Making Sense of Policy Implementation Process in Pakistan:

The Case of Hospital Autonomy Reforms

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Making Sense of Policy Implementation Process

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The Case of Hospital Autonomy Reforms

Betekenisgeving aan politieke implementatie processen in Pakistan

De casus: Onafhankelijkheid van ziekenhuis bestuur

(met een samenvatting in het Nederlands)

Proefschrift

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door

Aamir Saeed

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Promotor: Prof. Dr. P. Verweel

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List of abbreviations

AG	Accountant General
AIMC	Allama Iqbal Medical College
AMI	Autonomous Medical Institution
AMS	Assistant Medical Superintendent
BA	Bachelor of Arts (14 years of education)
BHU	Basic Health Unit
BOD	Board of Directors
BOM	Board of Management
BPS	Basic Pay Scale
C&W	Communication and Works
CE	Chief Executive (of the hospital)
CENTO	Central Treaty Organization also known as Baghdad Pact
CEO	Chief Executive Officer
CM	Chief Minister (of the Province)
CSS	Central Superior Services (Federal Bureaucracy)
DD	Deputy Director
DF	Director Finance
DHO	District Health Officer
DMOH	District Medical Officer of Health
DOH	Department of Health, (Govt. of Punjab)
ED	Executive Director
EDA	Economic Development Authority
FA	Fellow of Arts (12 years of education)
FCPS	Fellow of College of Physicians and Surgeons (Post Graduation for Doctors)
FGSH	Federal Government Services Hospital
FMOH	Federal Ministry of Health
GOR	Government Officers Residences
HCFA	Health Care Financing Administration
HFS	Health Financing and Sustainability (Project)
HR	Human Resources
ICT	Islamabad Capital Territory
IFI	International Financial Institutions
IMC	Institutional Management Committee
IMR	Infant Mortality Rate
ISI	Inter Services Intelligence

JHL	Jinnah Hospital Lahore
LHV	Lady Health Visitor
LIL	Learning Innovative Lending
MO	Medica Officer
MPA	Member of Provincial Assembly
ML	Muslim League (Political Party which led the movement for creation of Pakistan)
MS	Medical Superintendent
NCAHMEI	National Commission on Administration of Hospital and Medical Educational Institutions
NPM	New Public Management
NWFP	North Western Frontier Province
OPD	Out Patient Department
PEO	Principle Executive Officer
PGMI	Post Graduate Medical Institution
PHAP	Punjab Hospital Autonomy Project
PHC	Primary Health Care
PIC	Punjab Institute of Cardiology
PIMS	Pakistan Institute of Medical Sciences
PM&HI	Punjab Medical & Health Institutions Act or Ordinance
PPSC	Punjab Public Service Commission
PSC	Pay and Service Commission
RHC	Regional Health Center
SHL	Services Hospital Lahore
SMO	Senior Medical Officer
SWMO	Senior Women Medical Officer
USAID	United States Agency for International Development
WOT	War on Terror
WMO	women Medical Officer
ZAB	Zulfiqar Ali Bhutto (former Prime Minister of Pakistan)

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Chapter 1

Introduction, Research Question and Methodology

1.10. Introduction

Transnational capitalism has powered the development of the contradictory phenomena of globalization which impresses new constraints and frameworks for nation states and their external and internal policies (Silvestre, 2008). Loans and financial help from international organizations are never unconditional. It brings with it various reform packages and conditionalities that are to the detriment of the receivers. "While countries receive loans and financial help from international organizations, they also get packages of policy conditions to receive help" (Silvestre, 2008, pp. 101-102).Such recent reforms include privatization of social services, free trade regimes and deregulation of its economy. In case of health sector, IFIs proposed different prescriptions including standards and accreditation for hospital quality assurance, private health insurance, and hospital autonomy (Makinen, 1993, p. 2). The first two initiatives could not take root for reasons not known however the phenomenon of hospital autonomy was launched in Pakistan first at federal level and later at provincial level. The basic assumption of this reform was "that concrete benefits would result from allowing hospitals currently owned and run by the Government of Pakistan to begin to operate as autonomous entities" (Hildebrand and Newbrander, 1993, abstract). Pakistan was not the only country where this reform was prescribed by the donors. Some of the other countries included Indonesia, India, Jordan, and Thailand.

The initiative was launched at two federal hospitals on experimental basis on the condition that if found successful, this initiative will be introduced in provinces. In one of these hospitals, hospital management structure was altered for no less than seventeen times, as narrated by a respondent (DB4). Still the experiment was deemed successful and provinces were given go-ahead for the reform.

Though the constitution of Pakistan is federal in nature, yet in practice colonial tradition had stronger say on the way things are carried out in here. Despite health being a provincial subject, it is controlled centrally by Federal Ministry of Health (FMOH). In most of the situations, health projects and programs are proposed rather imposed by foreign agencies which are then planned and approved by the FMOH and later passed on to the provinces for implementation. In this regard, provinces don't have much to contribute as they are on the receiving side.

Since its inception, Pakistan has acquired a very significant position in world politics due to its geography. The piece of land which now makes Pakistan has always been a potential avenue through which Russian dream of reaching warm waters could materialize. British used it successfully to keep the Russians at bay. After the rolling back of British Empire from the sub-continent, the US took upon itself the responsibility of containing Russians. Pakistan has always been a key pawn in the US strategy be it tense 1960s when Gen. Ayub stood by US and provided them airfields which were used to reconnoiter Russian lands; be it Russian invasion of Afghanistan against which Gen. Zia-ul-Haq, with the help of US support stood firm that led to Russian defeat and withdrawal; or be it US War On Terror which was owned and supported by Gen. Musharraf's regime. Incidentally, timing of War on Terror and launching of hospital autonomy reform coincided and the War had great influence on the reform.

Hospital autonomy was launched in the province of Punjab through an ordinance presumably under the influence of federal government and donors. However, here political leaders presented this idea as a remedy for various problems being faced by hospitals including poor services, lack of facilities, insufficient facilities, rude behavior of employees, lack of medicines etc. The idea was taken as a local phenomenon where doctors were also involved in the process. Doctors had yet another meaning of the phenomenon. They saw it in the framework of generalist vs. specialist debate, where autonomy meant freedom for doctors from the control of bureaucracy. Doctors along with other specialist cadres had long contested the supremacy of generalist bureaucracy over them. They opined that specialist including engineers, doctors and other professional were the cream of the society and those who could not get admission in any professional institution then joined bureaucracy, which is mockery of the

merit. Bureaucrats then go on to head the governmental departments which then control different professional institutions including hospitals. They believed that generalist bureaucracy suited colonialists whose main concerns were maintaining law and order and collection of revenue.

According to Egger (1953):

> "the deficiencies in the public administration of Pakistan are not deficiencies of intelligence or understanding, but are the deficiencies inherent in an administrative system designed for a day that has gone by (p. x)…the colonial government was a law-and-order government, the function of which, except in time of famine, did not extend appreciably beyond internal tranquility and collecting the revenue (p. 1)".

This partnership between politicians and doctors, both joining for different objectives was thus successful in introducing the reform of autonomy of hospitals. Bureaucracy had to give in, at least for the time being, and teaching hospitals were granted autonomy. However all this was done in an abrupt fashion without developing any transition plan and rule framework which would govern the autonomy in the future.

Some among the doctors' community took it as if now they were all in all, without being responsible towards anybody. They had to make a wide range of decisions, some came out to be good and others bad, in different areas of hospital administration as no rules existed/ were developed (DEA6, B2) to govern their behavior. The same thing was seen as whimsical by others especially juniors. This newly found absolute authority without commensurate responsibility made some individuals arrogant, capricious and threatening towards juniors. As one respondent (E2) put it 'the powers to hire and fire made officers very stiff-necked and abusive'. This resulted in a reaction from the various quarters of society.

Meanwhile through a military coup, the democratic governments, both in center and province were sacked. The thrust and support that the autonomy initiative had from the political government was gone. Military government halted the process and the reins were again in the hands of bureaucracy. Later on, another version of autonomy was launched with altered governance mechanism, in which bureaucracy had more control, but that too was halted among searing criticism from doctors community

and media. An enquiry was conducted and yet another version was introduced which brought even more power for bureaucracy.

1.101. This system is still in place

The process of implementation of autonomy was punctuated by different turns, impacted by various actors. Different stakeholders had contrasting rather conflicting interests and objectives. Donors wanted to help government reduce subsidy towards health sector thus improving its capacity to repay its loans to donors. Politicians at provincial levels were interested in gaining political mileage by reforming health sector through autonomy. Doctors were weary of bureaucracy's hegemony over them and wanted to gain independence and autonomy from them. And the interest of bureaucracy lied in retaining the control of the health care institutions which would maintain their domination of the system.

These conflicting interests affected the implementation process of the reform of autonomy. Moreover each stakeholder made its own sense out of the phenomenon of autonomy which led to specific actions. This study argues that study and analysis of the implementation process at SHL will help us understand the context, dynamics of implementation and their relationship in Pakistan. To achieve this objective the following methodology was adopted.

1.20. Methodology

1.201. The study

The study is focused on the healthcare sector with reference to the policy implementation process of hospital autonomy intervention in Services Hospital, Lahore. While developing a background, the researcher will also touch upon the process of policy making especially in the context of Pakistan. Both these processes fall within the sphere of governance; hence this study concentrates on the governance aspect of the teaching hospitals with reference to autonomy intervention.

Ever since Pakistan got independence some 64 years back, social sector of Pakistan has been under great duress. It inherited underdeveloped and

weak rather neglected social sector from its colonial past. Provision of standard social services including health, education, infrastructure etc could not have been among the colonial objectives as it occupied these lands for making money. After the independence, Pakistan inherited the same state structure, laws, rules, personnel, objectives and mindset of the officials of the state which were developed to serve colonial agenda. Health was among the most neglected of the areas in social sector. The extent of its neglect can be gauged from the fact that its budget was around 0.6% of the GDP. Though the independence came along with promises and claims of rosy future, not much changed for the people of Pakistan. The image of Pakistan as a security state continued all along its life. Many conferences, seminars, programs, initiatives were conducted on health sector, some good and sincere suggestions were forwarded, however nothing worked for the masses. Continuous political instability, alternating martial laws, persistent bitter relations with and wars against India and proxy US wars first against USSR and later against so called terrorists diverted most of the money for security apparatus of the state. On top of it, every new demand for more resources from security sector was met by chipping a slice away from development budget.

Though this was an internal story of the state of Pakistan, elsewhere in the world, public sector was under tremendous criticism for being inefficient and ineffective. Its oversized structure was also being blamed for using too big a part of the social budget for its upkeep e.g. the study of Pressman and Wildavsky(1973) provides a detailed story of an unsuccessful mega project of federal government in the city of Oakland and the roots of its failure are found in poor implementation and lack of coordination of various governmental establishments.

It is not that no planning has been done for the amelioration of health sector in Pakistan, far from it, many ambitious, audacious, and full-of-promise programs were initiated including Primary Health Care, on the advice of international organizations like UNESCO, USAID etc. Yet most of them fell well short of their targets. Very few evaluation studies were conducted to find out what went wrong. And if there were a few of them, they were never used while devising future plans. All this was helped by very unstable and peculiar political environment where every new government would blame erstwhile government for all the current

problems. And the previous government will absolve itself claiming that current government is victimizing it.

There is a dire need to find out where does, all along the process, the fault lie. Where things go awry? This necessitated a study of the process of implementation of some social program. The findings of the study may later on be evaluated by future studies, and if confirmed, can be helpful in identifying the root cause of the problems and then addressing it.

Werner (2004) while commenting on the implementation research agenda identifies that such research needs to answer the questions like "What is happening?" and "Why is it happening as it is?" (p. 1). Following research questions were developed in the light of the conceptual framework to guide and direct the research process.

1) How the policy of hospital autonomy was implemented at the Services Hospital Lahore, Punjab?

2) Why the intervention got implemented the way it was implemented?

These questions will be investigated by employing the case study methodology in the light of Yanow's (1993) following remarks:

> agency staff, clients, and other policy stakeholders may form interpretations of policy language, legislative intent or implementing actions; and these interpretations may differ from one another and may diverge from the intent of the policy's legislators…These multiple interpretations may facilitate or impede the policy's implementation. Such interpretations on the part of policy stakeholders are not entirely open to analysis as objective facts: much of their meaning can only be elicited by an act of interpretation on the part of the researcher (p. 42).

1.202. Research Methodology

This observation leads the researcher to choose for qualitative interpretive research. The approach of the researcher consisted of the following points:

1. This is a case study of the process of implementation of hospital autonomy in Pakistan and how it was mediated all along by its context. Yin (2003) informs that the use of case study is beneficial where one "deliberately wanted to cover contextual conditions-

believing that they will be highly pertinent" to one's area of study (p. 13). This study is being called a case study because it tries to study the process in depth in one of the 17 hospitals where it was implemented. In depth study might have not been possible had the phenomenon been studied in large number of hospitals. This social phenomenon was a very complex one embedded in its context and involved a good number of stakeholders who had different and somewhat conflicting objectives. Yin (2003) observes that "the distinctive need for case studies arises out of the desire to understand complex social phenomena. In brief, the case study method allows investigators to retain the holistic and meaningful characteristics of real life events…" (p. 2). Moreover the research design incorporates requirements of the case study method like "the use of manifold instruments of data collection, the explanation of two basic questions: what happened, and why, the analysis of the research problem in its context, the composition of detailed and holistic descriptions of the context and issues within the case, and discussion of themes and issues emergent from the analysis of the case itself, among other aspects" (Silvestre, 2008, p. 107).

2. Although this is a single case study, on certain accounts, information was also gathered about other hospitals undergoing same intervention from individuals who represented them. This will in a way help the study stay clear off the shortcomings attributed to single case study.

3. After choosing the topic of hospital autonomy, the researcher started his search for certain sources which may provide comprehensive background information. As this was a relatively newer topic and the researcher did not have much knowledge about it, he started with the search of the topic of hospital autonomy on internet. The response was a list of a number of evaluative studies on hospital autonomy conducted in various other countries. With this piece of information the researcher was able to surmise that 'hospital autonomy' is not native to Pakistan and has some foreign origin. Another document found during the search was about some funding by a foreign authority to test hospital autonomy at Federal hospitals. This was another lead which suggested that hospital

autonomy was being implemented at Federal level as well and for which funding is being provided by International donors. Yet another project document named as "Pakistan-Punjab Pilot Hospital Autonomy...Project (Learning and Innovation Loan)" provided details of how this process will be undertaken in Punjab's tertiary hospitals. The focus of first phase would be "on improving emergency services and its associated clinical support systems (blood bank, clinical laboratory, diagnostic radiology" whereas "(t)he second phase would focus on improving one or two categories of non-emergency services (e.g., pediatrics, obstetrics)" (pp. 1-3).

4. "Case studies often involve putting yourself in the environment that is being studied. Entry sometimes can be difficult, and acceptance in almost always a problem" (Willis, 2007, p. 241). This researcher also faced number of issues while entering into environment as this field had an aura of formality, alienation and otherness. Respondents consisted of government officials, both bureaucrats and doctors. The issue was political and sensitive as well. Lack of research traditions in this society made matters worse. Research performs a very important function in that it creates knowledge necessary to tackle issues being faced by society. This society is different because it looks towards West for solutions of the problems which the society faces. Solutions are either imported or imposed. Resultantly neither elite need any research nor do they encourage it. In such a scenario, the researcher had to tread carefully. He used his personal connections to make an entry into the environment subtly and not intrusively. The researcher's strategy included allaying respondent's concerns, reassuring anonymity of their views, putting them at ease and showing flexibility. Researcher was always willing to empathize with the respondent and tried not to put them in any awkward situation. It really paid dividends and in most of the situation respondents became relaxed in short span of time and expressed their views rather freely.
5. The researcher accessed officials in DOH who provided useful information including some documents related to the initiative. They also guided him towards various sources and individuals who

were among the initiators of the intervention. Among them were some bureaucrats and doctors who were part of the team that devised this initiative for Punjab hospitals. Long unstructured interviews with them provided lots of valuable information and helped researcher understand the context. It also provided researcher with avenues for further enquiry. The documents found in libraries included some past reports on different initiatives to reform health sector in pre and post partition era.

6. Interviews with doctor who assumed the responsibilities of various hospitals as administrators later when autonomy was launched proved very insightful. The researcher was able to relive the experience with them. A lots of personalized and important information was made available which included how different stakeholder thought of the initiative, how the initiative went along, what problems were faced, who supported or opposed the process. Researcher came to know about different past and future administrators whom he later interviewed.
7. Researcher then proceeded to Federal Capital to gain understanding of autonomy initiative at Federal level and its relationship with same initiative in the province of the Punjab. By employing personal networking, the researcher was able to access such officials who were attached to the initiative from the very outset. Long unstructured interviews with them provided researcher the understanding of the process of implementation of hospital autonomy at Federal level, how policies were made in Pakistan, and what past and current contextual events impacted the process and what were the real issues of policy making and implementation in Pakistan. These discussions provided further leads to different administrators at Federal hospitals with whom unstructured informal interviews were held. Visits to various specialized and personal libraries proved very useful as a lot of past reports and documents were found which were not available in any public library.
8. As the information was pouring in from different quarters, it was falling in place making it possible for the researcher to make sense of what had happened and how. The researcher at times tried to reconfirm the story from different actors and in most of the

situations, it was confirmed which gave the researcher confidence to move ahead. In certain situations, additional insight helped the researcher further illuminate his understanding of the story.

9. Contrary to the quantitative analysis, where numbers count; the qualitative research stresses upon the quality of the information. It prefers significant few to insignificant many. The researcher approached most of the administrators of Service Hospital, Lahore who were part of the process at different tenures and lived through the experience of implementation of hospital autonomy at the hospital level. In total, the researcher conducted extensive interviews of ten administrators-cum-doctors. Some of these actors were involved in the planning of the initiative and others steered the process at implementation level. Researcher also interviewed three non-doctor employees who worked in administration. Researcher had the opportunity to get in-depth information from nine officers from provincial and federal bureaucracies. Majority among them were doctors. They also had been part of the process, some at planning and others at implementation level.
10. Most of the doctor-cum-administrators were skeptical and against the process of autonomy and thought that it was just an eye wash and real autonomy to hospital has never occurred. Other believed that some powers have been delegated to the hospital, yet it has not benefited the poor patients as now the attention is towards infrastructure building.
11. The nature of study necessitated that sampling be done from all stakeholders. As the researcher was new to the field so it preferred snow balling technique. Almost every interviewee was supportive enough to provide some further link which could be contacted for gathering further information. Researcher believes that it was due to the fact that a trust environment slowly developed during interview. And it had a lot to do with not audio-recording of the interview. The researcher kept on contacting the respondents and interviewing them until it became obvious that no new information is forthcoming.

12. Before embarking on the interview stage, the researcher studied extensively, met with experts and studied the context and then adopted the technique of conducting informal, unstructured interviews where it allowed interviewee to express his/her views freely and at length. Even that information which looked not directly relevant to the question proved to be relevant as it provided context which helped researcher understand the information. It also helped the researcher in understanding the mental bent of the interviewee. This technique relaxed the interviewee and the researcher was able to get the maximum out of them. Furthermore, the unstructured technique allowed interviewee to think freely which resulted in a natural flow of thoughts. Researcher tried to put questions in such a way that it appears continuation of the answer of the previous question so it became a enjoyable experience for the interviewee.
13. The researcher had to show a lot of patience in order to accommodate the timings, venues and view points of the respondents. In one incident, researcher had to visit an administrator for more twenty times as he was extremely busy and was always dealing with unforeseen circumstances. This may be seen as anomaly in structured and programmed western society, yet it is quite normal and customary here in Pakistan where people will give you appointment and still be unavailable; people will pour in any time and their non-accommodation will be seen as rude and discourteous. This is one of the reasons why doing research in the context of Pakistan is an uphill task. The views of the respondent were very vital for the researcher as he was in charge of the hospital at that time and had plenty of vital information available with him. Eventually, patience paid off and researcher was able to interview him at length as he felt obliged to provide good amount of information.
14. It would be pertinent to mention here that due to the political nature of the topic where most of the respondents were from various public institutions, it was not possible to audio-record the interviews. As audio recording can be used as evidence, most of them were reluctant to allow recording of the interviews. Moreover,

those who even allowed recording became very cautious and calculated in their uttering and did not express their views openly. In order to gain information which is most accurate and comprehensive the researcher then had to resort to transcription and took small notes. As immediately as possible after interviews, researcher developed elaborate notes with the help of this material so that the meaning and perspective of the interviewees is fully captured. This certainly was a trade off but its benefits outweighed its shortcomings.

15. Most of the primary data collected during interview was qualitative in nature. The data collected thus may appear hearsay to those who advocate for scientific, hard and empirical evidence, yet, this is an undeniable fact that not all people have equal amount and level of knowledge. Experienced, technically sound, and qualified individuals do know more that others in their areas. So the views of the one who matters do matter, even if he/she is an individual. Principal of democracy is inapplicable here.

16. The study seeks to answer two research questions which were listed at the start of the chapter. The first question is about 'what happened' with reference to the implementation of the intervention of hospital autonomy in SHL. This question is about a lived experience so its answer can be known from those individuals who were part of the process at different stages and who lived through it. Far from being a bottom-up affair, this whole process was a typical example of top-down approach. So all the stakeholders who could be considered on the top had power in the process and consequently could tell what actually happened. They included politicians, bureaucrats and doctor/administrators of the hospital. An effort was made to contact as many individuals as possible to understand what actually happened. With some exception most of the stakeholders were accessed and the researcher was able to build a story based on their observations. During the process of gathering data researcher found out that though most of the stakeholders agreed on the introduction of this reform, there was no agreed upon problem for which this solution was being proposed. Whether it was directed towards improvement of the management of the hospitals?

Was it an attempt to provide better services for the poor patients? Was it an effort to relieve government of its financial obligations towards hospitals? Was it an endeavor to free hospitals from bureaucratic control thus allowing them to be more efficient? Or was it a political ploy by politicians to gain popularity? The researcher was amazed to find so divergent objectives held by different stakeholders. The second question was aimed at finding out why the implementation process took the trajectory that it took. Even for the answer of this question, these stakeholders were to offer a lot. Different stakeholder raised deep rooted issues which became the basis for further inquiry. The researcher himself was also able to observe certain other issues which may have caused the process to take the course that it took. In order to understand those issues in depth and to make sense of what happened, researcher resorted to the literature about history of Pakistan, colonial policies and structures in subcontinent, specialist vs. generalist debate, power dynamics, basis of public-state relationship etc. The study of these issues in depth allowed the researcher to come up with plausible reasons about why process of implementation took the specified route.

17. Apart from these two stakeholders namely bureaucrats, and administrators both doctors and non-doctors, politicians were found to be very much part of the process. Efforts both formal and informal were made to seek appointment from current and former Chief Ministers; however, researcher could not access them as there was no response from them. This gap will be filled by reading different news items depicting the views of these two individuals.

18. Anonymity of the respondents is one area in qualitative research which has vastly been mentioned by the community. Going along with this tradition and considering the political nature of the study, the researcher has tried, to his maximum to keep the identity of the respondent hidden. A coding system has been developed for it and names of the respondent are not mentioned in the thesis.

19. The study could have been approached from various angles, however, the researcher thought it prudent to approach it from the angle of implementation. It is so because in the past innumerable

glossy plans and policies has been purposed with trumpeting loud claims of bringing about drastic improvement in different aspects of life, yet most of them have fizzled out without creating any significant impact save further burdening of masses with huge foreign debts. So it was very important for the people to know why such excellent plans fail to achieve their claimed objectives. Though written in US context, Pressman and Wildavsky (1984) book titled "Implementation: How great expectations in Washington are dashed in Oakland" proved to be a great help in understanding basic issues on the topic. Other sources and views of different scholars also provided useful insights and alternative thinking which helped the researcher to develop his analysis.

20. Yin (2003) while explaining various units of analysis that different case studies has been written about, asserts that "(c)ase studies have been done about decisions, programs, the implementation process, and organizational change" (p. 23). The unit of analysis for this case study is also 'the implementation process' as it studies as to how the process of implementation of hospital autonomy intervention went along.

21. Weick is of the view that "(t)he basic idea of sensemaking is that reality is an ongoing accomplishment that emerges from efforts to create order and make retrospectives sense of what occurs"(1993: 635). Schwandt (2005) explains sense making as a "process that includes the use of prior knowledge to assign meaning to new information…It is not simply the interpretation of information; rather, the continuous interaction with information allows meaning to emerge" (p. 182). And according to Fiss and Hirsch (2005) "(s)ensemaking stresses the internal, self-conscious process of developing a coherent account of what is going on (p. 31). In other words, sensemaking is a process whereby people develop meaning of actions in the light of the past happenings. An event is not something disconnected from its past rather it is a continuation of the past. The event can only be understood and will make sense when it is seen in its natural context.

22. Weick (1995) explains the process in these words, "sense making starts with three elements: a frame, a cue and a connection…frames

and cues can be thought of as vocabularies in which words that are more abstract (frames) include and point to other less abstract words (cues) that become sensible in the context created by the more inclusive words. Meaning within the vocabularies is relational. A cue in a frame is what makes sense not the cue alone or the frame alone" (p 110).

23. A 'cue' is a piece of information, content, event or phenomenon which occurs in a situation and which indicate that meaning is needed. Its meaning is vague or different from what it would be in its natural context. A 'frame' is a set of background knowledge, a context which may help in understanding of the content. This will provide information which will help in better understanding of the meaning of the event. If an event is seen in relation to its background it may provide better understanding and purer meaning. And 'connection' is a link which connects the cue with the frame. A relationship of the cue and the frame needs to be established so that they are seen as continuity – a meaningful whole. In the case of autonomy, the content cannot be understood in isolation; rather it needs to be seen in the back drop of the history. Only then its real meaning will be understood. Weick (1995) further explains how this connection is established:

24. Frames tend to be moments of past socialization and cues tend to be present moments of experience. Meaning is created when individuals can construct a relation between these two moments. This means that the content of sense making is to be found in the frames and categories that summarizes past experience, in the cues and labels that share specific present moments of experience, and in the way these two setting of experience are connected (p 111).

25. Weick's depiction of sense-making as "an activity in which many possible meanings may need to be synthesized" (p. 27) looks quite relevant for the study of the processes of meaning construction and enactment of policy of autonomy. The policy of autonomy is not just an objective reality imposed from the top which got implemented later on; rather it is constructed socially through the interplay of different stakeholders. It is in fact a continuation of its past. Its introduction may be seen by few as an outside intervention;

however the way it got implemented eventually was influenced by past happenings in health sector in Pakistan specifically and in the society of Pakistan generally.

26. Thus, in the case of autonomy of teaching hospitals reforms, "the state constructs policy while mediating the demands of the global economy (Currie, 1998), and the influence of "international development forces" (Torres, 1998, p. 351 as cited in Silvestre, 2008, p. 52).
27. Silvestre (2008) quotes Weick (1995) who says that "different stakeholders in the system interpret policies, and mediate their implementation at the institutional level in particular ways" (p. 8).

1.203. Concluding Remarks

The researcher chooses the case study methodology in which the technique of sense making was employed to understand the process of implementation of hospital autonomy reform. The process of implementation of the reform involved the contribution and interplay of different stakeholders in the process each having a unique understanding of the concept based on their objectives and interests. The technique of sense making lends us a helping hand in understanding the meaning of an event by establishing its connection with the 'frames' thus making it easier for the reader to cognize the grounded meaning. Putting these bits together leads us to draw a large canvas which then can facilitate the broader understanding of the whole process.

Chapter 2

General context of Healthcare sector

2.10. Introduction

The reality of the present cannot be understood properly without the knowledge of the past. Preceding data provides the background framework through which better sense can be made of the present reality. Likewise social reality is interlinked and one part of the society affects others and gets affected by others. Some aspect or part gains more importance at the cost of others, based on the priorities/ compulsions of the societies. So the understanding of some social reality calls for the understanding of the social context/framework, without which reality of the social phenomenon remains largely hidden or misunderstood. The framework might include information from history, geography, society, politics, institutions etc. Consequently, it can be safely said that history and context matter.

2.20. Context Matters

While commenting on the importance of contexts for understanding implementation Berman (1978) says that '(b)ecause implementation, like other human problem-solving activities ... arises from the interaction of policy with its setting, we cannot anticipate the development of a simple or single retrospective theory of implementation that is "context free". Grindle (1980) emphasizes the importance of relevant "politico-administrative context" within which the process needs to be seen (as Cited in Najam, 1995, p. 7). Yanow (1993) highlights the importance of "context specific meaning" (p. 46). Barret (2004) also shares the viewpoint when she comments that "(t)he very processes of policy implementation are themselves deeply politically dependent, having both a macro and micro political context" (p. 259). And Hill & Hupe (2002) have this to say about implementation: "For implementation theory and research this means that contextualization is important: 'implementation' is always connected to specific policies as particular responses to specific problems in society" (p. 5). All these views are emphasizing this very point that in order to

understand the process of implementation, it is important to see it in its natural context.

Hill and Hupe while mentioning different observations of various authors of institutional school of thought observes that "(s)uch observations suggest that an examination of a policy process – and accordingly of an implementation process – needs to be seen as occurring in organized contexts where there are established norms, values, relationships, power structures and 'standard operating procedures" (2002, p. 35).

Pressman and Wildavsky (1984) while explaining relationship between implementation and policy state that "(t)here must be something out there prior to implementation; otherwise there would be nothing to move toward in the process of implementation. A verb like 'implementation' must have an object like 'policy'". So the phenomenon of implementation is not likely to exist if policies are not developed. "(C)ontextualization is important: 'implementation' is always connected to specific policies as particular responses to specific problems in society". In other words, public policies are developed in order to respond to issues which are largely public in nature. Policy is "purposive course of actions" designed by government to manage public issues (p. 5).

In the light of the above discussion, it would be pertinent to present here some background of health sector of Pakistan in order to better understand the phenomenon of autonomy in the public sector hospitals in Punjab. This will cover general and broad sphere including relevant and recent global/regional events, their impact on the society of Pakistan and society's response to that; the nature and structure of the society of Pakistan, the description of the equation including public and other important stakeholders of the state, and the resultant governance mechanism including policy formulation process and its back ground; the relevant importance of social sector with reference to other sectors seen through financial and non financial indicators, the psychological makeup of the rulers and the ruled etc. This chapter will provide us the opportunity to identify those factors/events which have indirectly influenced the context. These are the factors which make an outer sphere or context in which healthcare sector operates. The next chapter will focus on the specific context of tertiary hospitals of Punjab which will include background of healthcare sector, history mapping important events and trends, nature and

characteristics of health sector and tertiary hospitals, major health related indicators, nature and extent of autonomy in pre and post autonomy eras etc.

2.30. International Context

The creation of Pakistan is attributed to the charismatic leadership of Mohammad Ali Jinnah who riding on the populist Islamic sentiments of Muslims of India constitutionally and politically, carved out of the subcontinent, a piece of land for the Muslim in the face of fierce colluding efforts and designs of British and Indian Congress. Millions of people were slain and perished during one of biggest migrations of the recent history at the eve of the separation of the subcontinent. However, an important fact which is ignored is that the bloodshed associated with the separation in fact started after the announcement of the creation of Pakistan.

It is a widely held view that the divide of the subcontinent was on Muslim - non Muslim basis. However, there is another perspective which is embedded in international politics. This may or may not be an alternative explanation of the creation of Pakistan, yet it certainly had influenced the phenomenon. I would call it the-great-game-perspective. The name 'the great game' is attributed to the secret war which was fought for nearly a century, between two most powerful nations of their time i.e. Victorian Briton and Tsarist Russia, "on lonely passes and deserts of Central Asia". Both of them had expansionist designs towards a common territory. The British advanced from subcontinent via areas currently part of Pakistan towards present day Afghanistan. They thrice occupied Afghanistan but could never establish their control over there in the face of fierce local resistance. Russian from the other side tried to reach Afghanistan after occupying one khanate after the other in the Central Asia. In around 1891, Russians even captured Chitral offensively, apparently to thwart the British design to capture the areas of central Asia under the occupation of Russia. British later made several diplomatic, military and strategic moves which ultimately succeeded in stopping the advances of Russian forces towards warm waters – their centuries' old dream (Hopkirk, 1990).

In the aftermath of World War II, the super power status of Britain shifted to US in the wake of its use of superior nuclear technology which ended the war to its advantage and with this shifted the responsibility to stop Russians

to reach the warm waters. This strategic move incidentally has lot to do with the creation of a country mostly consisting of those areas which Britain occupied at the later part of its occupation and which proved to be a potential bulwark against the offensive desperate Russians. According to one respondent (DBF1), 'once the British were gone it was the US influence that held sway on the decision making of Pakistan government'. The Russian invasion of Afghanistan in 1979 and subsequent US led Afghan 'Jihad' by Pakistan forces along with local Taliban provides strong support to this thesis. The recent US 'war against terror' to which Pakistan forces are again allies is no coincidence as US was also provided airport facilities at Badaber in Gen Ayub era (1958-69) from where US spy planes used to fly to reconnoiter Russian territory. Pakistan remained member of SEATO[1] and CENTO[2] as non-NATO ally in the region. However whether the leadership of Pakistan was consciously a part of this grandiose campaign is a question which need further enquiry.

This framework amply explains the reason why the equation of relative significance of rulers and the subjects has remained unchanged even after elapsing of sixty years of independence.

2.301. Impact of colonialism

"Pakistan's political culture is naturally a strong product of its past, including its people's earlier history under the British Raj. What Pakistan's leaders knew best from this inheritance was the so-called vice-regal system that made little or no provision for popular awareness or involvement. The system was designed to rule over a subjected population and intended to keep order and collect taxes" (Weinbaum, 1996, pp. 640-41).

The British came to the subcontinent in the era of Moghal emperor Shah Jahan in the 17th century to explore business ventures and then never went back, metaphorically. Though they did return literally in 1947 after partitioning subcontinent in two parts and handing over power to local representatives yet their everlasting impacts on the state, society, culture, structure and minds of the people are as strong as ever. According to Jones, "(f)or several decades Pakistan functioned no more than as a torn remnant

[1] South East Asian Treaty Organization

[2] Central Treaty Organization also known as Baghdad Pact

in a once great Empire" (1997, p. 324). In fact, situation is still the same even till today. Its impacts on modern day Pakistan can be gauged from the fact that all its political, social, legal and administrative structure of the state and society have either remained unchanged or altered slightly with original outlines given by the colonialists staying almost the same. Moreover the governance structure though morphed physically from colonial government to democracy, the underlying governance/management principles, styles, state–society equation, policies and methods have remained unchanged. Some of the institutions that they developed to meet their multiple objectives were civil and military bureaucracies, police administration, economic and legal structures.

"The British colonialists desired to extract assets out of their Indian empire, not to deposit their personal wealth in India" (Mahmood, 1990, p.13). The achievement of this objective was supported by "a competent strategic policy" and "relatively inexpensive administration". The manifestation of this simple and inexpensive arrangement was a generalist bureaucracy. Achievement of this objective necessitated that the law and order situation should be under total control. The structure that was developed in response to this need was police administration which then was put under the control of civil bureaucracy. And then they needed military machine to expand and safeguard their frontiers. To manage the commercial activities financial institutions like chamber of commerce, commercial banks, stock exchanges were established.

The constitutional cover to all these institutions and the society was provided through the British common law whose culmination was seen in the shape of Government of India Act 1935. According to Islam (2004, p. 318) "Pakistan's leaders devised the rules and institutions to perpetuate the colonial traditions". Based on this evidence, the researcher believes that most of the colonial institutions, rules and laws were adopted and are firmly in place in Pakistan till to date, rather have overgrown. These institutions decide the dynamics of state-society relationship, and if they are the same, the relationship remains the same.

2.302. Public-Bureaucracy-Politician Equation – continuation of colonial Legacy

A real litmus test to see whether the colonial rule has ended in Pakistan after 1947 would be to see the extent of change that has occurred in the relationships of the three most important constituent elements of a polity i.e. public, government and bureaucracy. Here the researcher would like to quote Egger (1953), a US consultant who advised the government of Pakistan on the redesigning of the government and bureaucratic structure of Pakistan. He said that the colonial government was "not a democratic government. Democratic self government requires no small degree of skill and sophistication on the part of all three of the constituent elements – the people, the politicians, and the public servants" (p. 2). He observed that out of three constituents in Pakistan "the people of Pakistan are the weakest element" (p. 2). Looking retrospectively towards the history of Pakistan, it appears that military bureaucracy can be bracketed with the civil bureaucracy in the said equation.

Egger (1953) further said that bureaucracy "is unquestionably the strongest of the three elements from the point of view of preparation and training, experience and organization. From the standpoint of its adaptation to the basic political realities of the New Nation, it is probably the weakest" (p. 6). He further comments on it by saying that it "is living in the past, and making all its comparisons and value judgments in terms of the civil service of undivided India" (p. 7). He believed that the remarks of Sir Percival Griffiths (1952), which he made about pre-partition ICS, are still valid for the civil service of Pakistan i.e. "despite their loyalty, dedication and efficiency, they are somewhat apart from the community which they serve" (p. 7).

These observations were made some fifty years ago yet they remain true and green as ever till today. The history of Pakistan is testimony to this reality. The civil service of Pakistan still stands far apart from the community they serve. They feel more close to the British/US counterparts as compared to the community they supposedly serve. They have always thought of themselves to be the elite class, which is more intelligent and intellectually sound than everyone else in the country and hence deserve exclusive rights, privileges and benefits, perhaps more than their ex-

colonial colleagues. Even till today, they are trained in the same vein. According to Haque (1997), due to various factors including "colonial origin, imitative postcolonial reforms, and exogenous nature of state bureaucracy in developing countries, there emerged a significant degree of incongruity or incompatibility between bureaucracy and society" (p. 434).

"The vice-regal traditions of colonial India were embedded in the plans for Pakistan's governance" (Islam, 2004, p. 318). And these bureaucracies, reminiscent of colonial era, are more powerful than they were in the past when they served the interests of their masters. They have been trained with the same paternalistic mindset which keeps on reminding them that they are more intelligent, knowledgeable while public is ignorant, incapable and knows nothing, so it is they who have to make decisions. In the present democratic setup, when they were expected to be an institution supporting the politicians for the purpose of serving the public, their structures and position has largely remained intact with huge amounts of funds being spent on them while masses are reeling under extreme poverty, filth and deprivation all over the place. As Chaudry (2011) puts it:

> The bureaucracy was not willing to surrender the powers it enjoyed before independence on the fallacious ground that better human resource ability gave it a more likely chance to deliver the goods. With the passage of time, the contempt with which the civil servant viewed politicians became increasingly evident…Within a couple of years of independence the CSP, established perhaps with the best of intentions, had maneuvered itself into a situation where it became the chief implementer of an over centralized state apparatus (p. 30).

Egger (1953) while explaining the real issue in the bureaucratic structure of Pakistan, states that "the deficiencies in the public administration of Pakistan are not deficiencies of intelligence or understanding, but are the deficiencies inherent in an administrative system designed for a day that has gone by" (p. x). While referring to the British administration, he said that "the colonial government was a law-and-order government, the function of which, except in time of famine, did not extend appreciably beyond internal tranquility and collecting the revenue" (p. 1). He said that "it is more important that it be firmly understood that the goal of the public administration is the constant raising of the level of the happiness and dignity of human life, the steadily progressive sharing over wider

segments of the population of the gains of the Nation, whether material or spiritual, among those who make the Nation what it is" (p. 1).

Explaining the implication of a democracy for a civil servant, Egger (1953) quoted an event from a novel 'A Bell for Adono' by John Hersey, in which one person tells the other person about the democracy. The man says "Democracy is that the men of the government are no longer the master of the people. They are the servant of the people. What makes a man master of another man? It is that he pays him for his work. Who pays the men in the government? The people do, for they pay the taxes out of which you are paid" (P. 7)

Gladieux (1955) was yet another consultant from US, hired to advice on how the structure of the Pakistan government be re-orientated so that it becomes fit for national development. Commenting on the colonial system, he said that it "was probably fully satisfactory as an instrument of assuring public order, the swift administration of justice, the prompt collection of taxes and the maintenance of accurate land record. In these respects the government system of Pakistan as taken over from un-divided India still serves it reasonably well" (p. 1). He opined further that now "the basic purpose and structure of government must be oriented to the development objective" (p. 1). He further said about the orientation of the system that it "still is substantially directed to the law and order function in its organizational, procedural, personnel and fiscal aspects" (p.1). Commenting on the inflexibility of the government machinery, he said that

> among the administrative leaders of Pakistan there is a tendency to regard public management in somewhat static terms. This is manifested by a reluctance or indisposition to disturb long established systems and practices, and by almost solid opposition to proposals for change which in any way affects the position or status of the dominant administrative group… what is called for in this connection is a greater appreciation of the dynamic character of government and the need for continuous improvement and adaptation to meet changing situation (p. 1).

Then commenting on the relationships between politicians and civil servants he observed that "political leaders, secretariat personnel and technicians have generally not learned to accommodate each other or to respect the peculiar distribution of each in the cooperative endeavor of

government" (p. 2). Other weaknesses that Gladieux (1955) has identified in the report are 'over-centralization and reluctance to delegate', decision making process 'having too much clerical orientation' and 'haphazard growth of organizational structure' resulting in not being able to fix responsibility on single individual.

Democracy could not take root in Pakistan and so civil service kept on dealing with the masses in a paternalistic way as they were doing in the past and never became servants of the people – the rightful owners of Pakistan.

2.303. Institution of Governor as an example of continuing colonial impact

Bose and Jalal (2004) observed that:

> (s)tates and provinces in both India and Pakistan have been subject to constitutional arrangements borrowed to a great extent from the Government of India Act of 1935. A centrally appointed governor and a cabinet headed by the chief minister might seem to replicate the president and the prime ministerial equation at the centre. But in actual fact the state governor has been for all practical purposes, like the centrally appointed members of the Indian Administrative Services, an active agent of the centre at the state or provincial level. If the Indian centre feels that a state is not being administered according to the constitution, the elected government headed by the chief minister can be dismissed and the state brought under what is euphemistically known as president's rule. The central governments in India and Pakistan have constitutional sanction to poach on both the legislative and the executive domains of the state. So although federal in form, the Indian and Pakistani state structures have been unitary in substance. Borrowing heavily from the colonial masters in the initial stages, the two state structures over time became increasingly more centralized (p. 206-7).

The artifacts built by the colonialist which till today are being used in letter and spirit have also helped in maintaining the gulf between the rulers and the subjects e.g. the edifice of governor houses. The expenditures on these offices, the security arrangements including sophisticated gadgets, security personnel and high barbed walls and their dictatorial role where they can

remove provincial governments at will all point to the fact that the inhabitants are a class apart quite like the British, totally detached and least concerned about the miseries of masses outside; they are not part of the public; they are different class; they fear public wrath. It is a million dollar question as to why they fear when they are locals and citizens of Pakistan. And why do they still need such apparatus like barbed and picketed high walled governor houses?

2.304. Need for a stronger Army

Another very important aspect of the state of Pakistan which has been identified by various authors in the previous section is the continued law and order orientation of the state. This orientation has a very profound influence on the state and society of the country. Bureaucracy is said to have 'law and order' orientation. It was the steel frame of Raj. The role of army was not much dominant in society as the rulers were directly controlling it. However, the institution of Army has constantly been growing in power since the creation of the country. There are at least two main factors which have contributed towards this phenomenon. First is explained by the great-game-perspective. The need to disallow Russia's long standing desire to reach warm waters has played strongly on the psyche of the powers in the West. This role was effectively played by the then super power- the British till their stay in sub-continent, yet, after their decision to grant independence to the sub-continent, the responsibility to stop communism was placed on Pakistan by the new super power – the US (Mukherjee, 2010). This certainly was a big ask from country like Pakistan which was very weak at its birth, however, right from the start US has been supporting the institution of Army with finances, arms and ammunition and training. In return, Army has been providing necessary support to US plans in the area the detail of which was presented above (Mukherjee, 2010). Involvement in all these international events has provided Army legitimacy, power and a big slice from the national budgets.

The second factor which afforded Army unconditional support and blank cheque from its countrymen was Indian threat. The countries of Pakistan and India came into being after the British decided to leave sub-continent. The division was based on religious lines so the contiguous Muslim majority areas were to be fused together to make Pakistan. A large number of

minority population from both the countries had to migrate to the country of their choice. The short span of time after announcement of the partition was a period of serious turmoil. The sufferings during migration, injustices during partitioning various assets including financial and military ones, and then the occupation of Kashmir greatly affected the psyche of both the public and the ruling class of Pakistan. These fears were further elevated by the subsequent wars with India in 1948, 1965 and 1971, yet, on top of all the issue of Kashmir – an unresolved dispute between India and Pakistan always necessitated a strong and large army. According to Mukherjee (2010), "the Pakistani military has always argued that it has a central role to play in the state because of the ongoing Kashmir issue (p. 76). So considering Indian factor a top priority, all possible funds were channeled towards achieving this aim.

To the detriment and neglect of general public, these conditions under which maximum funds were diverted towards raising and financing a large army somehow have persisted till today. Emergency conditions which are generally an exception in the case of most of the other countries of the world became the norm in Pakistan. That is one of the two biggest persistent holes in the public kitty, the other being debt servicing which has adversely affected the social indicators in Pakistan. In the budget for the year 2008-09 Rs.296bn have been allocated for defense, Rs.619.35bn for debt servicing and loan repayment, Rs.24.62bn for education and Rs.5.5b Rupees for health services. And as if this was not enough, four martial laws[3] spanning over a total period of 32 years has sapped whatever was left for the public.

In the colonial era the hospital facilities were primarily meant for British soldiers and civilians, then in order of priority were local bureaucrat and army men and at the last were general public which may be provided services if facilities were available (NCAHMEI, 1980). After independence, instead of British, it was now army which became the most powerful institution of the country, so on the same priority criterion, the hospitals of the forces now have ample funds, state of the art machines, stocks full of medicine and other related items whereas the public hospitals which are

[3] Field Martial Gen. Ayub Khan (1958-1969), Gen Yehya Khan (1969-1971), Gen Zia-ul-Haq (1977-1988), Gen. Pervez Musharraf (1999-2008)

already resource-deficient are advised the treatment of 'autonomy'. Autonomy as an intervention was suggested by the USAID's Health Financing and Sustainability project (HFS) which suggests "government hospitals to begin to operate as autonomous entities. They would receive indexed block annual subsidies from the government which would diminish over a period of years, with substitute revenue being generated through user payments (p: 1)".

2.305. Debt Trap

So though huge amount of money was and has been spent on the building and maintaining the military institutions and lot of criticism is poured on it for eating up big chunk of the budget, yet, in fact, the real issue here for which it is criticized is its involvement in political sphere of the country. What people really despise and don't digest is its intermittent imposition of martial laws in the country and not consuming big chunk of public budget as it can be somewhat justified because of geographical compulsions.

However what can't be justified and goes rather unnoticed is the ever escalating debt and its accumulating interest.. And all the governments whether civil or military, democratic or otherwise have generously contributed towards bringing the situation to this point. Instead of remaining within the available means and developing indigenous infrastructure and industry, all the rulers, adopting myopic and self-interested policies, have resorted to the acquisition of huge expensive loans. Every government sought the loans in the name of public interest and for the amelioration of masses conditions, yet only the rulers have benefitted. Islam (2004) throws light on the issue, during 90s, in the following words:

> "Pakistan's decade of democracy turned out to be a decade of grand corruption. Every elected government during this period was dismissed for corruption charges. The governments under Prime Ministers Bhutto and Sharif set records for corruption. Both these leaders were charged with siphoning off of hundreds of millions of dollars into dummy corporations and pricey real estate abroad. The stories of their legendary corruption have been published in the national and international press" (p. 327).

Then he presents some figures gathered from various surveys that show elite's image in the eyes of public.

> Over 95 percent believe that bureaucrats and politicians were corrupt and 76 percent thought that the generals were more corrupt now than 15 years ago. The Human Development Report in South Asia 1999 noted: 'The moral foundations of the state have been eroded by electoral fraud, advent of money politics, the criminalization of the political system and increasing corruption in public life (Islam, 2004, p. 327).

Khan (2001) here questions the possibility of any improvement in the society where most of the options for people are corrupt and after throwing one corrupt leader out of government, the masses find to their dismay that yet a more corrupt leader has been voted into the government. According to him,

> "though corrupt leaders can be thrown out of office in a democracy, the situation changes drastically if the culture of corruption is widespread in it. Then the possibility remains that the incumbent corrupt leader is to be replaced by another who is equally corrupt" (Khan, 2001, p.44).

The share of debt servicing is more than double the amount spent on military as mentioned in the previous section. Yet, it escapes attention of the general society and media as role of military in society appears so dominant and visible. The blame of acquiring loans gets washed away as most of governments are and have been removed whimsically, through agitational maneuvering or extra-judicial tactics and that paints the out-going government as an orphan - which needs to be sympathized. Consequently, whatever corruption charges are levied by the incumbent government on out-going government, are propagated to be political victimization and in the wake of weak judiciary and rule of law situation in the country, the accused re-emerges as a hero ready to take up the government once again. According to Mukherjee (2010), "(i)t must be admitted that Pakistan's civilian politicians have often acted, in their own interests, as arbitrarily as the military, with more corruption and less concept of real democracy and national unity "(p. 74).

Islam (2001) presents a picture depicting involvement of various elites of society in corruption using data gained through some surveys. According to him "(i)n a recent survey, 88 percent of the respondents felt that political leaders had become more corrupt during the last five years and 33 percent admitted to giving bribes." (p. 1349).

The other important factor towards debt trap is the role of IFIs which encourages, lures and pushes governments to adopt various reforms, projects and program for which these agencies are willing to provide funding. According to Terris, (1999),

> (t)hese neoliberal policies have been exported to the entire world through the International Monetary Fund and the World Bank, which have followed a consistent policy of demanding adherence to so-called "austerity measures"-austerity for the working and middle classes, and prosperity for the rich and powerful-as an essential condition for receiving loans for their hard-pressed economies (p. 153).

Neither the agencies nor the governments are interested in real sense in benefitting the masses; yet, both mutually agree to carry on. Resultantly, both IFIs and government become beneficiary whereas the masses are destined to face the awful consequences in days to come.

2.40. National Context

2.401. Nation State

In order to understand the social reality of Pakistan, which is a nation state, we need to understand how this concept of nation state was developed internationally and then how Pakistan has fared as a nation state. The concept of nation state has in its heart the theory of social contract. It "is based on the idea of a contractual agreement between the individual and the state, under which the power of the sovereign is justified by a hypothetical social contract in which the people agree to obey in all matters in return for a guarantee of peace and security"[4]. Citizens forgo some of their rights and freedoms e.g. paying their money as taxes to the government; obeying the laws thus curtailing their freedom; agreeing to pay fines on violating laws etc. in lieu of guarantees of peace and security, ensuring basic human rights for all, taking care of the poor and destitute etc. Though there was difference of opinion on what was expected of government, still government was expected to do these basic things.

Not very long ago, governments were considered responsible, and in certain countries still feel responsible for the creation of jobs, controlling inflation, providing housing, health services, supporting people affected by natural calamities, providing subsidies to different sectors of society etc. However, under the influence of private sector and in the wake of rising criticism of public institutions, the argument of reducing government, calling upon private sector, and NGOs to provide services which erstwhile were considered to be within the domain of government, and adopting philosophies and methods of private sector for government sector, gained momentum. The emergence of these new developments needs to be seen in the context of the idea of "nation state – seeing collective action as legitimized by notions of shared racial, cultural or linguistic characteristics" (Hill & Hupe, 2007). While commenting on the damaging role of capitalism, Hirsch (1995) argues that "the nation-state has been overrun by capitalist

[4] Downloaded from http://definitions.uslegal.com/s/social-contract-theory 28/02/2011 1:43pm

development and is no longer able to fulfill its previous important function" (p. 283).

The two issues that are connected and further explained the idea of nation state are 'development of democracy' and 'rule of law'. The new role of state needs to be seen in the backdrop of these two concepts (as cited in Hill & Hupe, 2002, p. 22). "(T)wo themes that provide very important contexts for the study of public policy implementation" are "concerns that activities of governments should be in conformity with the rule of law and ideas about democratic control over those activities (Hill and Hupe, 2002, p. 39). They explicate the connection between the rights of the people, and the role of state toward them. This background may help us understand the issues of governance, state-society relationship and situation of rule of law in Pakistan. Peace and security cannot even be conceived if there is no rule of law in society.

2.402. Rule of Law

Rule of law is a basic and necessary requirement for any civic society. We can only expect equality, freedom, justice and development in a society if rule of law is established there. If there is no rule of law, 'might is right' will be the order of the day and nobody will be able to predict or expect the likely result of any action. Hill & Hupe identify the implicit notion in the concept of rule of law that "citizens should be able to predict the impact of the actions of the state upon themselves and secure redress when affected by illegitimate actions" (2002, p. 22).

Wade (1982, as cited in Hill & Hupe, 2002) presents four aspects/meanings of rule of law which are presented below:

1. 'Its primary meaning is that everything must be done according to the law' (p. 22).
2. 'The secondary meaning of the rule of law ... is that government should be conducted within a framework of recognized rules and principles which restrict discretionary power' (p. 22).
3. Judiciary should decide any disputes on the interpretation of law and be independent of the state (p. 23).
4. The 'law should be even-handed between government and citizen' (p. 24).

Unfortunately for Pakistani citizens, none of these aspects of rule of law are to be found in Pakistan these days.

With reference to the first point, almost all the leaders of state whether political or military have considered themselves above the law. Abrogating the constitution, holding it in abeyance, interpreting according to one's interest, introducing amendments to suit their objectives, attacking courts should they decide against one and using delaying tactics on courts' verdict if it's against ones' interest are but a few of such actions with the help of which rulers have managed to stay above the law and ridicule it. In other words, law is not an objective reality out there rather what suits his/her majesty is the law. The following quote from Islam (2001) amply throws light on the rule of law status in Pakistan.

> The rule of law remains an anathema to Pakistani culture. The inherent cultural propensity to take the law in one's own hands has been reinforced by feudalism, customs, sectarian creeds and religious traditions. Police brutality and lack of redress are also cited as reasons to circumvent the due process of law…The overall effect, however, is a condition of endemic lawlessness and a total disrespect for the rule of law and judicial institutions. There seems to be no universal concept of law. Violation of rules is commonplace in everyday life. Traffic rules, customs and income declaration, school and university admissions, plane reservations and excess baggage rule are rarely respected. Recovery of bank loans, collection of taxes, telephone and utility bills remains problematic[5]. The idea of universal rules and laws that treat everybody equally is an anathema. People, particularly the elite and middle classes, prefer to be treated as special cases. Those who cannot have their way through influence, family connections, sifarish (recommendation), would often resort to bribe. Normal services that should be provided as a matter of course are allocated on the basis of ascriptive criteria or bribes (pp. 1347-48).

Such treatment of law by the rulers set examples for the public to emulate. Moreover, it becomes rather difficult for rulers to enforce authority of law in case they themselves have been violating it. Instead, they promote and encourage people to disobey and violate law so their violation does not

[5] Qureshi, O. Power to the Army. *The Herald,* February 1999, 76.

seem to be an outlier. And this discussion also clarifies the position of Pakistan with reference to the second point that government should be run within a framework of recognized rules.

With respect to the third point that it is judiciary which will give a verdict in case some disagreement on the interpretation of the some piece of law and that judiciary should be independent, the state and society of Pakistan miserably fails in this point as well. Judiciary derives its independence and power from its people. It's the people who rise up against any attack on the independence but in case of Pakistan the state structures, which are far too strong and developed in comparison to the public, have been successful in seeking verdicts of its choice from judiciary. In certain points in time when judiciary has managed to take decisions against present rulers is when it has public support behind it. Islam (2001) explains the status of judiciary in Pakistan in the following paragraph.

> By and large, the judicial structure left by the British still remains intact Its norms, values and ethos have undergone a radical change. In Pakistan's conflict-ridden polity, bitterly contentious issues between political actors have frequently resulted in judicial recourse…Early in its history, the Federal (later the Supreme Court) created the "doctrine of necessity" and "revolutionary legality" to justify the executive's illegal dissolution of the Constitutional Assembly, abrogation of the constitution and imposition of martial law. The same Court endorsed the martial law again in Nusrat Bhutto's case. It declared military intervention to be necessary and validated all actions pursuant to the military takeover, thus providing General Zia the legal basis to amend the constitution …Ignoring the advice of the Chief Justice and the Law Commission, Sharif bulldozed his Anti Terrorism Act through the Parliament…Many eminent lawyers and judges believe that the ordinary litigants have lost faith in the legal system and are clamoring for justice to be carried out in the streets rather than in the courts (p. 1341).

The following quote from Islam (2008) explaining the role of EU in building democracy and fighting terrorism, throws light on the status of judiciary in Pakistan:

> In contrast, the European Union has built up political credit among Pakistan's political elite – including lawyers, human rights activists

> and pro-democracy groups – by calling for free and fair elections, insisting on the need to restore the independence of the judiciary and focusing on a return to the rule of law (p. 1).

And the fourth point of judiciary being even-handed between public and state has also been covered in the previous point. The previous discussion has presented a clear picture of the state of rule of law. Now the second point i.e. democracy needs to be seen in case of Pakistan.

2.403. Democracy:

Democracy is a form of government where public is supposedly on the stronger side in public – government equation. Government activities are supposed to be according to the views of the public and for their good. In other words government should be run according to the wishes of the people, for their benefit, and they should have a say in how government is run.

The ideal and basic form of democracy is the one where people are directly involved in the running of communities and organizations. 'Absence of a split between policy formation and implementation' (Hill & Hupe, 2002, p. 28) is inherent in this type of democracy. They themselves make and implement policies. This type of democracy is called deliberative, 'participation-oriented' (Hill & Hupe, 2002, p. 106), or direct democracy. In practice, however, there is no dearth of situations where such direct involvement of the citizens is not possible and implementation will not be possible without the delegation of powers. These are the situations where bureaucratic institutions are formed. This type is known as representative or indirect democracy (Hill & Hupe, 2002, p. 106). Weber's notion of 'rational legal authority' also points to the fact that it is related to the concept of 'rule of law'. Rational order calls for a situation which is ordered, organized and hence predictable. Therefore, his favored mode of governance is bureaucracy which works like a machine regulated through a set of rules. However it does not go in harmony with the concept of democracy which is more concerned with the wishes of the public. "There is no suggestion that democracy is essential for the rational legal order" (Hill & Hupe, 2002, p. 24). When objective is a rationally ordered society, it is not necessarily a democratic one. Here we need to understand the relationship between democracy and government.

2.404. Democracy and Government

Box (2007) argues that "public service in a democracy is a paradox has been and continues to be a central issue in public administration" (p. 3). Hill and Hupe discuss this issue by providing some contrasting examples where in certain cases government structures developed before democracy was introduced so later on there was a need to democratize the government structure; in other situations democracy developed first and government structure were developed subsequently following democratic traditions, so the emphasis is on maintaining and safeguarding the will of the people over bureaucratic institutions.

> It is generally correct to say that large-scale government and democracy have evolved side by side. However, there have been differences between countries in the rates of growth of these two phenomena, and of course in the actual forms either large-scale governmental organization or democracy has taken. Two nations in the Western world are often contrasted in these respects: Germany, where complex governmental institutions were developed before democracy; and the United States, where democracy developed at a time when government activities were still very limited in scale. Other nations may be seen as somewhere between these two extremes.
>
> There is a sense therefore in which, while a key German preoccupation has been how to inject democratic control into the management of government, the American concern has been how to develop efficient government despite democracy. That contrast, at least as viewed from the American side, is brought out very clearly in Woodrow Wilson's famous essay that attempts to draw a distinction between politics and administration (1887) (2002, pp. 29-30).

Right from the outset, the suitable conditions for democracy were not cultivated by the leadership of the country. According to Weinbaum (1996):

> (t)he subsequent education of people to accept democracy through meaningful participation in their political affairs was minimal. Without wide public awareness and an effective public opinion, the political system gave wide berth to ambitious and corrupt political leaders. Instead of including a broad citizenry in the political process, power was concentrated in the hands of an elitist

> bureaucracy and overambitious military. The country's semi-feudal system with its sets of obligations and hierarchy provided similarly inhospitable soil for building a democracy (p. 641).

The following excerpts from Islam (2001) present a broad sketch touching different aspects of democracy thus showing the state of democracy in Pakistan.

> people have become cynical about the validity and "utility" of elections…Successive elections tended to return many of the same discredited politicians time and again…There were serious allegations of bogus voter registration…All political parties are suspected of tampering with voter registration…The legislatures have traditionally played minimal role in the country's governance… The governments (are) ruled by ordinance rather than by laws…Parliament had little control over the budgetary process…legislators often used public funds to distribute patronage…Most political parties do not have grassroots organization. Neither do they hold regular elections to choose their officials. Even when elections are held, they are unopposed. Leadership tends to be dynastic…The public is totally alienated from the police and the judicial system. Use of police by politicians, fabrication of evidence and registration of false cases against opponents is a common practice…Pakistani state is an incoherent juxtaposition of religious, secular and military institutions vying for legitimacy through contradictory norms and values (pp. 1336-51).

Identical views about the political culture of the society of Pakistan are expressed by Weinbaum (1996). He says that:

> large numbers of Pakistanis continue to believe that elections are exercises in intimidation and outright fraud. Moreover, very little of political life is seen as egalitarian. Politics tends to reflect the highly stratified character of social classes in Pakistan where, in general, most citizens see political debates and contests as largely irrelevant to their lives. Pakistan's voting turnout, usually greatly exaggerated in official reports as exceeding 60% of eligible voters, was probably between 30% and 40% in 1989 and 1993 (p. 645).

Elaborating on the role of politicians in the development of democracy, Mukherjee (2010) states that:

> (i)t must be admitted that Pakistan's civilian politicians have often acted, in their own interests, as arbitrarily as the military, with more corruption and less concept of real democracy and national unity…Successive governments have too often allowed parliament to simply rubber stamp the military's decisions and initiatives, spending billions on the military, whilst neglecting the basic needs of the people for justice, health, education, security and hope (p. 74).

For detailed description of the issue see for example Jalal (1995), Newberg (1995), (Haq) 1997, McGrath (1997), Rose and Evans, (1997), Bose and Jalal (2004).

2.405. Accountability:

A number of authors who have written about implementation have also touched upon this issue. Pressman and Wildvsky (1984, p. 255) believe that "(a)ccountability seeks to preserve existing relationship by holding the actors at the bottom responsible to the expectations at the top". This means that in top down implementation, policy makers at the top stay clear of the accountability pressures. It is the implementers who are in the focus when accountability is carried out. Their actions are considered responsible for the achievement or otherwise of the policies. And in most of the situations, policy is not in the spotlight. It is largely ignored and not considered in the evaluation stage. Krane in Box (2007) argues that "(n)o matter how well implemented, a poorly crafted or targeted policy will not be effective…if legislators produce poor program designs or choose to sketch policy in generalized terms, these choices affect the actions of administration as well as the attainment of successful policy performance (p. 32).

Lipsky while explaining the role of street level bureaucrats alludes to the paradox where on one hand they are treated as cog in the machine and on the other are afforded with lots of discretionary powers. It is very important that this discretion should be balanced with accountability. Since he is advocating bottom-up approach, he instead of mentioning hierarchical accountability, suggests activities like "encouraging clients' autonomy, improving current street-level practices and helping street-level bureaucrats become more effective proponents of change"(1980, p. 193).

Another way in which accountability mechanism can be strengthened is to make bureaucracy feel part of the society and people. In such a situation, public or their representative would like the bureaucracy to be democratized such that it works according to the wishes of the public. Democratization is required so that bureaucracy feels accountable to the public.

2.50. Characteristics of Social and Political Culture

Wilder (2009) while analyzing the unsuccessfulness of Civil Service reforms in Pakistan alludes towards the rather neglected aspect of the reforms i.e. its political nature. The understanding of the political culture and its characteristics is a pre-requisite for understanding of the political nature of any reform. He and other authors have highlighted various aspects of the social and political life the detail of which is given in the following pages.

2.501. Legacy of Executive rule

As has been argued elsewhere that state bureaucracies were the most important and influential institutions of the British Raj and they still occupy the same position in Pakistan. They have impacted the culture and psyche of the masses more than anything else. According to Newberg (1995),

> "(t)he vice-regal traditions of colonial India were embedded in the plans for Pakistan's governance… Pakistan's leaders devised the rules and institutions to perpetuate the colonial traditions. Its various constitutions created new versions of the vice-regal system. The strong executive tradition continues to dominate Pakistan's political and administrative structures. Every constitution has given primacy to a central executive power" (as cited in Islam, 2004, p. 318).

This results in the development of an "authoritarian and hierarchical political culture". In other words power is concentrated at the top of the hierarchy and the success or otherwise of the reforms depends on the individual and not on the system. Wilder (2009) then quotes a former cabinet minister who observes that, "Unless the chief executive or president believes in it and supports it nothing will happen. Because the bureaucracy always prefers the status quo, restructuring can only happen if the leader is interested" (p. 28). However, even if the key person is willing

to back the reform, change in environment may bring change in the priorities with the result that reform may not be his/her top priority. He gives the example of Gen. Musharraf who initially was convinced of and backed the Civil Services Reforms however, the initiation of WOT made him reprioritize his preference with the result that the reforms were relegated to lower down the priority level. Talbot (1999) also touched this point. According to him, the desire of strong center and direct control of far flung areas through the intermediaries such as 'land lords, tribal chiefs, princes' supported by local religious leadership was a cornerstone of colonial administration. And the desire of each regime at the center in Pakistan, whether political or military, to have strong center, to keep resources in its hands and to deal with political opponents and regional leaders with absolute force is grounded in this backdrop.

2.502. Political instability

Wilder (2009) considers this to be one of the major hurdles in the successful implementation of reforms. Most of the political governments got their tenure terminated and this has led the various heads of the governments to look for short term financial and political benefits instead of any long term reform agenda. He then mentions various remarks of the interviewees all giving more or less the same meaning that 'the reforms were put to halt no sooner the government got dismissed' (p. 20).

2.503. Ethnic Politics:

Ethnicity is one of the strongest factors which have impacted political arena in Pakistan. Majority of the masses feel strongly attached towards their ethnic group like Muhajir, Pathan, Punjabi, Sindhi, Baloach etc. as compared to being Pakistani. Civil and military bureaucracies dominated by Punjabis, blamed for their wrongdoings, were considered Punjabi institutions, more than anything else, by Bengalis in East Pakistan which later became Bangla Desh. Other minority provinces have also raised their voices at different times against Punjabi dominated state bureaucracies. Islam (2004) discusses the same phenomenon through Hofstede cultural dimension of individualism vs. collectivism. Hofstede considers Pakistani society as predominantly a collectivist society. "All sections of society function within the context of these social structures and the values

attached to them. Though the norms, values and institutions vary to some degree from region to region, the central place of the family and kinship remains constant". These strong bonds permeate formal organizations of the society and their demands lead towards political interference and nepotism. "Rules and norms based on family and kinship take precedence over professional or rational codes of conduct or even laws." Islam (2004, p. 322).

Talbot (1999) discusses this issue from a different angle. He presents it as clash between regional identity and Muslim nationalism which manifested in the events in Sind and Bengal and to some extent in NWFP during the Pakistan movement. A known Pushtun nationalist leader Wali Khan is quoted as saying that he had been a Pushtun for 4,000 years, a Muslim for 1,400 years and a Pakistani for forty years. He is pointing towards the bonding force of Muslim images which gelled different ethnicities during Pakistan movement, yet he considers it weaker and transitory as compared to ethnic identities which are far deeper. The strong bonds of these ethnic groups then open the door for political interference in organization which may lead to political appointment of below-merit candidates, choice transfers, out of turn promotions. And such situation understandably results in poor performance of institutions, corruption etc. And this is an established fact as pointed out by Cheung (2005) that "(i)n most Southeast Asian countries, public sector jobs provided employment for constituents and opportunities of patronage for political supporters, helping to consolidate the power of the ruling elites (p. 267).

2.504. Political intolerance

The other factor identified by Talbot (1999) was the culture of political intolerance embedded in ML's struggle against Congress and Unionists[6] in Punjab. In this background all opposition was termed as 'illegitimate', 'kufr' (apostate) and those opposing the standpoint of ML were termed as 'infidels' and 'traitors of Islam'. In post-independence scenario, ML leadership termed its opposition as 'anti-state' and being in collusion with India. In the same vein, there have been demands from various quarters that people having opposing political opinion that of Jinnah should be

[6] A pro-government party in pre-independence era dominated by landlords

"deprived of their rights of political expression, they should be debarred from seeking election to any future parliament or government and a ceiling should be imposed on their property". This intolerance plays very deleterious role in the society as everyone tries to snub the opposition and deprive it of any due benefit. This on one hand deprives society of any continuity of some good effort or project, it on the other, wastes precious public money at two points i.e. cost of undoing process and wastage of the resources used in the project which is undone.

2.505. Psychological make-up of Pakistani society

The psychology of both public and the rulers whether politician, military or civil bureaucrats has consciously or unconsciously been affected by different factors identified above.

The colonial style of governance depicted by civil bureaucracy has the most lasting of effects. "The service's values are buried deep within individual psyches and infused widely throughout the public organisational domain. The civil service is a cultural artifact" (Jones, 1997, p. 325). In the backdrop of this impact, opposition is seen as 'traitors' (Talbot, 1998) public is seen as 'subjects' (Jones, 1997:324) and all social activities are seen as 'law and order issues' (Chaudry, 2011, p. 20). The only valid way of solving social issues is by use of power.

2.506. Power distance

One of the dimensions Hofstede (1991) has used to explain culture is power distance and he gives Pakistan rating of 18 out of 52 countries which essentially means that "Pakistanis tolerate a rather high degree of inequality (Islam 2004, p. 317). Cultures with high power distance tend to give respect to authority, status and positions. Subordinates expect and tolerate to be bossed around. "Pakistani society does give credence and legitimacy to its elites" (Shafqat, 1999, p. 997). Instead of taking action themselves, they wait till the orders of superior arrive. Likewise those who are on the receiving end when find their way to the state corridors carry out the same methods of treating opposition because they unconsciously learn this from their environment. Anyone in power would deal others with force without being accountable to anybody. The powerful rulers have abrogated constitution number of times and they always get away with

that. The democratic rights like freedom of opinion and expression, right to disagree are all academic concepts only to be found in the texts of constitutions, available to the powerful only. “In Pakistan the transition to democracy is taking place, but the rules and the spirit of democracy is being violated blatantly. Democracy implies government by law, besides electoral competition, majority rule and respect for minority rights and dissent (Shafqat 1999, p. 1009)

2.507. Sycophancy

These factors have led to the development of the tradition of sycophancy and flattery in the society of Pakistan. This development is quite natural and understandable in the face of centralization of power in the hands of powerful, their use of power with impunity and rather weak justice system. When masses find that they can’t match with the powers of the superiors and any wrong perpetuated by them will not be redressed through justice system, they tend to resort to sweet talk, flattery etc. Anything that can offend the superior is avoided, even if its truth.

The researcher found this behavior even in the teaching hospitals. In one instance, the researcher met a senior doctor (DA1) who was holding a senior administrative position in a public hospital and who while discussing his way and style of administration characterized by obedience and total submission to the system narrated an incident. He told that some days back secretary health visited their hospital. There he asked us about the problems that we were facing in the running of the hospital. “But”, he said, “he could not dare talk in front of him and tell him their issues”. This is a typical behavior showing the same slave-master relationship that was seen when locals used to interact with the colonial masters. This shows the hidden fear that the public has towards the bureaucrats, and that is what bureaucracy want to sustain and that is what can ensure their continued rule over the masses.

This behavior is now not only specific with the bureaucracy alone. This behavior has permeated the psyche of masses in general, who happen to seize some power within their environment. For instance an employee of the hospital (E2) told that ‘powers to hire and fire made officers (in SHL) very stiff-necked, and abusive. One Lady Doctor (name hidden

intentionally) became MS. She was very abusive and did not spare anybody, so much so that an AMS who was abused by her had a heart attack'.

2.508. Lack of accountability

What makes this phenomenon even more deleterious and fatal for the society is that powerful is not supposed to be responsible. And unfortunately for the country, the impunity for the most powerful state functionaries including the President, Governors of the provinces, PM, Ministers etc. is provided by none other than the constitution of Pakistan 1973 itself which is supposed to be the custodian of the rights of the people. The constitution of Pakistan 1973 along with other constitutions developed in the country is but a copy/replica of the Government of India Act 1935 with some cosmetic and minute changes. The text of the article 248 of constitution of Pakistan 1973 is presented below for reference:

248. Protection to President, Governor, Minister, etc.

(1) The President, a Governor, the Prime Minister, a Federal Minister, a Minister of State, the Chief Minister and a Provincial Minister shall not be answerable to any court for the exercise of powers and performance of functions of their respective offices or for any act done or purported to be done in the exercise of those powers and performance of those functions:

Provided that nothing in this clause shall be construed as restricting the right of any person to bring appropriate proceedings against the Federation or a Province.

(2) No criminal proceedings whatsoever shall be instituted or continued against the President or a Governor in any court during his term of office.

(3) No process for the arrest or imprisonment of the President or a Governor shall issue from any court during his term of office.

(4) No civil proceedings in which relief is claimed against the President or a Governor shall be instituted during his term of office in respect of anything done by or not done by him in his personal capacity whether before or after he enters upon his office unless, at least sixty days before the proceedings are instituted, notice in writing has been delivered to him, or sent to him in the manner prescribed by law, stating the nature of the proceedings, the cause of action, the name, description and place of residence of the party by whom the proceedings are to be instituted and the relief which the party claims.

The Govt. of India Act 1935 provided this impunity to the head of the state and at the same time had no mention of fundamental rights for the people. This is quite understandable that an external power, which had occupied the country against the will of its masses, wanted to keep its functionaries above the law and allowed just enough rights to the masses which suited their interests. However, what is rather inexplicable and mind boggling is the fact that constitution of country like Pakistan which is purported to be a democratic state, on the one hand retains the same impunity for its state functionaries as delineated in Govt. of India Act 1935 and on the other, pledges fundamental rights for the masses. How can the fundamental rights of the masses be ensured when some governmental functionaries are let off the hook to do whatever they want without being answerable to any individual or institution? Whether it is ineptitude, willfulness or ignorance of those who developed this document is open for discussion.

As Islam (2004) puts it that "culture consists of the shared products of human society" (p. 312) so this cultural value of strong desire to wield power without being responsible, trickling down from the top, has permeated all factions of society. The researcher witnessed expressions of this cultural aspect at different points while exploring the trajectory of the implementation process.

2.509. Elite Culture:

As mentioned earlier, more than half of its age Pakistan has remained under military regimes which took over the governments using the pretext of poor performance of the political governments. All occupying army regimes promised a general election in '90 days' and all stayed for more than a decade with the lone exception being Gen. Yehya's whose promised elections led to the separation of the country. Under all such governments the main casualty were the general masses who had whatever meager say and relations with the government cut by the elitist military governments. And whatever was provided to them by a political government was undone by the next political government.

In the wake of political antagonism between different parties, diehard party allegiance and weak economic conditions, merit was sacrificed at the altar of party interests. This resulted in the whole scale political appointments in the public institutions which were already reeling under

financial constraints, inefficient management and bureaucratic interference. Majority of the appointments in the administrative posts in the public institutions were and are political which shields the administrators from accountability at least till their favorable government stays in power. As most such governments themselves faced legitimacy crisis, they neither had the mandate nor bothered to establish an accountability mechanisms for these public institutions. Moreover elites from all governmental institutions are more interested in receiving protocol treatment from these public institutions at the expense of general public which further reduces the chances of holding the administrators of these public institutions accountable for the provision of services to the masses. During a visit to SHL, the researcher was led to see an officer whose title was AMS (protocol). He was considered very powerful and resourceful person and was entrusted the task of arranging healthcare demands of public representatives, high ranking bureaucrats and government officials. His patients would be provided with preferential treatment ahead of ordinary people waiting in queues.

With a clear dichotomy between state and society, two parallel representative cultures have emerged in the country. The elite culture is represented by elite institutions, elite structures represented by residential localities, health and educational institutions, commercial and business markets etc., elite ceremonies, and the elitist's language - English. The elite – the significant few have traditionally been organized, educated in the subjects and language of the masters, control all type of resources and employ inter and intra group cooperation and follow the policies of the erstwhile masters hence - are powerful. Whereas culture of insignificant few either has no institution to cater for their needs or they have impoverished, neglected, resource-deficient institutions where public is served with disdain, carelessness and impunity. Public is disorganized, uneducated, resource deficient, deprived of basic necessities, hence lacks power to change the status quo. The institution of government all over the world is expected to protect and safeguard the unprivileged, handicapped, and the deprived but in Pakistan public had no genuine say or role in the formation of the government throughout its history. Elites from military or civil bureaucracies, business class, landlords and religious clan form governments. Their socio-economic position is so different and they are trained on such lines that they can't understand and visualize the issues

and problems of the masses. The result is that either public policy is based on the guidelines provided by international donors, which had immense say in the policy making process as governments in Pakistan have borrowed heavily from them, or made to protect the interests of ruling class; in both cases public interests, issues and participation is nowhere to be seen.

2.510. Conclusion:

The underlying theme of this discussion is that the government structure has overgrown to the exclusion of the society. Certain governmental bureaucratic institutions have received extra ordinary attention with reference to resources and consequent asymmetric power in comparison to public which at large has remained deprived and neglected.

Identification of these factors reinforces researcher's assumption that current post-independence era is all but the continuation of the colonial rule. The state and society is running on the same lines and principles enunciated by the British. The State-society relationship is much the same. Of course certain changes have occurred, some dynamics have changed but they are relatively insignificant and few and far between.

The colonial mindset, structure and principles continue to affect the society with public organizations being no exceptions. The treatment of teaching hospital with reference to their resources, management, control, discretion is mostly the same.

The researcher believed that certain factors including legacy of executive rule, political instability, ethnic politics, power distance, sycophancy, lack of accountability, elite culture have strongly affected the process of implementation of hospital autonomy.

2.60. Governance:

Barret (2004) discusses the phenomenon of globalization, and NPM regime, and how both have affected the way governments are run in most parts of the world. According to Dent et al, "(t)he term governance, has emerged in the wake of the phenomena of New Public Management (NPM)" (2007). It is under these influences that the reforms like privatization, deregulation, public private partnership, hospital autonomy etc. were initiated which resulted in diminished role of governments. 'Osborne and Gaebler (1992) term such new type of state as 'entrepreneurial government' whereas Hood (1995) terms it to be 'Headless Chicken State' (as cited by in Barret, 2004, p. 259). Such changes have directly affected the way public hospitals are run whereby their governance mechanism was altered towards diminished role of government.

Under this arrangement policy making is no more an exclusive domain of the government rather other actors including NGOs, civil society are also expected to contribute towards it. As far as implementation is concerned, bureaucrats who erstwhile were tasked to implement the policies were discredited under huge criticism from theories like public choice, agency and transaction cost. Terry (1998) while explaining the basic assumption of different theories influencing NPM shows what conclusions have been drawn from it:

> "Public choice theory and organizational economics [agency theory and transaction cost economics] start with the basic assumption that human being are rational economic actors driven by competitive self interest … this negative moral evaluation of human being deeply ingrained in these theories sends a strong message: Public managers require extensive policing (Mitnick 1975) for they cannot – and should not – be trusted" (p. 196).

After explaining the basic assumptions of neo-managerialism Haq (2002) says that it "basically implies the need for reducing the public sector (which suffers from the problem of principal-agent relations), expanding the scope of market forces that are relatively rational and efficient, and using market principles in managing public organizations" (p. 107). The objectification of these arguments appeared in the form of autonomy,

"privatization, deregulation, liberalization, corporatization, budget cutting, joint ventures, autonomous agencies, and so on" (Haq, 2002, p. 108).

The results of such measures was that bureaucracy was made to relinquish power and implementation of government policies were now to be carried out by private sector, NGOs and professionals. 'Buying' from private sector was the order of the day instead of 'making' under the supervision of bureaucracy.

So the responsibility of the issues which were previously considered to be within the domain of the government and for which government was held accountable has now been pushed under the umbrella of governance which apart from government includes private sector and non-governmental organizations. Governance, according to Milward and Provan:

> is concerned with creating the conditions for ordered rules and collective action, often including agents in the private and nonprofit sectors, as well as within the public sector. The essence of governance is its focus on governing mechanisms – grants, contracts, agreements – that do not rest solely on the authority and sanctions of government (1999, p. 3 as cited in Hill & Hupe 2002, pp. 14-15)

Now public issues are managed through governance mechanism and it is not only government rather different stakeholders which take part in the formation of the policies.

Pierre and Peters (2000) describe contemporary governance as having a 'multi-level' character where international, national and sub-national processes of governance are interlinked in a negotiated fashion. They see an emerging role of international organizations, taking over specific tasks of nation states" (as cited in Hill & Hupe, 2002, p. 180). This mode is affecting governance in Pakistan as well and the pattern mentioned above is clearly discernable here as well.

Another issue related to the idea of governance is that it has different meaning in different countries. "In the view of Pierre and Peters (2000, p. 7) the term 'governance' in Europe refers to 'new governance': ideas of the involvement of society in the process of governing. By contrast, in the USA the term 'retains much of its original steering conception'" (as cited by Hill & Hupe, 2002, p. 14). In order to understand the implementation of

hospital autonomy, it was in fact this 'steering' meaning which was behind this reform in Pakistan. Whether these meanings are in accord with social realities of society of Pakistan is need to be seen. Now we move towards specific context of the reform.

Chapter 3

Specific Context of Health Sector: A journey in the Past

3.10. Introduction

Health is probably one of the most important assets for a human being and can be regarded on the highest priority only after food. Only one who is healthy can live and enjoy life to its fullest potential and can contribute towards society. Conversely, if one does not enjoy complete health not only will one be unable to enjoy life, one will be a burden on society and society will have to expend resources to help him regain health. So a healthy man can contribute in many ways towards economic and social health of the society. Health is defined by WHO as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". To the researcher this probably would be an ideal which will not be possible to achieve at least in the near future. Even all people on earth having access to health facilities would be a very significant achievement. This research sees health only from physical aspect.

Under the UN charter, it has been identified to be one of the basic rights of every individual. So the provision of health services to the public has been considered one of the foremost responsibilities of the modern governments. These expressions have been formally validated by the Alma-Ata International Conference on Primary Health Care, held in 1978. It expressed 'the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world'. The Conference accepted and affirmed that health is a 'fundamental human right' and declared that "governments have a responsibility for the health of their people…" And according to World Health Report (2010) "(t)he World Health Assembly resolution 58.33 from 2005 says everyone should be able to access health services and not be subject to financial hardship in doing so".

Despite the recognition of this basic requirement for human, their misery continues in almost all parts of the world. Inadequate funds, lack of proper facilities, infrastructure and equipment, mismanagement of healthcare institutions, apart from other factors have led to a scenario where most of the populace especially in third world countries is deprived and cannot afford health facilities.

The burden of deteriorating health conditions was placed on poor performance of public sector as was done in other aspects of Life. The performance of health sector and the condition of public with regards to different health indicators has been no exception. It generally has been a neglected area in case of Pakistan. As is the case with structures of other aspects of life, the roots of the structure of Pakistan's health sector can be traced back to its colonial past. Colonialism has left irremovable marks on the current structure of Pakistan. Talbot (1998) argues that "(p)olitical and institutional inheritances from Raj… continue to exert a profound influence" (p, 53).

Colonization is defined as "extension of political and economic control over an area by a state whose nationals have occupied the area and usually possess organizational or technological superiority over the native populations"7. The British colonized the Sub-continent by force to achieve their objectives. According to Mahmood (1990), "(t)he British colonialists desired to extract assets out of their Indian empire, not to deposit their personal wealth in India" (p.13). The achievement of this objective was supported by "a competent strategic policy" and "relatively inexpensive administration". The manifestation of this simple and inexpensive arrangement was a generalist bureaucracy. According to Potter (1986) "the complete arrangement of the British colonial state observed generalists' domination and permanence, and it did not cater for professional know-how and novelty. Such a design also positioned generalists on top of the whole structure and technical experts to be drawn upon only when needed. Such an arrangement very well suited the objectives of the British. They were the colonialist. They were there to extort and extract money for the engines of their economy, industry and military might".

The resolution of the 6th Congress of the Comintern says that 'the entire economic policy of imperialism in relation to the colonies is determined by its endeavour to preserve and increase their dependence, to deepen their exploitation, and as far as possible, to impede their independent development' (Fox, 2008, p. 65). The colonialist relationship was based on the fact that the British were the ruler and the Indians were the ruled. It is the ruler who decides how to behave with the ruled; how and to what extent to address their issues and on what lines to develop the governance structure.

Moreover the fundamental principal of their way of administration was the 'maintenance of law and order' which is clearly manifested in the development of the Police, Military and Civil bureaucratic structures in their colonies including India. The same observation was made by the PSC (1962) which states that the underlying principle of the administration of the British Indian Civil Service was "good governance" instead of "self governance".

At the advent of British in India, local system of medicine was practiced over there. British introduced their own system based on their own research. But it was for the benefits of British men, including both civil and military and not for the locals. Public health issues relating to the locals were largely ignored. In their own homeland, they had developed Environmental Health Services in the 2nd half of 19th century e.g. pure water, proper drainage and sewerage, sanitary disposal of refuse and street cleaning. This was a paradigm shift in the concept of public health and prevented great number of preventable diseases of the public which still are so common in Pakistan. In the first half of 20th century, they turned towards the personal health services which materialized in 1948 in the shape of National Health Service. This scientific approach was not adopted in the sub-continent as perhaps it was not in line with their objectives. Moreover it would have required large amount of sums that could not be achieved through tax system which was already squeezing the masses. Only measures against such diseases were taken which had the potential to turn into epidemic, wipe away huge number of population and ultimately seize Englishmen as well like small pox, cholera, plague etc. Such measures were organized and supervised by sanitary commissioners who were appointed under Royal Commission 1859 which is considered to be the first real

development in the health administration in Indo Pak. It was established to find out causes of high mortality of English army men and civil population. Far reaching measures were suggested for both civil and military populations however they were not seriously implemented (NCAHMEI, 1984).

The plague of 1896 in sub-continent caused huge loss of human life. This created a feeling among the rulers that most of the deaths were preventable had there been proper system of sanitation and public health. The same findings regarding the strengthening the public health services were suggested by the Plague commission. The whole system of health management worked under the centralized command of the government, however considerable amount of decentralization was given to the health structure, first under Government of India Act 1919 and later under Government of India Act 1935. These measures improved the health facilities a bit but still India lacked a sufficient and comprehensive health management system for its populace. The total medical care budget in 1946-47 of undivided Punjab, Haryana and Himachal Pardesh combined was Rs.11.9m. The paucity of the amount can be gauged through a comparison with the budget of one hospital i.e. 'Lahore General Hospital' in 1983-4 which was worth Rs.16.18m (NCAHMEI, 1984).

Yet the development was significant considering the erstwhile situation of health management in the subcontinent. In Punjab, the provincial minister, Mian Sir Fazal-i-Hussain started a program of establishing new Tehsil and District Headquarter Hospitals and a civil dispensary every nine miles in rural areas. Local bodies on the other hand established rural hospitals and dispensaries in the rural areas and civil hospitals and dispensaries and were provided with handsome grant-in-aid. Federal government had no role in the whole process. Provincial governments were restricted to the teaching hospitals, some district headquarters and a very few Tehsil Headquarters. The hospitals and dispensaries at even important District Headquarters were maintained by local government (NCAHMEI, 1984).

Increasingly, the benefits of the medical facilities started reaching those citizens who joined the government hierarchy through a caste system where they received free medical treatment, not on the basis of the nature of the disease, but on the basis of which grade they belonged to. General public slowly started getting benefits from these services either through payment

or as a charity. However the budget of these hospitals was pathetically meager. One instance narrated by one member of the NCAHMEI commission who himself served in a district headquarter hospital is that the total budge for diet was just adequate to give only one patient one seer (kilogram approx.) of milk for six months whereas this was a 48-bedded hospital. Sub-assistant surgeons to civil surgeons were permitted private practice strictly at their residences after morning and evening official timings (NCAHMEI, 1984).

Lack of interest of the rulers towards the health of the ruled was manifested through the fact that there was only one medical college and one university in the area which is now Pakistan. And that too was in the province of Punjab. And perhaps that is why medical and health facilities were more developed in the province of Punjab in 1940s as comparison to other provinces is the location of these institutions. Moreover higher pay structure of officials in public health in comparison to the medical service was an indication of the preference of public health over curative health in the eyes of the government (NCAHMEI, 1984).

The involvement of the British in WWII caused a temporary delay in the social welfare development. Moreover the government had realized by then that it would not be possible for them to rule until they made serious efforts for the betterment of the ruled. In 1943 a commission with the name of 'Health Survey and Development Committee' was formed to suggest a comprehensive system for the social uplift of the society. The committee consisted of 24 members and submitted their report after 27 months of hard work in Dec 1945. The committee has since been known with the name of Bhore Commission on the name of its chairman. The conditions of health service of the India at that time closely resembles the prevailing conditions of the health sector of Pakistan and its recommendations, more or less, are valid even today.

Some of the main features of the Bhore report as listed in Iliyas (2008) are as follows:

1. "No individual should fail to secure adequate care because of inability to pay for it.

2. In view of the complexity of modern medical practice, the health service should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.
3. The health program must, for the beginning, lay special emphasis on preventive work. The creation and maintenance of as healthy environment as possible in the homes of the people as well as in all places where they congregate for work. Amusement or recreation is essential. So long as environmental hygiene of life of the individual and of the community remain uncorrected, so long as these and other factors, weakening man's power of resistance and increasing his susceptibility to disease are allowed to operate unchecked, so long will our town and villages continue to be the factories for the supply of cases to our hospitals and dispensaries, disease problems will continue to be a threat to the community. While defining the characteristics of the future doctor, the committee said that he should be a social physician protecting the people and guiding them to the healthier and happier life.
4. The health services should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served. The unit of health administration should, therefore be made as small as is compatible with practical considerations.
5. It is essential to secure the active cooperation of the people in the development of the health program. The committee suggested the establishment of a health committee in every village the task of which was to improve the environmental sanitation, control of infectious diseases and other purposes. Moreover a comprehensive program of health education covering all sections of the population was also proposed" (p. 23).

For the realization of these goals, committee suggested both short and long term plans. The long term plans were to be realized in 50 years while a couple of short term Five years plans were suggested as short term measures to address the immediate issues. Even to this day, these suggestions remain to be a very distant ideal yet to be achieved in the case of Pakistan.

The report was the first effort to suggest decentralization and autonomy for healthcare facilities as is mentioned in point # 4 above. The meaning of the autonomy in this context were that hospitals should be located as close to the people as possible and be allowed to make local decisions for the betterment of the patients.

One of the suggestions that were implemented, were implemented without certain safeguards and ultimately proved to be disastrous. The suggestion was to integrate two separate Inspectorates i.e. Inspectorate General of Hospital and Directorate of Public Health into Directorate of health services at the provincial level and DMOH and Civil surgeons in the districts into District Health Officers (DHOs), responsible for both curative and preventive health work in the field. The suggestion was implemented but without safeguards for the more important and less glamorous and less readily visible health preventive components. Moreover a wise strategy of allowing better pay structures for the public health officials in comparison to medical officials indicating their respective importance was done away with. As a consequence, District Health Officers, the successors of Civil Surgeons, became in charge of the District Headquarter Hospitals with the responsibility of all official medical work, got the higher pay structure and also the right to do private practice. Acute shortage of doctors ensured they had very successful practice but in the process the official and private duties got intermixed and the ultimate casualty was none other than the official health responsibilities. This also created a policy bias towards development of treatment facilities in the country at the cost of preventive structure (NCAHMEI, 1984).

However soon it became evident that given the combined load of district health administration and district head quarter hospital, one DHO cannot run the show. Resultantly, both the offices were again split with a separate medical superintendent for the hospital. But the new arrangement gave a clear advantage to the MS over DHO. He was an authorized medical attendant, had the powers to issue all types of medical certificates, had a house to live in, was provided with telephone at residence, was not required to tour and above all except for the MS of teaching hospitals, had the right of private practice. DHO had no official residence and thus lived in rented house, was not allowed private practice and was given only marginal monetary compensation for the loss of this right and had to be on tour on half of the month. To top it all had to bear the brunt of all crash programs initiated by government or various donor agencies. Clearly, due to more rigors and less remuneration, the job of DHO became less lucrative and less attractive (NCAHMEI, 1984).

The tendency to gain more power manifested through centralization of power at the centre and the same lesson was learnt by the provincial governments. In one case NWFP government, through one executive order, provincialized all the local government hospital and dispensaries and at the same time took away the budgets allocated for them. In the same vein, though slowly, other provinces followed suit with the result that in 1984 no hospital was controlled by local government. This led to the remote control and remote accountability of medical care institutions. This resulted in public looking towards the provincial governments for the provision of medical facilities. The only exception is federal areas which have separate medical facilities to cater for their employees (NCAHMEI, 1984).

In 1956, with the establishment of one unit[8], a West Pakistan Health directorate was established at Lahore with the regional offices, under Deputy Directors Health Services, in the field. This continued till 1962, when another restructuring was undertaken – towards even more centralization. Both the Provincial Health Directorate and Divisional offices were abolished and the secretariat took upon them the job of the provision of the health service along with its normal job of policy making, planning and budgeting. The Principal Medical Officers were posted to the Secretariat as Technical Section Officers and the Deputy Directors, Health Service as Joint Secretaries. The Regional offices were headed by Directors, dealing directly with the Secretariat. The situation continued till the abolishment of one unit where all the four provinces regained their independent position. Now there is one Technical Health Secretary (NCAHMEI, 1984).

Structural changes also took place at the Federal level. In 1953, Health Division was integrated with the directorate General of Health. In 1962, the Directorate General of Health was redesigned as Health Division and under it a Directorate of Central Health Establishment was created to administer subordinate organization under the FMOH. Meanwhile the Health Division has been taking over functions that were under the domain of provinces. The result is overburdening with host of administrative problems of

O. Power to the Army. *The Herald*, February 1999, 76.

[8] A pro-government party in pre-independence era dominated by landlords

attached/subordinate offices/ departments etc and complete neglect of their original responsibility of policy making and guidance. Ironically, it does not have any planning, programming and monitoring unit which should have been their foremost responsibility. The complete neglect of its basic responsibilities has taken its toll on health facilities, systems and the poor masses. Now it is concerned with issues like purchasing and delivering medicines to the Federal Health Establishments spread all over the country. For this purpose the budget of the purchase of the medicine is incorporated in the budget of health division through with payments are made and only a small amount is passed on to the individual institutions for their local purchase (NCAHMEI, 1984).

3.20. Health Programs and Policies

Pakistan did not make any independent health policy till 1990 though it incorporated health in all the 8 five-year plans. But these plans too did not receive due importance and health remained a neglected area. In the initial years, health infrastructure was targeted towards managing the colossal task of dealing with migration related issues which resulted due to the major influx of Muslim migrants from Indian Territory. In the later years sufficient budget was not allocated to the health sector. And even the allocated amount was not disbursed on condition of 'subject to the availability of allocated funds' e.g. in the 1st and 5th 5 year plan only half the allocated amount was released to the health sector.

Following is a table showing the different important events in the health planning in Pakistan.

Event	Year
All Pakistan Health Conference	1947
All Pakistan Health Conference	1951
All Pakistan Health Conference	1956
Medical Reform Commission	1959 (report published in 1960)
Rural Health centers scheme	1961
Health Study Group	1969 (report published in 1970)
System of Local Health Service in rural area	1969
Nutrition Survey of West Pakistan	1965-66 (report published in 1970)
People's Health Scheme	1972
Health made provincial subject	1973
Eradication of Smallpox	1976
1st National conference on Medical Education	1976
Concept of Primary Health Care	1976
School health Services Program	1980
National Commission on Administration of Hospital and Medical Educational Institutions (NCAHMEI)*	1984
Decentralization of health services in Punjab	1990
National Health Policy	1990
Social Action Program	1993-96
National Health Policy	1997
National Health Policy	2001

Table 3.1: Showing significant events in the healthcare sector of Pakistan

Source: Five Year Plans; Health Economics and planning by Fazli Hakim Khattak as quoted by Lashari (2004) and used with a couple of additions.

In the 2nd 5-year plan (1955-60) three medical colleges and 220 Rural Health Centers were planned to be set up. Malaria eradication program was initiated and eradication of small pox program in East Pakistan reduced the number of deaths in 1964 to around 50 from 79,000 in the year 1958.

In the third plan (1965-70) some improvements in the health indicators were made but the preventive side had weaknesses. It was a period which was fraught with political term oil and upheaval and most of the factors that ultimately caused the bifurcation of Pakistan started developing in this era. The social sector, which always had a lower priority, was severely hit.

Against the target for hiring 1700 LHVs, only 950 could be hired. Out of 547 planned RHCs, only 230 materialized.

The next plan i.e. the fourth one (1970-8) practically had two parts due to the separation of East Pakistan in 1971. The first part (1970-72) saw health sector even more affected and the developmental expenditure fell to partly Rs.59m. 0.47% of GDP. Contrary to this phase, the next phase (1972-8) saw unprecedented progress from Pakistan standards. The health budget rose to Rs.684.34m being 0.72% of the GDP. Health infrastructure was improved a lot. An intense debate got initiated under the new government to develop an elaborate health system and some policy frame work was developed. Malaria control program was re-initiated. Pakistan was declared free of smallpox on 18th Dec, 1976. The number of RHCs rose from 86 to 289. Community health workers (Health Guards) were introduced in the Northern Areas. The number of medical colleges rose from 6 to 15 and enrolment rose from 5400 to 9711. The number of LHVs increased from 1881 to 3250. Another significant step was the introduction of Drug Act in 1976. However the bias of the government against preventive side still persisted.

The fifth 5-year plan (1978-83) set quite ambitious plans. Around 625 RHCs and 4596 BHUs were planned but only around one third target was achieved. In the same vein, targets of Infant mortality rate (IMR), life expectancy etc. were set rather high but could not be materialized as planned. Apart from other administrative, cultural and social issues that contributed towards poor performance in the previous plans, this plan also faced the repercussions and ripple effects that reached Pakistan with the Russian Invasion of Afghanistan in 1978. It was not before 1989 that Russia pulled out of Afghanistan.

The next 5-year plan (1983-88) was executed in the same circumstances. Some headway was achieved in that most of the Union Councils were provided with BHUs. However targets in other fields were partially realized.

The targets of 7th Plan (1988-93) were again ambitiously set and yet met the same fate. IMR reduction was planned from 80 to 60, increase in life expectancy from 61 to 63 years, elimination of first, second and third degree malnutrition, and reduction in the occurrence of anemia in would-be mother by 50%. The gains were made in the areas of immunization. The

poor performance was justified by blaming the population growth rate which was quoted as 3%.

The 8th plan again concentrated more on building infrastructure of the curative side. In order to improve the social conditions of the public, Social Action Plan (SAP) was launched through donors like IBRD etc. The focus of the plan was on the improvement in primary education, primary health, population, rural water supply and sanitation. Rs.106.4m were spent in the first phase (1994-7) and another Rs.498m were spent during the 2nd phase (1997-2002). The only significant achievement of the plan was that for the first time that much amount was spent on the rural population, but its performance in terms of social uplift of the population has been rather dismal.

In all the eight 5-year plans the health sector was characterized by ad hoc mentality, lack of initiative, low priority, and guided by foreign health programs and funds. Some of the recent international plans and programs that guided and set the tone of the national health policy and implementation are Alma Ata Declaration 1978, Social Action Program, Millennium Development Goals (MDGs), Poverty Alleviation Program, hospital autonomy and devolution of powers and responsibility.

A brief introduction of Alma Ata Declaration and Social Action Plan has already been given. Millennium Development Goals (MDGs) were set by international agencies including UN in the year 2000. The declaration had 8 goals including the health, poverty reduction, gender balance, environment sustainability etc.

Indicators	1990	MDG Target up to 2015	Current position of Pakistan
Reduce Child Mortality			
Under five mortality Rate (/1000 live births)	140	47	105
Infant Mortality Rate (/1000 live births)	120	40	82
Proportion of fully immunized children (12-23 months) (%)	25	>90	53
Improve Maternal Health			
Maternal Mortality Ratio (/1000 live births)	550	140	350
Births attended by skilled birth attendant (%)	N/A	90	24
Contraceptive Prevalence (%)	12	55	30

Table 3.2: Showing some of the MDGS related to the health and the current status of Pakistan

Source: Progress on Agenda for Health Sector Reform, May 2003, Ministry of Health, as quoted by Lashari (2004)

The preceding table shows some of the MDGS related to the health and the current status of Pakistan.

The recent donor-funded programs currently underway is Poverty reduction Strategy Paper (PRSP) which is claimed to be a "clear shift from curative to preventive health care and focuses on disadvantaged, weaker sections of society especially those belonging to the rural areas". It is considered to be a holistic framework which acknowledges that "additional income alone, either through jobs or financial assistance, would not eliminate poverty unless the causes of poverty are addressed and eliminated. Therefore restoring economic growth; income distribution; social justice; and improving access to basic needs such as primary education, preventive health care, and population welfare service, are essential for winning the fight against poverty" (Lashari, 2004, pp. 19-20). The main focus of this program has been on the primary health care set up.

This was the scenario with reference to healthcare sector in Pakistan. Situation in the other social sectors have not been very different. According to the recent figures of Government of Pakistan, one third of the population still earns 1$/day. More recently, the information Minister of the current government admitted that now 70% of the population lives under

poverty line. Some of the other social indicators in comparison with other countries with similar GDP level clarify the situation.

Country/ Regions	Life Expectancy (years)	Adult literacy Rate (%)	Combined Enrolment Ratio (%)	GDP Per capita (PPP) $	HDI
Mongolia	63.7	97.8	70	1710	117
Pakistan	**60.8**	**41.5**	**37**	**1940**	**142**
Vietnam	69.0	90.3	64	2300	112
Sri Lanka	72.5	92.1	65	3570	96

Table 3.3: Showing a comparison of Pakistan's important social indicators with countries having almost same GDP as of Pakistan

Source: UNDP Human Development Report, 2004. P.12

Despite a significant bias of the past governments towards curative side of the healthcare, the condition of the public hospitals has not shown any significant improvement. The system and structure of curative healthcare was plagued by complex and multi-tiered organizational structures, centralized planning, centralization of authority, decision-making without information, want of job description and career structure, inappropriate and inadequate training of the facility staff, overstaffing and inappropriate distribution of trained personnel, no performance-based incentives for staff, subjective performance appraisal, ineffective monitoring and supervision, financial misuse and abuse, problems in provision of pharmaceuticals, supplies and equipment, Low & erratic level of equipment functioning and diagnostic services, tendency to promote costly medicines ignoring the cheap effective alternatives and declining academic standards depicted through irregular clinical teaching in hospitals, outdated curricula not responsive to the rural areas and community needs and decreasing value of degrees in foreign countries(DOH Report, 1998, pp. 6-7). The trust of public on the quality of service provided by the public hospital had dwindled a great deal. The service delivery side was facing such issues as political interference, staff absenteeism, out-of-pocket expenditures in public facilities, weak referral system, ineffective checks and balances at all levels, minimal community involvement, and low level of community awareness (DOH Report, 1998, pp. 7-8).

A large portion of government budgets allocated for health sector goes to tertiary healthcare and small amount is earmarked for primary healthcare

sector. Instead of developing and strengthening the primary sector an altogether different strategy was picked to solve the issue. The solution was presented through the World Development Report of 1993, "Investing in Health", which "reflected a marked change in the orientation of how healthcare services in resource-poor countries would be delivered" (Hall and Taylor 2003, p. 19). The main thrust of this paradigm shift was "the replacement of Primary Health Care (PHC) by "Health Sector Reform", based on market forces and the economic benefits of better health" (Hall and Taylor, 2003, p. 17). The suggested solution was to gradually make these hospitals financially self sufficient and autonomous. They were expected to raise their financial resources by themselves, through raising user charges, collecting donations and charity etc. This was expected to relieve governments of the financial burden that they had to shoulder in the shape of grants to these hospitals.

This solution in fact emerged out of intense debate going on at the international arena, regarding the performance of government sector. The success of MNCs and the rise of private sector all over the world created a context where the performance of public sector regarding the provision of services appeared even more dismal.

Resultantly, the performance of governments in most parts of the world came under increasing criticism in the recent past. Governments in most of the developing countries were already accused of inefficiency, and poor governance; but lately even the governments of developed countries like UK, USA, Australia, New Zealand etc. have attracted criticism for being incredibly inept, wasteful and non-responsive to the needs of the citizens Osborne and Gaebler (1992). The size of the governments, the scope of governmental activities, and the methods of the governments came under severe attacks. These attacks gave credence to the argument of reducing governments and managing them through the practices and principles of privates sector.

Consequently many reforms were introduced in the public sector following the election of Margaret Thatcher in UK (1979) and Ronald Reagan in USA (1980). In the wake of such rising tide of public criticism, numerous governments vowed to restructure their structures and processes.

This change in philosophy and approach was named as New Public Management. Some of the principles of such changes (i.e. NPM) as enunciated by Osborne and Gaebler (1992) in their book "Reinventing Government" are 'steering rather than rowing'; 'empowerment rather than serving'; 'injecting competition into service delivery'; 'funding outcomes not inputs'; 'meeting the needs of the customers not bureaucracy' and 'leveraging change through the market'. Some of the manifestations of these policies were privatization, deregulation, outsourcing, restructuring etc.

It took around a decade or so for these reforms to reach Pakistan. First sector in which such reforms were introduced was education sector where privatization started in mid 80s. In the 90s, a number of other initiatives were taken in this regard which include among others, privatization of number of state owned enterprises like State Cement Corporation of Pakistan, Steel Mill etc.; deregulation of PIA and other institutions; tenure track in public universities, devolution plan for local governments and autonomy of public hospitals. These initiatives are at different stages of its completion. Some have been resisted and have not been implemented as such, some have been partially in place and some have taken roots.

In Pakistan, as is the case with other countries, hospitals are operating under different governance categories. First category is private hospitals which are financed and governed privately by the donors (or their representatives). They are further sub-divided into three types; first, those being run purely on profit basis, second, being run on no-profit-no-loss basis and third which are run in the spirit of philanthropy or religion where expenses of the hospitals are met through alms, charity or private donations. Second category of hospitals is public hospitals and they are being governed, managed and financed purely by the government. Third type of hospitals are those public hospitals which have been given autonomy and they are being independently governed by a board of directors/management, managed partially by permanent and contractual employees, and financed partially by government and hospital's own funds.

In healthcare sector in Punjab, around 13 hospitals were given autonomy in the last ten years or so. The objectives of this hospital autonomy were to help reduce government commitments in the financing of public hospitals, to increase efficiency in hospital operations, contain costs, and raise the

quality of care. Moreover the government hospitals were to retain their social mission and to continue to provide free care to those unable to pay. These recommendations on hospital autonomy were offered in three categories: governance, management, and finance. It has been long since these hospitals are being run autonomously and a mix of appreciation and criticism is in the air about the performance of these hospitals. Since the management of public sector organizations is a public issue as it involves taxpayers' money, it is imperative to understand the extent to which autonomy has achieved its stated objective and how better it is serving its customers as compared to public and private hospitals.

3.30. Public Hospitals:

While referring to organizations as open system, Scott (2003) says that organizations "are open to and dependent on flows of personnel resources, and information from outside. From an open systems perspectives, environments shape, support, and infiltrate organizations" (p. 31). Organizations being subsystems of the bigger societal environment are bound to be shaped by the society and reflect its multiple characteristics including mental patterns, psychological makeup, power structure, values of the society etc. In this perspective, subsystems can also be thought of replicas or miniature models of bigger society.

In comparison to private sector hospitals, public sector hospitals better represent the larger society as its employees are public servants and all HR issues are dealt by the government; budgets are allocated by the government; it caters to multiple organizational objectives including provision of free or subsidized services to the general public, providing employment to the public; and are owned by government which is the representatives of the public. In this way, organizations apart from having their peculiarities can also be seen as replica-states as whatever goes on in the society at large is also reflected within the organization. On the other hand private sector hospitals no doubt are social systems nevertheless they are strongly influenced by the ideas, objectives and policies of the owners.

So the first and the strongest influence on the public sector organizations in Pakistan is the bureaucracy. According to Mahmood (1990), Pakistan is certainly a bureaucratic state — one in which the bureaucracy rules. Commenting on the generalist orientation of the civil service, Gladieux

(1955) said that "since the majority of such personnel tend to have essentially the same educational and experience background there is produced a civil service which tends to be quite uniform in interest and outlook". Such structure "was well suited to government in the law and order days of colonialism when it was necessary to keep the country under firm control through a small foreign bureaucracy". After the independence of the country, there was a strong need to develop professionally sound technocrats including engineers, doctors, scientist, economists, teachers etc. which could become the backbone of society. However, the dominance of the generalist bureaucracy stemming from their colonial past continued due to the peculiar circumstances prevailing in the country and never allowed this change to take place. This resulted in comparatively poor pay structures, under employment, declining standards of education and training, lack of respect and nuisance value in society for specialists (Kennedy, 1987). Their protests and demands for equitable treatment were heard and acted upon to some extent by the governments of ZAB and Gen. Zia regime. For example, doctors demanded PBS-19 deputy secretary post for doctors in the health department which was met. But the interesting thing which is observed is that they now have learnt to be as 'bureaucratic' as any other civil servant.

In the case of public teaching hospitals, all the types of decisions including HR, financial, purchases, infrastructural, developmental, structural were carried out by the Dept. of Health, Government of the Punjab. This automatically afforded them an unchallenged authority in the affairs of the hospitals. All the senior professors, administrators and officials of the hospitals were under the control of different governmental departments including Health and Finance and most of them were frequent visitors for different tasks and personal career problems. There is no concept of case moving as per merit. The aggrieved person will send the application forwarded by the head of institution, later visit the concerned section officer, request him for writing appropriate remarks, take the file to all concerned, approach them through contacts or other socially acceptable ways and in the process will develop the encyclopedic knowledge about the veritable affairs of the Department. This power over the doctors allowed the bureaucracy all kinds of interferences, favors, and protocol treatment from the public hospitals. The members of doctors' community had long demanded the freedom from the Health department control of the hospital

affairs so that decisions can be taken locally and the level of the services provided by the hospitals be improved. It was this specific 'meaning' that the doctors' community had in their mind of the concept of 'autonomy' when they asked for it.

3.40. Political interference in Public Institutions

One of the significant reasons of poor performance of public institutions in Pakistan is political interference in the working of the institutions. In a country which has been characterized by Hofstede (1987) as having high 'power distance' meaning high level of tolerance in the society for inequality of power between various groups, which has been ruled during and after colonialism by the nexus of landed and bureaucratic classes - both using absolute power of state and society to control the masses, and where assemblies and cabinets are loaded with the land lords, it is quite understandable that the public institutions will be regarded by the rulers as being under their personal control.

3.401. Sifarish

Added to this is the general milieu characterized by lack of rule of law where laws and rules are not respected and followed rather twisted and interpreted for ones' own good, organizational decisions are made for achieving personal interest and not for organizational good. This all translates into an environment where in most cases no legal, routine, and established right will be given to an individual until it is backed by *sifarish* (illegal recommendation) of some influential in the government or bureaucracy or by greasing the palms of the officials. This sifarish can not only help you in getting your legitimate job done which in normal circumstances may be very difficult, frustrating, time consuming and rather impossible, it can open doors for various illegal benefits and facilities.

3.402. Political employments

Cheung (2005) adds another important angle to the discussion when he says that "(i)n most Southeast Asian countries, public sector jobs provided employment for constituents and opportunities of patronage for political supporters, helping to consolidate the power of the ruling elites (p. 267). Once in power, these politicians deem public institutions as their personal

property. Induction of a large number of party diehards in public institutions including Pakistan International Airlines, Pakistan Railways, Pakistan National Shipping Corporation etc by different regimes is an established occurrence in Pakistan. Even different Army regimes after assuming power, placed their serving officers at the key civil organizations. The appointments at most of the key positions at public hospitals are also political in nature.

This gives rulers a 'legitimate' right to interfere in almost all areas of organization including postings, transfers, enquiries, leaves, treatment of patients. Since most of the administrators themselves are appointed through such mechanism, they feel obliged to listen and respect these demands. This may help some rightful individuals to get their rights but it also creates a situation where organizational interests are buried under postings of inept and corrupt officials to key positions, erosion of accountability, apathy towards hospitals assets including costly machines and equipment, purchase of outdated or irrelevant machinery, and last but not the least apathetic and poor public service.

3.403. Attitude of the hospital employees

The abovementioned factors along with commercialization of health services, excessive promotion of material aspect of life by the electronic media, higher standards of avarice set by the elite and lack of accountability has also contributed towards shaping the attitude of the government officials including health professionals into its present form. The attitudinal problems range from complete apathy and indifference to criminal negligence towards their duty of providing healthcare service to the general public. Patients especially the poor ones are generally treated with apathy and derogation, are overcharged, and ignored when they ask for some medical care and treatment. In most hospitals the janitorial staff would demand money on every possible occasion.

3.404. Meager Salaries of Employees

Apart from connivance from the superiors, it may also have a lot to do with the pitiable economic conditions of these staff. Their salaries are shamefully meager and inadequate to provide them with reasonable standard of life. They live in shanty towns, hardly make both ends meet,

have to support large families, hence are forced to resort to such practices. The complaints against doctors include absence from duty, coming late or going early from their duty, prescribing medicine of the brand that has obliged them personally, referring patients to private clinic etc. One of the very obvious reasons is the lack of accountability in all ranks of employees which may be due to the nature of service rules, connectedness to some powerful inside or outside the hospital, union pressure tactics – all this boils down to power, which matters a lot.

3.405. Lack of training

Additionally, employees working in such institutions are not properly trained. Since lot of postings are politically backed, so people selected are neither trained, nor bother to work and nor interested to train themselves. Any negligence, poor work or disobedience that may be noticed is politically handled.

Lack of resources is another cause of poorly trained staff. In fact where people are not provided with basic necessities of life, training is considered to be a luxury. And whatever training is available it is provided to the senior members of the organization and junior staff hardly gets any such opportunity.

3.50. Conclusion:

This section tried to capture those organizational issues which negatively affect the performance of the employees. Lack of accountability was discussed under the general context; however, it is a very significant issue in hospitals as well. Other issues include political interference which then lead to sifarish, political appointments in public institutions, attitude of employees; meager salaries of lower staff, and lack of their training etc.

This is the context and summary of various federal and province level, historical, social, psychological and organizational factors that carry importance with reference to the current study. The information detailed in this section will be used to make sense of the phenomenon of 'autonomy' of public hospitals in Punjab and how and why various actions took place.

Chapter 4

Literature Review

4.10. Introduction

The previous chapter provided the background and the salient features of the health sector of Pakistan. The information was presented to provide the reader a broader and local context with the help of which sense could be made of the phenomenon of the hospital autonomy. It has provided the description of various factors of different fields and different levels which caused the process of hospital autonomy to take a specific course that it took. The information presented in this section will be helpful in understanding the technical aspects and nature of the process of implementation of the autonomy initiative.

This chapter is meant to provide the researcher with a theoretical framework with the help of which the implementation process of the phenomenon of hospital autonomy can be seen and understood. It will present theories related to various approaches to implementation and throw light on various issues related to the process. This information will then help us understand the process of implementation of autonomy, its peculiarities, causes and lessons for the future. Thus this information will be used to find answer to the first question of the research i.e. How the policy of hospital autonomy was implemented at the Services Hospital Lahore, Punjab?

4.20. Implementation Literature

Answering these questions will also mean to identify and gain information from various stakeholders/ players/ actors who played their part and gave their meanings to the phenomenon of autonomy, thus affecting the process at various stages. People make sense of the phenomenon on the basis of their perspectives, values, interests, power and background. These factors vary for different people in a society, so they give a peculiar meaning of their own to the social phenomenon which generally suits their interests.

Hence, one particular phenomenon may have different meanings for different stakeholders. And when different stakeholders try to impose their meaning to the phenomenon based on their respective levels of power, the implementation process takes routes altogether different from the ones which were conceived by their initiators. 'How individuals make sense of change initiatives affects whether the change outcomes are in accordance with the anticipated outcomes or are in conflict with the anticipated outcome' (Balogun, 2006; Stensaker et al., 2008 as cited in Hope, 2010, p. 197). So the social reality is constructed through the interplay of various interest groups.

This perspective on social reality takes its roots from hermeneutics and interpretive school of thought. It differs from structural-functionalist perspective which assigns different functions to different institutions/entities/stakeholder in a society. Every part has to perform its task smoothly, in congruence with other parts, in such a way that they collectively work as a well oiled machine, stay in equilibrium while achieving a specific goal (Macionis, 2005). This view of social reality treats humans as an object or a part which is supposedly value-free, emotionless, interest-free, static, and detached-from-the-environment object which is a far too simplistic and myopic view of human beings. Far from it, human being is an entity which has its values, has emotions and takes strong influence of the environment.

Functionalist perspective provides a dichotomous view on policy implementation whereby policy making and policy implementation are seen as two distinct processes. Politicians and bureaucrats respectively are supposed to carry them out, as if both are two distinct parts, performing different functions. However, practice shows that both are interdependent and intertwined. Policy making, if done without consideration of how it would be implemented, is likely to be a futile effort rather a failed one. On the other hand if policy implementers don't share the rationale, true understanding of the policy, it is most likely to take routes not intended by the policy makers. (In a country like Pakistan which is quite rich in social capital and high in power distance (Hofstede, 1991), these two groups are connected through inter-marriages, common interests, both placed at higher echelons of power cannot work like that).

The social phenomena are better understood while seen in their particular contexts and may mean altogether differently if seen out of the context. So understanding of the contexts is very vital for the understanding of the process of implementation. Contexts are frames which are made up of the history, culture and other influences of the society. So I need to examine the history and culture of Punjab/Pakistan identifying its particular nuances and characteristics which led to the implementation of hospital autonomy. As we have done in the previous chapter, the understanding of such characteristics will lead us to make sense of why the process of implementation went along the way it went.

To explain the whole process, I will be referring to the literature in three fields i.e. implementation (touching governance as well); sense making (which may also include power dynamics) and autonomy will also be discussed with reference to power distribution in a society and its need during implementation.

4.30. Implementation:

Implementation is a social concept, and like other social concepts, it is ambiguous, slippery and difficult to explain. Most of the literature on implementation which existed before 1970s was developed in USA. It was strongly influenced by the principal of dichotomy between politics and administration as enunciated by Woodrow Wilson (1887). Policy making was thought to be the exclusive domain of the politicians as they, being the representatives of the public, were expected to make policies which reflected the interests of the public. Implementation, considered not so important a task was left to the bureaucracies which were then considered 'pair of hand' instead of 'minds. This approach is clearly influenced by the machine or rational thinking of that time. The post-war era demanded capital development projects, so a large number of such program/ projects were initiated including War on Poverty and Great Society programs of the late sixties (Barrett 2004, p. 259).

The ineffectiveness of such projects is already documented. It was one of those projects, in Oakland, that attracted the attention of Pressman and Wildavsky (1973) who studied the implementation process of the project and later wrote one of the most influential books "How great expectations in Washington are dashed in Oakland" on the subject. Since then the

subject has gained popularity among scholars and a lot of research has appeared on various aspects and issues relating to the subject.

Looking retrospectively, one finds that initially a good amount of literature developed along two contrasting approaches towards implementation namely top-down and bottom-up. As is common with the development of knowledge in different parts of life, these opposite views were then synthesized through different models. The next sections will explain the assumptions, methods and characteristics of these two approaches and different efforts to synthesize them.

4.301. Top-Down approach:

Top down approach puts the policy makers at the center of the process. It considers policy making and policy implementation to be two distinct activities, giving prime importance to policy making and taking implementation as a simple and straight forward process which will proceed as per plan. It is more of a prescriptive approach in which implementers are only told to carry out the instructions of the superiors.

Pressman and Wildavsky (1973) are considered to be the most important researchers of this approach (see, for example, Goggin et al., 1990; Parsons, 1995). Pressman and Vildvsky (1973) have adopted a general approach in which they offer a model for the analysis of the implementation process. They have tried to capture the nuances of implementation while writing a book on the Oakland experiment. This experiment was an effort by the Federal Government in Washington to solve the problem of unemployment which was 8.4% - double the national rate, by employing the unemployed African-American population of Oakland, California (p. 2). The project was to be executed by Economic Development Agency (EDA) which had previous record of working in depressed rural areas (p. 1). The idea was based on a series of public works and business loan programs which was expected to create more than 3,000 jobs directly and indirectly.

Different developmental projects including a large airport hangar, a marine cargo terminal with access roads, a 30-acre industrial park and an access road to the Oakland Coliseum were to be undertaken with the amount of $24m approximately. A further amount of $1.6m was available for business

loans conditional to the provision of an employment plan specifying how these companies would hire the long-term unemployed African-American residents of Oakland (p. 2).

On its face, it appeared that everything will go as per planning and it was only a matter of time before this project would be over with all expected outcomes realized. But four years down the road the results were far from satisfactory. For example, the training program never got started, jobs creation was far below expectation and went to unintended population, and the business loan program was an utter failure.

The authors after analyzing the situation identified a number of issues within the process. One of them was that though there was one goal i.e. to reduce unemployment, the solution depended on the implementation of two separate decision paths. First was to finance various public developmental projects and second was to prepare a hiring plan that ensured the actual employing of workers of targeted cities. So the complete success depended on the achievement of both decision paths. However increasing the decision paths only complicated the situations as it increased the number of decision makers; and decision makers in one path may not necessarily bother about the outcome of the other path (p. 110).

Second issue related to links in an implementation chain, or decision/clearance points. They argued that ultimate success of the program depended on the high probability of their clearance or approval. And even if most of them individually had higher chances of getting cleared, failure of only a few of them was enough to cause the utter failure of the project. Third issue was related to the delays caused by the ‘no’ of clearance at certain points and then incurrence of time and money to convert that ‘no’ into ‘yes’ (p. 116).

According to Pressman and Wildavsky (1973, p. xiii-xv), Implementation "means just what Webster [dictionary] and Roget [thesaurus] say it does: to carry out, accomplish, fulfill, produce, complete." They further explain the concept in these words "Policies imply theories... Policies become programs when, by authoritative action, the initial conditions are created... Implementation, then, is the ability to forge subsequent links in the causal chain so as to obtain the desired result". Here authors are taking processes of policy making and policy implementation as two distinct and detached

entities. Policy making is an effort to solve some social problem. Behind the solution lies some theory which is used as a basis for justification. Once policy is developed it is handed over to the implementers who subsequently have just to take certain steps like in some ideal model to successfully achieve its desired goals.

This definition explains implementation in causal manner in which policy making precedes implementation and implementation simply means carrying out policies which have earlier been developed. They see implementation as a complex process having a long chain of causality.

Van Meter and Van Horn (1975) also define implementation. According to them, '[p]olicy implementation encompasses those actions by public and private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions (p. 447). This definition is not much different from the previous definition. It also sees implementation in system theory perspective in which one process follows the previous one with the system having its start and finish points. It also sees implementation as a distinct process from policy formulation.

According to Hill (2002), Van Meter and Van Horn were critical of the general approaches adopted by Pressman and Wildavsky (1973) and other authors including Kaufman, 1960; Bailey and Mosher, 1968; Derthick, 1970, 1972; Berke et al., 1972). They opined that implementation should be guided by a sound theory. The theoretical framework offered by them included insights from organizational theory with specific reference to organizational change and control, study of the impact of public policy. They believed that success in implementation is more likely where change required is marginal but the goal consensus is high.

Van Meter and Van Horn's model identifies six points which are likely to contribute towards the successful implementation of any project (1975, p. 464)

- policy standards and objectives: identifying specific goals and standards for assessing performance' ;
- the resources and incentives provided for and made available;
- the quality of inter-organizational relationships between various agencies involved;

- the characteristics of the implementation agencies, including issues like organizational control but also, going back surely to inter-organizational issues, 'the agency's formal and informal linkages with the "policy-making" or "policy-enforcing" body ' (p. 471);
- the political, economic, and social environment; and
- the 'disposition' or 'response' of the implementers, involving three elements: 'their cognition (comprehension, understanding) of the policy, the direction of their response to it (acceptance, neutrality, rejection) and the intensity of that response' (as cited in Hill & Hupe, 2002, p. 46).

Bardach (1977) is also another writer who explains implementation from top-down perspective. He has made an excellent effort to help understand more systematically the process of implementation through the use of 'game' metaphor. He treats implementation as a 'game' and different actors/contributors involved in it as 'players' and then uses this concept to narrate the demeanors of various players along with the strategies that they adopt. According to him, the metaphor, "directs us to look at the players, what they regard as the stakes, their strategies and tactics, their resources for playing, the rules of play (which stipulate the conditions of winning), the rules of 'fair' play (which stipulate the boundaries beyond which lie fraud or illegitimacy), the nature of the communications (or lack of them) among the players, and the degree of uncertainty surrounding the possible outcomes"(p. 56 as cited in Adil Najam, 1995, p. 7).

Bardach sees implementation more as a "political" process than administrative one where success demands a committed follow through from the top. In it he represents the top-down approach. He also considers the contribution of the street level workers whom he terms as 'craftsman' as vital for the process. In this way he also has something to offer to bottom-up approach (1977 as cited Hill & Hupe, 2002, p. 48).

Bardach uses data from different sources including his own observation of the implementation of mental health reform in California. He presents a typology of implementation games, evaluates the sources of delay in implementation, and offers some recommendations for improving policy design. His book is treat to read as it is written with great fluency and command on the subject, yet is of not much help in improving our thinking

of the subject. Rather his conclusion carries a hint of pessimism towards expecting any worthwhile success in implementation when he says that:

> It is hard enough to design public policies and programs that look good on paper. It is harder still to formulate them in words and slogans that resonate pleasingly in the ears of political leaders and the constituencies to which they are responsive. And it is excruciatingly hard to implement them in a way that pleases anyone at all, including the supposed beneficiaries or clients (1977, p. 3 as cited in Adil Najam, 1995, p. 10).

The American authors Sabatier and Mazmanian were also concerned with the analysis of implementation of a policy decision made at the top. They identified three factors which could impact implementation. The factors are 1) 'tractability of the problem'; 2) 'non-statutory variables '; and the 'ability of the statute to structure implementation' (Sabatier and Mazmanian, 1980, p. 544 as cited in Hill & Hupe, 2002, p.49).

They further identified seventeen variables under these three heads and later synthesized them into six sufficient and generally necessary conditions for effective implementation. These conditions are:

1. Clear and consistent objectives (identified at initial stages)
2. Adequate causal theory (which may provide strong justification for the path and solution adopted)
3. Implementation process legally structured to enhance compliance by implementing officials and target groups (providing sufficient powers, incentives etc. to help the program sail through smoothly)
4. Committed and skillful implementing officials (to be achieved initially as well as during implementation)
5. Support of interest groups and sovereigns (consistent political support throughout the program)
6. Changes in socio-economic conditions which do not substantially undermine political support or causal theory (acceptance of the strong influence that these conditions may have on the process) (1986, pp. 23-25)

In nutshell, Sabatier and Mazmanian, (1980) recognized that hierarchical control may not be possible, however, by applying these six conditions the behavior of implementing officials can be kept within limits. This all certainly looks quite scientific; however, a lot more depends on the

discretion of the implementing officials who have very crucial role to play in the implementation stage.

This approach was characterized by clear cut distinction between the policy making and policy implementation processes, stage-model based rationality, control, and implementer's lack of empathy towards objectives of policy makers. Later various authors identified drawbacks in this approach. Some of them are:

- Statutes are formal documents and need to be clear and unambiguous so that implementation is done smoothly. However the process of legislation is fraught with ambiguity and compromises. "Passage of legislation often requires ambiguous language and contradictory goals to hold together a passing coalition" (Matland 1995, p. 147). Furthermore taking pieces of legislations as starting point ignores the "significance of actions taken earlier in the policy-making process (Matland 1995, p. 147)
- Implementation is seen as a pure administrative affair and role of politics is either ignored or underplayed (Matland 1995, p. 147). It is so because policy making and implementation are seen as distinct activities.
- In situations which include multiple actors are involved and they are pursuing multiple objectives, the success of implementation through this approach is likely to be very difficult (Hill n Hupe 2002, p. 43).
- It underestimates the influence of 'street level bureaucrats and other stakeholders who may completely change the objectives and directions of the program. According to Lipsky 'the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out' (1980, p. xii).

Brian Hogwood and Lewis Gunn (1984) offer some propositions which are more like recommendations to the implementers. The summary of these recommendations is:

- that circumstances external to the implementing agency do not impose crippling constraints;
- that adequate time and sufficient resources are made available to the program;

- that not only are there no constraints in terms of overall resources but also that, at each stage in the implementation process, the required combination of resources is actually available;
- that the policy to be implemented is based upon a valid theory of cause and effect;
- that the relationship between cause and effect is direct and that there are few, if any, intervening links;
- that there is a single implementing agency that need not depend upon other agencies for success, or, if other agencies must be involved, that the dependency relationships are minimal in number and importance;
- that there is complete understanding of, and agreement upon, the objectives to be achieved, and that these conditions persist throughout the implementation process;
- that in moving towards agreed objectives it is possible to specify, in complete detail and perfect sequence, the tasks to be performed by each participant; and
- that there is perfect communication among, and co-ordination of, the various elements involved in the program; and that those in authority can demand and obtain perfect obedience(as cited in Hill & Hupe, 2002, pp.50-51).

Most of these recommendations are more of an ideal type which can only be expected but cannot be achieved completely in real life. This may however be taken as an evaluation concept but its normative application in real life is a bit too idealistic. They themselves acknowledged this fact and alluded towards the 'unattainability of perfect implementation'.

The following table # 4.1 summarizes the major contributions of top-down researchers.

Writers	Year	Main contributions
Pressman and Wildavsky	1973	• Implementation is "the ability to forge subsequent links in the causal chain so as to obtain the desired result". • Policy implementation is distinct from policy making. • Multiple decision paths renders implementation difficult; successful implementation depended on clearance of all decision points; delays caused by 'no' for clearance and converting it to 'yes'
Van Meter and Van Horn	1975	• "Policy implementation encompasses those actions by public or private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions." • Criticized general approach to implementation and stressed the need to develop theory • Theoretical framework based on o organizational change and control o impact of public policy o inter-governmental relations
Bardach	1977	• Used 'game' metaphor to explain implementation; identifies the role of players, rules of play, fair play, boundaries, nature of communications, and degree of uncertainty. • Sees implementation as political process which demands commitment from top leaders. • Acknowledges the importance of street level workers
Sabatier and Mazmanian,	1980	• concerned with the analysis of implementation of a policy decision made at the top • identified factor that could impact implementation o 'tractability of the problem'; o 'non-statutory variables '; o and the 'ability of the statute to structure implementation'
Brian Hogwood and Lewis Gunn	1984	• Offered some propositions which looked more like recommendation. They are o External circumstances should not be crippling o Adequate time and resources be available o Required combination of resources for all steps be available o Policy be based on valid theory o Relationship of cause and effect be intervened by minimum variables o There need to be single implanting agency o Complete agreement on objective and should last till the end o Clear responsibility of tasks o Perfect communication among various elements of the process

4.302. Bottom-Up Approach:

Most of the scholars had realized by then that implementation was far more complex and political than what the top-down view suggested, and that top-down rationality was bounded by so many constraints - not envisaged by its proponents. Hence public policy was seen unlikely to work like an ideal efficient machine. Their thinking got a lead from the challenge posed to the rationality of Taylorism in management from bounded rationality of Simon (1955). A number of authors set out to offer an alternative approach.

In 1980, Lipsky came up with an alternative approach in his book Street-Level Bureaucracy: Dilemmas of the Individual in Public Services. His approach was identified as bottom-up approach. He has expressed his views earlier than Pressman and Wildavsky (1973) in 1971 in an article in which he questioned the order and control mind set and asserted that in reality it is the street level bureaucrats/ implementers who make policies. To him policy making and implementation are not distinct rather intertwined and interactive processes. Though policies are made by legislators in parliament, yet 'the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out' (Lipsky, 1980, p. xii).

The street level bureaucrats are those officials in different organizations who are involved in delivery of services. In practical life, they are "teachers, police officers and other law enforcement personnel, social workers, judges, public lawyers and other court officers, health worker, and many other public employees who grant access to government programs and provide services within them" (1980, p. 3). They come to the organizations with some ideals. There, during their service, they face a situation where they have to negotiate between their ideals and obligations to achieve organization's goals. The ambiguity and uncertainty of goals on one hand and the lack of effective performance measures in street-level bureaucracies on the other encourages workers to use their own discretion. Consequently, workers (street level bureaucrats) in order to deal with difficult and complicated jobs, develop routines and self-styled ways, which become actual policy (Lipsky 1980).

Lipsky also mentions number of the dilemmas of organizational life (p. xi). Street-level worker on the one hand find themselves as a small parts of a big machine which oppresses them through bureaucratic routines and rules. They are also faced with different kinds of ambiguities, uncertainties and limitation with regards to situations, objectives, and resources. And above all is the pressure from the top. In such situations, they try their level best to cope with the situation. Yet, on the other hand, they find a good amount of discretion available to them while carrying out different tasks. And it is this discretion which in reality makes them the real policy makers.

According to Lipsky (1980), in the presence of such discretion, accountability becomes a very important issue. He also suggests ways to improve such situations by "encouraging clients' autonomy, improving current street-level practices and helping street-level bureaucrats become more effective proponents of change (p. 193.)"

Another researcher, Benny Hjern from Sweden, who along with his colleagues David Porter, Kenneth Hanf and Chris Hull developed preference for bottom-up approach in policy implementation. His work was based on 'experiences gained while working on European employment and training programs in Berlin'. They studied 'policies based on interactions between several different organizations'. Here they identified that in implementation process a lot depends on the actors/organizations that are actually involved in implementation process rather it being a process driven from top through well-designed policies. Pressman and Wildavsky's work also highlights factors that might cause conflicts among different organizations. They coined the concept of 'implementation structure' within which activities take place. Such activities also 'formed through processes of consensual self-selection' (Hjern, et al, 1981, p. 220 as cited in Hill & Hupe, 2002, pp.53-4).

In their methodology, they identified certain relevant organizations and 'snowballed' to gain further information about other organizations which were related and involved in this project. This network of organization developed without any preconceived understanding about which organizations were likely to be part of implementation structure within which decision making will occur (as cited in Hill & Hupe, 2002, p.54).

In an article reviewing Mazmanian and Sabatier (1981) Hjern opined that their framework grounded in top-down approach is an effort to help politicians better control public administration. Thus it is fenced 'in the public administration notion of stable and sequential relationships between politics and administration'. Hjern and Hull (1982, p. 107) were of the view that implementation study should be 'organization-theory inclined' staying unbiased towards various actors. Lipsky, while discussing discretion held by street-level bureaucrats, has emphasized the need to devise mechanisms of accountability linking street-level bureaucrats and the public.

Susan Barrett and Colin Fudge (1981), hailing from Britain, contend that top-down implementation literature tends to depoliticize the policy–action relationship. They suggest political processes should continue throughout implementation. In their view it is not possible to see implementation and policy functions as two distinct entities. Moreover policy cannot be seen as 'constant' as it is a 'negotiated order' reached through the interaction of various actors who themselves might be having differing assumptions and interpreting the phenomenon in their peculiar ways (as cited in Hill & Hupe, 2002, p.55).

While defining the concept of implementation, they extend the argument of Hjern that if policy is "getting something done" then performance rather than conformance should be the main objective of the process. And compromise should be seen as a means to achieve it. According to them, much of the implementation action that takes place is in fact a 'compromise' between parts of an organization or between different organizations. This was a response to Pressman and Wildavsky (1981) earlier stand that 'if implementation is defined as putting policy into effect then *compromise* by the policy-makers would be seen as policy failure' (as cited in Hill & Hupe, 2002, p.56). So top-down approach views 'compromise' as something like a sin whereas bottom-up takes it as a part of the process.

Writers	Year	Main contributions

Lipsky	1980	• Implementation is political and more complex phenomenon
		• Public policy can't envisage all problems in advance
		• Its street level bureaucrats (SLBs) who practically make policies
		• SLBs face a dilemma
		  o See themselves as part of machine which binds them through rules and routines
		  o On the other hand, given discretion while carrying out various tasks.
		• His suggestion to make accountable are:
		  o Encourage clients' autonomy
		  o Improve street level practices
		  o Encouraging SLBs to become proponent of change

Benny Hjern	1981	• Identify importance of SLBs • Implementation structure • Stressed the need for sound theory
Susan Barrett and Colin Fudge	1981	• Policy making and implementation are not distinct process; policy is not constant rather 'negotiated order' • If policy means 'getting something done' then performance rather than conformance be the main objective of implementation

Table 4.2 summarizing contributions of bottom-up researchers

These two approaches can be seen as opposing stands or thesis-antithesis scenario. The pioneering approach took it as a process regulated and controlled from the top. Once policies were thrashed out immaculately, it was simply a matter of time before the implementation would be completed by the mechanical hands of the workers. In other words, top management was seen as the 'mind' and workers entrusted to carry out implementation as 'pair of hands'. This approach was attacked by others as

idealistic, and to some extent myopic. They opined that the real strength lied with the 'street level bureaucrats' who were provided with a lot of room and discretion in the process of implementation. And it was at the bottom, where the real power was to be found. In fact, both these approaches saw one phenomenon from two different angles. Later, efforts were made by other researchers to synthesize both the stands. In the next section, the work of some of the synthesizers will be surveyed.

4.303. Synthesizing Approaches:

Richard Almore*(1979)* can be seen as an earlier proponents of synthesizing both the approaches despite the fact that he strongly emphasized the use of bottom up approach. While suggesting a mix of these approaches he suggests a start of the process with a concrete policy and clearly laid down requirements. And then showing the incapacity of the policy or policy maker to control the process and to achieve the targets of their own choice shifts the emphasis to the street level bureaucrat who can use discretion and skills to solve the problem which may be encountered during implementation. He explains the process in the following words:

> Begin with a concrete statement of behavior…describe a set of organizational operations that can be expected to affect that behavior… (however) it is not the policy or the policy maker that solves the problem… problem solving requires skills and discretion…the greater the reliance on delegated discretion, and the less reliance on hierarchical controls – the greater the likelihood of affecting the target behavior. (Almore 1979, p. 80)

However before becoming a proponent of the synthesis, he was a strong advocate of bottom-up approach. He termed top-down approach as 'forward mapping' and bottom-up approach as 'backward mapping'. According to him the most important assumption of forward mapping i.e. "policymakers control the organizational, political, and technological processes that affect implementation" is nothing but a "noble lie of conventional public administration and policy analysis" (p. 603). He concludes his analysis of forward mapping by saying that "the most persuasive explanation for the persistence of forward mapping in the face of its obvious limitations is the lack of a suitable alternative". He then comes up with the alternative i.e. backward mapping. The rationale provided by him for this approach is that "the closer one is to the source of the problem, the greater is one's ability to influence it; and the problem-solving ability of complex systems depends not on hierarchical control but on maximizing discretion at the point where the problem is most immediate" (Almore 1979, p. 605).

Fritz Scharpf (1978), a German scholar wrote in an essay that 'it is unlikely, if not impossible, that public policy of any significance could result from

the choice process of any single unified actor. Policy formulation and policy implementation are inevitably the result of interactions among a plurality of separate actors with separate interests, goals and strategies' (as cited in Hill & Hupe, 2002, p.58).

Network theory was very much being discussed by the scholars at that time and Scharpf' thinking was influenced with this. He further says that, 'public policy making is still the only vehicle available to modern societies for the conscious, purposive solution of their problems' (1978, p. 349, as cited in Hill & Hupe, 2002, p.58). So these policies are a result of interaction of different actors. They achieve these results through 'coordination' and 'collaboration'. During the process, a network of organizations is formed. And this network is likely to facilitate the process of implementation.

Martin Smith (1993) says that:

> [t]he notion of policy networks is a way of coming to terms with the traditionally stark state/civil society dichotomy....State actors are also actors in civil society, they live in society and have constant contact with groups which represent societal interests. Therefore the interests of state actors develop along with the interests of the group actors and the degree of autonomy that exists depends on the nature of policy networks. (p. 67 as cited in Hill & Hupe, 2002, p.60)

Randall Ripley and Grace Franklin, two Americans (1982) scholars emphasize on the question of 'what is happening and why' (p. 10) and believe that we need to explore the process and should not be concerned with prescription (as cited in Hill & Hupe, 2002, p. 61). It is so because implementation is a social process and different stakeholders have their unique interests, and hail from different departments etc. Ripley and Franklin think that:

> Implementation processes involve many important actors holding diffuse competing goals who work within a context of an increasingly large and complex mix of government programs that require participation from numerous layers and units of government and who are affected by powerful factors beyond their control (1982, p. 9 as cited in Hill & Hupe, 2002, p.61).

They have made an observation that '[a]lmost no national or federal programs are implemented wholly or directly by the national government in

Washington' (p. 25). This is a governance pattern which may be discernable in almost all countries/societies based on federation principle and hence it is very much true in case of autonomy of hospitals in Pakistan as well.

They also point to the political nature of the process of policy implementation and also advocate for a specific type of policy for a specific situation thus avoiding taking sides and hinting towards a synthesis.

As far as Sabatier is concerned, he entered the field advocating the top-down approach but later on introduced the concepts of "advocacy coalition framework" which is quite similar to the network stand. In it he refers to 'a whole variety of public and private actors involved with a policy problem'. By doing so he appears to have adopted some features of bottom-up approach apart from his initial stand on top-down approach thus sort of advocating a synthesis of both the approaches (as cited in Hill & Hupe, 2002, p.64).

Jan-Erik Lane (1987) another Swedish scholar introduces the concepts of 'responsibility' and 'trust' representing two different approaches. He starts with identifying the fact that the word 'implementation' is used in two different meanings i.e. 'end state or policy achievement' and 'a process or policy execution' (p. 528). According to him top-down model concern 'responsibility side' whereas bottom-up is explained by 'trust side'. If there is no responsibility fixing, evaluation cannot take place and no one can be held responsible. And if during the process of execution, trust is non-existent; discretion will not be delegated downwards which will make execution a far cry. He explains his stand in the following words:

> An implementation process is a combination of responsibility and trust.... Without the notion of *implementation as policy accomplishment* there is no basis for evaluating policies and holding politicians, administrators and professionals accountable. On the other hand, *implementation as policy execution* rests upon trust or a certain amount of degrees of freedom for politicians and implementors to make choices about alternative means for the accomplishment of goals....
>
> Implementation theory has thus far been the search for some pattern or way of structuring the process of implementation in such a manner that there will be a high probability of policy accomplishment. This has resulted in a controversy between those

> who believe in control, planning and hierarchy on the one hand, and on the other those who believe in spontaneity, learning and adaptation as problem-solving techniques. A reorientation of implementation theory would be to inquire into how accountability is to be upheld in the implementation of policies and how much trust is in agreement with the requirement of accountability. (p. 543 as cited in Hill & Hupe, 2002, pp. 65-6).

In the light of the previous discussion, one can conclude that "it is not a question of choosing 'top' or 'bottom' as though these were mutually exclusive alternative" (Hanf, 1982, p. 171) rather both perspectives enlighten us from their own perspectives to understand the dynamics of implementation process.

Writers	Year	Main Contributions
Richard Almore	1979	• Introduced a mix of 'forward mapping' (top-down) and 'backward mapping' (bottom-up) approaches • His recipe: o Start with a concrete statement of behavior (T-D) o describe a set of organizational operations that can be expected to affect that behavior (T-D) o problem solving done by SLBs so they requires and be given skills and discretion (B-U) o the greater the reliance on delegated discretion, and the less reliance on hierarchical controls – the greater the likelihood of affecting the target behavior" (B-U)
Fritz Scharpf	1978	• Highly unlikely that a public policy can bear fruit through the actions of any single actor • Success – a result of interaction between different actors i.e. use of Network theory • Different actors interact through the process of 'coordination and collaboration' to achieve results
Randal Ripley and Grace Franklin	1982	• Explore questions: 'what is happening and why?', Need to study the process • Implementation a social process interacted by different stakeholders, each having unique diffuse competing goals/interests • They work in a complex mix of different government organizations, at different layers and affected by environment • Also talked about the political nature of the process
Paul Sabatier	1986	• Introduced the concept of 'Advocacy Coalition Framework' similar to Network Theory • Talks of 'a whole variety of public and private actors involved with a policy problem'
Jan-Erik	1987	• Implementation is an 'end state' and a 'process' • There are two sides of implementation Responsibility (for T-D) and Trust (for B-U) • If there is no responsibility, no evaluation is possible • If there is no trust, no delegation, and no execution

Table 4.3: summarizing contributions of researchers adopting synthesizing approach

Variables	Top-down perspective	Bottom-perspective	Synthesis
Policy decisions	Policy makers	The street level bureaucrats	Both
Starting points	Statutory language	Problem in a society	Both
Structure	Formal	Both formal and informal	Both
Process	Purely administrative	Networking including Administrative	Political-cum-administrative
Authority	Centralization	Decentralization	Both
Output/Outcomes	Prescriptive	Descriptive	Combination
Discretion	Top level's bureaucrats	Bottom-levels' bureaucrats	Both

Table 4.4: Differences between top-down, bottom-up implementation and synthesis perspectives

Source: taken from Paudel[9] and placed with certain changes.

The table 4.4 compares the three perspectives on implementation with reference to number of different variables.

4.40. Political nature of Implementation:

There are a number of authors who while emphasizing the political nature of implementation, question the 'dichotomy of politics and administration' stand. They argue that implementation is equally complex political process as policy formulation is (see for example Bardach, 1977; Barrett and Fudge, 1981; Ripley and Franklin, 1982; Palumbo and Calista, 1990 etc.).

Hunter and Marks, (2002) adopt a different approach to address the issue. According to them, there are four approaches namely structural, procedural/managerial, behavioral, and political which can be used to understand the phenomenon of implementation. First three are well understood and thought about, though fourth one i.e. political is generally neglected. He believes that even if implementation is effectively managed from other three approaches, it is likely to fail if it does not take into account the power dynamics. "Problems of performance and effectiveness are problems of power and politics – power imbalances, powerlessness, and the inability of some groups or causes to get their ideas or policies taken seriously" (p. 7).

[9] http://www.napsipag.org/PDF/Narendra-Nepal-JNU.pdf

Brodkin (1990) responds to the issue of politics-administration dichotomy by integrating the "study of implementation" with the "study of social politics". He views implementation as "policy politics – a continuation of conflicts to define social policy" thus doing away with the dichotomy. According to him, "policy politics is ubiquitous; it neither begins with the formation of policy proposal nor ends with enactment or defeat". While discussing the causes of the continuous eruption of conflicts and opportunities to assign different meanings to legislative policy intent he says that "contentious issues coupled with weak institutional mechanism of conflict resolution make it likely that social politics often will be irresolute". He contends the conventional wisdom that "the issues that become politicized almost always are value issues, not technical questions that can be answered definitively" (Nathan, 1984, p. 377 as cited in Brodkin, 1990) by suggesting that "when questions of value are not resolved politically, they may reappear in the form of technical or administrative questions during the implementation process". He sees implementation as a "vehicle for defining and redefining social policy" (Brodkin, 1990, p. 107-18).

The act of governing involves both processes of policy making and policy implementation since this is how the issues of the public are addressed. Woodrow Wilson (1887), one of the founding fathers of public administration strongly advocated the principle of dichotomy between politics and administration. According to this view politicians being the representatives of the public are better placed and legitimate candidates for the role of policy making. They know the issues of the public so they know better what policies should be devised to tackle their problems. Administration should not be part of the process as its job is only to implement. They should only be "responsible for the execution of the policy and not at all for the formulation of policy" (Maass and Radway, 1949). Logically, it appears a very fine argument but in reality, it is fraught with serious implications towards solving public issues. If the implementers don't understand or share the vision, spirit and mindset of the policy makers, it is very likely that the implementation be devoid of true spirit and the chances that implementation of policies will turn towards unintended directions will amplify. "The knowledge and expertise of public service practitioners are needed not only to carry out directives from elected governing bodies, but to assist decision-makers in understanding

conditions on the ground and the complexities of governmental operations"(Box, 2007, p. viii). So it would be naïve to conclude that both the processes are independent of each other.

4.50. The importance of meaning

'Politics is about creating a perception of legitimacy through the management of meaning, and it has to do with shaping a perception of reality and imposing this perception of reality on others' (Brown, 1995; Hardy, 1996 as cited in Hope, 2010, p. 199)

Most of the implementation research follows positivist traditions which is based on empirical and quantitative data and tries to capture the objective reality. Its inability to capture the meaning of a phenomenon which is grounded in individual's thinking and culture has led researchers to resort to interpretive approach. Interpretive approach is now being widely used in many fields to unearth the hidden reality and meaning of a phenomenon which cannot be captured by positivist methods. The field of policy analysis has also been delved into by various researchers who have adopted interpretive perspective (e.g. Palumbo and Calista, 1987; Torgerson, 1985; Yanow, 1990). This interpretive approach concentrates on understanding the meaning of a phenomenon. With reference to policy and implementation analysis, Yanow (1993) raises few questions e.g. "what does a policy mean? To whom aside from its drafters and implementers, does it have meaning? How do various interpretation of meaning affect policy implementation?" Such aspects of policy implementation which are not discernable objectively can only be captured through interpretation of different artifacts, words etc. Moreover, those involved in the process look at it through their own lenses / interpretation and develop different meaning based on their interests, background knowledge and objectives. These interpretations "may differ from one another and may diverge from the intent of the policy's legislators. This multiple interpretation may facilitate or impede the policy's implementation" (Yanow, 1993). And 'politics is about creating a perception of legitimacy through the management of meaning, and it has to do with shaping a perception of reality and imposing this perception of reality on others' (Brown, 1995; Hardy, 1996 as cited in Hope, 2010, p. 199). Such interpretations are not

discernable as an objective fact rather it is the researcher who digs out hidden meaning by understanding the phenomenon in its natural context.

4.60. Hospital Autonomy:

The drive to replace government with governance produced a number of regimes and initiatives, of which autonomy is one. Autonomy is defined as "the right of a group of people to govern itself, or to organize its own activities[10]"; "the ability to act and make decisions without being controlled by anyone else[11]". So autonomy is a state of independence where the organization or country is free to make its own decisions without being dependent on any external source for existence. I propose a conceptualization where autonomy is either achiever-driven or granter-driven. In the first instance, the autonomous body would have actively pursued it making certain efforts, struggles and sacrifices since power means controlling others affairs and resources and nobody relinquishes it on its own. And in the case of granter-driven autonomy which is granted by the granter, it is always for the benefit of the granter. Such type of autonomy will always depend on the objectives of the granter; it will be up to him to decide the extent and nature of the autonomy. In nutshell, such type of autonomy will in most cases be to the disadvantage of the receiver.

Hildebrand and Newbrander, (1993) produced a report which became the basis of hospital autonomy initiatives in Pakistan. According to them, "(h)ospital autonomy generally means that hospitals are at least partially self-governing, self-directing, and self-financing through the generation of revenues from user fees". This autonomy was granted in three areas namely, governance, management and finance. They also talked of granting limited amount of autonomy, so right from the outset the autonomy was never complete with the result that accountability was never fixed.

Chawla et al (1996) have defined hospital autonomy along two dimensions: the extent of centralization of decision-making ("extent of autonomy"); and the range of policy and management decisions that are relevant to hospitals ("nature of autonomy"). Extent of autonomy ranges from '0' denoting centralized system whereas '1' meaning decentralized system

[10] Downloaded from www.dictionary.cambridge.org on March 15, 2011, 11:00 am

[11] Oxford Learners Dictionary

where autonomy is the maximum. Nature of decision making includes participation in decision making on overall health (national) as well as hospital goals, and implementation of hospital specific functions, like strategic management, administration, procurement, financial management and human resource management.

As it is a relative concept so maximum autonomy occurs where all decisions are taken by the management of the institution and the situation where minimum autonomy occurs is where almost all of the decisions are taken by the government.

Key areas/functions of the hospital as identified in Chawla et al (1996) that are greatly affected by autonomy are

- Governing Authority and Administration
- Finance
- Human Resources
- Procurement
- Hospital Information Systems

Though, autonomy is a relatively new phenomenon, a reasonable amount of literature is available on the evaluation and experiences of autonomy. Chawla and Govindaraj (1996) conducted case studies of five autonomy experiences in five different countries to understand the phenomenon. The hospitals studied were APVVP Hospitals (India), Parienyatwa Hospital (Zimbabwe), Kenyatta National Hospital (Kenya), Korle Bu and Komfo Anokye Teaching Hospitals (Ghana), Parienyatwa Hospital (Indonesia) Chawla et al (1996).

The objectives of each case study were as follows:

- analysis of reasons why autonomy was given to the selected hospitals
- description of the approach and process for giving autonomy
- description of the nature and extent of autonomy
- assessment of the impact of autonomy on resource mobilization, efficiency, equity, accountability and quality of care
- suggestions for successful implementation

As far as first objective is concerned one common reason which was found in all but one hospital (Zimbabwe) was resource mobilization i.e. ability of the hospital to generate financial resources for running of the hospital

without the help of the government. Other objectives thus found were separating the policy formulation function of the MOH from health services delivery, freeing the hospitals from the constraints of civil service regulations, increasing management efficiency, improving the quality of care, and improving the overall public image of the teaching hospitals Chawla et al (1996).

Two different models were observed in so far as approach and process is concerned. In Kenya, Ghana and Zimbabwe the large tertiary and teaching hospitals were granted autonomy whereas in Indonesia and India autonomy was granted to district hospitals. Then in all countries but India, individual hospitals were made autonomous while in India an organization of hospitals was set up as a quasi-governmental organization to oversee the hospitals under its control and it was given autonomy.

A common denominator in all the case studies is that no hospital had any role in the overall health policy and even in the hospital goals. Governments have retained the right to make policies at national and local level. Hospitals were only the implementers. In the hospital domain, variation was witnessed with hospitals in India, Indonesia and Ghana having considerable autonomy in deciding hospital mission and goals but hospitals in the rest of the countries were found lacking freedom in the domain.

In so far as financial autonomy was concerned all of the hospitals were granted considerable autonomy. Autonomous hospitals could thus construct their own internal budget without regard to the ministry or treasury controlling allocations to specific line items. All hospitals shifted from treasury accounts to commercial banking, and were no longer required to follow government accounting systems. The hospital management in all cases was encouraged to mobilize resources, though many restrictions were put on raising revenue through fee collection. Hospitals had been allowed to keep revenue raised through fee charge. In Indonesia hospitals could use fee collections for salary incentives, operations (drugs, spare parts), hiring of contract personnel, and food service and laundry.

In the case of procurement of drugs, medical and non-medical supplies for the hospital, as well as purchase of hospital equipment hospitals in most of the countries enjoy considerable autonomy. However situation in Ghana

and Zimbabwe is somewhat different where the hospitals still purchase from central stores.

Most of the hospitals enjoy significant amount of freedom in the running of day to day affairs and Management Boards of the hospitals provide excellent support in buffering the hospitals from the government influence.

The case of the management of human resource have been different where autonomy have not been available to the hospital for hiring and firing of the employee not even in those cases where hospital employees cease to be government employee after autonomy. In all countries but Kenya, respective public service commission still retains the authority of hiring and firing.

These case studies also tried to learn about the impact of autonomy on a number of factors. Following table provides a brief detail of the impact of autonomy on each factor:

Evaluative Criteria	Levels of Impact			
	Adverse Impact	No Change	Some Improvement	Substantial Improvement
Efficiency		Zimbabwe, Ghana	India, Kenya	
Quality of care and public satisfaction		Kenya, Zimbabwe	India, Ghana	
Accountability	Zimbabwe	India, Kenya, Ghana		
Equity	Zimbabwe, Ghana	India, Kenya		
Resource Mobilization			Zimbabwe, Ghana, Kenya	India

TABLE 4.5: Impact of Autonomy

Source: (Chawla, Govindaraj, 1996)

There is a great dearth of literature on the experience of autonomy in the public hospitals of Pakistan. However, in recent past some noteworthy efforts have been made by some scholars e.g., Collins CD et al (2002), Tarin EH (2003), Zaidi SA (1994), and Abdullah and Shaw (2007).

Zaidi SA (1994) in his article identified various stakeholders in the health planning in Pakistan which include “international agencies, government officials, pharmaceutical companies, health personnel and community and citizen's groups”. However, after analysis, he concluded that “(p)robably

the most important factor influencing health planning is the influence of international donors, governments and agencies". He also visualized that recent ideological tilt towards marketization of public sector was quite likely to affect the health planning in Pakistan in future (astract).

The study of Tarin (2003) was focused on identifying factors which influenced the policy process for government initiatives in the Punjab (Pakistan) health sector 1993-2000. His study further identified factors which principally influenced the policy process in terms of their origin, design and implementation. These are: "(1) the absence of clearly defined principles and purposes; (2) the insufficient involvement of the stakeholders; (3) the lack of a holistic view of context, focusing on the health sector; (4) the shortcomings of the policy machine-, (5) the need for a proper implementation structure; and (6) the administrative fatigue of donors" (abstract).

Abdullah and Shaw (2007) being the latest contributors only cover the process of autonomy till the time when first ordinance was in force. It is sort of an evaluative study which tried to evaluate two separate attempts of autonomy in Pakistan, one in Punjab which included Sheikhupura Pilot Project and the granting of institutional autonomy to a number of public hospitals of Punjab and the other in NWFP province which included autonomy to four largest public sector, tertiary care and teaching hospitals in the N-WFP which included Lady Reading Hospital (LRH); Khyber Teaching Hospital (KTH); and Hayatabad Medical Complex (HMC) in Peshawar; and the Ayub Medical Complex (AMC) Abbottabad.

None of these researches have tried to study the process of autonomy from the point of view of implementation and none has studied it using interpretive approach.

(Hospital) Autonomy considered by its initiators/implementers as an objective, formal and hard reality depicted by its formal proposals, rules, legislative Acts, and formal actions is indeed a subjective construct brought in existence by the interplay of various social actors involved and related to the arena of health management especially at the tertiary level. This social reality is constructed through the interaction of these stakeholders who are again influenced by its environment be it social, economic, political, geographical, historical or international. All of the formal stakeholders

including politicians, federal and provincial bureaucracies, doctors (both technical/professional and administrator) etc. who were thought to have power/authority and influence in this arena had their own meaning of the term (hospital) autonomy, influenced by their interests (institution, position, objectives, expectation etc.). Apart from these, other stakeholder including employees, patients and media also had their own meaning of the concept. The position of these different stakeholders was so far apart and their objectives/meaning of the concepts was so divergent that consensus on one meaning was next to impossible. This situation is explained by relative power distribution that stakeholders possessed in the society and at different decision points. Whosoever had more relative power at one point in time prevailed at that particular situation.

Autonomy is defined as personal freedom, ability to make one's decisions and delegation of power to lower cadres so they can take decisions independently. So, autonomy has a lot to do with power i.e. delegating and using power. The meaning and significance of power varies from society to society and is explained by its history, social structure, relationship of government and society, view of the fellow human beings and the world view held generally by the society. With respect to power, societies vary, as was explained in the famous study of Hofstede (1983). He explains power distance as: "the extent to which members of a society accept that power in institutions and organizations is distributed unequally. A society's Power Distance norm is present in the values of both the leaders and the led, and reflected in the structure and functioning of the society's institutions". In a society which he considered to be high on 'power distance', where everyone has the tendency to use power, to retain power and where those on the receiving end of power equation respect it and want to grab it themselves and use it when they get the opportunity, autonomy is supposedly a scare commodity. It becomes even more apparent in the wake of elite culture where powerful are absolved of any crime and pathetic law and order situation where laws and rules are like the nose of wax which can be molded by elite to suit their interests.

So the meaning of autonomy, its giving and taking are embedded in the society of Pakistan and can be understood only its natural context. The understanding of this concept will be very helpful in understanding the social dynamics of the society in Pakistan.

4.70. Conclusion

Literature surveyed in this chapter has first identified different types of implementation and conditions under which a particular type is likely to be used. It has also touched upon the fact that implementation is not just a managerial task which is to be planned by policy makers and then handed over to the implementers for implementation, rather a political one which if ignores power dynamics in a society may end up as a total failure. Cognizance of this fact leads us to explore the power dynamics of the society. Since state is the strongest institution in a country, its nature is discussed in the light of the concepts of globalization, governance, nation state etc. It also requires the study of history of state in Pakistan both pre and post-independence which may enlighten us about the nature of state – society relationship, and role of power in it. This aspect has been explored in previous chapters. Other related issues like democracy, rule of law and accountability have also been discussed.

Previous section based on the review of the related literature is a prelude to the chapter on the presentation, analysis and finding of the data that was collected during this research. This particular research was directed toward answering two questions i.e. what happened? And why did it happen? with regards to the implementation of hospital autonomy initiative at SHL.

As has already been discussed that various reforms having market-orientation were implemented under the rubric of neo-liberalism in majority of the countries of the world including Pakistan. Apart from other reforms like privatization, deregulation, Public-private partnership etc. reforms of autonomy of teaching hospitals were also introduced in first at federal level and then on provincial levels. After experimenting them at federal level, they were introduced in couple of provinces including Punjab. Under these reform a significant amount of changes were introduced in different aspects of the hospital including governance mechanism, management, finance, HR, purchasing etc. These changes which incurred huge amount of costs, changed the outlook of the hospital. It made hospitals responsible for arranging for their own expenses, which forced them to introduce user charges, slash free medicine facility and increase charges of different nature.

In a finance-starved country like Pakistan which only spends around 10% of its GDP on the social sector, it was a shocking jolt to its poor masses on both accounts i.e. costs of introducing reforms and withdrawing of medical facilities which were already meager and insufficient. With this context placed in perspective it becomes very essential to understand *what actually happened* with reference to the reforms of hospital autonomy and then to analyze and find out as to why and how all this happened, what were the causes of happenings, what are the results of the reforms, and what was the reality of the reforms,

This research has made a modest effort to find out the answers to these nagging questions because therein lies an opportunity to understand the dynamics of governance equation members of which are the rulers and the ruled. And the solution of any problem depends on how and how well the diagnosis of a problem has been made.

Chapter 5

REALITY OF HOSPITAL AUTONOMY: Observations, Narratives, Findings and Analysis

5.10. Introduction:

This chapter attempts to answer the two research questions. In doing so, the researcher presents the research findings and analyzes the data gathered from different sources during the research process with the help of three constructs of the conceptual framework i.e. macro context, micro context and their impact on the process of implementation of hospital autonomy.

First question is about the narration of the process of implementation, identifying its course, peculiarities, turns and twists, and nature and issues. The journey will be traced retrospectively, using sense making technique, right from the inception of the idea, making of the policy, implementation at federal level, conception at the provincial level, and then implementation at provincial and hospital levels. Answer to the first question will be based on presentation of the primary data gathered from various stakeholders through interviews and observation. Data related to all the three constructs i.e. macro, micro contexts and their impact on implementation process will be employed to narrate the story. Other secondary data housed in official documents will also be used to fill gaps in the case study.

Second question relates to finding out why the reform of hospital autonomy was implemented in a particular way in which it was implemented. It calls for making use of back ground knowledge, knowledge gained from societal actors and embedded in people, and documents. These include knowledge about global factors, historical factors, governance mechanism and style, center-province relationship, culture, politico-socio-economic factors etc. The analysis of this data will help us understand the underlying factors and reasons which impacted the implementation process and led it to take the route that it took.

The relevant data will be presented in each level and then will be analyzed so as to clarify its role in the implementation process of hospital autonomy. At the end, a focused summary will be presented to further enlighten the understanding of the issue.

5.20. Analysis and Discussion for question 1:

The first question of the research was:

"How the policy of hospital autonomy was implemented at the Services Hospital Lahore, Punjab?"

This required explaining the detail of the process as it went along during its trajectory. This has been done in earlier part of the chapter. It is also important to explain different characteristics of the process as has been covered by the literature.

5.30. The Case Study:

The case study is based on the analysis of primary and secondary data gathered from various levels and different sources such as donors as de facto policy makers, bureaucrats at federal and provincial levels as their supporters in policy making and implementation, politicians as official policy makers and guardian of the implementation process, doctors as participants in designing the reform and then acting as implementers/ administrators at various teaching hospitals, and as practitioners, employees of the hospitals; past data and use of academic literature.

The policy making and implementation of hospital autonomy reforms in Pakistan is found to be a very complex, informal and interactive process which cannot be mapped and explained by any formal text book on the subject. Though provision of health services is a local subject, yet it is strongly influenced by national policies which in turn are strongly affected by global politics including policies of donor agencies.

As these policies were implemented in hospitals, hospital actors were sure to be affected by these policies. And since they were also entities having their own objectives and interests, they also impacted, mediated, and implemented the policies in hospitals. The actual trajectory of the implementation process was thus the result of the interplay of all these actors.

5.301. Policy Implementation of autonomy reforms at SHL:

Services Hospital Lahore was chosen as a case study to demonstrate the complex nature of the process of policy making and implementation of Hospital autonomy reform in the context of Pakistan. Services Hospital is among the 13 teaching hospitals which were granted autonomy in the province of Punjab. It is situated in the city of Lahore, capital of the province of Punjab. It would not be out of place to give here, a brief background of the different phases of the process of implementation of Hospital autonomy.

5.3011. Services Hospital, Lahore (SHL): An overview

Services Hospital has been chosen as a case study to understand the phenomenon of autonomy as it was understood by various stakeholders involved in the governance level. Services Hospital is a general/teaching hospital working within the administrative domain of provincial government of Punjab. It is affiliated with Services Institute of Medical Sciences which was instituted by the Government of the Punjab in 2002. Earlier it was affiliated with Post Graduate Medical Institute (PGMI), Lahore.

In 1958, a separate OPD exclusively for the Government patients was set up in Mayo Hospital, Lahore. After two years, it was shifted to its present location, having 55 beds capacity, with the name of Wahdat Hospital, Lahore. In the same year, it was renamed as Services Hospital, Lahore. It was affiliated with AIMC (Allama Iqbal Medical Complex in 1977 till AIMC shifted to its new location near Johar Town in 1995. Later SHL was affiliated with PGMI. The hospital was made autonomous in 1999.

SHL provides almost all medical and surgical specializations available in Pakistan to its patients. According to the estimates of SHL administration, around 612,863 patients were treated in 2005 and around 2000 patients visit OPD of SHL daily to receive medical treatment.

There are 19 departments in medicine and surgery combined and the current bed capacity of the hospital is 1196. The maximum number of wards is 5 which are in general surgery and general medicine has 4 wards.

Location of SHL is such that injured passengers of accidents on inner city, Motorway M2, Multan Road and Ferozpur road can be rushed to it speedily.

Its location makes it convenient for the inhabitants of Shadman, Ichchra, Samanabad, Gulberg, GOR I, II and III, Model Town, Garden Town and other nearby localities to visit SHL for medical treatment.

The services of more than 462 professional and competent Doctors including Specialists, senior registrars, MOs/SMOs/WMOs/SWMOs, FCPS (Part-II) and house officers are available to SHL. The number of staff nurses is around 424 and the paramedic staff is other than that.

The budget for the year 2005-06 of the hospital is as under:

Institutions	Amount Rs.(m)
Services Hospital, Lahore	575.812
[12]SEMS	47.667
[13]SIMS	187.289
Nursing School	14.387
Total	825.156

Table 5.1: Budget for SHL year 2005-06

In the year 2005, 623,697 patients approached OPD of SHL for treatment. SHL provides free services/treatment to a large number of patients e.g. in year 2005, 63% of patients were provided the facility of diagnostic services free of cost. (Source: Performance report of SIMS and SHL, 2005)

Services Hospital can be seen as an open system having links with different stakeholders of the society.

The idea of hospital autonomy was initially introduced at the Federal level in early 90s. FMOH with the technical and financial support of USAID introduced this concept. It was implemented at two hospitals namely Pakistan Institute of Medical Sciences (PIMS) and Federal Government Services Hospital (FGSH). Under the arrangement of the scheme, it was also introduced at the province level, whereas conclusive evidence was not available to prove the reform achieved its acclaimed objectives at federal level.

[12] Strengthening of Emergency Medical Services

[13] Services Institute of Medical Sciences

In the province of Punjab, it was introduced in 1998 with the promulgation of an ordinance which was later ratified by provincial assembly. Most of the Teaching Hospitals were granted autonomy and their management was shifted from the control of Provincial bureaucracy to the new structure. During the next decade, the process has continued adopting a punctuated equilibrium sort of pattern. The process was punctuated by various twists and turns which saw the process halted, re-started with new vigor, redirected by various power players. The story of the process is presented in the following pages to appraise the reader of peculiar nuances of the culture and commonalities found with other environments.

The findings of the case study are presented in the following pages in such a manner that the global context comes first, followed by the national context and at the end description of the implementation of the reform is presented.

The findings is further analyzed using the notion of sense making which can help explain a social reality participated and influenced by different actors that might have distinct objectives and aims.

5.302. Global Context

The structure and role of state has undergone a sea change in the recent past. From a stronger, dominant and intrusive role, it has turned smaller, regulatory in nature and has delegated a good number of its functions to other sectors. All this has been done under the influence of the process of globalization. "(T)he state has not only adopted market-driven policies such as streamlining, privatization, deregulation, and liberalization to transfer its major socioeconomic activities to the private sector, it has also transformed the remaining public sector into businesslike entities in terms of role, structure, orientation, and organizational culture" (as cited in Haque, 2002, p. 104). Different globalization forces, institutions, and regimes "have prescribed or advocated, adopted or imposed, major policy reforms" spanning different aspects of life in number of third world countries. "In particular, the Bretton Wood institutions such as the World Bank and the International Monetary Fund have used both covert influence and overt pressure on the economically vulnerable Third World nations to adopt such policy reforms in favor of globalization" (as cited in Haque, 2002, p. 103). All this "is in line with the preconditions of globalization

requiring minimal state intervention and maximum market expansion" (Haque, 2002, p. 104).

While depicting the situation which involves implementing different types of reforms in various countries of the world, Haque (2002) states that

> based on the prescription and pressure of the World Bank and the International Monetary Fund, massive privatization and deregulation initiatives have been undertaken in most Asian, African, and Latin American countries. Some of the well known examples include Argentina, Bangladesh, Brazil, Chile, Indonesia, Malaysia, Mexico, Nigeria, Pakistan, the Philippines, South Korea, Thailand, Uganda, and Venezuela (World Bank, 1994a, 1994b). In these countries diverse modes of privatization, including divestment, leasing, equity sales, management contracts, and corporatization, have been adopted in major sectors such as telecommunication, airlines, electricity, petroleum, automobiles, television, fertilizer, tobacco, banking, insurance, and so on." (p. 109).

Health sector being part of the social sector which has erstwhile been taken care of by the government also got hit by various such reforms. One of the early momentous initiatives of this area was the World Bank's World Development Report (1993), "Investing in Health". It saw the delivery of the healthcare services as a tool to achieve economic development which might be realized through improved health of the populace rather than being the result of economic growth.

This movement put aside most of the efforts and vision that Alma Ata Declaration, 1978 with its slogan being "Health for all by the year 2000" envisaged. Alma Ata Declaration was considered to be a quantum leap towards improving health of all humans on earth. Pakistan was among the 130 countries who were signatories of this conference. Declaration V of the conference says that 'Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life'.

The tool suggested to achieve this objective was Primary Health Care which

1. "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
2. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience." (Declaration of Alma-Ata, 1978)

One of the doctors (DEA6) commenting on this said that 'there was a worldwide trend that hospitals were being given autonomy and were expected to run independently without any financial obligations towards governments'.

5.303. Federal Context: Pakistan

Health reforms were introduced as part of their international agenda by International Financial Institutions in most third world countries which were entangled in debt trap. Pakistan at that time was engaged in the so called Afghan Jehad – war against USSR as a proxy to USA. It was economically ruined because of war and was forced to seek financial support from IFIs. So in 1990, with the support of the U.S. Health Care Financing Administration (HCFA), FMOH conducted a broad based survey to identify areas where 'organizational and financing reforms' could be undertaken and which were to be financed by donors.

In 1992, the services of United States Agency for International Development (USAID) were made available to the government of Pakistan. USAID provided the services of HFS to FMOH. FMOH with the technical assistance of HFS interacted with a broad range of stakeholders and resultant report was presented in a workshop in 1992. The findings took the shape of a report titled "Policy Options for Financing Health Services in Pakistan" which was presented to the government of Pakistan. It identified four areas of priority for the healthcare sector. These are as follows:

- Development of a quality assurance mechanism for hospitals
- Granting autonomy to government hospitals
- Development of private managed-care insurance

- Development of new financing and organizational models for rural health delivery services (Hildebrand and Newbrander, 1993, p. ix)

A number of workshops were conducted during the process of finalization of the initiatives and ultimately in 1993 a final decision to experiment the concept of autonomy in Islamabad Capital Territory (ICT) was taken. Two hospitals were chosen for the purpose namely Pakistan Institute of Medical Sciences (PIMS) and Federal Government Services Hospital (FGSH). One administrator at PIMS revealed during interview that 'since the introduction of this concept, some seventeen different types of arrangements/ restructurings have been tried in this hospital till 2008'. After the implementation at Federal level, the autonomy initiative was to be taken up by the provincial governments first as test cases in certain hospitals and later all hospitals were to be granted autonomy on this model. Financial assistance for the projects was provided by the donors. The overall result of these initiatives was thought to be that "Pakistan's health sector would become more financially sustainable and the growth in the government's resource burden for health would be reduced" (Makinen, 1993, p. 1). The detail of the recommendations of this report will be provided at the appropriate place.

As the experiment was in process at federal level, it was expected of provincial governments to start spade work for the concept simultaneously. Resultantly a situation analysis was conducted by DOH with assistance of World Bank. Granting autonomy to the hospitals was proposed as the remedy for all these ills.

5.304. Provincial: Punjab Hospital Autonomy Project (PHAP)

Under the guidelines and recommendations of the report, DOH envisioned a project to test the hypothesis "that the granting of greater managerial and financial autonomy to government hospitals in Punjab province would cause these hospitals to improve the quantity and quality of their services" and to develop systems, protocols, standard operating procedures (SOPs) and mechanisms for the protection of the poor. To launch this pilot project extensive technical assistance was required coupled with equipment and manpower support. World Bank agreed to the financial support up to US$5 million out of total cost of US$6m for the project from the Learning Innovative Lending (LIL) track (WB Report No. PID6895, p. 1-3).

The project identified a number of problems in the running of teaching hospitals which included "poor attendance of staff morale; absence of service standards; low quality of services; lack of participation of stakeholders; inappropriate financial, management and information systems; and insufficient resources". The project tested the hypothesis that "these problems can be significantly reduced, and services improved, by granting these hospitals a large degree of managerial and financial autonomy, coupled with performance agreements and clearly delineated managerial accountabilities". It proposed that these targets would be achieved with the poor equitably sharing the benefits of the improvement and without putting extra financial burden over the government. These objectives were to be achieved "through a combination of better governance, increased efficiency and enhanced resource mobilization". This pilot project included "three large teaching hospitals and one DHQ hospital in Punjab Province, in three different cities. Each of the hospitals had more than 500 beds and a medical college was attached to three of them". Initially the project covered the emergency department and later it was to include Pediatrics, and Obstetrics and Gynecology (WB Report No. PID6895).

Side by side, Department of Health (DOH), Government of the Punjab, in 1998 conducted an assessment survey to determine the factors that affected the performance of the public health sector. The report[14] identified various structural and management problems in the health including complex and multi-tiered organizational structure, centralized planning, centralization of authority, lack of proper and reliable information system, weak human resource management, inappropriate and inadequate training, overstaffing and understaffing at the same time, incentives not performance-based, subjective performance appraisal, ineffective monitoring and supervision, inadequate financial support, problems in provision of pharmaceuticals, supplies and equipment.

The report also identified various service delivery issues plaguing the public hospitals which included political interference, staff absenteeism, out-of-pocket expenditures (unofficial fees) in public facilities, Low & erratic level

[14] Decentralization, Autonomous Institutions & District Health Government, Department of Health, Government of Punjab (official document) , 1999

of equipment functioning and diagnostic services, tendency to promote costly medicines ignoring the cheap effective alternatives weak referral system, ineffective checks and balances at all levels, minimal community involvement, and low level of community awareness.

Four options were considered to be available to address the issues mentioned above. These options are as follows:

a) Leave the things as such – tendering with the existing system
b) Privatize the Health Facilities and reduce financial burden
c) Improve efficiency through decentralization of authority to existing management structures
d) Introduce a new participatory governance structure premised on devolution of powers to the institutional level and redefine the government role.

Eventually it was decided that the (d) option be adopted and hospitals should be given autonomy.

In a coup d' état by Gen. Perveiz, the government of PM Mr. Nawaz Sharif was sacked. However the autonomy initiative in hospitals continued under the PM&HI 1998 till the year 2002. Most of the hospitals were being run on the whims of the CEs of the hospitals in the absence of rules which were never framed. Though some individuals in some hospitals showed considerable improvements in certain areas like free medicine, improved cleanliness, and better discipline etc. still as a system it could not develop and criticism were poured on them from different quarters.

Moreover after the Oct 1999 takeover of the military regime, the army administration got involved in the matter. They let it continue till the end of 2002. However in the absence of formal rules and incomplete structure of IMC, the system either could not work or was not allowed to work and the process was stalled in 2002. But it was not long before hospital autonomy was re-launched with new zeal and zest after introducing a number of changes through PM&HI Ord. 2002 in the same year.

The new set up functioned for only few months before the new government (military) suspended it as well on the grounds that it has failed to achieve its desired results. Moreover, different stakeholders including media criticized the system strongly and highlighted its drawbacks. Thereafter,

another fact finding commission[15] was constituted under the headship of Justice Mujaddid Mirza which was required to look into the complaints originating from different stakeholder and come up with suggestions regarding changes in the system.

In the light of the commission's report, yet another piece of legislation in the shape of 'Punjab Medical and Health Institutions Act 2003' was enacted and present setup is being run under this legislation (PM&HI Act 2003). The following pages provide a detailed view of how all this unfolded in a span of a decade.

5.305. Mapping the territory:

As has earlier been mentioned that the autonomy is defined as delegation of powers and Hildebrand and Newbrander (1993) report which was the fundamental and most comprehensive document on the issue suggested that the autonomy be given in three areas i.e. governance, management and finance. Employees working in an organization are considered to be the most important resource of an organization. Even if an immaculate and efficient system is in place, it will not bear fruit in case employees are not willing and able to carry out tasks assigned to them. So if autonomy was to be granted in three areas mentioned above and the control of employees remained in the hands of DOH, in reality autonomy will be considered not transferred. If the very people who were to be delegated the powers in the areas of governance, management and finance, remained subordinated to the officials in DOH, in reality the delegated powers would still be in the hands of DOH. The same concerns were raised by different informants when the researcher inquired them about the reality of autonomy. One respondent (B2) said that 'service structure of the doctors was not touched much and is still being looked after by the health department'. Another respondent (DEA5) was of the view that 'autonomy will be meaningless until HR function is also delegated to the hospital administration'. So for the purpose of the study, HR along with other three functions will be taken as constituting real autonomy.

[15] Justice Mujaddid Mirza Report (2003)

The recommendations of Hildebrand and Newbrander (1993) report titled "Policy options for financing health services in Pakistan" in the area of governance was that the ownership of the hospitals should remain with the government, that financing should be shared between the government and the private sector, that a board comprising of the representatives of government, the concerned community, and the medical profession should be granted the power to oversee the operations, management, and financing of the autonomous hospitals. The boards, in lieu of the complete responsibility towards hospital, were to be given commensurate authority to hire and fire the employees and to reward performance through performance related pay.

In the sphere of management, hospital management was to be entrusted the task of selling their services to the paying patients. And for this they needed to develop and learn new skills with the assistance and experiences of private sector. Administration was expected to develop their mission and their marketability. It broadly suggested a structure be made up, at the top, by a board of directors, who will hire an Executive Director (ED) and will head the top management of the hospital. ED will be assisted by Deputy Directors (DD) in areas like administration, finance, nursing, medical, support services. And these DDs were to oversee the middle management.

In the area of finance, the recommendations were based on the belief that "operating and capital funds can largely be made up from user payments on a phased basis over a ten-year period". The hospitals were expected to raise finances "by increasing utilization of their services, by improving the efficiency of their operations, and by generating more revenues from patients" (p. 11). The inability of the patients to pay for the health services was to be managed through the insurance and zakat [16]mechanism.

Having presented the salient features of the report, we now turn towards discussing details of the three attempts on the initiative of the autonomy i.e. PM&HI Act 98, PM&HI Ord. 2002 and PM&HI Act 2003 one by one with respect to four areas constituting autonomy. We start the section by

[16] Zakat is a compulsory tax to be paid by Muslims whose incomes are above a specified level. The tax is collected by Islamic state and spent on heads specified by the Holy Quran which include the poor and destitute. It can't be spent on Muslim who can pay Zakat.

presenting an overview of the situation prevailing prior to the autonomy initiatives.

5.306. Pre-Autonomy Scenario

5.3061. General conditions

"Public hospitals are an important part of health systems in developing countries, and depending on their capacity, act as first referral, secondary or last referral facilities, generally responsible for 50 to 80 percent of recurrent government health sector expenditure in most developing countries. These hospitals utilize nearly half of the total national health expenditure in many of these countries" (Khan et al, 2006, p.3). A situational analysis by the same report found hospitals characterized by "inefficient management and highly centralized decision making structures, with inefficient delivery of service, combined with decreased utilization of facilities and declining public confidence. Availability of medicine was poor and bed occupancy remained low with costly diagnostic and operative equipments remaining out of order. The whole system was found to be inclined towards the privileged and was unsympathetic to the poor. The overall quality of service was short of the expectation of patients and attitude of staff was generally apathetic and rather hurting to the patients (Khan et al, 2006, p.3).

One of the senior doctors (DEA6) commented on the issue by saying that

> 'previous system had miserably failed. System was completely centralized through the administration of DOH. Professorial staff did not perform their duties'. He further said that when he took over the hospital he found out that '76 hospital junior level employees working in the houses of different government official in the morning who would not attend the hospital'.

Another doctor (DA2) who was part of the planning and conception team which pioneered this project in Punjab and who later came to be the CE of another teaching hospital commented on the conditions that prevailed in pre-autonomy scenario in his hospital in this manner:

> 'Professor used to sit for only max of 45 min in the outdoor. They would take no lectures. Nurses' hostels had become a brothel house. There were 70 wanted criminals in the boys' hostels.

> Bathrooms were filthy. JHL had probably the best sports complex but chokes of flood lights were stolen. A large number of buses which needed change of spare parts and a little bit of service were declared scrap. We had an excellent sterilization plant provided by Chinese but it was lying out of order. Chinese engineers were living in the doctors' colony. When I asked them why they were not managing/maintaining the plant, they said that MS would not pass bills of small amount. On my request, they turned on the Plant in just one day. The sweepers had turned roguish and ill-disciplined. Every lab technician used to do second job in some private lab. Library was in chaos. Doctor had books issued for years. They had libraries established in their homes with library books on the pretext that they have to prepare for lecture. There was a professor who was also warden of boys hostel, free food was sent to his home daily for many years.

He also talked about the relationship between teaching hospitals and DOH by saying that the 'prior system was in total control of bureaucracy'.

As was narrated by one doctor (DA2) who was part of the autonomy initiative that 'the CM was my patient. We both were concerned with the deteriorating conditions of public hospitals and lack of proper health services to the poor'.

Yet another version of why autonomy was initiated was that during a visit of "Chief Minister to a teaching hospital located in Lahore he found that the equipment was lying unused simply because the hospital authorities had not been able to obtain the necessary permission from the Health Department for making these units functional" (Khan et al, 2006, p. 3).

'Previous system has miserably failed' were the comments of a senior doctor (DEA6) who was also involved in the designing of the autonomy initiative. The structure of provincial health department was split in two wings whereby the field service of health was looked after by Director General Health whereas the teaching and tertiary side was managed by Principals of teaching colleges and Medical Superintendents of hospitals. All these officials reported directly to the Provincial Secretary Health.

Teaching hospitals and attached medical colleges though were formally linked yet it all depended on the informal relationships of the heads of the two institutions as both directly reported to Secretary Health. As both

institutions were independent in structure but dependent on each other, any tension between the heads would render the smooth running and coordination a far cry. The main casualty of this sour relationship was poor patients.

5.3062. Governance

'System was completely centralized through the administration of DOH.' (DEA6) The hospitals were totally under the control of bureaucracy represented by DOH in provinces and Ministry of Health in federal area. It was the sole prerogative of the bureaucracy/ government to appoint head of the hospitals. Hospitals were managed by MS whereas the attached teaching hospitals had principals. All the policy decision making was carried out by the DOH. Doctors had no say in the policy making and could only give suggestions. In the matters for transfer, posting, recruitment, enquiry, creation of posts the institutions could only make requests/ proposals to the bureaucracies wherein lied the real power to make decisions.

5.3063. Management

Management was carried out by the doctors/administrator appointed by the DOH and in line with general trend in society most of the appointments were political in nature. In the view point of one senior doctor (DEA6) 'professorial staff did not perform their duties' in the hospitals. He went on to say that

> 'some of the problems in pre-autonomy situation were that the professors/consultants did not attend the outdoor; conditions of cleanliness were pathetic; the private rooms were allotted to the MPAs who had occupied the rooms, and persisted with their possession; equipment were outdated and new machines became useless without them being unpacked.

5.3064. Finance

One of the major and perennial problems for the hospitals has been limited resources and insufficient utilization. And this was understandable given a constant 0.6% of GDP allocation for health sector since pre-independence

era for most part of life since its independence. This increase is attributed to some development expenditure for the construction of BHUs.

Most of the financial decisions were made by Department of Finance in consultation with Department of Health. The hospital administration could only make proposals. Purchasing decisions of all hospitals were also done centrally by the DOH. The process was very bureaucratic and lengthy and 'lack of comprehension of the actual needs of this highly specialized and technical sector killed or distorted most initiatives'. 'And the medicines thus purchased were of very mediocre quality' (Bilal: unpublished report). Finances were distributed on ratio basis based on previous allocations and not on rational need based framework. One officer who also worked in different autonomy–given hospitals explained the previous scheme in the following words:

> Hospitals were given grants by DOH but hospital administration was not authorized to expend the resources on their own. If the hospital administration wanted to purchase some machinery or equipment, they would prepare a case giving justification for the purchase and send it to DOH. The summary will move from section officer up to the secretary and then back to section officer. If the permission was granted, the summary will be sent to the DOF where it will again go through the same process and then the project will be approved. Then the tendering process will start and the lowest bidder will be given order. Hospital administration then would make bills and submit to AG office which will after going through the due course prepare the cheques which then would be handed over to the concerned party. In certain cases the machines purchased will be outdated or not up to the specifications with the result that the equipment will live rest of its life in the packing boxes – never opened or made use of in the hospitals. In this scenario, the MS was principal accounting officer, but he was virtually powerless.

While commenting on the relative power of MS and Secretary Health, he said that 'in pre-Autonomy situation MS had minimal powers. He was only allowed maintenance expenses up to Rs.20,000/- which is just a peanut. And ultimate powers lied with Secretary Health'.

5.3065. Human Resource Management

The HR function of the hospitals was in total control of DOH. Appointments of doctors were made through PPSC whereas all other HR activities including promotion, leave, annual evaluation etc. was in the hands of DOH. One respondent (DA2) while expressing his views on different HR issues which were being faced by doctors in pre-autonomy situation said that"

> 'there was no system for the training of your doctors. FCPS which was established in 1962 could not deliver. PMA was in the hand of people like Kh. Sadiq and Mehmood Malik who only served their interest. There was no system for doctors' promotion. They were promoted through PPSC. This is gross injustice. Why Doctors should go through this procedure when bureaucrats, army officers get departmental promotions'.

Apart from applying for various services, doctors had to go to secretariat by themselves and get their application through by using connections, bribery etc. One doctor (DEA6) expressed his views on the topic in these words 'selection was done through PPSC which were delayed till the sons and daughters of influential passed the exams. There was nepotism all around'. Hospital staff was also hired by DOH. Whimsical postings, erratic staffing, nepotism and political influences were some of the ailments which plagued the hospitals due to centralized control of the bureaucracy. The recruitment of doctors on permanent basis was stopped completely since 1996/1997 at base level that is PBS-17. "The junior doctors are more frustrated because of an insecure future. There hasn't been any recruitment of doctors by the provincial public service commission for the past over 10 years and those hired on contract are working under pathetic conditions. Many young doctors are leaving the country or are even leaving the profession" (Syed, 2005).

On the other hand, in hospitals 'absenteeism, lack of punctuality, unionism' were rampant and patients were the main victim. 'In certain hospitals the staff and doctors were surplus and in others seats were lying vacant'. For example 'in the De` Montmorency College for Dentistry in Lahore as against a sanctioned strength of 8 full Professors in various disciplines of Dentistry, it only had 2 who were also reported to be on their way out' (Bilal: unpublished report, p. 15). Likewise 'the tension between teaching an non-

teaching doctors was rising as teaching doctors enjoyed more benefits and privileges while non teaching doctors had to do most of the work in hospitals'(Bilal: unpublished report, p. 15). This gulf was due to the nature of the jobs where former enjoyed better terms.

5.307. Punjab Medical & Health Institutions (PM&HI) Ord. / Act 1998

5.3071 .Introduction

The abovementioned scenario prevailed in teaching hospitals and was cited by DOH in one of their documents as causes for initiation of autonomy. Whether autonomy was the remedy of all these ills or not, it was implemented in a momentum created through the pressure of donor agencies. Consequently, in a hurry the "Punjab Medical and Health Institutions Ordinance, 1998" was issued through Governor of the province and later PM&HI Act 1998 was promulgated by the Punjab Assembly in 1988 by virtue of which decision was made that all teaching hospitals and attached medical colleges in Punjab be granted autonomous status in phases.

According to Decentralization (1999) report of DOH,

"The following four hospitals were granted autonomy in the first phase of the project.

- Jinnah Hospital & Allama Iqbal Medical College, Lahore.
- Lahore General Hospital, Lahore.
- Holy Family Hospital & Rawalpindi Medical College, Rawalpindi.
- Punjab Institute of Cardiology (PIC), Lahore.

A 3rd party study was conducted in 1999 by DOH for the abovementioned hospitals which reported that visible improvements were noticed in the following areas:

- Punctuality of staff
- Availability of consultants in outpatients department
- Admission procedures
- Diagnostic services

- General Cleanliness
- Repair & maintenance of equipment

Third party also recommended improvement in the following areas:

System development, especially Management Information System and Financial System

Protocol and procedures standardization for emergency handling

The findings and recommendations of the 3rd party encouraged the policy makers to replicate autonomy to other institutions in the province. Later the following hospitals were granted autonomy in 2nd and 3rd phase'.

Phase-II

- Sheikh Zayed Hospital, Rahim Yar Khan.
- Bahawal Victoria Hospital & Quaid-e-Azam Medical College (QMC), Bahawalpur

Phase-III

- King Edward Medical College, Mayo Hospital, Lady Wellingdon Hospital and Lady Aitchison Hospital, Lahore.
- Nishtar Medical College & Hospital, Multan
- Services Hospital & Post-graduate Medical Institute (PGMI), Lahore.
- Sir Ganga Ram Hospital & Fatima Jinnah Medical College (FJMC), Lahore
- Children Hospital & Institute, Lahore
- Allied Hospital & Punjab Medical College (PMC), Faisalabad"[17].

5.3072. Governance

With the issuance of ordinance CEs took charge of the affairs of the hospitals including SHL on 02/08/99. According to the clause (5) of PM&HI Ordinance 1998, the composition of the IMC was based on the following pattern:

- Chief Executive — Chairman
- Dean/Principal of concerned Medical Institute — Member
- Medical Superintendent of concerned hospital — Member/secretary

[17] Decentralization, Autonomous Institutions & District Health Government, Department of Health, Government of Punjab (official document)

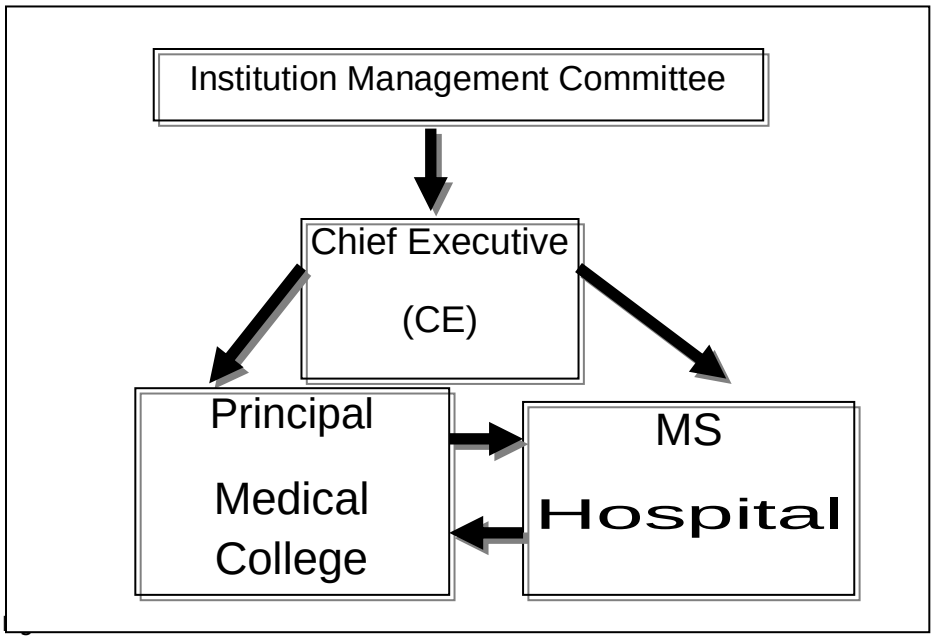
- Five non official members proposed by the members listed above and approved by the Government.

The non official members were to be proposed to the Government by the official members i.e. CE, Principal and MS of the hospital. The Government was then to scrutinize the nominated members and to give its approval. In case of any disagreement, the Government was to re-invite proposals for approval of the nominee.

The establishment of the IMC was left to the respective CEs perhaps in the spirit of granting autonomy to the hospitals. According to one very senior doctor who also held administrative postion in the hospital (DEA6), 'an IMC was constituted to manage the affairs of the hospitals independently. There were 3 official members and 5 non official members. The list was sent to the DOH later'. But as this initiative meant depriving bureaucracy in DOH of their powers to control the affairs of the hospitals, it willingly or otherwise did not play any role in approving the IMC with the result that it never was constituted in most of the hospitals and same was true for Services Hospital, Lahore (SHL) as well. And in some hospitals where it was formed, it was the CE who handpicked the members as he alone was considered responsible for this for he has to run the hospital. In case of members being nominated by CE, it was natural that CE would be in authoritative position and members would be obliged to take the stands adopted by the CE. Under these circumstances, IMC could not perform the task of accountability of the CE and turned out to be a rubber stamp in the hand of CE.

However, as narrated by CE SHL (DEA6), 'Instantly afterwards (before the IMC members' names were sent and approval was granted by the government) all the government departments including DOH, Finance, C&W and AG office, which hitherto were providing various essential services to the hospitals were pulled back by the bureaucracy' on the ground that now when autonomy has been granted, it was all CE's affair. Instead of this being a smooth transition where services could have continued till hospitals developed their own capacity for such services, an abrupt pulling back the services meant disaster for the hospital. It certainly was a big ask from CEs, most of whom were mere medical doctors and did not have management degrees or enough experience for such a test.

The below-mentioned diagram shows the relationship of different management personnel in the top management hierarchy of a teaching hospital. Though the IMC is shown superior to the Chief Executive (CE) in this structure, yet in the absence of IMCs the Chief Executive emerged as the key figure in this arrangement. A whole long process was followed before reaching this stage.



Source: DOH

In SHL, no IMC was set up till the last with the result that CE had complete powers as well as responsibility in this respect. And since no rules were framed to control and regulate the performance, relationships and behavior of the people at the helm of affairs, the exercise turned into a one-man-show.

5.3073. Rules of the game:

Rules are a must if an organization has to work effectively and to persist continually. As has been mentioned earlier that this initiative was a foreign idea - introduced and backed by International Donors and implemented by very strong political government - a very rare phenomenon in Pakistan, so

the bureaucracy in DOH willingly or otherwise did not play any role in the development of the rules.

In the pre-autonomy situation, it was bureaucracy which was running the hospitals, so when this new idea was discussed and thrashed out among political leadership, DOH and Doctors/ administrators, the framing of the rules should have been on the top of the list. One government official representing the DOH revealed that 'IMCs were developed however no rules were framed for the regulation of committees'. One respondent (DEA6) during interview told the researcher that 'bureaucracy did not want to give autonomy, they were made to do so by the then CM Shahbaz Sharif. When bureaucracy could not stop it they created hurdles in that' (DA2). According to clause 5(3) of the PM&HI Act 98, "no act or proceeding of the (Institutional) Management Committee shall be invalid merely on the ground of the existence of any vacancy or defect in the constitution of the Management Committee". In practice, no rules were framed/ approved with the result that CE had to take a number of decisions on his own to run the hospital. Had he not taken any decision, CE would be blamed of incompetence and incapacity.'

As per the official arrangement, it was Chief Executives of the hospitals who were to frame the rules which were then to be submitted to DOH, with final approval coming from the political leadership. A senior doctor (DEA6) who was part of the pre-autonomy framework and later became CE of SHL told that 'all rules were framed; everything was in black in white. The rules were sent for approval to DOH. Meanwhile the army took over and everything was hushed up because bureaucracy did not want it to succeed'. Another respondent (E3) expressed his views on the issues in these words;

> bureaucracy deliberately let the things go as they were aware of their strength in the system and knew it would be difficult for the management to defend their decisions in the absence of any formal rules. And when the limit was crossed and autonomy started looking dysfunctional, a heap of criticism was poured on the management with the result that everything was reversed and strings were again in the hands of bureaucracy. As the real responsibility of provision of health services lies with the government, it was bound to come back in the lap of bureaucracy - being part of the government. Till today a lot of audit paras

> (objections) are still pending against the decisions of the management of the hospital.

Abdullah and shaw (2007) put forward another point of view. According to them:

> The powers of the CEs were predicated on them working through the IMC, but the initial nominations of members for these committees, proposed by the CEs were blocked by the Provincial Government on the grounds that it went against the spirit of autonomy for an official to nominate non-official committee members (p. 52).

By combining all these contrasting viewpoints, the last one appears to be most plausible and close to reality and thus sums up the issue.

5.3074. Management

Autonomy meant differently to different stakeholder. CE in SHL took autonomy as complete independence from DOH and in the absence of any formal rules or IMC, had to make all kinds of decisions in his jurisdiction including hiring new contract employees, drawing higher salary (the amount of which was though indicated by the government during pre-autonomy meetings but was not notified), local purchase of imported medicine at much lower than the market rate, getting costly equipment repaired which was declared scrape long ago etc.

Such decisions by a doctor were too much for bureaucracy which had complete dominance and control in the affairs of the hospitals in erstwhile system. Whether made in good or bad faith, these decisions later were not owned by the bureaucracy and consequently a number of audit objections were placed against such decisions for not being as per government rules (which existed in pre-autonomy state of affairs).

The first CE (DEA6) of the hospital narrated one such incidence. He said that

> when he took over as CE, a large number of junior doctors who had cleared FCPS part I were working without any salary. Some money was lying in one head so he decided to divert that amount towards the salary of these doctors with every one getting Rs. 7000 each. The next day, the news was flashed as a scandal (*perhaps on the*

> *behest of someone bent upon failing the system or was it media always in search of some news worthy item*) that CE had distributed money among his near dears. So the Governor called him. He defended his position stating that hospitals were run by junior doctors and not by professors. How long could they go along with that injustice? Then in the meeting 2500 paid seats of junior officers were created. He was made head of the committee. There arose the issue of how would the seats be distributed on which he proposed that it should be decided on the basis of the strength of the hospital. The total salary of the teachers was decided to be Rs. 8000 per head inclusive of basic salary plus different permissible allowances. The summary went to the finance department which objected to it by raising a technical issue that since these posts were training posts, therefore they could not be given any allowances. Consequently their salary was set as low as Rs.4210/- which was the basic salary part.

While narrating another such incident he said that 'whenever any foreign qualified doctors approached him he offered them jobs in the hospital. He opened a number of new departments including plastic surgery, neurology, with their help'.

Then he gave the example of centralized purchasing of medicine by the DOH. He said that

> they (DOH) bought local cheap medicine which was not really effective. I proposed them that medicine should be bought from multinationals. If we can buy in bulk, we can get it around 40% off from market rate as companies will be saving on packaging, labeling, advertisements etc. The whole system was to be managed by a pharmacy which would also raise finances for the hospital. At the pharmacy medicine will be bought from multinationals in bulk, much below the market price and sold to the public with some margin but below market price. In case of Clefron which was priced as Rs.243 and its price for retailers was Rs.220. I bought it at Rs.170 and sold it at Rs.225 in pharmacy of the hospital thus earning Rs.55 on medicine and that money was again spent on buying more medicine for the patients.

He also referred to the issue of private practice whereby

> he encouraged the doctors of the hospitals to start private practice in the hospital. In the earlier system, there was no incentive for

> the doctors whose share was only 35% and further tax cut even reduced this amount. More over there was no income for the hospital as the rest was taken by DOH. So, the new scheme was approved. This scheme approved 80% share for the surgeon and 20% for the hospital. Hospital income through this scheme increased by Rs.9m out of which Rs.2.7m were the result of CE practice. This one-year-income was more that the income earned by hospital in 50 years. I also earned lot of money but it was my effort. Later I was blamed of corruption and of taking away huge amount of money. In fact it was my hard earned money and I paid share to the hospital as well.

Commenting on yet another administrative issue he told the researcher that:

> when he took over there were 52-seater buses standing on bricks in the hospital. They had already been declared scrape. He spent around 1-2 lacs (0.1 or 0.2 m) of rupees and they were in first class condition. Buses were on routes for employees without any fare.

Pointing to another administrative issue, he said that:

> there were around 76 hospital employees working in the houses of different government official in the morning. I pulled them back for the service of the hospital. There was a lot of pressure on me from various officials but I showed firmness. One official rang me asking in a very angry tone why his employee has been taken back. I asked them to which organization the employees belong to? When replied, services hospital, I enquired how come then they are your employees. Later that evening that official came to my office in a very changed and light mood asked if that employee can continue working in his home after official timings of the hospital. I told him that I had no objection once they are free from the hospital.

He also mentioned his performance with regards to infrastructure where 'improvements were made and outdoor was shifted to its new position. A new 140 bed emergency was built. He also thought of developing an intensive care emergency but could not get formal approval.

> There was also other side of the story. As one of the senior employees of the hospital put it 'Chief Executive hired media men who would keep him and his activities in media. A cycle of self praise, public relations started which badly affected patient care.

> In Post-autonomy scenario, even the staff of CE became very rude and treated employees with disgust. Now more emphasis was on number and infrastructure e.g. how many machines are out of order or in working conditions? How many equipment were purchased? How many rooms were built, how many patients were treated?

In response to the claims of the CE with regards to the provision of medicine produced by multinationals one employee of the hospital told a different story. He said that:

> there was one MS who worked in pre-autonomy scenario. He was very honest, sincere and efficient doctor. Moreover, throughout his service he served at SHL, so he knew every employee and doctors by name and by nature. Some people despised him because of his tough behavior, but he never penalized anyone for his liking and disliking. He was happy with the one who delivered. As he knew all the backdoors and loopholes, he slowly centralized everything. By his efficient working he had the stocks of medicine completely filled. There was still enough medicine for the next whole year when the budget for the next year was announced. The management of the hospital pondered on what to do with this year budget for medicine. So they decided to purchase costlier medicine and propagated through media that SHL is providing such and such medicine. The result was that the number of patients to SHL increased appreciably, but when that stock was finished the quality of medicine decline to the old standards. Later when the autonomy came in to effect, they could not go along with the MS and he was changed only after two years.

In one instance narrated by one employee of the hospital (E2), some doctors asked a patient to fetch some medicine from the dispensary; he was told at the dispensary that the medicine was out of stock. When he informed the doctors, one of them remarked that 'you should have brought 3 or 4 bricks' (referring to too much civil work going on in the hospital). In the absence of IMC, there was no body to whom CE was accountable and results were whimsical decisions in certain cases. All those anomalies were later judged and audited through the prevailing government rules and the researcher was informed by different sources that till today a large number of audit paras are still pending against the CE.

In the case of complete unchallenged authority in the hands of the CE, the management of the hospital which was CE's team became very arrogant and derogative towards their subordinates. A senior employee of the hospital (E2) threw light on the issue by saying that, 'the powers to hire and fire made officers very stiff-necked, and abusive. One female doctor who became MS was very abusive and did not spare anybody. So much so that an AMS who was abused had a heart attack. They would order food from McDonalds and sit till late and order employees to stay in the office with them without offering them any food or incentive'.

While pointing towards other drawbacks of the system, he said that:

> patients suffered in many ways in post-autonomy scenario. One aspect is the increased user charges which made treatment difficult for the poor. Secondly, patient care was replaced by rhetoric and report making. Earlier there were 250 or so house officers and each ward had around 10 officers. They would prepare the patients for the operation next day, will have all tests done and all other necessary arrangements. Now the number of nurses and doctors has decreased. This has resulted in the deterioration of the patient care level. There was a lot of emphasis of reports which were demanded by Government and supplied by the hospitals. Moreover, now more emphasis was on how many machines are out of order, how many have been repaired.

One bureaucrat (B2) expressed his views about the effects of autonomy by saying that

> 'poor have been the main victim of the system. Charges of health services have shot up. Their surgery is delayed for months. Doctors use space, facilities, reputation of government hospitals and get share from the income of the hospitals. They get share from the income generated by operations in the morning as well. They are making lacks of rupees. They have no professionalism'.

Perhaps all this was inevitable in a situation characterized by lack of responsibility, rules or IMC. However decisions had to be made to keep the hospital running. The same CE would have been blamed had the hospital stopped due to pending decisions.

5.3075. Finance

The autonomy was given to the hospitals hurriedly through PM&HI ordinance 1998. As has been mentioned earlier that no sooner did the ordinance was issued bureaucracy pulled back all the services previously being provided to the hospitals including financial support. And according to CE of the hospital,

> in one week's time a cheque worth Rs. 62.7 million for the salary disbursement was received by the hospital and there were no official in the finance department to manage the affairs. This was managed within one week by hiring Deputy Director Finance and employees of the hospital had their pay slips in their hands.

As far as salaries of the CEs were concerned it was decided at the outset that they will be paid as per the market rate which was thought to be around or more than two hundred thousand rupees whereas in their regular pay scale they were getting roughly around 50 thousand rupees. But what actually transpired was that no further headway was made in this regard by DOH. In this vacuum where no rules existed, some heads of the institutions had the salary paid to them by the hospitals in which they were working and those who waited for some official mechanism or permission in this regard from DOH kept on waiting till the last without any success. According to one of the CEs (DA2), 'we were promised a salary of 250,000 pm however for the three months that I worked there I was not given a single penny nor any arrears were given to me later'. One of the officials of DOH also gave more or less the same comments. According to him (B2), 'they (CEs) were not paid equal salaries and some even were paid nothing. Some were on regular pay scales and others were hired on contract with hefty salaries in laks'[18].

5.3076. Human resources

As has been substantiated earlier that autonomy would have been meaningless in case of HR functions not being transferred to hospital administration. However under this scheme, human resource functions of all doctors and employees above Grade 17 largely remained within the control of the DOH and were not transferred to the respective

[18] One lak = 100,000

boards/management of the hospitals despite. When the idea of autonomy was floated, lot of people resisted it considering it to be a threat to their permanent job. Moreover they wanted to continue receiving benefits and security of the government job. To eliminate the resistance and make this idea palatable, the services of Grade 17 and above officers were not transferred to the respective hospitals. Since this group had power in the system, so to accommodate them, the scheme was amended. However, it strongly dented the actual spirit of the reform.

Though doctors served in the hospitals yet they were not directly answerable to the CE, especially professors who always guarded their independence strongly as in certain cases some professors were senior to CE. Moreover they were specialists and enjoyed complete freedom and authority in their area of specialization. So they wanted to preserve their autonomy. According to one respondent (DBP1) 'Professor Doctors who were in line control as head of medical college but performed their duties in hospitals were found not being answerable to MS hospital, sought to find some solution of the issue'. This scenario violated the principle of unity of command and raised the question of their accountability which was never addressed as this group enjoyed inherent powers.

Moreover it also meant that these officers including doctors will remain under the control of DOH but this idea is totally against the spirit of autonomy. If the doctors, who were to be delegated management of the hospitals and who were to be autonomous in their decision making, remained under the control of DOH, the spirit of the autonomy will be defeated. How could they be able to free themselves of the influence of DOH and how could they be able to make independent decisions? And if they could not, the autonomy will be meaningless. On the contrary, most of the officials of DOH wanted to enjoy health services for themselves, their family and acquaintances, so they would never hold them accountable by any wrong done by them in the hospital.

5.3077. Aftermath

According to one official of DOH (DBP1),

> 'meanwhile third party evaluations were carried out by a local auditor. Some mystery client surveys were also conducted. In the result of the findings, a number of professors were suspended due to being absent from their jobs. This created a backlash; they moved their strings in political and social arena with the result that lots of criticism erupted in media and government circles'.

Due to the different reasons mentioned earlier, a general sense of dissatisfaction with the autonomy initiative either evolved in response to the performance of hospital administration or impacted by certain stakeholders. The martial law administration under Gen Musharaf's after some deliberations decided to halt the process.

5.308. Punjab Medical & Health Institutions (PM&HI) Ord. 2002

5.3081. Governance

One of the officials of DOH (DBP1) told that 'army government took over and stopped the initiative/ reform. Then army monitoring teams were established, and they conducted independent inquiries. Later on, despite a lot of criticism from bureaucracy and politicians, army rep announced the resumption of the intervention'. The autonomy initiative was again re-launched through (PM&HI) Ord. 2002. This ordinance was the next step in the punctuated equilibrium of the process of implementation of autonomy in the province of Punjab. Autonomy status of the hospitals was reinstated only after a month of halting the process. This time around the role of government in the development of the structure of the management was quite prominent and imposing and bureaucracy came back strongly which in fact defeated the very spirit of autonomy, at least from the perspectives of doctors' community. According to one of the doctors (DEA6), 'and in 2002, the whole (previous) system was put to halt and a new scheme was designed which offered few powers to the administration of the hospital headed by BOG. The administration thus made was toothless and most of the actions needed further approval of the Health Secretary'.

A very fundamental issue which came to the fore during the process was the absence of accountability mechanism. The institution of IMC was suggested in the previous scheme; however it could not be formed for reasons already stated. The CE of the hospital was to suggest the names; but no government official was to be a member of the erstwhile IMC as that would have gone against the spirit of autonomy. However in this new scheme the over arching body which was named as 'Board of Governors' (BOG) included two members i.e. Secretary Finance and Secretary Health who were part of bureaucracy. Moreover, the right to appoint non-official members was taken back from head of the institution and now DOH was to provide the list and Governor had the powers to approve the final names. Alike observations were made by a former CE of the hospital about the changes made in the later schemes in these words:

> 'In 2001, Hasan Waseem Afzal (Secretary DOH) and Dr Mahmood (minister for health) introduced certain changes in the rules in 2001 which took certain powers back. In 2002, the whole system was put to halt and a new scheme was designed which offered few powers to the administration of the hospital. The administration thus made was toothless and most of the actions needed further approval of the Health Secretary'. The members of BOG were given handsome packages including various perks and benefits. Apparently, the selection of non-official members was not transparent as such procedures were laid down for appointment of members which would suit the whims of the officials of DOH. The board was also entrusted with most of the powers including the power to remove the Principal Executive Officer (PEO) if needed without assigning any reasons. In this scheme of things, most of the powers lied with the BOG and not with the CE (who was called PEO in new setup) as was the case in the first arrangement. Of course DOH enjoyed maximum powers as it appointed members of Boards, made rules and appointed PEOs. This situation was totally against the demands of doctors that they should be allowed to run the hospitals independently and be freed from the influence of bureaucracy.

While developing social knowledge humans naturally tend to get influenced by the previous knowledge. This was ever so evident from the new PM&HI ordinance. In the previous scheme, in most of the hospitals, IMCs could not be developed for reasons mentioned earlier with the result that CE became

all too powerful. This was perhaps the biggest drawback perceived by the bureaucracy. So in the new scheme CE who now was named PEO (Principal Executive Officer) was given minimum powers and BOG was given all the authority even to remove the PEO without giving any reason. Moreover they were entitled to very lucrative salaries and benefits out of meager hospital resources. All the members had almost absolute powers in the hospitals. But this created yet another anomaly whereby BOG's accountability mechanism was forgotten completely. This resulted in misuse of power by members of BOG and they were reported to interfere even in technical aspects of the hospitals. This observation was also made by the Justice Mujjadad Mirza commission (2003).

The objectives set by the donors got influenced/ compromised by the local context and the autonomy now meant solving the local issues being faced by the hospitals and its environment and the context was represented mostly by local issues e.g. tussle between generalists vs. specialists. Others as indicated in a presentation by DOH to Governors were "constitution of board of governors, institutional private practice, security of service of government officers, surgical and medical audit, protection of poor and vulnerable, and role of the government" (DOH, 2002).

The following diagram shows the hierarchical relationships of various important officers in the top management of an AMI (Autonomous Medical Institution) as enunciated in the PM&HI Ordinance 2002 which was promulgated by Punjab Assembly on 19.01.2002.

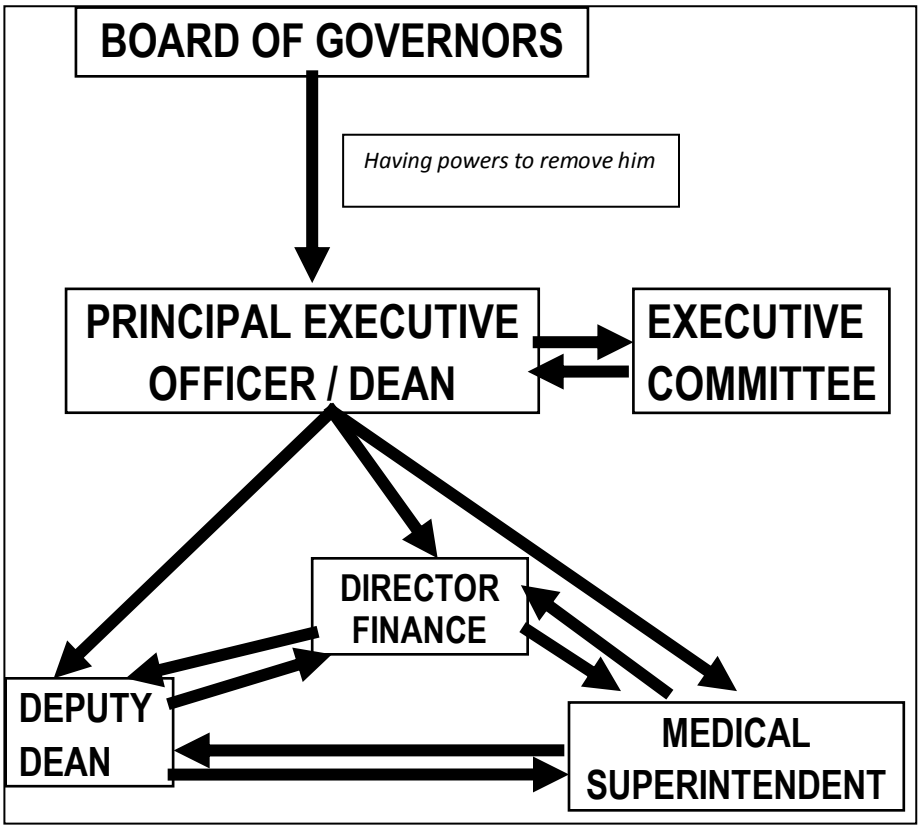


FIG 5.2: Structure suggested in the PM&HI Ordinance 2002

Source: DOH

5.3082. Management

Principal Executive Officer (PEO) also acted as Dean of the college. To manage the financial affairs of the Autonomous Medical Institution (AMI), a position of Finance Director was created. The Deputy Dean, Director Finance and the MS of the hospital worked under the leadership of the PEO. For day-to-day business the Ordinance provided for constitution of Executive Committee comprising PEO as its Chairman and Deputy Dean, Medical Superintendent, Director Finance and a nominee of the Board of Governors as its members. It took DOH six month to select Boards of Governors and get their approval from the Governor Punjab.

Official powers of government with reference to AMIs are explained under clause (8) of PM&HI Rules 2002 which reads as " Government may require

the Principal Executive Officer of Board of Governors to furnish any information, return, statement or statistics regarding any matter concerning the institution and give directions in furtherance of the objectives of the ordinance". That shows clearly the extent of autonomy and independence from control of bureaucracy these rules have provided to AMIs.

The performance evaluation methods laid down for hospitals employee were also the same which were used by other government offices. Under this arrangement officers were required to fill a form called ACR which was finally submitted to the DOH. The necessary details of this ACR schemes are laid down in Rule # 11. In the same vein AMIs are obliged to follow the relevant Provincial government rules for discipline, general conduct, Pension, General Providence Fund etc (Clause 12). The obligation to follow government rules was surely bound to render the autonomy initiative meaningless as these detailed, cumbersome rules were likely to rob the hospitals of its ability to make quick decision under autonomy. Consequently, hospital administration became dependent upon government departments for their understanding, interpretation and implementation.

5.3083. Finance

The comment of a senior doctor of SHL (DEA1) sums up the story about the grant of financial autonomy to the hospital under the scheme. He said that 'bureaucracy never passed on the financial powers to the hospitals. Even the purchasing has to be done through the purchasing manual of the government. They wanted that hospitals earn money by themselves and spend by their standards'. Hospitals were dependent on the government for the grant of the necessary resources. Referring to the powers of the BOG the clause 2(ii) of the PM&HI Rules 2002 says that "Board may request the Provincial Government to sanction additional Grant-in-aid on case to case basis".

Director Finance was now to be a BPS 19/20 grade officer from Audit and Accounts Department, Government of the Punjab. He has to work on deputation in the hospital and needed recommendation of the PEO for its posting there [clause 13(3)].

Powers of varying degree have been delegated to Board of Governors, Principal Executive Officer, Deputy Dean, and MS with respect to creation and abolitions of posts, approval of development work, auctioning of surplus items, sanction of telephone, purchase and replacement of motor vehicles, their parts etc, purchase of medicine, machine and equipment, stationary, paying different utility charges and fee. This certainly appears a big, genuine improvement at least on paper.

5.3084. Human resources

PM&HI Ordinance and Rules 2002 mentioned about shifting the services of the existing employees to the respective institutions however they were to remain under the services of the government and were liable to be transferred to other institutions under the government (clause 8). Due to the still existent pressure and influence of bureaucracy on the current system, staff including senior doctors still unconsciously considered Govt. rules as criteria for running the hospital. There was not much difference in the conditions prevailing under PM&HI Act 2003 either.

The selection of officers BPS 17 and above was to be managed by the 'Departmental Selection and Promotion Committee' which was to be nominated by BOG. The approval of these selections was the prerogative of the BOG. The selection of employees of BPS 16 and below were also the responsibility of the Committee, however it did not require the approval of BOG rather 'Executive Committee' was competent enough to approve such recommendations.

5.3085. Aftermath

This ordinance attracted strong resentment and criticism from the doctor's community and media. Consequently Government appointed a commission under the headship of Justice Mujjadid Mirza to look into the complaints made lodged by different quarters.

A number of criticisms on the constitution and performance of the members of the Board from multiple quarters were recorded in Justice MuJaddad Mirza Report on Autonomy (2003). Some of them are 'majority of non-technical (medical) persons in the Board, Secretary Health and Secretary Finance having absolute powers to approve the decisions of BOG,

interference of members of BOG in technical activities of the hospital, absolute powers of BOG to sack PEO without giving any reason, and no accountability mechanism for BOG'.

In the light of the commission's report, yet another piece of legislation in the shape of 'Punjab Medical and Health Institutions Act 2003' was enacted and present setup in being run under this legislation (PM&HI Act 2003).

5.309. Punjab Medical & Health Institutions (PM&HI) Act 2003

5.3091. Governance

Again in this Act, the previous happenings influenced the structure and its details. BOG, its unlimited powers, perks of the members etc. were done away with but what was not curtailed was the power and influence of bureaucracy which became even stronger as the official permanent members of the board. Listing, selection and nomination of the non official members were now the sole prerogative of the DOH. In the same vein, DOH had the right to appoint "Principal … among the teaching cadre" who all along had been under the control of DOH (clause 7). The final selection authority of MS of the hospital was again DOH which has to select him out of the three, proposed by the Board (clause 7). Hospital officers and employees were to be governed by the "Punjab Civil Servants Act, 1974 and the rules made thereunder" (Clause 9).

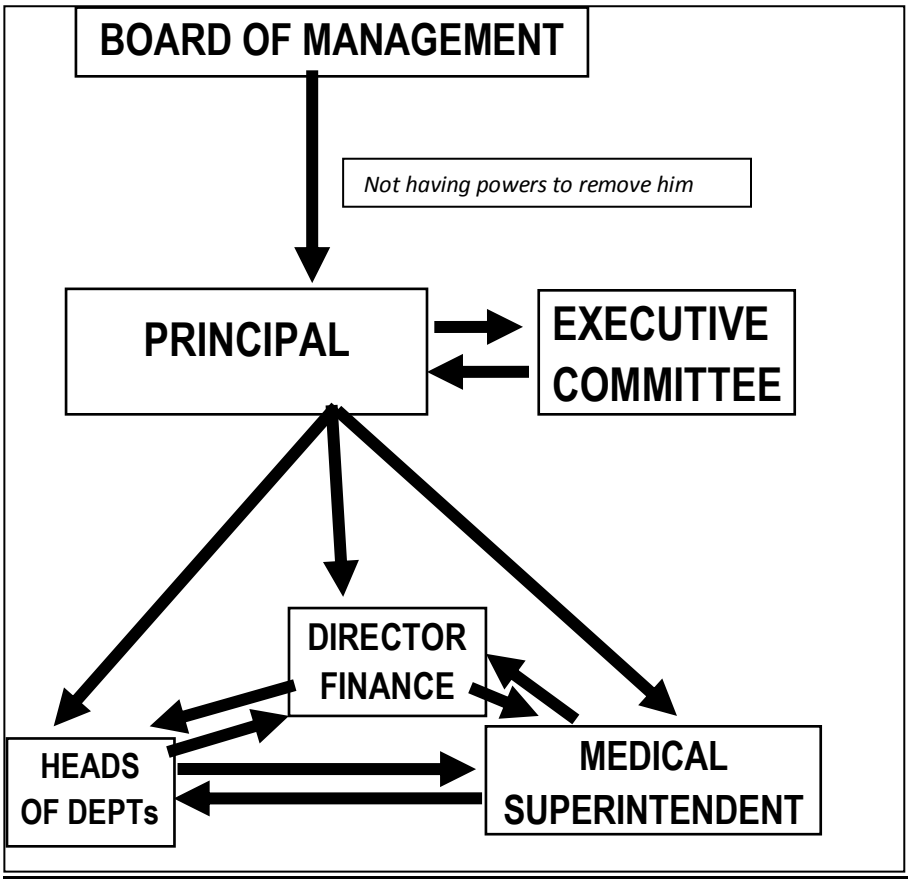


FIG 5.2: Structure suggested in the PM&HI Act 2003

Source: DOH

The above mentioned diagram shows the governance/management structure proposed under the PM&HI Act 2003. The following observations were made by an official of DOH (B1) about the structure. He said that:

> through a legislation i.e. 2003 Act, the triangulation administrative network of Principal, MS (may be more than one e.g. KE) and Dir Finance under BOG was set up. MS also has to act as secretary to BOM which eats up much of his time which actually should be devoted towards management and clinical issues of the hospital. MS is normally a seasoned doctor having experience of around 20-25 years on the other hand Principal is generally not that experienced. Moreover, MS has to work under Principle who has got most of the powers and MS works as his subordinate'. While referring towards the heads of the Boards one official of DOH (B1) said that '(t)he

chairmen of the Board were picked from general public and specially industrialist to achieve the following objectives:

1. They will assist institutions in getting donations from philanthropists.
2. They will offer donation to hospital from their own resources.
3. To make the hospital financially viable so that the financial support from government is reduced gradually'

As detailed in the following table 3, Board of Management (BOM) replaced the BOG. In the previous scheme, the real power lied with the BOG. Moreover, it consisted of known personalities from different prestigious professions except from health sector. One of allegations placed under the 2002 scheme as discussed in Justice Mujjadad Mirza Report, was that BOG members, none of whom was a professional doctor, started poking nose in the day to day professional affairs of the hospital. In the new scheme, the power to sack the principal was taken back from the board and now Principal was the one who holds the actual power. Moreover all the perks and benefits provided to the members of the Board were withdrawn and they were only entitled to some TA/DA on the day of the meeting. Frequency of the meeting was once every three month in the previous scheme and now it is once a month. The membership of the executive committee which was constituted to run the day to day affairs of the hospitals and which included PEO, one nominated member of BOG, Deputy Dean, MS and Director Finance was broadened and now one doctor representative of junior doctors (Grade 17/18) and Head Nurse have been included in the committee. The government had retained the right to nominate these two members.

A brief comparison of PM&HI 2002 ordinance and 2003 Act is as follows:

Issue	AUTONOMY UNDER PM&HI ORDINANCE 2002	CHANGES INCORPORATED IN PM&HI ACT 2003
Objectives	• To improve Medical and health Institutions • To give them autonomous character in order o To provide quality and affordable health care with special dispensation to poor and vulnerable sections of society o To enhance the quality of education in health sciences	Establishment and efficient management of Medical and Health Institutions
Name of governing Board	Board of Governors	Board of Management.
Secretary of the Board	Principal Executive Officer	Medical Superintendent
Whether Board had the powers to sack PEO/Principal	YES	No mention/powers taken back
Number of official members	3	4 -Excluding MS
Number of non-official members	Five	Six
Pool from where Non-official members will be chosen	Educationist, Eminent Jurists, Financial experts, philanthropists, management experts, distinguished retired Civil/military Officers	Eminent retired Professors of Medical Colleges, renowned retired Doctors from General Cadre added to the previous list
The perks and privileges of non-officials members	To be determined by the Board of Governor.	Not entitled to any perks and privileges
Tenure of a non-official member	5 years	4 years
Removal of Non-official member	May be removed by Govt. without assigning any reason	No mention of such provision
Meeting Schedule for BOG	Once in three month	No mention
Title of the Head of the institution	The Principal Executive Officer (PEO)	The Principal

Table 5.2: Comparison of PM&HI Ord. 2002 & PM&HI Act 2003/Source: (Malik et al, 2003)

While commenting on the governance structure of the hospital, one employee of SHL touched the issue of power distribution between MS and the Principal. To show the extent of the power of MS who is responsible for the management of the hospital, he (E3) expressed the following views:

> In the pre-Autonomy situation MS had minimal powers. He was only allowed maintenance expenses up to Rs.20,000/- which is just a peanut. And ultimate powers lied with Sec Health. The current situation is no different where MS is subordinated to Principal who is supervised by the Board. And Secretary Health along with Secretary Finance is the official member of the Board. In such a system responsibility is not fixed and passing the buck is the norm of the day. While explaining his point he narrated an example where one MS - fully authorized officially, allowed the construction of a bath room. Bath room was constructed. However later on the principal who happens to be the boss of the MS strongly disliked the construction and ordered a major change in the design.

One former CE of the hospital (DEA6) stated that 'it is powerless as compared to the initial scheme where CE was all in all and need no approval from DOH. In current structure, most of the decision needs endorsement from Secretary Health'.

5.3092. Management

One official of the DOH (B1) mentioning the drawback and internal dynamics of management structure of the hospital stated that "(b)ecause of an air of competition between MS and Principal, Dir Finance develops a nuisance value (e.g. JHL has a staff of around 100 men under Dir Finance. Receptionists are under his control".

5.3093. Finance

It was the observation of many interviewees which included bureaucrats, government officials, and hospital administrators etc. that autonomy will be meaningless until the hospital which is given autonomy is financially independent or it has assured financial inflow which can be expended as per the discretion of the hospital authorities. The reality of the autonomy in AMIs can be gauged from the fact that 'they receive up to 95% of their resources from government' as was explained by the one respondent (B3).

And there is no difference between pre or post autonomy scenarios as far as this ratio is concerned. The rest 5% of resources of AMIs used to be generated through user fee and parking fee etc. However the current political government (in 2010) in order to be politically popular has announced that no parking fee will be charged in AMI's parking. It has also announced that there will be no hospital charges for beds or operations and that medicine will also be free. This decision has provided as sigh of relief to inflation-burdened society. Yet from the perspective of financial resources of the hospital, this on the one hand has resulted in the drying up of whatever finances hospitals were raising from their own sources and on the other has resulted in the complete consumption of the funds in only 6 months which in fact were to cater for the whole year's need of the hospital'.

The following expressions of one employee of the hospital (B3) corroborate the observations of the researcher in this regard.

> Autonomy without financial aspect is meaningless. The original scheme of autonomy considered reducing the governmental financial liability towards hospitals in phases. However this is impossible in our case. The new government had to make some popular political decisions to gain some popularity. In line with this policy of government, parking fee was waived off, self finance fee for MBBS in attached teaching hospital was disallowed and free medicine and medical tests were ordered for the patients. So hospital was deprived of whatever resources it was generating itself. All this resulted in the consumption of the budget in 6 months which was meant for full year. Letter after letters were sent to Sec DOH for additional funds but to no avail. No more money was sanctioned. And hospital administration was left alone to face the brunt of hapless poor patients.

While throwing light on the comparison of the current and previous financial management systems of hospital the same respondent (B3) said that:

> In the current scheme i.e. 2003, the tasks which were erstwhile the responsibility of AG Office have now been entrusted to Director. Bills are prepared and cheques are issued by DF. Cheques are signed by Principal and DF jointly. The cheques are then sent to the Treasury office, which works under the control of Finance

> Department. In the recent year(i.e. 2010), unprecedented floods have put great financial pressure on the provincial government so in most of the government department, situation is pretty critical. While further explaining this situation, he told the researcher that the salary cheques of the employees for the month of July have still not been cashed and now the salary of August is also due for which cheques have also been sent[19]. Only yesterday hospital was informed that it had been decided in principle that the salary cheques would be cashed only after the hospital furnishes a certificate confirming that the cheques were of salary and not any other item. In other instances, the cheques against equipment purchased and installed are sent but are withheld and not paid by the treasury office. However those parties which can bribe or have political clout or relationship with bureaucracy get their cheques cleared.

5.3094. Human Resource Management

With the promulgation of PM&HI Act 2003, rules were also revised and now these rules take care of hospital management including human resources of the hospitals. As far as human resources are concerned not much has changed. Board can hire employees in 1-16 grades on contract. The appointing authority for officers above Grade 17 is the government with special selection board having powers to recommend. This recommendation is of course not binding on the government.

PM&HI Rules 2002 talked about transferring the services of the government employees to the institution but in 2003 Rules, no such intention is shown and employees have to remain under the control of the government.

In nutshell, by virtue of being the appointing and controlling authority for Boards, hospital administration and doctors and officer in Grade 17 and above, bureaucracy has complete control on the running of the hospitals is situation is more favorable to bureaucracy right now than what it was in pre autonomy scenario i.e. pre-1998 era.

[19] The meeting took place on 31/08/10.

5.310. Conclusion:

Through the details presented in the previous section, the researcher has made a humble effort to construct a story narrating how the process of implementation of hospital autonomy took place. The objectives and meanings of the concept of autonomy were in a constant state of flux all through the process. Different stakeholders had a peculiar meaning of the concept which reflected their interests. At different points during the process, different stakeholders had relative power status; however in most of the situations, it was one group of stakeholders who was more powerful than others. In such a scenario, the meaning of the powerful stakeholder prevailed over that of others. It was able to dictate its terms and to get its version of autonomy established at that specific point. So the actions related to the autonomy were derived from the meaning that prevailed. At other points during the process, the power dynamics would have changed. The power had shifted to the other stakeholder due to the alteration in social conditions and now his meaning of the concept was valid and held sway. This new meaning would demand different kinds of actions which will lead to different outlook of the concept.

Furthermore, in the face of so many meanings of the concept held by various stakeholders, the evaluation of this reform becomes very tricky. Each meaning imposes different conditions and demands different kinds of results. An effort can be made to find out as to what extent the objectives of each meaning of the concept got realized independently, however, it would be unrealistic to expect an overall evaluation of the reform.

5.311. Analysis of the Implementation Approaches:

5.3111. Top-Down

As is evident from the data presented above that initially, the top-down approach was adopted for the implementation of the reform of hospital autonomy. IFIs including IMF and WB had been instrumental in forcing upon most of the third world countries such policies as privatization, deregulation, autonomy etc (for details see Terris, 1999; Haque, 2002). Such policies have been thrust upon them as conditionality for receiving loans. Pakistan is among such countries which were hit by these reforms.

FMOH, Government of Pakistan adopted these policies which were then implemented first at federal level and later at the provincial level.

The report developed by Hildebrand and Newbrander (1993) explains the process of developing this report whereby number of meetings were arranged involving different stakeholders which were "aimed at improving quality, efficiency, and equity in the Pakistani health system" (p. 14), and gives the impression that the intervention of autonomy along with other three solutions which included standard and accreditation of Hospitals, Insurance system, and Organizing and Financing rural health services evolved out of consultation among various stakeholders. For example it says that:

> This consultative approach was designed to gain the benefit of the wisdom and experience of all the important actors in the Pakistan health sector. It was also intended to build consensus for the proposed approaches to the reform and for the designs chosen to carrying them out" (p. 4).

However, abundant literature on implementation of autonomy intervention in other countries of the world on the same lines and principles led by IFIs suggests that the solution were pre-decided (Charoenparij et al, 1999; As-Sayaideh et al, 2002; Bossert et al, 1997 etc). All such activities were only a case of impression management. This qualifies one of the characteristics of the top-down approach which places policy makers at the centre of the process. The whole process revolves around policy makers and they are the ones who call the shots and other stakeholders are not in the picture at all. Those for whom policy is being developed are outsiders. The policy is not devised to cater for the needs and issues of the masses rather it gets its inspiration from the objectives of policy makers. According to Hunter & Marks, (2002) "(p)olicy failure or an implementation gap can occur when policy is imposed from the centre (meaning top/federal) with no thought given to how it might be perceived or received at local level" (p. 7). This amply explains why reform of autonomy faced such eventuality.

Second characteristic of this approach is that it considers policy making and policy implementation as two distinct processes. As has been explained in the case study that it were principally donors and then FMOH which were involved in the policy making. And once the objectives, policies, funds etc. were agreed, and put in place, their role diminished to a greater extent. In

the centre stage now were provincial governments and hospital administration which were expected to carry out the policies and to implement it on the ground. This shows that the implementation approach adopted for this reform initially was top-down.

Contrary to what Pressman and Vildvsky (1973) observed in their project in Oakland, here in the case of autonomy, there was no unanimity or consensus on the objective/goal of the project. Though at the planning stage piloted by IFIs, all present at the policy forming stage endorsed their view point, yet, as the process unfolded, and whenever they found the ball in their court, every stakeholder made all his efforts to dress his meaning on the phenomenon of autonomy.

Brian Hogwood and Lewis Gunn (1984) are among the top-down theorists. Their proposition/ suggestions encapsulate most of the thoughts of this approach. Their approach suggests that given these suggestions are followed the likelihood of the success of implementation will be enhanced. Here the researcher would like to analyze the implementation of autonomy reform through the lenses of their suggestions.

1. Their first proposition suggests that external environment should not create hurdles in the smooth implementation of the process whereas different meaning held by other stakeholders tuned out to be main hurdles. If we analyze the external environment in the case at hand, it appears that the environment was not all that supportive and it did impose crippling constraints on the implementation. For example, autonomy as suggested by the donors was likely to divest bureaucracy of its strong financial and bureaucratic control over healthcare system including hospitals. As the policy descended on them from the top which included FMOH, IFIs and political government, they could not withstand the pressure and gave in. However, the moment the policy making stage ended and implementation stage begun, bureaucracy was able to impose its influence. It used different measures which could undo most of what deprived them of their authority and control. Their role in pulling back the services of all support departments from hospitals, indifference in making rules for autonomy, and lastly, the ultimate picture of autonomy where their control over hospital affairs was restored with the responsibility to provide health services to the

public shifting to hospitals administration, are but few evidences which prove the point. Other crippling constraints came in the shape of removal of political government by Martial law administration which actually owned the reform. Then there was War on terror, which took away all the focus from reform related issues to those concerned and created by the war. Thus, the external circumstances created numerous hurdles in the process.

2. Next proposition was about sufficient time and resources which should be made available to the program. Contrary to this the main objective of the program was to reduce government's financial obligation towards public hospitals. Instead of improving the provision of resources, the objective was to reduce resources. In such a scenario, the question of providing sufficient resources is really an irrelevant one. However adequate time was given. When the program took route other than the one originally planned, it took more time, and its deviation away from the desired objectives was even greater. So ample time available here was a disadvantage instead of being a support to the program.

3. This proposition related to the fact 'that policy to be implemented is based upon a valid theory of cause and effect'. The aims and assumptions of the initiative as enunciated by the report produced by Hildebrand and Newbrander (1993) are presented below.

> This report is based on the assumption that concrete benefits would result from allowing hospitals currently owned and run by the Government of Pakistan to begin to operate as autonomous entities. These benefits would include reducing the amount of government funds needed to run these institutions by replacing much of the public subsidy with user fees. Autonomous hospitals would operate using private-sector management principles which are expected to improve efficiency in operations, contain costs, and raise the quality of health services. This would be done while still retaining the hospital's social mission of providing free care to those who are unable to pay (p. 3).

The theoretical foundations of this reform and other such reforms which were directed towards reducing the role of government and

increasing that of private sector came from New Institutional Economics. Such reforms have been accused of benefiting "the few while overlooking the worsening problems of internal poverty and unemployment and external uncertainty and vulnerability, erosion of citizens' access to basic services due to these reforms, including withdrawal of subsidized welfare services and reduction in public sector employment, not to mention the unaffordable market-based prices of various public sector services" (Haque, 2002: p. 114), 'hollowing out the state' (Barnett, 1999) etc. The changes in health sector have been even more painful. According to Haque (2002) "in many Third World countries in Asia, Africa, and Latin America, the government's financial support for some of the basic services has declined, and although these changes were pursued in the name of greater efficiency, they have adversely affected the welfare of low-income citizens in these countries" (p. 115). In some of the poorest countries including "Chile, Colombia, Ecuador, El Salvador, Honduras, Mexico, Peru, and Thailand" the public spending has been below 3% (p.114), whereas in Pakistan it is constant at around 0.6% with only one exception where it rose to 0.7% for one year.

According to Terris (1999) "the World Bank published in I987 its Financing Health Services in Developing Countries: An Agenda for Reform, which proposed "an agenda for reform that in virtually all countries ought to be carefully considered." This included four policies: (1) charge users of government health facilities; (2) provide insurance or other risk coverage; (3) use nongovernment resources effectively; and (4) decentralize government health services" (p. 153). These four policies are very much similar to those presented in the report of Hildebrand and Newbrander, (1993) which became the basis of Hospital Autonomy Reforms in Pakistan. Terris (1999) later informs that "(t)his is the strategy which is being applied worldwide, in the industrial as well as the developing countries" (p. 154).

Moreover, these reforms take citizens as customer. This analogy is very problematic. Among citizens there are poor and rich; government traditionally levied taxes on the rich and the poor were subsidized. Government was expected to take care of at least basic needs of everyone in the society irrespective of their ability to pay

for them. Whereas customers are those who are able to pay and so not all citizens can be customers therefore those who can't pay are deprived of their right to live. In a society where around 70% of the population is living below poverty and struggling for two meals a day, it would be very unrealistic to expect from them to pay the proposed user fee. According to Terris (1999), ""the adjustment policies have served to aggravate the social, political, and institutional breakdown which to a greater or lesser extent had begun to take place as far back as the I970s" (p. 154). The impact that these policies had over the masses in Pakistan is not much different. So the validity of this theory is really questionable rather it has inverse cause and effect relationship to the one it proposed.

4. With reference to the next point, the relationship is found to be opposite to the one suggested, so there is no question of it being a direct relationship and not to mention of their being any intervening variables.

5. This point calls for having a 'single implementing agency'. However in this particular case, there was no single administering/ implementation authority which would take the process all along till its end as was the case in reforms in education sector in Pakistan where the institution of HEC was designed and developed to ensure the implementation of varying policies of education reforms (Jahangir, 2008). In other words, the process was not managed by a single institution which would oversee its implementation process from start to finish.

   Moreover, there were more than one implementing agencies e.g. FMOH, DOH, Hospital administration/ doctors and they had strong dependency relationships. DOH being provincial institution strongly depended on FMOH – a federal ministry for policy guidance and resources, hospital administration was appointed by DOH and it also depended on it for policies and resources. Alongside being dependent on other agencies, these agencies also enjoyed fair bit of discretion in carrying out different policies. This discretion allowed different agencies to interpret and mould the process according to its objectives and interests.

6. The next recommendation of Hogwood & Gunn (1984) was that there should be complete agreement on the 'objectives to be achieved' and that this condition should continue till the end. What actually transpired in this case was totally opposite to this. Not only differences were found among different stakeholders on the understanding and meaning of the concept, there was total disagreement on 'objectives to be achieved' based on their personal agenda and interest. This disagreement continued till the end of the process, with every stakeholder bending the trajectory of the process wherever it could, to suit its objectives. Thus this case could not qualify even this condition.
7. The requirement of the next point was that the details, sequence and tasks to be performed should be immaculately delineated so that success in implementation is achieved by mere following the detailed plan. With reference to the case study, it has already been pointed out that there existed no agreement among the stakeholders regarding the objectives of the process, with the result that no details were planned and agreed upon. And if there were any proposed by the predecessor, the successor did away with that in the light of its own objectives.
8. The last point asked for perfect communication mechanism and the ability of the authority to obtain complete obedience. When the researcher approached some doctors in SHL, they told that they were never part of this plan. They were never communicated as to what was the need, objective and rationale of this reform. It just dawned on them one fine morning that the reform was to be implemented in the hospitals of Punjab. Similarly lots of communication gaps were found between administrators and DOH. So the communication was far below the required level. As far as obedience of subordinate agencies was concerned, it was neither demanded nor was possible in the wake of political interference and weak rule of law culture. For example, IFIs moved away from the scene once policy was framed and implemented at federal level, so they did not demand obedience at provincial level with such vehemence. Professors of certain departments were 'kings' as narrated by one employee of SHL, in the sense that they were the

authority in their respective departments and were not subordinate and answerable to MS who was administrative head of the hospital. Political interference in the system made obedience even more difficult. One MS of SHL narrated an incident where he 'reprimanded an employee whose performance vis-à-vis cleanliness was found wanting. The next day a senior bureaucrat called telling that he has an acquaintance working in the hospital and that he should be taken care of. When asked who was the person? He named that very person'. Another employees talked of an incident where 'the services of one doctor were returned back to DOH on account of his poor performance, he had these orders cancelled and got himself appointed back to the hospital against the wishes of the principle. Apart from these incidents, almost every respondent complained about the perennial issue of political interference in the hospital.

Conclusion:

So the analysis of the process seen through the lens of the suggestions put forward by Hogwood and Gunn (1984) clearly indicate that the process went against almost all recommendations. This explains the 'how' of implementation process. Though it surely adopted a top-down approach at the outset, yet it miserably failed to follow the conditions set by different top-down researchers. The proceedings of the process emphatically called into question the assumption of the top-down theorists that policy making and policy implementation are two distinct processes i.e. policy makers only have to design the process and policy makers have just to follow the guidelines to achieve the successful completion of the project. What eventually was identified was that these two processes were interconnected and intertwined. Policy making has to visualize the issues and problems that implementers might have to face. Moreover this social process is not like just pushing the button on and the tube light will start glowing. Here in social life, even if you develop a circuit, and then push a button, things may go wrong as this circle involves humans, who have feelings, emotions, personal objectives quite contrary to the one held by the planner and then all these things are not static, they are prone to change. So the project should be seen as a whole from planning till implementation and led by one individual or group of individual who takes it along till its very end. Bardach (1977) also supports the last point who

very rightly observes that implementation is a political process and different stakeholder/players use power tactics to advance their interests.

So here, when once the ball was set rolling, the process was participated, interpreted, and implemented by various stakeholders at different stages of the process. It was at this stage that the process was thrown in the lap of 'street level bureaucrats' who skillfully or manipulatively used power tactics to give peculiar meanings to the concept which suited their interests and shaped the process accordingly. It was at this stage that the misty outlines of bottom-up approach started becoming clearer.

5.3112. Bottom-up Approach:

Lipsky (2010) defines *street level bureaucrats* as those "who interact directly with citizens in the course of their job, and who have substantial discretion in their execution of their work" (p. 3). However, Hjern et al (1981) talk about the involvement of different organizations/ organizational actors in the process of implementation process. The researcher thinks it prudent to use the concept of stakeholders who can influence the process of implementation at different stages. In other words, anyone who gets affected by the implementation of the process will, in one way or the other, try to influence the process. Following is a description of what meanings did many stakeholders assign to the concept of autonomy as it was under the influence of these meanings that they eventually tried to impact the process.

As far as the objective of Donors i.e. the introduction of the reform of autonomy in Pakistan and later in Punjab is concerned, it has been implemented in both levels though the present status and conditions are far removed from what was actually prescribed. Moreover, the spirit of the reforms i.e. to free government of its financial obligation towards public hospitals has evaporated a great deal. Despite giving them administrative autonomy, financial grants to the hospitals are still continuing interestingly. As one bureaucrat (B2) put it 'the grants of governments to public hospitals have increased since the introduction of autonomy'. Different schemes to make hospitals raise their own funds have only succeeded partially. Though user fee has been levied on the patients, and the facility of free tests and medicine drawn back, it has not contributed much to the funds of the hospital. Donor were successful during the process only to the extent that

they had control and enjoyed power in the policy planning when they led the process and loan-money was yet to be transferred to the government. Donor did not have any significant role in the next stages.

Federal bureaucracy got involved at the initial phase of the program as they are the ones through whom foreign programs and projects are initiated in the country. Though this particular initiative, contrary to earlier ones, was meant to clip their wings yet they had to be involved as they are the main implementing structure. At this stage of the process, they enjoyed diminished levels of power as donors were on the rampage, dictating their pre-planned agenda. Not much is known as to how federal bureaucracy exerted itself during the process, as the focus of the research was at the level of the teaching hospital at provincial level which was directly under the control of provincial governments. So the researcher was only able to observe the provincial bureaucracy from a closer distance.

However the federal government performed two main tasks, 1) to implement autonomy intervention at two hospitals i.e. Pakistan Institute of Medical Sciences (PIMS) and Federal Government Services Hospital (FGSH), observe the findings and 2) pass on the instructions to the provincial governments to initiate the process at their level. Both these meant reduction in their power and control over resources and decision making.

Directly concerned with the management of teaching hospitals at provincial level was the provincial bureaucracy i.e. DOH. As was narrated by one informant (DEA6) that the 'system was completely centralized through the administration of DOH'. DOH was in complete command and made all decisions of important nature concerning hospitals including purchase of equipment, machinery, medicine, infrastructural development, hiring and firing of doctors, setting user charges etc. Grant of autonomy meant stripping all authority and control that they had over hospitals from them. It was a death knell and serious blow to their interests. It also meant loosing specialist vs. generalist struggle which was being waged between the two groups since the creation of the country. A situation where one group is deprived of power and other assumes it, calls for politics i.e. use of power tactics to grab power. This particular situation pushed bureaucracy into accepting the reform agenda thus relinquishing their power and authority to hospital administration. This certainly was an undesirable option for them which took away their long established power and status.

Thus this meaning of the situation held by the DOH guided their actions and subsequent events provided ample evidence to suggest that they were able to wrest back most of the powers they stood to lose in the aftermath of autonomy reform. In fact they were better placed as the 'dirty' work of being responsible in front of public and media for the management of the hospital and provision of the services to the masses now rested with the hospital administration headed by BOM. And the constitution of the BOM was administered by DOH itself which included retired bureaucrats and generals along with Secretary Health and Secretary Finance all birds of the same flock.

The last of the stakeholders which were involved at the governance level were doctors. Doctors are part of the specialist cadre whose other major members include engineers, economists, educationist etc. The terms 'generalist', 'professional' and 'technocrat' are used synonymously here in Pakistan. Instead of understanding the point of view of doctor as a separate community, it would be more advantageous to understand their stance as part of the bigger community i.e. specialist.

Generalist vs. specialist:

Ever since the inception of the country, generalists and specialists cadres have been embroiled in a brawl in which both have been vying for the same pie with the result that a gain by one group is a loss for the other. And a society running on the principle of 'might is right' and as Chaudry puts it that 'everything is possible in Pakistan' (2011: xvii) the powerful has a clear advantage over the weak. The demands of bureaucrats which include 'attractive terms and conditions of service, security of tenure, a rapid promotion, and attendant levels of inter-institutional prestige' not only reflect their anti-egalitarian, contemptuous and ethnocentric standpoint; they are distributed rather unequally in their favor (Kennedy, 1987).

In the colonial era, the generalists held sway as they were the 'steel frame of Raj' and had clear preference over specialists. After the partition, Pakistan continued with the same administrative structure, however the scenario was changed. Independence meant freedom from the Raj and now nation did not require steel frame in that very sense. Moreover in the era of colonialism, as shown elsewhere in the thesis that the social sector received minimum attention with the result that the cadres of specialist

were far less developed hence their importance vis-à-vis bureaucrats was significantly low. However, after independence indigenous technical institutions rapidly swelled in number and specialists sensing betterment in their status and position demanded authority positions to run the institutions. "Indeed, the problems facing the technocratic community belie any immediate or easy solutions – underemployment, declining standards of educations and training, and unfavorable comparison with the career prospects of expatriate colleagues. Perhaps more importantly, such episodes are also indicative of the long simmering controversy between technocrats and generalist in Pakistan's administrative system" (Kennedy, 1987, p. 153). And to top it "(t)he bureaucracy was not willing to surrender the powers it enjoyed before independence on the fallacious ground that better human resource ability gave it a more likely chance to deliver the goods (Chaudry, 2011, p. 30).

Chaudry (2011) quotes Zahid Hussain who while writing an article in the daily 'Times of Karachi' dated 21/10/1956 was sharply critical of the Secretariat where 'domination by the general administrator to the almost complete exclusion of the technician' was order of the day (p.43). This observation was made after around a decade of the independence of Pakistan; however, it holds its water even till today. He further goes on to say that "(s)till living in the past and trying to emulate Nicholson, Edwards and Campbell, CSP officers conveniently forgot that an independent Pakistan required different mindset (Chaudry, 2011, p. 53).

In Pakistani society, there is a growing gap between the self-image of a civil servant-that he is achiever, holds authority, power and possesses superior intellect, and that this has been demonstrated by the success in the competitive examination. This self-image keeps the civil servant beholden to power and encourages detachment. Then there is a public image of the civil servant-which is that the civil servant is arrogant, aloof, authoritarian, corrupt, symbolising coercion and injustice. Over the years this gap between the self-image and the public perception has widened (Shafqat, 1999, p. 1013). Both these images have not only held ground, they have been further established.

The vision and guideline of a training program designed for a particular class informs of what is expected of them and what functions will they be performing in the days to come. According to Chaudry (2011), "(a)fter

independence, Pakistan decided to maintain the exclusive and select method of training CSP officers. The Civil Service Academy established in Lahore, had distinctly British flavor and was, in fact, not very different from Hailey bury College of one hundred and fifty years earlier…The academy had set out to produce jacks of all traders in the true generalist traditions (p. 63).

One of the effects of development of local specialist institutions after independence was that now the best of the best among younger lot started going to specialist institutions which included medical and engineering, instead of competing for civil service positions. Those who could not qualify for these professional institutions joined civil service as second choice and by virtue of being part of bureaucracy ended up being heads of specialist institutions. This led to resentment and bitterness in specialists who demanded that they being expert in their concerned areas should be appointed as heads of specialist organizations.

Furthermore, being part of the nation which has seen diminished degree of rule of law over the years and where 'might is right' rule explained the social dynamics, they unconsciously learnt the same lessons from the environment, and learnt to wield power themselves. Commenting on the law and order situation and its causes, Islam (2001) says that "The rule of law remains an anathema to Pakistani culture. The inherent cultural propensity to take the law in one's own hands has been reinforced by feudalism, customs, sectarian creeds and religious traditions. Police brutality and lack of redress are also cited as reasons to circumvent the due process of law" p. 1347). In the ensuing years, the younger lot of specialists thought it prudent to join civil services in ascending numbers and thus gain power in place of entering into the tricky specialist vs. generalist struggle where chances of their success were few and far between.

Within this background, when the reforms of autonomy were imposed by IFIs, with claimed objectives of helping governments shed off its financial obligation towards hospitals, doctors saw the realization of their long standing dream of assuming authority in specialist institutions by pushing bureaucracy out of hospitals. That is why when autonomy was launched in a hurry in 1998; most of the doctors thought that now they had complete authority and can wield power the way they want. It was at this point that they became the most powerful of all the stakeholders and gave their own

meaning to the concept of autonomy which was far removed from the one presented at the outset. Their subsequent actions clearly reflect their peculiar meaning of the concept.

Among the doctors' lot some really did excellent job, but they were only individuals' acts. In the wake of lack of rules, non-constitution of BOM, support of political government and bureaucracy being on defensive, number of complaints from different quarter were heard about their being arrogant, considering themselves all powerful and not considering themselves answerable to any authority. What they did not realize was that they were up against one of the most established, organized and commanding institutions of the country (Islam, 2004). Institutionalized frameworks stand better chance of succeeding against less institutionalized ones. Institutionalization doesn't last long without established rule structure and that is exactly what happened in the case of autonomy reforms in hospitals. Autonomy without proper rules and support could not last long. "Given the historical legacy and current structure of the bureaucratic system of Pakistan, one inescapable conclusion is that the rules of the game are staked to favor generalist administration over technocrats" (Kennedy, 1987, p. 176).

These conditions provided bureaucracy with a golden opportunity to strike back. The political government which championed the idea had been dismissed by then, and the experience of doctors running the hospitals could not prove its efficacy. New political government had to depend on bureaucracy as it was involved in the previous stages of the reform. This was yet another turn in the trajectory of the process of implementation of reform of hospital autonomy. With doctors losing some of their credibility as administrators for various reasons, of course, not all of their making, bureaucracy was able to snatch back most of the cards, a position from where it could dictate its terms vehemently. Later events saw bureaucracy gain the lost ground slowly and steadily and eventually it helped herself into a position where it was better placed than the past. One of senior employee (E3) of the hospital sketched the situation in the following words:

> …no purchase decision can be made without the presence of representatives of DOH in hospital Boards, whose consent is very essential for the decision. Again instead of preferring better quality products, the old lowest bid scheme is still in place. There is a

> little improvement in the quality of medicines as no medicine can be purchased without the approval of DTL (Drug Testing Lab) which works under the control of DOH. After comparing both the system his conclusion was that it all was the case of 'old wine in new bottle'. This autonomy process was all eye wash. Some powers have certainly been given to the hospitals. They have been made responsible for the quality of service. However they don't have any meaningful authority and real authority still lies with DOH.

5.3113. Synthesis Approach:

Most of the researchers adopting this approach realized that almost no program is ever implemented by following only one approach; rather it is always a combination of both top down and bottom up approaches. It is only that the mix is different which is contingent upon the context.

Almore (1979) made his recipe through the mix of forward and backward mapping which was characterized by first developing a concrete statement of behavior and then depending on the street level bureaucrats by offering them reasonable amount of discretion.

Scharpf (1978) opined that it was highly unlikely that a project could succeed without the interaction of different concerned organization, so he stressed upon the need to use the processes of 'coordination and collaboration' among network of organizations for the success of the project. Sabatier (1986) used the term 'Advocacy Coalition Framework' which is more like Network theory approach proposed by Scharpf.

Ripley and Franklin (1982) talked about the need to study and understand the process of implementation due to its social nature. Through their research they identified that the process of implementation is not a mechanical process rather interacted by various interest groups who might be obliged to impact it as the process would be impacting theirs.

Jan-Erik (1987) adopted a different approach of studying the implementation process. He opined that for a process to succeed there needs to be 'responsibility' and 'trust' in the process - both representing top down and bottom up approach respectively.

In the light of the literature, the following observations with respect to the process of autonomy reform can be made.

As was mentioned at the start of the topic that every process is a combination of top-down and bottom-up approach and the combination depends upon the context. And we have seen that the context of reform was characterized by high power distance, strong impact of colonial rule represented by very powerful bureaucratic structure, relatively powerless populace and very weak and nascent traditions of delegating autonomy. In such a scenario, the synthesis mixes in Pakistan are likely to have a higher degree of top-down characteristics.

Of course, the implementation processes are very much likely to adopt a network approach which calls for the interaction of a number of related organizations, however, in the context of Pakistan the process of implementation is likely to be high in top-down characteristics which essentially means that networked organizations are less likely to be involved in policy making, less likely to be delegated good enough discretion and are only expected to carry out implementation activity. This pattern is sure to lead to the failure of the process in the wake of lack of proper involvement of all the concerned organizations / stakeholders. This was what exactly happened in this case where hospitals officials and employees were not involved in the process. They had to be part of the network but were not considered important enough to be involved. According to one respondent (E2), mostly employees had not idea as to what autonomy actually meant.

It was seen in the process of implementation of hospital autonomy reform that responsibility fixing remained the most difficult issue as every stakeholder was found passing the buck. Everyone was interested in using the authority but despised to be held accountable. And in case if the responsibility is fixed on certain stakeholder, it cannot be held accountable because of its power and authority and weak justice system in the society. The following remarks of a respondent (B2) crystallize the situation. According to him:

> ‘one major cause for the failure of autonomy was lack of accountability structures in the system. All those responsible for different excesses were never held accountable. There was one experiment after the other. People minted money and then they were replaced with another setup. He said that different mechanisms like clinical/professional audits and vigilance committees were proposed in

> various schemes however they were never put to use. Boards were given responsibility for that but since they are also part of the society; they wanted to get served by the doctors. They expected senior doctors to be their personal physicians. In such a situation they can't initiate accountability process. (Same is true for bureaucracy (DOH) whose officers also needed the services of the doctors for their near dears.) He again blamed the culture of the society where everyone asks for autonomy, power and independence yet nobody likes to be monitored and held accountable for his deeds'.

With reference to trust, it can mostly be found in egalitarian and rule based societies. Trust is not a unilateral affair. In fact it's a bilateral and mutual process. Those at the receiving end are almost always willing and ready to trust because they have no other option. The real trust occurs when those at the top are willingly willing to trust. So in high power distance society, trust is likely to be a rare commodity. One respondent (B2) said that 'public is not empowered' And in the absence of trust, there would be less delegation of power and discretion with the result that street level bureaucrats will not be involved and take responsibility, hence, the implementation process will likely meet its eventual destiny i.e. a failure. In the case under study, the responsibility kept on shifting from donors to politicians to bureaucrats to Boards of hospitals to heads of hospitals. And at the end it fizzled out in the air. Everyone got away with that. However the comments of a respondent (B2) cleared mist from the confusion. When the researcher asked him that in current scenario who was responsible for the health services for the people as a lot of confusion surrounds the situation he replied that 'in reality the government still was responsible for it'.

Trust was almost lacking rather the situation was characterized by mistrust between different groups who had to work in concert to make the reform a success e.g. politician vs. bureaucrats, bureaucracy vs. specialists, hospital administrators vs. employees. The remarks of one respondent (B2) sum the whole story. He said that 'after around 12 year of the process we are back to square one'.

5.3114. Political Nature:

Health Issues are mostly studied from technical side or epidemiological or economic aspects. It has rarely been studied from power and politics angle.

The reform of hospital autonomy, though, initially was implemented to relieve finance-starved government of its financial obligations towards public hospitals, ended up being shaped by political contests between different power groups of the society. Political forces used the battle field of these reforms to settle their scores and to gain points over their opponents. "These reforms are not solely about financial circumstances or social values, but are also initiated and shaped by these political contests (Aaron and Schwartz 1984; Grogan 1992; Brown and Hughson 1993; Saltman and Otter 1993; Van de Ven, Wynand, and Schut 1994; Chinitz 1997 as cited in Geva-May and Maslove (2000). The social and political life goes like this. Geva-May and Maslove (2000) while quoting a number of other authors state that "we are not the first to note that the treatment rendered to health care systems is not necessarily undertaken when the symptoms appear but is the result of external political factors". Hunter and Mark (2002) propose that:

> (a) political approach to implementing policies to tackle health inequalities would seem intrinsic to the complex reality of changing practice and perhaps challenging vested or entrenched interests. Implementation in this policy area is by definition multi-levelled, multi-organisational and multi-professional. It involves political bargaining and conflict, or at least the potential for such. Therefore, a political strategy for implementation is as important as a strategy for agreeing more technical factors. 'Unless and until we are willing to come to terms with organisational power and influence, and admit that the skills of getting things done are as important as the skills of figuring out what to do, our organisations will fall further and further behind' (Pfeffer 1992: 12).

This shows a clear weakness in the strategy of the policy planners at the top that they did not realize the importance of political aspect, and though certain stakeholders were convened for consultation in policy making process (which in reality was endorsement of already developed plan), they were not part of the policy implementation process as such and people or their true representation was a missing link.

In case of implementation of hospital autonomy at SHL, this political approach would have better suited to capture the complex realities fraught with bargaining among different power groups, vested interests, conflicting goals and variegated political agenda. Problems of implementation may be

caused by poor management skills, and faulty policies, but in an environment where there is a absence of rule of law, and might is right, the problems are more likely to be political in nature. Lampinen and Uusikylä (1998) observed during a research on the implementation of EU directives that the factors which are likely to influence implementation are “political institutions (high stability) and political culture (high levels of trust) (as cited in Hill & hupe, 2002: p. 127). Both these factors have been discussed in depth while analyzing the case study.

Weick explains this phenomenon through the concept of sense making when he says that "(t)he basic idea of sensemaking is that reality is an ongoing accomplishment that emerges from efforts to create order and make retrospectives sense of what occurs"(1993, p. 635). Schwandt (1995) explains this concept even more explicitly by alluding sense making as a “process that includes the use of prior knowledge to assign meaning to new information…It is not simply the interpretation of information; rather, the continuous interaction with information allows meaning to emerge” (p. 182).

Hospital autonomy reform though was a new intervention from outside; it soon became merged in the stream of past events with multiple stakeholders dressing it with their own meanings. This analysis may lead us to the conclusion that morphing social life or impacting social change in a society is a very complex task and can never be achieved without clear understanding of the problem, identifying right solution and then by sincerity, will and commitment. Moreover, those efforts of social change which go against the ground realities of a society are unlikely to have an impact until their force is greater than the strength of the society.

5.3115. Evaluation

Its evaluation became a very tricky issue as process was mediated and influence by different stakeholders holding contrasting objectives. These different objectives shaped the reform and gave it different meanings. This caused the reform to shape away from its earlier form and rendered the evaluation of the process difficult rather meaningless. Evaluation of any program is performed in the light of it objective(s) but if they keep on changing, based on the interests and objectives of the different stakeholders and their relative power within the system, the process of

evaluation becomes meaningless. That is why it is more important to understand the trajectory and twists and turns of the process than evaluating its outcome.

5.40. Question # 2.

The second question of the research was:

'Why the intervention got implemented the way it was implemented?'

'The way it was implemented' part of question relates to various characteristics of the process which were identified in question # 1. A summary of these characteristics is given below:

5.401. First Observation:

Process initially adopted Top-Down approach.

Following are some reasons presented to explain why the implementation of Hospital Autonomy reform adopted a Top-Down approach:

5.4011. Reforms backed by IFIs

As has amply been established in the answer to the question 1 that such reforms were based on the neoliberal foundations of NPM. The assumptions behind these reforms were that "competitive market forces operate more efficiently than a monopolistic state sector; that the role of government should be reduced and confined mainly to security and enforcement; that people behave rationally to maximize profits and are more appropriately served through market competition; and that the government provision of social services is wasteful" (Haque, 2007, p. 180).

According to Haque, "NPM has been reified into a global model (2007, p. 179) and resulted in the introduction of many reforms, of which hospital autonomy was one. Apart from Pakistan, such reforms were introduced in other countries including India, Zimbabwe, Kenya, Ghana, Indonesia (Govindaraj & Chawla, 1996). As has already been established that these reforms in Pakistan were introduced by IFIs as conditionality to the loans that the country has been receiving from them over the years. Although, an exercise to involve 'key' stakeholders including senior doctors in the developing of the reform was carried out yet the exercise was nothing more than rubberstamping as the recipe was already developed. This fact was narrated by a number to respondents. DBF1 said that such reforms were introduced "under the political or international pressure". Respondent

(DEA1) remarked that this was "a political decision enforced by International agencies". On researcher's reference to involvement of donor agencies in this scheme (autonomy), another respondent (DA2) who incidentally was the personal physician of the CM of the province said that 'may be Shahbaz Sharif had something of this sort in his mind, but the implementation side of it was totally indigenous'. And last of the comments are quite conclusive on the topic and sums up the whole story. According to (DBF2):

> we as a country are 'donor driven'. Having borrowed so much from foreign donors we are in no position to devise our own policies. So whatever agenda is dictated from the lenders, we have to comply with that. Same is true for this reform. World Bank wants to run the public hospitals like business units and not on philanthropy. It is not concerned with the plight of the people rather with the agenda which will ensure that it gets its money back. It was in 1993 that WB came up with this idea. Deliberations and meetings with government officials continued till it was materialized.

All the above discussion leads us to identify the first reason i.e. the reform agenda was thrust upon and imposed by IFIs on policy makers so it has to be top-down approach.

5.4012. Presence and continuation of colonial structure and spirit

The identification of the governing style of British administration which understandably adopted a top-down approach and its continuity in the current day Pakistan have sufficiently been established in chapter three of the thesis. The "vice-regal system…made little or no provision for popular awareness or involvement" (Weinbaum, 1996, pp. 640-41) as it did not need to do that. After all colonization relationship is not such relationship where colonizer involves the colonized in the policy making.

However, the new governing system i.e. democracy under which Pakistan was to start its journey as an independent country certainly is known to involve the masses in the policy making matters. But as has been established earlier that though certain democratic institutions like Election Commission, political parties etc. were of course implanted, the country largely remained devoid of the true spirit of the system. No serious effort was ever made to introduce equality in the society, to mass-educate the

population, to involve them and to genuinely solve their issues. This was so because the structure of the government largely remained the same ever since colonial period where bureaucracy, which solely remained at the helm of affairs at least in the initial years, was not used to serve under democratic environment. It only learnt to receive policies from their masters and to implement them as such.

It was not necessary for them to find out whether these reforms were aligned to the environment, needed as such, and solved the issues being faced by the public and hospital. So when the reform agenda was handed over to the federal bureaucracy, it passed it on to the provincial level where it was implemented through bureaucracy. In this case, bureaucracy was not interested and enthusiastic about the reform, as it was likely to deprive them of their hold on hospitals. So in this case the main driving forces behind the reforms were senior doctor and politician though bureaucracy was very much part of the process from the outset. However, the approach essentially remained top-down and hospital administration and hospital employees were not involved in it at all rather some of them told the researcher that they knew about autonomy only through newspapers and during initial years not many knew what autonomy actually meant for hospitals. One respondent (DEA4) told the researcher that 'there was no involvement at the grass root level though meetings of high officials were conducted'.

5.402. Second Observation:

> Different other stakeholders (with their own meanings and objectives) impacted upon the process at different stages where they were relatively more powerful, with the result that the initial objectives of the process kept on being replaced by newer one held by other stakeholders.

As has been identified earlier that governments of different countries of the world including Pakistan were forced to adopt and implement the hospital autonomy reforms by different IFIs. As typical top-downers these agencies apparently assumed that policy making and policy implementation were two distinct processes and that the main job was to develop policies by highly qualified scholars. And attaching certain amount of dollars, for the consumption of the implementers, would easily ensure smooth

implementation of the reforms. This is a typical scientific management approach adopted by F. W. Taylor who took upon himself the task of designing plans and policies and Schmidt was entrusted the task of implementation. He was expected to follow the guidelines developed by Taylor and the reward in the shape of raised income was a surety should he successfully follow them. So the IFI assumed the process to be a managerial one.

Yet, far from it, the process blossomed as an entirely political social reality which was constructed through the interaction of these stakeholders who were further influenced by their environment be it social, economic, political, geographical, historical or international.

Ripley and Franklin observed more or less the same phenomenon and noted that "Implementation processes involve many important actors holding diffuse competing goals who work within a context of an increasingly large and complex mix of government programs that require participation from numerous layers and units of government and who are affected by powerful factors beyond their control" (1982, p. 9). In the case at hand all of the formal stakeholders including politicians, federal and provincial bureaucracies, doctors (both technical/professional and administrator) etc. who were thought to have power and influence in this arena had their own meaning of the term (hospital) autonomy, influenced by their interests (institution, position, objectives, expectation etc.). Apart from these, other stakeholder including employees, patients and media had their own understanding of the concept. But as this study tries to look at the phenomenon of autonomy from a governance angle, it will only consider those stakeholders that are part of the governing mechanism i.e. International donor agencies, politicians, bureaucrats and doctors/hospital administrators. These were the four stakeholders/ actors who being involved in policy making, governance and management are related more closely with this perspective. The position of these different stakeholders was so far apart and their objectives/meaning of the concepts was so divergent that it was not possible for one agreed upon meaning to emerge or one of these meanings to prevail throughout the process. This situation is explained by relative power distribution that stakeholders possessed in the society and at different decision points. Whosoever had more relative power at one point in time prevailed at that specific time.

Autonomy as defined elsewhere as personal freedom, ability to make one's decisions and delegation of power to lower cadres in order for them to take decisions independently; so it has a lot to do with power i.e. delegating power and using power. The meaning and significance of power varies from society to society and is explained by its history, social structure, relationship of government and society, view of the fellow human beings and the world view held generally by the society. With respect to power, societies vary, as was explained in the classical study of Hofstede (1983). In a society which he considered to be high on 'power distance', everyone has the tendency to use power, to retain power and those on the receiving end of power equation acknowledge, respect and want to grab it themselves. In nutshell, autonomy in such conditions is supposedly a scare commodity. So with reference to this case study, the meaning of autonomy, its delegation and receiving are embedded in the society of Pakistan. The understanding of this concept will be very helpful in understanding the social dynamics of organizations in Pakistan.

5.4021. Donors

It would be very instructive here to take cognizance of what meaning did the donors had about the idea of autonomy. According to Weick, "(t)he basic idea of sensemaking is that reality is an ongoing accomplishment that emerges from efforts to create order and make retrospectives sense of what occurs"(1993:635). Thus sense making tries to make sense of current events in the light of past ones. Weick (1995) while explaining the mechanism of the process states that:

> Frames tend to be moments of past socialization and cues tend to be present moments of experience. Meaning is created when individuals can construct a relation between these two moments. This means that the content of sense making is to be found in the frames and categories that summarizes past experience, in the cues and labels that snare specific present moments of experience, and in the way these two setting of experience are connected (p 111).

The act of policy making of autonomy which took the form of the report "Policy Options for Financing Health Services in Pakistan" developed by USAID for FMOH is 'cue' in Weick's terminology. This cue is to be viewed through the prism of past events. The later parts make such an effort by

connecting the process of policy making and implementation of autonomy with its past thus making sense of the processes.

According to (Hildebrand and Newbrander, 1993), "(h)ospital autonomy generally means that hospitals are at least partially self-governing, self-directing, and self-financing through the generation of revenues from user fees" (p.8). While discussing hospitals, it further says that "(g)iving them some autonomy is a way to empower the hospitals' management and to allow these institutions to become largely self-financing and self-governing" (p. 8). It means relinquishing governmental control of institutions, riding government off the responsibilities of providing health care services to public and freeing government of its obligations to provide financial support to public hospitals. All these actions are in line with the neo liberal agenda of reducing governments' size and influence and boosting role of extra-governmental sectors especially in the provision of essential services. These reforms are likely to serve two purposes; on the one side, it is likely to allow the flourishing and growth of private sector and on the other it would reduce government's financial liability towards hospitals thus improving its ability to pay back its loans to the donor agencies.

Hall and Taylor (2003) also observes the same approach of donors when they explain that under the influence of NPM and other related regimes "(e)mphasis was placed on reducing government involvement in all aspects of society" (p. 19). And "(m)arket forces became the dominant model for service delivery" (p. 19). While referring towards the World Bank approach they point towards their "emphasis on using the private sector to deliver healthcare services while reducing or removing government services. User pays, cost recovery, private health insurance, and public–private partnerships became the focus for delivery of healthcare services". Other authors including Haque (2002) have also written extensively on the topic. To sum it all the donor's meaning by autonomy was to help the government shed off its responsibility towards financing public hospitals and other health infrastructure and suggest alternative means for financing the hospital, thus improving government's capacity to pay back their loans to donors.

Contrary to previous argument, one of the suggestions of the report was to "(m)ake more resources available to the health sector by increasing the share of the gross domestic product allocated to health". This only was a

proposal – just a filler, meant not to be implemented as it was against the spirit of the reform. According to one interviewee (DBF1):

> government is spending 4% of budget and 1% of GDP. As for GDP ratio spent over health sector, it had remained the same since pre-independence times… 80% of our budget is locked in the heads of debt servicing and defense. It can't be changed at all.

Furthermore it assumes that by giving autonomy the control of hospital which was previously in the hands of bureaucracy will be transferred to the community. "As community participation on the board increases, control over the hospital would be gradually transferred to the community, which is in the best position to assess its needs, make trade-offs between service options, and determine the ability of clients to pay for services" (p. 12). Taken leniently, it can be described as wishful thinking and if seen seriously, it is a flawed argument developed to the exclusion of contextual realities. As has been described earlier that governance model prevalent in Pakistan is not democratic in nature. Public has been and is nobody in the whole equation. Egger (1953), a US consultant who advised the government of Pakistan on the redesigning of the government and bureaucratic structure of Pakistan observed that "out of three constituent parts in Pakistan i.e. the people, the politicians, and the public servants, the people of Pakistan are the weakest element" (p. 2). This sixty years old observation does hold its water till today. Community would have been the last entity to which the control of the hospital would go. And this is what actually happened, where the control relinquished by the bureaucracy boomeranged back to bureaucracy in a decade's time.

The executive summary of the report suggests that by granting autonomy to the hospitals the "growth in the government's resource burden for health would be reduced" (p.1). The report sees governmental spending as a burden on government exchequer instead of taking as the responsibility of the government towards public which clearly signify the philosophy of this reform. Here the schism between government as custodian of the rights of the citizens and government as a business entity become vividly evident.

The report also highlights general understanding that prevailed in workshop discussions which eventually contributed towards the development of the report, that "government hospitals should be granted managerial and financial autonomy and should receive indexed block annual subsidies from

the government" (p. 11). The main intentions of the reform of autonomy were to relieve government of its financial obligations towards public hospitals. This throws light on the overall plan that donor had in their mind while devising these reforms.

5.4022. Politicians

One of the senior doctors (DA2), who were made part of the initial autonomy process and later CEO of a public hospital, told that 'the CM was my patient. We were both concerned about the deteriorating conditions of public hospitals and lack of proper health services to the poor. Then I was sent to Cuba and Iran to study their system by the CM. I myself had vast experience of working in UK system. So we were very clear about the idea'. These expressions indicate that the CM was interested in improving the health facilities for patients through the intervention of autonomy. The same doctor informed the researcher that 'CM may have been under obligation of donors to initiate the autonomy process but the implementation of the intervention was totally indigenous'. However, official documents of DOH and World Bank[20] reveal that autonomy project in the province of the Punjab was already going on and this could not have happened with the CM of the province being ignorant of it. One senior employee of the hospital (E2) cited different incidents including a black mailing campaign by sanitary workers which literally brought hospital functions to a halt and damage to very expensive hospital equipment during a rare flood in the city of Lahore, as reasons why CM went for the option of autonomy. So officially politicians were under obligation of the WB to go ahead with the project but publicly they proclaimed that autonomy may bring improvements in hospital working and thus better services for the poor. Autonomy as proposed by the donors was likely to make health services more expensive for the public as government grant was to be slashed to zero levels in 10 years yet politicians claimed that this initiative will bring better services for the public. However in reality, the grants to the health sector increased in the next government (B2). Probably the reason for this was that at that time the government in Punjab was

[20] World Bank Report No. PID6895

established under the umbrella of Gen Musharraf' military government who was fighting war on terror alongside USA and was receiving financial aid from her. He also needed legitimacy for his military government to be able to continue waging war. So to avoid getting too unpopular money was channeled towards health sector.

There is another side to it as well. The mention of sour relationships between politicians and bureaucracy in Pakistan has already been made in chapter three. It is embedded in the historical realities where bureaucracy on behalf of their British masters used to rule the country and there was no mention of public or their representatives. After the independence of the country, politicians being the representative of the public, became the head of the government and bureaucracy was supposed to take orders from them. But in reality, bureaucracy hardly accepted the changed role and the history of Pakistan is testimony to it. According to Chaudray (2011),

> "(t)he bureaucracy was not willing to surrender the powers it enjoyed before independence on the fallacious ground that better human resource ability gave it a more likely chance to deliver the goods. With the passage of time, the contempt with which the civil servant viewed politicians became increasingly evident…Within a couple of years of independence the CSP, established perhaps with the best of intentions, had maneuvered itself into a situation where it became the chief implementer of an over centralized state apparatus" (p. 30).

In the case of health sector as well, politicians were interested in divesting bureaucracy of its power that they had in controlling the health sector. So in nutshell, politicians officially thought autonomy in the same vein as did the donors but publicly they showed it as a remedy to solve the nagging issues of health sector in Pakistan and in the process disempowering bureaucracy. With reference to the issue of reducing financial grants to the hospitals and health sector, it cannot be said with certainty whether they were genuinely interested in it, as were the donors. The reason for this doubt is that in the coming year, this aspect of autonomy could not be realized as ordained initially. The politicians at provincial level were rather interested in achieving political mileage by doing some political action to ameliorate the conditions of the masses vis-a-vis health services and

slashing already shamelessly meager health budget would only make them more unpopular.

5.4023. Doctors

As far as doctors are concerned, they have long been battling along with other specialists against the administrative hegemony of the generalist bureaucracy. As early as in 1946, the Bhore Report which was developed by a committee appointed by the British Government asked for autonomy and decentralization of the health services so that they are available to majority of the population in all parts of the empire. It indirectly informs us of the miserable health facilities available to the masses at large. The report was forgotten amidst the turbulent and violent events of partition of sub-continent. In the ensuing years after independence, a number of seminars were conducted and committees were formed which also suggested the decentralization of the health services but situation did not improve and health sector never became a priority area for the governments. Though health was considered a provincial area, most of the planning and programs were concentrated at the federal level. Provincial DOH were only expected to carry out the plans and projects that were designed and suggested by the federal government under the influence of donors with the result that provinces could not develop their indigenous plans suited to the people of the country. According to one interviewee (DBF2) 'once, under some external pressure, provinces were passed on some money to make purchases of the medicine on their own. However, provincial bureaucracies refused to take the responsibility on the grounds that they did not have the capacity for it'. In fact, these institutions were not trained to be autonomous and independent in there thinking and actions.

At the provincial level, health structures worked under the influence of DOH. All the decision making regarding governance, administration, HR, finance, purchasing was made at the provincial dept of Health. So doctors were very frustrated and angry on the situation. One of the doctors (DEA5) when interviewed explained the situation like this.

> Those who can't get admission in medical and engineering colleges complete master degrees, appear in the CSS exam and join civil service. Later they become the head of the technical institutions.

Another senior doctor (DEA3) illustrated the point by giving his personal example in these words.

> Bureaucracy is dominant over the cream of the society. After passing intermediate exam he moved to the medical college. After graduating in 5 years through extremely hard work and one year of house job he moved abroad for post graduation. On his return he had to appear before a committee for selection against a government job and there he found his class fellow among the interviewers who could not get enough marks for admission in medical college. So he took the route towards CSS, cleared Civil Services exam and got posted in DOH. He said that second raters were ruling the country. He said this was a unique country where by doing FA (intermediate, 12 years education) you could become president of the country. He said that the base of the structure of our country was flawed.

The doctors wanted to be independent and free from the influence of bureaucracy and wanted to be their own masters. This demand of doctors was rather genuine as too much centralization greatly hampered the ability of hospitals to make quicker decisions and to provide better services to the public. However as is the case with other sectors of society where everyone wants to have authority but without any commensurate responsibility, in most of the autonomous hospitals this accountability structure could not be developed and doctors obviously, became autocrats themselves in certain cases. The comments of one employee (E2) of the hospital on the issue are as under:

> The powers to hire and fire made officers (doctors) very stiff-necked, and abusive. One lady doctor who was appointed as MS was very abusive and did not spare anybody. So much so that an AMS who was abused had a heart attack. They would order food for themselves from McDonalds (a status symbol in this culture) out of hospital funds, sit till late and order employees to stay in the office with them till late without offering them any food.

So what doctors meant generally by the concept of autonomy was that they should be freed from the control of bureaucracy and be allowed to make their own decisions and they should not be held accountable to anybody.

5.4024. Bureaucracy

The steel frame of the Raj, as the bureaucracy was called in the heydays of British colonialism in the subcontinent, has been the main beneficiary of the pre-autonomy situation. It had enjoyed all the powers and control over the resources and decision making in all areas including health sector. The extent of their authority and the psychological awe that they enjoyed in society can be gauged by an instance that was narrated by a senior doctor of a public hospital (DA1).

> Some days back Secretary Health visited over hospital. There the Secretary asked us about the problems that we were facing in the running of the hospital. But', he said, 'he could not dare talk in front of him and tell him the issues being faced by the hospital administration'.

In such a scenario where the autonomy drive was strongly pursued by the donors and vigorously backed by politicians and doctors, bureaucracy had but to join the choruses as per the saying 'if you can't beat them join them'. It was a sure looser in the wake of impending autonomy drive. But old habits die hard. Nobody likes to relinquish authority and same was true for the bureaucracy. So though they joined the drive sensing the demands of the time yet they used different power tactics to derail the system. The details have already been presented in the previous section. The end result of all this was that after couple of attempts to develop a viable governance structure, the Secretaries of Health and Finance Departments ended up being members of BOM of every teaching hospitals – a full circle where the same group which hitherto held control of the system and from whom powers were to be transferred to hospitals, itself became the custodian of autonomy. It was so because no exclusive mechanism or institution was available and developed for the purpose.

Almost all of the doctors and even those in the FMOH were unanimous in their view that 'autonomy was not granted in the true sense right from the outset' and that 'bureaucracy never wanted to give autonomy'. So for bureaucracy autonomy meant a necessary evil which if could not be avoided should be managed in a way that their interests were not compromised.

This finding of the research endorses Haque's (1997) thesis about bureaucracy when he says that:

> (i)n developing nations, one of the most dominant features of state bureaucracy is its inherited colonial legacy, in spite of the postcolonial rehabilitation and reforms in the administrative super structure. Although the recent pro-market reforms under structural adjustment programs, including privatization, deregulation, and liberalization have created certain challenges to bureaucracy, especially in terms of its size and scope, there has been minimal change in its inherited structural, normative, and behavioral formations(p. 432).

So that was the potpourri of meanings that were held by different stakeholders. Interestingly all these meanings interacted mutually and prevailed at different stages of implementation of the process of autonomy depending on at one particular point who was the most powerful stakeholder.

Yanow (1993) who is a strong proponent of using the meaning of the phenomenon in order to have its deeper understanding, also raised such questions as "(h)ow do various interpretations of meaning affect policy implementation?" (p. 41). He then goes on to suggest that these interpretations "may differ from one another and may diverge from the intent of the policy's legislators. This multiple interpretation may facilitate or impede the policy's implementation" (p. 42). In fact meaning is a view point of an individual about a phenomenon which is based on his/her interests, objectives and knowledge. Influenced or motivated by these factors, an individual makes all its efforts to establish its view point. And when different individuals behave in the same fashion, a struggle ensues in which the one who is most powerful prevails.

The detail of which stakeholder became powerful at which stage and how it was able to influence the process of hospital autonomy has already been detailed in Question # 1 under the heading of "Bottom-Up approach".

5.403. Third observation:

> Nature of the reforms was such that it did not fit well with the socio-culturo-administrative norms and realities of the society with the result that it could not succeed in achieving the objectives set by its initiators.

5.4031. Peculiar and contextual meaning of autonomy

Pakistan has a peculiar meaning of autonomy. As per the constitutional parameters, Pakistan is a federal state where federation has to keep just enough subjects under its control to be able to run the state. The federating units i.e. provinces are to be autonomous in most of the areas of the life. In other words constitution provided maximum autonomy to the provinces so they could carry out their functions as per their local requirements. Almost all constitutions developed in Pakistan have been modeled on the framework of Government of India Act 1935 which contrary to historical British style of unitary government, visualized federal structure. This federal structure remained in practice in sub-continent for "around 80 years" (Rajashekara, 1997, p. 245) before the partition but became the model for both the newly independent countries. In the erstwhile scenario, the British had to adopt unitary model necessitating strong centre as their occupation of sub-continent was based on gradual annexation of the adjoining areas. Even after the war of independence (called mutiny by British) in 1857, when the control of the state shifted from East India Company to British Government, the state structure remained unitary in nature.

According to Chaudry (2011), "(t)he British were here not to promote the cause of India but to further their (British) commercial and other interests and to achieve this end they first set up the East India company and latter the ICS" (P. 20). He further quotes Hunt and Harrison (1988) who opine that "(m)ore than Her majesty the queen, her secretary of State for India or the Viceroy, it was the three lettered service (the ICS) that ruled the sub-continent of India for over a century and a half down to August 1947" (p. 51).

Interestingly, there has been little change in their status after the independence of the country e.g. Chaudry quotes A.R. Adair, the British Deputy High Commissioner who reported in 1964 that the administrative system (of Pakistan) "differs little from that followed in the old days of the ICS and it is the "steel framework" of the CSP, the residue of and successors to the ICS, which runs the country" (British Papers, as cited in Chaudry, 2011, p. 51).

Bureaucratic administrative structure has been controlled and run by CSP class since the inception of Pakistan – the heirs to ICS who carried along the same tradition on which ICS was established and trained i.e. centralized governance framework. They were trained to keep and use power, to make policies at the centre and to implement them in the provinces. There was only negligible amount of autonomy that was allowed to the provinces. The subjects looked towards the rulers with awe, and learnt the same governance style and practiced it themselves. Those at the top made all efforts to gain power and those at the bottom expected to receive orders. Power, gained through whatever means was considered legitimate and accepted by the masses.

So autonomy has been a scarce commodity and least practiced in the context of Pakistan. There is a clear divide in the society of Pakistan between the rulers and the ruled. The tradition, history and structure of the country called for centralization of the power at the top. This model went along, equally acceptable to both rulers and the ruled initially. However, later voices for more autonomy and independence were raised from different quarters after independence. But they were denied keeping with colonial traditions. The prime example of this was East Pakistan whereby East Wing of the country separated by thousands of miles of Indian land was kept under strong central control without offering them the amount of autonomy guaranteed in the constitution. The relationship of the two parts could go along for only 24 years before East wing had to be given complete freedom instead of previously asked-for autonomy necessary to cope with their peculiar context. Other smaller provinces have been raising voices for greater autonomy but their voices have been silenced by strong establishment at the centre. At institutional level, certain institutions, however, began to emerge which were either given autonomy or were established as autonomous institutions. But it had been a hot fought battle as bureaucracy does not enjoy granting autonomy to institutions under its control. In the next section, we will attempt to explore the dynamics and nature of the governance model prevailing in Islamic Democratic Republic of Pakistan.

5.4032. Governance Model of the state of Pakistan

Democracy

According to Shafqat (1999), "(d)emocracy implies government by law, besides electoral competition, majority rule and respect for minority rights and dissent". Pakistan, on paper, is a democratic country and different formal institutions representing democracy can surely be found in length and breadth of the country. However, if one tries to look for different constituents as mentioned above, in the state of Pakistan, one will certainly be shocked to find majority of them missing. Still Shafqat takes a lenient and sympathetic view by calling it a 'quasi democratic set up' but then wonders as how to 'adapt and operate' in it. Later he explains the situation by commenting that "in Pakistan the transition to democracy is taking place, but the rules and the spirit of democracy is being violated blatantly" (p. 1009). This lenient view serves no good purpose except confounding the situation even further and finding its solution even harder. It certainly is not the model which is being practiced in the West. It's simply a continuation of the previous system that existed before independence in the garb of democracy. It is just old wine in new bottles.

The establishment of democratic institutions in countries has adopted two patterns in most parts of the world based on the fact that whether government structures developed before or after the introduction of democracy. Hill and Hope (2002) offer analysis of the phenomenon by giving two contrasting examples. First example relates to the United States where government structures developed gradually under the shadow and influence of democracy. It was the natural flow of general conditions and the war of independence that caused the development of democratic ideas and concepts which later became the guiding principles of society on which the governance structure of the country was erected. So the democratic principles preceded the governance structure of the country. Quite contrary to this is the example of Germany where governance structures existed long before the need of the introduction of democracy was felt in these countries. Introduction of autonomy was done under the principle of 'nation building'. Under this arrangement either the current structures were morphed into democratic ones or new ones based on the requirement of democratic principles were introduced. Democratic institutions were

nurtured closely, were guarded and institutionalized to ensure no other Hitler gets any further chance to scare the world again.

The case of Pakistan does have a greater resemblance to the case of Germany in that democracy was introduced externally at the eve of independence of the country whereas the government structures and traditions existed long time ago based on colonial traditions. However what was different in the case of Pakistan was that though democratic institutions were erected in the country at the eve of independence, democratic principles like equality, accountability, transparency etc could not take root in the society. In the absence of any serious 'nation building' effort by the USA as was the case in Germany, nascent democratic principles could not compete well with colonial governance style in Pakistan which was upheld and carried along by colonial bureaucracies and which strongly impinged upon the psyche of the people here.

Furthermore, perhaps introduction of democracy in Pakistan was not a high priority agenda of USA as military governments suited more to its international designs and objectives. As Mukherjee (2010) elaborates on this point that

> US establishment has always found it easier to deal with a military general than to get involved in messy local politics, but the point is not so much that the US always supports generals, but rather that US support for democracy in Pakistan has come second to broader geopolitical considerations, thus enabling the generals to secure substantial external backing (p. 74).

Three stints of military governments all lasting for more than a decade as compared to none of the political governments being able to last for its legitimate tenure is testimony to this fact in a way. All the military governments including that of Gen. Ayub, Gen Zia and Gen Musharraf have been close allies to various US international campaigns and enjoyed very close and cordial relations with the US government. All these generals ruled the country like absolute dictators – not being accountable to any institution or masses.

The so-called democratic governments which found opportunities in between were in most of the cases, under the complete influence and authority of the military governments and acted in most undemocratic

fashion thus suppressing the voice of opposition and setting highest standards of corruption. In a TV program, when one politician of current government was asked as to why your political party is charged of highest level of corruption whenever its gets chance of coming in the government, the reply was 'do we not have right to corruption'. They also thought themselves accountable to none - neither towards masses nor judiciary. That is how the democratic traditions of being answerable, being open and being equal could not take root in the country, so whatever is done by the powerful in the society is likely to go unpunished and unaccounted for.

Thus, in the presence of very strong colonial bureaucracies both military and civil, democratic institutions could not take root. These bureaucracies did not have the need and habit of following the will of the people rather they always ruled people. That is how they were structured, raised and trained.

So far from an ideal democratic country anchored on the democratic principle of "government of the people, for the people and by the people" the governance model of Pakistan emulated colonial structure. Government of India Act 1935 was adopted after some cosmetic changes. All the laws, rules, manuals, codes and structures designed to achieve colonial objectives were inherited in letter and spirit in the newly freed country. The status that public enjoys in a democratic set up was not granted to the public at the eve of independence when the country was declared as democratic republic. The state structure gave least priority to the public and most to the state represented by their representatives and civil and military bureaucracies because the system, structure, institutions and mindset has largely remained the same. It has always been biased towards the powerful – the *bourgeoisie* of the society.

This situation has strongly influenced almost all aspects of life in this country. Due to the peculiar priorities of the state, the state institutions were far more developed as compared to the public institutions. Moreover poor governance, wrong priorities, and external pressures put enormous strain on the public kitty. It could not finance the king like life styles of its rulers and ambitious international security projects. Consequently, huge amount of money was loaned by different financial institutions which was to be paid back along with ever escalating interest. Beside a sizeable part of the resources going to the security institutions, this is an equally big

crevice in the public exchequer. Taken together, these two heads eat up around 75-80 % of its budget which has almost always been a deficit one requiring further loaning. As one of the respondents (DBF1) put it 'our 80% of our budget is locked in the heads of debt servicing and defense. It can't be changed at all. One HRD report (1998) of planning commission said that this scenario can't be changed till 2020'. That scenario depicted the picture that was in 1998, the financial loans that governments have received ever since had made matter even worse.

The main casualty of this situation was the social sector which was catering to the needs of general public. The social sector's share in the budget has been hovering around 10% of the total budget. One of the respondents (DBF1) amply sketched the whole situation when he said that:

> we are so deeply entangled in debt trap that we cannot change the status quo. The option of increasing our health budget from the current below 1% does not exist for us. He said that defense budget, debt servicing, subsidies and salaries of the government employees are voted items meaning thereby that they can't be debated in the parliament. The first two items account for around 80% of the budget. And more than 50% of the remaining budget is earmarked for salaries. So we are left with only 10-12 % for running the whole country.

Even this around 10% social budget is not spent totally on the public rather it receives further blows. Almost every year a significant amount of budget lapses as it could not be expended in the year. The structure even lacks the capability to spend the meager allocated budget, the major reason being centralization of power and resources and incapacity of the structure . And then there is an ever present sword of corruption which slashes away a quite substantial portion of already depleted resources. Thus what is actually spent on the public is even lesser than the stipulated around 10%. Situation becomes even graver should we take into account the rural-urban divide where rural areas are far more under developed and lacks basic necessities of life and here resides around 70% of the population. Thus the money spent on different sections of society represents their relative importance.

An interesting fact can be discerned by the comparison of pre and post independence budget scenarios. There has not been any significant change

in the ratio of development vs. non development budget. In the pre-independence era the bulk of the budget was shared by law and order and remittance back to home and the situation is not any different in current times where bulk of the budget is spent on law and order and debt servicing. The share of the public in the budget is more or less the same and so is their fate.

If we try to analyze as to why so much difference is found between East and West with reference to the fate of the people, what is different in the west was that it were the people, the masses who went through the process of *renaissance* which was guided by their revived believes, thoughts about reality of man and universe, the nature of relationships between public and government and the role of religion in state affairs etc. These views were strongly influenced by their view about life. It were the people who decided what to do, what not to do and how to do, so using their rationality, collective wisdom and rediscovered knowledge from their past, they came up with ideas about how to restructure their life and society after *renaissance*. They chose their representatives who shared their views about matters mentioned above. So whenever they became part of the government, they had to conform to the agreed upon fundamentals and values of the society and moreover people were generally all alert to question and raise their voices should anyone of them cheated or deviated from the agreed upon principles. Furthermore, it was not left to the masses alone to safeguard societal values and interests, rather such institutions were developed which could perform these functions. Of course the force of self interest is built in all humans; however, institutionalization did a reasonably good job of upholding fundamental values of society. So the agreed upon values like equality, freedom, humanity, secularism became the basis on which the societies were erected. And the state and society largely shared the same vision and interests, thus both developed side by side.

The situation in the sub-continent was 180 degree opposite. Historically, due to different reasons the general public in the sub-continent were not revived, they did not know their rights; they could not rally around or develop any significant movement which could help them organize and rediscover themselves. Their only worth mentioning role in the society was that they had to pay taxes. Any resentment from masses was to be dealt

with naked force through institutions which served rulers' interests. They were divided on different lines and did not have shared concepts and views about life. This caused one external force after the other to subjugate and exploit them. The rulers developed institutions which served their interests not of the masses. People had no role in the policy making. Even under the democratic governments, which could only be called sham, that existed in fits and starts after independence, apart from paying taxes, the only involvement of the masses in the system has been to cast votes whenever they were afforded an opportunity. They were to receive only the leftover of the rulers. In place of both the state and society having common and shared objectives and interests, they had conflicting and opposite ones. So the policies that the state was following represented the interests of the ruling class, and were not meant to solve the problems the public and society was facing.

In the case of hospital autonomy, the reform had nothing to do with ameliorating the health services for the masses. It was only directed towards relieving government of its financial liability towards public hospitals. It was an enforced prescription of the IFIs which was happily accepted by the rulers as with its implementation was attached certain amount of dollars which were to fall again in the lap of the leaders. They owned and trumpeted these reforms as a panacea for all the health issues and problems and pursued it vigorously. Yet what public got from these reforms was narrated by some informants that researcher met during data collection.

One employee of the hospital (E2) used these words to explain the situation:

> One big issue in post-autonomy scenario is that patients have suffered in many ways. One aspect is the user charges which had made treatment difficult for the poor. Secondly, patient care was compromised through rhetoric, report making. There was a lot of emphasis of reports which were demanded by Government and supplied by the hospitals. Chief Executive hired media men who would keep him and his activities alive in the media. A cycle of self praise, public relations started which badly affected patient care.
>
> In Post-autonomy even the staff of CE became very rude and treated employees with disgust. Now more emphasis was on how

> many machines were out of order, how many had been repaired. In one instance, some doctors asked a patient to fetch some medicine from dispensary; he was told that it was out of stock. When he informed the doctors, one of them remarked that you should have brought three or four bricks (referring to too much civil work going on in the hospital). Earlier there were 250 or so house officers and each ward had around 10 officers. They would prepare the patients by conducting necessary tests and undertaking other formalities for the operation next day. Now the number of nurses and doctors has decreased which has resulted in the deterioration in the patient care level.

One senior doctor (DE1) commented on the situation like this:

> current dual system has slaughtered the merit and responsibility lies both on bureaucracy and management of the hospital. He said the recommendation of the professors having 25 years or so experience for junior efficient doctors are turned down and decision are made whimsically. All service rules are ignored while making inductions.

And one bureaucrat (B2) explained the situation by saying that:

> the poor have been the main victim of the system. Rates of health services have shot up. Their surgery is delayed for months. Doctors use space, facilities, reputation of government hospitals and get share from the income of the hospitals. They get share from the income generated by operations in the morning as well. They are making lacks of rupees. They have no professionalism.

Democracy is about equality, freedom, and fundamental rights, yet here democracy is used to exploit the masses. All the institutions of democracy are installed in the society in imitation to the west. They certainly do not perform the same functions that they perform in the west. Political parties are hereditary in nature and not ideological, bureaucracy is hand maiden to the politicians, and courts are acceptable to the rulers to the extent that they give verdicts which suits ones interests.

Sial (2011) presents a picture of the current state of affairs with reference to the governance mechanism prevailing in the society in the following paragraph:

> State officials seen more committed to perform obligations assumed under secret agreements against territorial sovereignty. State is facing illegal interference in its exclusive internal affairs. State has lost its capacity to frame its policies according to its national priorities. Its parliament seems to have imperfect control over decision-making process. Parliament doesn't seem to have self-regulating capacity. The executive organ seems not accountable to the parliament. Public service system has lost its capacity to deliver national services and has converted the range of its obligations to its privileges. State economy indebted to national as well international monetary institutions to the tune of billions of dollars have rendered its economic independence vulnerable. State exchequer extracted out of its poverty-ridden population and territorial possessions is spent upon luxurious spending and have no return for its citizens. Judicial system has been made subservient to executive organ. Armed and resourceful sections of society have replaced system of rule of law with rule of force in the country (p. 127).

Accountability

Policy making and policy implementation processes are of such nature that it involves huge amount of public money on one side and solution of some important public issue which is likely to affect public at large on the other. In other words, it is vital that the objectives should be achieved effectively and efficiently. Failure in both the criteria need to be analyzed and looked into so that problems are identified and solved or those responsible for the failure be held accountable. If that is not done on regular basis, inefficiency and ineffectiveness will be a regular feature of the society and this is exactly what has happened in the case of hospital autonomy in Punjab.

In order to fully understand this issue of accountability we need to have a comprehensive view of the process. So if take a start from the process of policy making, in a democratic polity, it's the people who solve their issue by themselves. If they could not do it themselves, they delegate powers to their representatives. So basically, it is the representatives of the people in a democratic country who undertake the task of making public policies. And in Pakistan, which is considered to be a sovereign and democratic country, the public representatives should be making policies. However, as has been

established already in the case study that the policy or initiative of hospital autonomy was introduced and imposed by the IFIs. And though they completed all the formalities which are considered necessary for making policies representative of the views of almost all the stakeholders, the final shape of the policy document was more or less the same as was introduced in other countries which shows that the whole process was just an eye wash.

This is the first stage where accountability issue arises. Public representatives must be held accountable for cheating the public when they adopt the policies imposed by the foreign powers and claim that they have devised these policies. In a country like Pakistan, policies have always been externally enforced; elites at the top of the hierarchy in Pakistan only make it palatable for the people, retaining the crux of the policy intact in most of the cases. Then these policies are delegated downwards to be implemented. Since the policy makers may not be convinced themselves, they just complete the formalities and pass the buck. In the culture characterized by high power distance, no finger ever is directed towards the top. And since those at the top already know the fate and reality of the policy, no accountability fixing is carried out. In case it is done, those considered involved paint it political and thus get away with it.

The next section contains the discussion of the three organizational structures that were designed under three different regimes of hospital autonomy initiative so how accountability side of the issue was ensured.

If we look the first case of PM&HI Act of 1998, we find that Chief Executive was made responsible for the efficient running of the hospital. He had to work in consultation with the IMC. CE was entrusted with the task of nominating members of the IMC. Here one local objective of the reform is being clearly met i.e. role of bureaucracy has been trimmed down to the lowest. However soon after the introduction of this reform, the political government in the province was dethroned by coup' d'état of Gen Musharraf, which did away with the backing and support that doctors and this initiative had with the result that bureaucracy regained its lost position. It ensured that IMC were not formed which could have saved CE of all the responsibility and accountability of the process. IMCs were to make news rules to run autonomous institutions but when they were not formed there were no new rules. Now CE believed that the previous rules of the

Punjab government will not be applied to the new structures and it will only be run under new rules whereas new rules could not be framed. So the first autonomy initiative went along for around three years in this state of ambiguity. The running of the institutions needs decisions and decisions are made according to some rules, and when there are no rules, the decisions of the people at the top become rules and final words. In such a scenario, the question of accountability just disappeared. It only reappeared once the process was put to halt and all kinds of accusations and blames started surfacing.

The next issue with reference to accountability was that officers and doctors above grade 17, some of whom were senior to the CE, remained in the service of the government i.e. under the control of DOH and thus did not feel accountable to the CE. This was yet another issue where spirit of the autonomy was missing. How could the institution under CE be considered autonomous when the employees working in his institution did not feel accountable to him? How then could he be held accountable for all the affairs of the hospital?

When the next legislation was being framed, this issue gained maximum attention. In the second version of autonomy, CE now named as PEO was rendered toothless and all the institutional powers were entrusted to the BOG whose members were to be nominated by the DOH. So in reality DOH gained maximum power and should have been held accountable for all that happened. As was established by Justice Mujjadad Mirza Commission in their report that members of the BOG, most of whom were industrialist, started poking their nose in the technical issues of the doctors. This happened because the issue of the extent of authority and responsibility of the members of BOG was not visualized and addressed. They were given limitless powers without establishing any viable mechanism of accountability. And if they were responsible to anybody, it was DOH.

The question of how to bring balance in the powers of the members of the boards was addressed in the next legislation where Secretary Health and Secretary Finance were made permanent members of boards of all the hospitals. Moreover, retired bureaucrats and army generals were made head of the boards. The extent of the powers of the board can be gauged from the comment of a respondent (DBF1) that ‘one section officer of finance department can question and undo the recommendations of the

board of the hospital'. So in this way, boards became directly controlled by the bureaucracy whereas head of the institution which was now called Principal was held accountable for the performance of the institution without much power.

As has been presented in the previous section that different governance schemes were tried for the hospitals, however, each one of them failed and each tilted the balance gradually towards bureaucracy. It has already been explained that bureaucratic institutions were developed specially to cater for the needs of the colonialist rulers and it preserved its status and position in the years after independence. It was undoubtedly one of the most developed and powerful institutions of Pakistan and in a state of political instability, it was not possible for politicians, doctors and even donor to deprive them of their position. Only one option remains i.e. to democratize the bureaucracy somehow. Page (1985) through his analysis suggests that democratization of bureaucracy has been attempted in three different ways:

1. 'Representative bureaucracy: a system is more democratic when the socio-economic and ethnic backgrounds of top government officials resemble those of the nation as a whole' (pp. 163–4).
2. 'Pluralistic approach: democracy in public decision making ... guaranteed by the absence of centralized political authority' (Page, p. 164).
3. 'Institutional view': in which 'democratic "control" exists to the extent that representative institutions participate in policy-making' (Page, p. 164 as cited in Hill & Hupe 2002, p. 28-9).

Second type of approach relates to US society and first and third types are representatives of British traditions. As US followed second model, so it "had an impact upon the way implementation processes are conceptualized in the United States." Interestingly none of these types explain the bureaucracy in Pakistan. However Page (1985) refers to certain public officials seen as 'power elite' who challenge the democratic control on policy formation (as cited in Hill & Hupe, 2002, p. 29). Even that description does not fit well with Pakistan's bureaucracy. In case of Pakistan, it is not only certain public officials who would act like 'power elites'; it is indeed the whole structure of bureaucracy – brought up in colonial traditions which would see itself superior and wiser to the public. In this scenario, bureaucracy would not feel accountable to the public or

their representatives. “In many ways the dominant view until very recently has been to accept the case for top-down – organizational – accountability” (as cited in Hill & Hupe, 2002, p. 32).

Moreover, all these initiatives are responses to the problems being faced by western societies, where ground realities with regard to public-government relationship, citizens’ rights, economic conditions, industrialization, power distance, extent of state independence etc are very different from the one prevailing in Pakistan. These initiatives are not in consonance with the ground realities of Pakistan and cannot address issues here until either the ground realities become identical or they are tailor made to the conditions in Pakistan. “Privatisation has also been abrupt and imposed on many nations by external sources, with little prior analysis of market conditions and the importation of inappropriate models and practices” (Desai & Imrie, 1998, p. 636). Until political stability remains a stranger in Pakistan and masses are educated through some mechanism or they become aware of their rights, situation is quite unlikely to change.

This is one of the biggest dilemmas of top-down implementation. If a policy is faulty and inappropriate for the achievement of a specific goal, it would be foolhardy to expect implementers to achieve the stated goal with such a policy? And for that matter, how can they be held accountable? In a culture where everyone likes to wield power, control others but loathes to be subordinated and held accountable, whatever happened in the case of hospital autonomy was all but expected.

Rule of Law

Rule of law is one of the most essential ingredients of a modern society and its absence leaves its inhabitants to the mercy of the powerful. The more one observes the lack of it in a society, the more it becomes clear to one that the society is the depiction of the principle of ‘might is right’. No program or project can be expected to achieve its objectives if law does not rule in the society. The situation of rule of law in society was discussed in the previous chapters. Here are a few comments of the respondents which will throw light on the extent of the rule of law that prevails in public organizations including hospitals. But before turning to the comments of the respondents, here is the narration of an incident reported by an official to the researcher in a Public Hospital.

> According to him, once one old graduate student i.e. a doctor, who later went on to join Civil Service, visited him. He asked him that it was a general perception that civil servants consider themselves above law and bend laws for their near and dears, so what was his views on it.
>
> In response he narrated an incident of the time when he was undergoing training in Civil Service Academy, Walton. He told that one day his family elders asked him that some property had to be transferred and that it was an emergency. He said that he got a bit worried as such jobs involve a lot of hassle and frustration, could not be done normally, and needed a lot of time, some connections in concerned office and bribery as well. Meanwhile, he talked to one of his teachers who was also a civil servant. He told him not to worry and to see the senior officer in the concerned department as he was a civil servant.
>
> He said that one day he went there but got really disappointed to find a large number of people, mostly hailing from rural areas, waiting for their turn. He said that he went to the secretary to the officer and told that he wanted to see him. The secretary without looking at him told that he was in meeting. He said that then he gave him his card which showed that he was a trainee in the Civil Service Academy. The secretary's mood instantly changed, he took the card and went inside. Moments later he was called in.
>
> According to him when he entered inside, he found the officer reading newspaper and taking tea. He welcomed him, offered tea and started talking about the academy, teachers and other related issues. Then he asked why he was here. When he told his problem he said that government had placed a ban on the transfer of property but let's see what we could do about it. The officer then called his clerk and ordered him to type three letters, one, notifying the lifting of the ban; two, notifying the transfer of his property and; three, notify placing the ban again.

Situation was not much difference in SHL where different respondents shared different examples from their environment where mockery of the rule of law was made. One administrator (DEA5) holding a key position provided varied examples to highlight the dismal rule of law situation in the hospital and which mimic that of larger society. According to him:

> If as per the transfer policy of the government, it is decided that no one will occupy a post for more than three years in a particular station, politically connected person will stay in bigger stations for more than 20 years and will not be transferred but ordinary weak officer will be transferred even before the completion of the three years. He said we have a strange culture that we do not follow the rules. An illiterate person when boards a plan, puts the garbage in the dust bin and the moment he is in Pakistan he would never put garbage in the dust bin and throw it on all the places. He said I got the premises of the hospital whitewashed. Only after half an hour of white wash, I found a dirty foot print of a male shoe, deliberately placed to make the wall dirty. He told me when a doctor joins the health service of the government, the first clause of his job contact clearly delineates that he will not establish a private hospital and we find mushrooming of the private hospitals owned by doctors. And this is not without the connivance of the government. He narrated a story whereby a high court judge called him and asked that a person whom he has sent to the hospital be given a medical fitness certificate without having medical checkup. When refused, MS was threatened of severe consequences. An MPA contacted him in some previous executive post. He asked that a person be hired in his department. Doctor told that the posts have already been advertised against which people have applied and now interview stage is approaching. How a person can be incorporated at this stage if he has not applied before the due date. He insisted and threatened of dire consequences.

Another respondent who also served the hospital in administrative capacity showed how disrespect of laws by the political elites of the society paralyzed normal working of the hospital. He (DEA4) said that:

> while in office, he had to face a lot of political interference in the areas of recruitment, prisoner's treatment, disciplinary action, gaining fitness test. He said once he received a call from a higher up who said that I am sending a person who is having hepatitis C please certify that he is medically fit. In another instance, he said I reprimanded an employee whose performance vis-à-vis cleanliness was found wanting. The next day a senior bureaucrat called telling he has an acquaintance working in the hospital and should be taken care of. When asked who was he? he named that very person.

To the much astonishment of researcher, a respondent (DE1) introduced a legitimate rule designed and practiced to ensure rule of law is violated. He mentioned 'DO – demi official letter which is sent directly from the office of the chief executive of the province i.e. CM or in the absence of political government office of the governor house to any officer in the province and its following is binding on him'. These letters are a sort of recommendations for various elites or aides of elites for the provision of preferential treatment to them. Commenting upon the damaging consequences of such practices in hospitals another respondent (DEA2) expressed that:

> such demands put extra load on already overburdened system and structure, create hurdles in the normal flow of working and puts general public under a sense of deprivation. It further creates a false impression that system is not working and needs push from higher ups. (Already depleted structure is put under extra burden and that compromises the performance of the hospital).

Another administrator of the hospital (DEA6) depicted how rules are trampled by the bureaucracy under their feet to make personal use of public property. He told the researcher that when he took over the hospital as the head,

> there were around 76 hospital employees working in the houses of different government officials in the morning. So he pulled them back for the service of the hospital. According to him, there was a lot of pressure on me from various officials but I showed firmness. One official rang me asking in a very angry tone why his employee has been taken back. I asked them to which organization they belong to. When replied, Services Hospital, I enquired how come then they were your employees. Later that evening that official came to my office in a very changed and light mood and asked if that employee can continue working in his home after official timings of the hospital. I told him that I had no objection once they are free from the hospital.

Some employees of the hospital tried to explain the situation by throwing light on the social psychology of the society. One respondent (DEA5) said that:

> we have a strange culture that we do not follow the rules. An illiterate person when boards a plan, puts the garbage in the dust

> bin and the moment he is in Pakistan he would never put garbage in the dust bin and throw it on all the places.

Another respondent (DEA4) tried to identify the root causes of the deterioration of the society in the following words:

> He said honesty and straight forwardness has become stigma in our society and is looked down upon by the people. The one who earns money through unfair means becomes respectable. He said the problem is with our thinking; it has rotten. He said that in order to be able to think you need independence, whereas our society has been pushed in a situation where they are struggling for the basic human rights like health and education. These basic necessities have become luxury in our environment. There is a serious resource imbalance. The collective/ national decisions are taken in personal rather collective interest. He said our whole society is living under fear. In our childhood we never had the courage to speak in front of our elders. He said that it is the colonial legacy and has been institutionalized in our society. In our government offices we frequently use the phrases like 'your obedient servant', 'yours obediently', 'your humble servant' etc. we have been brought up in a fearful environment which does not help develop confident and bold personalities. We don't have a participatory style. Our minds are blocked. We don't think. We are always on the lookout for cheating deceiving and, lying with others.

Apart from these comments coming from various respondents, the researcher was able to identify and observe a number of instances during the research process where rule of law was flouted, the first being at the stage of policy making. It is the rule of the country that the policies and plans for different issues in the country are developed by the parliament and its associated organizations. However, as was mentioned in earlier discussion that the policy of the reform of autonomy was adopted at the behest of IFIs.

Second observation is about promulgation of law. It is the law of the land that any law which is to be applied in the society is to be issued and ratified by the parliament of the country or province, however, it was observed that statutes concerning autonomy were enforced and issued as ordinances through the use of emergency power of the governor of the

province whereas there was no such emergency which would call for invocation of emergency powers.

Thirdly, as was decided among politicians, bureaucracy and doctors that new laws would be developed which would govern the structure and process of the reform of hospital autonomy, yet despite the submission of the draft of rules by doctors, rules were not framed and approved and reform was allowed to be carried out at the whims of the administrators of the hospital. In the absence of such rules, whatever was ordered by the head of the institution was seen as law and when the process was halted by the Martial law government; all those orders were declared null and void which appeared so when compared with already applicable government laws and rules.

5.50. Final Remarks

If we are looking through all the data, our findings show that the process of autonomy in the heath sector is influenced by several societal, political, administrative and local factors.

The idea came from western donors with the best intentions coming from their believe that the state must give space to society but these donors underestimate the power of the colonial past, which is organized in the bureaucracy and the hierarchical top down mentality. We have seen that the administrators were not able to tackle the political decision making but were at the same time able to frustrate the implementation by using their position in the process of implementation. Like the classical study of Pressman and Wildavski showed, it is not in the political differences but in the factors of implementation itself that the project failed.

It was not only due to the power of administrators that saw their power fading away. It was also in the process of top down implementation itself. Nearly every necessary factor in the eyes of authors of top own planning was neglected. That protected the power base of the administrators but a lot of knowledge or necessary factors for top down planning were overlooked by donors and politicians. This could have been a chance for the space that politicians and administrators leave for directors and doctors of the hospitals. But also the necessary factors that are mentioned in the literature of bottom up implementation were not fulfilled. Therefore the

directors of hospitals and doctors were not able to manage the process of autonomy by themselves.

Also for this project we have to conclude that the well known phrase “Good intentions aren’t good enough” counts. Without the knowledge of the colonial heritage in power relations, ways of thinking and without a good analysis of implementation processes, the project had little chance of success. And because of the situation in health care the real losers in the process were the patients as the progress that was hoped for could not be made.

The literature shows that when there is a coalition between politicians, administrators, directors and doctors of hospitals and probably clients and donors the knowledge of implementation is necessary to succeed where otherwise good intentions will fail. And at the other end: that without the knowledge of the heritage of colonialism and the political power structure we know that even with the best implementation approaches top-down or bottom-up, we will fail too. That was the situation in many processes in western countries and that is the situation in Pakistan.

Samenvatting

Onder invloed van processen van globalisering importeren ontwikkelingslanden als Pakistaan westerse organisatieconcepten, welke aanbevolen en vaak gefinancierd worden door westerse donoren. In Pakistan is op deze wijze in de gezondheidszorg gestart met de implementatie van het concept autonomie van ziekenhuisbestuur. De Pakistaanse gezondheidszorg in het algemeen en ziekenhuizen in het bijzonder werden tot die tijd vooral bestuurd vanuit sterke bureaucratische bemoeienis waarin zowel ziekenhuis bestuurders en artsen weinig invloed hadden. De gedachte van sponsors en politici was dat veel van de zwakke kanten, waaronder vooral de lage kwaliteit van de zorg, op deze wijze verbeterd zouden kunnen worden.

De studie vertrekt vanuit de vraag wat zich in de praktijk heeft afgespeeld en probeert een duiding te geven waarom het op deze wijze is verlopen De case studie en de interviews met verschillende stakeholders geeft allereerst aan dat de introductie van het begrip autonomie plaats heeft gehad in een ingewikkelde context, waardoor veel van de gedachte opbrengsten achterwege zijn gebleven.

De auteur beschrijft verschillende fenomenen die van belang zijn voor de duiding van de contexten, die van invloed zijn geweest op de wijze waarop het implementatieproces is verlopen. Van groot belang is de impact van het koloniale verleden op de denkwijze en positie van de ambtenarij en de verhouding van de ambtenaren met de politici in Pakistan. Bovendien wordt het optreden van ambtenaren beïnvloed door hun relatief grote afstand ten opzichte van de samenleving zelf. En tenslotte blijkt de politieke situatie van Pakistan en daarmee het implementatieproces beïnvloed door de wisselende politiek constellatie en staatsgrepen vanuit het leger. Ook wijst de auteur op de specifieke invloed van de juridificering als antwoord op de specifieke situatie, die meer dan in westerse landen het proces van implementatie reguleert.

Deze omstandigheden hebben op verschillende wijzen invloed op een op zichzelf technische implementatie en de wijze van implementeren. Zo is de politieke instabiliteit meer regel dan uitzondering, spelen politieke verhoudingen tussen centraal gezag en specifieke gebieden een rol, is er

sprake van een grote machtsafstand in de samenleving tussen autoriteiten en uitvoerenden op allerlei niveau. Tenslotte is er sprake van een elite cultuur en gebrek aan accountability.

Bovengenoemde aspecten hebben niet alleen een invloed op het succes van autonomie van het besturen van ziekenhuizen maar ook op de gekozen strategie van implementeren. De auteur geeft een uitgebreide theoretische beschrijving van zowel topdown als bottom up modellen als mede benaderingen die een synthese proberen te zijn. Uitgangspunt voor de beschrijving van de topdown benadering is de klassieke theorie van Wildavski aangevuld met moderne uitwerkingen als Sabatier, Hogwood en Hupe. Voor de beschrijving van de bottom up bendering wordt de klassieke studie van Lipsky over de 'street level bureaucrats' verder uitgewerkt met behulp van auteurs als Hjern, Colin en Fudge.Voor de synthese benadering is de bijdrage van Almore, Smith en Scharpf in beeld gebracht. Deze benaderingen zijn met elkaar vergeleken om een beter beeld te krijgen op hun specifieke uitwerkingen. Uiteindelijk vraagt de auteur extra aandacht voor het aspect van politiek en betekenisgeving als belangrijke aspecten van implementatie.

In de empirische studie wordt het verloop van de implementatie onder invloed van de genoemde aspecten beschreven als een discontinu proces waarin tal van stadia zijn te onderscheiden waarin de betekenisgeving van het begrip autonomie als de positie wisselingen in de machtsbalans van politici, ambtenaren, directeuren en artsen aan de orde worden gesteld. Gedurende het proces van herdefinitie worden verschillende modellen gebruikt waarin de positie van de 'principal executive' ten opzichte van de 'board of directors' en het 'executive committe', en de ' medical superintendent' worden herzien. Soms slaat de balans - in termen van machtpositie - om naar de ene dan weer andere partij afhankelijk van de politieke situatie en de positie en invloed van de ambtenaren. Opmerkelijk is vooral de positie van de ambtenaren. In eerste instantie zien ze hun bevoegdheden vanwege het concept autonomie verkleinen maar juist omdat men dan iedere vorm van sturing op implementatie vrijlaat, ontstaat de onrust die weer vraagt -gesteund door een tijdelijke coalitie met politici - om meer grip. Tegelijk blijkt, als men die grip lijkt terug te krijgen door meer centrale sturing weer op zich te nemen, dat politieke machtsovername door het leger het spel op nieuw op de wagen brengt.

Vooral opvallend is het onvermogen van participanten in het ziekenhuis handen en voeten te geven aan het concept op een wijze die klaarheid brengt en werkzame verhoudingen oplevert. Professionele naïviteit over de eigen dynamiek van besturen verhindert een eensgezind optreden en implementatie van de consequenties in de interne verhoudingen, waardoor de buitenwereld weer grip krijgt op de bevoegdheden die in het geding zijn bij autonomie.

In analytische zin kan opgemerkt worden dat het proces van autonomie aangepakt is vanuit een top down perspectief. Donoren en politici hebben het initiatief dat als een grand design moet worden ingevoerd. Probleem in deze casus is dat er geen unaniem beeld is van het in te voeren concept wat het - naast tal van andere tekorten van top down planning – moeilijk maakt een heldere boodschap te communiceren. Maar ook bekende problemen met topdown planning zoals het optreden vertraging vanwege de vele participanten en momenten van besluitvorming waren niet voorzien. De studie laat ook zien dat de momenten waarop bottom up processen mogelijk waren, de betrokkenen in het ziekenhuis niet bij machten waren bestuurlijke helderheid en druk naar buiten te organiseren. Professionals (doktoren) opereerden als individuen in het politieke proces zoals ze gewend zijn hun vak te beoefenen maar schoten tekort in het beïnvloeden van het proces van betekenisgeving aan het concept autonomie en het politieke proces. Hoewel beide elementen van implementeren een rol spelen is er geen sprake van synthese. De voornaamste oorzaak wordt door deelnemers toegekend aan het gebrek aan transparantie en accountability. Er was gebrek aan monitoring en reflectie op het proces. Participanten in het ziekenhuis twijfelen bovendien aan de meerwaarde van het proces voor de uiteindelijke kwaliteit van de zorg voor patiënten.

In de studie wordt geconcludeerd dat het proces vooral te lijden heeft gehad onder de aanwezigheid in de ambtenarij van een oude koloniale spirit waarin vooral machtsafstand is gecreëerd tussen overheid en samenleving. Men houdt van een afstand grip en staat liever geen bevoegdheden af aan een lager orgaan. In dit geval waren ambtenaren niet enthousiast maar moesten onder druk van donoren en politiek aan het werk. Ze hebben daarom van afstand toegekeken hoe het top down opgedragen maar niet begeleide proces vastliep om hun oude greep te herstellen.

De studie laat ook zien dat verschillende stakeholders op verschillende momenten in het proces met relatief meer en minder macht hun positie en betekenis hebben in gebracht maar het resultaat was dat de oorspronkelijke idee steeds werd overschaduwd door nieuwe opvattingen van stakeholders en geen duidelijk perspectief als leidraad heeft gediend.

De studie concludeert dat donoren met goede bedoelingen maar met gebrek aan goede politieke en technische analyse implementatie processen opgang brengen zonder zich te realiseren wat de mogelijkheden van deze – op zichzelf vanuit hun standpunt – gewenste veranderingen zijn. Anders gezegd: de beoogde hervormingen pasten niet in de sociaal-culturele bureaucratische regels van ambtenaren. Ze pasten ook niet bij de werkelijke situatie van ziekenhuizen in Pakistaan met als gevolg dat deze interventie voor autonomie niet kon slagen zoals gewenst in de ogen van de donoren. In termen van veel beleidsbeschouwingen geldt ook voor deze studie: Good intentions are not good enough.

Chapter 6

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Curriculm Vitae

Aamir Saeed was born on May 27th, 1967 in Gujranwala, Pakistan. He received his Bachelor Degree in Arts from Government College, Lahore in 1986. He then went on to complete his Masters degree in Public Administration from Department of Public Administration, University of the Punjab, Lahore. He conducted and later completed his doctoral research work under the supervision of Dr. Paul Verweel, Utrecth School of Governance, Utrecht University, the Netherlands.

He has been associated with the education sector for the last two decades first as administrator and later in the capacity of a teacher. He has also taught at Aitchison College, Lahore. Currently he is serving as Lecturer in the Institute of Administrative Sciences, university of the Punjab, Lahore, Pakistan.