REGULATION OF PRIVATE HEALTH CARE IN PAKISTAN

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SUMMARY STATEMENT

For a public health professional working in a developing country like Pakistan, the DrPH degree offers a unique opportunity. Its basic advantage over the more traditional PhD is that it is multi-disciplinary and more practical and applied, while having research as only one of its components. The main application of the skills learnt during the three years will be to try and effect change in the state of health care delivery, rather than add to the body of academic knowledge. It thus addresses the needs of mid-career public health professionals, who are likely to be placed in job situations that require a broad range competencies and less depth or specialization. The three components of DrPH can provide that training. The taught element can be used to overcome shortcomings in previous training as well as address future career needs; the professional attachment to observe the working of another public health organisation and learn practical lessons from it; and finally the thesis can provide the means to apply the skills and knowledge which have been acquired from the first two components and develop a specific area of expertise.

In terms of time and career management as well, the DrPH is perhaps more efficient than other degrees: rather than it being a break in one's career, each component contributes skills, practical experience, personal contacts and a specialized area of research which aims primarily to contribute to policy or to solutions in a real setting, with the involvement of real public health actors and processes.

My particular area of interest was the regulation of private health care in Pakistan. I had been working as a public health professional in the government sector for the past ten years. While the public sector has suffered from financial constraints and mis-management, the private sector has grown at an enormous pace, largely unregulated and partially at the cost of the public sector. The need of the time therefore was to develop expertise, which would be able to contribute towards harnessing the energy of the private sector through appropriate regulation.

My previous qualification, while providing basic knowledge of public health, was lacking in certain key areas and the taught element of the DrPH was very well suited to fill the gaps. The compulsory components consisted of courses in Management, Communication Skills and Research Methods and Paradigms. All three were areas in my previous training, which needed strengthening and which are absolute requirements for a career in public health today.

The study units, which were available in the taught element, were also extremely useful. I took Health Economics for Developing Countries, as it was very relevant for me, coming from Pakistan, to learn about economic principles and their application in health care, including the analysis of financing alternatives in the health sector and to assess health policy from an economic perspective.

I selected Financial Management to understand and interpret financial information and to learn how to use this information in decision-making for example by using such techniques as costing and pricing of health care.

Lastly, I selected Organisational Management as it taught basic principles from the administrative sciences like anthropology, social psychology and sociology of organisation and management, for organisational problem solving.

During the first term, I audited two more courses which were Health Policy, Process and Power and Health Economics. The first taught theoretical approaches to policy making, with analysis of the political system within which policies are made and the process of policy identification, formulation, implementation and evaluation. The second provided valuable theoretical knowledge on economic ideas, which can be used in pursuit of better health and health services.

I chose my professional attachment with the World Bank, Washington DC, as it is a major player in the health field and one of the biggest donors in this area in Pakistan. Having had some knowledge of its operation from the client country side, it was of value to observe the working of the Bank from the other perspective. Thus it provided an opportunity to understand how the Bank operates, how it might affect national policies

and what lessons client countries might learn from it. Using a case study of health sector reform project in West Bank and Gaza, all these aspects were observed. In the same context, the Bank's policy towards regulation of private health care was also observed, considering that the Bank is a major proponent of the private sector participation in health care provision.

Finally the thesis provided the opportunity to study the specific problem of private health care regulation in Pakistan. The combination of skills learnt from the taught courses in the first term and the experience of working with an organisation like the World Bank helped immensely at this stage. In order to fill gaps in knowledge identified from a study of previous policies, first hand data were collected by mapping existing regulations, conducting key informant interviews and a stakeholder analysis. The aim was to produce a document, which would contribute to future policies or solutions aimed at the regulation of private health care in Pakistan.

In conclusion therefore, it may be stated that the DrPH is ideally suited to mid-career public health professionals like myself, who aspire to take up higher-level management positions in the future and to influence policy making processes.

ABSTRACT

The private health sector in Pakistan has been expanding rapidly, largely unregulated and partly at the expense of the public sector. While there have been previous attempts at formulating policies for the regulation of this sector, these have not always been based on ground realities, with the result that they never reached the stage of implementation.

The objectives of the thesis were: 1) to describe and evaluate the existing regulatory framework governing health care provision in general and private health care provision in particular both at federal & provincial levels; 2) to explore the views and perceptions of key stakeholders regarding existing regulations and the reasons for their effectiveness/non-effectiveness; 3) to identify whether and how regulatory mechanisms can be made to work effectively; and 4) to explore the views of stakeholders regarding the potential for alternative mechanisms for ensuring the quality of formal private medical services, including the role of information dissemination to service users/the public.

The methods adopted to achieve the stated objective were mapping of the existing legislations and a stakeholder analysis. The results showed that the existing legislations on regulation of health care provision were scanty, weak and inadequate and required radical re-structuring. The stakeholder analysis demonstrated the conflicting interests of the state and the private providers, the role of the powerful medical community and the views of the service users, who were shown to be the ultimate victims. Avenues for alternative regulatory mechanisms, including one based on information dissemination were explored and their feasibility discussed.

It is hoped that the information gained from this study, by reflecting the views of the various actors in this process, will contribute towards the formulation of a policy for regulation of private health care provision in Pakistan, which is realistic, feasible and sustainable.

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INTRODUCTION

The central question, which is addressed by this thesis is the gap which exists between theory and practice or the stages of policy making and implementation, in Pakistan, on the specific issue of the regulation of private health care. Successive governments have admitted the inadequacy of the existing system, recognized the need for reform and have formulated national health policies. An understanding of the history of health policy making in Pakistan can help to explain the reasons why these policies have not been successful. The climate of political instability, excessively centralised approaches, and most importantly a failure to acknowledge and involve the key stakeholders are some of the factors which can be seen as significant problems in the policy making process. Moreover there is a dearth of statistical and documented information and this thesis, while attempting to ground itself as much as possible on available evidence of the local context, serves also to demonstrate the lack of factual information on which health policies are based in Pakistan.

The main aim of the thesis therefore is to identify the existing gap between policy making and implementation regarding the regulation of private health care provision in Pakistan. This is to be done by assessing the current regulations and regulatory mechanisms, by identifying gaps and proposing policy options for regulating private health care provision in the future. By including the needs and views of key stakeholders in this exercise, it hopes to provide a picture based on ground realities, thus furnishing the tools for effective policy making.

Based on the above considerations the specific objectives are:

1. To describe and evaluate the existing regulatory framework governing health care provision in general and private health care provision in particular, both at federal & provincial levels.
2. To explore the views and perceptions of key stakeholders regarding existing regulations and the reasons for their effectiveness/non-effectiveness.

3. To identify whether and how regulatory mechanisms can be made to work effectively.
4. To explore the views of stakeholders regarding the potential for alternative mechanisms for ensuring the quality of formal private medical services, including the role of information dissemination to the service users/the public.

In order to achieve the stated aim and objectives, the thesis maps and analyses existing regulations, using key informant interviews to support the analysis. Further, with the help of a stakeholder analysis, which was retrospective as well as prospective, it examines the reasons for the absence of regulations and the effectiveness/non-effectiveness of the few existing ones. It also explores the feasibility and potential of future policy options, specifically information dissemination, to support or strengthen regulatory mechanisms.

The thesis begins by describing the increasing role of the private sector in health care provision and the reasons attributed to its global increase. It discusses its various characteristics and the problems associated with private sector activity, reviewing the literature to identify possible solutions, which address these problems. This chapter reviews the literature on regulation, its theoretical basis, definitions and its role in the health sector. It also describes the regulatory experiences of developing countries, the role of the state in the regulation of health care provision and an understanding of regulation within the policy making process.

The second chapter describes the health system in Pakistan, the public and private health care sectors and the lack of adequate private sector regulation. It reviews the attempts of successive governments to make policies during the last decade, identifying gaps in knowledge. The thesis then proceeds in the third chapter to describe the methodology used for primary data collection in this study. This leads on to the fourth chapter, which presents the results and analysis of the mapping of existing regulations along with the information obtained from key informants. The results and discussion of the stakeholder analysis are presented in the fifth chapter, while the sixth and final chapter presents conclusions and recommends policy options for the improvement of the quality of private health care provision in Pakistan.

CHAPTER 1
PRIVATE HEALTH SECTOR AND THE CONCEPT OF REGULATION

ROLE OF THE PRIVATE HEALTH SECTOR

The relative roles of the public and private health care sectors in developing countries have changed considerably during the last two decades (Bennett et al 1997). In many developing countries the state provision of health care became widespread after independence from colonial rule (Zwi and Mills 1995). Thus, by the 1980s the state had become viewed as the primary player in the health sector of most developing countries (Bennett et al 1997). This position of the state was affirmed by the Alma Ata declaration in 1978, which led to a stronger state focus on supporting the development of free health care services to cover entire populations (Gwatkin 2000). However, because of the resource-constrained environment, especially the effects of global economic recession and structural adjustment programmes in the 1980s, changes in the prevailing ideologies and the poor performance of the public sector in many developing countries, a vacuum has been created in health care delivery which is increasingly being filled by the private sector.

There have been three main reasons attributed to the global increase in private sector activity within the health sector (Kumaranayake 1998).

1. Health sector reform

During the last two decades, the overall development focus has changed quite considerably because of the severe economic difficulties faced by many developing countries. It became clear in many countries that the state alone could not bear the burden of comprehensive health care provision to its people and according to Gwatkin (2000) the euphoria of 'Health for all' was replaced by 'health sector reform', compelling many developing countries to embark upon major reforms of their health sectors, which included encouraging the private sector. These reforms were also externally driven by international donors like the World Bank. The publication of the World Bank's 1987 report 'Financing health services in developing countries: An agenda for reform' (World Bank 1987), played an important role in this regard. The influence of this report could not

be ignored, as the World Bank had become the major external funder of the health sector investment in developing countries (Abbasi 1999a). The World Bank's most important piece of work in the health sector, the 1993 'World Development Report: Investing in Health', which has had a substantial impact on national and international debates on health policies in the developing countries (World Bank 1997a), also encouraged development of the private sector as an alternative means of health care provision (World Bank 1993). The hypothesis was that increased private activity would free up resources, which could be allocated to the more needy in society. Those patients who were willing to pay for health care would choose to use private sector services, freeing up public resources (World Bank 1987; World Bank 1993; Bennett et al 1997). The underlying rationale for encouraging private health care provision was an optimistic belief that the greater efficiency of a market led development would provide the necessary solutions to the health care crisis being faced by the developing countries (World Bank 1987; World Bank 1993).

2. Poor public sector services

The increase in private sector activity has also been taking place independently of health sector reform. Generally, the private sector has expanded in many countries because of the inability of the state sector to provide quality service to the people (Bennett et al 1997). Poor performance of the public sector, mainly due to the economic constraints and under investment in health by developing countries, lead to a situation where services provided by the public sector were often of poor quality with long waiting times and inadequate supplies (Cassels 1995). While the private sector was growing to fill the vacuum created by the poor performance of the state sector, this growth was rather slow in countries facing economic recession. Bennett et al (1997) have suggested that economic recession not only reduces state funding for health care but also restricts people's ability to pay for private health care. Thus, although there may have been some expansion in the formal private sector, this was on a smaller scale as has been documented in cases of Malawi and Zambia (Ngalande-Banda and Walt 1995; Berman et al 1995).

3. Increased consumer affluence

In countries where there has been rapid economic growth, the demand for private health care provision has outstripped state supply because of the perception that private care is of higher quality (Bennett et al 1997; Kumaranayake 1998). This has led to the emergence of clinics/hospitals providing health care using high technology equipment (Yesudian 1994). Nitayaramphong and Tangcharoensathien (1994) found out that, in Thailand, where private involvement in hospital provision is extensive, unnecessary technology was often adopted. These private clinics and hospitals were mainly concentrated in wealthy urban areas where consumers would be able and willing to spend in order to have what they perceived to be quality and efficient services.

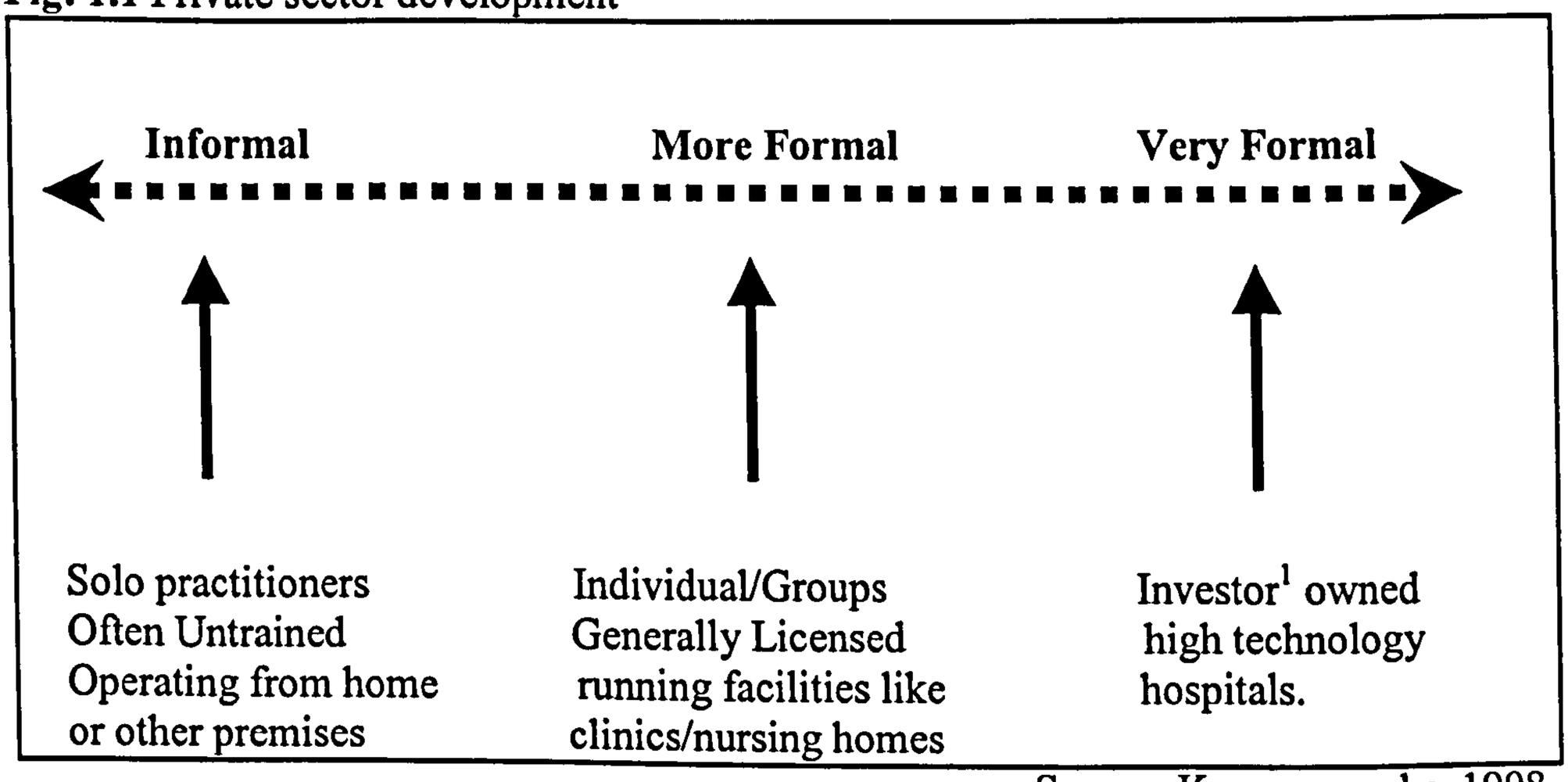
CHARACTERISTICS OF THE PRIVATE HEALTH SECTOR

In contrast to other sectors, privatisation in the health sector refers to increased participation of the private sector rather than the wholesale divestiture of public assets (Kumaranayake 1998). The World Health Report (2000) has stated that private provisioning and financing have already played a much greater role in health care than was suggested by the characterization of the health systems in most developing countries, which are dominated by the public sector (WHO 2000). Even in countries with low levels of private sector activity, out-of-pocket payments for health services often exceed one-third of the national health expenditure (Berman et al 1995). The size of the private sector varies from country to country. For example, in Indonesia more than 60 percent of health expenditure was in the private sector (Aljunid 1995). In India about 57% of the hospitals and 32% of hospital beds are in the private sector (Bhat 1999). Countries like Zimbabwe, Kenya and India respectively have 67, 40 and 73 percent of all physicians working in the private sector. (Hanson and Berman 1998).

In many developing countries when people seek treatment for an illness they visit a private provider first (Gwatkin 1999). Berman (2000) has described the case of Egypt, which is one of the few countries where country level data are available, where more than half of outpatient care is obtained from private physicians. Feachem (2000) has stated that lower income countries have health systems, which are more private in finance and

provision than higher income countries. McPake and Mills (2000) have stated that that the private sector was not exclusively being used by the upper income groups. Rather a range of private providers cater for various socio-economic groups from unqualified 'quacks' operating in rural and poor urban areas, to well equipped hospitals in the richer urban areas. Therefore it is important not to consider the private sector as a homogenous entity. Furthermore, the extent and type of private sector activity varies between countries and even within the same country. Kumaranayake (1998) has characterized private sector development on a simple continuum (Fig.1.1). In most countries these different types of private sector providers co-exist side by side.

Fig: 1.1 Private sector development



Source: Kumaranayake, 1998

McPake and Mills (2000) have argued that the perception that the performance of the private sector is superior can be mainly attributed to information asymmetry and relative lack of technical knowledge among consumers. There are few studies available that compare public and private sector quality of care (Smith et al 2001). However, the available evidence reveals serious anomalies in the quality of care being provided by the private sector (Swan and Zwi 1997). Private providers seldom provide preventive care

[1] Any private individuals or groups who invest capital in hospitals

and are generally involved in irrational prescribing practices especially antibiotics and injectables (Aljunid and Zwi 1997).

Other characteristics associated with private sector activity in the health sector of many developing countries include poor physical infrastructure, shortage of skilled staff, misuse of public resources within the private sector (e.g. private practice of public sector doctors) and medical malpractice and negligence (Bennett 1991; Bhat 1999).

NEED FOR REGULATION

The World Bank's 1993 World Development Report on health, which promotes private health care provision in order to improve quality and decrease costs, has acknowledged a significant role for regulation, both of financing and provision to achieve the benefits from private health care provision:

> "Strong government regulation is also crucial, including regulation of privately delivered health insurance to encourage universal access to coverage and to discourage perverse practices that lead to overuse of services and escalation of costs. As less developed countries take steps to encourage a diversified system of health service delivery, they need to strengthen government's capacity to regulate the private sector. Regulations are required to ensure that quality standards are met, that financial fraud and other abuses do not take place, that those entitled to care are not denied services" (World Bank, 1993).

Muschell (1995) and Kumaranayake (1998) have described regulation as a response to address problems which arise in private production, financing and delivery of health services. Mogedal et al (1995), after reviewing the privatisation and health sector reform processes in Botswana and Tanzania, concluded that:

> "privatisation and cost-sharing, as presently introduced may cause deterioration both in equity and cost-effectiveness if corrective measures are not taken in terms of regulatory frameworks"(Mogedal et al 1995).

Sen (1999) has stated that the role that markets play must depend not only on what they can do, but also on what they are allowed to do. Therefore, the response to many of the problems being faced by most developing countries in dealing with the private health care markets is a call for the imposition of regulation (Bhat 1996; Kumaranayake 1998).

Daniels et al (2000) have suggested that since the private sector often competes with and weakens the public sector, therefore it requires strong and efficient regulation if it is not to undermine equity.

The necessity of a regulatory framework to underpin and control private sector activity is clearly manifested in the American health care system, which is among the most market oriented in the world, yet one of the most regulated sectors in the American economy (Phelps 1992; Kumaranayake 1998).

DEFINITION AND TYPES OF REGULATION

Regulation has been defined as 'the activity by which the rules governing the exchange of goods and services are made and implemented' (Moran and Wood 1993). It is where a government or state exerts its control over the activities of individuals and firms (Roemer 1993). More specifically, regulation has been defined as 'action to manipulate prices, quantities and quality of products' (Maynard 1982; Kumaranayake 1998; Hongoro and Kumaranayake 2000). The action is often described as the regulatory intervention or regulatory mechanism (Kumaranayake 1998). Moran and Wood (1993) in describing regulations, use the following typography:

Formal Regulations

Formal regulations are those regulatory interventions where there is a mix of formal rule-setting and contractual arrangements. These types of interventions require that there be precise controls or incentives which are established and monitored by a regulatory body. World Bank (1997b) has described them as 'institution-intensive' approaches to regulation, as their success is dependent on strong institutional capacity of the state.

They include:

Legal restrictions or controls

These are to ensure that participants conform to statutorily legislated requirements. If they do not, then they are faced with threat of punishment. Along with these formal rules there may be informal codes of conduct or guidelines which might not be binding on the

regulatees (Moran and Wood, 1993). These types of legal restrictions can only be successful where there is adequate capacity and resources, both for enforcement and monitoring. Marquez (1990) has stated that even in countries with enough resources, legislated controls may not control the cost and quality of the service being provided, as these kind of interventions are designed to micromanage the regulatees behaviour. Obtaining detailed information about the regulatee is time consuming and costly, and is more difficult where there is no incentive for the regulatee to reveal the true information.

Incentives and incentive regulation

The apparent ineffectiveness of legislated regulatory controls in many developing countries may have shifted the focus towards incentive regulations. Chambers dictionary[1] has described an incentive as 'something which incites to action' a stimulus to work more efficiently or productively. Laffont and Tirole (1993) have described regulation based on the use of incentives as incentive regulation. Incentives can be financial or non financial. For example in the health sector, governments can give financial incentives to the private providers like tax subsidies, loans at low or no interest etc. or they can give incentives through purchasing or contracting out service delivery to private providers.

Interest in using incentives to achieve regulatory goals has grown because of the realization that, given the institutional, informational and capacity constraints, the enforcement of legislated mechanisms is often limited. Moreover for incentive regulation to have greater probability of success, there is an equal or greater need for monitoring to ensure that objectives are achieved and incentives are not misused (Kumaranayake 1998).

Informal Regulations

Informal regulation is described as a system which uses cooperation between parties (e.g. health professionals, the ministry of health) to achieve outcomes (Macintosh 1997; Kumaranayake 1998). Macintosh (1997) has argued that cooperative approaches could be more useful for meeting the needs of the concerned parties than the adversarial approach that characterises formal regulation, where the state is pitted against private sector

[1] The Chambers Dictionary, New Edition 1999

individuals or organisations. The success of informal regulations is dependent upon the motivations of individuals. Lindbeck (1997) suggests that regulatory interventions in the case of informal regulations can include the development of good practice norms. Improvements are driven by social norms where people change their behaviour in response to social rewards such as approval or disapproval of others. World Bank (1997b) has described the informal regulations as "institution-light options" which are more likely to work in settings where the institutional capacities of the state are not strong. Kumaranayake (1998) suggests that these institution-light options may be combined with more formal approaches like incentive regulation, but based on simple rules. However if the focus of informal regulations changes from social norms to economic incentives where individuals will behave in response to the material rewards then the informal regulation would not be feasible, instead more formal regulatory approaches would be required. Informal regulations can also include bottom-up approaches to underpin regulations such as public information and local initiatives to strengthen service users' voices.

Other types of regulatory interventions that have been described in the literature are:

Self-Regulation

Within the health sector there is a tradition of self-regulation especially among health care professionals, the roots of which can be traced back to the 'Hippocratic oath' (Moran and Wood 1993). Thus, instead of an independent regulatory body, professionals are often regulated by a group of peers (e.g. medical councils) who have the authority under existing legislation to license and sanction them. However, there are questions of self-interest, protection of one's peers and transparency in the case of self-regulation. Even without self-regulation, a close relationship between the regulatory body and the regulatee may jeopardise the implementation of regulation, as the regulatory body may be sympathetic towards, or easily manipulated by, the regulatees. This phenomenon has been described as regulatory capture.

Accreditation

Accreditation has been defined as the procedure by which an authoritative body gives formal recognition that a body or a person is competent to carry out specific tasks (Scrivens 1996). In the health sector, accreditation is usually used for larger facilities such as hospitals rather than for individual providers. Accreditation could provide a way for health facilities to 'signal quality care' based on the acceptable external standards. Nandraj et al (1999) have stated that there are four basic elements in an accreditation system: first, it is voluntary; second, standards are laid down; third, compliance with standards is measured by external review; and fourth, compliance is represented in a standardised way for example good or/bad rating scale.

The aim of accreditation is more educational than restrictive and it is a voluntary rather than a mandatory procedure like regulation (Scrivens 1995). It is also different from regulation, where the state takes the initiative and responsibility of setting standards. In accreditation, an independent body with the support of the professional organizations monitors the agreed standards. Moreover, Scrivens (1998) has stated that in accreditation the standards are set at higher levels, known as 'optimal achievable standards', to encourage the staff and management to aspire to higher levels of quality. Whereas in regulation the standards are normally set at minimal levels which when achieved show the fitness of the organisation to trade. Salisbury (1997) has also differentiated accreditation from regulation by stating that accreditation recognizes the need to reach consensus between a range of actors including government and professional organizations, and negotiate mutually acceptable ways of monitoring private sector services. The distinction between regulation and accreditation has become increasingly blurred however, because accreditation has taken on a more mandatory character in settings where most private providers participate in the system and failure to achieve and maintain accreditation results in a providers services not being purchased (Scrivens 1998).

Nandraj et al (1999) have described various models of accreditation, which might be considered in developing countries. One of the models is standards-based, where

hospitals are rated according to their compliance with different set of standards regarding facilities, equipment and manpower. Another model is based on 'a total quality assurance' approach, which involves implementing the accreditation in those institutions that are working to improve their quality. A third model of accreditation is based on the 'citizens charter approach' that would involve making hospitals user-friendly by providing information to service users about the services being provided, expertise of the staff available and procedures for redressing grievances.

Although the structure of each accreditation model and its specific goals are likely to be related to historical and cultural factors and the configuration of the health system in a particular country, all the models have one common goal, that is to improve the quality of care. Scrivens (1998) describes four possible purposes for accreditation: first, that it would create a conducive environment for medical practice; second, it could be used as a monitoring tool to ensure safety and proper functioning of hospitals; third, to inform the public about the accredited status of the hospitals; and fourth the status of an hospital can be graded in such a way as to provide comparative information to service users about how well it is doing compared with other similar providers. Thus it can assist service users to make informed choices or encourage local pressure to be put on health facilities to improve.

Regulation based on information dissemination

Scrivens (1998) has stated that in USA and Canada findings of the accreditation surveys have to be made public, thus serving the purpose of providing public information on quality of services. The rationale for making this information to the public is to inform service users about the services they may wish to buy so that they can make informed choices.

The concept of the 'informed consumer' driving quality and efficiency improvements in service provision which was stated by the World Bank (World Bank 1993) is now being propagated by the World Health Organisation (WHO 1999). The WHO's concept of a 'strong purchaser' implies that individual patients can play such a role. Kumaranayake

(1998) points out that service users, whose participation has traditionally been neglected in much of the literature on regulation in health care, may be able to play an important role in bringing about a change in the behaviour of the providers. For example, in Zimbabwe educational campaigns against excessive injections and prescriptions were thought to be successful (WHO 1991). In Pakistan, the provincial government of the Punjab was reported to have launched a successful media campaign along side strict administrative measures against the pharmaceutical companies who were involved in the production and distribution of low quality medicines in the market (Mirza 1998).

Afsah et al (1997) have suggested that governments could allocate fewer resources to setting rules regarding cost and quality of the services being provided and instead, allocate more for collecting and disseminating appropriate information. This would thus enable service users and providers to interact in ways which would promote socially desirable patterns of production and consumption.

However, there is no evidence that provision of information to service users would be effective in improving the quality of the service being provided in the health sector of developing countries. The limited experience of information dissemination in the health sector in developing countries has been around social marketing (Smith et al 2001).

There is some evidence of the effectiveness of this approach in monitoring the performance non-health utilities. One good example is Indonesia's 'Environmental Impact Management Agency', which is responsible for controlling industrial pollution. The agency analyses, rates and publicly discloses the performance of public or private agencies. Afsah et al (1997) have argued that performance indicators, once publicly disclosed, can provide a powerful incentive for reducing negative externalities and may encourage the performance of reputation-sensitive facilities. Furthermore, certification of good or bad performance may translate to gains or losses in attracting clients.

ROLE OF REGULATION IN THE HEALTH SECTOR

Moran and Wood (1993) have described the roles that regulation can play within the health sector and identified the following areas:

Market entry and exit

The regulation of market entry is the most important role that has to be performed, because it decides who shall be allowed to engage in the activity, and what conditions they must meet in order to be allowed to do so. According to Moran and Wood (1993) these rules of market entry vary from highly permissive to exceptionally restrictive. In most countries there exists some basic legislation with respect to market entry for medical professionals such as physicians, nurses and pharmacists.

Competitive practices

The second key role that regulation can play within the health sector is the regulation of competitive practices. Competition is allowed in most societies in the provision of goods and services, but there is almost always a limit placed on the extent of that competition and laws are framed to restrict the exploitation of honest by dishonest persons and to protect the consumers. For example, drugs may not be marketed by pharmaceutical companies, until they have satisfied safety tests; or health professionals may be prohibited from competing for patients by advertising their services, thus providing consumer protection in the form of ethical codes governing the relationship between doctor and patient.

Market structure

A third key role, related to the control of competitive practices and practice entry, is the regulation of market structure, especially where the information to consumers is imperfect. Thus, the decisions need to be made about what kind of institutions will be allowed to provide goods and services. Market structure regulation also tries to influence the distribution of providers. In some instances geographical distribution is regulated, and/or incentives are offered to encourage service provision in under-served areas (Kumaranayake 1998). Many countries have requirements regarding the registration of private and public facilities (e.g. hospitals, clinics and nursing homes). However, legislation regulating health facilities is not as extensive as those governing health personnel and is generally less demanding in standards than those found in the developed world (Roemer 1993).

Remuneration

The fourth key role is the regulation of payment. All regulatory systems have to make some decisions about what financial relationship, if any, is to exist between the patient and the doctor. It could range from the doctor setting the fee to no money changing hands at the time of treatment, where the payment is funded by a third party, whether government or health insurance company. In many cases there exist more detailed rules governing both prices and actual method of charging. As there are great variations in how far these rates can be regulated, therefore some decisions about the extent and form of regulation have to be made, even if the decision amounts to leaving the service user and provider free to negotiate charges.

REGULATORY EXPERIENCE OF DEVELOPING COUNTRIES

There is little evidence on the impact and effectiveness of regulatory interventions in developing countries. Also there has been a notable lack of comparative analyses of country experiences, examining the success of alternative regulatory interventions. Available information tends to be from case-studies which draw upon a country's experience with a particular reform or policy. Given the differences in country experience and the range of regulatory interventions, it is difficult to draw out general lessons (Bennett et al 1996). However, it has generally been observed that the degree to which the regulations are enforced and effective in the developing countries is low (WHO 1991; Asiimwe et al 1993; Yesudian 1994; Kumaranayake 1997).

Bennett et al (1994) state that in most developing countries, basic legislation exists that governs the registration/licensing of health care providers, establishment of professional bodies, restriction against dangerous and unethical clinical practices and the production and distribution of drugs. Despite limited evidence, it would appear that there are systematic problems in the implementation of regulations in developing countries Soderlund and Tangcharoensathien (2000) have stated that 'paper regulations' often precede effective regulation of health sectors in many countries. While legislative efforts are made to regulate private health care provision, there is often insufficient effort to carry these regulations through to proper implementation. Roemer (1993) has commented

that legislation regulating health facilities is not as extensive as those governing health personnel and is generally less demanding in standards than that found in the developed world.

Soderlund and Tangcharoensathien (2000) have argued that the remarkable similarity in regulations between countries with different health systems suggests that they are all based on a common legislative template rather than on an understanding of the particular context of the health sector of the country concerned. Moreover, in many developing countries health care regulations are more likely to be out-of date, particularly in those situations where the private sector has often expanded substantially (Mills et al 1997). In Thailand the Medical Premises Act governing private health care facilities was established in 1963 when there were only six or seven private hospitals in the country (many of which were non-profit). By 1997 the Act had not been amended despite the fact that there were then nearly 350 private hospitals in Thailand, mainly for-profit ones (Bennett 1997).

Experience from Thailand also suggests that once the private sector has become a very powerful player in the health system, it is much more difficult to put in place a regulatory structure than at earlier stages in the private sector's development (Bennett and Tangcharoensathein 1994). Also, the greater the size of the private sector, the greater would be the resources necessary to ensure effective regulation.

Several countries have experienced that the design of appropriate regulatory mechanisms is difficult and enforcement imposes high administrative costs. A review of the existing literature suggests that the central problem is lack of state capacity and resources to monitor and enforce regulations (Kumaranayake 1998). Ngalande-Banda and Walt (1995) examined the case of Malawi, after the government allowed health professionals to enter private practice. The government had previously laid down some basic standards for their premises and the drugs which private practitioners would be allowed to sell. It was envisaged that the medical council would make initial inspections of the premises for any one applying to open a private practice as well as subsequently conducting spot checks. However in a survey of private practitioners, Ngalande-Banda and Walt (1995)

found that 73% of the practitioners were not following the basic standards laid down in the 1989 statute, which allowed private practice. The main reason for this was thought to be the lack of adequate resources, because of which this level of monitoring could not be continued. Also in Malawi, although the Medical Council has managed to maintain its basic functions of licensing practitioners, limited funds have prevented it from securing regular patient reports of the practices of private practitioners, or from ensuring that practitioners attend refresher courses on an annual basis. It is officially responsible for carrying out both of these functions (Ngalande-Banda and Walt 1995).

Resource shortages have also been cited as a major problem affecting the effectiveness of regulatory bodies in other countries. In Nigeria, a special commission to stamp out counterfeit drugs suffered from the fact that it had no vehicles, and there were no telephones in the regional offices (Bennett 1997). In Ghana medical and professional councils were established during the 1950s; however it was only during the late 1980s that these bodies started to receive funds from government so as to operate effectively (Bennett 1996).

In most developing countries regulations are implemented through professional bodies such as medical councils. Medical councils are statutory bodies that are meant to set the standard of medical practice, monitor the activities of registered professionals, and check for and discipline any malpractice. The unwillingness of these professional bodies to investigate and publicise cases of malpractice of its members has also been cited as a problem. Bennett and Ngalande-Banda (1994) presented the case of the Zimbabwean medical council, which has not publicized any cases of malpractice for fear of damaging the reputation of the profession. Soderlund and Tangcharoensathien (2000) have stated that this issue of regulatory capture is more prevalent in those countries where governments have little capacity to design regulations themselves and hence recruit the regulatees to devise the regulatory framework.

Nandraj (1994) has cited the case of India where the implementation of rules and regulations for practitioners fall under the respective state medical councils which are comprised mostly of doctors. The integrity of these medical councils has been questioned

as complaints to councils have been ignored, mislaid or only brought to a hearing when considerable pressure has been exerted by consumer organizations. In Malaysia only 39 complaints came before the Medical Council in a five year period despite many more accusations of malpractice in the newspapers (Aljunid 1995). In Zimbabwe the Ministry of Health has had to intervene on occasion to ensure that malpractice hearings were publicized rather than 'hushed up' by the medical council (Bennett and Ngalande-Banda 1994). Analysis of experience in the industrialized world suggests a similar situation: medical councils have been reported as being more concerned with protecting the role and reputation of the professionals rather than with protecting the health of the patient (Bennett 1996). Nevertheless the problems do not lie only with medical councils. Licensing and inspection divisions of government ministries (including the Ministry of Health) tend to be susceptible to corruption (Bennett 1996). Licenses may be granted to the politically powerful or wealthy rather than to those providing satisfactory facilities.

Most of the existing regulatory mechanisms in developing countries are in the form of legal/legislated controls. Their effectiveness is partly dependent on the response of those being regulated. In situations where large profits (rents) are being made, providers will attempt to protect these profits/rents and this 'rent seeking behaviour' may lead to adverse consequences. For example, studies have found that hospitals respond to the threat of regulation in ways which may lead to a decline in quality of services and increase in mortality rates (Marquez 1990). Thus, even in countries with enough resources, legislated controls may not control the cost and quality of the service being provided, as this kind of regulation is dependent upon the detailed knowledge of the regulatee. The Indian consumer protection act 1986 (COPRA) is a good example of legislated control. Case law has brought private medical practice under India's 1986 Consumer Protection Act (COPRA). Although this act has been able to create awareness among the private providers about the regulations (Bhat 1999), its limitation....including the inability to make judgements about technical quality of the care provided....has raised doubts about its effectiveness. Experience so far indicates that COPRA, on its own, has limited effectiveness for changing provider behaviour to improve quality standards (Bhat 1996 and 1999).

The apparent ineffectiveness of legislated regulatory controls in many developing countries has shifted the focus towards incentive regulations. Incentive regulations may take the form of subsidies to the private health sector, tax exemption, interest free or low interest loans, or government guarantees for borrowing on the private markets (Laffont and Tirole 1993). Also the government can reward performance through purchasing private sector services for example through contracting out or inclusion of those who perform well as preferred providers in national social insurance schemes.

Although government subsidies to private health care providers appear widespread, there have been few attempts to evaluate their effectiveness. In Thailand until recently, significant subsidies were being given to the private sector through tax relief on high technology equipment imported from overseas, although increasing the availability of high technology equipment was not in line with official Ministry of Health policy. Moreover, the Board of Investment continued to provide corporate tax relief to new private hospitals starting up in Bangkok, although the bed to population ratio in Bangkok was already higher than MOH targets (Bennett and Tangcharoensathien 1994). In Malaysia a government programme to encourage private practitioners to offer Hepatitis B vaccinations by subsidizing the vaccine foundered when cheaper vaccines became commercially available (Aljunid 1995). Bennett and Ngalande-Banda (1994) have cited the case of Zimbabwe, where during the early 1980s vaccines were provided free to private practitioners. However, it was found that private practitioners were charging for immunizations, thus the programme had to be ended. Other subsidies to the private sector often have very poorly defined objectives and are open to capture by influential groups.

There are examples of some middle-income countries like Taiwan and Brazil, which have used accreditation of hospital facilities as a means to improve quality and standards of facilities. Huang (1995) has described the case of Taiwan, which has successfully implemented a system of accreditation over the past 15 years; now eligibility for payment by National Insurance is linked to accreditation. There are however, lack of studies in the literature reporting its use and effectiveness in low income countries.

ROLE OF THE STATE IN REGULATION

In most countries the role of the state in relation to health is changing (World Bank 1997b). Saltman and Ferroussier-Davis (2000) have argued that there is a need for the realignment of both the configuration and the application of the states authority in the health sector for achieving agreed policy objectives. The concept of 'stewardship' has therefore been suggested as an appropriate basis for reconfiguration of the role of the state in the health sector (WHO 2000). The concept of stewardship has been defined as a "function of the government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry"(Saltman and Ferroussier-Davis 2000). This concept, which envisages the key roles of oversight and trusteeship for the state, has religious roots (WHO 2000). Thus the notion of stewardship, which could be found at the heart of both the Christian and Jewish faiths, has also been associated with other religions. Saltman and Ferroussier-Davis (2000) have described the Islamic institution of 'Hisba', which organized the public administrative functions in both moral and technical dimensions (Box 1.1). This could be of significance for Islamic countries like Pakistan, where under the constitution, Islamic law and traditions are supreme. In this context the institution of Hisba, which has its origins from the Caliphate times, could be used by the State, as the basis for an effective dialogue with the private health sector.

The concept of stewardship has been related to the concept of regulation (WHO 2000). As its emphasis on trust and the persuit of the common good, resembles the most important rationale for regulation, that is, to serve the public interest (Baldwin et al 1998). Moreover much of the emphasis in stewardship is on regulation, whether undertaken by the state or by private bodies, which would regulate their members under the rules determined by the state. Therefore, stewardship seems to be dependent on the power and capacity of the state (WHO 2000). There are however, concerns regarding the capacity of many states to effectively play stewardship role. Saltman and Ferroussier-Davis (2000) have stated that certain political, social, economic and religious patterns could play an important role in the implementation of stewardship approaches. There are also concerns about the consequences of globalisation, which could potentially hamper

the ability of the states to design and implement desired regulatory strategies (Saltman 1997).

Box 1.1: Stewardship: The Hisba system in Islamic countries

The institution of Hisba was developed to carry out the function of stewardship in Islamic countries more than 1400 years ago. The hisba system is a moral one as well as a socio-economic institution, whose raison d'etre is to ordain good and forbid evil. The functions of the muhtasib (the head of Hisba system) can be classified into three categories: those relating to (the rights of) God; those relating to (the rights of) people; and those relating to both. The second and third categories are related to community affairs and municipal administration. The main foundation of Hisba was to promote new social norms and develop the required system to ensure the adherence of various sectors of society to these norms.

The first muhtasib in Islam was a woman called Al Shifa, appointed in Medina, the capital of the Islamic state, by the second caliph, Omar ibn Al Khattab, almost 1450 years ago and given authority to control the markets. The muhtasib could appoint technically qualified staff to investigate the conduct of different crafts, trades and public services, including health services. The muhtasib received complaints from the public but could also order an investigation on his or her own initiative.

Medical services were also regulated by the Hisba system. Physicians and other health specialists had to pass professional examinations and possess the necessary equipment before being licensed. The muhtasib had to ensure compliance of practicing physicians to moral and ethical norms, including equitable provision of services and protection of the public interest. In the field of pharmaceutical services, technical publications were prepared, including monographs describing standards and specifications for various drugs as well as methods of quality assurance. The system also included inspections and enforcement mechanisms. Like many other institutions, the Hisba system underwent drastic modification with the advent of western colonization: its functions were transformed into a number of secular departments and its moral content reduced.

Source: Al-Shaykh al Imam Ibn Taymiya 1985, Public duties in Islam: the institution of the Hisba. The Islamic Foundation, Markfield, UK

Adapted from The World Health Report 2000

REGULATION AND THE POLICY PROCESS

Regulation has been described as an inherently political process, balancing the interests of different actors (Moran and Wood 1993). The actors can include the state, health care professionals, commercial interests groups, non-governmental organisations, professional

organizations and service users. A policy review of regulation therefore can only be undertaken through a clear understanding of the overall policy making process.

Walt and Gilson (1994) have commented that health policy has excessively focused attention on the content of reform, and neglected the actors, processes and the context within which policy is developed. In reality there is a complex set of interrelationships where actors are influenced by the context within which they work. The context is affected by factors such as instability or uncertainty created by changes in political regime, by ideology, by historical experience and culture. The process of policy making is in turn affected by actors, their values and expectations and their positions in power structures. The content of policy will reflect some or all of the above dimensions. Thus they argue that the traditional focus on the content of policy neglects the other dimensions of process, actors and context which can make the difference between effective and ineffective policy choices and implementation.

Using the Walt and Gilson (1994) model of policy analysis, it is considered important to look at all those dimensions of policy making which contribute to the policy process. Focusing on the context, it is imperative to understand the particular political culture within which policies are made and implemented. As regards the actors the identification of stakeholders is essential as regulation can only be ensured by the compliance of the various stakeholders in the health system (WHO 2000). Smith et al (2000) suggest that tools like political mapping (Reich 1994) and stakeholders analysis (Brugha and Varvasovszky 2000) can be useful to assess levels of stakeholder importance and influence. Existing literature on health policy analysis has shown the importance of recognising the role of stakeholders. Ugalde (1978) demonstrated in the case of Colombia and Iran how a tight circle of the medical profession dominated the policy making process. A similarly strong position of a small elite of health professionals was also described in Mozambique by Walt and Cliff (1986).

The overall process of policy making also needs to be studied by identifying the power dynamics, the conflicts between different actors, role of vested interests and groups and the way decisions are taken and implemented. Walt and Gilson (1994) describe the power

structures which influence policy, particularly in the context of low income countries, where the existence of large gaps between top and lower level bureaucrats, between doctors and nurses, and between policy elites and managers can play a role in the policy making process.

The Walt and Gilson (1994) model is a useful way to look at regulation policy as it emphasizes the interrelatedness of various dimensions of the policy process. The influence of context (historical, political, economic and socio-cultural), overlaps with critical role of actors, which in turn influences the values inherent in policy and the actual choice of policies. Seeing policy as a dynamic process is however the key to the analysis.

CHAPTER 2
PAKISTAN'S HEALTH CARE SYSTEM

BACKGROUND

Pakistan is a country of 137.5 million people (Government of Pakistan 2000). It is a federal republic with four provinces; Punjab, Sindh, NorthWest Frontier Province (NWFP), Baluchistan and the semi-independent state of Azad Jammu & Kashmir (AJK). Punjab is the largest province comprising 55.6% of the population (Government of Pakistan 2000). The other governing units include Islamabad Capitol Territory (ICT), Federally Administered Tribal Areas (FATA) and Federally Administered Northern Areas (FANA). Pakistan's economy is largely agricultural, with a Gross Domestic Product (GDP) of US$ 480 per capita (World Bank 1999) and an average growth rate of around 5% per annum, making it one of the relatively better off countries in the South Asian region (Haq 1997).

At the time of independence in 1947, the recommendations of the Bhore Commission (which was constituted by the then British administration of India to make recommendations for the development of a health system in the sub continent) were adopted as the guiding principles for the development of Pakistan's health system (Khattak 1996; Green et al 1997). Foremost among these was that no individual should fail to secure adequate health care because of inability to pay for it. These principles helped successive governments to develop a multi-tiered health care system, with care free at the point of delivery. In 1947, the areas that comprise Pakistan inherited a very weak health sector. Over the last fifty years there has been a considerable improvement in the distribution and availability of health services and facilities (Government of Pakistan 1997). The health of the population in Pakistan has shown considerable progress over the last few decades (Table 2.1).

However, despite this progress, Pakistan still lags well behind the averages of health indicators for all low-income countries in important respects, even though Pakistan's GNP per capita is above the average (Haq 1997). Zaidi (1999a, 1999b) has stated that, although

Pakistan had enviable rates of economic growth for most of the last fifty years, its social sector development in general and health sector development in particular has been disappointing. Being situated in a strategically important but volatile region of the world has meant that health and other developmental issues have been a low priority on the government agenda (Haq 1997).

Table 2.1: Health indicators for national five-year plans 1978-98.

INDICES	4th plan 1978	5th Plan 1983	6th Plan 1988	7th plan 1993	December 1998
Infant mortality rate Per 1000	120	110	100	95	86
Crude death rate Per 1000	14	12	10	9.1	8
Maternal mortality rate Per 1000	6-8	6-8	5-7	4-6	3.5
Life expectancy					
Male	54 years	55	57	61	63.6
Female	53 years	54	56	60	63.3

Source: National Health Policy, 1997

HEALTH CARE EXPENDITURE

Pakistan's public sector health care system provides care with either no or minimal charges at the point of service delivery. Although per capita expenditure on health has increased from Rupees 3.52 per month in 1978 to Rupees 160 in 1997-98, (Government of Pakistan, 2000), keeping in mind the total burden of disease in the country the total government spending on health is relatively quite low. In absolute terms, the total government health expenditure more than doubled during the nineties. However, since there was a considerable inflation during that period, the comparison between 1991/92 and 1997/98 shows an increase of just 19% in real terms over the entire seven-year period (World Bank 1998). This situation reversed in the financial year 1999-2000 when, even in absolute terms, the total outlay on health sector (federal plus provincial) showed a decrease of 29.9% over the previous year (Government of Pakistan 2000). Table 2.2 shows that the total government expenditure on health as a percentage of GNP has declined between 1996/97 and 1999/00 from 0.8 to 0.5 percent of GNP.

Table 2.2 Health expenditures (Million Rupees)

Year	Public sector health expenditure (Federal + Provincial)			Change (%)	As % of GNP
	Development Expenditure	Current Expenditure	Total Expenditure		
1996-97	6485	11857	18342	12.2	0.8
1997-98	6077	13587	19664	7.2	0.7
1998-99	5492	15316	20808	5.8	0.7
1999-2000	5547	9051	14598	-29.9	0.5

Source: Economic Survey, 1999-2000

The percentage of total government health expenditure in relation to GNP in Pakistan is very low even by Asian standards. A study of twelve Asian countries (Bangladesh, China, India, Indonesia, Korea, Malaysia, Myanmar, Nepal, Papua New Guinea, Philippines, Sri Lanka and Thailand), in the late 1980s, estimated the mean of this percentage at 1.3 percent of GNP (World Bank 1998).

PUBLIC HEALTH CARE SYSTEM

In Pakistan health care provision is the responsibility of the state. However, because of the resource-constrained environment, partly a result of the geo-political situation in the region, the government has not been able to meet the demands of the growing population. Therefore the growing gap between supply and demand is being filled by the private sector. Thus, the health care delivery system is a mix of both public and private providers. The public (i.e. government) health delivery system is composed of the following facilities, classified according to the service package they deliver and the range of functions they perform, as tertiary, secondary and primary care facilities:

- Tertiary care facilities are the teaching hospitals situated in the big cities of all the four provinces. These are high technology health establishments providing specialized and super-specialized services. Their average bed capacity is around 1000.

- Secondary care facilities include the Tehsil (i.e. sub district) Headquarter Hospital (THQ) and District Headquarter Hospitals (DHQ), which are located at these respective levels. These hospitals provide both inpatient and outpatient services. Bed strength for DHQ hospitals varies from 125 to 350, while THQ hospitals have 40 to 60 beds.
- Primary care facilities include the Basic Health Units (BHU) and Rural Health Centres (RHC). The BHUs provide curative and preventive outpatient services for catchment populations of about 10-15,000 people. The RHCs are 8-20 bed small rural hospitals where diagnostic and operation theatre facilities are available. There are 3-4 BHUs within the catchment area of a RHC. The RHC forms the first level referral care facility with in the public health system.

In the public sector, federal and provincial governments operate tertiary care hospitals in the larger urban areas. In rural areas and smaller towns, the provincial governments, State Government of AJK and federal administrations of ICT, FATA and FANA operate an extensive infrastructure of first level facilities and secondary hospitals, supported by several federal programs. The existing national network of health services in the public sector consists of 877 hospitals, 530 Rural Health Centers (RHCs) and 5152 Basic Health Units (BHUs). The total availability of beds in these health facilities is estimated to be 91,919 (Government of Pakistan, 2000).

The government is by far the major provider in rural areas, and it is also the main provider of preventive care throughout the country. NGOs play only a modest role in the provision of health care in both urban and rural areas (World Bank 1998). Zaidi (1988) has stated that Pakistan's health care system has a strong urban bias in terms of service provision and delivery and that it has a disproportionate emphasis on curative care at the expense of preventive and primary health care. The model of health care in Pakistan focuses heavily on 'medical care' rather than on 'health care'. A doctor-oriented curative care model implies that there is an inverted pyramid of health personnel (Zaidi, 1999a). Thus, the health care system, with doctors as the main focus, has resulted in a situation where there are almost three doctors for each nurse, and fifteen doctors for each lady health visitor. The reason for this inverse ratio is the decision taken in the seventies, by

the then populist government of Prime Minister Zulfiqar Ali Bhutto, to open numerous medical colleges in all the four provinces of the country. This was done in order to encourage more middle class students to join the medical profession which was considered to be a highly respected as well as lucrative profession, hitherto only open to the upper classes. Nursing on the other hand has had a rather negative image and was not the preferred profession specially for young women, particularly when the option for entering a medical college was available (Zaidi 1988).

Table 2.3: Health manpower and population per health staff

Health Personnel	Up to 1997	Up to 1998	Up to 2000
Registered Doctors	78,470	82,682	87,105
Registered Dentists	3,159	3,444	3,867
Registered Nurse	28,661	32,938	35,979
Population per doctor	1,636	1,590	1,578
Population per Dentist	40,652	38,185	35,557
Population per Nurse	4,480	3,992	3,822

Source: Economic Survey, 1999-2000

The inadequacies of the public sector service mean that the private sector is heavily used. Total public and private health expenditure in Pakistan represents 2-3 percent of the GDP (PMRC 1998). During the nineties less than one percent of the GDP was allocated to public sector health care with private expenditure accounting for the rest. Since there are no proper national health accounts in Pakistan accurate data on household expenditures on private health services and goods are not available. World Bank (1998) has suggested that in Pakistan, the household expenditure on privately provided health services and goods may be equivalent to three times the amount of government health spending. The National Health Survey (PMRC 1998) has found that the use of government doctors represented approximately 21 percent of overall utilisation of health provider services. Pakistanis see a government doctor on average slightly more than once a year (1.2 times) as compared to 4.2 times for other types of health care provider (PMRC 1998). This is despite the fact that, while many providers present themselves as physicians, it is only the

government sector that ensures the credentials of those providers (PMRC 1998). The private sector is now by far the main provider of health services as 46 percent of people seek care from private doctors when they fall ill (World Bank 1998). Nonetheless, the sheer size of the population and the extent of need ensure that public facilities remain overcrowded. It is therefore quite common for poor people to wait for several hours to get a five-minute consultation with a doctor (Daniels et al 2000). The public sector also supports the private sector indirectly. Almost all the public sector doctors run their own, often lucrative, private practices and they use the public sector to launch their careers and to locate clients (Zaidi 1988; Zaidi 1999a; Zaidi 1999b).

PRIVATE HEALTH CARE SYSTEM

In Pakistan, the private sector, which has always been there in the background filling the gap between supply and demand, is now recognised as having a major share in the health care market (Zaidi 1999b).

The private health sector comprises both for-profit and not-for profit components but the share of non for-profit private health care is very small to the extent of being negligible (World Bank, 1998). It is the for-profit private health sector, which forms the bulk of private health care provision in Pakistan. About 30% of all private health facilities are located in the rural areas, where 67.5% of the population resides (Government of Pakistan 2000). The rest of the private health facilities are located in the urban areas (World Bank 1998).

Private providers range from general practitioners to specialists. In Pakistan the private sector staff mix is highly skewed: about 40 percent of the technical work force are doctors, and less than 10 percent are nurses (World Bank 1998). Over the years Pakistan has seen a tremendous increase in the number of doctors entering the private sector. Thaver (1998) has stated that the excess supply of doctors in Pakistan has led to situation where formally trained doctors can even be found in the slums where they have set up their own private practices.

Private health facilities include clinics, nursing homes and hospitals ranging from small owner based establishments with fewer than five beds to large hospitals and medical complexes. An important development in the last several years has been the emergence of large-scale investor owned hospitals. Hospitals like Shifa International hospital, Islamabad, have issued shares and trade as public limited companies.

Despite their considerable presence in the country, information about the role, nature, structure, functioning, type and quality of care of private health facilities remains inadequate. A World Bank report (1998) has stated that the private health sector in Pakistan is characterised by numerous small, unregistered private hospitals and private physicians working solo or in small group practices. According to this report[1], the private sector was dominated by more than 20,000 "clinics", i.e. the small, office-based practices of general practitioners. Other private sector facilities included more than 300 maternal and child health centres (also known as maternity homes); about 350 dispensaries, which were outpatient primary health care facilities; and more than 450 small to medium, sized diagnostic laboratories. There were also more than 500 small and medium sized private hospitals with about 30 beds per hospital an average. All major population centres now have medium and large private hospitals with varying degrees of high technology capacity. However, private urban hospitals are mainly concentrated in the nine large cities[2]. These cities account for more than 75% of the private sector hospital beds (World Bank, 1998). Incidentally, all these cities also have public sector teaching hospitals, which are attached to various medical colleges.

The infrastructure of many of the large investor-owned private hospitals is reported to be good (World Bank 1998). Their information systems are modern and professional management and quality monitoring are reported to be much better than in public sector hospitals. However in smaller hospitals the quality of service is reported to be poor. Most of these private hospitals use the services of 'visiting consultants' who are employed by the public sector hospitals (Zaidi 1999a). Irrational and unethical practices like

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[1] The figures quoted in the report are from the census of the health facilities, conducted by the federal bureau of statistics in 1988.

[2] (Abbotabad, Faisalabad, Hyderabad, Karachi, Lahore, Multan, Peshawar, Quetta, and Rawalpindi/ Islamabad).

unnecessary investigations, consultations and surgical interventions are believed to flourish in private hospitals. In the absence of any documented evidence on the state of or quality of care being provided at the private health facilities, attention to the serious anomalies in the functioning of private providers (doctors as well as hospitals) have relied on the print media. Box 2.1 shows a typical example of many similar cases which are being reported in the press at regular intervals.

Box 2.1 'Wish for child leads woman to medical misery'[1]

Lahore: A young woman's wish to become a mother led her to very serious medical complications, due to apparent negligence of a Professor and Head of Gynaecology dept at a prestigious teaching hospital. The mistreatment was meted out at a "five star' private hospital owned by the professor and his gynaecologist wife. According to Saira Mehmood, 27, who has been married for 11 years but was issue less. Consultations with many doctors led to no solutions. She had a chance encounter with the Professor who convinced her of his competence and claimed to have dealt with many cases of infertility successfully. He also suggested that since the rates of his hospital were almost equal to Shaikh Zaid Hospital, it would be better for Saira to be treated at his private hospital. When Saira consulted the Professor for an ultrasound examination she was told that she had an ovarian cyst and endometriosis (a growth within the abdominal area) for which she would have to under go operative laproscopy. Saira underwent the operation during which the professor apparently perforated the colon and then attempted to stitch it himself instead of calling in a general surgeon. According to Saira, the professor carried out a procedure involving major abdominal surgery without her or her family's consent and during the process overlooked the perforation of the gut Saira was discharged two days later. Her family paid Rs. 62,000 for the treatment. A day later Saira developed abdominal distention and pain. Her family contacted the professor who had by then left on holiday. As Saira's condition worsened she was rushed to the Shaikh Zaid Hospital, where she was operated upon by a surgeon but the damage had already been done. Saira remained in the intensive care unit for 21 days and her discharge summary prepared by the professor of surgery reads that the patient developed gut injury after laproscopy for ovarian cyst/endometriosis. Then a major surgical emergency procedure was carried out. According to the medical experts contacted by the correspondent this was a case of gross negligence which speaks for itself. The procedure laid down for reporting the medical negligence to the Pakistan Medical and Dental Council are hardly known to any body outside the medical profession.

[1] http://jang.group.com/thenews/sept98

While government health services are 'free', widespread dissatisfaction with government health care has made people accustomed to paying for medical care in the private sector[1]. Private health care provision in Pakistan is generally financed by direct out-of-pocket user payments. From an economic standpoint, private services and facilities are funded on the basis of fee per item of service. The lack of access to health insurance poses a major problem in financing privately provided care for catastrophic episodes of illness or injuries. As long as the insurance market is constrained and payments occur direct from patients or employers, there are implicit brakes on cost escalation (Ashir et al 1993).

NEED FOR HEALTH SECTOR REFORMS

The importance of the private health sector in Pakistan means that public policy cannot be restricted to managing public sector provision; the government must act in order to protect the public as well as foster the efficient development of private health services (World Bank 1998). At present there would seem to be a consensus in Pakistan on the need for fundamental reforms in the health sector, specifically on the issue of the regulation of private health (Government of Pakistan 2000). The beneficial impact of private health services cannot be achieved unless there is a process that brings the unregulated private health sector within a 'net', so that its potential benefits could be harnessed for the population's benefit. However, there is much disagreement on the type of reforms required.

In 1990 the Pakistan Peoples Party-(PPP) led federal government, which had been elected to power following eleven years of military rule, formulated a National Health Policy. It underlined the need for an increased role for the private sector in health care provision, recognizing at the same time the need for proper regulation of this sector. For this purpose the policy outlined the proposed mode of regulation (Government of Pakistan 1990). It recommended that private hospitals, clinics and laboratories would be regulated by a commission (financed by the Association of Private Hospitals and Clinics), which would be headed by a retired high court judge. The proposed commission would fix fees for laboratory tests, diagnostic and surgical procedures, develop standards

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[1] Berman, Harris (1992). Trip Report for Policy options for financing health services in Pakistan. HFS project.

for private hospitals and nursing homes, grading them on the basis of available facilities, and making this information available to the public. However there is no evidence that this policy was based on the views of the stakeholders involved. When this policy was announced, one of the factions of the Pakistan Medical Association (PMA), supported by the then provincial government of Punjab (Punjab being governed by a coalition of parties opposed to the Federal Government of the PPP), opposed it and also organized a protest 'Long March' of doctors to the federal capital Islamabad[1]. This was to force the Federal Government to back down on its health policy. Due to the early dismissal of the then Federal Government by the President of Pakistan and the ensuing political instability, this policy never reached the stage of implementation.

In 1993, a study commissioned by the Federal Ministry of Health with the assistance of United States Agency for International Development's (USAID) Health Financing and Sustainability Project (HFS) recommended financing and organizational reform initiatives to improve quality, efficiency and equity in the Pakistani health system. This five-volume report, as well as making detailed recommendations on various aspects of the health system, also made recommendations regarding the private sector, especially private hospitals. The report recommended federal legislation for the setting up of a 'Healthcare Provider Accreditation Council' (HPAC) with provincial chapters. The HPAC would have the power to set minimum standards, monitor compliance and award accreditation to the facilities demonstrating compliance (Becker 1993). The proposed voluntary accreditation system was to be based on the incentives of increased prestige for the accredited hospitals and publicity in the media. In addition, the study also recommended that the federal government should consider instituting a system of compulsory hospital registration and licensing. As the USAID stopped its operations in Pakistan, with the imposition of sanctions under the Presseler Amendment of Foreign Assistance Legislation in the United States Congress, and there was yet another change of government in Pakistan, no follow up to the recommendations of this study took place (World Bank 1998).

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[1] The News International, Lahore August 10, 1999 'Professional rivalries create rifts in PMA' by Z. Niazi.

In 1997, the third general election in seven years returned the Pakistan Muslim League (PML) to power with a large majority in the parliament and the provincial assemblies. Another National Health Policy was announced, which included health policy guidelines till the year 2010 (Government of Pakistan 1997) and envisaged radical reforms in the health system of the country. This policy, like its predecessors, recognised the expanding role of the private sector and the need for its regulation. It proposed the setting up of a commission, which would establish an appropriate legal and regulatory framework to improve the quality of private health care, discourage unauthorized practices, along with eliminating inadequately equipped facilities. It would also set and enforce standards of care with the help of the Pakistan Medical Association and other professional organisations.

In addition, the policy underlined the need for a balance to be created between public/private health care responsibilities. It proposed the accreditation of private hospitals and clinics and recommended a more effective role for the Pakistan Medical and Dental Council. The policy proposed the setting up of autonomous district health authorities, giving financial and administrative autonomy to the tertiary care hospitals for better management, and the institutionalisation of private practice by public sector doctors. While this was a national health policy, the process of its implementation was initiated only in the province of Punjab where the government enjoyed absolute majority in the provincial assembly. Moreover it has been traditionally thought that once a policy initiative is successful in one province, it can be replicated in the other provinces (Aslam 1999). Implementation focused mainly on to the public sector[1], the regulation of the private sector remaining low on the priority list[2].

Thus while successive governments have admitted the inadequacy and shortcomings of the existing system and recognized the need for reforms to foster the efficient development of the private sector[3], there has not been any significant progress in this regard. Perhaps the most important reason for this has been the climate of political

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[1] The Punjab Medical and Health Institutions Act 1998
[2] The News International Lahore, August 1999
[3] National Health Policies, 1990 & 1997

instability in the country, where no government has succeeded in completing its term in office. Another obstacle has been the lack of any serious effort to evaluate the existing system or to try and identify the various stakeholders in the private health care provision who are key to any reform that is planned. Moreover, while all these policies have recommended better 'dissemination of information' to the general public, be it in the form of grading, accreditation or some other model, there has been not been much attention given to the feasibility or acceptability of these models. Anecdotal evidence suggests that previous policies/studies have reached their conclusions without a proper evaluation and without taking into account the perceptions of stakeholders. As a consequence they have come up with recommendations, which, while theoretically plausible, were unlikely to be implemented on the ground. There is a need to understand the dynamics which underlie the resistance to any changes in the status quo and, on the basis of that information, to then determine what kind of reforms have a realistic chance of working.

The following gaps were therefore identified in the existing knowledge base:

- Lack of evaluation of the existing system of regulation. There has been no systematic review and evaluation of the regulatory mechanisms governing health care provision in Pakistan in general, and private health care provision in particular.
- Failure to consider the interests and views of various stakeholders, essential to the success of regulatory process.
- Failure to involve the stakeholders in developing and evaluating the policy options.

CHAPTER 3
STUDY DESIGN AND METHODS

The following study was designed with the specific purpose of addressing the gaps in the existing knowledge base on the issue of health sector regulation in Pakistan. Various factors combined to make the study a challenging one. Firstly, while regulation has been on the agenda of various governments during the last decade, it still remains an unfamiliar and vague concept, even among health professionals, thus making it difficult to discuss it in a meaningful manner. Secondly, in the absence of a 'research climate', officials, especially at high levels, were not comfortable with the idea of answering questions from a researcher, especially when it related to the working of their organizations. Thirdly, the absence of any legislation on freedom of information made it difficult to get official documents in order to back up anecdotal evidence.

AIM AND OBJECTIVES

The overall aim of the study was to identify the existing gap between policy making and implementation regarding the regulation of private health care provision in Pakistan with a focus on formal private medical provision.

The objectives of the study were:

1. To describe and evaluate the existing regulatory framework governing health care provision in general and private health care provision in particular both at federal & provincial levels
2. To explore the views and perceptions of key stakeholders regarding existing regulations and the reasons for their effectiveness/non-effectiveness.
3. To identify whether and how regulatory mechanisms could be made to work effectively.
4. To explore the views of stakeholders regarding the potential for alternative mechanisms for ensuring the quality of formal private medical services, including the role of information dissemination to service users/the public.

SETTING

Two cities, Islamabad and Lahore, were selected for the study. Islamabad is the federal capital, the seat of Parliament and the location of the Federal Government. Under the 1973 constitution of Pakistan, the country was declared a federal republic, therefore establishing two levels of government, federal and provincial. While the constitution recognizes health as a 'provincial subject' (Rizvi 1992; Fazeel 1997), the federal government has the power to legislate and frame policies in the health sector that would be applicable to the whole of the country. The main responsibility for managing the health care system lies at the provincial level however (Lippeveld et al 1991). It is therefore imperative when looking at health policy matters in Pakistan to study them both at the federal and provincial levels.

The main study was conducted in the city of Lahore, which is the capital of the Punjab province and the seat of the provincial assembly and provincial government. The choice of Punjab province for the provincial level study was for three reasons. First, Punjab is the largest province in the country, comprising 56.6% of the population. Secondly, because of the relative affluence of this province, private sector activity in health has been more rapid in this province. According to the World Bank (1998), out of nine cities nationally showing rapid growth in private health sector activity, four were in the Punjab alone. And thirdly, Punjab was the province where the agenda for health reforms was first initiated by the government after assuming power in 1997. A pragmatic consideration was that the researcher had personal experience of working in the Punjab Health Department. Being the second largest city of Pakistan, with a population of 6.2 million and a well-developed infrastructure and a range of health care services, makes Lahore an important centre for a large proportion of the population of Punjab.

Lahore has a wide range of health care provision in both the public and private sectors. In the public sector, there are 26 hospitals including the six tertiary care teaching hospitals[1]. The combined bed capacity of all the public sector hospitals is 8031 beds (Government of

[1] Mayo Hospital, Services Hospital, Jinnah Hospital, General Hospital, Ganga Ram Hospital, and Lady Willingdon Hospital.

Punjab 1998). All the tertiary care hospitals are attached to the three medical colleges[1], which are governed by the Punjab Health Department. Also, a federally administered postgraduate teaching hospital operates in Lahore. Apart from these there are a number of other public sector hospitals run by Federal and Provincial organizations including the Armed forces, Pakistan Railways, Water and Power Development Authority (WAPDA).

Over the years Lahore has seen a rapid growth in private hospitals with varying bed capacity. Complete data on the number of private hospitals were not available as there is no law requiring private health facilities to be registered. However, the Punjab development statistics (1998) states that there were 12 private sector hospitals operating in Lahore with a combined bed capacity of 3246 on the 1st of January 1997. The same document, from which these statistics are quoted, defines 'hospital ' as an institution having ten or more than ten beds. Direct observation by the researcher revealed that even according to this definition, there are many more hospitals operating in the city than listed in the official statistics. Many of the doctors working in these private hospitals are employed in one of the above mentioned public sector teaching hospitals, as evident from the openly advertised boards of these doctors outside the private hospitals. Doctors receiving the highest merit in the examination of the Punjab Public Service Commission (which is the constitutional body that selects doctors for jobs in the public sector hospitals) are awarded postings in Lahore.

METHODOLOGY

The main aim of the current study was to identify the existing gap between policy making and implementation regarding private healh care regulation. Using the Walt and Gilson (1994) model of policy analysis, it was considered important to look at all those dimensions of policy making which contribute to the policy process. Focusing on the context, it was imperative to understand the particular political culture within which policies are made and implemented. The content also needed to be given some consideration and understood within this framework.

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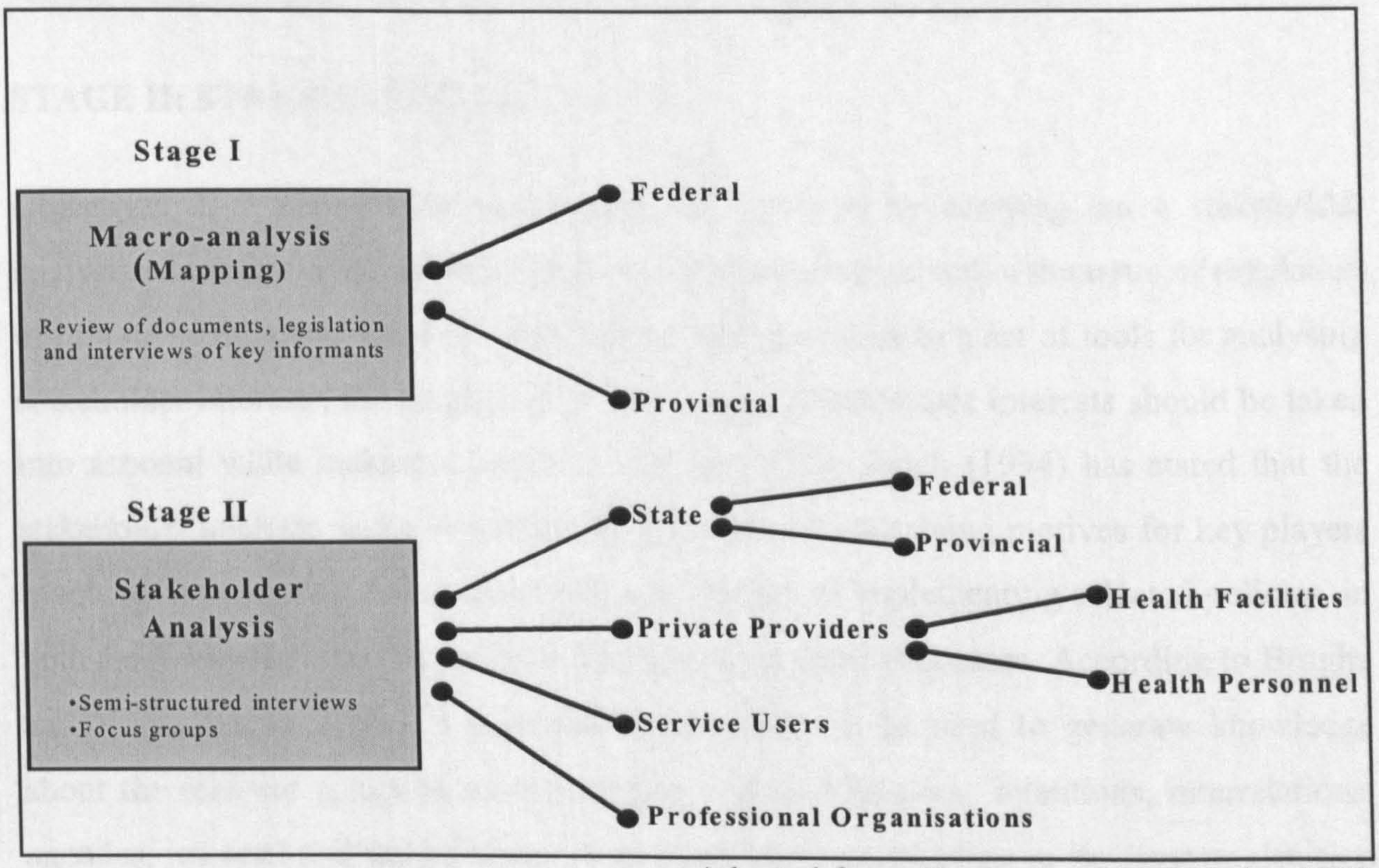
[1] King Edward medical college (KEMC), Allama Iqbal medical college (AIMC), Fatima Jinnah medical college (FJMC) and a post graduate medical institute (PGMI),

The study was qualitative in that it described and evaluated the existing regulations for the health sector and analytical in that it analyzed the views of the actors who could influence the policy process as well as those who could potentially be affected by it. A particular focus was on assessing stakeholders' views and receptiveness to the use of information dissemination, an option recommended by many previous health policies, as an intervention for underpinning regulations (see chapter 2). The research strategy of the study is given in figure 3.1, which shows the stages of the study.

Figure 3.1: Research Strategy



Adapted from: Kumaranayake & Lake, 1998

STAGE I: MACRO-ANALYSIS

The first stage of the study was a review and documentation of existing legislation governing the health sector in Pakistan, both at federal and provincial (Punjab) level. In order to achieve the first objective which was to describe and evaluate the existing regulatory framework, it was decided to use secondary data to obtain the relevant information. Information was collected through a review of official documents, policy statements by government officials and media reports, to document any proposed steps

being taken by the government in the context of regulation of private health care provision. In addition, any organizations or bodies formed as a result of relevant regulatory legislation were also examined. However it was anticipated that due to poor data availability, more than one source of information would have to be used. For this purpose it was decided to also include interviews with key informants which included officials of the concerned regulatory bodies as well as officials involved in the health sector reforms in Punjab, wherever supplementary information was needed. Thus triangulation (WHO 1994) was carried out not only to gather data but also to improve the validity of data obtained from different (sometimes informal) sources.

STAGE II: STAKEHOLDER ANALYSIS

Objectives 2, 3 and 4 were considered best achieved by carrying out a stakeholder analysis which could include the views of all the actors involved in the issue of regulation of private health care. The term stakeholder analysis refers to a set of tools for analysing stakeholder interests, the purpose of which is to indicate whose interests should be taken into account while making a decision (Crosby 1992). Reich (1994) has stated that the stakeholder analysis seeks to portray the explicit and underlying motives for key players involved in the policy and to assist decision-makers in implementing selected policies, in both cases highlighting the political dimensions of these processes. According to Brugha and Varvasovszky (2000) a stakeholders analysis can be used to generate knowledge about the relevant actors so as to understand their behaviour, intentions, interrelations, agendas, interests and the influence or resources they could bring to the bear on decision making processes.

Its relatively recent use as a health policy analysis and research tool reflects a recognition among policy makers of the central role of actors or stakeholders - individuals, groups and organizations - who have an interest (stake) and the potential to influence the actions and aims of the organization (Crosby 1992; Walt 1994; Brugha and Varvasovszky 2000). Although stakeholder analysis is advocated mainly to contribute to better quality strategic planning, a retrospective analytical component is an inherent feature of the effective use of the tool to explain and understand the current policy context (Brugha and

Varvasovszky 2000). The prospective dimension, depending on the purpose for which the tool is used, can vary from outlining and making recommendations on policy options to a more active process of promoting and facilitating policy development. There is no particular data collection technique specifically associated with stakeholder analysis and interviews of the stakeholders are standard ways for obtaining information (Crosby 1992). Varvasovszky and Brugha (2000) have stated that face-to-face interviews using checklists, semi-structured interviews and structured often self-administered questionnaires can all be used to collect data from primary sources. For groups of people, other techniques like focus groups, informal group discussions and workshops could be used (Varvasovszky and Brugha 2000).

The rationale for the choice of the various stakeholders is given in a later section, but the justification for the specific methods used to carry out the analysis is given here. As described later, all stakeholders except for the service users were individuals in positions of authority, who were not easily accessible or keen to share their views on a potentially controversial subject. Thus it was important to employ a method which would be acceptable and conforming to the prevalent culture. In much the same way as Liddle (1992) has documented in the case of Indonesia, there is a Pakistani mind set and cultural ethos which needs to be taken into account when considering the policy environment. Respect and deference for elders and those in authority, the need to avoid confrontation or open disagreement and not to appear to question the views of others is part of that culture.

A semi-structured interview was considered the best option as it allowed certain flexibility while following broadly pre-determined themes (WHO 1994). A totally unstructured interview would perhaps have suited the people being interviewed more as it would have let them steer the conversation in the direction they wanted, but it would have been less likely to achieve the study objectives. A structured self-administered questionnaire, which they could fill at their convenience (or get filled by their subordinates) might also have been preferred by them. A very formal structured interview on the other hand, would have been a much quicker and direct way of getting the relevant information, but unacceptable to the individuals being interviewed as they would have

felt threatened by it. A semi-structured interview, held in the style of a discussion therefore was the compromise solution which took care of the sensibilities of the interviewees as well as providing the needed information. It had the advantages of allowing personal contact, in-depth exploration of key issues and being flexible enough to allow both the researcher and the interviewee to follow new leads and explore fresh ideas (WHO 1994). The use of the term 'discussion' facilitated easier access than a request for an 'interview' would have had, which would have put people on their defensive. Most respondents felt more at ease when they felt their opinions were being solicited rather than feeling that they could be asked difficult questions. It needs to be noted however that all respondents were informed about the purpose of the research and verbal informed consent for the 'discussion' was always obtained.

To ensure reliability, a meticulous record was kept of all interviews and the process of obtaining data and its analysis were documented in detail. Since tape recording was not an acceptable option, careful note taking was done. As far as validity is concerned, "the nub of qualitative research----and its claim to validity----lies in the intense involvement between researcher and subject. Because the moderator can challenge and probe for more truthful responses, supporters claim, qualitative analysis can yield a more-in-depth analysis than that produced by formal quantitative methods" (Mariampolski 1984). This one-to one involvement was achieved in all the interviews conducted. Moreover the method of triangulation was also used to improve validity (WHO 1994; McPake et al 1999). This was done in two ways (WHO 1994): data triangulation, by collecting information on the same subject from multiple informants and methodological triangulation by using other sources of information, including some 'grey material' and newspaper items, to supplement and corroborate the information received from the interviews. It needs to be noted that since there is no freedom of information law in Pakistan which allows one access to official documents, obtaining such information or 'grey material' can be considered 'interference in the affairs of the government' which is punishable under the law. However, if it is voluntarily provided by an official, as sometimes occurred during this study, it is considered acceptable. A secondary point in this regard is that such material is only available if the issue is one currently on the

government agenda. The case of private health care regulation, as the officials interviewed explained, was not on the agenda at that particular point in time and therefore no documents, memos, or other directives existed.

The method selected to obtain the views of the service users was that of focus group interviews. (The justification of doing so is provided in a later section). In the case of documentation of the focus groups, initially tape recording was attempted but it had to be abandoned in later groups due to unacceptability and instead an assistant was used to take notes. Quotes from the focus groups have been provided in the results.

Stakeholders can consists of individuals, organizations, different individuals within an organisation and networks of individuals and organizations (Brugha and Varvasovszky 2000). ODA (1995) has stated that stakeholders are persons, groups or institutions with interests in a policy project or program and can be of the following types:

Primary stakeholders are those ultimately affected, either positively or negatively.
Secondary stakeholders are the intermediaries who can influence the project outcomes (by delivering aid to the primary stakeholders).

For the present research on the regulation of private health care in Pakistan, the following groups were identified as the stakeholders:

STATE

State, being the trustee of the national health is responsible for ensuring the provision of good quality health care to its people, either by providing it itself or through those outside its direct control. According to Article 7 of the Constitution of Pakistan, 'the state' means the Federal Government and the Parliament (Senate and National Assembly), Provincial Government and Provincial Assembly, and such local or other authorities in Pakistan as are by law empowered to impose any tax (Rizvi 1992). The organizations, which represent the state in the health sector at the Federal and provincial (Punjab) levels include:

- Federal Ministry of Health, Government of Pakistan, Islamabad
- Punjab Health Department, Government of Punjab, Lahore

Constitutionally, the Federal Minister of Health and the provincial health ministers are responsible for policy formulation and implementation. However in practice, since Pakistan has a long history of having been ruled by civil or military authoritarian governments, the institution of civil bureaucracy has gained so much strength that the respective administrative secretaries of the federal ministry of health and provincial health departments, who are the members of the elite civil service have more influence on the functioning of their organizations than have the ministers. The Human Development Report (1999), while describing governance in Pakistan, has stated that:

> "In parliamentary democracy the position of the civil servants is clearly a subordinate one and they are policy executors not the policy makers. However, because of the weak, inexperienced and segmented political leadership, the civil servants are themselves engaged in the twin functions of the formulation and implementation of the policies. Most of the cabinet ministers are thought to be inexperienced in the affairs of the government" (HDC 1999).

Despite the common perception in Pakistan that the ministers are just the figureheads and have very limited involvement in policy making, the author attempted to meet the Federal Minister for Health and obtain his views. However, because of his non-availability, it was decided to exclude ministers from the list of potential key informants in the present stakeholder analysis. The selection of key informants was from top officials, as identified from the organograms (Appendix 1) of the respective organizations. The key informants who were selected are listed below:

Federal Ministry of Health, Islamabad

- Secretary, Ministry of Health
- Director General, Health
- Deputy Director General Health (International Health)

Punjab Health Department, Lahore

- Secretary, Department of Health
- Additional Secretary, Health (Admin)
- Director General Health Services

PRIVATE PROVIDERS

Private providers are those who work outside the direct control of the state and, in most cases, operate on a for-profit basis (Bennett 1992; Smith et al 2001). Hanson and Berman (1998) have described providers as individual practitioners, groups of practitioners or facilities (clinics, hospitals or other institutions). As private providers are liable to be the most affected, either positively or negatively, by any regulatory mechanism, they were included as stakeholders. Although, private health providers include stakeholders like pharmacies and laboratories, there is no official recognition or information available on their role as direct providers. Also in most contexts more is known about the more visible parts of the private sector such as those providers who are more formally trained and organised (Smith et al 2001). This study therefore focused only on health personnel and facilities directly providing care. Thus the providers that were included in the study were:

- Private Health personnel (Doctors)
- Private Health facilities (Hospitals)

Private Sector Doctors

There are two categories of doctors who practice in the private sector. The first are public sector doctors who also practice privately, but with restrictions. Clause 6 of the appointment letter[1] of the public sector doctors states that:

> " You will not be permitted to open any clinic, nursing home, private hospital. The private practice shall be confined to seeing patients at your own residence or in the patients house or in the private wards of the hospital to which you are attached"

The second category, though a minority, are those doctors who practice purely in the private sector. Moreover an additional dimension of private practice in the cities is the predominance of 'specialist' practice. The criteria of selection of doctors for the study therefore, included doctors belonging to both categories, who had obtained higher post graduate/specialist qualifications. The doctors included in the study therefore were:

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[1] No. SO (Admin-1) 5-2/88 Government of the Punjab, Health Department, Lahore

- Public sector specialist doctors having practices in private hospitals
- Private-only specialist doctors

The sampling frame was obtained from a list of doctors compiled by the Punjab Health Department, which included the names of all the professors, associate and assistant professors working in the teaching hospitals of Lahore. While this list gave no indication of whether these doctors also had private practices, it could safely be assumed that the majority would be doing so. The plan was to randomly select every third doctor on the list and request him/her for an interview. If that particular doctor did not have a private practice, the immediate next one on the list was to be selected. However it became immediately obvious that the list was incomplete, inaccurate and at times providing false information. Some doctors who were on long-term leave from the government service were still on the list, while there were others who were drawing a salary against a certain post but not actually serving in that position. It was attempted to obtain a list of doctors from the individual hospitals themselves but this too was not feasible as this list was very difficult to access. The reason probably being the fact that many of the posts were filled in an irregular way and the managements were reluctant to share the information openly. The strategy was therefore modified to one of convenience sampling and doctors were selected directly by visiting teaching hospitals during the official working hours.

Doctors were approached and the purpose of the investigation was explained. Those doctors practicing in private hospitals were identified and they were asked for an interview. Approximately a quarter of these refused to speak on this issue citing mainly shortage of time as the reason, as well conveying the impression that they did not consider the research important enough to warrant their time. However it was implicit that the refusal was also because of a certain wariness to talk on a practice which was not strictly legal and the fact that the then Chief Minister Punjab had recently embarked on radical reforms in the health sector, targeting the management structures of public sector hospitals to improve efficiency. Most doctors however agreed to give their views, mainly because they perceived the researcher to be one of them. An additional reason for their agreement could have been that some of them hoped that the researcher, who had identified himself as having been affiliated with the World Bank, might be able to convey

their anxieties and views, as the health sector reform was known to be a World Bank funded project.

The question of bias needs to be addressed at this point. It is possible that the views obtained were only from those individuals who were willing to be interviewed and those who refused may have differed in some way from those who agreed to be interviewed. Those doctors who did agree did so because they felt they could fully trust the researcher. Their views therefore were quite open and frank and only shared because they were talking to someone whom they considered to be one of their own. The selection bias is thus to some extent balanced by the special consideration given to the researcher due to his particular identity as a doctor which enabled in-depth interviews to be conducted.

Fifteen doctors of various specialties were interviewed. A list was also compiled, at this point, of the private hospitals where these doctors practiced.

The second category of doctors, who were practicing exclusively in the private sector, was selected from this list of private hospitals. The hospitals were visited and the doctors who were present at that time were requested for an interview. The doctors were approached during the evening hours as this was the usual time when people seek private consultations. The sampling was of a non-probabilistic type and the issue of selection bias was considered minimal. No problems of accessibility or unwillingness to be interviewed were encountered, probably because the issue of dual public private practice was not involved. Another possibility for such easy accessibility could be the lighter work load on these doctors as compared to the public/private doctors as a result of which they had more time to spare for interviews but this was not thought to be a major issue. As doctors practicing purely in the private sector form a minority, only ten doctors in this category were interviewed.

Private Sector Hospitals

Private hospital owners/managers were interviewed in order to get the views of this group of private providers. An initial problem faced during the selection of private hospitals to be included in the study was that there was no available list of hospitals in the city, as

facility registration is not a requirement by law and anybody can set up a health facility wherever they wish. Thus, information regarding their total number and bed capacity was not available. In addition, there is no distinct definition of what comprises a hospital. The researcher observed that there were many types of private health facilities operating in the city, calling themselves hospitals, which had varying levels of bed capacity, emergency services, and staff strength. However, according to the 1997 notification of the Federal Finance Ministry[1], which was issued to exempt the customs duty on the medical equipment imported for the hospitals, the Government of Pakistan acknowledged only those private health facilities as hospitals which had fifty or more beds.

The author initially decided to include hospitals, which had a minimum capacity of 50 beds for the study. However, background interviews by the author showed that although many hospitals might have imported duty free equipment by declaring that they were operating at a 50 plus bed capacity, in reality many of them were not operating at that level; or alternatively, they were not willing to reveal their actual operational bed capacity. A reason for non-disclosure about bed capacity which was not explicitly mentioned was that lower bed capacity could be used to evade other federal and provincial taxes.

Because of the above-mentioned problems, therefore, the author decided to include hospitals with a minimum bed capacity of 25 beds. This decision was aided by the fact that the list of hospitals which had been made at the time of interview of public sector doctors, regarding their place of private practice, consisted of hospitals having a bed capacity of 25 or more; they also fulfilled the other criterion of being general hospitals providing emergency services. The final list comprised of nine hospitals[2].

Apart from the nine hospitals included in the study, the author interviewed the management of the United Christian Hospital (UCH). This hospital was one of those two

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[1] Notification (Customs) SRO 1318(I)/97, Government of Pakistan, Ministry of Finance and Economic Affairs, Islamabad.

[2] National hospital and Medical complex, Adil Hospital, Rashid Hospital, Omar Hospital, Cardex Hospital, Akram Medical Complex, Ammar Medical Complex, Surgimed Hospital and Medical Complex, Ittefaq Hospital

large-scale investor-owned/NGO controlled hospitals which were providing services to a particular 'clientele', (Shalimar Hospital is run by the Lahore Chamber of Commerce and Industry (LCCI) and caters primarily to the members of the chamber and their families. The United Christian Hospital UCH caters mostly to the Christian population) while also providing services on a for-profit basis to the general public. In addition, one speciality hospital was included: the Shaukat Khanum Memorial Trust Hospital (SKMT). It is headed by Mr. Imran Khan, former cricketer turned politician, who is a vocal proponent of reforms in the health sector. It was included so as to get his views on private health care and its regulation.

SERVICE USERS

People who use the services of doctors practicing in private hospitals are the ones that would stand to benefit the most from better regulation of the private health sector. Therefore, such service users were included as stakeholders. In contrast to the other stakeholders, where the key informants were individuals, it was decided to use a group interview technique for service users. There were two constraints militating against interviewing service users individually: firstly, a very large number would be needed to get a proper range of opinions and experiences; and secondly most private hospital owners would not allow their clients to be interviewed on their premises. (An attempt was made to contact service users at the premises of the hospitals themselves; permission was denied in most cases). Moreover, individual interviews would have made the logistic task of identifying individuals and arranging times and venues for interviews very lengthy as well as expensive.

Focus group discussions have the advantage of providing a lot of information quickly and at less cost than individual interviews. Moreover they are considered particularly useful for identifying attitudes and behaviours in a population, as they can indicate the range of opinions and ideas in a community (WHO 1994). While questionnaires are more appropriate for obtaining quantitative information and revealing how many people hold a certain opinion, focus groups can explore how these opinions are formed (Kitzinger 1995). They have been used successfully to assess needs, develop interventions, test new ideas or programs, improve existing programs and generate a range of ideas on a

particular subject (WHO 1994). This is particularly relevant for the present analysis, as the purpose was to assess the effectiveness or non-effectiveness of the existing regulatory mechanism, expectations and needs of the service users and their opinion on the possible use of information dissemination as an intervention to underpin regulations.

Two categories of service users were considered for the focus groups, depending on the type of health care chosen by them. One category consisted of service users for whom private health care was the first choice and the second category consisted of service users who had first tried the public option but had then come to the private sector. These categories were selected because it was considered that they would allow an insight into the performance of the private providers from two different perspectives. Adults of all ages and either sex were included. While it might have provided more detailed information if the group discussions had been categorized by age and sex, it was not considered necessary for the purpose of the research. What was required was the service user insights on the kind of care given by private providers and the issues that they considered important in this regard. The other selection criteria was that the individual had used a private service within the previous year and that in each group there were a mix of individuals who had used in-patient and out-patient services of a private hospital.

In each category a key individual was initially identified through personal contacts and he/she was asked to find additional informants who had also used a private hospital in the last year. The process of snowballing (WHO 1994) or chain sampling was then used to identify other likely participants. Each group had between 6--8 individuals. The aim was to conduct at least two focus group discussions in each category or to the point when no further new information could be elicited.

A total of four group discussions were eventually conducted. Each discussion was conducted at the residence of one of the participants.

Category A: Users of private health care as a first choice

Group1: There were six participants, four of them were women and two were men. The ages varied between 20 and 60 years.

Group2: There were seven participants, three of them women and four men. Ages varied between 25 and 65 years.

Category B: Users of private health care who had first tried a public sector option

Group1: This group consisted of four retired couples. Thus there were eight participants, four men and four women. Their ages ranged between 50-75.

Group2: There were eight participants in this group. Five were men and three women. Their ages ranged between 30-45.

While the other stakeholders were asked about policy issues regarding regulation, with the service users the emphasis was on their needs and perceptions as lay people and service users. A list of open-ended questions/themes was used as a reference point and guide during the discussions. These questions were arranged in a manner which would facilitate discussion; however there was no pre-determined sequence.

Reliability was ensured by careful documentation. An assistant took notes while the researcher moderated the discussions. In all focus groups the researcher was able to gain the confidence and trust of the participants. As a result everyone participated and discussion was frank and open.

PROFESSIONAL ORGANISATIONS

Professional organisations were the intermediaries or 'secondary stakeholders' according to the definition of ODA (1995), who could influence the outcome of the policy on regulation of private health care in Pakistan. In the present study the following associations representing private providers and service users were included:

- Pakistan Medical Association (PMA), Lahore Chapter.
- Private Hospitals Association (PHA), Lahore
- Consumer Rights Commission of Pakistan (CRCP)

Key individuals from these groups of secondary stakeholders were selected for more detailed discussions.

LIMITATIONS OF THE STUDY METHODS

Various problems were encountered during the phase of data collection. The biggest being, gaining access to the identified individuals. For each category of stakeholders a different strategy had to be applied. In some cases, particularly those of high profile bureaucrats, 'a connection' or 'contact' was able to gain entry. In others, entrance was facilitated by using the fact of having worked at the World Bank. While at other places an interview was granted on the basis of being perceived as being associated with a prestigious foreign university. In the case of many doctors, the fact that the researcher himself was a doctor provided entry, as he was perceived as being 'one of them'.

The potential biases that could arise as result of these methods have been considered. In all cases it is possible that the researcher was able to access only those who were able to be convinced into sharing their views and therefore it could be hypothesized that the opposing views were not adequately reflected. However as Reich (1994) states, understanding the policy making process in developing countries is not a simple task. It is often opaque to outsiders and even insiders are uncertain about it. Thus only by being perceived an insider and one who was validated by either other known people or by a prestigious organisation, was it possible to gain the trust of those who held key positions in the policy making process. Moreover, the results of the interviews showed that the views given by the various individuals were not one-sided and reflected all points of views.

The issue of validity which arises due to the bias has been considered, as it is generally thought that the validity of convenience sampling is low (WHO 1994) and the generalisability of the data obtained can be questioned. The results show however, that the views were representative of the general trend and they were given validity through the method of triangulation which provided consistent responses from different sources.

It can be also be argued that the information obtained from this analysis is not generalizable, because of the fact that it is very context specific. Also that because it so dependent on the context, it can become quickly outdated particularly where political situations are unstable, as in Pakistan. Walt and Gilson (1994) defend the need to carry

out such a policy analysis on the ground that it is a necessary tool to be able to influence policy outcomes. Thus while it is recognized that this information may not be widely generalizable, it is nevertheless important in the present policy making context in Pakistan and the process of analysis and political mapping (Reich 1994) is one which can be replicated elsewhere.

CHAPTER 4
MACRO-ANALYSIS

This chapter provides the results and discussion of the mapping or macro-analysis stage of the research. It describes the existing legislation governing the health sector at the federal and provincial levels. At the federal level, it first provides an overview of all the legislation that relates to the health sector (table 4.1). Since the focus of the present study is on the regulation of private health care provision, focusing on doctors and private hospitals, only legislation dealing directly with these aspects of the health sector is described in more detail. This information is supplemented with an in-depth description of the organisation responsible for the implemention of that legisalation and an interview with the person in charge of that organisation.

At the provincial level, those legislation considered relevant to the issue of regulation of the private health care are described, followed by interviews with key individuals. The findings are discussed at the end of the chapter to provide an understanding of the results of this stage of the analysis.

FEDERAL LEGISLATION

Table 4.1 shows the various acts and ordinances governing the health sector in Pakistan. It also provides information regarding the objective of the legislation, the bodies formed for their enforcement, and finally the relevance of these legislation for the present study.

Federal legislation is passed by the parliament and has jurisdiction extending to the entire country.

Table 4.1: List of health sector legislations and their relevance to the study

Legislation	Objective/purpose	Bodies set up under the legislation	Relevance to the study
Unani & Homeopathic Act 1965, amended 1995	To promote and popularise the Unani, Ayurvedic and Homeopathic systems of Medicine, regulation and registration of Practitioners	National Council for Tibb and National Council for Homeopathy	No
Medical & Dental Degrees Ordinance, 1982	To repeal the Medical degrees Act 1916 to allow institutions authorised by the government to grant degrees in medicine and dentistry in Pakistan.		Only to the extent that this was the first formal recognition of the non public sector medical institution in Pakistan
Drugs Act 1976	To regulate the import, export, manufacture, storage, distribution and sale of drugs.	Provincial Quality Control Boards in all the provinces	Yes, as an example of a regulatory body
Pakistan Nursing Council Act 1973	To consolidate the laws relating to the registration and training of nurses, midwives and health visitors	Pakistan Nursing Council	No
Pharmacy Act 1967 Amended 1973	To regulate the practice of pharmacy.	*Pharmacy Council of Pakistan *Provincial Pharmacy Councils	Yes, as an example of a regulatory body
Social Security Ordinance 1965	To introduce a scheme of social security for certain employees or their dependents in the event of sickness or death	Provincial Social Security Institutions	No
College of Physicians. & Surgeons Pakistan Ordinance 1962	To promote specialist medical practice by arranging post-graduate medical education and awarding higher diplomas like FCPS and MCPS.	College of Physicians and Surgeons Pakistan was established to encourage Pakistani doctors to obtain specialist training within the country rather than going abroad for degrees such as FRCS or MRCP.	No
Medical & Dental Council Ordinance 1962	To consolidate the laws relating to the registration of medical practitioners and dentists and to establish uniform minimum standard of basic and higher qualifications in medicine and dentistry.	Pakistan and Medical Dental Council by abolishing the Provincial Councils set up under 1951 Act	Yes, being the only regulatory body for medical practice in Pakistan

Allopathic System (prevention of misuse) Ordinance 1962	To prevent the misuse of allopathic system of medicine by unqualified persons		Yes, as it allows only those who have registered their qualifications with the Pakistan Medical and Dental Council to practice medicine.
Pure Food Ordinance 1960	To consolidate and amend the laws relating to the preparation and sale of food items in the provinces in order to maintain purity and quality.	*Office of the public analyst at the provincial level *Health and sanitary inspectorates at the local authority level	No
West Pakistan Epidemic Disease Ordinance 1958	To empower the provincial governments to deal with the situations like epidemics by invoking special powers if the existing laws are insufficient.		No
Public Health (Emergency Provision) Ordinance 1944	To make special provision regarding public health in case of emergency and to prevent the spread of human disease by maintaining adequate medical and other essential services		No
Factories Act 1934	To protect persons from being subjected to unduly long hours of bodily strain or manual labour		No
Dangerous Drugs Act 1930	To centralise the control over certain operations relating to dangerous drugs and to increase and render uniform penalties for offences relating to such operations		No
Poison Act 1919	To consolidate the laws which empower the provincial governments regulating the importation, possession and sale of poisons whether wholesale or in retail.		No
Lunacy Act 1912	To consolidate the laws relating to lunacy		No

The above table identifies drug and pharmacy acts as relevant to the present study. These have been selected as they provide examples of regulatory bodies at the provincial level, set up under federal legislation. The Allopathic Systems ordinance had relevance to the extent that it highlights the role of Pakistan Medical and Dental Council as a regulatory body, but in the context of unqualified practitioners. Since the focus of the present study was on the regulation of private health care provision, specifically allopathic practitioners and private hospitals, the above acts were not considered in further detail. The Pakistan

Medical and Dental Council Ordinance 1962 was the only legislation which dealt directly with the issues being investigated.

Pakistan Medical and Dental Council Ordinance, 1962

This ordinance consolidated the laws relating to the registration of medical practitioners and dentists and reconstituted the Medical and Dental Council in Pakistan. The aim was to establish a uniform minimum standard of basic and higher qualifications in medicine and dentistry. It was under this ordinance, that the Pakistan Medical and Dental Council was constituted.

PAKISTAN MEDICAL AND DENTAL COUNCIL (PMDC)

This is an autonomous body of the medical profession, which was reconstituted under the Pakistan Medical and Dental Council Ordinance 1962 thus abolishing the provincial medical councils, which had been working under the Pakistan Medical Council Act of 1951.

Composition of the PMDC

According to the PMDC ordinance 1962, the total membership of the Council is fifty-nine. These are as follows:

- One member to be elected by the National Assembly from amongst its members;
- One member from each of the four provinces, to be nominated by the Provincial Governments;
- One member each to be elected by the Syndicate's of each Pakistani University from amongst the members of the medical and dental faculty (presently numbering eleven);
- Four members to be elected from amongst themselves by the registered medical practitioners;
- Four members to be nominated by the Federal Government, of whom at least one shall be a member of the Armed Forces Medical Services;
- Two members to be elected from amongst themselves by registered dental practitioners;
- One member to be elected by the teaching staff of every medical and dental institution in Pakistan from amongst the Professors on its staff; (presently numbering thirty-one).

- One member of the legal profession to be nominated by the Chief Justice of Pakistan;
- The Director General of Health, Government of Pakistan.

While this is the maximum strength of the Council, it is not unusual for the Council to operate at a lower strength. This is because various organisations, which have to nominate members to the Council, do not do so on time. The Council elects its own President and Vice President, from amongst its members. Nevertheless, it has been a tradition that the Director General Health, Government of Pakistan, acts as the ex-officio President of the Council[1].

Functions and Powers

The main objective of the PMDC is to regulate medical and dental education in Pakistan, to establish uniform standards of basic and higher qualification and to maintain the register of qualified medical and dental practitioners in the country.

The main functions of the Council are:

- To recognise and register medical and dental qualifications granted by medical institutions within and outside Pakistan.
- To recognise and register additional postgraduate medical qualifications granted by medical institutions in or outside Pakistan
- To inspect the examinations held by medical or dental institutions in Pakistan;
- To recommend to the Government for the withdrawal of recognition of medical or dental institutions in Pakistan
- To maintain a register of medical and dental practitioners possessing qualifications which are recognised
- To remove the name of any medical or dental practitioner from the register
- To make regulations generally to carry out the purposes of the Ordinance

The Council has issued a code of medical ethics, which the council expects all doctors to follow, whether working in the private or public sector, as it relates to the overall practice

[1] Pakistan Medical & Dental Council, Islamabad

of medicine in Pakistan which is not allowed unless the doctor is registered with the PMDC. The Council is responsible for all policy decisions. It meets at least once a year, or when there are sufficient items for the agenda which need policy decisions. It acts through a secretariat and various committees.

Secretariat

The Council has an independent Secretariat, which is based in the federal capital Islamabad. The Secretariat is headed by the Secretary, who is the Chief Executive of the Council and is responsible for all the secretarial work, including the implementation of the decisions of the Council. The Secretariat liaises with the Federal and Provincial Governments, health departments, universities, medical colleges and allied agencies for the implementation and execution of the decisions of the Council. It also liases with the foreign licensing bodies and councils. The Secretary, PMDC, has delegated the powers granted to him under the PMDC Ordinance to various officials in the provincial health departments, to lodge complaints of negligence and malpractice.

Committees of the Council

The Council has the following committees for carrying out various functions:

Executive Committee

The Executive Committee is responsible for administration, finance and other related matters and is composed of the President, Vice-President, Secretary and five members of the Council.

Recognition Committee

The Recognition Committee is headed by the Vice President of the Council and is responsible for equating, and recognising the various degrees which have not been included in the various schedules of the Ordinance and been obtained from countries outside Pakistan. This Committee determines the equivalence of foreign degrees with the Pakistani degrees. It also certifies the experience gained in health institutions outside Pakistan for the purpose of appointment in Medical and Dental Colleges of Pakistan.

Curriculum Committee

The Curriculum Committee is headed by the Vice President of the Council and meets periodically to review the medical curriculum and see if any changes are required.

Disciplinary Committee

The Disciplinary Committee is headed by a lawyer, who is nominated by the Chief Justice of Pakistan. The Committee is responsible for initiating disciplinary action against doctors as and when a complaint is received for professional negligence or misconduct.

Postgraduate Medical Education Committee

The Postgraduate Medical Education Committee is headed by the Vice President and is comprised of the representatives of the medical institutions who are involved in postgraduate training. This committee is responsible for laying down the standard of postgraduate medical education leading to the degrees of FCPS, MD, MS, PhD, Phil.

Staffing Committee

The Staffing Committee is responsible for stipulating the minimum qualifications and experience for teachers and examiners in the undergraduate and postgraduate medical and dental institutions in the country.

Dental Education Committee

The Dental Education Committee is responsible for laying down the standard for dental education in both undergraduate and postgraduate institutions and all other functions related to dental education in the country.

Provincial Offices

The Council has four, provincial sub-offices located in each provincial capital. The main purpose of these offices is to provide information and advisory services to doctors in matters of registration with the Council. They act more as 'post-offices', handling correspondence between doctors and the Council, rather than serving as functional or independent units.

VIEWS OF THE SECRETARY PMDC

An interview with the Secretary PMDC was sought in order to clarify certain information about the role and functioning of the PMDC. Such information was either not documented or unavailable in the public domain. Furthermore, there was some anecdotal evidence regarding the Council, which could only be verified by a senior official of the Council.

The Secretary PMDC is a non-medical person, who has been in this position for more than ten years. He was interviewed to find out his views and perceptions about the PMDC. Questions were asked regarding the effectiveness of the PMDC in controlling the market entry of doctors and whether in his opinion the Council was meeting the objectives for which it had been set up.

At the outset the Secretary expressed satisfaction with the working of the council. However, when questioned on why the council did not take any action regarding the many cases of malpractice reported in the press, he replied that the PMDC could only take action if alleged malpractice was formally brought to its notice, and, without this, action could not be taken. He reported, that the Council cannot take action only on the basis of press reports. The complaints have to be logged through a formal procedure, a copy of which was provided to the researcher (which, significantly, was not available otherwise). Moreover, the Secretary stated that Council is based in Islamabad and did not have infrastructure of its own to monitor its effectiveness and to ensure that its regulations were being followed. Therefore it has to operate through the provincial health departments, who have been delegated the authority to report cases of malpractice to the Council so that action could be taken. An average of four to five cases per year is reported in this manner and he stated that appropriate action was taken on these occasions.

When questioned as to whether doctors who obtained post graduate degrees from foreign institutions, which the PMDC did not recognise, were practising as specialists in private hospitals, the secretary did not have a specific response. However he reiterated that it was the responsibility of the provincial health departments to point out such practices and

bring them to the notice of the Council. According to him the Council is not provided with enough information on the various cases of malpractice going on in the provinces.

When he was asked whether the PMDC should become decentralised and hand over functions to provincial levels to facilitate enforcement, the Secretary reminded the researcher that the Council had originally been set up as provincial level bodies but these were dissolved to set up a central body in 1962. The Secretary defended the action taken forty years ago and gave the opinion that the Council was subject to a lot of political manipulation and, whereas a federal body could cope with such pressure to some extent, it would be very difficult to resist it at the lower provincial levels. He believed power needed to stay centralised.

The Secretary was asked how the PMDC had adjusted to the changing profile of the medical profession in that there were now a large number of doctors who were working outside the public sector. In response, he reported that the PMDC had a very limited infrastructure and could not monitor the activities of the ever-enlarging health sector, particularly the private health sector. He seemed to show more interest in medical education, specially the new private medical colleges opening up in various parts of the country, rather than in the monitoring of private hospitals, country-wide.

PROVINCIAL LEGISLATION - PUNJAB

A review of provincial legislation regarding the health sector revealed that there was no Punjab specific legislation addressing the health sector until 1992 and the health sector was being governed solely under the federal legislations described in table 4.1. However, since 1992, there has been new acts and ordinance governing health ; these are described here to demonstrate the changes occurring in the Punjab Province in the health sector, which could have indirect implications for private health care provision. These also contain some useful concepts, which could be used in a future regulatory mechanism in the province.

The Punjab Health Foundation Act, 1992

The objective of the Punjab Health Foundation Act was to promote, develop and finance the health services in the private sector. Under this act the **Punjab Health Foundation (PHF)** has been established with the objective to promote, develop and finance health services in the private sector. Management of the PHF is vested in a Board of Directors. However, its day to day business is transacted by a Managing Director who is the Chief Executive of the PHF who performs those functions as may be assigned to him by the Board.

Functions of the Foundation

The Foundation takes measures, which it deems necessary for the promotion, development and financing of health services in the private sector in the Punjab province. Thus the Foundation may:

- Establish or cause to be established health institutions and allied projects;
- Give grants to health institutions for the purchase of land, construction of buildings, purchase of equipment, furniture and for other allied projects;
- Give loans to health institutions;
- Provide loans to doctors for opening clinics;
- Assist health institutions and doctors in getting loans from Government, development authorities and housing agencies controlled by the Government;
- Assist the private sector in providing necessary facilities for population welfare programmes;
- With the approval of the Government raise loans and receive grants; and
- Perform such other functions as may be assigned to it by the Government.

Punjab Medical & Health Institutions Act, 1998

This Act was promulgated to establish and improve the Medical and Health Institutions and to give them an autonomous character in order to provide quality health care for the people of the Punjab.

The Punjab Health Institutions Rules, 1999

Under the Punjab Medical and Health Institutions Act 1998, the Governor of the Punjab issued the rules to establish District Health Governments (DHG) for the districts. According to these rules the DHGs were given the responsibility to act as health services provider, and to administer and manage all health facilities, programmes and other ancillary services at the district level. Also the rules bind the DHG to perform such other functions as may be assigned to it by the Government of Punjab.

Punjab Transfusion of Safe Blood Ordinance, 1999

The main objective of this ordinance was to regulate the blood transfusion activities in the province. Under this ordinance, **Punjab Blood Transfusion Authority** has been established to develop a uniform policy covering all aspects of safe blood transfusion based on the current developments in the field.

The functions of the authority include:

- Registering, issuing and renewing annual licenses to the blood banks.
- Ensuring that guidelines issued by the authority are strictly followed.
- Ensuring that the blood banks are managed and run by qualified professionals, preferably having post-graduate qualification in blood transfusion, haematology or clinical pathology as recognised by the Pakistan Medical and Dental Council.
- Carrying out periodic inspections where necessary.

VIEWS OF THE OFFICIALS INVOLVED IN THE HEALTH SECTOR REFORMS

Key informant interviews were conducted with the individuals who were actively involved in the health sector reforms underway in the province of Punjab. These key informants included:

- The Advisor to the Chief Minister, Punjab (health sector reforms)
- Deputy Secretary, Chief Minister Secretariat (Implementation)
- Executive Director, Special Projects (The World Bank, DFID, Asian Development Bank assisted), Government of Punjab.

The mapping stage of the study revealed that most of the legislation in the health sector in Punjab province had been passed during 1998-99. In the usually slow moving bureaucracy, not only had acts been passed in the assembly but various proposals had actually been put into practice. This included giving autonomy to the teaching hospitals, setting up of district health governments, a blood transfusion authority and regulation of the pharmaceutical sector.

The purpose of meeting the key officials involved in these reforms was to find out the reasons and motivation behind this fast pace of reforms in the health sector in Punjab. The unanimous opinion of the three respondents was that these reforms were the result of the initiative of a single man, the Chief Minister of the Punjab. Through the sheer momentum that he had created, public opinion had swung in his favour, thereby stifling the various voices of protest and resistance.

They were also asked why new structures or authorities were being set up when there already existed a health infrastructure in the province. The response to this was that the old system was so decrepit and inefficient that it simply did not have the capacity, will or competence to carry out or implement new reforms. Therefore it was necessary to bypass the old system and replace it with a new one with fresh ideas and increased competence.

On the matter of regulation of the private health sector and the absence of it in recent legislation, the officials were questioned as to why this was so and whether it implied that the government did not recognise it as having important implications for the health sector. In answer it was said that the government did understand the importance of the private sector, but because this sector had grown partly at the expense of the public sector, it was thought important to revamp and revive the public sector first. It was in this context that various steps like the institutionalisation of private practice and autonomy of hospitals were being considered. However, once this had been achieved, it was on the government's agenda to take up the matter of the regulation of the private health sector in the second stage of the reforms. The provision for such action had been kept in the present plans and therefore the matter would not have to go back to assembly, but would be able to proceed without any impediments. In this regard the Advisor to the Chief

Minister referred to the clause in the Punjab Health Institutions Rules 1999, which bound the DHG to perform such other functions as may be assigned to it by the Government. The Executive Director of the Special Projects also mentioned that a reason for keeping this in the subsequent stage was also the current lack of technical expertise in regulatory issues and therefore it was planned to seek assistance from the World Bank/DfID in this regard.

DISCUSSION

In general there has been little federal legislation regarding the health sector in Pakistan. While there are a few acts/ordinances that are regulatory in nature but they deal with the pharmaceutical sector, non-allopathic practitioners, nurses etc. The only legislation which can be considered relevant to the present study is that of the Pakistan Medical and Dental Council Ordinance 1962, under which the Pakistan Medical and Dental Council (PMDC) was constituted. The main objective of the PMDC was to oversee standards of medical and dental education in Pakistan. However, the responsibility of the maintenance of a register of duly qualified doctors entitled to practice medicine or dentistry in the country has provided it the role of a regulatory body of the medical profession. It controls entry into and exit from the profession, as it is responsible for disciplining and if necessary removing doctors deemed unfit to practice from the register.

The role of the PMDC has remained the same from the day of its inception. Comprised mainly of doctors, illustrated by the fact that 43 of the 45 members of the council are doctors[1], it acts as a self-regulatory body of the profession. There have been reports in the press in which it has been alleged that the PMDC has become a tool in the hands of the powerful medical community, which had a vested interest in maintaining control of the Council. A clear illustration of this 'regulatory capture' is the way rules were amended to elect a new President of the Council. Until February 2000 it had been a practice to elect the Director General of Health as the President of the Council. However, when it became clear that the Federal Ministry of Health was contemplating a crackdown on a number of private medical colleges in which senior doctors had stakes, the rules were amended and one of the senior doctors was elected President[2].

Another important fact is that the ordinance under which it was created, addressed only public sector facilities/hospitals and there was no consideration given to the private sector. This was understandable because, until 1982 (see table 4.1) and the establishment of Agha Khan Medical University, the formal or corporate private health sector was still

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[1] List of the members of PMDC, August 1999
[2] http://nation.com.pk February 19, 2000

non-existent. Over the past two decades, there has been a mushrooming of private hospitals and lately of private medical colleges, which has become a lucrative business venture for investors for whom public welfare is perhaps not the first priority. In 1999[1], the role of the PMDC in the private sector was enhanced to some extent through an amendment to the Pakistan Medical and Dental Council ordinance 1962; however this amendment only dealt with the establishment of private medical and dental teaching institutions in the country.

Doctors who are employed in the public sector have to comply with the PMDC regulations, which requires all doctors wanting to practice medicine or work in any hospital (public or private), anywhere in the country, to have their qualifications registered with the PMDC. This includes postgraduate medical qualifications, whether obtained in Pakistan or abroad. The Public Service Commissions, which select doctors for public sector jobs, do not entertain the applications of doctors without a valid PMDC registration certificate. On the other hand, doctors, especially specialists who opt for the private sector, while under the same obligation, are able to get work without having registered their postgraduate qualification or experience with the Council. Because of lack of enforcement ability of the PMDC, the doctors face no penalty for not obtaining the registration. (There is no documented case of such a penalty ever having been levied). On the other hand, obtaining registration might mean paying a substantial amount of money to the Council. For the owners of the private hospitals, it is a lower priority than the commercial success of their hospitals and therefore they do not demand it either.

A crucial weakness of the PMDC is its lack of enforcement capacity and its inability to implement its regulations. It is centrally based in Islamabad, functioning through the provincial health departments, which do not fall under the chain of command of the Council. Thus the Council is able to recommend certain actions but it is left to the discretion of the provincial health departments to implement them or not. Evidence of its weak enforcement capacity can be seen in the flagrant violation of its code of ethics. To cite an example, clause 2 of article 30 of the PMDC Ordinance clearly states that:

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[1] www.dawn.com April 4, 1999

> "No registered doctor shall use or publish in any way whatsoever any name, title, description or symbol indicating or calculated to lead persons to infer that he possesses any additional or other professional qualifications unless the same have been conferred upon him by a legally constituted authority within or outside Pakistan."

Related to the above is another requirement of the code of ethics, which states that:

> "Name plates may be fixed on the premises where the medical/dental practitioner practices and at his residence. The nameplate should not be ostentatious. It may include academic qualifications in small letters, and may mention the particular type of specialty of the medical practitioner. It should not mention the past and present appointments held by the practitioner. The name plate should not exceed 36x24 inches in size."

However it is a common sight in all cities in Pakistan to see huge boards outside private hospitals, making exaggerated claims of qualifications and expertise. There has not been a single case where this has been challenged or objected to by the PMDC. The procedures of the PMDC are also user 'unfriendly' and extremely cumbersome. For example the procedure to lodge a complaint of negligence or malpractice against doctors involves witnesses, magistrates, time and money[1]. Moreover the majority of people are quite unaware of the PMDC's existence or the way to go about making a complaint.

Lack of infrastructure and enforcement ability of the PMDC has made it ineffective as far as its role as a regulatory body of the medical profession is concerned. In this context, a draft report[2] submitted to the Planning Division, Government of Pakistan, reported that the PMDC has confined itself to setting standards for medical education and recognition of degrees and does not concern itself with the practice of registered practitioners even when blatant foul play is committed.

In the context of provincial legislation in Punjab, the government has been encouraging the private health sector to share the burden of health care provision with the public sector in the province. The Punjab Health Foundation was set up to provide assistance in

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[1] 'Complaint against medical and dental practitioner and action thereon' PMDC, Islamabad
[2] 'Study of the Role, Extent and Regulation of Private Health Sector in health care delivery in Pakistan' draft proposal submitted to Ministry of Planning and Development, Government of Pakistan, 1999

this regard. Its envisaged role was to reduce bureaucratic delays and to facilitate and expedite the establishment of private health facilities. However, while this was done successfully to some extent, no mechanism was put in place to regulate the growth that resulted as a consequence of these steps. A possible related consequence because of the comparatively higher financial rewards in this sector may have been the indirect effect of transferring energies from the public to the private sector, producing a situation where the growth of the private sector was taking place at the cost of the public sector.

The provincial government took some major steps during the past few years in order to revive and strengthen the public health sector. It was assumed that this would also have beneficial effects on the private sector. One of these steps was the provision of autonomy to the teaching hospitals in the province under the Punjab Medical and Health Institutions Act 1998, which decentralized management from the provincial secretariat to the hospitals themselves. This was to enable hospital managements to discipline staff without the authorization of the provincial health department. This could have a far-reaching effect in that doctors working in those autonomous hospitals could be compelled in a more efficient manner into complying with the rules under which they had been employed. One such rule would be the strict adherence to the rule which prohibits public sector doctors from practicing in private health facilities. Uptill now this as more or less been ignored because of the inability of the public hospital managers to check this practice.

The other step was the formation of district health governments under the Punjab Health Institutions Rules 1999. This was to enable district health governments to take measures according to the needs and priorities of the district population. This is important from the point of view of the present study as more autonomous or powerful district health administrations could be much better able to regulate the private heath sector at the district level. However in the foreseeable future, the capacity of the districts to have professionals with experience in regulatory issues in the health sector seems doubtful.

Another important legislation, which was enacted during the past couple of years, was the Punjab Blood Transfusion Ordinance 1999. Under this act the Punjab Blood Transfusion

Authority was set up, bypassing the existing health department, which had been dealing with this issue for years and which had proved to be totally ineffective in regulating the blood transfusion activities in the province. The establishment of a new authority was therefore necessitated because the old system did not have either the capacity or the will to carry out any new initiatives, especially with regard to the involvement of the private sector in blood transfusion services. A positive example set by the new authority was that it included qualified experts as well as representatives from the public and private sectors and the service users. This was a major step forward from the previous arrangement where the functions were being carried out exclusively by employees of the Punjab Health Department, irrespective of whether they had the required expertise for the job or not. The fact that the private sector and the service users had been excluded from participating in the process was also a disadvantage. The new authority stands a better chance of success in regulating and checking the prevalent malpractices in blood transfusion, precisely because it is more inclusive and because it recognises all the relevant stakeholders.

CHAPTER 5
STAKEHOLDER ANALYSIS

This chapter will describe the results and discussion of the stakeholder analysis which was conducted to ascertain the positions of various stakeholders on the issue of regulation of the private health care provision in Pakistan. It consists of two sections. The first section describes the responses of the individuals selected from each category of stakeholders. This description is provided according to the broad themes which were discussed. The second section consists of a discussion of the results, which is structured again in terms of the themes for the analysis. Thus for each theme the views of all categories of stakeholder are discussed in turn.

The broad themes on which semi structured interviews were based are given below but, in each individual interview, various other specific themes were also discussed depending on the respondent's position and interests. All of these are covered in the results.

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the existing ones.
- Perceived need for regulation of private health care provision.
- Views regarding alternative mechanisms for regulation and capacity of the government to assume new/ enhanced roles. The respondent's position on this issue and their opinions on any alternative mechanism were explored.
- Opinions on the utility and feasibility of regulation model based on "information dissemination". It was explained to the respondents how such a model might work, including the possibility of grading of hospitals according to minimum standards of quality and making this information available to the general public.

STATE

The first category of stakeholder was that of the state. As described in chapter 3, key informants at the federal and provincial level were identified (Appendix 1). Their views are reported in this section.

FEDERAL MINISTRY OF HEALTH

Federal Secretary Health

The Federal Secretary Health is the administrative head of the Federal Ministry of Health. It is the senior most post in the federal health bureaucracy. The Secretary's post is always occupied by a member of the prestigious Central Superior Services of Pakistan, a medical person having been in this post on only one or two occasions. The present incumbent was a non-medical person, having been in this post for less than six months.

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the few existing ones

The Secretary gave a historic perspective about the reasons for lack of legislation on private health care provision in the country. He reported that the issue of lack of regulations has various causes. Firstly, after the restoration of democracy in 1985 till the general elections in 1997, the country has been successively governed by weak political coalitions which were more preoccupied with their own survival than with taking on powerful lobbies like that of doctors. Secondly, health is a provincial subject according to the constitution. Although the Federal Government can issue policy directives to the provinces, even this was not done, as the Federal Government did not take any initiative in the matter.

When asked about the relevant legislation e.g. Pakistan Medical and Dental Council (PMDC) Ordinance 1962, the Secretary, although aware of the particular legislation, avoided going into details. However, he mentioned that it was under this act that the PMDC was constituted, which had over the years become an instrument in the hands of the powerful medical community and therefore worked more to protect the interests of this community.

- Perceived need for regulation of private health care provision

The Secretary responded that there was a real need for such regulations. The private sector had expanded over the last two decades and to some extent the government encouraged this expansion to ease the financial burden on the public sector. However the expansion has gone on, more or less, without any regulations. Another way in which the government policy had somewhat backfired was that the higher financial rewards attracted many doctors from the public sector to spend their time and energy in the private sector. Thus, instead of the envisaged sharing of health care, the policy resulted in the growth of the private sector at the cost of the public sector. In his opinion regulation would have to address both the cost and quality of health care being provided by the private sector.

- Views regarding alternative mechanisms for regulation of private health care and the capacity of the government to assume new/ enhanced roles.

The Secretary was rather non-committal on this issue. He did however say that reforms were underway in the health sector in the Punjab, which were being led by the Chief Minister of the Punjab. The Chief Minister carried a lot of authority, as he was the brother of the Prime Minister as well as having a two third's parliamentary majority in the Punjab Assembly. He envisaged the possibility that the Government of the Punjab might include private health care regulation in its agenda at a later stage. He considered government to be appropriate for enforcing regulation rather than a private sector body, but agreed that at present the government institutions did not have the capacity to fulfil this role and that a new authority would be needed for the purpose. He gave the examples of NEPRA, (National Electric Power Regulatory Authority) and Natural Gas Regulatory Authority. To maintain uniformity among provinces, he was of the opinion that such a body should be a federal one with provincial chapters.

- Opinion on regulation model based on "information dissemination"

The Secretary seemed to think it was a realistic proposal and showed interest in it. He felt that in the prevailing circumstances it was a most appropriate and 'doable' model.

Director General Health

The Director General (DG) Health heads the technical wing of the Ministry. This position has always been held by a medical doctor. Under the 1973 rules of business of the Pakistan Medical and Dental Council, the Federal Director General Health is also automatically elected as the ex-officio chairman of the PMDC. The present incumbent is a professor of surgery and a practising surgeon (having a private practice as well) and has held the post for the last year and a half.

- Views about lack of regulation of health private care provision and effectiveness/non-effectiveness of the few existing ones

The DG was a reluctant respondent and did not want to speak on the issue of lack of legislation in health care in general and private health care in particular. On being asked regarding the effectiveness of the PMDC he flatly refused to answer and suggested the researcher contact the Secretary PMDC.

- Perceived need for regulation of private health care provision

The DG Health was of the opinion that the present regulations were adequate as there was already a system in place in the form of the PMDC. He however referred to proposed legislation that according to him was being sent to the Federal Cabinet for approval. Under this legislation, a federal authority would be set up to register those private health facilities, which fulfilled a minimum standard. He referred the researcher to the Deputy Director General for further details.

- Views regarding alternative mechanisms for regulation and capacity of the government to assume new/ enhanced roles.

On this point he reiterated that the PMDC was the right blend of government and professionals, which could best protect the interests of both patients and the medical community. He gave the example of the United Kingdom where a similar system was working successfully in the form of the General Medical Council (GMC). He believed that the private sector needed encouragement rather than un-necessary checks as it was relieving the burden on the public sector services.

- Opinion on regulation model based on "information dissemination"

He agreed that there should be minimum standards for private hospitals with respect to the services they provided and the staff they employed but was sceptical about how effective or influential this would be in affecting the choice of service users.

Deputy Director General (International Health)

The Deputy Director General (DDG) is one of four deputies working in the technical side of the Ministry of Health. He was the senior-most DDG and was the one the Director General had referred the researcher to. He is a medical doctor with post-graduate training in health management. He had been in the present post for more than a year, before which he had been working in the same ministry as the Assistant Director General. He was extremely forthright in his views partly because he had been in the ministry for several years and had an insiders view on many relevant issues.

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the few existing ones.

According to him the biggest reason for lack of regulations was that they were perceived as a threat to the vested interests of the medical community. Secondly, the people who are in a position to take policy initiatives are beneficiaries of the status quo and therefore they have no motivation to bring about change. This included the civil bureaucracy as well as the politicians. Regarding the PMDC, he was of the opinion that theoretically it could have been an effective body, but over the years it has not been able to keep pace with the rapid changes in the health sector. In his opinion the Council has just been confined to the role of giving recognition to various degrees. Moreover it was a federal body, based in Islamabad, having no presence in the provinces making implementation/monitoring a difficult if not impossible task.

- Perceived need for regulation of private health care provision

He strongly suggested that there was a real need for regulation of private health care in the country. He was of the opinion that both cost and quality issues needed to be addressed. Private facilities needed to be registered as well as to conform to minimum

standards. There needed to be rules and regulations for doctors working in the private sector as well.

- Views regarding alternative mechanisms for regulation and capacity of the government to assume new/ enhanced roles.

When asked about mechanisms for regulation, he also mentioned, as did the DG, the proposed federal legislation regarding registration of private health facilities which was sent to the law ministry for their opinion on the legal position. However he also provided a copy of the response from the law ministry, which is partially reproduced below:

> "The subject dealing with the control of hospitals, nursing homes, dispensaries, laboratories and clinics do not fall within the Federal Legislative List or Concurrent Legislative List. Meaning thereby that the legislation on this subject can only be made by the provincial assemblies. The proposed law, however, can be made applicable to the Islamabad Capital Territory, unless, two or more Provincial assemblies by a resolution authorise the parliament for making such law in accordance with the article 144 of the constitution for the provinces as well."

The provincial governments were thus required to legislate in this regard. Since the provinces did not ask the federal government to act on their behalf, any regulatory mechanism would have to be dealt with at the provincial level. He was of the opinion that the provincial governments should legislate on this issue and set up an autonomous regulatory authority to implement and monitor. In his view existing health departments had failed to carry out this responsibility and neither did they have the capacity to handle such a task.

- Opinion on regulation model based on "information dissemination"

He was very positive about such a regulatory mechanism and felt that provincial regulatory bodies could easily adopt this sort of model. He suggested that hospitals should be made to comply with certain minimum standards, which included the condition that public sector doctors would not be employed by or allowed to work in private hospitals. A strong media campaign informing people of the merits of these hospitals would then make a lot of difference to the general public who used private health facilities.

PUNJAB HEALTH DEPARTMENT

Provincial Secretary Health

The Provincial Secretary Health is the administrative head of the Punjab Health Department. He directly supervises the tertiary care/teaching health facilities and the other health establishments and programmes in the province through the Director General of Health. Although there have been instances where senior doctors were appointed to this post, traditionally it has always been held by members of the Civil Superior Services of Pakistan. The present incumbent is a non-medical person, working in this post for the past two years. The Secretary was initially reluctant to be interviewed, but later agreed. Nevertheless, he called on three of his subordinates at the time of interview to assist him.

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the few existing ones

The main reason, in his view, for lack of regulation was the powerful lobby of doctors. He reminded the author that any time there was a move to initiate regulation, there was a call for strikes from the medical community, which put the government in a difficult situation. Similarly, the move for registration of private health facilities could not reach fruition because the majority of such hospitals were owned either by doctors, their wives or children. However, he went on to explain that the lack of regulations in health care had to be seen in the context of the political situation in the country. The private sector had flourished during the past two decades when the country had been governed by either weak coalitions or different parties in power at the centre and in the provinces. However at the present time, both the federal and the provincial government of Punjab are of the same political party, enjoying two-thirds majority in the legislatures. Thus the Chief Minister has been able to initiate radical reforms in the social sectors, especially health. In this regard he mentioned the implementation of pharmaceutical regulations where the Chief Minister had refused to come under pressure of the pharmaceutical manufacturing lobby.

Regarding the effectiveness of existing regulations, he said that the PMDC was the federal body which was responsible for initiating any action and the provincial health departments could only act at their advice. Although he was aware that there had been

numerous reports in the media of malpractice and negligence in the private sector, he could not recall any cases where any action had been initiated except for one recent incident when the PMDC had formally asked the provincial government to shut down an illegally operating private medical college in Faisalabad.

On the question of why public sector doctors were allowed to violate the existing rule which bars them from practising outside their homes or the hospitals where they are employed, the Secretary seemed very much aware of the blatant disregard of regulations. He reluctantly acknowledged that it had been due to mismanagement on the part of the health departments, where power was too centralised. He reiterated that doctors had a very strong and influential lobby, which actively resists checks and regulations; and also the fact that bad example was being set by the leaders of the medical community like the professors of various medical colleges, therefore encouraging their juniors to follow suit. Lahore, being the provincial centre was particularly important in this regard as most doctors wanted to stay in the city and be employed by the prestigious teaching hospitals there. Even those who had been posted outside the city managed to maintain practices in Lahore. He was of the opinion that the doctors used their ranks, titles and hospital privileges to enhance their private practices, to the detriment of the public sector, but felt hopeful that with the new reforms which included giving autonomy to hospitals, such practices could be curbed to a certain extent through the decentralized managements of the tertiary care hospitals.

- Perceived need for regulation of private health care provision

In this context he mentioned that the Government of Punjab had been encouraging the private sector to take a greater share of the health burden from the public sector. The Punjab Health Foundation had been set up to foster such public-private partnerships and was giving loans to doctors to establish private facilities. However, he reported that this encouragement had been given without any checks and balances. He stated that there was a strong need for regulation of this fast growing sector, as there was no established standards of quality, cost and services; and the private health sector had turned into a lucrative market for profiteers without any social responsibilities. Moreover, the growth

in the private sector had led to further deterioration of the conditions in the public hospitals. He thought that any regulatory mechanism would have to take into account both the cost and quality issues of the private health care. He also suggested facility registration could be an important method of ensuring that only those facilities which complied with certain minimum standards of quality and service could operate.

- Views regarding alternative mechanisms for regulation and capacity of the government to assume new/ enhanced roles.

He reported that health sector reforms were already underway. He was not very clear about the government's capacity to assume an enhanced role but stated that the government would have to play a major role and perhaps a new authority would need to be set up to monitor quality issues in the private sector. On being asked specifically about the possibility of decentralizing the PMDC to the provincial level and having provincial bodies responsible, as was now the case for the pharmaceutical sector, he agreed in principle. But he then stressed the need for strong 'federal controls' whereby power needed to be vested with federal bodies so as to keep a uniform system in all the provinces of the country.

- Opinion on regulation model based on "information dissemination"

The secretary gave a positive response to this idea and asked his subordinates about a World Bank report with similar proposals on the grading of hospitals. He considered it a practical idea but suggested that instead of voluntary, the system would have to be a mandatory one.

Additional Secretary Health (Admin)

The post of the Additional Secretary Health has always been occupied by members of the Civil Superior Services. The present incumbent was also a civil servant and a non-medical person, having been in this post for about a year. The Additional Secretary mostly repeated the points made by the Secretary Health. The main ones are given below;

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the few existing ones.

He considered the lack of political will and the strong pressure group of doctors as the main factors behind the lack of legislation on regulation of health sector. He was of the view that the existing legislation was not effective because of an over-centralised system of management, where effective monitoring and implementation was very difficult.

- Perceived need for regulation of private health care provision

He was a strong advocate of having a regulatory framework. He was of the opinion that this was the right time to initiate action in this regard as reforms in the health sector were already underway and the Chief Minister was in a strong enough position, as well as having the will to withstand pressure and over-rule resistance.

- Views regarding alternative mechanisms for regulation and capacity of the govt to assume new/ enhanced roles.

He was very receptive to new ideas and having just returned from a Asian Development Bank-sponsored workshop of private health sector activities in Tokyo was very enthusiastic and motivated about doing something in this context. He mentioned that the government was planning to set up a task force, which would look into this issue and invited the input of the author in this task force. However, he did not specify any particular model for the regulation of private health care.

- Opinion on regulation model based on "information dissemination"

He was extremely receptive to the idea and was willing to discuss it further at an official level, once a proposal had been properly formulated. The point he especially appreciated was that instead of putting the burden of imposing punitive action on law-breakers on the government, the service users would gain the power of exerting pressure on them by rejecting their services. He gave the example of the strong media campaign to curb malpractices in the pharmaceutical sector.

Additional Secretary/Director General Health

The Additional Secretary (Technical) is a doctor and from the general administration cadre of the Punjab Health Department. The current incumbent held a degree in public health and was involved in the health sector reforms underway in the province. He also

held the additional charge of the Director General Health of the province, as the government considered him more suitable for the job at the present time of reforms.

He was present at the time of the interview with the Health Secretary and provided input when asked by the Secretary, during that interview. He was also separately interviewed later and the salient points are given below.

On most issues he seemed to agree with the views given by the Secretary. He was specifically asked about the new proposal for District Health Governments and whether private sector regulation would be included. In response to this he explained that at the moment there was no proposal to include regulation, but that once such governments were in place and the rules of business are set up then regulation would definitely be considered.

Regarding grading or information based regulation he thought the system could work very well in urban centres. Strong media campaigns could be used very successfully to inform the public of the merits and drawbacks of private hospitals. Once the example is set in big cities, especially Lahore, it could be replicated in smaller cities and other regulations incorporated within it.

PRIVATE PROVIDERS

The second category of stakeholders was that of private providers. This was divided into health personnel, who were further categorised into those specialist doctors who were practicing in both the public and private sectors and those who were practicing exclusively in the private health facilities. The views of the two groups of doctors and the managements of private hospitals are given in the following section.

PUBLIC/PRIVATE SPECIALIST DOCTORS

15 doctors falling under this category were interviewed individually. They were all working in various teaching hospitals in Lahore as assistant, associate, or full professors and only four were members of the Pakistan Medical Association. Their interviews were structured around the same broad themes as used for the other categories of respondents.

Some additional issues were also discussed which are reported along with the results. The results of all fifteen interviews are presented together.

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the few existing ones

The reasons given by the majority of the doctors in dual public private roles on the lack of regulation were that the government lacked political will and health had never been a priority on its agenda. Moreover, there was a consensus that, in Pakistan the real policy makers were the bureaucrats who were beneficiaries of the status quo and were therefore not motivated to bring about any real change. Bureaucrats spent huge amounts on their personal perks and got a lot of favours from the health services, while facilities available to the ordinary public kept deteriorating. The senior doctors gave examples of the undue favours which the bureaucrats were in the habit of asking from the doctors. These included free check ups for themselves, their family and friends, referrals for treatment abroad at the public expense when the treatment was either easily available in the country or entirely unnecessary. They exploited the services of doctors, visiting them at their private practices and getting free treatment. In exchange, they allowed the doctors privileges and favours in setting up private practices, and turned a blind eye to their flagrant disregard of regulations. All the doctors interviewed were resentful of the fact that, although the doctors were also graded as civil servants, they did not receive the perks which bureaucrats availed of.

All the doctors interviewed were aware of the PMDC requirements regarding registration of their qualifications, as it was necessary to possess this registration before appearing for an interview for a government job through the Public Service Commission. However, most of the doctors were of the opinion that the PMDC was a useless body as foreign qualified doctors encountered difficulties in obtaining their registrations because of bureaucratic hurdles and unnecessary complications, whereas these could be easily overcome through either giving a bribe or using a connection with a powerful bureaucrat or politician.

Regarding the code of ethics and other current regulations of the PMDC, all the doctors felt that these regulations were outdated and irrelevant. On the point of public sector doctors having private practices, they were strongly defensive. They were unanimous in the view that their conditions of work and salaries were not adequate to allow them a reasonable standard of living. They felt that although, they were much better qualified their jobs lacked a lot of facilities available to the Civil Service members e.g. housing, free transport, telephones, servants and-more importantly-the prestige that went with those positions.

When asked about the phenomenon of 'chair practice' whereby public sector doctors used the name and status of their government positions to enhance their private practices, all but one accepted that this was the case. This was the reason that, in spite of the low salaries, doctors preferred to keep their public sector jobs as well. As one of them commented the general public, because of low levels of literacy and awareness, still give a lot of importance to titles and ranks. Others felt that it was the best way to establish a professional reputation in a highly competitive market. Some felt that the prestige and respect that such titles imparted were important and felt good.

The mushrooming of the private sector was also a reaction to the state of the public facilities. One doctor commented that by working in the private sector at least they were able to provide some good quality health care whereas in public hospitals, doctors felt helpless and frustrated because of the lack of resources.

Other doctors made the point that the present administrative system is so centralised that to get every little thing done, permission had to be obtained from the Health Secretariat which took time, effort and made the everyday running of hospitals a frustrating nightmare. Particular mention was made of the fact that there was no authority to discipline, hire or fire para-medical and even menial staff.

- Perceived need for regulation of private health care provision

All the doctors agreed that there was a need for regulations of doctors as well as facilities. However, where doctors and the issue of malpractices were concerned, they thought that

the institution of the PMDC was quite suitable for the purpose. However they stressed that cost in the private sector should not be regulated. Moreover there was strong adverse reaction to the idea of banning public sector doctors from private practice. Most respondents agreed about the need for regulation of private hospitals and their policies. There was consensus that many hospitals were operating purely as profit-making enterprises and were exploiting the public as well as giving a bad name to the doctors practising there.

- Views regarding alternative mechanisms for regulation and capacity of the govt to assume new/ enhanced roles.

There was general agreement on the point that the bureaucracy should not be involved in enforcing regulations. If there had to be any regulation, it would be acceptable only if it was to be implemented by the medical profession itself. Three of the most senior doctors interviewed thought it possible to have a separate cell in the health department to handle regulation; but the rest were in favour of a separate regulatory body whose rules were set predominantly by the doctors themselves. They thought that the role of the PMDC could be strengthened in this context.

- Opinion on regulation model based on "information dissemination"

There was a guarded response on this issue and most doctors felt that considering the general state of affairs in the country where there was so much corruption and lawlessness, it was doubtful whether such a system, or for that matter any system, could work.

PRIVATE ONLY SPECIALIST DOCTORS

Ten doctors in this category were interviewed. None of them were members of the Pakistan Medical Association.

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the few existing ones.

All doctors in these interviews had similar perceptions about the reasons for lack of regulation in private health care. They all blamed the mutually beneficial relationship

between the senior public sector doctors and the bureaucrats for the maintenance of the status quo.

The existing regulations were totally ineffective in their view as they felt very strongly that public sector doctors were getting away with completely illegal practices. The fact that they were able to work in public as well private hospitals, using their influence in the former to promote their private practices, was an example quoted by all. Further, they pointed out that there was a conflict of interest when public sector doctors became owners of private hospitals. There were cases where perfectly good equipment in government hospitals was rendered useless so that patients would have to use the equipment in private hospitals. They also believed that most public sector doctors with private practices were tax evaders.

Six out of ten of these doctors had registered their postgraduate qualifications with the PMDC. However they had done so only, because they had previously applied for government jobs, which they did not get. The other four had not registered their postgraduate qualifications and felt that there was no advantage for them to do so, as it was not a requirement in private hospitals. They thought that it was a hassle to go all the way to Islamabad and then go through further bureaucratic red tape to do so. They also mentioned that although they gained no advantage from being registered, the PMDC charged a substantial fee for the service. This practice was also quite arbitrary, different fees being charged for different degrees and experiences.

- Perceived need for regulation of private health care provision

There was unanimous agreement among doctors in full-time private practice that strong regulation was needed. Particular emphasis was laid on the issue of private practices of public sector doctors. They felt it gave those doctors an unfair advantage and had a detrimental effect on the practices of purely private sector doctors.

Concerning the regulation of private hospitals, most doctors felt that these hospitals were charging very high fees to increase their profit margin. This was embarrassing to the doctors, as patients were being over charged and the general perception was that all the

fees were going to the doctors. Very few people understood that the hospitals take a fixed percentage and the doctors the remainder of the fee charged from the patients. Some hospitals had package deals for a certain procedure and if the patient over stayed or there was an extra expense, it was deducted from the doctor's fee.

- Views regarding alternative mechanisms for regulation and capacity of the government to assume new/ enhanced roles.

The doctors agreed that an alternative mechanism for regulation was needed. They also felt that the government alone was incapable of implementing or managing such a system and therefore the private sector should definitely be involved in it; also that regulation should target both quality as well as cost of services. However they were not specific about how this could be done.

- Opinion on regulation model based on "information dissemination"

All ten doctors considered this a workable idea but again stressed the point about public sector doctors saying that an important information which needed to be provided regarding hospitals was the number of full time doctors it employed.

MANAGEMENTS OF PRIVATE HOSPITALS

Six out of the nine selected hospitals were owned by public sector doctors, either serving or retired. In all nine hospitals the owner himself was the chief executive or executive director and interviews were conducted with all of these owners.

Gaining permission to interview was relatively easy with those owners who were doctors themselves. However the non-doctors were suspicious of the author's identity and motives and it was a difficult task to gain their trust and convince them that the author was not spying on behalf of the government or some other agency.

In all nine hospitals 70-80 percent of doctors were public sector doctors engaged in dual practice and 20-30 percent were purely private. However they were all unwilling to give the exact numbers of doctors, both public and private, who were working in their hospitals. These hospitals were all located in the well-to-do sections of Lahore and had

all set up their own pharmacies; only two of them were members of the Private Hospital Association.

The majority of doctors working in private hospitals work on a share basis whereby the doctors keep 65-70% of the fee and give 30-35 percent to the hospital. However the very senior or well-reputed specialists who have big practices work on a fixed monthly rent basis.

- Views about lack of regulation of private health care provision and effectiveness/non-effectiveness of the few existing ones

Most owners were rather evasive on this question. The explanation most often given was that regulation was weak because the government needed to encourage the private health sector as it was unable to provide health care to the people on its own. If the government imposed strict regulations, no one would have invested their hard-earned money in this sector. The assurance had to be there that owners' investments would be safe to boost confidence and encourage more people to invest. Moreover, they considered that the private sector was in its early days and was just getting established, thus it was perhaps still too early to talk about regulations.

All the owners also voiced dissatisfaction with the fact that the government was taxing them so heavily on various services and that it was already very difficult for them to get any returns from their investments. Federal as well as provincial taxes were imposed on them which included income tax, wealth tax, property tax as well as taxes on utilities which were charged from them on a commercial basis. Their 'businesses' being highly visible, they felt more exposed and vulnerable, to the whims of low level tax inspectors who as a common practice presented them with inflated figures in order to get a commission. Any more regulations would be open to the same kind of corruption and exploitation. This could prove to be the last straw on the camel's back and they could be forced to pull out.

On the question of existing regulations, the owners who were doctors were aware of the PMDC and its regulations but the non-doctors had very little awareness about it.

However, all of them said that PMDC registration was not required or checked at the time when the doctors are given permission to start practising in their hospitals. They did say that since the majority of doctors working in private hospitals are already government employees, therefore it is assumed that they are registered with the PMDC. For the purely private doctors, their highest qualification is checked.

On being probed regarding the government regulation, which bars public sector doctors from practising in private hospitals, they were unconcerned. They maintained that it was a matter between the doctors and the government and if the government chose to turn a blind eye to it, they could hardly be held responsible.

Pursuing this question further they were asked about the proposal accompanying the autonomous status of hospitals which could restrict public sector doctors to their respective hospitals. Six out of the nine owners reported that it would adversely effect their hospitals. The other three opined that, although there was no doubt that it would cause a temporary loss of business, there was a large enough reservoir of doctors in the private sector that the vacuum would be filled eventually, bringing the business back to normal. However they all agreed that the public would take time to adjust to the change as the titles and ranks of doctors were a major factor affecting their choice of doctors.

- Perceived need for regulation of private health care provision

On this question all the owners were quite unequivocal in their opinions. They made two main points. Firstly that the quality of service being provided at private hospitals was in any case better than that at government hospitals; therefore the government needed to put its own house in order before trying the regulate the private sector. The second point was that the prevailing system was so corrupt that it was an extremely difficult task to try and run their hospitals in an honest way. Everyday they had to interact with various inspectors of gas, electricity and taxes who had to be bribed just to avoid getting inflated bills or false charges for non-payment or tax evasion. If yet one more inspector were to be unleashed on them it would make it impossible to run their hospitals.

- Views regarding alternative mechanisms for regulation and capacity of the government to assume new/ enhanced roles.

On being questioned about alternative mechanism for regulation, the owners felt that with the present levels of corruption in the government and the system in general it was not possible for any regulatory mechanism to work. The present one was ineffective and so would any other be as long as the culture of dishonesty, bribery and corruption continued.

All of the owners however stressed the fact that the government needed to give incentives to the private sector to carry on the 'good work' of providing quality health care to the public instead of putting further restrictions on them. They however, felt that a regulatory system in which the private sector also had an input had better chances of being implemented. The owners who had a medical background had further ideas, for example about setting up minimum standards. The non-doctors just felt that as long as the private sector was involved and their interests were protected this would be acceptable.

- Opinion on regulation model based on "information dissemination"

The owners agreed in principle to the idea but were apprehensive about how it would be implemented. They feared that like all other regulations it would fall into the hands of people who would misuse it and use it to exploit the owners of hospitals. If successfully done, they felt that it would encourage a healthy competition between hospitals and bring about a change for the better. They did however voice concern about how such a system could affect costs and how it would be funded.

MANAGEMENTS OF SPECIAL STATUS HOSPITALS

As explained in chapter 3, there were a few private hospitals in Lahore, which were outside the criteria of the present study but it was still considered necessary to provide information about them as they played a significant role in the private health care provision. The two representatives selected for this purpose were the United Christian Hospital (UCH) and Imran Khan's cancer hospital, the Shaukat Khanum Memorial Trust (SKMT).

Their views on regulation are presented briefly in the following section. Imran Khan was forceful in his opinion that the present sorry state of affairs in the health sector was a political issue and that it had come to this because of the vested interests of groups in whose advantage it was to maintain the status quo. As far as existing regulations or the PMDC were concerned, neither he nor the Executive Director of the UCH seemed to be aware of the role or efficacy of either. They were very much in favour of the need for the regulation of the private sector, particularly the issue of dual practice of public sector doctors which they felt was a major factor in the deterioration of public services and in impeding the healthy growth of the private sector. They also agreed that a new regulatory body would be a positive step but were firm in their views that such a body had to have the participation of the private sector in it.

As far as a model based on information dissemination was concerned, they were extremely positive about it. In particular Imran Khan was emphatic that the public had to be treated with respect and the authorities needed to understand that the public, despite being poor and largely illiterate, was still very aware and intelligent and perfectly capable of making the right choices if they had the necessary information. He gave the example of his own hospital where once the reputation had become known, the general public put complete confidence in it. Those who could afford it not only paid for the services but also generously donated, enabling thousands of others to benefit from free treatment. He emphasized that because of the people's awareness and support the hospital had been a success against all odds. It was therefore extremely important, he thought, to provide people with information and let them set standards through their demands and the exercise of free choice rather than forcing sub-standard services on a helpless and uninformed public.

SERVICE USERS

The third category of stakeholders was that of the service users. Focus group discussions were conducted to obtain information from the service users. This was done in order to achieve the following objectives:

- To get the opinion of service users regarding their experience with the health service and the reasons for their choice of public or private services.
- To get information on the level of awareness of service users regarding existing regulations, and for those who were aware, their opinion on the effectiveness or non-effectiveness of those regulations.
- To make an assessment of their needs regarding regulation. Should there be more checks and balances? From a consumers point of view what kinds of regulations would be desirable (quality, cost, hospital practices etc.)?
- To get feedback regarding a different approach: what did they think of information based regulation? How would it improve their interaction with the health service? Would it be useful? Did they think it was a workable or realistic proposal? Could they recommend any improvements in such a system?

The results will be presented according to the four main points stated above. For each point the results of each group will be included. Where ever possible, quotes have been used to illustrate points. Quotes have been selected which were most representative of the views of the group.

- Experience of health care services and reasons for choice of public or private option

On the introduction of this topic all the focus groups turned into personal accounts where instead of a general discussion, every participant wanted to relate their personal experiences. However a general trend could be discerned from these accounts. The views of all the participants regarding their experience of health care services were strikingly similar. The general opinion was that public services were deplorable and although the private option was slightly better, it was not of the quality they expected after being charged so exorbitantly. Depending on the age, profession and financial situation of individuals their choice of service differed but their opinions were quite similar.

Those who had chosen private health care as their first option had positive things to say about it:

"Private health care is a much better option, for those who can pay. Facilities are getting really good now----we have modern labs, equipment, the hospitals are clean, unlike government hospitals. Of course one has to make an effort to find the best doctor and the right place but once that is done one can more or less trust them to do a good job. At least you can expect that the doctor will give you enough time and all the patients who are paying will receive equal attention."(FG No. A2)

"Most people would like to try the public option as private hospitals are so expensive but their experience in the public hospital is so negative; and one hears so many harrowing tales of how people were mistreated that it is now thought safer to go to a private hospital. At least if you are paying for a service you can hold someone accountable."(FG No. A1)

But others had been disappointed by the service provided by the private hospitals.

"Government hospitals are really dirty and crowded and the doctors are over-worked and indifferent. It is much more convenient to go to a private hospital, even though it is more expensive. But the conditions of the private hospitals are not great either. I went to one of the most well known hospitals for the delivery of my child. My consultant who is a professor at one of the government hospitals had recommended it to me. He had assured me that he himself would attend to me when the time came but in the event my baby was delivered by a junior doctor. The hospital room had cockroaches and the air-conditioning was turned off during the night. My baby was taken away immediately after delivery and on my husband's enquiry was told that she had been taken to the nursery as that was hospital policy. I was keen to feed the baby myself and we had to struggle with them over this. When the baby returned she had been vaccinated without our permission. When the bill was handed to us it included electricity charges, nursery charges, fees for a paediatrician who had vaccinated the baby (which should have been free), medicines and equipment which they had requested before the delivery but which had not been used. Many of the cleaning staff was standing in line for tips as well. Moreover the hospital people were extremely reluctant to give us a proper receipt. " (FG No A1)

"My wife needed to get an operation and various doctors were recommended to me by my friends and acquaintances. We had already decided to go to a private hospital seeing the state of the government hospitals. Most of the professors in government hospitals have their private clinics or they practice in one of the big private hospitals. We chose one and went to him a couple of times but he ordered so many tests each time and kept sending us to his wife's lab, so we changed from him. Then we went to another one, but his fee was too high and so we changed a third time and finally got the operation done."(FG No. A2)

"The boards outside the hospitals or clinics are so confusing, they have long lists of abbreviations which we don't understand, but they try to convey the impression

that the person has many degrees and qualifications. Sometimes you go into a clinic expecting someone very qualified but instead find a junior doctor. Also, even if they have worked as an intern for a few months in some speciality they pose as specialists and charge the fee for specialists. It can be very dangerous too as happened to a friend of mine who was in a major accident. She was rushed to a hospital where the consultant was a general surgeon but attempted to do plastic surgery on the girl and in the process botched up the job so badly that the girl eventually had to be taken abroad for reconstructive surgery. The doctors there too were aghast at the way she had been handled. But no one said anything to that doctor and he is still practising and one wonders how much damage he has done to other people"(FG No. A1)

Among those who had tried the public option first and then gone on to a private facility there were generally negative views about the state of the public services.

" Being a retired government officer I am entitled to free health care, therefore it is my first choice. For many minor problems, it works out very well as it saves a lot of money as well as being convenient in the sense that we go to a familiar place where the staff recognise us and treat us with respect. In private hospitals it is very indifferent and cold. But if God forbid there is an emergency or a major problem, the public hospital often lets us down. The emergency facilities are not proper and at the crucial time they don't have syringes or drugs, the doctors are careless and the surroundings are dirty " (FG No. B1)

"It is shameful, what has happened to the medical profession and the way these big doctors behave. I had a surgical emergency and because my brother was a doctor who had been working in a government hospital, he immediately took me there. His colleagues who were all junior doctors were very attentive and did all they could, but the consultant was nowhere to be seen. After lying in the cold operating theatre for two hours, we were informed that the consultant had cancelled the list and that to get prompt treatment it would be better if we went to his private hospital. I was rushed there in a critical state and eventually got treated. The consultant charged his full fee although in the old days it used to be against doctor's ethics to take fees from colleagues and their families. But if I had not been able to afford the private hospital I could have died...and if this is the way they treat people who are their colleagues, then imagine what happens to the general public."(FG No. B2)

Participants also explained why people chose certain hospitals:

"The doctors who are big professors in the government hospitals all work in private clinics and hospitals too and many patients go to them because of their name as professors or teachers in these government hospitals and they use their prestige and status to enhance their private practices" (FG No A2)

- Awareness of existing regulations: were they effective?

The majority of the participants showed very limited awareness of the existing regulations. However even those who were aware did not seem to take them very seriously, reflecting the general attitude in the society regarding rules and regulations.

> "I don't think many people know about their rights or any regulations." (FG No A1)

> "How can you ask such a question when you are part of this system……you know there is no law in this country. I don't know what laws there are but even if I did do you think it would make any difference…if we went to the court, the courts are corrupt, and they would bribe the judge or something. We would end up losing more money, time and effort." (FG No. A2)

> "We have rules for so many things ……how many do we respect …how is this any different?"(FG No. B1)

> "Sure there must be regulations but they are only of any use if they mean anything----most people don't know of any regulations but even if they did they don't trust the system. We all know the legal system, the rampant corruption and the loopholes in everything. Nobody can ever be proved guilty here." (FG No. B2)

- Assessment of needs regarding regulation

There was a strong consensus regarding the need for effective regulations, and the implementation of the existing ones.

> "Definitely there is a need for checks and balances. There are so many things wrong with the system and anyone who is unfortunate enough to get ill and seek medical care falls into a vicious circle. If he's lucky he survives it, but if he is not he becomes a victim and there is no way to prevent it. It is the one occasion in life when one needs to be able to completely trust the system and be assured that it is going to take care of one ----it should not be a matter of luck." (FG No. A2)

> "When we go to a hospital we need to know that the doctor is genuinely trained and capable, the hospital is well equipped, the lab results are correct, that no one is trying to con us out of our money, the drugs that are prescribed are the ones we really need and not prescribed merely to promote business in the family pharmacy----but we can't be sure of any of that." (FG No. B1)

> "Hospitals should provide service round the clock…..not like now…..when patients are attended by junior staff and have to wait for the senior consultant to

arrive .....after all one pays for the consultant's services. One also needs to be sure that emergency services are really there and not just falsely advertised" (FG No.A1)

A point brought up repeatedly was one of cost:

Patients never know how much a certain service will cost in any hospital. One is told about the fee of the doctor but by the time the consultation is over there are many other things which have been added on. This causes a lot of problems and then they don't want to give proper receipts either."(FG No B2)

- Feedback on information-based regulation

The general feedback was extremely positive and most of the participants thought it was a good idea, but there was scepticism regarding its chances of being translated into actual policy.

"It will actually make a lot of difference if it can be done. The media and information is a very good tool-------see how everyone knows about family planning ever since they started advertising on TV and radio and even on bill boards across the cities" (FG No. A1)

"It will make it so much easier for people to make an informed choice about where to go and it will force the hospitals and doctors to put their houses in order. Now people just choose by reputation and word of mouth but if people knew beforehand which facilities are provided by a certain hospital, the doctors, their exact areas of expertise and experience, their times of availability, and precise costs, it would make life much more easier. "(FG No. A2)

"The problem in this country is that everyone has great ideas and thinks he knows the solution to all the problems ....but it is all talk .....no one ever does anything. This idea is as great as any other could be, but we will comment on it when it is implemented. "(FG No. B1)

"These doctors are all powerful people ...do you think in our culture they will ever allow such a scheme to take off. It is all idealistic talk...we need to think realistically....." (FG No. B2)

PROFESSIONAL ORGANISATIONS

Another category of stakeholders which could be considered as intermediary or 'secondary stakeholders' was that of professional organisations or associations. The views of representatives of three of these organisations are presented in the following section:

PAKISTAN MEDICAL ASSOCIATION (PMA)

The Secretary General of the Lahore chapter of the PMA was interviewed. This chapter is the second largest in the country and the largest in Punjab, claiming to have a membership of ten thousand doctors. However because there are so many factions of the PMA operating currently, it was not possible to ascertain which one was the genuine or real representative of the medical community. According to an investigative report published in the leading newspaper[1], the PMA was originally formed under article 17, clause 1 of the constitution, which allows the formation of an association. Thus its main function is to safe guard the interests of the doctors. It remained a single body till 1980. Thereafter, acute professional rivalries between groups of doctors and exploitation by religio-political parties started a gradual process of disintegration. Currently the PMA is divided into seven factions: two based at the federal capital, Islamabad, two in Punjab and three in Lahore city itself. An eighth faction is planned for the purpose of reunifying the PMA. The particular faction of Lahore chapter was selected because it was based in the original PMA house (although this matter was also under legal dispute).

The President of the Lahore chapter of the PMA was a senior professor of orthopaedics at King Edward Medical College and Mayo Hospital complex. He was also one of the owners of the National Hospital Complex, the latest private hospital opened in Lahore (included in the present analysis). However, since he was out of the country the Secretary General of the PMA was interviewed.

It is generally thought that the PMA is not genuinely working for the benefit of the medical community but is being used by its office holders as a launching pad to get into politics or to gain personal clout with the officials of the health department. The PMA is used most of the time to get preferred postings or transfers done. It has therefore consistently opposed any reform of the health sector. This was also seen at the time of the reforms instituted by the Government of Punjab, including the proposal to give autonomy to public sector hospitals, when various factions of the PMA strongly opposed the

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[1] The News International' Lahore, August 10, 1999

proposal[1]. However its lack of effectiveness was exposed at this time, when the government went ahead with the reforms despite the opposition from the PMA. A major reason for this was the fact that the PMA was divided into so many factions and they could not present a united stand against the government. Doctors being a very powerful group, it can be assumed that if they could forge unity amongst their ranks, the PMA could play an effective role in supporting or opposing any proposed regulations.

None of the doctors interviewed in the private providers category, including those four who were members of the PMA considered it a worth while body, which was capable of looking after the interests of the medical community. In fact it was blamed for dividing the community at the behest of the various political governments.

The interview with the Secretary General did not provide any relevant information. The main point from the interview was that he agreed on the need for regulation, provided doctors were given added incentives, facilities and the hold of the bureaucracy over the medical profession was broken. The interview did not provide the impression that the PMA was providing a substantial or issue based representation of a professional community's interests.

PRIVATE HOSPITALS ASSOCIATION

It is a thirty year old association headed by an 85 years old retired professor of radiology who is in fact, the life president. Only two of the private hospitals included in the study were members of this association. In fact it represented only small diagnostic centres and clinics who met occasionally to fix the rates for the services they offered.

The only relevant information that was elicited from this interview was that there was a need for regulation to be done by a mix of the public and private sectors. He agreed that a system based on information dissemination or grading of the hospitals was needed and the general public had a right to be provided correct and full information about the health care they are paying for. However for such a system to succeed it was important to safeguard against the prevalent evil of corruption.

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[1] The News International Lahore, September 9 1999

CONSUMER RIGHTS COMMISSION OF PAKISTAN (CRCP)

There is little awareness of this Commission either at the official level or the general public level. It was also not possible to establish contact with any representative of this association. It is mentioned here however, because a newspaper statement was issued on their behalf, which was reported in the press[1] as:

> 'The Consumer Rights Commission of Pakistan (CRCP) has proposed the formation of Health Regulatory Authority (HRA) like NEPRA and PTA to determine quality, supply, standard and prices of medicines and medical services. It urged the government to act promptly to regulate the private health care market after consulting the people in the medical profession, and the consumers to stop the exploitation of simple and helpless consumers at the hands of private providers who are acting purely from profit motives'.

[1] The News International, Lahore, September 26, 1999

DISCUSSION

The following section will provide a discussion on the results of the stakeholder analysis. This will be presented in terms of the four main themes which were addressed. Since the role of the professional organisations was thought to be limited, their contribution is discussed briefly at the end of the section.

1. Lack of regulation of private health care and the effectiveness/non-effectiveness of the few existing ones

STATE

The purpose of discussing this theme with the representatives of the State was to seek the views of those individuals who were involved in the policy making process in the health sector. As mentioned earlier because of the weak political institutions in the country, the bureaucracy has taken over the role of policy makers (HDC 1999). Six top health officials of the federal and Punjab governments were therefore interviewed. It was expected that these officials would be able to throw some light on the reasons for the lack of regulation in the health sector and provide an informed view regarding the reasons for the ineffectiveness of the existing ones. However it was seen that the understanding of the issue by these officials was quite superficial except for those who had training in health management like the DDG health. While they were agreed on the fact that the private sector had expanded recently and that this growth had originally been encouraged by the state to share the responsibility of health care provision, none of them seemed aware that this was one of the conditions for the Structural Adjustment Programme proposed by the World Bank/International Monetary Fund during the last two decades (Zaidi 1999a). They also did not acknowledge their own role in the unregulated growth of the private sector, attributing it to the constant state of political instability and the lack of political will to implement any kind of far reaching measures.

Furthermore a clear divide was seen on the issue of lack of regulation, depending on whether, the government official was a practicing doctor or not. The former, like the Federal Director General Health, felt that there was no need for any further regulation, however the non-practicing doctors holding administrative positions and non-medical bureaucrats were in agreement about the need for regulation. They felt that there was a very powerful medical

lobby that resisted any attempts to regulate private health care provision. The same divide was apparent regarding views about the PMDC (which in effect is the only existing regulatory body) and its effectiveness. The practicing doctors considered it adequate and seen to be serving its purpose, playing the same role as the General Medical Council in the United Kingdom. However, the other group felt that the PMDC was highly ineffective and only serving as a tool in the hands of the medical community to safeguard its vested interests. There was also quite a lot of ambiguity about who should be doing the regulation. Though there was agreement on the fact that over-centralized systems of management in the country as a whole had been a major obstacle in the proper implementation of any regulation, the federal officials were of the opinion that health being a provincial subject, regulation had to be a provincial responsibility, and the provincial officials thought that since the PMDC was a federal body, the responsibility had to be primarily federal. Thus it was seen that the State itself was divided in its stance on the issue of regulation which is reflected in the lack of effective policies.

PRIVATE PROVIDERS

Doctors

The views of the doctors' community were considered of paramount importance as their agreement and participation in any attempts at regulation is essential. By discussing with them the reasons for the lack of regulations and the effectiveness/non-effectiveness of the existing ones, it was hoped to get their point of view on this issue so that it could be represented in any future attempts at regulation. Two categories of privately practicing doctors were interviewed, i.e. those who were state employees and those who were exclusively working in the private sector. While they were all agreed on the point that there was lack of political will and that health had not been the priority of any government, there was a sharp difference of opinion on all other points. The doctors working in the state sector blamed the bureaucracy for the lack of regulations; notable exceptions to this view were those doctors who had occupied senior administrative positions, whose stance was relatively softer towards the bureaucracy. However the doctors working exclusively in the private sector laid the blame for lack of regulation squarely at the door of the mutually beneficial coalition between state sector dual practice doctors and bureaucrats.

This split in opinion was most visible on the contentious issue of the existing regulation regarding dual practice, prohibiting public sector doctors from practicing in private hospitals. It was seen that the state sector doctors considered the ban to be unfair as the government salaries were inadequate, compared to the perks and privileges available to bureaucrats. The doctors working exclusively in the private sector on the other hand held the opinion that the flagrant violation of this regulation was a serious issue. It was not only illegal but also lead to a conflict of interest as doctors working in the public sector improved their private practices at the expense of their patients in the public sector, as well as by exploiting them. Thus there was a chain of discontent: the private sector doctors blamed the public sector doctors for playing a negative role in the private sector, damaging their practices; and the public sector doctors resented the perks and privileges of the bureaucracy.

As far as the PMDC was concerned it was seen that there was a wide awareness among doctors regarding its requirements, but compliance was only in cases where it was necessary to secure a public sector job. Otherwise there was neither a perceived need to comply nor any fear of being penalized if those requirements were not fulfilled. It seemed evident that the role of the PMDC was one of convenience for the doctors. They accepted those aspects which suited their purpose, for example supporting the self regulatory role of the PMDC, while rejecting other aspects which dealt with the code of ethics, which were restrictive and outdated. It was apparent that the PMDC was not considered to have a valuable or useful role. It was perceived to be out of touch with ground realities, lacking the infra-structure, mandate, as well as willingness to play an effective role in the health sector and fulfilling only a perfunctory role.

Private Hospitals

The active compliance of this group is also considered essential for effective regulation, particularly as in the present circumstances there is no legal requirement for facility registration or maintaining minimum standards. However, the results of the stakeholders analysis showed the majority of private hospital owners to be evasive and somewhat unwilling to speak about the issue of lack of regulation and the in effectiveness of existing ones. Their interest was focussed on protecting and getting good returns from their investments. Moreover it was their perception that the government needed to give as much

incentive and encouragement to the private sector as possible, as the public sector had failed to meet the public demands and it was the need of the government to have a flourishing private health sector. An implicit assumption in their position was that they could dictate terms to the government and therefore the imposition of further regulations was not a practical option as it would have the effect of discouraging the private sector.

Regarding the PMDC, the owners of hospitals who were doctors themselves were aware of its regulations but did not give them much importance, while the owners who were not doctors were not even aware of the regulations. It was evident that the main interest of this group was in protecting its vested interests, thus for example on the regulation barring public sector doctors from practicing in private hospitals, the owners showed a preference for the status quo. Much of their profits depended on public sector doctors bringing in patients to their private practices and a compliance with the ban could mean a drastic fall in their patient numbers as well as in their staff capacity. Moreover, they gave the impression that they believed that any change was improbable, therefore they could safely disengage themselves from the debate, thus explaining their indifferent attitude towards the issue.

Their disinterest could also be explained by the fact that the PMDC's role as far as private hospitals were concerned was quite limited. While its legal jurisdiction did theoretically extend to the overall practices of the doctors themselves, it did not even cover the employment policies or practices of private sector hospitals, as its mandate was restricted to the practices of public sector hospitals. This was because it still operates under the original mandate given to it in 1962 when private hospitals were non-existent. An amendment was made in 1999 (see chapter 4) to include the private sector but this was limited to private medical education facilities and not extended to private hospitals.

SERVICE USERS

There was a general lack of awareness among service users regarding the existence of any regulation. Moreover there was a feeling of apathy and scepticism as to the effectiveness of regulatory approaches in the health sector or any other sector of society.

2. Perceived need for regulation

STATE

This theme was particularly significant in this category of stakeholders, as it elicited the response of the policy makers regarding the need for change and improvements. It was seen that there was a unanimity of views at both federal and provincial levels regarding the need for regulation. There was a strongly felt need to introduce checks and balances in the private health sector. However the lack of political will and political instability as well as the strong medical lobby were considered to be opposing forces in this process. There was a sense of recognition and approval of the actions of the Chief Minister of Punjab who had shown a determination to take on the various powerful groups and a realisation that this was a unique opportunity to introduce regulations into the private health care system.

The single exception to these views was the Federal Director General Health who being a practicing surgeon himself, was quite clear in his views that any regulation on doctors would discourage the private sector and would be detrimental to the development of better health care services. In his opinion PMDC was playing the same role as the GMC in Britain and was adequately covering the regulation of doctors. He did however concede that health facilities needed to have minimum standards introduced. This dissenting opinion again highlighted the issue of conflict of interest that has been evident in this analysis so far.

PRIVATE PROVIDERS

Doctors

Two important points could be seen here. First that in general there was agreement among doctors regarding the need for regulation, thus showing an acknowledgement of the fact that the unregulated growth of the private sector had to be checked. The second and more significant point was that there was a difference in opinion regarding the kind of regulation that was needed. The doctors working in the public as well as the private sector were in favour of rather less stringent regulations, their focus being on the introduction of registration of private facilities and minimum standards of quality. On the other hand the doctors working exclusively in the private sector were much more vocal and vociferous in their demand for strict regulations. They were more concerned about the

freedom of dual practice, which the public sector doctors enjoyed and demanded much stricter regulation on that particular issue. Thus it was evident that the perceptions of need for regulation were focused on the regulation of competitors and the safeguarding of vested interests.

Private Hospitals

There was a clear division of opinion on the issue of the need for regulation among the owners of hospitals. The bigger and more established hospitals of the private sector like Ittefaq Hospital, SKMT and UCH, were very much in favour of regulation. They felt that strict enforcement of minimum standards and registration of every private facility would work in their interest as it would eliminate sub-standard facilities, and a healthy and fair competition would raise overall quality. However, among the owners of smaller hospitals and especially where the owners or partners were doctors themselves, there was strong opposition to regulation. They felt over-burdened with existing regulations and believed that more regulations would put them out of business. They complained of cut-throat competition, heavy burden of taxation and utility costs and a corrupt system where they had to give bribes at every step to get things done. The prospect of one more inspector looking over their shoulder was completely unacceptable to them.

These sentiments need to be considered in the context of the prevalent tax evasion culture in the country. (According to official statistics, out of a total population of almost 140 million, only 1.2 million are tax-payers. More than three fourths of these are government servants whose tax is deducted at the source, thus the people voluntarily paying tax is miniscule). This culture of bribery, tax evasion and corruption was one of the justifications given by the Supreme Court of Pakistan in its judgment validating the military takeover of October 1999[1]. In the case of the hospital owners (mostly the smaller hospitals), whose main objective in opening these facilities was to make a financial profit, the process was reciprocal. Thus it was common practice for them to offer bribes in order to save money on taxes, utility bills; and for the inspectors for their part to blackmail them to get their commission. A vicious and self-perpetuating cycle was thus created.

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[1] "Text of Supreme Court verdict in military takeover case" http://www.dawn.com/2000/05/13/text.htm

SERVICE USERS

The service users were all agreed about the need for regulation. They strongly felt that the private health sector was operating totally without any checks and balances and there was no system of redressal which was open to the public, in case of any wrong doing. They expressed a need for regulation of cost as well as quality and felt that it was necessary when they resorted to the private sector for health care, that there was some way of ensuring that they received value for their money.

3. Views regarding alternative mechanism for regulation of private health care and the capacity of the government to assume new or enhanced roles

STATE

This theme aimed at getting the response of the representatives of the state regarding alternative mechanisms for regulation of private health care. As mentioned earlier there have been various attempts at the regulation of this sector by previous governments and this was also an indirect way of assessing the depth of knowledge and awareness of the issue among individuals who were currently in positions of policy making. The results showed that the state officials at both federal and provincial level were in general rather vague about the issue of alternative mechanisms for regulation of private health care. Their responses were superficial and they avoided going into details, showing a lack of knowledge and awareness. They were all agreed on the fact that an alternative mechanism was needed, and that both the cost and quality of private health care needed to be regulated. They were also agreed on the point that the government did not have the capacity to handle this role and therefore there was a need for a new regulatory body. However no one seemed to have clear ideas as to what such a regulatory body would entail. There was ambiguity at the federal level regarding the degree of legislation they were able to do on this issue as well as whether the regulatory body needed to be based at the federal or provincial levels. The provincial officials, though more receptive to new ideas, were nevertheless equally unsure about what an alternative mechanism could be. Their enthusiasm came across as a way of getting new ideas from the researcher so as to get into the good books of the Chief Minister for whom health sector reforms was a special project.

PRIVATE PROVIDERS

Doctors

The majority of doctors both in the private and public sector were agreed that an alternative mechanism for regulation was needed. There was consensus on the fact that the government did not have the capacity to take on such a role and therefore a new regulatory body was required, but again there were no concrete ideas as to what such a mechanism could be. The public sector doctors were adamant on the point that any new regulatory body needed to be free from the influence of the bureaucracy in order to be effective and therefore the best option would be a body controlled by the medical profession itself. In other words they were in favour of a model of self-regulation. The private sector doctors felt that no regulatory body could be effective without the input of the private sector. The only disagreement seemed to come from senior doctors in administrative positions who were quite apathetic to the whole issue and considered it an unnecessary fuss. They seemed to think that a small additional cell in the health department would be adequate to manage all regulatory problems in the private sector.

Private Hospitals

As with other stakeholders, the owners of health facilities were also quite unsure about what alternative mechanisms for regulation could be put in place. Predominantly, there was a great degree of scepticism regarding whether any system of regulation could work in the present state of affairs and they considered the government totally incapable of handling such a role. However they felt if a new mechanism were to be implemented it would have to be an independent body to have the slightest chance of success and the participation of the private sector had to be a key factor in it.

A common refrain amongst both categories of private providers, doctors as well as private hospitals, on alternative mechanisms for regulation was regarding the need to involve the private sector. They were all agreed that a purely government body would be unacceptable, as besides being incapable of carrying out such a task, it would be hostile to their needs and open to the same problems of corruption, apathy and excessive bureaucracy. It would therefore not bring about any meaningful change other than adding another level of bureaucracy and corruption to the existing system. The involvement of the private sector

could safeguard against these problems and therefore was essential if a real change was intended.

SERVICE USERS

Considering the low degree of awareness of service users regarding the issue of regulation, the question of alternative mechanisms and options was not put to them in detail. Their general opinion about regulation was that there needed to be some mechanism, which would ensure good quality and service, so that the public had the assurance that they were getting the best service possible. They were not concerned about what such a mechanism could be as long as it worked. One point that they were quite vocal about was that both public and private options needed to be available to the users so that good quality service was available to the common man who used a public health facility as well as to the people who could afford to use private health facilities.

4. Regulation model based on information dissemination

STATE

Most state officials, when questioned about a possible model of regulation based on dissemination of information to the general public, seemed receptive and open to the idea. The impression received was that due to a lack of in depth understanding of the issue any new idea was being received without a critical appraisal of its pros and cons. With the exception of one individual who was vaguely aware that this sort of a model had been previously suggested, there was no awareness of the fact that all the previous health policies had contained generally similar proposals. However, especially at the provincial level, the officials seemed eager to know the details of such a proposal and how it could be practically implemented, once again illustrating the interest generated by the Chief Minister. The Federal Director General Health, however, although agreeing that imposing minimum standards would be a good step, was not particularly enthusiastic about the idea of information dissemination.

PRIVATE PROVIDERS

Doctors

On this issue again there was a clear difference of opinion among public sector doctors and those working exclusively in the private sector. The doctors having dual practices in the public and private sector were dismissive of the idea and considered that such a model did not have a realistic chance of working. They seemed confident that other factors which influenced the choice of hospitals among the public. For example, the physical proximity, the specialty care being offered and the status of the doctors who were practicing there were more important and that a vague system of grading on issues which the general public could not easily understand, would have little influence on their choice of hospitals.

The doctors working exclusively in the private sector were more enthusiastic about the idea. However it seemed clear that their interest in the model extended only to the point where it meant exclusion of public sector doctors from private hospitals.

Private Hospitals

Generally all the owners and management of private hospitals welcomed the idea of a regulation model based on information dissemination. The response however varied slightly according to the type of facility. The smaller hospital owners who were struggling to keep up with new competition and high maintenance costs were apprehensive that such regulation would put additional pressures on them and in particular were afraid that if misused it could turn out to be another instrument to exploit hospital owners. Owners of more modern and new facilities seemed less apprehensive and felt that open information would only encourage healthy competition and improve overall service quality.

The bigger and more established hospitals like SKMT, Ittefaq and UCH were categorically in favour of such a model of regulation. They felt that the public, although not highly literate or aware, was nevertheless discerning and mature enough to understand and make reasonable choices if presented with sound and complete information. They thought it would work to their advantage as well as the public's if the public was aware of which hospitals employed staff who were there full time, where minimum standards of quality

were met, the kind and hours of service that was being offered and a clear statement of the qualification and degree of specialization of the doctors who were working there.

Thus it was evident that an information-based regulation model would be supported by most private hospitals to some extent, except by those who were running sub-standard facilities and therefore stood to lose from such a system were to come into operation.

SERVICE USERS

There was an extremely enthusiastic response among service users to the idea of regulation based on information dissemination. They strongly felt that their choice at present was impeded because of incomplete or at times even false and misleading information. They were very vocal about the need for better information about the various aspects of services being offered at hospitals and an independent system of grading of facilities, which would inform the general public about the quality of those facilities. They felt that once the public had that information they could make an informed decision regarding their choice of hospital and although cost would still be a major factor influencing that choice, at least there would be an assurance that whatever facility they choose they would get value for the money they had paid.

PROFESSIONAL ORGANISATIONS

Analysis of the role of professional organisations like the Pakistan Medical Association, the Private Hospitals Association or the Consumer Rights Commission suggested that these were merely representative bodies in name. On the ground they had no influence on policies, individual or group actions. They were used as a platform by individuals, who had personal and political ambitions, and did not represent the community in whose name they had been formed. Abbasi (1999b), quotes Richard Skolnik, the World Bank sector leader for Health Nutrition & Population in South Asia, as saying that "In South Asia you have medical associations who barely know who belongs to them and who doesn't". Other literature also corroborates this impression that in countries where health care has traditionally been provided by the public sector, no organization of professionals, populations or patients has emerged to ensure accessibility, equity or quality (Ferrinho et al 1999). This very much describes the picture in Pakistan as well.

Thus it was seen that with the exception of the PMA, all the other organisations were of a very small scale and not fulfilling any constructive purpose. The PMA however could potentially play a very important role as there were a large number of doctors in the country, who formed a very powerful lobby at the national level. This was understood by all political parties and governments in power, as they tried to win influence within this lobby by creating politically based factions of the PMA, thereby minimising its influence by dividing it within itself.

A united and non-partisan PMA, operating within a legal framework, with clearly spelt out functions and duties, could provide an extremely useful body which could represent the needs, anxieties and legitimate demands of the medical community and with whom the government could carry out a meaningful dialogue.

CHAPTER 6
CONCLUSIONS AND RECOMENDATIONS

RATIONALE FOR THE STUDY

The private health sector in Pakistan has been growing very rapidly for the past two decades. Due to the resource-constrained environment, this growth was initially encouraged by the government in order to share the task of health provision. However it was left largely unregulated and with the passage of time it became evident that this growth was occurring partially at the cost of the public sector, which was suffering from under-investment (see table 1.2) and deteriorating as rapidly as the private sector was expanding.

Recognizing the importance of health sector reform, and the need for the regulation of the private health sector, successive governments in the last ten years tried to formulate policies on this matter. Because of the frequent changes in governments, these policies could not be implemented. These policies had adopted proposals which were based on international experiences of regulatory approaches which had been successful in other settings. However, they lacked an essential component, which was indigenous input, and an evaluation of acceptability and feasibility in the local context. As outlined in the beginning of this document this study has identified the following gaps in information for policy-making:

- Lack of evaluation of the existing system of regulation.
- Failure to consider the interests and views of various stakeholders, essential to the success of regulatory process.
- Failure to involve the stakeholders in developing and evaluating the policy options.

The primary purpose of the present study was therefore to fill these gaps in information and provide a sound foundation, based on local realities, to facilitate and inform future policy options.

KEY FINDINGS

The information that was gained as a result of these two stages of inquiry can be summarised as follows:

Role of government as trustee

The review of legislative framework governing the health sector in Pakistan shows that very little has been done in this area (see table 4.1). The few legislations that exist are old and outdated and deal only with the public sector. Legislation dealing exclusively with the private health care provision is non-existent. Thus the government has failed to fulfil its stewardship role (Saltman and Ferroussier-Davis 2000), which requires it to be the trustee of the health and welfare of its citizens. Being an Islamic Republic, it had a religious responsibility towards its people as well, as illustrated by the institution of Hisba (see Box 1.1). However this responsibility has not been fulfilled by the government either.

Problems in the policy-making process

A major part of the problem regarding health sector reform in general and the regulation of the private sector in specific has been the faulty process of policy making in Pakistan. This in turn could be attributed to the climate of political instability in the country, which has had non-elected governments for more than half of its existence. Because political institutions are weak, the individuals who do emerge as representatives (at those times when there is an elected government), are often not sufficiently competent for policy making roles. They function merely as figureheads in their respective ministries. Therefore, almost by default, the bureaucracy, which is the only stable element of the administration, has taken over policy-making roles (HDC 1999).

It needs to be borne in mind however, that these bureaucrats are also not necessarily trained to handle policy-making in the health sector. Their area of expertise is in administration, which can be in any government department, whereas formulating health policy requires specialised and in-depth knowledge of the health sector (Bennett et al 1996). While there are trained health professionals, in this set up, they are often at a

lower level in the decision-making hierarchy, because of the dominance of Central Superior Services in top positions.

Moreover policy-making needs to reflect the needs of the population as well as being accountable to it. While a public representative is in a position to undertake both these responsibilities, the bureaucracy is not bound to do either. In fact it often has vested interests, which can conflict with its decisions. For example in the matter of regulation of the private health sector, this study found that there were established connections between the senior bureaucrats and the powerful medical lobby, working to the mutual benefit of each. Some of the stakeholders believe that, while the bureaucrats enjoyed various medical services and associated benefits, they in return turned a blind eye to various unlawful practices and disregard of regulations.

Lack of clear roles of federal and provincial governments

Regarding the roles of the provincial and federal governments, there were many grey areas where it was not clear which level's jurisdiction applied. Though health was considered to be a provincial subject, the federal government also retained some powers in overall policy formulation. This created confusion, specifically in relation to regulation of the health sector, and ultimately lead to inaction as neither side wanted to accept responsibility. One reason for this ambiguity could be that there have been repeated occasions when the constitution has been suspended and the country has been ruled by non-elected governments, when all powers become concentrated at the federal level. This is also the present situation after the military coup of 12th October 1999, which has since been legitimised by the verdict of the Supreme Court of Pakistan on the case of military takeover[1], which again is centralizing power with the Federal Government.

Overly centralized, ineffective role of the PMDC

The PMDC was formed forty years ago as a centralized body, when the country had two wings, East and West Pakistan, the formal private sector was virtually non-existent and there were only a few hundred qualified doctors in the country. After the separation of the

[1] "Text of Supreme Court verdict in military takeover case" http://www.dawn.com/2000/05/13/text.htm

eastern wing, the new constitution which was adopted in 1973, declared the country to be a federal republic with independently functioning, federal and provincial tiers of the government, health being delegated as a provincial subject. The PMDC however continued to exist as a central body, not responding to the changed government structure, the increase in the number of doctors or the expansion of the private sector.

According to its mandate, the PMDC was primarily meant to monitor the quality of medical education, which was the role preferred by its members as well. However, it also had the task of regulating the entry of doctors into the medical profession and to ensure discipline within it. While it was arguably performing the first task to some extent, it was considered largely ineffective as far as the second was concerned. It had neither the infrastructure nor the capability to be able to properly regulate the health sector. Moreover there was a lack of awareness and confusion within the official health establishment as to the role and jurisdiction of the PMDC. While it was meant to operate through the provincial health departments, for example for cases of malpractice to be brought to its attention, the results suggest that the provincial authorities were unaware of this responsibility and were under the impression that the process was the reverse. Additionally there was consensus on the point that the provincial health departments did not have the infrastructure to enforce regulations.

Conflict of interest between public and private sectors

While the growth of the private sector began at a relatively low level, in the form of increasing numbers of small private clinics, it gradually expanded in scale to include small and big private hospitals, and most recently private medical teaching institutions (see chapter 2). Moreover, this kind of growth was limited to a few large cities (World Bank 1998), where there were the largest numbers of government teaching hospitals. This was ascribed partly to the belief that government sector doctors, who had access to a large clientele and possessed the status and prestige which came with their position, but lacked a monetary incentive, cashed in on the opportunity which private sector practice provided to them. The majority of the clinics, hospitals and teaching hospitals, as shown in the study, are owned or managed by doctors who are already established in the public

sector. This has had the effect of creating a conflict of interest and could be instrumental in the growth of the private sector at the cost of the public sector.

The great demand for health services has also meant that, from a purely business point of view, it was seen as a commercially sound idea to invest in this sector. Therefore a large number of private hospitals have emerged which are being run purely as business ventures. The lack of a minimum standards regulation or requirement for registration has meant that there was no guarantee of quality in these hospitals. While from a free market perspective it could be considered that competition would have encouraged better quality, there have been two factors at work. Firstly, demand exceeds supply, and thus it has been possible to get away with providing low quality services; and secondly, the hospitals run by public sector doctors use their positions to attract patients and therefore the competition is not a healthy or fair one.

Thus divisions are created between those doctors working only for the private sector and those who are working both in the public and private sectors. The doctors in the first category are resentful because they feel that those who worked for the government use their privileges to get an unfair advantage and the quality of public sector hospitals is suffering because of the dual practice of many doctors.

Divisions are also seen between private hospitals employing public sector doctors and those employing only private sector doctors as the latter again feel that they had to operate at a disadvantage.

Consensus on perceived need for regulation

The need for regulation was expressed unequivocally by all concerned parties, but the differences lay in who was perceived to be in need of regulation and by whom. Thus the private sector doctors pointed towards the public/private sector doctors and vice versa; the private hospital owners would accept regulation but as long as the regulatory authority was not run by the government; the doctors' community as a whole, in order to protect its interests, backed the weak PMDC saying with a few minor changes it could be adequate. It seemed therefore that everyone accepted regulation as inevitable, but wanted

to work it to their own maximum advantage, without incurring any damage or loss themselves.

Alternative mechanisms and the idea of ' information dissemination'

Despite the fact that during the last few years there had been various national health policies, dealing specifically with the issue of regulation, and that there was a perceived need for regulation among the various stakeholders, it was observed that there was a lack of awareness and clarity regarding the concept of regulation. The response to ideas on possible alternative mechanisms was vague in most cases. The instinctive reaction by each group however was to safeguard its own interests, and let someone else bear the cost of regulation.

The response to a possible model based on information dissemination was varied. Primarily, given past records of achievement there was scepticism that any model, whatever it may be, could work in the prevailing circumstances. However there was a clear separation between those who stood to gain from such a mechanism, and those that did not. All those who thought they were providing good quality services and were doing so in a fair and above board manner, welcomed the idea of information dissemination to the general public, while those who were possibly bending rules in their jobs, gave a guarded response. Once again the service users welcomed the idea of open access to information the most enthusiastically and emphatically as it offered the best chance of ensuring that they got value for their money.

Service users the ultimate victims

The only group which stood to gain everything and not lose anything from effective regulation are the service users, who are the ultimate victims of lack of policies, internal power politics and low quality services. While they obviously lacked technical knowledge regarding models of regulation, they were the most clear about the various aspects of health care which they thought should be regulated. However they were the ones who were the most sceptical as well. They were wary of new proposals having heard many promises before which had not been kept.

Role of professional organisations

While Article 17 of the Constitution (Fazeel 1997) provides the right to form associations there is no specific legislation which gives professional organisations any powers or authority. Thus it was observed that most professional organisations were ineffective and non-representative. The Pakistan Medical Association has no influence or credibility among the medical profession. It is politicised and divided and unable to play a useful role for the community it professes to represent. The Private Hospitals Association was found to be representing a few diagnostic centres and the Consumer Rights Association was not traceable except in newspapers. To enable these organisations to play a constructive role for their respective membership or have a part in the policy making process, as previously suggested in the health policies of 1990 and 1997, it might be necessary to provide a formal and legislative backup under which they can operate, so that their opinion may have some legitimacy.

In the light of the above key findings, the following policy recommendations were made. While the recommendations are all important, they have been prioritised in the order in which they need to be implemented as the changes have to be incremental in nature. A solid foundation will need to be created first and further changes built on that. Thus the recommendations in order of priority are:

POLICY RECOMMENDATIONS

- Federal and provincial roles in the health sector should be addressed to remove ambiguity. As health care delivery and regulation are a provincial responsibility, the provincial governments need to assume that role (refer to memo of Federal Law Ministry given in Chapter 5). In this regard the Federal Government should take the initiative and issue a policy directive to the provincial governments to legislate for the regulation of health care provision.
- Professional organisations should be provided legislative support in order to make them more effective and representative. They need to present themselves as unified and genuine representatives, having proper rules of business in order for their opinions to have more legitimacy.

- The Pakistan Medical and Dental Council should be re-structured and its role re-defined. The Federal Government should amend the Pakistan Medical and Dental Council Ordinance 1962. The function dealing with monitoring of medical education, including the certification and recognition of medical degrees obtained within and outside Pakistan, should remain with the PMDC at the federal level, while that dealing with the maintenance of register and issues of malpractice, negligence and discipline, should be delegated to the provincial level. In this regard the Drugs Act 1976 and Pharmacy Act 1973 can be good examples.
- Provincial governments should legislate to create a separate and autonomous Health Regulatory Authority, consisting of representatives of the public sector, the private sector (doctors as well as owners of health facilities) and service users, on the pattern of the Punjab Blood Transfusion Authority (See Chapter 4). This authority should operate at the provincial level. It should be able to licence doctors (having PMDC certified degrees). It should also give licences to health facilities, which have satisfied a minimum standards requirement, e.g. infrastructure, equipment, staffing, set by the authority. This licensing should be mandatory (regulation) as opposed to voluntary (accreditation), thus differentiating it from earlier proposals which advocated accreditation. (It is considered that accreditation would work in those situations where the private sector is already functioning well and needed extra incentives. In the local situation in Pakistan, it would be more appropriate at this stage to set and enforce mandatory regulation as the private sector is not thought to be functioning as well as it could).
- Regulatory authorities should initially be set up in provincial capitals, Lahore being the obvious starting point for Punjab. Once operational, they should be taken down to the level of districts, giving the newly formed district health governments the task of regulation which they would perform under the supervision of the provincial authority (see Punjab Health Institution Rules 1999).
- For private sector hospitals to obtain a licence from the regulatory authority it should be made a condition that they employ the majority of their staff from those in full time private practice. This would help limit the growing problem of dual practice among public sector doctors. It is considered that at this stage it might be relatively

easier to bring private hospitals into a regulatory net before this sector grows to an unmanageable scale.

- While the recent provision of autonomy to the teaching hospitals in Punjab is a step in the right direction and will improve local management standards, it is essential that in the long term the service and pay structure of public sector doctors should be separated from the mainstream civil service, removing the perception of relative inequality among doctors, due to the greater perks and privileges enjoyed by the bureaucrats. Improvements in salaries would make it possible as well as fair to restrict and control the private practice of government sector doctors.
- This ban should be absolute for doctors at the junior level, but partial at the more senior, consultant levels. In the shorter term however private practice should be institutionalised, thus letting the doctors earn more but not at the cost of the public sector.
- Information dissemination should be a part of the new system of regulation. This is essential as it is the strongest demand of the service users who have shown a willingness to pay for services if they are provided the information required to make an informed choice. It has the potential of providing the maximum benefit to the users if implemented properly. For this purpose it is essential that the print as well as the electronic media is fully utilized, in consideration of the fact that in today's urban Pakistan, television is the most powerful tool available to provide information to the general public. The Health Authorities could disseminate information on the type of facilities available and the number and speciality of staff, for which purpose a grading system could possibly be adopted.

In conclusion, it is important that any policy, which is formulated for the regulation of private health care, should consider the needs of individuals and groups who have a stake in that sector. It should be fair, equitable and transparent as well as efficient, but above all, it is essential that its ultimate beneficiary should be the common man. According to Paul-Shaheen (1998) "the perception of a crisis serves as a powerful catalyst for political action, creating a window of opportunity for policy change". In the present situation in Pakistan, the time is right for action, what is required is vision and will.

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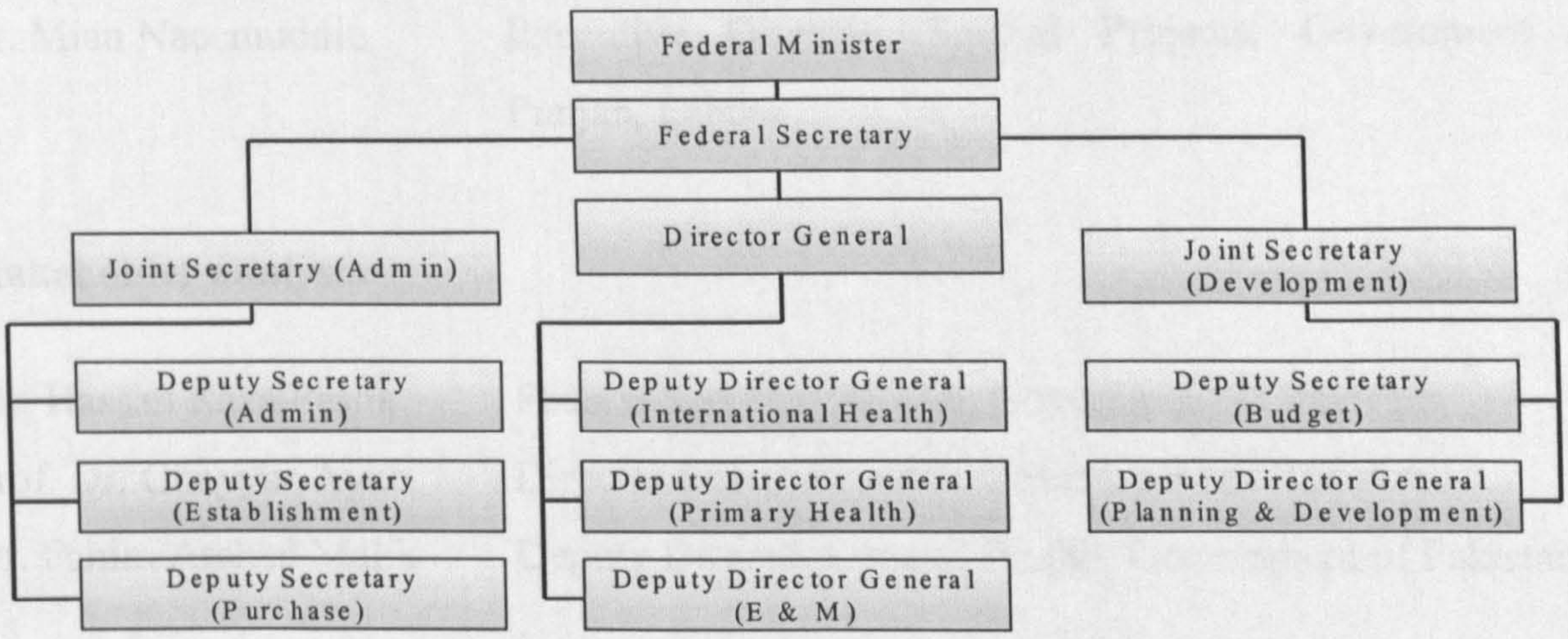
APPENDICES

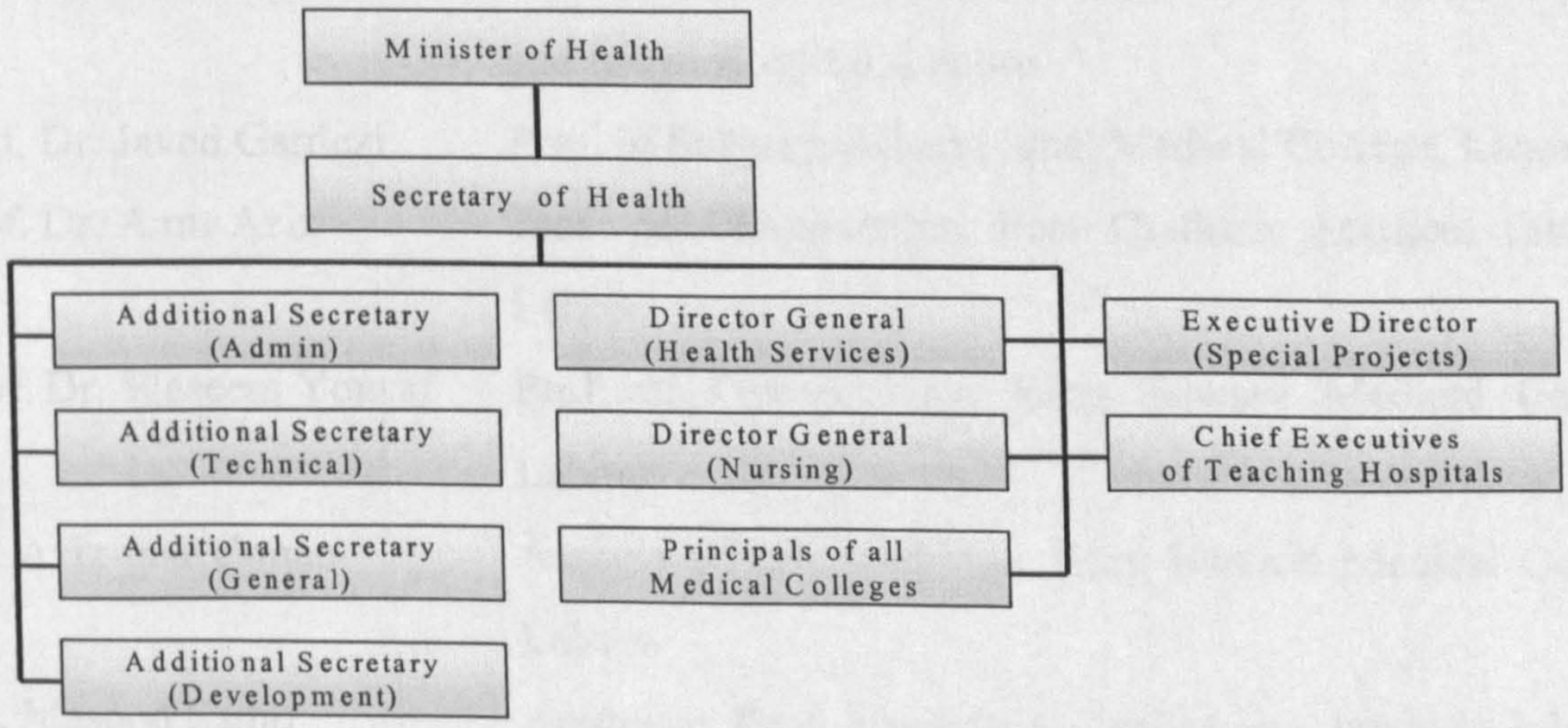
APPENDIX 1: ORGANOGRAMS

FEDERAL MINISTRY OF HEALTH



Source: Ministry of Health, Islamabad

PUNJAB HEALTH DEPARTMENT



Source: Department of Health, Punjab

APPENDIX 2: LIST OF KEY INFORMANTS FOR THE STUDY

Macro-analysis

Mr. Sayyed Ehtram Ali	Secretary, Pakistan Medical and Dental Council, Islamabad
Dr. Zafar Qureshi	Advisor to Chief Minister Punjab
Dr. Ijaz Munir	Deputy Secretary Chief Minister's Secretariat, Lahore
Dr. Mian Naeemuddin	Executive Director, Special Projects, Government of Punjab, Lahore

Stakeholder analysis

Mr. Hassan Raza Pasha	Federal Secretary Health, Government of Pakistan
Prof. Dr. Ghayyur Ayub	Director General Health, Government of Pakistan
Dr. Fahim Arshad Malik	Deputy Director General Health, Government of Pakistan
Mr. Ismail Qureshi	Provincial Secretary Health, Government of Punjab
Mr. Nazeer Saeed	Additional Secretary Health, Government of Punjab
Dr. Tahir Parvez Mir	Additional Secretary Health (technical) ex-officio charge of Director General Health Services, Government of Punjab
Prof. Dr.Mumtaz Hassan	Principal/Chief Executive King Edward Medical College and Mayo Hospital, Lahore
Prof. Dr. Javed Gardezi	Prof. of Surgery, Allama Iqbal Medical College, Lahore
Prof. Dr. Amir Aziz	Prof. of Orthopaedics, Post Graduate Medical Institute, Lahore
Prof. Dr. Waseem Yousaf	Prof. of Gynaecology, King Edward Medical College, Lahore
Dr. Aziz-ur-Rehman	Associate Prof. Medicine, King Edward Medical College, Lahore
Dr. Masood Sadiq	Associate Prof. Paediatric Cardiology, Institute of Child Health, Lahore

Dr. Aftab Asif	Assistant Prof. Psychiatry, King Edward Medical College, Lahore
Dr. Asjad Khan	Assistant Prof. Paediatric Cardiac Surgery, Institute of Child Health, Lahore
Dr. Kamran Cheema	Assistant Prof. Accidents & Emergency, Post Graduate Medical Institute, Lahore
Dr. Ahsan Shamim	Assistant Prof. Orthopaedics, Fatima Jinnah Medical College, Lahore
Dr. Khalid Kamal Pasha	Assistant Prof. Paediatrics, Fatima Jinnal Medical College, Lahore
Dr. Waseem Amir	Assistant Prof. Gastro-enterology, Allama Iqbal Medical College, Lahore
Dr. Haroon Babar	Assistant Prof. Cardiology, King Edward Medical College, Lahore
Dr. Ali Haider	Assistant Prof. Ophthalmology, King Edward Medical College, Lahore
Dr. Khalid Rahman Yousaf	Radiologist, Allama Iqbal Medical College and Jinnah Hospital Complex
Dr. Huma Majeed Khan	Consultant Surgeon
Dr. Afshan Siddique	Consultant Dermatologist
Dr. Faisal Sultan	Consultant of Internal Medicine
Dr. Asif Kyani	Consultant Ophthalmologist
Dr. Zarqa Taimur	Consultant Physician
Dr. Anwar Khan	Consultant Paediatrician
Dr. Amir Iqbal	Consultant Thoracic Medicine
Dr. Lubna Farooq	Consultant Radiologist
Dr. Shazia Khalid	Consultant Pathologist
Dr. Ali Gardezi	Consultant Endocrinologist

Brig. Dr. Manzoor Mirza	Medical Superintendent, Ittefaq Hospital, Lahore
Dr. Javed Aslam	Executive Director, Ammar Medical Complex, Lahore
Dr. Sadaf Farman Ali	Executive Director, Cardex Hospital, Lahore
Prof. Dr. Nusratullah Ch.	Executive Director, Surgimed Hospital Complex, Lahore
Prof. (retd.) Dr. Zafarullah	Executive Director, National Hospital and Medical Complex, Lahore
Dr. Shehla Akram	Chief Executive, Akram Medical Complex, Lahore
Dr. Aziz Rana	Chief Executive, Omar Hospital, Lahore
Mr. Shiekh Abdul Waheed	Chief Executive, Adil Hospital, Lahore
Mr. Hamayun Rashid	Chief Executive, Rashid Hospital, Lahore
Mr. Imran Khan	Chairman, Shaukat Khanum Memorial Trust, Lahore
Dr. George William	Executive Director, United Christian Hospital, Lahore
Dr. Azim udin Zahid	Secretary General, Pakistan Medical Association Lahore
Prof (Rtd) Dr. Ibrahim	President. Private Hospital Association Lahore.

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