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Understanding Policy Making and Implementation in Pakistan: A Case of Hospital Autonomy Reforms

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Abstract

Pakistan a complex country – with great unrealized potential – has its peculiar history, culture, traditions and dynamics. Most important contextual factors are its colonial legacy which involves governance model including civil and military bureaucracies; generalist vs. specialist debate and political instability. Policy making and implementation are vital processes of the governance systems of a society. In Pakistan, these processes are strongly influences by its colonial legacy. There are various different ideal models which explain these processes however most of such models are normative in nature and don't explain the happenings which occur in Pakistan vis-à-vis these processes. While studying the Hospital autonomy reforms, a behavioral descriptive model appears to emerge which explains a few dynamics of Pakistan governance system. At policy level, it was found that Hospital Autonomy Reforms were international capitalist agenda imposed through donor on different countries including Pakistan. At the implementation level, the findings of the research are that this process is not a straight forward, apolitical process rather very much a political one in which different stakeholders influence it according to their interests.

Key words: Hospital reform, public policy, implementation, colonial legacy

Introduction and methodology

Policy making and implementation are two very vital processes of the governance system of any country and part of policy process (Sutton, 1999). Policy making involves developing policies to address problems being faced by a society. In a democratic polity this is considered to be the domain of the public representatives. Once policy is developed, it is handed over to the executive part of the government i.e. bureaucracy who then carries it out in such a way that the need of the society is met. Policy making is seen as a political process (Birkland, 2010) as different parties, interest groups, pressure groups, media etc. try to influence it such that it eventually suits their interests. However, Policy implementation has been seen an administrative, rational and apolitical process where implementers are considered to be impartial, rule-bound, selfless, machine-like entities who would just stick to their task and perform the it efficiently. Wilson (1887) alluded to this phenomenon as dichotomy between politics and administration.

Hospital autonomy reforms were initiated in Pakistan in 1990 (Abdullah & Shaw, 2007).First they were launched in two hospitals of ICT (Islamabad Capital Territory) and later introduced in thirteen Teaching hospitals of Punjab in 1998. Due to different reasons, the reforms were halted twice; however, since 2003 it is in process. This case study attempts to understand the process of development and implementation of the policy of these reforms. Different stakeholder including politicians, doctors, bureaucrats, and the employees of Services Hospital Lahore were interviewed. Apart from this various documents including the initial USAID report, World Bank project for Punjab, and other related official documents were used for acquiring contextual and secondary data. While going through the data collection process, researcher got exposed to myriad of nuances of governance system of Pakistan. At the final stages, the researcher was able to construct a story of how this policy was developed and how later it was implemented. So in this article, the case study of implementation of hospital autonomy reforms is used as a prism to visualize the type of governance system which prevails in Pakistan and in the process to find out as to what extent the proposition of dichotomy of politics and administration holds true in the case of governance system of Pakistan.

The case study was conducted in the traditions of qualitative research where in depth interviews were conducted with the key stakeholders including administrators of the hospitals, doctors, bureaucrats both federal and provincial. Keeping in view the political nature of the topic, interviews were not audio-recorded, rather they were transcribed. In order to ensure that the meanings of the interviewee were not lost, the transcription was done the same day with the help of the notes of the interviews. The names of the respondents are replaced by codes to ensure their anonymity. This research was an exploratory research where information had to be dug out, so snow ball sampling was used where every respondent provided lead to some other key figures who had been part of the autonomy project at some stage. To understand the implementation process at the local level, Services Hospital was chosen and information was retrieved from various present and past key stakeholders.

The case Study

Federal Context: Pakistan

Policy Making

In 1990, with the support of the U.S. Health Care Financing Administration (HCFA), Federal Ministry of Health (FMOH), Govt. of Pakistan undertook a broad based study to identify areas where 'organizational and financing reforms' could be introduced and later could be financed by donors.

In 1992, HFS on the behalf of FMOH developed a report "Policy Options for Financing Health Services in Pakistan" after interacting with a broad range of stakeholders, which was presented to the government of Pakistan. It identified four areas of priority for the healthcare sector which are as follows:

1. Development of a quality assurance mechanism for hospitals
2. Granting autonomy to government hospitals
3. Development of private managed-care insurance
4. Development of new financing and organizational models for rural health delivery services (Hildebrand and Newbrander, 1993, p. ix)

This case study focuses on the 2nd reform i.e. autonomy of government hospitals. Here it would be pertinent to understand the objectives of autonomy set by the report so that it can be assessed later as to what extent they were realized during its implementation stage.

Objectives of the Autonomy

Hildebrand and Newbrander (1993) report titled "Policy options for financing health services in Pakistan" gave recommendations in three areas i.e. Governance, management, and finance. So the detailed objectives set in this report for autonomy are as follows.

The recommendations in the area of governance ware 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 delegated the power to oversee the operations, management, and financing of the autonomous hospitals. In the sphere of management, hospital management was to be delegated the task of selling their services to the paying patients. And for this they needed to learn and master new skills from experts in private sector.

In the area of finance, the recommendations were based on the assumption that "operating and capital funds can largely be made up from user payments on a phased basis over a ten-year period". The term 'phased' meant that government grants to hospitals were to be slashed to zero in ten years' time. 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 mechanism.

Implementation at Federal Level

In 1993, as a first step, a final decision to test the concept of autonomy in Islamabad Capital Territory (ICT) was taken. Two hospitals namely Pakistan Institute of Medical Sciences (PIMS) and Federal Government Services Hospital (FGSH) were selected for the purpose. Commenting on the nature of reforms, one administrator at PIMS expressed 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 impact of these initiatives was supposed 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, et al. 1993, p. 1).

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

Provincial: Punjab Hospital Autonomy Project (PHAP)

As per the recommendations of the report, Department of Health DOH developed 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" 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 initial findings identified a number of problems in the management 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". (WB Report No. PID6895).

Having presented a brief background, the attention is now turned 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 three areas constituting autonomy. We start by throwing some light on the situation prevailing prior to the autonomy initiatives.

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

Introduction

Under these circumstances, "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, four hospitals were granted autonomy at the first stage.

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 eight more hospitals were granted autonomy.

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:

The establishment of the IMC was left to the respective CEs perhaps in the spirit of autonomy. According to (DEA6), 'Instantly afterwards 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 had been granted, it was all CE's affair.

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.

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.

Rules of the game

Rules are a must if an organization has to work effectively and to persist continually. As this reform was 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'. Another 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).

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 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… So the Governor called him. Later the total salary of the teachers was decided to be Rs. 8000… The summary went to the finance department which objected to it on the ground 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.

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. 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 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 … throughout his service served at SHL… so he knew every employee and doctors by name and by nature... By his efficient working he had the stocks of medicine completely filled. Next year 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…

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'. In the absence of IMC, there was no body to whom CE was accountable and results were whimsical decisions in certain cases.

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.

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.

Perhaps all this was inevitable in a situation characterized by lack of responsibility, rules or structure of 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.

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.

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

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 representatives 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. 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. Some 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 objectives set by the donors got influenced/ compromised by the local context and the autonomy which 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."(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.

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.

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.

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".

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

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 there under" (Clause 9).

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.

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".

Finance

It was the observation of many interviewees including bureaucrats, government officials, and hospital administrators that autonomy will be meaningless until the hospital is financially independent. The reality of the autonomy in AMIs can be gauged from the fact that 'they receive up to 95% of their resources from government' (B3). And there is no difference between pre or post autonomy scenarios as far as this ratio is concerned. The following expressions (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. In line with the policy of new 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. 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.

Discussion

Policy Making

This case study attempted to understand the development of Hospital Autonomy Reforms and its implementation through a retrospective look. In this section, an effort will be made to contextualize these processes.

As far as the development of policies is concerned, Pakistan has a unique process of developing public policies. Pakistan inherited a very strong bureaucratic structure which was developed to cater the needs of the colonial powers (Wilder, 2009). The policy making was basically the domain of the colonial rulers and then bureaucracy was trained to perform this task at local level. Commenting on the policy making process in Pakistan, Islam (2001) observes that 'the legislatures have traditionally played minimal role in the country's governance'. And Sial thinks that "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" (p. 127, 2011).

In the past three decades, the world has seen a complete domination of capitalist ideology, after the demise of socialist pole, advocating neo-liberal market driven policies. Under this regime, advanced capitalist states and international Institutions like WB and IMF have pressurized and enticed third world countries to adopt privatization, liberalization, deregulation etc. (Haque, 2002). The case at hand i.e. Hospital Autonomy Reforms was initiated in Pakistan under the influence and pressure of USAID and WB. Such Hospital Autonomy Reforms were also introduced in other countries including Indonesia, India, Jordan, and Thailand (Saeed, 2012). And these reforms did not originate from the local arena and were not developed in response to the poor services provided by the public teaching hospitals.

Before that Pakistan adopted development model in 60s which was modeled on the Marshal Plan that US chalked out to reconstruct and develop Europe after its structure was devastated in WWII. And later ZAB's drive towards nationalization was inspired by socialist agenda. So this brief analysis highlights the fact that Pakistan ever since its 'independence' has been under the influence of super powers and donor agencies and most of the policies adopted and implemented in the Pakistan has been suggested or enforced by them and the role of legislature in this regards has not been significant at all.

Policy Implementation

Far from being a straight forward managerial task (Taylor et al, 1997) after the policy has been developed, the implementation of the hospital autonomy reforms, as depicted in this case, turned out to be a political one. The way implementation process went along, has a lot to do with its peculiar context. Three factors assume importance with respect to the context of this case study namely colonial legacy, generalist vs. specialist tussle and political instability.

The colonial legacy has strongly influenced political and administrative institutions of the country (Islam, 1989). Steel frame of Raj, as the bureaucracy was called, was the most significant and powerful institution of the colonial governance structure. In order to keep it more efficient, it was raised on the generalist traditions as it was meant to subjugate local population and was geared to keep order and collect taxes[i]. After the independence, these objectives of the governance system were to change for social development, yet in continuation to its past traditions, and under the compulsion of its rules, codes and procedure, it only did what it was designed to do.

In this age of development and enlightenment the system is still dominated by generalist administrators and specialist are not allowed to hold sway in the institutions. These reforms were designed to grant autonomy to the hospitals such that they could make quicker decisions at the hospitals in the field of governance, management and finances. Though it was an international agenda, but locally it was likely to deprive bureaucracy of its hegemony and control over the hospitals. The main drivers of these reforms were politicians and power was being transferred to the doctors i.e. specialist in this case. In the first go, under the control of politician, the autonomy was granted to the hospitals; however, no sooner did army strike the political government down; bureaucracy started the process of grabbing the power back.

Silvestre while studying the implementation of educational reforms observed that 'when policy documents "reach" the institutional level of the universities, policies are filtered, constructed, and understood by its stakeholders" (p.21, 2008) . It was true in the case of hospital autonomy reforms as well. Different stakeholders, at implementation process, tried to give their own meaning to the reforms. Politicians who are considered part of internal structures that reinforce the globalization process (Haque, 2002) were making it sure that they carry out their part of the job effectively. Doctors, in tradition of specialist vs. generalist debate, wanted to break the shackles of bureaucracy, thus being able to independently run the institutions. And bureaucracy - a shrewd veteran, smilingly and patiently overseeing the process, being content that soon it will have its turn when the balance of power will be back in their favor.

Policy can result in intended as well as unintended consequences (Taylor, 1997) because as mentioned earlier it is not a straight forward step. When it reaches at the implementation stage the power dynamics change, now the 'street bureaucrats' have more power. Same was the case with the Hospital Autonomy Reforms where governance of hospitals involved significant amount of resources, prestige, and facility of free and 'protocol' treatment. Different stakeholder impacted the process according to their interests with the result that the end state became different from what was conceived by the initiators.

And lastly, it can be concluded on the basis of the above discussion that the view based on the dichotomy of politics and administration could not hold its water in this example where implementation came out to be seen as a political and complex process. Both the process of the policy making and implementation need to be seen as two parts of the same process and there should be involvement of policy implementers in policy making, otherwise policy will likely result in unintended results.

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