?

16. Can you tell us; is there any regulatory action available to curtail the cartelization of private health sector?

17. Are there any regulations available for countering the following market failures?

    a) Pharmaceutical lobbies
    b) Doctor-Labs Nexus
    c) Manufacturer of Medical Equipment

18. Do you agree that current regulatory mechanism of private health sector needs some improvements? If yes, please give some recommendations?

Annexure III - List of Interviewees (Key Informants)

Regulatory Authorities

1. Dr. Zafar Iqbal Gondal, Executive District Officer (EDO) Health, Rawalpindi.
2. Dr. Shahid Perwaiz, District Health Officer (DHO), Rawalpindi
3. Dr. Ahmad Nadeem Akbar, Registrar PMDC, Islamabad
4. Dr. Hassan Oroj, Director Health Services, CDA Islamabad
5. Dr. Shahid Ansari, IG Hospitals, Ministry of Health, Islamabad

Executives/Administrators of Private Hospitals

1. Dr. Zaheer, CEO, Shifa International Hospital LTD. Islamabad
2. Mr. Manzoor Ahmad, Administrator, Ahmad Medical Complex, Rawalpindi
3. Dr. Tariq, Owner, Harley Hospital, Rawalpindi
4. Mr. Kamran Arshad, Administrator, Bilal Hospital, Rawalpindi
5. Brig. (R) Dr. Pervaiz Rasheed, Private Clinic Owner, F-8 Markaz, Islamabad
6. Fawad Mughal, Manager, Ali Medical Centre, F-8 Markaz, Islamabad
7. Dr. Akhtar Butt, Owner, Akhtar Health Clinic, G-9, Islamabad
8. Dr. Tariq Rahman, Owner, Prime Dental Care, Saidpur Road, Rawalpindi
9. CH. Amir Muneer, Administrator, Hearts International, Rawalpindi
10. Mr. Shahzad, Owner, Ayesha Hospital, Saidpur Road, Rawalpindi
11. Dr. Nasser Ranjha, Owner, Private Health Clinic, I-10 Islamabad
12. Dr. M. Sohail, Owner, Tazeem Memorial Hospital, Satellite Town, Rawalpindi
13. Dr. Syed Mubarak Ali Zaidi, Owner, Rahat Hospital, Saidpur Road, Rawalpindi
14. Dr. Taliya, Owner, Taliya's Clinic, G-9 Markaz, Islamabad
15. Dr. Shahid Sharif Randhawa, Director YUSSRA Medical College & Hospital, Rawalpindi

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