Health Sector Reforms:

Factors influencing the policy process for government initiatives in the Punjab (Pakistan) health sector 1993-2000

By

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

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Finally, I take responsibility for any shortcomings and errors left in this thesis. This research, which took root in public health management, branched to anthropology and politics, led me to the domain of sociology and social policy. This journey from the human disease to societal issues was, nevertheless, interesting and one I enjoyed.

Abstract

The health sector in the Punjab (Pakistan) suffers from many shortcomings and to combat these, successive governments undertook different reform interventions. The most critical of these took place during the period 1993-2000, when the Punjab government introduced seven reforms in rapid succession, with decentralisation as a strategy common to all. Substantial inputs were made, but some of these were abandoned, others forgotten and yet others remained. Nonetheless, like many countries, where few governments have initiated any planned evaluation of reform efforts, there is also no evidence of any study having been undertaken in the Punjab.

This study aims to explore factors that influenced the policy process for the health sector reforms undertaken by the government and to draw lessons for contributing to ongoing and future initiatives. In preparing to achieve this aim, frameworks were developed for the health system and the policy process for health sector reform.

This is a qualitative research study, which employs a case study approach. Four cases were selected for study and, based on a framework for analysing the policy process, data was collected using interviews, focus group discussions and document reviews. With the help of a tailor-made computer-assisted data processing system, the qualitative data was analysed and findings are presented as four single-case studies. The cross-case analysis led to generating discussion and developing a multiple-case study and identifying factors influencing the policy process for the Punjab health sector reforms.

The study revealed that six factors 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. Given these findings, there are certain implications for the Punjab health sector, particularly overhauling the policy machine, developing the capacity of policymakers for policy analysis, and broadening the stakeholders' base.

Key words: Pakistan, Punjab health sector reforms, decentralisation, health sector reforms, policy process, factors influencing reforms, qualitative case study research

Contents

Figures

Tables

Referencing the official documents

This thesis brings evidence, *inter-alia*, from the official documents of various agencies in the government of Punjab (Pakistan). Since, these are different from standard bibliographic references, the example and table below show the format used for citing them. For example, a reference to a typical official document cited as "GoPb (1996) SO (D-1) 35-4/95 March 29, 1996, Re: Minutes of Meeting, Health Department, Lahore" will mean as below:

Table 0.1: - Referencing the official documents

Reference elements	Explanation
GoPb	Government of Punjab or the author/agency under which authority the referenced document has been issued.
(1996)	Year when the document was issued. This is different from the year when a particular file, where the document exists, was created (see below).
SO (D-1) 35-4/95	Official number assigned to the document or file, where the referred document can be found. This varies for the different government agencies. In this case 'SO' denotes the section officer; 'D-1' stands for the specific location which is 'Development-1'; '35-4' is the index number of file; and '95' means the year when the file was created.
March 29, 1996	Date when the referred document was issued by the authorised agency of the government.
Re: Minutes of meeting	Subject given on the referred document.
Health Department, Lahore	Government agency or department where the referred document exists.

In other words the referenced subject document i.e. 'Re: Minutes of meeting' will be in a file bearing number '35-4' created in the year '1995' by the 'Development-1' section of the 'Health Department' was issued on 'March 29, 1996' under the authority of the Government of Punjab which is available in the Health Department, Lahore. Further the referenced document may be placed in another file. In such cases where possible the page number of secondary document is given.

Acronyms

BHU	Basic Health Unit
BOG	Board of Governors
CDC	Communicable Disease Control
CE	Chief Executive
DDO	Drawing and Disbursing Officer
DFID	Department for International Development
DGHS	Director General Health Services
DHA	District Health Authority
DHDC	District Health Development Centre
DHG	District Health Government
DHMT	District Health Management Team
DHO	District Health Officer
DHQ	District Headquarters (Hospital)
DHS	Director Health Services
DMC	District Management Committee
DRC	Divisional Recruitment Committee
EDSP	Executive Director of Special Projects
EPI	Expanded Programme on Immunisation
FGD	Focus Group Discussion
GoI	Government of India
GoP	Government of Pakistan
GoPb	Government of Punjab
HSA	Health Services Academy
HSR	Health Sector Reform
HSRO	Health Sector Reform Organisation
HSRU	Health Sector Reform Unit

IA	Institutional Autonomy
IMC	Institutional Management Committee
IMF	International Monetary Fund
KfW	Kreditanstalt fur Wielderaufbau
LAC-HSR	Latin American Countries' Health Sector Reforms Initiative
LGP-2000	Local Government Plan, 2000
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MoH	Ministry of Health
MNA	Member National Assembly
MO	Medical Officer
MPA	Member Provincial Assembly
NGO	Non-Governmental Organisation
NHS	National Health Services
NIDs	National Immunisation Days
NRB	National Reconstruction Bureau
ODA	Overseas Development Administration
OECD	Organisation for Economic Cooperation and Development
PAEME	Pakistan Association of Electrical & Mechanical Engineers
P&D	Planning and Development Department
PHDC	Provincial Health Development Centre
PHC	Primary Health Care
PHSSC	Punjab Health System Strengthening Component
PIU	Project Implementation Unit
PMA	Pakistan Medical Association
PML	Pakistan Muslim League

PMT	Project Management Team
PO	Planning Officer
PPP	Pakistan Peoples Party
QDSP	Qualitative Data Processing System
RHC	Rural Health Centre
SAP	Social Action Programme
SFHP	Second Family Health Project
S&GAD	Services & General Administration Department
SMO	Senior Medical Officer
SO	Section Officer
SPP	Sheikhupura Pilot Project
TA	Technical Assistance
TBA	Traditional Birth Attendant
THQ	Tehsil Headquarters (Hospital)
TOC	Table of Contents
TOR	Terms of Reference
TPE	Third Party Evaluation
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children Emergency Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHW	Village Health Worker
WMO	Woman Medical Officer
WHO	World Health Organization

Introduction

"It was a very exciting time, I must say".

(A senior bureaucrat in the Health Department)

The health sector in Punjab (Pakistan) faces many problems *inter-alia*, the centralised approach to health management and organisation; inadequate financing and inequitable distribution of resources; insignificant community involvement exhibited in the under-utilised services; poor quality of care; and the traditional expectation of a free health service held by society. To combat these successive governments made interventions, most critical during 1993-2000. However, some of these were abandoned, while others were forgotten, and yet others are still struggling to survive. Why did this happen? This is the core issue for this study.

Notwithstanding a great deal of interest in health sector reforms all over the world, few systematically planned studies have been undertaken (Gross *et al*, 1998). This is also true for the Punjab. The current study, therefore, is an original work and like many qualitative researches breaks new ground (Health Services Research, 1999), adding to the body of knowledge. The results can, therefore, be used to determine the course of planning and implementing policies for reforms, both ongoing and in the future. This is applicable particularly to the Punjab health sector, but is also generalizable to countries of similar socio-economic status.

This study aims to explore factors that influenced the policy process for the government initiatives undertaken in the Punjab health sector during the period 1993-2000. Drawn from this aim, the major objectives of the study are:

1. to develop a framework for describing the structure and functions of the health sector;
2. to describe the changing structure and functions of the Punjab health sector;
3. to establish a framework for analysing the policy process for health sector reforms;
4. to analyse the policy process for the reforms undertaken in the Punjab health sector during the period from 1993 to 2000;
5. to explore factors that influenced the policy process for reforms; and
6. to draw lessons for the ongoing and future reforms.

Thesis presentation

This study picks up from an ailing health system in government care (health sector), which was repeatedly given therapy in terms of reforms. The objective is to review the prescription process, but not to determine its impact on the patient; although it is noted, what happened to the prescription, *per se.* In other words, it moves from general to the specific, presented in seven chapters. The study of contextual grounds (chapter 1) and conceptual developments (chapter 2) led to designing an analytical framework (chapter 3). The application of this framework following the case study approach is narrated as the research process (chapter 4). The outputs are the contents or findings presented as case studies (chapter 5), which are discussed and interpreted as factors influencing the policy process (chapter 6). The thesis concludes (chapter 7) by identifying the contribution of this study to the knowledge, relating findings to the existing material and highlighting the implications for the Punjab health sector. Different chapters are, nevertheless, briefly introduced below:

Chapter introduction

This study aims at exploring the policy process for reforms. In this perspective, Chapter 1 examines the Punjab health sector for establishing the context. For this purpose, drawing from literature, a framework is theorised for describing the structure and functions of the health sector and a brief account of the current status and a resumé of government reforms undertaken in the Punjab are given.

Chapter 2 is about the concepts which underpin this research. After conceptualising the reform phenomenon, decentralisation is explained essentially because this panacea served as a common strategy for different reforms. Concepts surrounding policy are explored including different frameworks developed for studying the policy process. While discussing these concepts, however, a conscious effort is made to contextualise the situation in the Punjab health sector.

Chapter 3 develops a framework for analysing the policy process. Notwithstanding a theoretical base and examination tool available; how is this applied in a research setting? Chapter 4 documents the process for studying the selected reforms. This is qualitative research which employs a case study approach. Four cases were selected for study and based on the framework for health sector reform data was collected using mainly individual interviews, focus group discussions and document reviews.

What was the policy process for the government initiatives undertaken in the Punjab health sector during the period from 1993 to 2000? Chapter 5 responds to this question. The data was processed and analysed using the framework approach. The

findings are presented as four single-case studies, each derived from their respective case data. Tailor-made computer software, the Qualitative Data Processing System explained in chapter 4, facilitated this analysis.

Chapter 6 is the cross-case analysis, made to develop a multiple-case study of the policy process for the reforms in the Punjab health sector. Discussions held in this chapter identify wide ranging factors contributing to the fate of reform initiatives. These are: (1) the absence of clearly defined principles and purposes; (2) a lack of a holistic view of the context, focusing on the health sector; (3) the shortcomings of the policy machine; (4) a need for a proper implementation structure; (5) insufficient involvement of the stakeholders; and (6) the administrative fatigue of donors.

The thesis concludes with chapter 7 by retrospectively looking at the research question and variables for addressing them, identifying contributions to the knowledge, limitations and the need for further research. Notwithstanding a deviation from the originally laid down objectives, the implications of this study are highlighted to logically conclude the arguments. It is emphasised for the system physician (reformer) to 'heal thyself' by overhauling the policy machine, institutionalising the policy analysis and broadening the stakeholders' base. Further, given that the country has undergone a devolution process, the study highlights the need for research into how far the shortcomings of the policy process for the reforms of 1993-2000 have been avoided.

1. The context

1.1. Introduction

This study aims to explore the reforms undertaken in the Punjab health sector. In order to establish the premise and context of the study, this chapter examines the Punjab health sector by:

1. drawing from literature, a framework is developed to analyse the health system;
2. examining the Punjab health sector using the framework to understand its structure and functions. The discussion extends to identifying the issues and problems summarised in section 3; and
3. giving a brief resumé of different reform initiatives undertaken in the Punjab in order to set the stage for the next chapter.

This study of the Punjab health sector is assisted by pre-fieldwork (chapter 4) and the researcher's experience of working in the Punjab Health Department.

1.2. Health system

What is a health system? Much confusion surrounds this question and according to the World Health Report, 2000, given the complexities of today's world, it may be difficult to define a health system (WHO, 2000). The health system is a complex entity and has increasingly become so, because of the extensions, both in physical terms as well as in the understanding of its dynamics, which have occurred in recent years. Notwithstanding this, an attempt is made in the following to survey different definitions for a broader understanding of a health system and to develop a framework for examining the one operated by the Punjab Health Department.

1.2.1. Definition

Health has the same meaning as defined by the World Health Organization (WHO). That is, it is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (WHO, 1978). The system, whether biological, social or mechanical, as defined by Koontz and Donnel (1984), is a set or assemblage of things connected, or interdependent and interacting so as to form a complex unity. However, given that this definition sounds like a static notion of a

system, a further search is needed. Roemer (1991) considers system as a functional unit and defines it as a set of inter-related and inter-dependent parts, designed to achieve a set of goals. These constituent parts or things (objects, organs or organisms) are, however, unable to achieve results by acting individually or operating alone; instead these have to work together (Dorland, 1985). Since these concepts are applicable to systems in general, this thesis is about a health system, and its definition needs contextualising in a social systems' perspective.

Miller (1965 cited in Ellencweig, 1992: 2) describes three elements of a social system. Firstly, their boundaries are flexible, which is a reflection of their dynamic nature. Secondly, they are multi-dimensional and are made up of several variables, which interact to form a complex entity. Thirdly, the system's output affects the processes in the environment and inputs from the environment affect the system's internal processes. Further, in this context two approaches, inventory and relational, appear to dominate the literature regarding the health system.

Roemer (1991), using the inventory approach, defines the health system as a combination of resources, organisations, financing and management that culminates in the delivery of health services to the people. In a similar vein, Kielmann and Siddique (n.d) hold that the health system comprises three elements, as concentric circles: the communities, the health services delivery system and the environment. According to them, service inputs, support systems, input distribution and service outputs together with health service management and organisation make up the health services delivery system. In this model, allied sectors fall within the remit of the environmental ecology, which include political, social, economic, ecological and other environmental systems.

The World Health Report for 2000 defined health system to, "include all activities whose primary purpose is to promote, restore or maintain health" (WHO, 2000: 5). This definition, while giving a sense of being nearer to the inventory models, is used to measure functions against objectives to determine the performance of the health system over time and among countries. In this way, the health system appears to have been reduced to an input /output device. How the activities match and relate with each other is not taken into account.

Frenk (1994) defines the health system using both inventory and relational approaches. He identifies the health care providers, collective mediator or state and the population or communities as the main actors, while other minor components that contribute to the formation of a health system include the 'resource generators' and 'allied sectors'. Applying the relational approach, he argues that the

aforementioned actors are engaged in a complex interaction primarily in terms of the transfer of resources and inputs, the delivery of services, and the processes of regulation and control. Thus, although a compromise between the two approaches is maintained, this model fails to adequately emphasise the role of environment as a constituent of the health system.

Tareen and Omar (1998) envisage the health system comprising three sub-systems: 'government; 'services providers' and 'communities' or recipients. They argue that the latter two elements interact with each other – a relationship that is controlled and mediated by the first element i.e. government, and that this phenomenon takes place in an environment where many more such systems exist. This model considers the 'resource generators' of Frenk's (1994) model, as embodied in the 'government' and is simpler and emphasises taking into account the community as part of the health system. Similarly, they consider the environment as part of the health system; however remain short of highlighting the resource generators distinct from the government. Further, the trends of sourcing /contracting out of different services necessitate considering 'support services' as a component of the health system separate from service providers. But, this model does not recognise this distinction.

Barker (1995) takes a different position. She emphasises that systems should not be defined in terms of the component organisations or agencies, but as the set of processes and activities that are carried out towards the delivery of health care. In her opinion, the health system is "a real life system of complex social institutions and relationships within which individuals and groups have complex agendas and goals, which change over time". Whereas this model broadens the view in terms of the relations' approach, it is of little help in the analysis of a health system. That is, whose activities and processes?

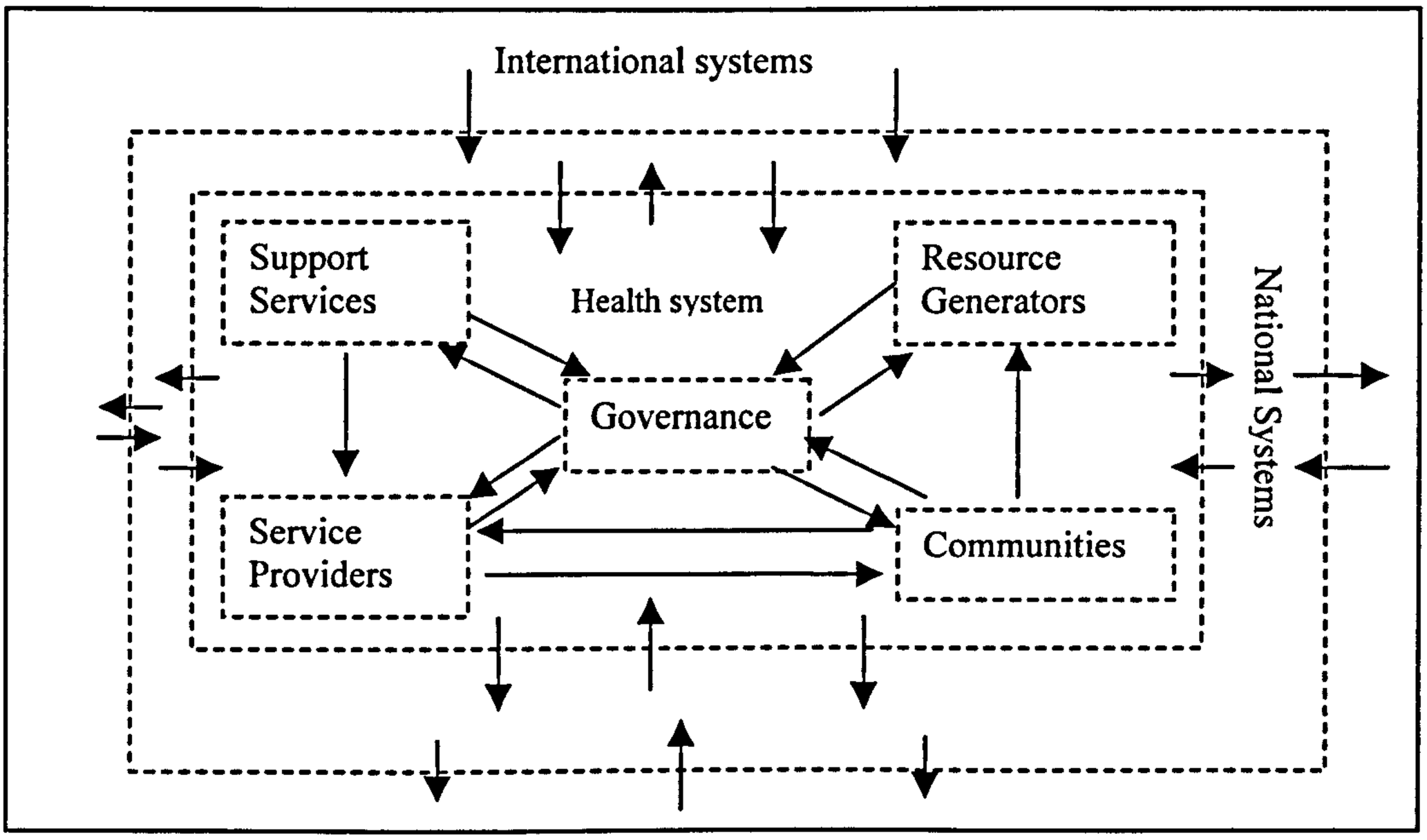
It is, therefore, clear that literature abounds with varying concepts of the health system, and that different authors lean towards either inventory or relational approaches, while defining it in a social context. Similarly, others fail to take into account certain components of the health system. Thus, there is a need for a fresher look at defining the health system; and responding to that, this researcher developed a working definition. Accordingly it is defined below:

> The health system comprises five sub systems: governance; health care/services; communities; resource generators; and support services. These constituents of the health system are in an active relationship with each other – a phenomenon that takes place in an environment where other such systems are also operative.

1.2.2. Theoretical framework

The above definition of health system forms the basis of a framework which is depicted figuratively (Figure 1.1) constructed to explain the relationships in the Punjab health sector.

Figure 1.1:- Theoretical framework for the Punjab health sector



The in-depth study of this framework points to the health system having a number of attributes which are given below:

1. The health system comprises a number of subsystems, while itself it is located in a universe where many more systems – both national and international – are also operative. These subsystems will be explored further in the next section, where the framework is applied to examine the Punjab health sector.
2. Health is an open system with porous boundaries, permitting interaction with other systems and their constituent subsystems; thus providing avenues for inter-sectoral collaboration, which may be both bilateral and multilateral.
3. Boundaries of different subsystems are flexible and there is a bilateral and multilateral interaction between them. By virtue of this, however, there is a risk of one subsystem overlapping and or usurping the boundaries of the others.
4. The aforementioned characteristic provides opportunities for decentralising the decision-making powers from one level to the other, both vertically and horizontally, from a central subsystem to the periphery in an organisation.

5. Since communities are an element of the health system, this framework underpins the importance of taking them into account in terms of their involvement in decision making and addressing their needs.
6. Governance being one function of the state, the health system communicates with the government at higher echelons in the hierarchy; thus facilitating channelling resources and policy guidelines to the subsystems.
7. In addition to the aforementioned vertical communication, there is also lateral dialogue by governance with other systems, especially ensuring the right size and skill mix of human resources required for the health system.

This framework is universal in nature, for this can be applied to any level in the hierarchy and even to the individual subsystems. This assumption, as noted earlier, facilitates establishing decentralised units within the health system. Further, the application of the above framework is not limited to the health system, but can be applied to any social system at any hierarchical level.

1.3. Punjab health sector

In the preceding section, a framework was established to examine the health system. Before its application, it is considered useful that a distinction is made between health system and health sector. Accordingly, drawing from the definition of the health system, if the focus is on the public sector, excluding nongovernmental and allied national systems, it is called the health sector. This distinction is necessary in order to be sure of dealing with the government reforms undertaken in the Punjab Health Department – a specific part of the broader health system (Berman, 1995), which is the case in the current study. Further, although, there is a large and growing private sector, this will not be discussed, as it is not in the scope of this study.

In the following, the above framework is applied to the Punjab health sector for describing its subsystems. However, this begins with a brief introduction of various developments, particularly focussing on the post-colonial era.

1.3.1. Developments

Punjab is a province of Pakistan, which shares boundaries with all other provinces: Northwest Frontier Province and Baluchistan in the west, Kashmir in the north, Sindh in the south and Indian Punjab in the east (Figure 1.2).

Figure 1.2:- Map of Pakistan

Since Punjab remained under colonial administration, the health sector bears many imprints of pre-independence recommendations of the Bhore Commission, 1945 (GoI, 1946). However, since they are not in the scope of this study, in the following certain salient developments in the post-independence era are given.

Health is on the 'Concurrent List' of the National Constitution of Pakistan. This constitutional provision empowers both the federal and provincial governments to undertake interventions in the health sector. However, it is primarily the provinces that manage the health sector in accordance with the policy guidelines laid down by the federal government.

Pakistan, upon independence from Great Britain in 1947, inherited a relatively less developed health system. For instance: there was one bed for 2,225 persons; one doctor for 100,000 people; and two medical colleges which were inadequate to meet the growing needs of health in terms of human resource. However, in the period from 1947 to 1970, very little health planning took place and emphasis remained on establishing urban based hospitals. Nevertheless, a major intervention – the vertical international assisted Malaria Eradication Programme – was launched in 1961. This programme was later redesigned to create a Communicable Disease Control (CDC) programme as it failed to achieve its purpose.

The 1970s saw a shift in the approach to health care delivery. For example, the government decided to double the health budget after every three years. Further, a people's health policy was promulgated, which envisaged the introduction of a generic drugs scheme. However, upon resistance from drug companies, this scheme was later withdrawn. Also the hospital and urban bias of health services continued as several new medical colleges were opened. These medical colleges produced a large number of physicians. However, given the low salaries, poor infrastructure and a host of other factors, the newly trained doctors did not join the public sector; instead they left the country or preferred to remain self-employed. Thus, the public sector health services remained poor (Peabody *et al*, 1999: 319). In 1978, Pakistan signed the Alma- Ata Declaration, acknowledging the central role of primary health care and emphasising equity in health care. In the same year, smallpox was eradicated and instead of a Small Pox Eradication Programme an Expanded Programme on Immunisation (EPI) was started in a selected tehsil of all districts.

During the 1980s' the health infrastructure was expanded, so that each union council with a population of about 25,000 had a Basic Health Unit (BHU) and at each markaz with a population of about 100,000 a Rural Health Centre (RHC) was established. Similarly a Tehsil (THQ) and District Headquarter (DHQ) hospital was established in each tehsil and district respectively. In 1982, to enhance the coverage of outreach primary care, an Accelerated Health Programme comprising EPI, Control of Diarrhoeal Diseases (CDD), and Training of Traditional Birth Attendants (TBAs) was started.

A major development during the 1990s was the launching of a Social Action Programme (SAP) aimed at consolidating existing services and redirecting public expenditure in favour of the social sector. Under the umbrella of SAP, a donor funded Second Family Health Project (SFHP) was launched to bridge the increasing gap between the availability of resources and health sector coverage for improving the performance of different health programmes. To complement this, a Health Care Development Project was implemented to improve the availability of trained human resource, especially nurses and paramedics. In 1994 a National (erstwhile, Prime Minister's) Programme for Family Planning and Primary Health Care was launched, extending the basic health services to households.

Under the SFHP, a number of major structural changes were introduced in the Punjab health sector. In addition to a pilot project in district Sheikhupura, District Health Authorities were tested in districts Multan and Jhelum. Autonomy was granted to all tertiary hospitals and a beginning was made to extend decentralisation to the districts by establishing District Health Governments in ten districts (Collins

et al, 2002). To provide legislative cover to these reforms, the Punjab Medical and Health Institutions Act, 1998 was promulgated. But, then the progress took a different direction. The new government, which came to power in October 1999, implemented a Local Government Plan, 2000 hereafter called LGP-2000. The developments beyond 2000 are not in the scope of this study; however, to complete the argument, these are described below.

1.3.2. Devolution of the districts (post-study developments)

The new government visualised devolution of powers and responsibilities at three levels of revenue division: province, district and union council. In the new set up, according to the LGP-2000, a department of the elected district government is responsible for health and population welfare in the district. Contrary to the previous efforts, this intervention uses a cross-sectoral approach, and with few exceptions, involves decentralising all government departments. The salient implications of LGP-2000, relevant to the health sectors are as follows (NRB, 2000):

1. The structure and functions of the erstwhile divisional tier ceased to exist on 14th August, 2001. However, the government has been considering raising the status of divisions to the provinces (Dawn, 2002).
2. The district is a basic unit of governance and administration, each following the revenue division has three tiers: Union Council, Tehsil, and District.
3. For the bigger cities, the term 'City Districts' has been introduced. For example, Lahore (capital of Punjab) is a city district, where a 'city government' replaced the hitherto local government system.
4. The district health officer, now called executive district health officer is responsible for Public Health, Child & Women Health, and Population Welfare. Also, the Medical Superintendents of the district and tehsil hospitals are under the control of this office.
5. Citizens' Community Boards are proposed for different levels of health care to enable the proactive elements of society to participate in community work and activities related to development.

1.3.3. Elements of the health sector

Earlier in this chapter (1.2.2) reference was made to the different elements of health sector. These are: governance, communities, service providers, resource generators, support services and environment. In this section these elements are introduced in the Punjab perspective, however, starting with communities which are the focus of the health sector:

1.3.3.1. Communities

The community consists of people living together in some form of cohesion; and varies widely in their socio-economic profile and size, ranging from a cluster of homesteads to hamlets, villages, towns and cities, where they are organised formally or informally. These organisations, whether social, political or those based on some interest, may take different forms like firms, trade unions, political parties, interest groups etc (Rifkin *et al*, 1988). The importance of such bodies lies in that they provide an avenue for community entry; people by this means come into an active relationship with the healthcare providers and health governance (Tareen and Omar, 1997, Tarin and Thunhurst, 1998). Further, the communities are in active contact with the resource generators to whom they contribute resources for feeding into the system (see figure 1.1).

72.5 million or 55.6% of the population of Pakistan live in the Punjab province and this is expanding at the rate of 2.55% annually. The influx of Afghan refugees, which started in 1978, contributed to a population growth and the continuing disturbance in Afghanistan was a source of fresh arrivals. Pakistan, in 1999 hosted over 1.6 million Afghan refugees, a significant number of which was located in the Punjab. The rural/urban distribution is 68.7% and 31.3% respectively. Males outnumber females; for every 100 females there are 106.9 males. The average household size is 6.4 persons, which has marginally declined from 6.8 persons in 1981. Age distribution reveals that approximately 43% of the population are less than 15 years of age. The population-density is 353 persons per square kilometre, 85% of which has access to some kind of healthcare (GoP, 1999).

1.3.3.2. Governance

According to the World Bank, this is "the manner in which power is exercised in the management of a country's economic and social resources" (The Mahbub-ul-Haq, Human Development Centre, 1999: 29). In a similarly narrow manner, the United Nation Development Programme defines governance as the "exercise of economic, political, and administrative authority to manage a country's affairs at all levels" (*ibid*). However, the Commission on Global Governance offers a broader view of governance, as "the sum of the many ways individuals and institutions, public and private, manage their common affairs" (*ibid*). In that sense, governance is different from routine management or administration, but it is nearer to the concept of stewardship insofar as its purpose is concerned. Saltman and Davis (2000) view stewardship as a "particular type of governance linked with agency theory and the concomitant role of the state as an agent for its citizens". In other words, governance

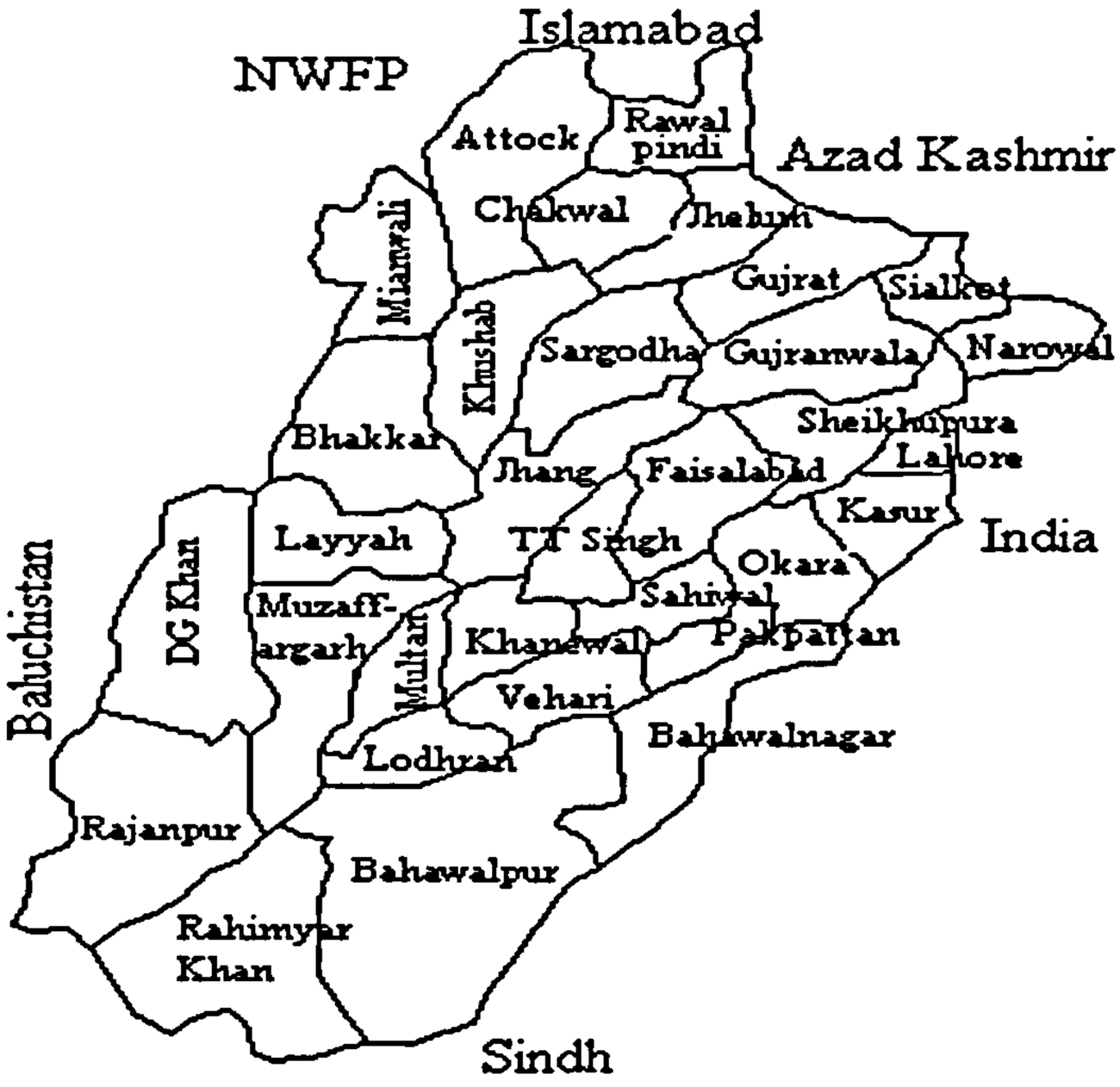
is a function of state, embodying the 'sum of many ways' to ensure various sub systems of the health system perform for achieving its overall goals and protecting the interests of the communities. That is, in this way, the state not only mediates, but also facilitates the health providers in providing services, which are responsive to the needs of the communities.

The major role and functions performed in terms of governance are financing, regulation, and control and administration (Frenk, 1995). These functions vary in an organisation, depending on the extent of decentralisation, and may also overlap. That is, in a most centralised system, governance includes all three functions, while in a decentralised system it may only be confined to regulation. The governance function percolates both vertically in the hierarchy and may have federal, provincial, district and local levels, as well as horizontally across various component organisations at each level in the health sector.

In the following paragraphs, governance functions are described, including a brief commentary on the related issues and problems. Moreover, since social issues and policy have a bearing on the government's preferences for health sector, these are also studied. However, it commences with an introduction of the revenue division, as this forms the basis for the control and administration of the Punjab health sector.

Revenue division of the Punjab

Figure 1.3:- Map of the Punjab



The Punjab has 34 districts (Figure 1.3), each having a varying number (2-5) of tehsils. In rural areas, the union council is a basic administrative unit, 4-5 of which comprise a markaz. A group of 4-6 markaz, in turn, constitutes a tehsil. Each union council is divided into 6-8 mauzas or villages. The urban areas, depending on population size may be

a metropolitan or municipal corporation, town committee and cantonment board that are further divided into the urban/rural wards or union councils (DGHS, 1996).

Social issues and policy

Pakistan is a low income country where 40% of the population live below the poverty line and out of this number 11.6% live on less than US$1/day. Poverty is important, because it affects negatively health status, constraining the population's ability to access health-related services. Similarly, education has a bearing on health status, especially when mothers have basic schooling. However, given that the overall literacy rate is 42% - 55% for males and 28% for females, this situation adds to the worsening of the health status. Sanitation and safe water is a key to the prevention of infectious diseases. However, only 55% of rural households have access to such an amenity (CIA, 2002; WHO, 2000). No wonder then, as noted (1.4.2), infectious diseases form the major bulk of morbidity and mortality. To address such issues, a Social Action Programme launched in 1993 focused on basic health, rural water supply and sanitation, primary education, and population welfare. Decentralisation was also its agenda and figured in the National Health Policy (GoP, 1996). To that end, the government during the 1990s undertook several reforms, which are the subject of this study. This agenda has also been reiterated in the government's programme for reconstruction as outlined in LGP-2000 (NRB, 2000).

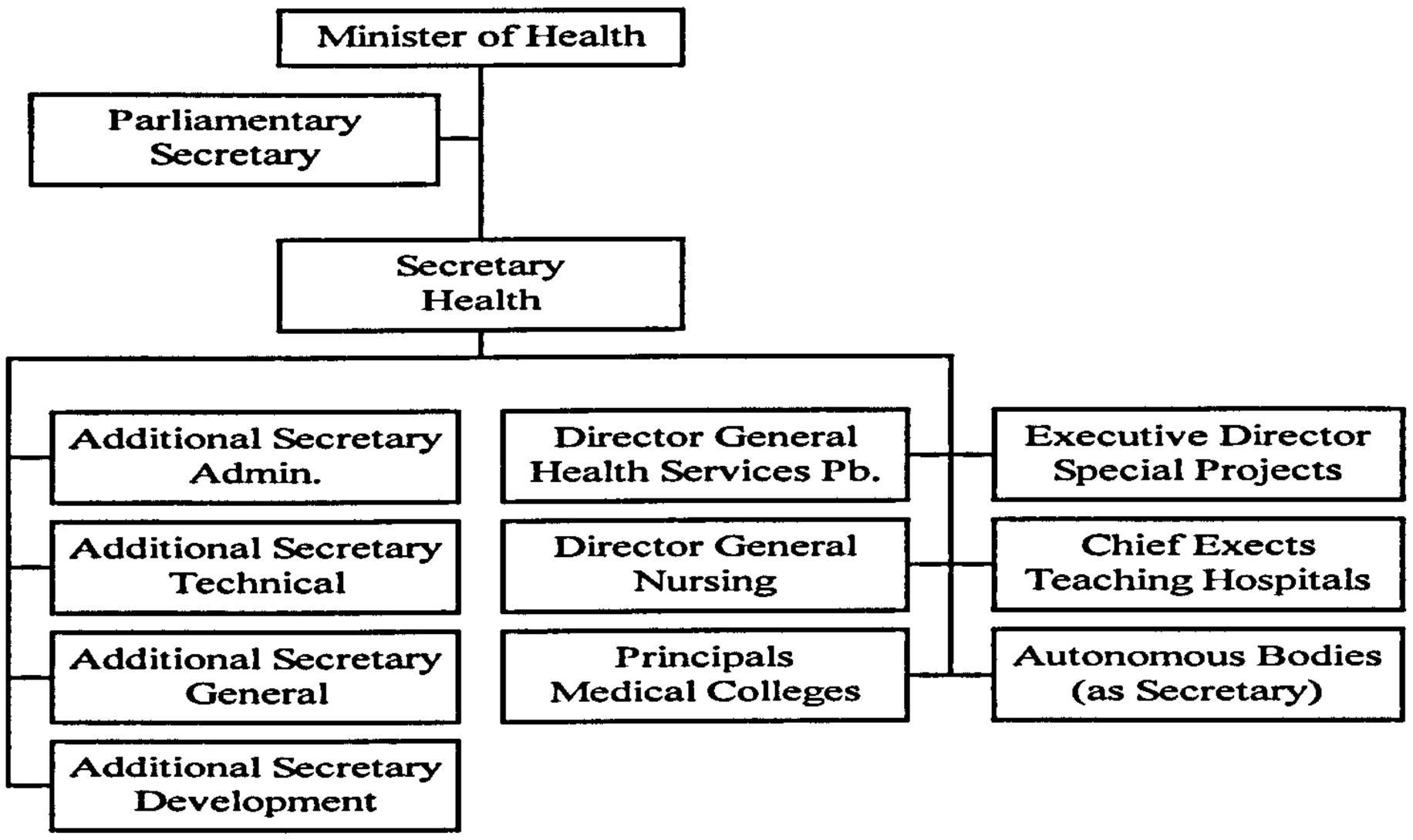
Control and administration of the health sector

The health sector organisation, which originally had a functional structure, by the addition of internationally funded projects and programmes, evolved into a matrix structure. The Punjab health sector organisation as a result expanded: comprising 96 major organisations, about 5000 health care outlets and employing over 100,000 staff. Together with these developments, there has been compartmentalisation in the health sector. That is, different programmes like health education, EPI and CDC were developed as vertical hierarchies within the health sector organisation. And alongside these new structures, the old were allowed to remain, often leading to duality and overlapping of functions (Appendix-1.1).

The top management drawn, both from civil servants and medical profession, has further complicated the organisational structure of health sector (Figure 1.4). The health secretariat staffed mostly by the civil servants constitutes the government and administrative department. A senior civil servant, secretary to the Government of the Punjab heads the health secretariat. On the other hand, the Directorate General Health Service staffed by medical professionals is at the apex of the line Health

Department to supervise health services in the periphery. A director general health services (DGHS), usually a most senior professional, heads this organisation.

Figure 1.4:- Organisational structure – health secretariat



Similarly, there is a parallel Directorate of Projects and Nursing, headed by a civil servant and a most senior nurse respectively reporting directly to the secretary health. Likewise, medical colleges, teaching hospitals, autonomous bodies and certain special institutions report directly to the secretary health in health secretariat.

Regulation of the health sector

Two types of regulatory mechanisms are employed in the health sector. Firstly, there are certain autonomous or semi-autonomous bodies created under some legislative cover. These bodies act as watchdogs and maintain discipline amongst members of the profession in the performance of their obligations through measures like licensing, certification and accreditation. Secondly, the National/Provincial Assemblies have enacted a number of laws including the adoption of laws promulgated during the pre-independence British Rule. Under the powers conferred by these laws, the governments in the centre or province formulate rules for use in the health sector organisations. This researcher identifies twenty-nine such Acts of the National and Provincial Assemblies relevant to the health sector.

Financing of the health sector

The health sector in Punjab is financed through a variety of sources: state, donors and clients` out-of-pocket contributions. There is no mechanism of pre-paid financing like a health insurance scheme in the Punjab (WHO, 2000). Although the

government of the Pakistan Muslim League (1997-99) visualised a National Health Card Scheme in its manifesto, this was not implemented. The 'health account' is not maintained, but the financing of health from various sources is described below:

1. The outlay of state funding of health sector during the 1999-2000 year was Rs. 14.6 billions (Rs. 9.1 billion for the current and Rs. 5.5 billion for development expenditure). This expenditure is equivalent to 0.5% of the GNP or US$ 3/ per capita. This situation of poor health financing is exacerbated by the budgeting routines, especially for recurrent expenditure. That is, whereas the development budget identifies capital resources on the principle of zero-based budgeting, the recurrent expenditure is budgeted based on historical expenditure. Further, stringent purchase and audit procedures make the incurring of allocations difficult, with the brunt falling on recurrent allocations.

2. Donors include mainly the World Bank, Asian Development Bank, Department for International Development (UK), Kreditanstalt fur Wielderaufbau (KfW, Germany), Islamic Development Bank, WHO, and UNICEF. With their assistance, several developmental projects have been undertaken, mostly under the umbrella of SAP. However, this programme, after initial successes, dwindled and finally closed (Dawn, 2002a). According to an official of a donor agency, the provinces lost interest and the districts, which should have been the focus of programme implementation, were neglected.

3. The clients contribute from out-of-pocket expenses to the financing of healthcare. For example, hospitals mainly provide emergency cover, while clients procure medicine and other supplies needed for treatment. Similarly, food is also arranged by patients themselves (Medical Superintendent, 1991). This situation extends to secondary and primary care facilities and outreach services, e.g. people contribute to the purchase of needles and syringes for immunisation.

1.3.3.3. Healthcare providers

The healthcare providers range from a unit service focused on individuals to the comprehensive care provided to communities, localities and regions. In a household, this may be personal care as a result of a health promotion message delivered on radio or a mother treating the childhood diarrhoea using home-made Oral Rehydrate Salt (Kleczkowski *et al*, 1984). The TBAs, traditional healers, or community health workers offer such services in communities. In the public sector, these services are provided by out-reach workers in rural areas, and at population centres static curative services are added to the package. That is, health services in the Punjab are inclusive, i.e. higher-level care facilities provide lower level care with or without

referral and comprise a network of health programmes and about 5,000 health facilities (DGHS, 1997). Briefly, these are (World Bank, 1992, GoPb, 1993):

1) The tertiary care facilities, often attached to a teaching institution, are situated in the big cities. These facilities have specialist referral services and also serve as a place for the training of medics, nurses, and paramedics.

2) The DHQ and THQ hospitals are secondary care referral facilities, where specialists like physicians, surgeons, radiologists, oto-rhino-laryngologist, ophthalmologists, paediatricians, gynaecologists and obstetricians are available. The bed strength for a DHQ hospital varies from 125 to 350, while a THQ hospital has 40 to 60 beds.

3) The RHCs, BHUs, Maternal and Child Health (MCH) centres both urban and rural, sub health centres, and dispensaries are the first level primary care health facilities. Whereas the former two were added to the health care infrastructure during the 1980s, the other three are the legacy of the old continuing system.

   The RHCs are 8-20 bedded small rural hospitals where diagnostic and operating theatre facilities are available. These act as a first level care referral facility. The BHUs are out patient facilities with 2 beds available for emergency and obstetric care. The MCH centres, although built-in to the structure of rural health centres and basic health unit, are also independent units in the rural and urban localities. Sub health centres and dispensaries are the satellite outpatient services in rural areas staffed by a dispenser appointed from an RHC.

4) The primary health care (PHC) is also offered through outreach services: i) health education services; and ii) outreach teams for rural areas. For the former there is no formal set up in the districts, but at the provincial level, there is a special section. The outreach teams, one for each union council, usually comprise a vaccinator, a CDC supervisor, and a sanitary inspector. They visit the households to provide preventive and promotive health care to the people on their doorsteps. Similarly, the federal government launched a National (formerly Prime Minister's) Programme for expanding the availability of family planning and primary health care services to the rural areas and urban slums. Although, not provided globally, one lady health worker is appointed to serve about 200 households through a health house established in her own home.

5) Through the outreach services and parallel to the mainstream healthcare delivery network, different health programmes have also been organised for combating specific diseases. These are listed below:
   a) Reproductive Health Services
   b) Health Education

c) School Health Services
d) Expanded Programme of Immunisation
e) Integrated Management of Childhood Illnesses
f) Communicable Disease Control
    i) Sanitation and Environment
    ii) Malaria Control
    iii) Tuberculosis Control Programme
    iv) Leprosy Control Programme
    v) ARI Control Programme
    vi) HIV/AIDS Control Programme
    vii) ORS and Control of Diarrhoeal Diseases
g) Food & Nutrition

6) In addition to Allopathic medicine, Tibb and Homeopathic medicine is also provided in the public sector through a network of 128 Tibbi dispensaries and 128 Homeo dispensaries. The government established a Tibbia Medical College, which grants degrees in Tibb after four years of study. A national council for Tibb and Homeopathy has been established as a watchdog for alternative medicine practice, and a section in the Directorate General of Health Services is responsible for the control and administration of these services (DGHS, 1997).

1.3.3.4. Resource generators

The resource generators may be: (a) human resource institutions such as the schools and universities; (b) technology producing research organisations, firms and companies; and (c) financial institutions (Frenk, 1994). The resource generators relate to the communities from where they receive resources like pupils and funds for feeding into the governance. The latter operates as a mediator determining the nature of the relationship between the former two, i.e. resource generators and communities. Since financing of health services has already been considered (1.3.3.2), it will not be discussed here. However, a brief introduction to human and technological resources is given below:

1) Human resource establishments like schools and universities are the hub of the health sector to produce human capital. There are over 157 health human resource institutions in the Punjab, including a whole range of undergraduate and postgraduate pre-service and in-service institutions (DGHS, 1997).
2) Technological resources include research and developmental organisations responsible for developing techniques for the diagnosis, management of illnesses

and maintenance of healthcare standards. In the Punjab health sector, there are a few organisations that work towards this objective and include the following:

a) Pakistan Medical Research Council – Punjab branch;
b) Standardisation of Medical Equipment – established in secretariat; and
c) Other research organisations e.g. Institute of Public Health.

1.3.3.5. Support services

The support services constitute instruments, largely determining the efficiency and effectiveness of the health system (Barker, 1996: 24-26). Primarily performing staff functions, these services include: management information systems, supplies and inventories, estate and equipment maintenance and quality assurance. Often support services are taken jointly with the service providers, and overlap those functionally in certain areas. For example, they facilitate the healthcare providers in delivering services and may also support the management in discharging its governance role. However, the framework for this study considers them as being separate because in that case it is easier to conceive of the outsourcing of services. In the Punjab health sector, a number of support services are organised which are listed below:

1) Health Management Information System
2) Transport Maintenance Organisation
3) Health Equipment Maintenance Organisation
4) Estate Management – through Buildings Department
5) Drugs Administration and Quality Control
    a) Procurement and Supplies (Government Medical Stores Depot)
    b) Provincial Quality Control Board (Drugs)
    c) Drugs Testing Laboratory
6) Surgeon Medico-Legal
7) Chief Chemical Examiner
8) Blood Transfusion Services and Serologist to the Government of Punjab
9) Government Public Analyst
10) Bacteriologist to the Government of Punjab

1.3.3.6. Environment

Study of the health system environment is essential, notably because many answers to ill health are found outside its domains (WHO, 1978). It is argued that the health system exists in an environment, which may be internal or external. The former hosts different sub systems of the health system. The latter is external to the

boundaries of the health systems and has two layers harbouring the national and international hegemonic systems respectively. The former refers to the nation state and people in terms of their history, culture, health problems, economy, welfare and political systems. These national systems could be either allied or others. In the Punjab, the former include the Local Government and Rural Development, Education, Population Welfare, Social Welfare and Punjab Social Security Institutions. The latter, which include politics, economy, agriculture, food and industry, do not directly concern the health sector, but affect health. International systems include bilateral and multilateral aid organisations, international economic agreements and non-governmental organisations. These institutions, because often control the developing countries by setting boundaries in terms of agreements and conditionalities, are also called hegemonic (Twaddle, 1996).

In the case of Punjab, the hegemonic systems include the World Bank, International Monitory Fund, Asian Development Bank, the United Kingdom Department for International Development, German KfW, Islamic Development Bank, WHO, UNICEF, and other UN agencies. For binding recipient countries these institutions employ different instruments e.g. structural adjustment programme. While aimed at rectifying macro-economic imbalances, Bennett (2001) argues, these programmes have an adverse impact on the developing economies including Pakistan.

1.4. Health status and issues

In the preceding section the structure and functions of the Punjab health sector were discussed. This section will examine the status and issues impacting on it. In this regard a considerable quantity of literature both published and non-published is available (GoPb, 1993; World Bank, 1992; World Bank, 1998). However, this study relies on a survey report (GoPb and DFID, 1999). This report is comprehensive and its structure is compatible with the framework used for this study. Regarding the timing of the survey, this relates to the later part of the study period, but this researcher is confident that the situation would have been same in the initial years. Therefore, its findings are considered valid for the purpose of this study.

This survey was conducted in ten districts, selected for geo-political reasons to introduce the District Health Governments – one of the reforms, on which this research is focussing – with the intention of establishing a baseline situation of the district health system in the public sector. It may be noted that the main focus of report is on primary and secondary care in the rural areas; nevertheless the issues and problems identified are crosscutting and extend to tertiary care as well. A

snapshot of the same will be presented here. However, the scene is set by presenting some key indicators of health and the burden of disease.

1.4.1. Key indicators of health

Life expectancy at birth for males is 60.6 and for females it is 62.3 years. The crude birth rate has declined from 41.7/1000 in 1984 to 33.8/1000 in 1997. Similarly, the crude death rate has witnessed a decline from 10.9/1000 in 1984 to 8.9/1000 in 1997. However, the total fertility rate remains at 4.4 in 1999. The infant mortality rate, which was 112/1000 in 1984 declined to 84/1000 in 1997, and the maternal mortality rate was 340 per 100,000 live births (GoP, 1999). Four million cases came to public sector health facilities in one year, the majority suffering from communicable diseases: acute respiratory infections (31%), diarrhoeal diseases (23%), malaria (6%) and scabies (3%). Similarly, 40% of children below 5 years suffered from some degree of malnutrition (DGHS, 1997).

A review of the key indicators reveals that the health of the population in Punjab (Pakistan) has improved over the years. However, the country is still some way behind the average for low-income countries including those with a comparatively lower GNP per capita. The burden of disease indicates that communicable infectious diseases account for the bulk of morbidity and mortality. Other important causes are reproductive health problems and nutritional deficiency disorders. Thus, according to a study, Pakistan "is still in the epidemiological transition, with basically preventable or readily treatable diseases affecting primarily young children and women of reproductive age accounting for a dominant share of mortality and morbidity" (World Bank, 1998: iii).

1.4.2. Issues and problems

Findings of the above mentioned survey report (GoPb and DFID, 1999) reiterated the often-raised concerns and the need to undertake reforms (GoPb, 1993; World Bank, 1992; World Bank, 1998). Briefly, the following gaps have been identified:

1. The district health officer lacks capacity in terms of human as well as financial resources and the authority to effectively deliver and supervise health services in a district. Performance indicators are not used.
2. The PHC facilities are generally ill equipped, under-staffed or under utilized; many of these are ill planned and badly located. A large number of posts of doctors, especially lady doctors, remain vacant. Trained manpower, especially nurses, lady health visitors and laboratory technicians, is in short supply.

3. The non-salary components of PHC programme are not adequately provided for in the provincial budgets. These include expenses on drugs, diagnostics, repair and maintenance, utilities, monitoring and supervision, transportation, in-service training and health education materials.

4. There exists a gender imbalance as the health staff and managers are predominantly male. This results in poor rapport between the facility staff and the female population who are the critical link to reach young children.

5. At the DHQ/THQ level hospitals, there are shortcomings in emergency care, surgical services, anaesthesia and laboratory facilities, and maintenance/ repair of medical equipment.

6. Political interference in decisions, such as recruitment, transfers and disciplinary actions, has resulted in lowering the efficiency and was a major demoralizing factor for the managers and staff. One outcome of this phenomenon is that the staff are often absent from their work places and their attitude towards the general public is unfriendly.

7. Lack of a functioning referral system is the major reason on the one hand for poor handling of obstetric and other emergencies in rural areas, and on the other puts undue pressure on tertiary hospitals.

8. Private practice engaged in by the public sector physicians and specialists is a universal malaise. It is at the expenses of time and energy which government doctors should be spending within hospitals.

9. Family planning services are provided as a vertical program, indicating an absence of health/population linkage essential for a successful population programme. These services are generally not available in all health outlets, and the non-availability of female staff in rural areas compounds this problems.

10. There is centralisation of management with little powers delegated to the lower levels leading to the inefficient use of resources and control. The stringent purchase and audit procedures further deter the incumbents from incurring expenditure in the public sector.

11. The inefficient use of resources added to the economy drive is exhibited as shortages of medicines and consumables, giving rise to the poor service quality and lack of community confidence. As a result, people are alienated from the public sector and often ignore its existence, not to mention its utilisation.

1.5. Reforms in the Punjab health sector

In the preceding section, the status of the Punjab health sector was described. To remedy the problems, the government of the Punjab (GoPb) made repeated but diverse attempts for reforms, and table 1.1 identifies seven different major initiatives undertaken in the health sector during 1993-2000.

Table 1.1:- Health sector reforms 1993-2000

Implementation period	Name of initiative implemented
1993-98	Sheikhupura PHC Pilot Project
1996/97	District Health Management Teams
1997-00	Delegation of Financial Powers to Senior Medical Officers at RHCs
1997-01	Contract Appointment of Medical Officers and Lady Health Visitors
1997/98	District Health Authorities
1998-	Granting Autonomy to the Medical and Health Institutions
1998/99	District Health Government

These reforms, as indicated earlier (1.3.1), were introduced under the overall ambit of SFHP and SAP. Four of these reforms: (i) Sheikhupura Pilot Project (SPP); (ii) District Health Authorities (DHA); (iii) the Granting Autonomy to the Medical and Health Institutions (IA); and (iv) District Health Governments (DHG) are selected for in-depth study, and will be reported as case studies in chapter 5. However, a brief resumé of the remaining three, constructed from the intelligence gathered during the pre-fieldwork stage of this study, is presented in this section. Nonetheless, it will be noted that decentralisation was the strategy common to all these initiatives.

1.5.1. District health management teams

District Health Management Teams (DHMTs) were established in 1996-97 with the aim of consolidating healthcare in a district by bringing both the primary and secondary care under the authority of DHO (PHDC, 1996). The rationale was that managing a district health system in this way was likely to improve the efficiency, performance and competency through the improved operational management and on-the-job training and supervision by the DHMTs (Omar, 1996).

The concerned divisional director health services (DHS) issued a notification laying down the membership, responsibilities and roles, procedures and resources for the DHMTs. All components of the district health system, except communities, were represented. A planning sub-committee was formed to develop a district profile and

district annual plan. While no additional resources were allocated for this new body, it was entrusted with a wide range of responsibilities for managing the health system through regular inspection, monitoring and meeting.

DHMTs were established in 17 districts, where district health development centres existed and the DHS and or DHO were receptive. A workshop format was used as a tool to launch the DHMTs. The issues addressed in the workshop included: agreement on its membership and the constitution of the planning sub-committee, roles and responsibilities, salient features of district profiles and a district annual plan, and the mechanism for the working of DHMTs. A profile for eight districts and a manual for district planning were prepared[1]. However, there was no structured follow up and there is no evidence that the DHMTs ever met subsequent to their notification (Griffith, 1997).

1.5.2. Delegation of financial powers to the senior medical officers at Rural Health Centres

This intervention was made in 1997 in a bid to decentralise financial powers and bypass the bureaucratic channel to ensure on-time availability of resources to the RHC. This arrangement also gave the senior medical officers (SMO) a voice in management. That is, hitherto as part of the healthcare provider subsystem, in the new set up the SMO had an enhanced governance role.

The RHC was declared the accounting unit and its in-charge SMO was delegated the powers of drawing and disbursing officer (DDO). This led to the RHCs appearing in the provincial budget book. S/he was declared a DDO in category-IV; empowered to incur expenditure according to the financial rules, bill the district accounts office, and receive cheques and payments from the State Bank of Pakistan. S/he was responsible for undertaking such activities as prescribed and made answerable to a regular annual audit. The concurrence of the DHO was sought only if the amount likely to be incurred was beyond the SMO's financial powers.

Seven workshops, each of two days' duration, were arranged at the Provincial Health Development Centre (PHDC) for the training of SMOs. The topics covered included, decentralisation and the challenges it poses for human resource and financial management and the DDO procedures. Out of the total of 289 SMOs, 196 (68%) participated in training. However, the intervention had some problems and concerns were raised. The SMO of the RHC had been delegated financial powers in respect of the facility of which s/he was in-charge. However, for BHUs and other

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[1] Personal communication with a Programme Director in the Provincial Health Development Centre

facilities in the catchment area of the RHC, the DHO continued to function as DDO. Furthermore, the administrative authority for the RHC staff also remained with the DHO. Moreover, this initiative added to the functions – accounting and audit – for the SMOs, while no additional resources were provided[2].

1.5.3. Contract appointment of medical officers and lady health visitors

This intervention initiated in 1997 was aimed at filling the vacant positions, curbing absenteeism and bringing discipline and efficiency into the health sector. This reform envisaged also replacing the existing centralised human resource management and in a way evading the protection enjoyed by the civil servants under the Civil Servants Act, 1974. Since contract employees are not covered under this Act they are subject to summary proceedings for any misconduct.

A Divisional Recruitment Committee (DRC) headed by the DHS was constituted to recruit and select the medical officers (MO), Women Medical Officers (WMO) and lady health visitors (LHV) for contract appointments against specific positions. The list of the successful candidates was then forwarded to the secretary health, who formally made orders for their appointment. To these non-transferable incumbents, a better pay package was offered. Similarly, in the case of absence from duty or any other misconduct, the incumbents would be dismissed from service at the recommendation of the DHS.

A manual 'Training 2000[3]' outlining a curriculum for the orientation and training of doctors appointed on contract was published. The master trainers were trained at the PHDC and a two days induction training of contract doctors was undertaken in the District Health Development Centres (DHDC). However, this activity did not continue for long, mainly because the trainees would be too few in number to run such a course. Later, a ban was imposed on contract appointments. This ban was relaxed, but an officer from the Army Monitoring Team of the area was inducted onto the Divisional Recruitment Committee.

However, contrary to the expected improvement in the efficiency and effectiveness of the health system, this type of employment arrangement increased the frustration of doctors and other incumbents. That is, this intervention eroded the health services organisation, as it became difficult to decide, who the government would promote to

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[2] Discussion of this researcher with a number of senior medical officers in charge of a Rural Health Centres

[3] This title takes its origin from that it was expected to select and train 2000 contract doctors.

grade 18, when the pool of the regular incumbents in grade 17 was exhausted. Also the government did not devise a system for absorbing contractual doctors into the regular health services[4].

1.6. Summary and conclusion

In this chapter a framework was developed to describe the structure and functions of the Punjab health sector. The intelligence gathered during pre-fieldwork, coupled with the knowledge and experience of this researcher helped in achieving this objective. Further, drawing from secondary source, issues confronting the health sector were explored. To address these problems the government undertook different remedial measures, using decentralisation as a common strategy.

Despite substantial inputs, a number of these were abandoned, others forgotten while some remained. Given this study aims to examine why these trajectories occurred; chapter 1 has established the context, providing a base for discussing the concepts surrounding different initiatives undertaken in the Punjab health sector. This will be done in the next chapter.

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[4] Personal communication of this researcher with a Deputy Secretary of the Health Department

2. The Concepts

2.1. Introduction

In the preceding chapter a framework was developed to examine the structure and functions of the health system. It revealed that because of the many issues confronting the Punjab health sector, the government made repeated and diverse attempts to reform and that decentralisation was a common strategy for these initiatives. This chapter, in this background, sets out to:

1. conceptualise the health sector reform in section 1;
2. explain the strategy of decentralisation in section 2; and
3. explore the concepts surrounding the policy arena in section 3.

In the discussion that follows, a conscious effort is made to contextualise the concepts to the Punjab health sector. The reader may, therefore, expect the discussion to be informed with examples from the Punjab health sector.

2.2. Health sector reform

There is a diversity of opinion about what constitutes health sector reform. The confusion, as Flood (2000) argues, is intensified by the ever-emerging phrases and acronyms for denoting the arrangements between government, private insurers, purchasers, providers and patients. Therefore, it is considered necessary that some agreed understanding of the phenomenon is evolved. This section attempts to achieve this objective in three sub-sections. Firstly, the terms are defined followed in sub-section 2 by a resumé of developments that occurred in the concept over time. Finally, a debate is presented about why there was a vicious cycle of reforms, identifying a conceptual gap; and what should be done to avoid such occurrences?

2.2.1. Definition

The term reform refers to "a change made to a system or organisation, in order to improve it, remove unfairness etc" (Longman, 1995: 1188), and is distinct from revolution or evolution. The former denotes a "great, usually sudden social and political change, especially the changing of a ruler or political system by force"

(*ibid*: 1217). The latter, on the other hand, is a "gradual change and development of an idea, situation or object" (*ibid*: 470). These terms are introduced because similar situations were encountered in the Punjab health sector. In October 1999, there was a sudden change of the ruler and political system – from a democratically elected government to an autocratic military rule. Further, the reforms that were initially confined to the health sector and remained in the range of deconcentration and autonomy were expanded to invoke devolution and establishing district governments with elected assemblies. Similarly various observers saw the reforms undertaken during the study period as passing through the evolutionary phases[5].

Reform implies building upon and improving what exists in order to convert it into another or a better form or an amendment or altering for the better some faulty state of things (Oxford English Dictionary, 1971). In this regard, it has been argued that any reform, by default, must aim to reconstruct an existing structure or system in order to enable it to achieve its original end(s) in an improved way (Seedhouse, 1995). However, the question arises as to what should warrant 'reconstruction' and what is meant by 'improved way'? Gonzalez-Block (1997: 191) regards the reform phenomenon as "the removal of evils or corrupt elements out of the body politics or to the willed evolution of the social system towards a better stage of being". But, this is a narrow definition, focusing on governance issues in society.

Berman (1995: 15) notes that reform "signals something substantial and fundamental, complex and extensive implying, at least, a change in what is done, how it is done and who does it". In this background, he defines the health sector reform as a positive change that implies "a process of sustainable, purposeful change to improve the efficiency, equity and effectiveness of the health sector". This definition is comprehensive encompassing the nature and purpose of change as well as the outcome; and can also explain certain associated terms using the health system framework. Accordingly, health care reform or health services reform means change in the health care or health services component of the health system. Similarly, health system reform envisages the broader change involving the relevant sectors in the environment where the health sector operates.

Notwithstanding the above definition, in order to enquire into a reform initiative and to draw questions for that, a further question is posed: what are the dimensions of change that merit a reform? Although this is a critical caveat, it is not to narrow the concept, but is an attempt to draw the specifications for comparative purposes. Accordingly, any change to be called reform must satisfy five conditions: (1) the

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[5] Discussion of this researcher with a number of officials in the Punjab Health Department

delineated area of activity that is to be reformed; (2) the originally desired purpose of this delineated activity; (3) why the existing set-up did not achieve the desired purpose or was achieved at an unwanted cost; (4) how such a situation was addressed; i.e. what was the reform; and (5) to determine that the intervention is actually happening, it is essential to install an information system (Seedhouse, 1995; Berman, 1995). Dougherty (1996: 4) added more variables to these determinants, i.e. such an intervention should lead to: (i) improved health statistics, (ii) a financially leaner system with sustainable growth, and (iii) a system, which is politically acceptable, enjoying support among the citizens and health services providers.

2.2.2. Developments

Gonzales-Block (1997) identified three overlapping generations of health system reform: structural consolidation, managerial changes, and introduction of market pressure during the 20th century. The former two generations, collectively, are also termed bureaucratic reforms, distinguishing them from market reforms. The structural reforms, which precede the managerial reforms, refer to the creation of new health services and institutions like the National Health Service (NHS) in the United Kingdom (UK), and introducing different decentralisation moves. The managerial changes refer to: financing interventions like the introduction or modification of health insurance systems, improvements in policy process such as employing cost-efficiency methods for selecting health service packages, and health management improvements by granting autonomy to hospitals and institutions. Similarly, three variants of market reforms are: internal market reform and purchaser -provider split, managed care competition reform and managed care (Sheaff, 1999; Flood, 2000). The market reforms, as will be seen, are not relevant in the Punjab perspective. However, to encapsulate the developments, it is worthwhile to briefly review these reforms.

- The internal market reforms introduced in the UK and New Zealand require the purchaser – the government appointed agency e.g. health authorities – to enter into contracts with the competing public and private health providers.
- In managed care competition reforms introduced in the Netherlands, there is competition between the insurers on the basis of cost and quality. The insurer, in this arrangement, has both a purchasing and management function in addition to risk bearing, and a government appointed agency facilitates transaction between the consumer and the insurer/purchaser.
- Managed care is a component of managed competition reform. However, since this type of reform has become increasingly important, it merits separate consideration. The provider, in this case, within a pre-determined allocation,

released in advance, is responsible for caring for a defined population. By this arrangement, compared to the remuneration method, the providers retain any savings in return for assuming the responsibility for any possible loss. The consumers, in this system, choose from the managed care plans and in case of any utilisation of services from outside the plan, are subject to paying out-of-pocket (Flood, 2000; Battistella, 1993).

So far, the terms used to designate different types of reforms have been introduced. In the following, drawing mainly from the World Health Report, 2000 (WHO, 2000) the chronology of the appearance of various reforms on the scene during the 20th century is given. Correspondingly, a commentary is made about the occurrence and relevance of different generations of reforms in the Punjab.

2.2.2.1. First generation reforms

The first generation reforms, traced during the 1940s and 1950s extending to the 1960s, marked the founding and extension of the national health care and social insurance systems in richer countries. This era corresponds to the withdrawing of colonial rule from developing countries including the Indian sub continent, of which the Punjab (Pakistan) forms a part. Since the colonial health services were purpose specific, driven by the needs of overseas colonial rulers and local élite these could hardly meet few of the needs of the larger indigenous population (Collins, 1994). Therefore, first generation reforms in developing countries are seen as occurring during the early post-independence years. These are, in a way, post-independence continuation and expansion of the colonial health care system (Gish, 1979). Banerji (1974) notes, the 'Brown Englishmen' – the local members of the hitherto Royal Indian Civil and Medical Services trained in the traditions of western countries – had a profound effect on shaping post-colonial health services. Thus, from 1947 through to the 1970s, mass campaigns were launched against specific health problems like malaria and smallpox, leading to eradicating the latter, while containing and maintaining the prevalence rate of the former. This period also saw the urban bias and emphasis retained in medical colleges and teaching hospitals in the Punjab (see also 1.3.1).

2.2.2.2. Second generation reforms

The hallmark of second-generation reforms was primary health care, as a means to achieving universal coverage. Developed countries during this era were able not only to integrate primary health care into the whole system, but also moved in the latter half of the 1980s to the next generation of reforms (WHO, 2000). However, the Punjab, as indicated earlier (1.3.1), starting in the late 1970s through the 1980s,

followed this course. Pakistan signed the Alma-Ata Declaration, and to increase health coverage an integrated network of rural and urban facilities was established. This expansion bore the imprints of the recommendations of a pre-independence Bhore Commission, 1946 (GoI, 1946). However, the gap between coverage and resources increased, also affecting the quality of services. Different programmes failed to achieve their purpose. In this regard particular reference is made to the referral system, which was difficult to operate (WHO, 2000; Siddiqi *et al*, 2001). The lower level services were poorly utilised; the patients bypassed them and went directly to the higher level of care. While this could be attributed to the bias for tertiary and urban based health care, the overall deteriorating status of the Punjab health sector (1.4) heralded different reforms undertaken during the 1990s.

2.2.2.3. Third generation reforms

Whereas the first and second generation of reforms were oriented to healthcare supply and the providers were granted a predefined budget, the strategy for the third generation reforms changed so that "money follows the patient". Managed care was introduced, emphasising the strengthening of primary health care in order to avoid unnecessary hospitalisation, as a mean to cost savings (WHO, 2000). In this sense, role of government, is redefined i.e., the market forces combined with government planning drive the health system. This approach requires the "purchaser – government appointed authorities, private insurers, or risk-bearing groups of health providers – to proactively manage and allocate resources amongst different health care needs" (Flood, 2000: 1).

However, the Punjab was some way behind, attempting to follow the course during the 1990s. As a matter of fact, as in other low-income developing countries, the policies continue to address basic systemic questions such as allocation priorities, role of government vis-à-vis private and non-government organisations, capacity building in key support and delivery systems, and content of the service package (Peters and Chao, 1998). Only in one of the reform initiatives – DHG – the language of third generation reform was used. However, because this initiative could not be implemented, the Punjab did not go into this phase, instead it moved backwards.

Led by the WHO and UNICEF, National Immunisation Days (NIDs) were launched repeatedly against the priority diseases – polio and vitamin-A deficiency disorders. *Sine qua non* to accepting the conceptual and pragmatic dominance of selective primary health care, this practice has eroded the healthcare network established for comprehensive primary health care. For about one month for preparation before, two weeks for implementation and at least two more weeks for consolidation, the entire

health sector focuses only on work related to each NID (Khan *et al*, n.d). Consequently, routine immunisation coverage, which was among the highest during the 1980s[6], sank to its lowest ebb in the 1990s, and Pakistan is still among countries where polio is prevalent. During 2001, it reported 85% of the confirmed polio cases in the Eastern Mediterranean region and 25% of such cases globally (WHO, 2002).

2.2.2.4. Beyond the third generation

By the close of the 20th century, developed health systems, such as in the USA, were again faced with access problems, escalating costs and rising concerns about quality. However, while they were preparing to move into another round of reform (Dougherty, 1996: 1), the Punjab, after having experimented with several reform initiatives, embraced devolution. The military government implemented its LGP-2000 (1.3.2). All government functions and responsibilities, including the levying of taxes, have been devolved to the district (Dawn, 2001). An elected assembly headed by a Nazim manages affairs, while the civil servant deputy commissioner re-designated as the district co-ordinating officer assists him/her. Thus, the districts can now plan, implement and monitor their activities, while the provincial authorities concentrate mainly on policy development and supervision (PHDC, 2001).

2.2.3. Vicious cycle

So far, in the discussion, it was noted that in the 20th century, whereas a generation of reforms overlapped the other, developed countries outpaced the developing health systems. That is, the former moved into the next generation, while the latter were still struggling with the preceding generation of reforms, and even sometimes moving backward. Further, in many cases, the same issues emerged again with varying intensity. Why did this vicious circle happen? Moreover, indeed the search for a better tomorrow should never stop, but was there any factor in the reform process that triggered the next round of reforms? To ascertain this, focusing on the study period including the latter half of the 1980s to 2000, the reasons propounded for reforms vis-à-vis the proposals made in the context of developing countries are contrasted in the following discussion.

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[6] The EPI in Pakistan, after evaluation in 1984, won international recognition. The coverage against vaccine preventable diseases in Punjab exceeded 95% in children of 2-5 years age and 81% in less than 2 years. Source: discussion with a medical officer of the Punjab's EPI programme

2.2.3.1. Why reforms?

There is a huge body of literature about reforms, but given the boundaries for search laid down above, the following examples are selected for outlining the reasons for reforms:

- The World Bank (1987: 2-3), generalising the characteristics and performance of health sectors in developing countries noted three main issues: insufficient resources, inefficient services, and inequity in the distribution of benefits from health services.
- Cassels (1995) puts the issues identified by the World Bank in a different language. That is, inefficient use of scarce resources and inaccessible services, which are not responsive to the needs of people.
- In the Punjab perspective, a World Bank (1998) report notes: insufficient focus on preventive interventions, gender imbalance, excessive centralisation of management, negative staff attitudes and absenteeism, political influence, lack of openness, weak human resource development and insufficient non-salary budget.

2.2.3.2. What reforms?

Turning to what remedial measures or initiatives were suggested vis-à-vis the problems identified, the prescription by the above three authors are given below.

- The World Bank (1987: 3-7) proposed four agenda items for health financing: user charges, insurance coverage, effective utilisation of non-government resources, and decentralising the government health services.
- Cassels (1995) lists six main components of reform programmes: improving the civil services; decentralisation; improving the functioning of ministry of health; broadening health financing options; introducing managed competition; and working with or outsourcing services to the private sector.
- For Pakistan (Punjab), the World Bank (1998) proposed four interventions: (i) achieving a sharp focus on service priorities, (ii) stressing cost recovery, (iii) encouraging hospital autonomy, and (iv) improving efficiency and management of government services. Further, a number of options including decentralisation were also proposed to realise the last (fourth) agenda item.

2.2.4. Conceptual gap

From the above, it is seen that each author suggested a range of interventions for remedying problems confronting the health sector. For studying these further the framework for health sector developed earlier (1.2.2) is applied to classify both the

issues identified and the reform agenda suggested. Accordingly, in table 2.1 below, the authors are plotted in the vertical columns vis-à-vis the problems (in white) and remedies (in shaded) for the different components of health systems given horizontally. Support services are missing from this table because no author addressed these either not seeing these as problem area or no remedies on offer.

Table 2.1:- Mismatch between health sector issues and suggested remedies

Author	Governance	Provider	Communities	Resource generator
World Bank 1987 (Problems)	-	Inefficient services	Inequity in the distribution of benefits	Insufficient resources
World Bank 1987 (Remedies)	Decentralisation	-	-	User charges, insurance coverage, utilisation of non-governmental resources
World Bank 1998 (Pakistan specific problems)	Gender imbalance, centralised management, negative staff attitude and absenteeism, political interference and lack of openness	Less focus on preventive services	-	Low non-salary budget
World Bank 1998 (Pakistan specific remedies)	Hospital autonomy and improving efficiency and management mainly through decentralisation	Sharp focus on service priorities	-	Cost recovery
Cassels A (1995) (Problems)	Inefficient use of resources	An-accessible services	Non-responsive services	Scarce resources
Cassels A (1995) (Remedies)	Improving civil services, decentralisation,	Improving MoH functioning		Broadening health financing options

Key: Non-shaded cell: Problems Shaded cell: Remedies

The study of table 2.1 leads to, at least, the following four observations:

1. While defining problems some components from the analysis were missed: only one author (Cassels) considered all the elements of the health system while identifying the problems. However, none of them addressed all the components

when suggesting the remedies. For the individual components, the communities were the most disadvantaged. In one case, some remedy was offered to meet their demands. Governance and financing topped the agenda for all three authors, while providers were considered by two of them.

2. The World Bank (1987) document did not identify any governance issue facing the world health systems. However, according to its 1998 study, the Punjab suffered from an array of such issues.

3. Generally, the reform package was not proportionate to the problems. The World Bank (1987) prescribed decentralisation, while correspondingly there were no governance issues. Further, problems were identified concerning both the communities and providers, but commensurate measures were not suggested in the reform package.

   In the case of Pakistan the prescription largely matched the diagnosis, except for community demands and behaviour. Similarly, Cassels (1995), while comprehensively identifying issues, including those relevant to the community, did not correspondingly prescribe the remedies.

4. The generic reform package did not match the development stage of the target health system. For example, the package proposed by Cassels (1995) has elements from all three generations of 20th century reforms, including managed competition and outsourcing.

One may like to defend Cassels' (1995) views that a generic prescription was prepared for a range of countries at varying development levels. However, the question arises; given the shortage of an indigenous capacity for policy analysis, who will determine the nature and method of administering the reform intervention to the ailing systems? For example, it is dangerous to recommend market changes for countries which already face access problems because the former are likely to exacerbate the latter.

2.2.5. System thinking approach

The World Health Report, 2000 attributes the failure of primary health care to the lack of attention given to the *demands* of people; instead the focus remained on their presumed *needs* as determined by providers. The report concludes that because the two concepts did not match, the system that was built on these concepts failed (WHO, 2000: 14). This principle of mismatches between the 'why' (a *raison d' être* or the underlying aetiology) and 'what' (remedial measure or prescription) of reform leading to the failures is also applicable to the other situations. That is, the reforms failing to deliver and the same issues occurring again and the reformers were

prescribing the same remedy in a different wrapping. Ham (1997: 135), in the case of five developed countries, noted that "if health policy in the late 1970s and early 1980s was dominated by the concern to achieve cost containment at the macro level, and in the late 1980s and early 1990s focused on measures to increase efficiency and enhance responsiveness at the micro-level, then in the mid 1990s attention has turned to the cost-effectiveness of health care and the difficult choices involved in setting priorities". Thus, it was primarily economic concerns that underlay the reform efforts made cyclically over time. Interventions were made, which provided a solution in the short-run, but in the long-term the problems recurred, and there was a need to intervene again. This is because of the narrow vision of the health system held by the "system physicians" (policymakers); they looked for some short-term symptomatic relief and not the long-term cure.

Notwithstanding the above, the question still arises – what could have been done to avoid such occurrences? Fraser and Wilson (2002) argue that for bringing about a change the stakeholders need to change the way they think and work, for it is relevant to understanding the complexity involved in health care. They propose a 'systems thinking' approach, the basic tenet of which is to involve all those who are part of the system being explored. Further, because the health system is a social system, there are many relations and interactions between its different components. Like any medication which is attended by a risk of iatrogenicity and idiosyncrasy, tinkering, in any manner, with any component of a system is likely to give rise to a ripple effect, with the other components of the system reacting in response. In this regard, it is essential to understand two features of how the systems work: reinforcing and balancing. In the former case, there is a positive vicious cycle – one event, giving rise to more of the same output. For the latter, however, after triggering, the resulting event will give rise to an event, which will, in turn, limit the first event (*ibid*). Putting this in a different way Flood (2000) observed that the relationship between assuring universal access, controlling costs, and ensuring high quality was a 'zero-sum' game. That is, assuring access is likely to increase the cost and containing the cost, in turn, might diminish quality and *vice-versa*.

2.3. Decentralisation

In the Punjab health sector, several reform efforts were made in rapid succession, nonetheless, employing decentralisation as a strategy common to all these (1.5). It is, therefore, pertinent to examine decentralisation in greater depth, and this section looks at this aspect in two sub-sections. Firstly, after defining concepts, various forms of decentralisation and the rationale for introducing a decentralised structure

are given. Secondly, the experience in the Punjab health sector is considered in order to contextualise the discussion.

2.3.1. Conceptual dimensions

2.3.1.1. Definition

Although, many authors (see 2.3.1.2) have worked on the subject, the definition of decentralisation offered by Rondinelli and Cheema (1983: 18) still remains the most commonly referred one, and is upheld. Accordingly, decentralisation is:

> the transfer of planning, decision-making, or administrative authority from the central government to its field organisations, local administrative units, semi-autonomous and parastatal organisations, local government, or non-government organisations.

2.3.1.2. Forms of decentralisation

The transfer of decision-making authority, which is the hallmark of decentralisation, may however be seen as a continuum, with centralisation and decentralisation, as the moves made in the opposite direction. And depending on the nature of authority and its transfer from the centre to periphery, "a number of decision-making structures including the delegation of power and devolution" (Green, 1999: 60) is brought into place. This consideration invokes identification of a number of ideal types of decentralisation (Smith, 1967; Johnson, 1973; Elder, 1973; Rondinelli and Cheema, 1983; Battistella, 1993; Collins, 1994; Griffith, 1998) which include the following:

1. Functional deconcentration
2. Prefectoral deconcentration
3. Devolution
4. Decentralisation to local bodies
5. Delegation to semi-autonomous bodies
6. Transfer of functions to non-governmental organisations
7. Federalism
8. Establishing of public sector markets
9. Regionalism
10. Fragmentation[7]

However, practically we can only identify certain approximations or mixtures or structures in transition. For example, decentralised structures in the Punjab health

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[7] This form may be considered by some as a critique of decentralisation (Collins and Green, 1994). However, given that the transfer of decision making is on a continuum, fragmentation is an extreme form of decentralisation.

sector are distinct from the ideal types, and complicated. Here the question is not only the transfer of authority from centre to the peripheral unit or a lower tier in the hierarchy, but also what type of authority is being talked about. That is, it involves considering the authority both vertically as well as horizontally at each level in the hierarchy. It is not only the different levels in the organisation, but also what functions are performed at each level. For example, since all three functions of governance are performed at each organisational level, three major forms of decentralisation – financial, administrative and legal – are identified in the Punjab health sector (Collins *et al*, 2002), and are explained below:

- Administrative powers, and for that matter the principles and code of conduct for regulating and maintaining efficiency and discipline and other human resource management issues, are drawn up by the Services and General Administration Department (S&GAD). These include the authority to appoint, promote, undertake disciplinary action, transfer, grant leave, assess training needs and decide about the period of training etc.
- The extent of control over resources varies from one tier to the other in the health sector hierarchy, which is determined by the Finance Department. An office or agency in receipt of a budget is the Accounting Unit and the in charge officer is authorised to draw and disburse the amount, depending on his financial category. There are four categories of drawing and disbursing officers, determined by the Finance Department. Any expenditure beyond the specified limit, laid down by the Finance Department, is authorised by an officer higher in the hierarchy.
- In addition, there is a plethora of other functions, which do not fall within the ambit of either administrative or financial functions. These are legal functions, performed at different levels in the hierarchy of the health care network and are governed by various enactments. This researcher identified 29 major laws relevant to the health sector.

2.3.1.3. Rationale

Decentralisation is a political issue that hinges on the power distribution within the state system and access to the political decision-making process and allocation of public resources. Therefore, its application should not be limited to resolving the technical issues of efficiency and effectiveness in management and organisation (Collins and Green, 1994). However, the issue is much more complicated. The meaning of decentralisation may be different for different people, and accordingly its implementation in an organisation will hinge on its background. For example, in Pakistan, according to Rondinelli (1983), decentralisation was believed by the

bureaucracy, as a tool to: (i) foster community participation, and (ii) extend the control of the central government – two mutually incompatible objectives.

Nonetheless, decentralisation has become a popular part of the policy approaches adopted by various governments, both with implicit and explicit objectives. The former are complex and often difficult to identify, yet they exist (Conyers, 1983). An inventory of the explicit reasons or rationale for decentralisation is given below (Rondinelli and Cheema, 1983; Rondinelli, 1983; Collins and Green, 1994; Gross and Rosen, 1996):

1. Increases the responsiveness to local needs, because decisions are made by those who have access to information and are familiar with the local conditions;
2. Facilitates the mobilisation of the underprivileged and community participation;
3. Improves access of the poor to public goods and services;
4. Promotes national unity and political education because it promotes involvement of communities at local level;
5. Softens the resistance to change by the stakeholders;
6. Allows a greater opportunity for inter-sectoral collaboration;
7. Overcomes the disadvantages of centralised and distant bureaucracies by reducing red-tape; and
8. Facilitates the adaptability, flexibility and efficiency in the management of the systems.

2.3.2. Decentralisation in the Punjab health sector

Decentralisation in the Punjab can be traced to the colonial era, e.g. the recommendations of a Royal Commission upon decentralisation appointed in 1904 and which reported in 1908, formed the basis for promulgation of an All India Act, 1919. Through this legislation, the subject of health was shifted from the central to the provincial list of functions. Later, under the India Act, 1935 provinces were granted autonomy, making the provincial legislature and provincial governments responsible for developing and implementing their internal policies (GoI, 1928).

The post-colonial health sector in the early phase, led by the local remnants of the Indian medical and civil service, was a continuation and extension of the colonial health care system. Another feature, as Collins (1994) notes, during the post-independence period was the continuation of programmes and the introduction of other disease specific vertical programmes, isolated from the mainstream health care system. A senior planner commented that the district health system, "as a result, was

being run not as an integrated district health system – it was something else, a fragmented system. There were, at least, 7-8 organisations within the district that were reporting directly to the province or some office outside the district..."

During the 1990s decentralisation was a national agenda and constituted a central point of the national health policy (MoH, 1998a). The SAP supported it by laying down two top priority policy areas: provision of preventive health services, and increasing decentralisation of authority to the district level. Under the overall umbrella of SAP, a SFHP was implemented, and decentralisation of authority to the district level was a dated covenant of this project (GoPb, 1993). For meeting donor requirements and to address issues in the health sector, the government of Punjab made repeated attempts at reforming the health sector. However, some of these were overtaken by the events and others progressed towards decentralisation, yet others led to a different outcome. Some authors mention 'centralisation through decentralisation' or 'decentralisation as a means for re-centralisation' in developing countries (Conyers, 1983; Collins and Green, 1994). In the Punjab, however, decentralisation was mayhem[8] leading to a *status quo*. And, it was a joint venture of the politicians and bureaucracies, with the latter dominating the process. An observer painted the latest situation as follows:

> There is a general feeling that the generalist bureaucracy through semi-literate politicians wanted to undermine professionalism, eliminate the poor through corporate culture of commercialising and privatising the health care in a country where 1/3rd population lives below the poverty line. Ironically, there was no real ownership of the decentralisation concept either at the provincial government or at other levels. It was being nurtured and introduced by those politicians and civil servants who believe in and are trained on centralisation. Mughals, Ranjeet Singh and Gora Sahib [local designation for the colonial English boss] are still their favourite. The model of decentralisation/autonomy for the Punjab Health Department should have been indigenous, incremental and designed by the stakeholders who were to deliver. It should have been a problem solving and bottom up approach without ignoring the environment or living in an island. You will not be surprised to know that we have not learnt any lesson either from the recent history of the health sector reforms or the past history of the Mughal era. Same things have happened again in 2002 in the same old way. So ... we are proudly at square one[9]!

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[8] Extract from an interview of this researcher with the minister for health, Punjab.
[9] Comments of a senior officer made in his email of February 13, 2002 addressed to this researcher.

2.4. Policy

The reforms have a bearing on the overall purpose, context, strategies and the institutional capacity to implement the proposed changes. Further, these changes, whether taking place in the health system or in any of its sub systems, have implications not only for the individual sub system they are focused at, but also, as WHO (1993 cited in Berman, 1995:16) propounds, on the overall policies and institutions of the health system. Thus, there is a need to explore the policy arena. This objective is achieved in this section, firstly, by defining health policy, drawing from the explanation of policy in general. Secondly, the debate on policy analysis is presented. Thirdly, the policy process is reviewed from the perspective that it is an important variety of policy analysis.

2.4.1. Conceptual debate

2.4.1.1. Definition

The dictionary meaning of the word 'policy' is "a course of action that has been officially agreed and chosen by a political party, business or other organisation" (Longman, 1995: 1089). This definition implies, at least, three elements of policy: (i) it is a string of activities and not a one point in time action; (ii) the activities are formally agreed to; (iii) by some organised body, political or otherwise. The policy could also be of an individual's act as, "a particular principle that you believe in and that influences the way you behave" (*ibid*: 1089). In the context of this study, it is the former with which we are concerned. But, this temporal definition of policy takes us nowhere (Hill, 1997), because the term is vague and has been used in many ways. For example, Hogwood and Gunn (1984) provide an inventory of ten different ways the word 'policy' has been used. These range from an expression of a general purpose or decision of government to a theory or a process for a much longer time.

Given the large vocabulary and synonyms for the word 'policy', it may be distinguished from decision, as opposed to that it involves a series or network of decisions. However, it is less readily distinguishable from administration or bureaucracy, since these terms denote the carrying out or implementing policy (Parsons, 1995). Sometimes, there could even be no policy on certain issues, as this is "an attempt to define and structure a rational basis for an action or no action" (*ibid*: 14). Similarly, Heclo (1972) defines policy as "a course of action or inaction rather than a specific decision or action". But, to what end? So, the debate is still far away from its logical end. Exploring the concept further, Hill (1997) identifies six attributes of a policy which are given below:

1. A decision network may be involved in producing actions taking place over a long period of time.
2. Policy is not expressed in a single decision, but in terms of a series of decisions, which together comprise the common understanding of what the policy is.
3. This is dynamic, and a decision in the chain of events may change over the course or process of policymaking.
4. Following the Hogwood and Gunn (1984) model, .there may be termination or succession of policy.
5. Non-decision underlies much of the political activity aimed at maintaining the *status quo*.
6. Action over a period of time without being formally sanctioned by a decision may also form policy i.e. street level bureaucracy contributing to policymaking.

Although comprehensive, yet the above definition of policy is unidirectional and maintains the non-specified nature of actions or decisions. Gordon *et al* (1977) term policy in the sense "to describe a range of activities including: (i) defining objectives; (ii) setting priorities; (iii) describing a plan; and (iv) specifying the decision rules". According to them, "these characteristics of policy differ not only in their generality and the level at which it is supposed to occur, but also in whether policy is assumed to be entirely prior to action or at least partly a *post hoc* generalisation or rationalisation". They advocate "a recursive relation between the policy and action, with policy itself representing an essentially dynamic set of constructions of the situation". In other words, policy is a course of action or a web of decisions, which iterate before being finalised.

2.4.1.2. Health policy

After having explored the definitions of policy in general terms, we can define it in the health perspective. According to Foltz (1996), because the health sector in any country is part of its general policy environment, the observations made on policy in the preceding section usually also hold true for health policy. In other words, the aforementioned definition of policy can be adapted to health policy by adding the descriptor 'health'. However, Walt (1994: 41) defines the term as "health policy embraces courses of action that affect the set of institutions, organisations, services, and funding arrangements of the health care system. It goes beyond the health services, including actions or intended actions by the public, private and voluntary organisations that have an impact on health". This study follows this definition; therefore, the subsequent discussion may be seen in this context.

2.4.1.3. Types of policies

Hill (1997: 12) refers to Lowi's (1972) classification of policies. Accordingly, *distributive* policies concern the provision of services or benefits to particular groups in the population. *Redistributive* policies consist of deliberate government attempts to change the distribution of income or wealth through, for example, tax. *Regulatory* policies involve imposition of restriction on the behaviour of individuals or groups. Finally, in the case of *constituent* policies, the state is engaged in the design and redesign of institutions.

Webb and Wistow (1986) introduce three categories of policies: service, resource and governance policies. In their view, policy in the service context consists of commitment to meet the 'specified type and level of need in a particular way' – the aim, which is constrained by the resources. Therefore, they argue that the term 'policy' denotes the orchestrated confluence of services and resources, thus raising the question – what orchestrates this confluence? They term such policies that determine the orchestration of confluence as governance policies, specifying the role of the state in terms of philosophy of management and control within the public authority. To these three sets of policies, Challis *et al* (1988: 37) added a fourth, the fiscal policy concerning the level and structure of taxation and related issues.

Walt (1994) takes a different view in developing the typology of policies. She divides policies into 'high' and 'low', borrowing the terms from international relations literature. The major decisions concerning the national economy or security concerns influenced by the most powerful or ruling class are high policies or macro or systemic policies. Such policies fall in the domain of the government and take the shape of law through legislature. Low policies, also called sectoral or micro policies concern relatively ordinary issues influenced by specific interest groups. However, a particular policy may not be static: a low policy, depending on the action by the interest group, e.g. media may become a high political agenda and *vice-versa*. Furthermore, the low policies may add on incrementally and over time change to systemic policies. Table 2.2 reproduces Walt's (1994: 43) typology of policies.

Table 2.2:- Policy types and levels

	High policies	Low policies
Policy type	Macro policy Systemic policy	Micro policy Sectoral policy
Policy level	National government State government Regional authority	Ministry of health Local health authority Institute (e.g. hospital)
Policy example	Regulation of private practice Civil services reforms	Introduction of breast screening Change in vaccine policy

2.4.1.4. Policy levels

Frenk (1994) proposes four policy levels and the matching objectives and issues addressed through reform and the resultant change (Table 2.3). Accordingly, although a change at any level, for the reform to be comprehensive, he stresses, the intervention should contemplate changes at all levels of policy.

Table 2.3:- Policy levels vis-à-vis objectives, issues and type of change

Policy Level	Objective	Issues	Type of change
Systemic	Equity	Basis for population eligibility and Institutional arrangements: • Public agencies involved in the healthcare • Level of government • Public/private mix • Population involvement • Resource generators • Other sectors with effect on health	Restructuring or redesigning
Programmatic	Allocative efficiency	• Priority setting • Cost-effectiveness of interventions	Re-orientation or re-programming
Organisational	Technical efficiency	• Productivity • Quality of care	Re-organisation
Instrumental	Institutional intelligence for performance enhancement	• Information system • Scientific research • Technological development • Human resource development	Re-enforcement

Source: Frenk J (1994)

Briefly, the *systemic* level policies concern the role and responsibilities of the major components of health system and refer to those aimed at determining population eligibility in order to ensure equity or fairness of the system. The *programmatic* level policies address the contents of health service in terms of the actual programmes and interventions, e.g. package of universally available services through priority setting for achieving allocational efficiency. Cost-effectiveness analysis is often used for this purpose. The *organisational* level policies are about technical efficiency, concerning how best the health services are provided. Finally, the *instrumental* level policies are intended to generate institutional intelligence needed for better system performance, and take the form of collecting data and use of health system information, research and technology and human resource development.

2.4.2. Policy analysis

In the literature the terms 'policy study', 'policy analysis' and 'policy science' are used. Hogwood and Gunn (1984: 29) prefer "using policy study for descriptive accounts and policy analysis for prescriptive exercises, with policy sciences as an umbrella phrase to cover both". Walt (1996), however, believes that policy analysis incorporates also policy process, and serves both to describe and prescribe the policies. This definition is followed, because, as will be seen, the description and prescription are inseparable.

Policy analysis is an important aspect of policymaking, and there is wide-ranging concern of it having often been neglected, especially in the health sector (Gordon *et al*, 1977; Walt and Gilson, 1994; Frenk, 1995; Barker, 1996). Therefore, in the ensuing pages, an account is given of how the concept developed, what are the different analytical approaches, and how to conduct a policy analysis exercise.

2.4.2.1. Conceptual development

According to Parsons (1995), it was Lindblom who first used the term policy analysis in 1958 and indicated the need for its formalising as a scientific non-quantitative and largely non-theoretical method away from the conventional quantitative and theoretical economic methods. He observed that alternative public policies differ only slightly, because in his view the political procedures are incremental. That is, the successive policies are only incrementally different from each other and the method of analysing these, he called incremental analyses. Later, Dror (1967) proposed developing policy analysis as a broader professional discipline, essentially building on the concepts for system analysis. He argued that the contribution of system analysis, like a Programme-Planning Budget System, was mainly due to the "wisdom, sophistication and open-mindedness of the few outstanding practitioners of system analysis". To sustain the innovation, he advocated for developing such "institutional arrangements, professional training, and job definitions, which will provide the desired outputs with … not necessarily outstanding personnel" (*ibid*).

The main features of policy analysis suggested by Dror (1967), however, point to this phenomenon being a 'state centred' compared to the lately advanced 'society centred' approach (Walt, 1994: 4). The former is concerned with the actors within the state institutions, while the latter is concerned with analysing how far the outsider's interests have influenced the state. In this regard, a reference is made to class (where a particular social class dominates decision-making and the outcome always favours that class), pluralistic (different groups compete to influence,

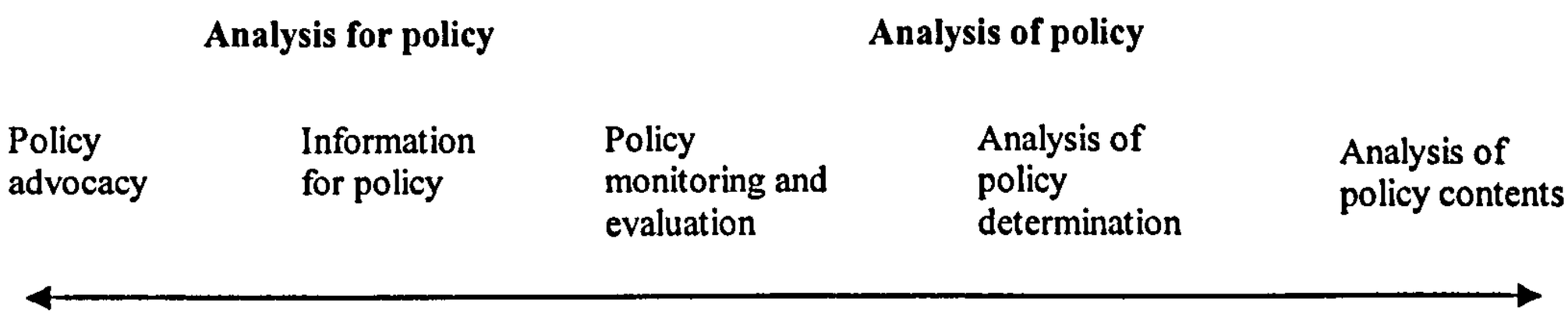
although practically the one who shouts louder is heard) and public choice (the state is itself an actor) approaches (*ibid*).

Further, the conceptual boundaries of policy analysis have since expanded, borrowing theories from a number of social science disciplines. Heclo (1972) indicated that in this approach various parts of 'multi-disciplines' have been integrated into a coherent 'inter-discipline'. That is, the disciplinary boundaries for policy studies are fluid "as policy concerns organising purposive action in a society by the state authority, it is concerned with meta-choices, i.e. choices as to how others shall make their choice in whatever sphere the public authority is intervening" (*ibid*). And given that the policies are expressions of these meta-choices, the policy study straddles a number of academic disciplines, including sociology, psychology, economics and management (Parsons, 1995).

2.4.2.2. Approaches to policy analysis

Barker (1996) distinguishes between the analysis carried out with the aim of furthering the academic work in health policy; and the studies a health manager within the organisation intends to develop in order to strengthen policy process. This distinction is based on the earlier attempts at separating the 'analysis of policy' or knowledge of policy and policy process from 'analysis for policy' or knowledge in the policy process. The former denotes how the problems are defined, agendas set, policy formulated, decisions made and policy evaluated and implemented. The latter implies the usage of analytical techniques, research and advocacy (Parsons, 1995). This distinction indicates a dichotomy in the usage of these terms, reflecting a division of disciplinary concerns. Yet, Gordon *et al* (1977) argue that there is a continuum, with the two phenomena overlapping at some point (Figure 2.1).

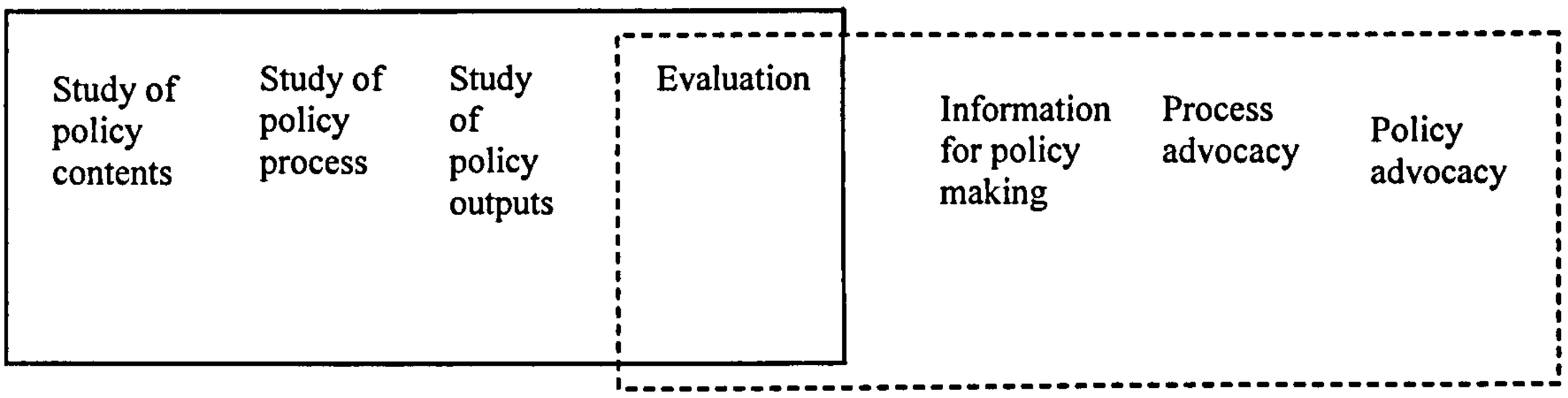
Figure 2.1:- Policy analysis – a continuum



Source: Gordon *et al* (1977)

To the above range of approaches identified within the rubric of policy analysis, Hogwood and Gunn (1984) add two more: process advocacy and study of policy process (Figure 2.2).

Figure 2.2:- Types of policy making



Source: Hogwood and Gunn, 1984: 29

In the case of the policy process, according to Hill (1997: 4) "attention is focussed on the stages through which issues pass, and attempts are made to assess the influence of different factors on the development of the issue". And such a study "can consist of individual case studies or attempts to devise generalizable but largely descriptive propositions about the nature of public policymaking" (Hogwood and Gunn (1984: 27). Since, this thesis is about 'analysing the policy process for the Punjab health sector reforms', the policy process is studied in a greater depth. Before that however, a brief resumé of the methods and techniques for analysing the policy process is given.

2.4.2.3. How to conduct policy analysis

Much more will be said on this topic in the next chapter. However, to complete the argument, the issue is briefly introduced here, focusing on how this discipline grew to the current practice. Lindblom (1958) proposed to study policy employing methods, which contrary to the conventional methods are characterised by relatively less reliance on theory; a partial or fragmented view of the important variables; a close intertwining of the search for values and facts; and no policy presumption of the kind employed in the conventional method. Later, Dror (1967) specifying these methods as 'qualitative method' noted that the policy analysis would heavily rely on "Gestalt-images, qualitative models, and qualitative methods instead of the main emphasis being placed on explicit knowledge and quantitative models and tools". Heclo (1972), in his review article took the debate further. He identified that 'case study' was the dominant approach employed in policy studies. According to him, the case studies are unique in theory construction and with their ability to 'move' with the reality of the dynamic world of policy process. Finally, Hill (1997) noted the

case study approach appropriate for policy analysis. However, for studying the impact of a policy, he advocates the combined use of a case study and quantitative method. About the particular techniques employed, Barker (1996) describes three broad categories. The first is 'asking the public', which may involve methods like individual interviews, focus group interviews and/or group interviews. Second is 'asking the experts', employing methods ranging from brainstorming to the Delphi technique and consensus building conferences. While the aforementioned categories are aimed at collecting information, the third category of methods deals with the processing and analysing of data, and includes operational research and techniques such as cost benefit analysis and cost effective analysis.

2.4.3. Policy process

Policy process, according to Foltz (1996) is the process by which a government or a society sets its activities and allocates resources. It is complex and dynamic, but important, which the policy analysts should not ignore, because it is "created by the interaction of decisions, policy networks, organisations, actors and events" (Minogue, 1993: 11). Further, the policymakers knowing the policy process are likely to improve the way the policy for reforms is formulated.

Almost every author on policy science has attempted at establishing the model for studying the policy process. Broadly, these are stagist or comprehensive; and in the following, the most commonly encountered ones are presented briefly:

2.4.3.1. Stagist models

The Easton model, which has received considerable attention, has seven stages (Box 2.1). As elaborated by Jenkins (1978 cited in Hill, 1997: 23) he contemplates the political systems as the "black box" for policy process, and like biological systems exists in an environment, where a variety of other systems like social and ecological systems are also operative. The demands by individuals and groups and support in terms of voting, obedience to the law and payment of taxes constitute the input that is fed into the black box of decision making for conversion into the decisions and policies of authorities as output. The output is in turn feedback into the system as input. By this approach, Hill (1997) argues, complex political phenomena can be better conceptualised. Further, the policy process can be disaggregated into a number of segments, making it amenable to analysis.

Box 2.1

Easton model

1. Initiation
2. Information
3. Consideration
4. Decision
5. Implementation
6. Evaluation
7. Termination

Hogwood and Gunn (1984) go further in devising a model for studying the policy process comprising nine steps (Box 2.2). However, this model, unlike Easton's, makes no selection or adoption of a particular policy after option analysis, and "goes beyond a simple identification of stages to suggest actions that ought to occur. As such, it offers a version of a rational model of decision making" (Hill, 1997:23)

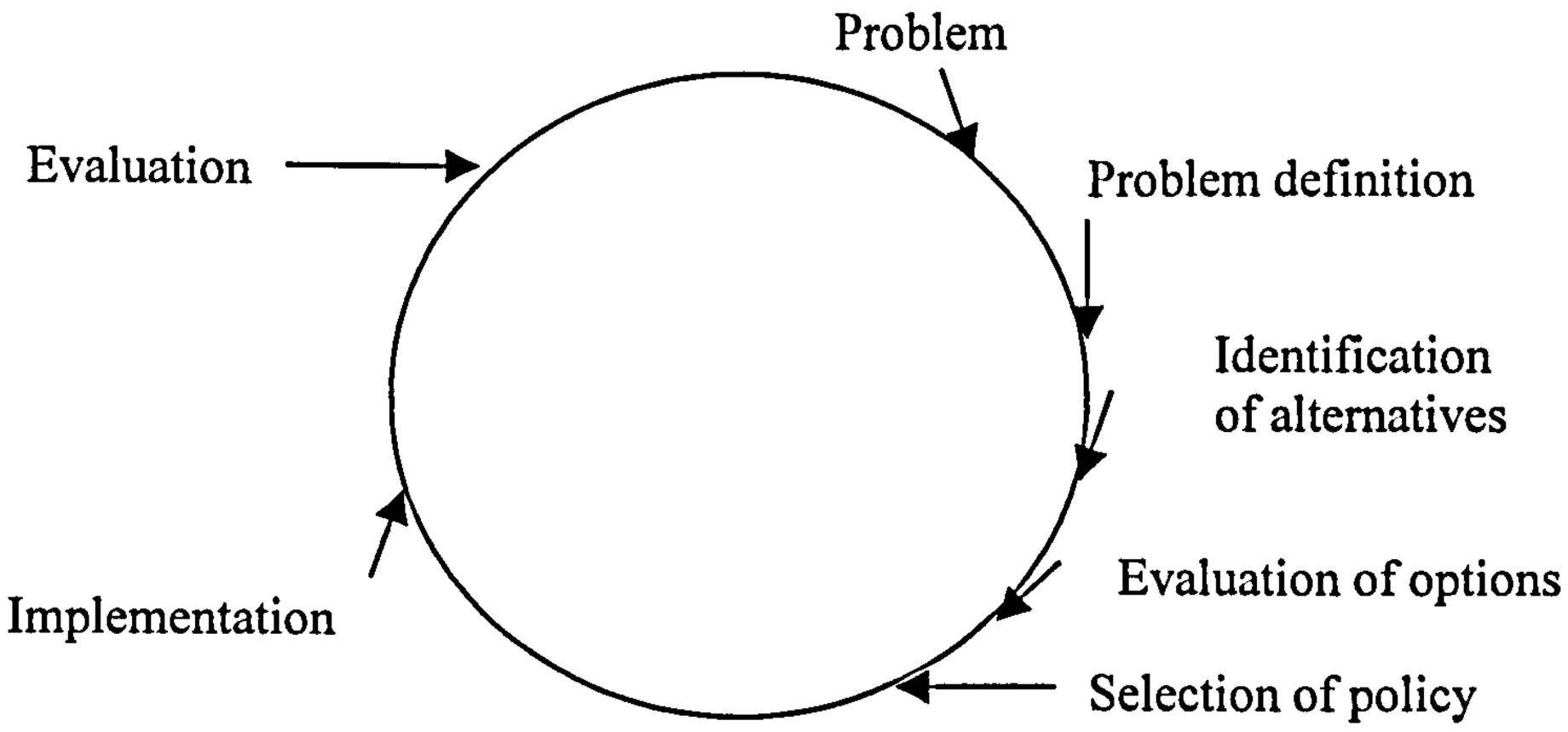
Box 2.2

Hogwood and Gunn model

1. Deciding to decide (issue search and agenda setting)
2. Deciding how to decide (issue filtration)
3. Issue definition
4. Forecasting
5. Setting objectives and priorities
6. Option analysis
7. Policy implementation, monitoring, and control
8. Evaluation and review
9. Policy maintenance, succession, or termination

Parsons (1995: 77), although not happy entirely with the stagist approach, presents the policy process in a cyclic fashion. The various steps involved include problem definition, identification of alternative solutions, option evaluation, selection of preferred policy option, implementation, and evaluation (Figure 2.3). Like the earlier models, this is rational or logical and shares their merits. However, the question arises, how distinctly the different stages are demarcated from each other, and to what certainty the next stage occurs? For example, as Walt (1994) argues, policies may remain only intentions or may be implemented in a way that distorts the original intentions of policymakers.

Figure 2.3:- Policy life cycle (Parson's model)

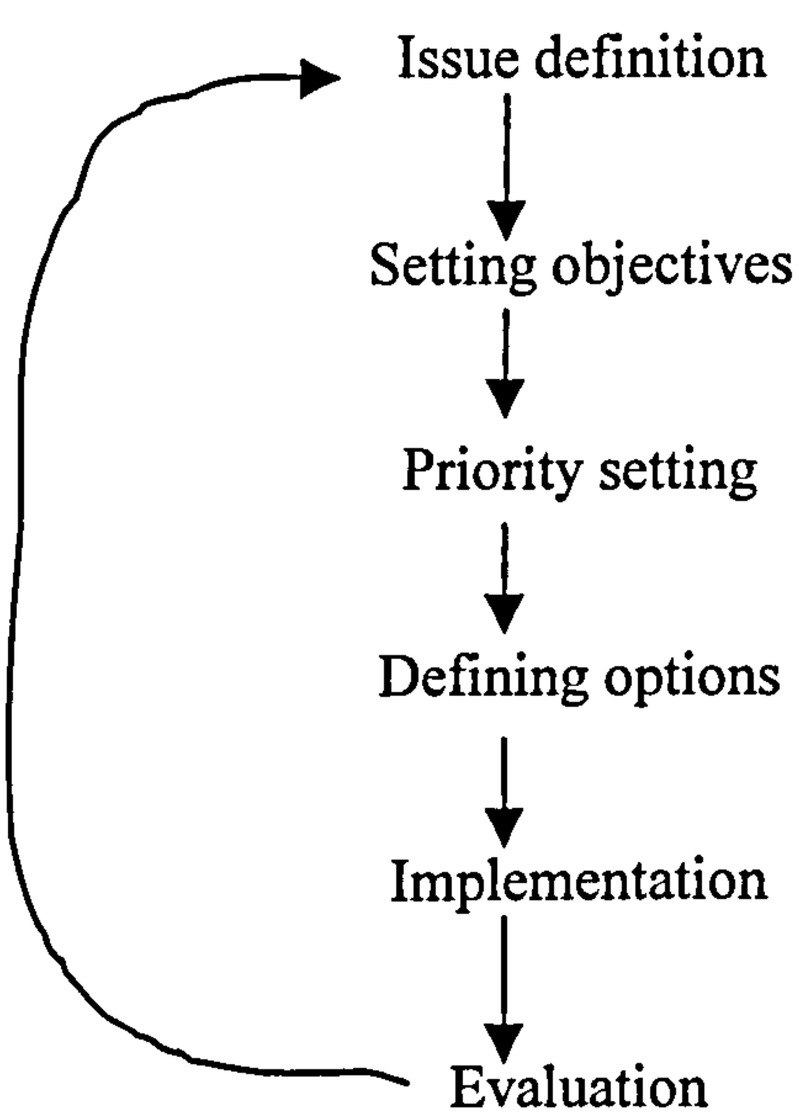


Source: Parsons (1995: 77)

Barker (1996) relates the policy process to planning, distinguishing a number of steps involved in the policymaking process (Figure 2.4). Her model, which draws mainly on the Hogwood and Gunn's model, is deficient in that after defining options, no policy is selected or adopted for implementation. Yet, she advocates

policymaking as an evolutionary process, often beyond the control of the health managers. She stresses that such a managerialist approach is unworkable, although development of strategies is possible. That is, the policymakers need to carefully analyse the policy system distinguishing the environmental constraints that are to be lived with and what features of the health system are amenable to change.

Figure-2.4:- Stages in the policy making process (Barker's model)



Source: Barker (1996: 28)

2.4.3.2. Critique of stagist models

From the above, it is obvious that there is a degree of disagreement about the different stages of policymaking, but Hill (1997) argues that this approach has an advantage as it offers the opportunity for carving out the segments of the policy process for an in-depth analysis. Nonetheless, 'stagist' models have been subjected to the following critique (Foltz, 1996; Hill, 1997; Jenkins-Smith and Sabatier, 1993):

1. The process is not so logically ordered and smooth as portrayed in different models. In fact, some stages may occur simultaneously, while others may be skipped. Similarly, the health sector, unlike a mechanical system, is not static; it is changing. The "social engineer", therefore, has to react accordingly and adjust the instrumentation.

2. The policy process involves the inter-organisational and intra-organisational interactions within and between different levels in the government hierarchy – a relationship that itself is also subject to change (by some supra-body). There is, therefore, a meta-policymaking, i.e. the concern is not only with securing a

specific outcome, but also with changing the basic rules of the game, including determining the outcome.

3. The causal explanation – how policy moves from one stage to the other – is not provided by the stagist approach, and it cannot be tested empirically.
4. The stagism characterises policymaking as a managerialistic top-down process, excluding the role of 'street level bureaucrats' in policymaking.
5. It fails to provide an integrated view of the analysis of the policy process and knowledge, information and research used. The policy analysis does not take place in the evaluation phase, but continues throughout the process.

2.4.3.3. Parsons' model

Parsons (1995: xvi), sharing the above critique on stagist models, combines different stages of policymaking and proposes three broad and overlapping phases of analysis and an overarching meta-analysis to consider the methods and approaches used in the policy study. These three phases: meso-analysis, decision-analysis and delivery analysis are briefly described below:

- How the issues and problems are defined and the agenda is set, is called meso-analysis. This is the pre-decisional stage of the policy process involving identification and anticipation of problems or opportunities that suggest the need to consider some action. After that, a conscious decision is needed to make a choice of issues, based on explicit criteria. Once a problem or policy issue has been identified, then it is analysed in order to define it in its depth and breadth.
- Decision analysis, considers how the process of decision making *per se* takes place. This phase involves processes like forecasting, objectives setting and options analysis. Forecasting is speculating as to how the situation will develop if it is allowed to continue, and concerns the expected future and may be established by extrapolation, using judgmental or certain modelling techniques. Setting objectives and priorities relates to the desired future and is central to the administrative and political rhetoric. Since there could be several alternatives to achieve a particular objective, these alternatives are analysed using techniques like cost-effectiveness analysis, cost-benefit analysis or decision analysis to finally select the best alternative for implementation.
- How the policies are administered and managed is dealt with by delivery analysis, which encompasses policy implementation, monitoring and control, evaluation and review, and maintenance, succession, or termination. However, in order for the implementation to be effective, it is essential that potential problems are anticipated beforehand and measures to combat these are built into

the programme. Monitoring implies seeing whether the intervention made is performing as planned, and if not then remedial measures may become necessary. Unlike implementation, which includes monitoring and control that focuses on output, the evaluation and review concerns the outcome, shifting the focus to whether the policy is working as intended or requires a review? And this review may entail maintaining and replicating the policy or incorporating certain changes and succession or termination.

2.4.3.4. Comprehensive models

The comprehensive approach considers the policy as a unit and analyses the process in its entirety. The most cited examples of this approach, taken into account for this study, include Walt and Gilson (1994), Frenk (1995) and Gonzalez-Block (1997).

- Walt and Gilson (1994) consider in their model three basic elements: context; content; and process interlocking with actors that assume the central role. This model does not take into account the principles and purposes which guide the formulation of contents and provides direction to the proposed reform.
- Frenk (1995) argues that for appraising any reform proposal four fundamental factors must be kept in mind. These include: problem; proposal; protagonists and the broad principles and purpose that should be defined as measures to formulate the vision and mission of the health system under reform. He omits 'process' from his model since in this case, reform is yet to be implemented.
- Gonzalez-Block (1997) conceives the health sector reforms in terms of their content, process, purpose and scope. The actors, in his analytical scheme, are placed in the health system, which according to him has two dimensions: (a) actors, and (b) interaction amongst the actors. This model, although relatively comprehensive, fails like that of Walt and Gilson (1994) to recognise the importance of principles or the greater 'why' of the reform.

2.5. Summary and conclusions

Chapter 2 explored the concepts surrounding reform, decentralisation and policy, contextualised in the Punjab health sector. After attempting to define health sector reform and associated terms, its development over time was traced. It was noted that with the new millennium, the reforms went beyond three generations seen during the 20th century in developed countries. On the other hand, developing countries were way behind. Whereas the reforms, one after the other, might have been necessary for evolving a better tomorrow, their introduction in this way was partly due to the lack

of system thinking by the policymakers. That is, problems were identified and interventions made, without regard to the re-enforcing and/or balancing attributes of the health system. Therefore, either the problems requiring introducing reform got multiplied or remained unaddressed, giving rise to the need for yet another reform.

In the Punjab it was seen that decentralisation was a strategy common to different initiatives, nevertheless used as a means to maintain the *status quo*. One may, however, wonder why this happened? Collins *et al* (2000) argue that decentralisation has consequences, indicating a need to explore the policy process for developing an understanding of decentralisation and the resultant decision-making structures.

Therefore, the concepts surrounding the policy arena were explored. Since 'fuzziness' surrounds this concept (Kroneman and Zee, 1997), various definitions of policy were discussed followed by a debate on analysing policymaking as a process. Different models and frameworks developed for studying the policy process were also reviewed. Whereas the stagist models have been widely criticised, the most cited comprehensive models lacked perfection, indicating a need for developing yet another. In order to respond to this call, in the next chapter this researcher sets out to develop a framework for analysing the policy process for health sector reform.

3. Conceptual framework

3.1. Introduction

Chapter 2 explored the concepts surrounding health sector reform, decentralisation and policy in order to identify a framework for analysing the policy process. As this attempt was unsuccessful, this chapter embarks on establishing one for the reform initiatives undertaken in the Punjab health sector. This is done by:

1. drawing from the discussion in chapter 2, a conceptual framework is developed for the policy process;
2. making a commentary on the component tenets of the framework in order to have a better understanding of this analytical tool; and
3. developing a hierarchy of variables as a guide for the application of framework to studying the reform initiatives selected for this research.

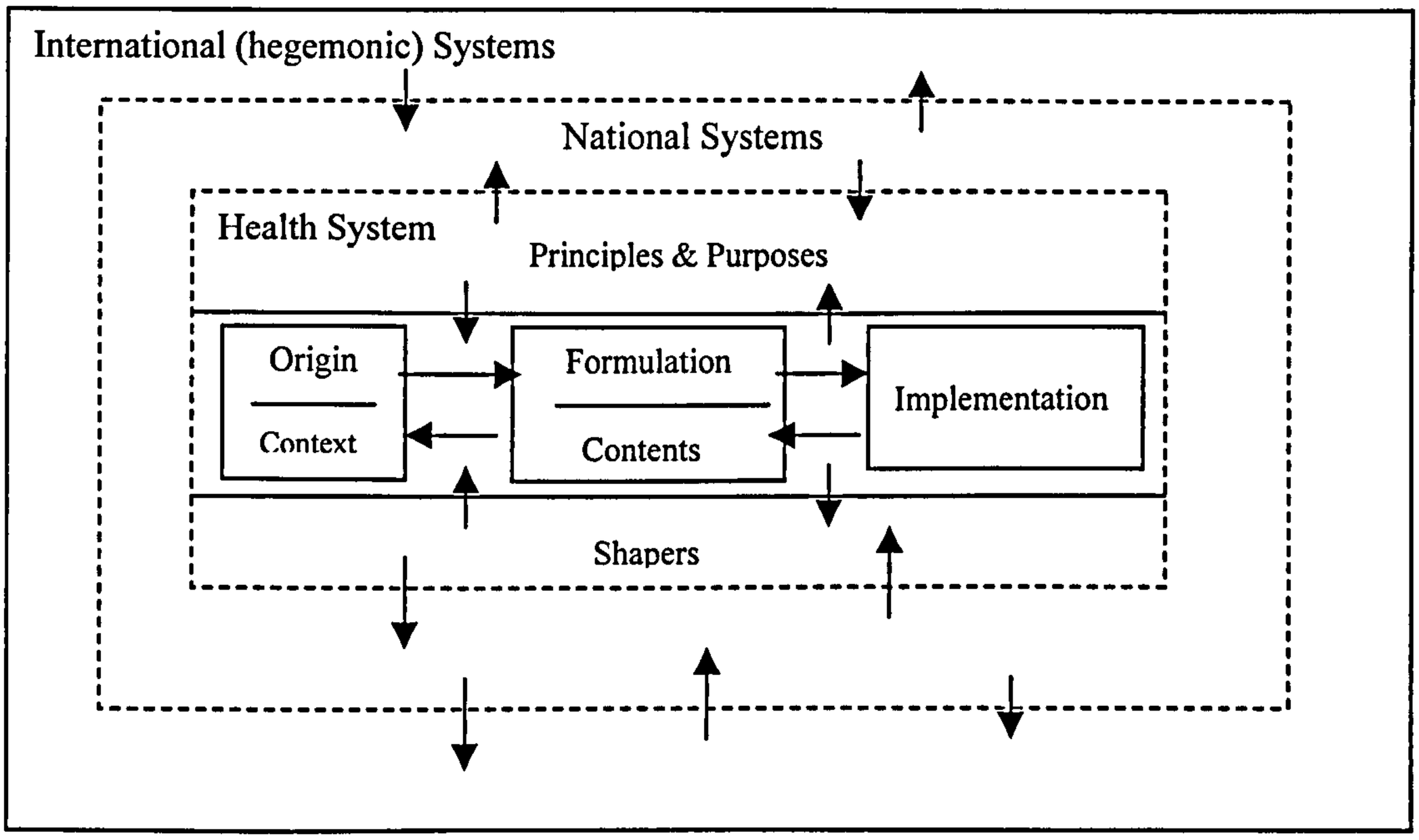
3.2. Framework for analysing the policy process

A framework is needed to establish a common understanding and as a means of analysing the policy process for the reform initiatives. For this purpose a number of frameworks were reviewed (2.4.3). However, since those lacked the needed comprehensiveness, it is done again, nonetheless, drawing different elements from them. Similarly, the definition of health policy process that forms the basis of the framework, developed for the purpose of this study, draws on the definitions of health sector reform (2.2.1) and debate on policy (2.4) as below:

> It is a process that originates in the health sector and leads to formulating its contents, which are then implemented. This process is guided by certain principles and the shapers remain operative throughout, contributing to the outcome. The health sector, which hosts the reform(s), forms its context and environment, where other reforms may also be happening.

The above definition of the policy process can be depicted figuratively (Figure 3.1). Accordingly, this framework builds on and is nested in the framework developed earlier for conceptualising the health sector (1.2.2).

Figure 3.1:- Conceptual framework for the policy process



This framework is based on the assumption that the policy process is divided into three overlapping phases: origin, formulation and implementation, while principles and purposes, and shapers are operative throughout the process. That is, reforms take their origin in the health sector which hosts them and forms their context. After passing through the formulation or designing of contents these are implemented, and feedback into the health sector, before any decision is taken about their succession, termination or maintenance. However, this process is not that simple. It is complex and dynamic – a notion supported by the following attributes of the framework:

1. The policy process is not sequential, for in real life, such a disciplined process in a social system, like the health sector, rarely takes place. This is an iterative process, i.e. different stages communicate back and forth as indicated by the bi-directional arrows, and the net result is often an outcome of the multiple factors.

2. The *principles and purposes* set out for the policy guide the shapers in their actions. These may be drawn from political or closely related ideological reasons and determine the overall direction for the policy process.

3. The *shapers* are embedded in the health sector. Unlike the actors (a word used by other authors), who come to play a pre-defined role, the shapers are proactive. They form a part and influence the direction of the process and the consequent output. The shapers could be individuals, groups and organisations.

4. The *environment* or *context* is both internal and external. The former may be a component of or the entire health sector, depending on the comprehensiveness of

the reform. The external environment is divided into two orbits: the inner orbit hosts the national systems, while the international systems are in the outer.

5. *Contents* form the body of a policy and are the fine tenets or a set of decisions aimed at transforming the contextual grounds to a statement of the desired future, including the identification of the means to achieve that.

6. *Implementation* or administration is important; policies are meaningless unless these are enforced. Peters (1978) considers that policies may be of advantage to some and disadvantage to others, indicating these have both objective as well as subjective components. The former concerns providing gratification and deprivation to the citizens, while the latter is about the way these are delivered – a point where the administration of policy becomes important in policymaking.

7. The decision making *process* overarches the whole phenomenon; therefore it is not separately labelled in the figure. That is, this concerns not only the course of action, i.e. one phase running into the other, but also how the shapers and principles impinge on this phenomenon.

8. The dotted boundaries in the figure identify the policy process as a social phenomenon which is open and therefore amenable to the effect of factors prevalent in the environment and *vice-versa*. That is, the relationships between the reform, the health sector and its environment are dynamic, directing both inwards and outwards (see arrows).

9. The reform may be taking place in the entire health sector or in one or more of its components or even in some other sector. Since it is a social phenomenon, it will have an effect across the boundary of other health sector components and the reforms being undertaken there, but also across the sectors as well.

10. Different stages in the policy process involve inter-organisational interactions at different levels in the government (Health v/s Finance) and between different national systems at the same level (Health and Law). However, given the relatively weak position of the Health Department, the Finance or Law Department might affect and actively contribute to the resultant health policy.

11. There could be a supra-ordinate shaper or body, e.g. individuals like the chief minister or structures like the Chief Minister's Secretariat, impinging on all national systems. They may even change the system and structure within which the policy process occurs, influencing the very basis and contents of the policy.

12. The international systems may exert influence on account of their demonstration effect or the conditionality attached to them. However, most of the national

systems in developing countries, not developed to the level of developed countries, are ill-equipped to absorb and sustain such intervention.

3.3. Tenets of framework for analysing the policy process

After having described general features, the individual tenets of the framework are discussed below. Particular attention will be paid to the application of this framework in studying the policy process for the Punjab health sector reforms.

3.3.1. Principle and purpose

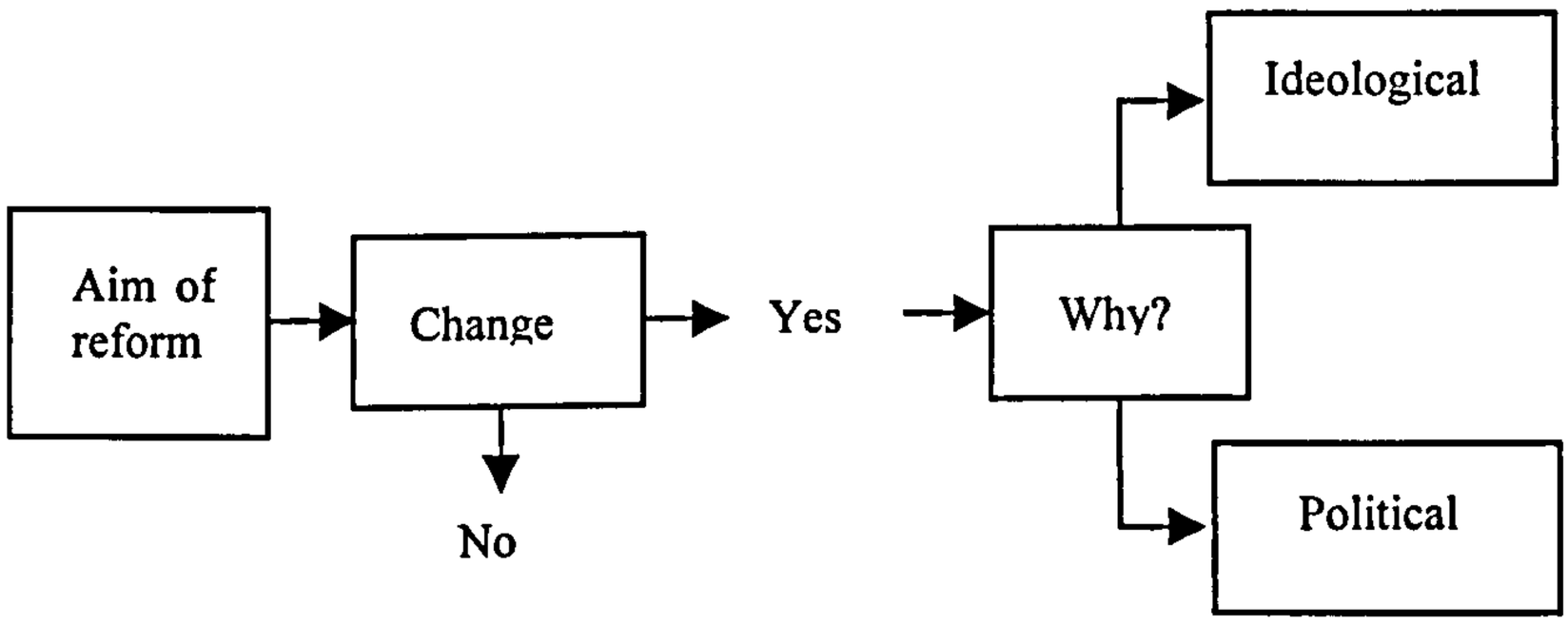
Seedhouse (1995) emphasises that unless a reformer has first thought out what is meant by reform, and defined the principles that should guide the reform process, any cogent change cannot even begin to be made. In his view, the reform must be forward looking and should lead to a higher stage of development. But, this is a general statement of purpose which needs further specification. Hammer and Berman (1995) identify three poles around which the international debate on the strategies for health sector reform revolve. These are: (i) improving aggregate health status, (ii) improving equity and reducing poverty, and (iii) improving individual welfare. Although this approach focuses on health, it provides a narrow concept that does not take into account all the aspects of reform. The focus is mainly on the recipients of the service, while the providers and mediator or governance are not considered. Frenk (1995) expands this concept and proposes four principles: citizenship, pluralism, solidarity, and universality. Similarly, he suggests three purposes: equity, quality, and efficiency. He argues that a system that bases its mission on such principles and purpose should satisfy both the users and the providers. Since this is a comprehensive approach for laying down the principles and purposes for health reform, it is therefore, adopted for the purpose of this study.

However, consideration of principles or values and the purposes of reform take the discussion into the political arena and political ideology held by the reformers. Three reasons have been proposed for this. Firstly, different people may value health differently. Secondly, it involves the re-distribution of resources, i.e. the question of 'who gets what?' or 'whose priorities?' are addressed. Thirdly, there is always some response to a policy – negative from those who do not get and positive from recipients, nonetheless both in turn affect the policy process. In other words this aspect of the conceptual framework addresses the broader question as to 'why' the reform initiative was being introduced (Peabody *et al*, 1999). This question is critical, because this concerns the laying down of objectives, which in turn influences the contents of the reform package, and thereby determines the resulting

shape of the health sector. Gilson (1999) identifies three policy objectives: explicit, short-term political and philosophical. According to her, "explicit objectives are modified both by the way in which health services are viewed by citizens, providers and government, which in turn are a reflection of the particular philosophical, historical, and cultural context of reform, and by short-term political strategies that tend to emphasise the importance of cost containment and the use of policy to support re-election". These objectives, in her opinion, influence and determine the shape of the health systems and any reforms introduced there.

To explore the principles and purposes underlying the Punjab health reforms, the following logical sequence for directing the enquiry is contemplated (Figure 3.2) and two questions are framed – whether the reform was aimed at bringing about some change, and what was the motivation behind the initiative? That is:

Figure 3.2:- Identifying the principles and purposes



1. Firstly, to know whether the reforms were aimed at bringing some substantive change in the health sector? This consideration is essential, because often bureaucracy and politicians may not mean what they appear to be involved in. For example, Webb and Wistow (1986) noted that the public sector makes more progress on paper than on the ground.
2. Secondly, it is about understanding the motivation for change: ideological or political (Gilson, 1999). Ideology concerns the principles and purposes proposed by Frenk (1995). Politics, however, deals with the electoral demands and related pressures, although this may overlap the former.

3.3.2. Shapers

This facet of the analytical framework addresses the question as to 'who sets the agenda?' (Walt, 1994) or 'who is at the helm of affairs?' for identifying the problems, determining the need for intervention, including the setting of a vision and strategies, and finally implementing and evaluating reforms. This may be the government or organised interest groups, whether international like the World Bank,

the International Monetary Fund and other aid agencies or national, such as Non Governmental Organisations, Chambers of Commerce and Industry (*ibid*).

Glassman *et al* (1999) from their analysis of reforms in the Dominican Republic identified five key groups of players: public sector, private sector, unions (or civil politicians), political parties (or public politicians) and other non-governmental organisations. Chinitz (1995) refers to such shapers as the sub-governments, determining the contents of public policy and shaping its process. According to him, "there is no real indication that the general public supports the health reforms *per se*". And he attributes this state of affairs to the politician's lack of interest in shaping the people's opinion regarding the substance of reforms. Notwithstanding the different shapers identified above and the observations made by Chinitz, this study emphasises that the search for shapers must not lose sight of the end users - for whom this entire set up is created. An intervention will not have the desired output – like improved health status – unless the individual and communities choose to benefit from it. Therefore, in Brazil, for example, the National Health Council, which has a strategic role in developing and controlling the implementation of national health policy, has 50% representation drawn from the end-users. The government, health care groups, and providers constitute the remaining 50%. This arrangement, it is noted, serves to voice the interests of the community, and fosters its participation in the policy process (Collins *et al*, 2000).

Walt and Gilson (1994) classify actors as societal, political and public. By societal, they mean the role of trade unions, the business community, and marginal social groups as well as political parties influencing the politics. The political actors denote the political trends; social stratification including class, ethnic and regional loyalties; foreign donors and investors, and the size and quality of the Civil Service. Finally, it is the Public or Civil Service, which is important because of the role it plays in implementing the reforms. While, this is a comprehensive classification, Frenk (1995) offers a pragmatic way of identifying actors. He brings all the components of the health sector on the basis of his model for the health system as actors, categorising them as: providers, resource generators, government, and the population. However, this model does not take into account the environmental factors, especially the national and international hegemonic systems.

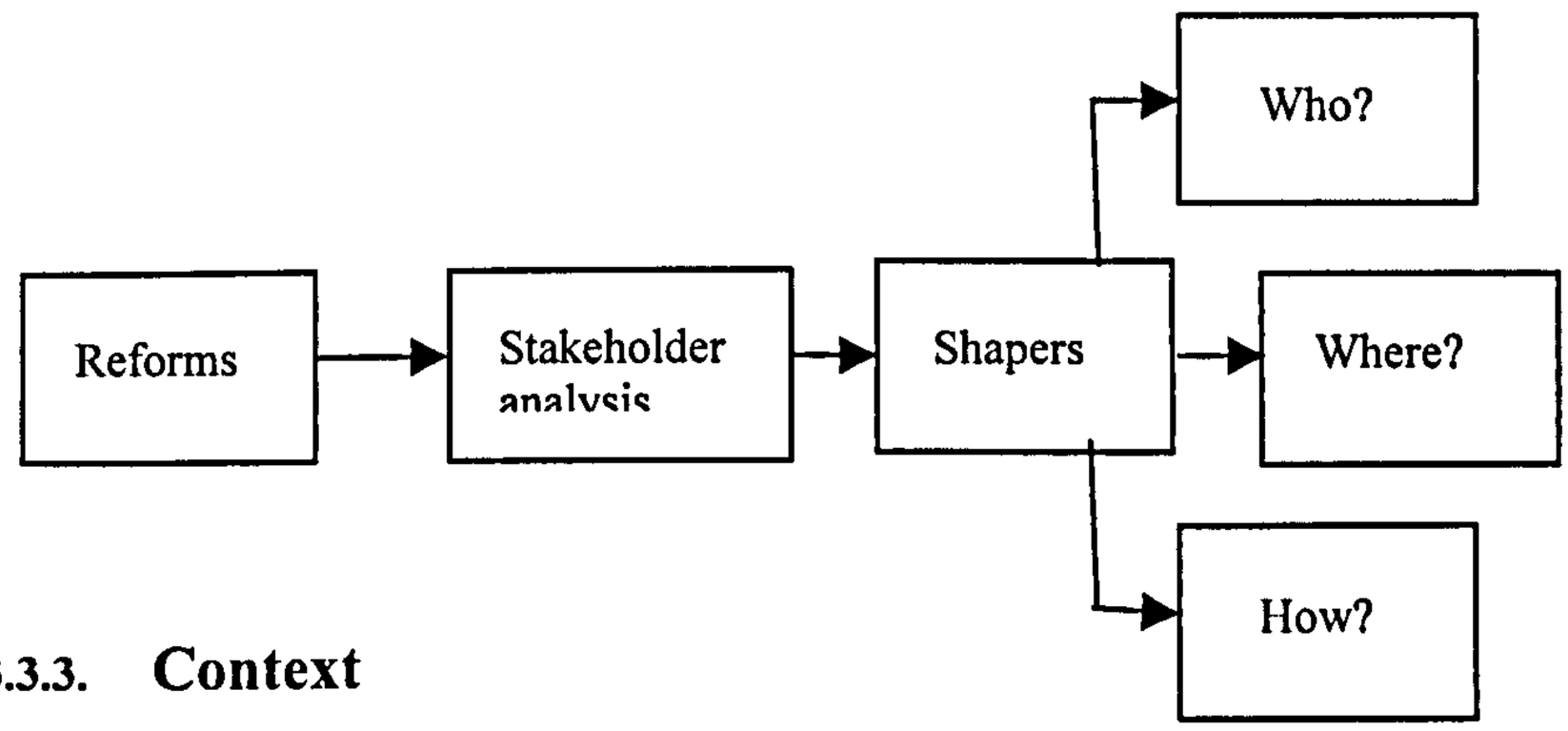
The next question is how to identify the shapers and their role in the policy process! The stakeholder analysis has been advanced as a policy toolkit to identify shapers and their characteristics (ODA, 1995; Brugha and Varvasovszky, 2000; Varvasovszky and Brugha, 2000) and as Frenk (1995) indicates, to anticipate their prospective role in policymaking and devise strategies for mobilising their support

for the policy. This exercise, run both prospectively as well as retrospectively, is particularly helpful in:

1. identifying the shapers and their attributes, i.e. importance, interest and influence held by them;
2. locating their position in the health sector i.e. end-users or communities, providers, governance, resource generators, support services and environment.
3. determining their role, e.g. leaders, supporters, bureaucracy, media, donors and civil society (see 5.1 for definition of these roles).

Analysis of shapers for a particular reform can be presented as in Figure 3.3. That is, in the first stage different shapers are identified, for example by their designation. Second, they are classified according to: (i) attributes or who; (ii) location or where; and (iii) role or how they shaped the policy process.

Figure 3.3:- Exploring the shapers



3.3.3. Context

Seedhouse (1995: 1) noted that "transformations are undoubtedly taking place, but they are almost always based on incomplete thinking, and are often on account of reasons which do not make sense". By this, he emphasises the need for taking into account the context or 'where' the reforms are introduced. This is because the shapers of reform do not work in isolation, but as Walt and Gilson (1994) argue, they are influenced by the context within which they live and operate, at both the macro-governmental and micro-institutional level.

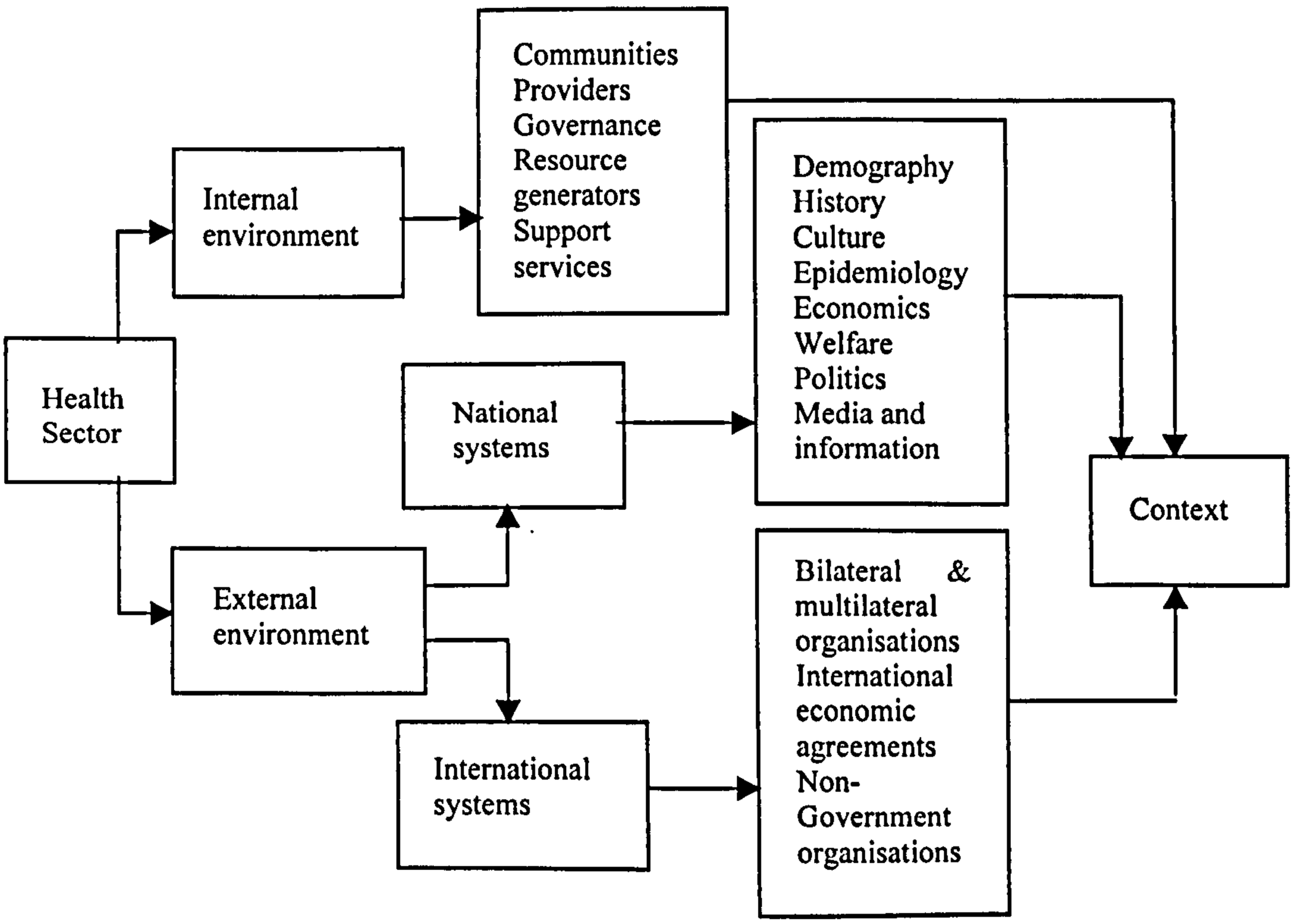
Frenk (1995) terms context as 'problems' the reforms are aimed to solve and include changes in the demographical, epidemiological, educational, technical, cultural, political and economic situation. Likewise, Collins *et al* (1999) identify six categories of contextual factors or rationale for reform: demographic and epidemiological, socio-economic, economic and financial policy, politics and the political regime, ideology, public policy and public sector, and external factors. Cassels (1995) notes that despite the health sector being riddled with problems and

poor indicators necessitating reforms, some stimulus is needed to evoke the reform process. In his view, it is the political, economic and the changing role of the government which serves as a stimulus to trigger the reform process. This is more so, given the uncertainty and conflict that surrounds policy choice. Walt and Gilson (1994) usefully indicate health policy, which used to be decided by the medical élite with a consensus, as 'low politics'. However, after the 1980s, it became a 'high politics' agenda item. Economic Adjustment Programmes, like cuts in budgets, introduction of user fees, promotion of the private sector etc, contributed to more actors appearing on the scene (*ibid*).

Collins *et al* (1999) emphasise understanding the policy context as a critical element of policy analysis, as it contributes to the development of policymaking in four ways: (i) developing the objectives of health sector reform, as it explains why an issue is or is not on the agenda; (ii) policy appropriateness, by increasing the acumen of policymakers to appreciate uncertainty; (iii) policy process, by enabling better understanding of the complex interactions between the actors and the context; and (iv) political feasibility of change and providing space for manoeuvring.

Having underlined the importance of understanding context this can now be explored using the framework for policy analysis. Accordingly, the problems (in the terms of Frenk) or factors heralding reform can be determined by exploring the context at least at three levels (Figure 3.4).

Figure 3.4:- Analysing the context



Firstly, it is the internal environment of the health sector that is under reform and the problems or issues which it faces, justifying the introduction of intervention. This level of enquiry can also be taken in further depth to the individual components of the health sector. Secondly, the national systems, in the inner orbit of the external environment, are taken as context and any problem and intervention made there is seen in relation to these. Finally, the international systems, which are in the outer orbit of the external environment, form the third analytical level of context (Twaddle, 1996). It may, however, be noted that these levels are inclusive and the outcome of context analysis would largely depend on where the analyst positions him/herself. That is, a holistic view will require studying the context at all levels.

Another feature of this framework is that each of these levels has two strata: crisis; and the usual situation. Alford (1975: xii) argues that crisis serves as a political weapon in the hands of interest groups, within and outside government, who use it for diverting resources from one programme to the other and arousing public opinion. This distinction, nonetheless, raises the question; who determines the critical nature of the context? This question was partly dealt with under 'shapers', while the remainder will be explored when we discuss 'process'.

3.3.4. Contents

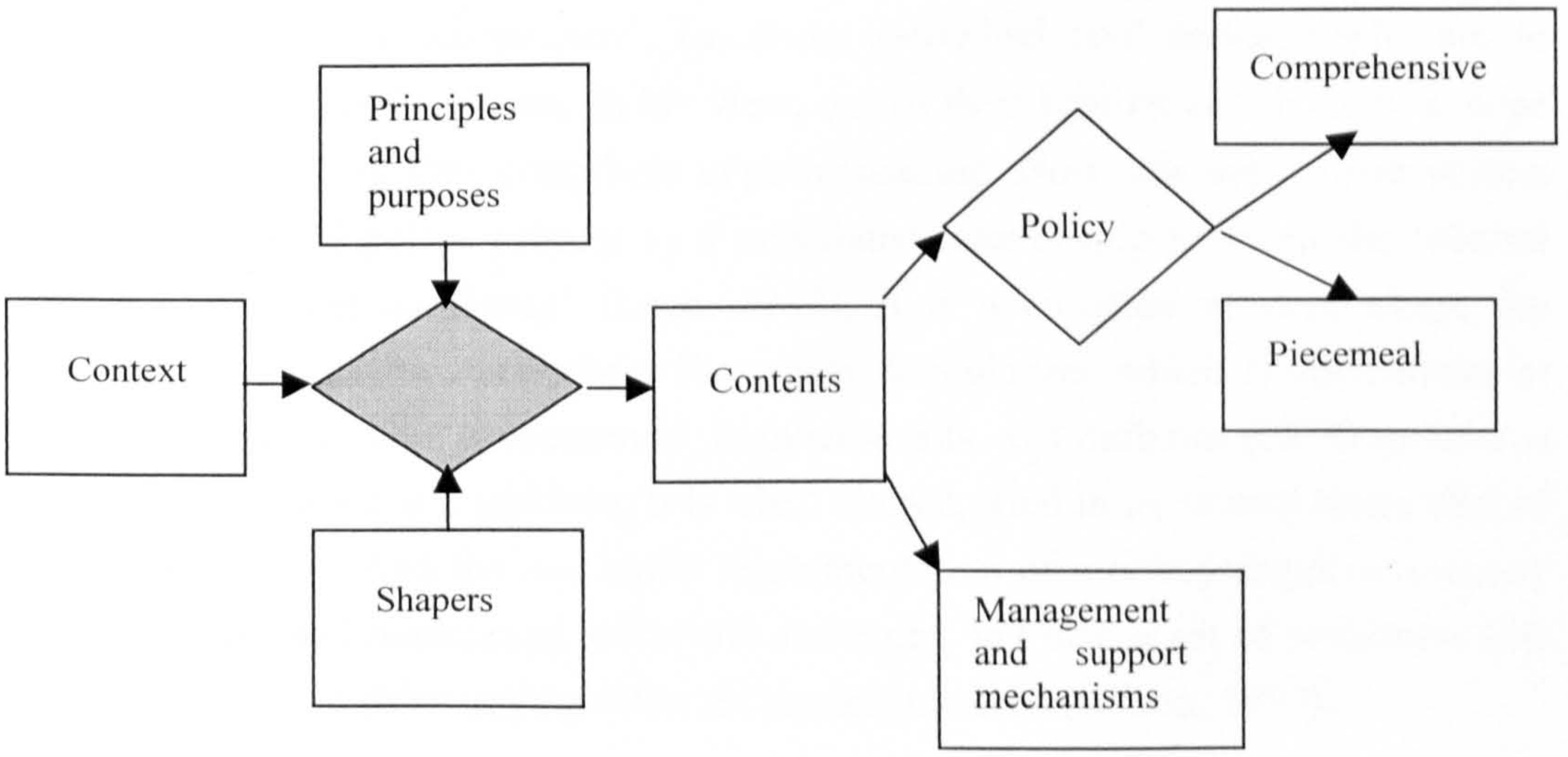
The contents form the body of a policy and are the fine tenets or a set of decisions aimed at transforming the contextual grounds to a statement of the desired future, including the identification of the means to achieve that. The contents correspond to the design or formulation phase of policy making. In this regard it has already been discussed that the reformers or shapers guided by the principles and purposes muddle through the contextual factors for developing the contents of reform. In this pursuit, however, care is needed, as already indicated (2.2.5) as any change in one part of the health sector will have a ripple effect and other components will respond to this intervention. Moreover, as noted earlier (2.2.4) a suggested set of interventions, in many cases, was in disregard of the contextual factors, so there was a mismatch between the "why" and "what" of reforms.

Frenk (1994) proposed four policy levels and the matching objectives and issues that may be addressed through a reform and the resultant change (2.4.1.4). From this, one may infer that reform may range from a piecemeal or low-level policy change to a complete comprehensive restructuring. That is, there could be another category of reforms, where the change is built gradually, i.e. incrementally, and it is argued that a piecemeal change at one point in time may develop flesh over time to develop into a comprehensive reform package. Gonzalez-Block (1997) distinguished such

reforms from those gradually built-up, depending on their contents. According to him, the comprehensive reform denotes the "policy formulation and implementation that comprises the systemic, programmatic, organisational and instrumental policy levels through explicit strategies sustained in well documented experiences and theories, and implemented with the support of a specialised authoritative agency with consensus building capacity". Although a useful interpretation, it is likely to complicate the analysis. For this definition incorporates too many variables including those arising from implementation, which although overlapping the formulation phase of the policy process, is considered separate by this framework.

The contents are the 'what' of the policy for reforms and in terms of a research variable for this study address the question of 'the government's concepts and design of reform'. While this framework highlights the relationships between various phases of the policy process, the scheme for identifying policy levels is borrowed from Frenk (see table 2.3 in chapter 2). Thus, the policy contents may be analysed at two levels. That is, the context with input from the policy machine and other stakeholders in policymaking guided by principles and purposes is processed in the "black box". The output of this process is the policy content, which is analysed first to segregate the policy *per se* and questions may also be asked about, e.g. management systems and support mechanism to manage the change and to build the capacity of the implementing agency. Was a communication strategy developed and to what extent was this used to consult and involve the stakeholders? Secondly, the policy is examined for determining the policy level addressed in terms of it being comprehensive or piecemeal (Figure 3.5).

Figure 3.5:- Determining the contents



3.3.5. Implementation

Implementation is an important aspect of the policy process (Walt, 1994) and it has been argued that the public sector is often ineffective in doing it (Hogwood and Gunn, 1984). For this observation Pressman and Wildavsky (1973 cited in Hogwood and Gunn, 1984: 197) identify three causes. These are: (i) bad execution; (ii) bad policy; and (iii) bad luck. While the former two are self-explanatory and are under inquiry, bad luck is attributed to the circumstances beyond the control of implementers. In this background, Hogwood and Gunn (1984) prescribed a ten-point model for 'perfect implementation', as given below:

1. The circumstance external to the agency does not impose crippling constraints.
2. Adequate time and sufficient resources are available.
3. The required combination of resources is available.
4. Policy is based on a valid theory of cause and effect.
5. The relationship between cause and effect is direct, and there are few, if any, intervening links.
6. Dependency relationships are minimal.
7. There is an understanding of, and agreement on, objectives.
8. Tasks are fully specified in the correct sequence.
9. Communication and co-ordination must be perfect.
10. Those in authority can demand and obtain perfect compliance.

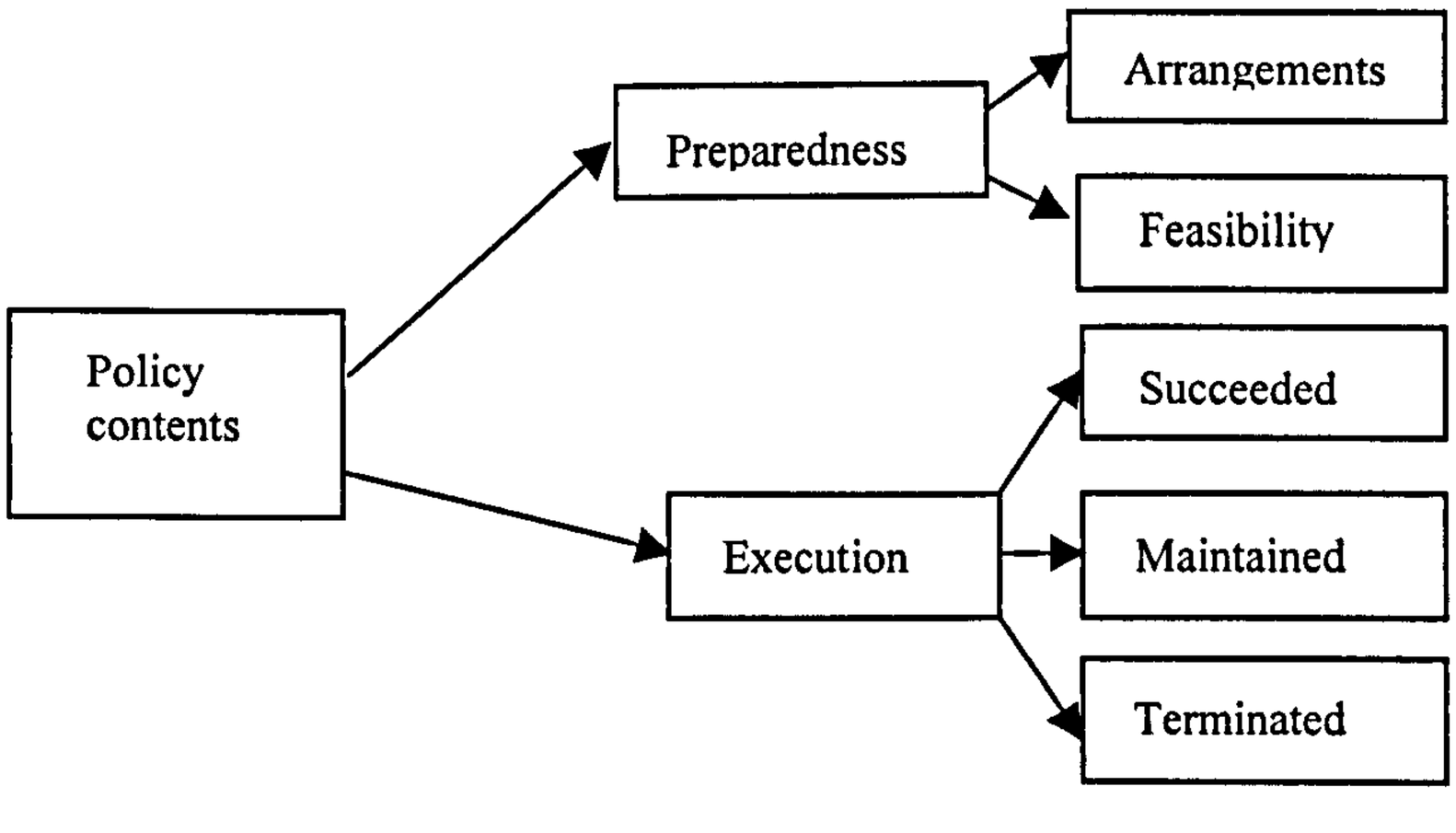
But, this top-down approach to implementation has been criticised for being too managerialistic and authoritarian and instead a 'bottom-up approach' has been advocated (Hjern and Porter, 1981). In this regard, Lipsky (1980) propounds the idea of 'street level bureaucracy', i.e. those individual civil servants who are in active contact with the clients. In his view, out of their routine and devices to cope with work pressures, they contribute to policymaking. However, subsequent writers saw this phase of policy process as a negotiated relationship between the 'central steering and local autonomy' (Lane, 1987). It is a complex process where the implementers contribute actively to the policy formulation, which is not a linear or sequential, but iterative phenomenon. In other words, as Lindblom (1958) maintains "a policy is directed at a problem; it is tried, altered, tried in its altered form, altered again and so on". And the successful implementation of a policy requires not only good political and managerial skills and strategies, but also a set of principles that govern the relationships among different parties involved (Gilson, 1999).

Implementation involves the question, 'how' the policies are administered and managed, i.e. it concerns the execution, monitoring and control of policy

implementation. In other words it looks into government procedures for managing reform, including knowing their ultimate fate – whether continuing, replicated, modified and continuing, or terminated. However, what was the implementation process for the health sector initiatives undertaken in the Punjab health sector? This is studied from two aspects: preparedness and execution. The former may appear a part of the design phase of policy process, but is considered with implementation, because this is about developing a set of tools or infrastructure needed to actually commence or execute the reform. And during this phase, the planners should be in active dialogue with the managers (Green, 1999). Further, looking at the normative way of policymaking in the Punjab health sector, this aspect is often left for the implementers to work on (see Appendix 3.1 for the Punjab public policy process).

Nonetheless, to analyse the implementation aspect of policy process at first level, the status of preparedness is adjudged by addressing questions like political feasibility and testing technical feasibility. The next level addresses the questions surrounding execution, mainly whether the initiative is maintained, terminated or has been replaced (Figure 3.6). Since, evaluation or impact of policy is out of the scope of this study, it is not discussed and no question is framed for the enquiry.

Figure 3.6:- Exploring the implementation



3.3.6. Process

Classically defined, the process is "concerned with the way the policy is made and implemented" (Hill, 1997: 1) or more explicitly, it is "the process by which a government or society sets its activities and allocates resources" (Foltz, 1996). In other words, it concerns the broader question of 'how' the reform is undertaken in terms of origin, formulation and implementation. In this regard, it was noted that the process overarches the whole phenomenon *of policymaking* and concerns not only the course of action, but also how the shapers and their principles affect the process.

In other words, this aspect of analysis deals with looking into the "black box" in order to determine how decisions are made. The policymaker in this exercise is seen negotiating within and outside, with the organisations and individual actors whose concurrence may be necessary for policy implementation. Given that there could be such inter-organisational politics and manipulation, it may become difficult to even locate the real policymaker. This makes it difficult to prefigure the process, because this is dynamic, the nature of the relationship between policy actors and the world around in which they operate is diffused (Gordon and Lindley, 1977). Highlighting this phenomenon, Gilson (1999) argues that reform processes are not simple technical strategies, but involve social changes that are value-laden and often conflict-ridden. According to her, it is "the values, actors, and actors' perspectives that hold significant importance over the content and process of reform". In other words, this needs determination: how did various shapers contribute towards the reform process? Further, at the heart of this question lies another question – what determines that a particular decision will be made in a given way?

The above aspect of enquiry was considered in the section on principles and purposes, and shapers. A reference was made about how shapers influence the decisions or policy. It was conjectured that this relates to the notion of power and output, i.e. the shape a particular policy takes, depends on the manner power is distributed in society. In this regard there are different views (Barker, 1996; Walt, 1994; Brugha and Varvasovszky, 2000). Briefly, *Pluralists* view power as diffused throughout a society, so that no group alone holds absolute power. *Marxists*, however, view it differently. According to them power is distributed, but not equally – he who shouts louder, is listened to. Instead, they see power distributed among classes and state functions to ensure the continuing dominance of these classes. Based on this theory, *élitists* view the power confined in the hands of an influential few. In *corporatism*, the state has the power to overcome the conflict between labour and capital. P*rofessionalists* see power concentrated in the hands of the professional élite, who prefer their own interests to the public they serve. In this regard the technocracy and bureaucracy (especially the generalists) are also relevant. The former denotes *technocrats* making the decisions, often using rational techniques. Similarly, the generalist *bureaucrats,* although being in the service of political masters, are powerful due to their knowledge and expertise.

Perhaps, as Walt (1994) brings evidence from literature, it is artificial to classify decision-making approaches: rational, incremental or mixed scanning. Nonetheless, explained briefly, *rational* means that the policymaker follows various steps in a logical and scientific order and the result was a rational decision, which achieved the purpose most effectively. The *incremental* model presented by Lindblom (1959),

accepts at the outset that only a few issues can be resolved at a time, i.e. policy making is a serial phenomenon and the policymaker has to come back and forth to address different issues, i.e. he is still "muddling through". Therefore, the rational approach implies describing 'how it ought to be made', while the incremental is grounded in the activities considering practical insight and describes 'how it is made' (Walt, 1994: 51). *Mixed scanning* propounded by Etzioni (1967), however, encompasses both the aforementioned models. This is the middle position between rational and incremental approaches, where the policymaker divides the process into the micro and macro decisions – the latter are taken first, while the former are looked into later during implementation.

Ham (1997: 119-120) identified four approaches to a reform process: (1) big-bang reform, where the reforms are introduced in a short period of time and are driven by a government committed to their implementation; (2) incremental reform is a cautious gradual build-up over a long period of time; (3) bottom-up reforms, which originate in the lower echelons, and are adopted by the higher levels contrary to the top-down approach, where the top tiers dictate the process; and (4) "reform without reform"; where change continues to occur despite there being no central policy or plan. In other words, instead of trying to build change in the whole of the health sector in one go, the pieces where the consensus can be built are identified and implemented. This approach to reform can also be regarded as an incremental one.

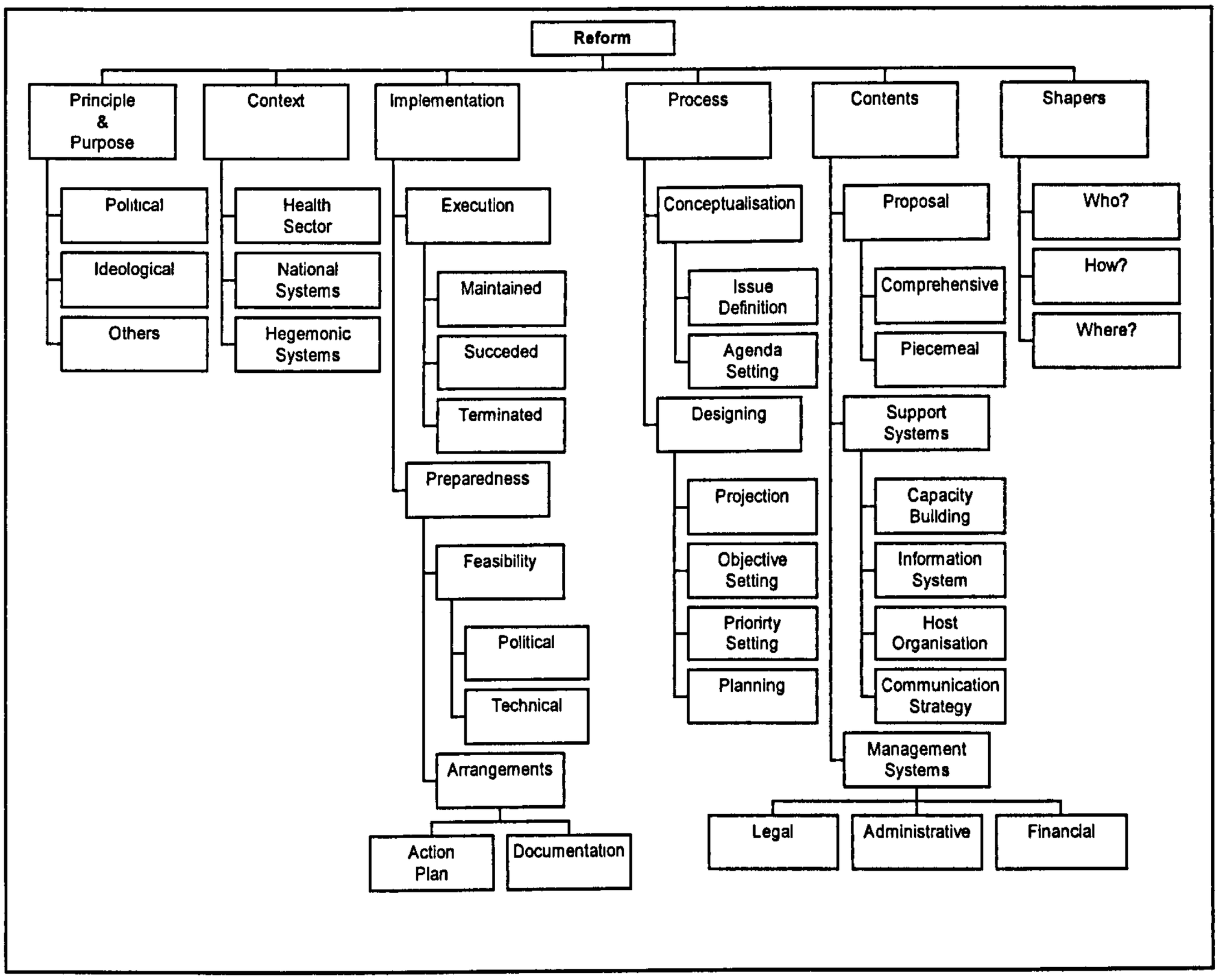
Nevertheless, to analyse the process various questions are framed. For example: how was the issue identified and how was it decided to bring this (issue) on the political agenda? How were the objectives and priorities fixed and then how were those addressed? The enquiry may extend to finding about option analysis, projection techniques, planning etc. The implementation phase is distinct and analysed separately. This is because the implementation largely concerns the output, while the process is about the way the decisions are made in developing a particular policy. Further, this may be noted that because the process is dispersed throughout overarching the whole phenomenon of policymaking, it is not depicted figuratively as the other tenets of policy process.

3.4. Summary and conclusion

Based on the concepts explored in chapter 2 a theoretical framework has been developed in chapter 3 to analyse the policy process for health reforms. This framework has six components: principles and purposes; shapers, origin or context; contents or formulation; implementation and process. In addition, a number of

variables drawn from each of these components (Figure 3.7) were identified in order to frame an enquiry for addressing the research question.

Figure 3.7:- Analytical hierarchy for the policy process



Thus, the stage has been set for examining the policy process for the Punjab health sector reforms undertaken during the period 1993-2000. In the next chapter the research process or methodology is explained for applying the analytical framework developed in this.

4. Research process

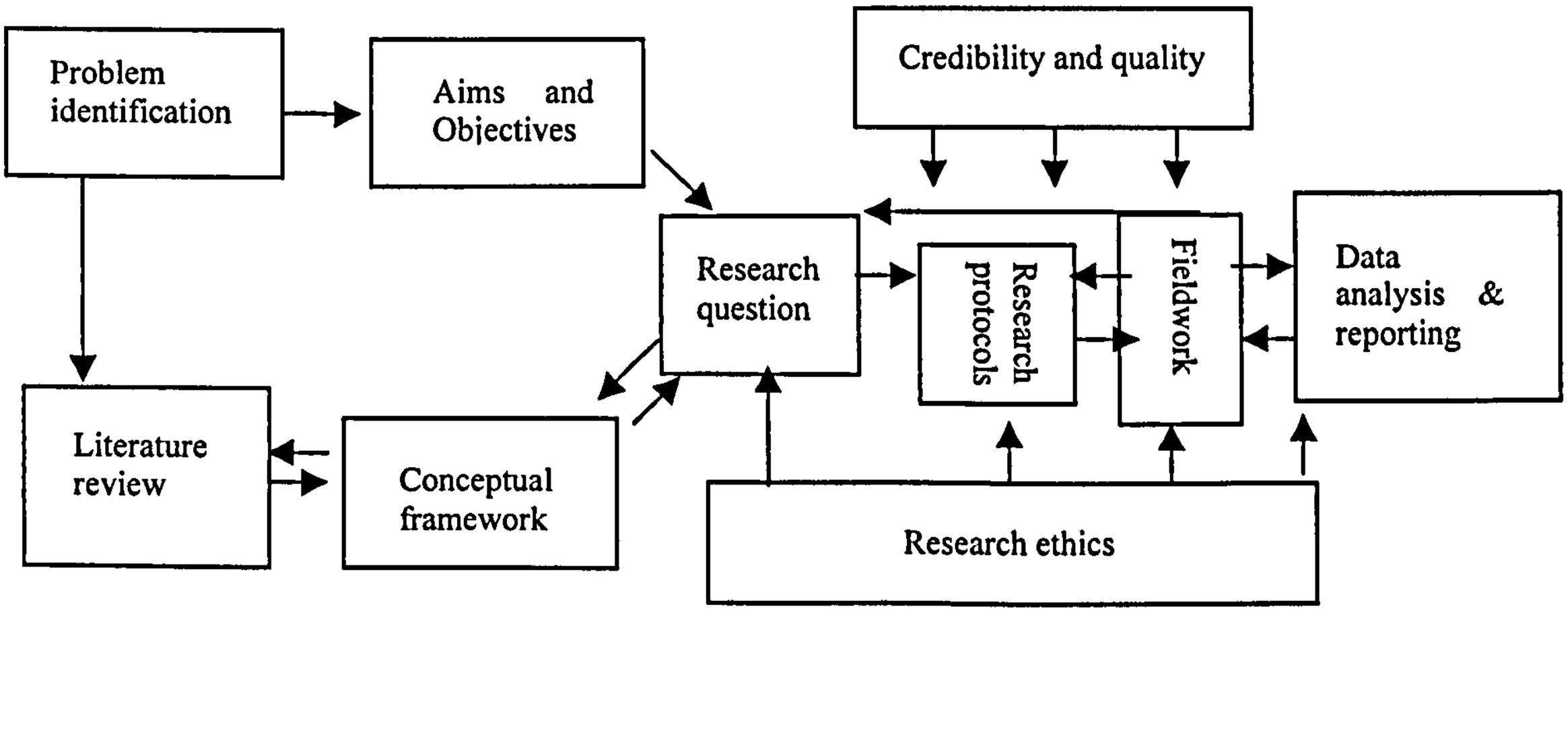
4.1. Introduction

So far, we have established the context and explored the concepts surrounding this study, an exercise that culminated in developing a framework for analysing the policy process for the Punjab health sector reforms. This chapter documents the process or methodology employed for investigating the reforms. In other words in terms of Silverman (2000: 232), it is telling the readers "how we gathered data, what data we ended up with and how we analysed them". This objective is achieved in this chapter by:

1. dealing with the general issues about this research in section 1;
2. explaining the research design and methods in section 2;
3. providing an account of the process for conducting the fieldwork in section 3;
4. answering the question how data was transformed into results in section 4; and
5. presenting the strategies about how the credibility, ethics and quality of this qualitative research have been upheld in section 5.

The research process for this study is seen in figure 4.1, below. That is, the problems identified in the health sector led to establishing the aims and objectives and defining the research question; a process that was guided by literature review and the conceptual framework. Research protocols were developed and used to collect data that were analysed and reported, guarded by the research ethics and its credibility and quality was ensured through knowledge, rigor and research skills.

Figure 4.1:- Research process



4.2. General issues

4.2.1. Purpose

According to Patton (1990: 150), definition of purpose is central to research. He provides five alternatives, albeit, on a continuum with no hard and fast line of demarcation between them. These are:

- basic research to contribute to knowledge and theory,
- applied research to illuminate a societal problem,
- summative evaluation to determine a programme's effectiveness,
- formative evaluation to improve a programme, and
- action research to solve a specific problem.

The purpose of this study is to conduct a form of applied research, which has certain elements of basic research and formative evaluation. However, within these technical remits the aim of this study is "to explore factors that influenced the policy process for the government initiatives undertaken in the Punjab health sector during the period 1993-2000". Drawn from this aim, the major objectives of the study are:

1. to develop a framework for analysing the health sector;
2. to describe the changing structure and functions of the Punjab health sector;
3. to establish a framework for analysing the policy process for reforms;
4. to analyse the policy process for the health sector reforms undertaken in the Punjab health sector during the period from 1993-2000;
5. to explore the factors both enabling and disabling that influenced the policy process for reforms; and
6. to draw lessons for the ongoing and future reforms.

4.2.2. Question

The research question(s) represents the facet(s) of an empirical domain, which the researcher wishes to explore (Huberman and Miles, 1998). Ritchie and Spencer (1994) note that in applied policy research questions are broadly in four categories: contextual – identifying the form and nature of what exists; diagnostic – examining the reasons for what exists; evaluative – appraising the effectiveness of what exists; and strategic – identifying new theories, policies, plans or actions. According to Yin (1994), the researcher may, in certain exploratory case studies, undertake fieldwork before a research question is defined. Tellis (1997), however, argues that only an experienced researcher could use this option. Since, once a broad question has been defined, Keen and Packwood (1999) note, then either of the two approaches is

applicable. Firstly, a set of precise questions is developed at the outset and data collection and analysis is aimed at answering these. Secondly, the earlier stage of fieldwork is used to feed into identifying and refining the specific questions.

Given the above liberty and caution, the formulation of the research question in this case has been an iterative process, and, as seen in figure-4.1, this benefited from the conceptual frameworks and their applications. According to Miles and Huberman (1994) the research question may be general or particular, descriptive or exploratory. In this case, however, it is mainly exploratory and moves from general to specific by breaking the former into a number of specific sub-questions.

Given the aims and objectives (4.2.1), this study addresses the question as to "what factors influenced the policy process for the government initiatives undertaken in the Punjab health sector during 1993-2000". Since, this question has several facets, and as Miles and Huberman (1994) noted, this is the case in any qualitative inquiry, it is surrounded by more questions and sub-questions which are given below:

1. What is the changing structure and functions of the Punjab health sector?
    1.1. What is the organisation of the health sector?
    1.2. What are the role and functions of various components of the health sector?
    1.3. What are the status, issues and problems in the Punjab health sector?
2. What was the policy process for the health sector reform initiatives undertaken in the Punjab health sector during the period 1993-2000?
    2.1. Which reform initiatives were undertaken during the period 1993-2000?
    2.2. Who and how did they influence the shaping of reform initiatives?
    2.3. What were the principles and ideology behind the reforms?
    2.4. Why were the reforms introduced, or what factors or issues preceded the introduction of reforms?
    2.5. What were the scope and proposal in terms of concepts and design?
    2.6. How did the government conceptualise and design the reforms?
    2.7. What was the process for implementing reforms?
    2.8. What was the eventual fate of the reform initiative?
3. What were the factors that influenced the policy process and lessons for the ongoing or any future reform initiative in the health sector?

4.2.3. Significance

Despite a great deal of interest in health sector reforms all over the world, few systematically planned studies have been undertaken (Gross *et al*, 1998). This is also true for the Punjab and this study where the focus is on analysing the policy process and determining the factors that influenced the output of reform initiatives. Sofaer (1999) argues this situation is largely due to the health sector researchers borrowing theories from the social science disciplines instead of developing their own.

The current study undertaken in the Punjab perspective, therefore, is an original work and 'like many qualitative researches' breaks new ground adding to the body of knowledge (Health Services Research, 1999). The government as well as donors can use the results to determine the course of action for planning and implementing the reform policies whether ongoing or for a future undertaking.

4.2.4. Boundaries

Given the research question (4.2.2), this study has several dimensions. It would, therefore, be reasonable to identify the mandate posed by this study. However, it may be noted that this is not going to be a hard and fast boundary, as all factors and influences in the context need to be taken into account (Lincoln and Guba, 1985).

This is a qualitative research study, primarily applied with certain elements of basic research and formative evaluation. The case study approach has been used to study different stages of the policy process – conceptualisation, formulation and implementation – with the aim of (retrospectively) analysing the policy process. Gilson (1999) notes such an approach as a means for evaluating health reform. However, a distinction needs to be made here between summative and formative evaluation. The former is aimed at assessing effectiveness once an intervention or programme has stabilised. This study, however, is a formative evaluation, which uses process data and is aimed at improving the policy/programme.

The lessons emerging, in or over time, may be seen as remedial suggestions, and are part of the researcher's effort to carry the argument to its logical conclusion. Nonetheless, this study is exploratory: it determines the factors, which influenced the output of reforms undertaken in the Punjab health sector. However, since it poses also "what" questions, in addition to "why" and "how", it has explanatory elements as well.

4.2.5. Research type

The research methods are commonly distinguished between those essentially qualitative or quantitative research methods. According to Schwandt (1997), qualitative, an adjective attached to a variety of social inquiries, is a blanket term for various methods. Creswell (1994: 1-2) explains this as "an inquiry process of understanding a social or human problem based on building a complex, holistic picture formed with words, reporting detailed views of informants and context in a natural setting". The quantitative study, alternatively, is "an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers and analysed with statistical procedures, in order to determine whether the predictive generalisation of the theory hold true" (*ibid*).

This study employs qualitative research methods. This is because, as Keen and Packwood (1999) propound, given the aim is to understand the reasons for the success or failure of an intervention, the researcher cannot have control over conceptualising, formulating and implementing policy. Further, the experimental designs are not feasible and the observational designs have limited value. Moreover, according to Myers (2001), "motivation for doing qualitative research, as opposed to quantitative research, comes from the observation that, if there is one thing which distinguishes the human from the natural world, it is our ability to talk!" He adds that "qualitative research methods are designed to help researchers understand people and the social and cultural context within which they live". But, why use qualitative research in this particular case, is the next question to address.

The health system, which is the object of this study, is complex in terms of its ingredients, dynamics and relationships. To study a system of this nature, one needs to employ methods that have a holistic approach, and qualitative methods offer this possibility (Barker, 1996). Further, there is a lack of agreed research tools and frameworks to study the health system, which adds to the dilemma and challenges. Since the qualitative methods are flexible, innovative, iterative, and allow the researcher to study issues in depth and detail, they are most suited to such a situation (Patton, 1990). Qualitative methods emphasise the context and process and are concerned with describing the detail of what is going on in a particular setting (Murphy *et al*, 1998). The researcher is, therefore, in a position to record the case in its entirety in order to develop a case study.

Qualitative research is dynamic in nature, which is suitable for examining the intentions, social constructions and meaning in culture and structural processes and historical changes using techniques of interview, observation and document review

(Grbich, 1999). In a similar vein, Sofaer (1999) notes that qualitative research helps move the inquiry towards a meaningful explanation. Therefore, he maintains, this is of particular importance in policy studies, because "the rich descriptive capacity of qualitative methods can result in a far more complete and often far more compelling articulation of the intervention". This is precisely the situation for the current study, which is predominantly exploratory and "curiosity" underpins its posture. In such settings, Chenail (2000) argues, qualitative research is an appropriate methodology.

However, as stated earlier, qualitative research embraces an array of methods: case study, action research, ethnography and grounded theory. This researcher identifies them as 'approaches' for distinguishing from data collection techniques or methods. Nonetheless, the next question is, which approach should be used and 'why'?

4.2.6. Approach

The case study approach is used in this study. This "consists of an intensive, detailed description and analysis of a particular individual or event" (Moore, 2001). Yin (1994) identified three types of case studies: exploratory, explanatory, and descriptive. The *exploratory* case studies are considered to answer 'what' questions, as a prelude to some social research. The fieldwork and data collection may be undertaken ahead of defining research questions, but the framework must be created beforehand. The causal studies use an *explanatory* approach to answer 'how' and 'why' questions. The *descriptive* case studies require that the theory covering the depth and scope of the case under study be defined at the start (Tellis, 1997). To these types, Stake (1994: 236-247) added three more: intrinsic, instrumental, and collective. The *intrinsic* case study is undertaken because the researcher is interested in knowing more about a particular case. If the objective is to have insight into a particular issue or refinement of a theory, the *instrumental* case study approach is employed. The *collective* case study is used when more than one case is studied to inquire into a certain phenomenon. The objective of adding more cases to the study is to have a better understanding of what is/has been going on.

What type of case study approach was employed in this study? Stake (1994) indicates that the researcher could simultaneously have several interests and it is often difficult to distinguish, especially between the intrinsic and instrumental case studies. Similarly, the boundaries between different approaches as proposed by Yin (1994) are not distinct either. There is always some overlap between them and it is essential, according to Yin, for the researcher to explicitly define his/her approach before embarking on a study. Accordingly, as indicated earlier (4.2.4), this study is primarily exploratory with explanatory and descriptive elements. However, why was

the case study approach adopted? This approach, since allows a focus on a particular policy case (Blaxter *et al*, 1996), is used to study the reform initiatives undertaken in the Punjab during the 1990s. Keen and Packwood (1999) propound that in the policy process a number of stakeholders are involved and each one of them has their own interpretation of events. Capturing these views, in their opinion, is often possible using "interviews or other qualitative methods within a case study design".

Nevertheless, a case study approach has also certain limitations. The focus is on one or just a few case(s) and a limited number of participants selected purposefully may not be typical to generalise results. Yin (1994: 30-32), however, forcefully argues against such an assumption posing a counter question: "How can you generalise from a single experience?" In his view, in a case study, the researcher's goal is "to generalise theories (analytical generalisation) and not to enumerate frequencies (statistical generalisation)". Or, as Tellis (1997) notes, the "goal of study should be to establish the parameters, and then should be applied to all research. In this way, even a single case could be acceptable, provided it met the established objective". Lincoln and Guba (1985: 233) building on an earlier work by Ford (1975), conceptualised "qualitative information isomorph" – a termination point of a sampling frame. According to them, the sample – large or small – is sufficient when it is not profitable to add even one participant. This may be taken as an objective way of determining the size of the sample, but purposeful and convenient sampling for qualitative research prevails in the literature.

Another criticism is about the lack of adequate 'rigour' in the case study approach, which according to Yin (1994) may allow bias to influence the findings and the conclusions drawn. Ratcliffe and Gonzalez-del-Valle (1988) define rigour as "the scrupulously precise and scientifically exact application of research methods for gathering data and of analytic techniques used to treat and analyse the data". They note that although much emphasis is laid on rigour during training, the concern for it during the research process is uncommon. Yin (1994), building on this, argues that such a deficiency is not unique to a case study, but could also enter in all other research approaches. He acknowledges, however, that in case study research this issue has not been well attended to. Therefore, he emphasises determining the skills possessed by the researcher, as a part of designing the case study protocol.

4.3. Study design

Boundaries for this study, in general terms, were defined earlier. Here the concern is about study design, where three considerations are important: location or spatial, participants or inclusion criteria and instruments or data collection tools. These are discussed below, on the premise that qualitative research allows a flexible design and does not require an *a priori* well-defined framework (Murphy *et al*, 1998).

4.3.1. Spatial consideration

The study focuses on the Punjab province (Pakistan) and the reform initiatives undertaken in the public sector health systems during the period 1993-2000 are reviewed. Since Lahore is the capital of the Punjab, where the political head offices, provincial health secretariat, directorate, special projects and offices of other major stakeholders of reform are located, the research was based there. However, the researcher also travelled to several other locations, including Multan and Jhelum, where the DHAs were established. Journeys were also made to places including Jeddah (Saudi Arabia), where the exiled ex-chief minister of Punjab lives, to discuss and interview key informants and to hold workshop sessions.

4.3.2. Inclusion criteria

For those working with statistical inferences, qualitative sampling can be confusing. It is purposive and many strategies can be used depending on the purpose of the study (Byrne, 2001). In this case, it is primarily criterion sampling, but purpose and convenience overarches the process. As to the size of the sample, there can be no single answer. Mainly, it was data saturation used as an indicator to stop recruiting more participants. Nonetheless, how the cases, participants and documents were selected for inclusion in this study is given below:

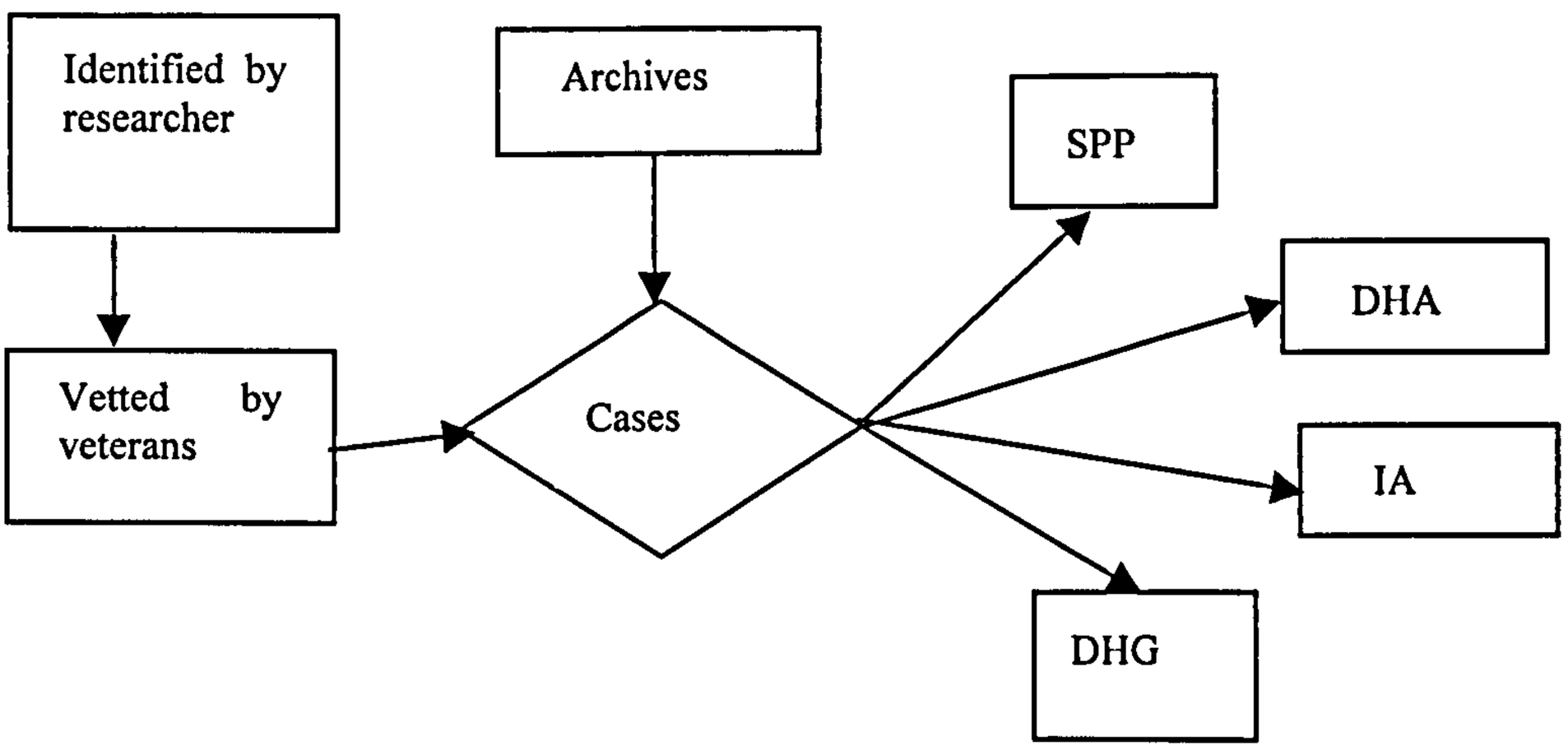
4.3.2.1. Cases

The qualitative researcher is often content even with one well-chosen case study, because as Yin (1994) argues the cases may have several sub-cases embedded within them. Contrarily, however, Miles and Huberman (1994) advocate that multiple cases may be included in a study. It is helpful, in their view because given the varying nature of different cases in terms of comprehensiveness and the development stage achieved, such a strategy offers a better understanding of the policy process. Further, constraints like accessibility of data and availability and willingness of subjects to participate in a study necessitated sampling, so four cases were selected for in-depth study. This selection was also due to the overlap in their

major interventions, as some were not representative of the whole process. However, it was purposive sampling, and given the aim and objectives of this study, four cases (SPP, DHA, IA and DHG) were considered an adequate "frame" to analyse and explore the policy process that "undergirds" this study (*ibid*: 27).

The process for selecting interventions for study is given in figure 4.2. That is, this researcher constructed a list of reforms undertaken during the study period (1.5) which was later validated in a session with the senior permanent staff of the Health Department and finally confirmed from a review of the archives.

Figure 4.2:- Selection of cases



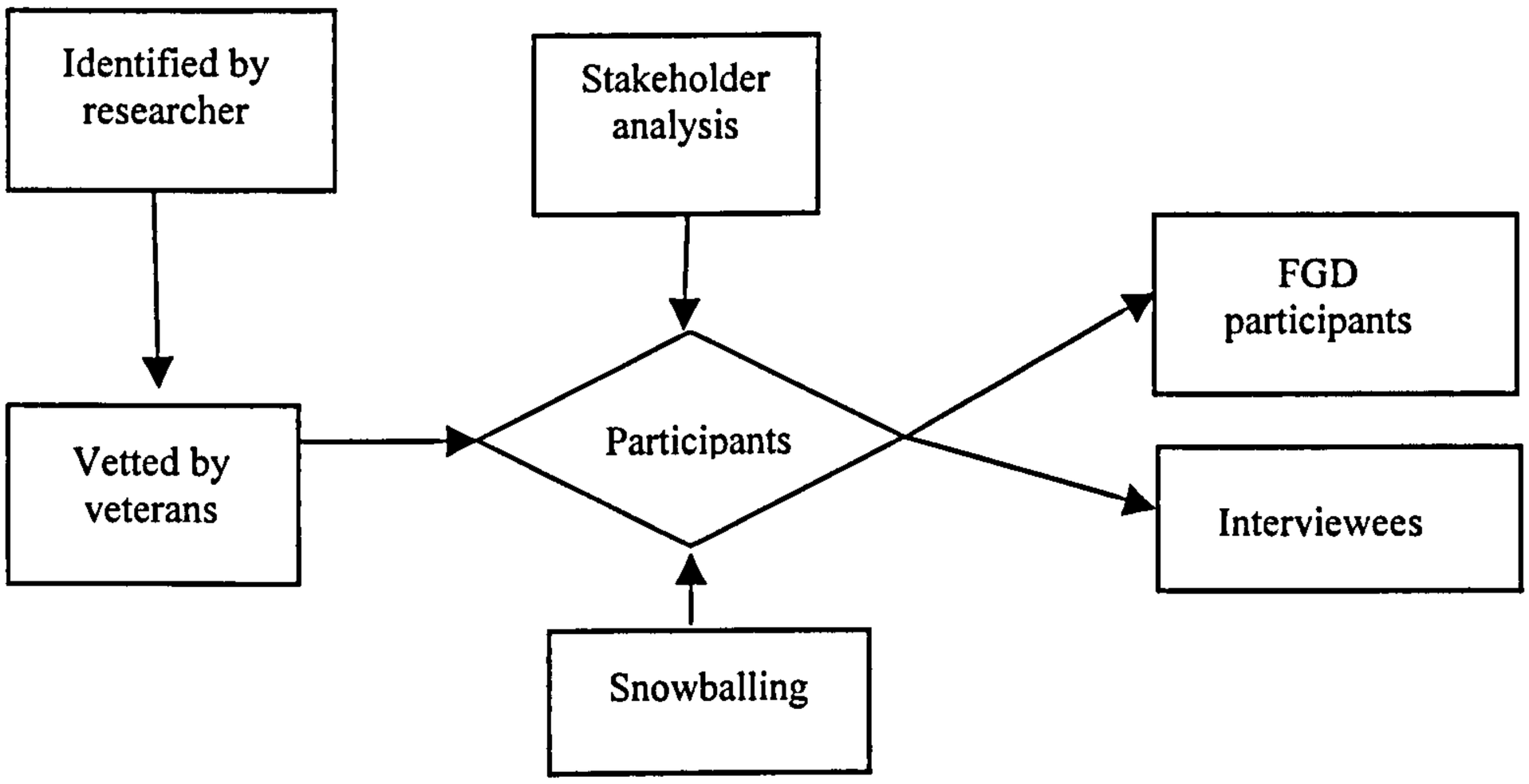
4.3.2.2. Participants

Keeping in view that four reform initiatives were studied, the shapers and their respective locations in the health system varied and their identification was also contingent on a snowballing effect. A final list of such persons was, therefore, left until the researcher started the fieldwork. This approach is adopted because qualitative methods allow sampling in this manner (Murphy *et al*, 1998).

In response to the request of this researcher for allowing access to the officials and documents, the government appointed a committee comprising the senior permanent staff of the Health Department. This committee assisted this researcher in drafting a list of concerned officials and documents for consultation by the researcher (GoPb, 2000f). A meeting of this committee held on May 27, 2000, refined and largely verified the erstwhile tentative list prepared by the researcher. In order to substantiate this evidence a session on 'stakeholder analysis' was organised as an aid to identify the main actors and for whom the success and failure of a particular case mattered. Out of the list so devised, participants were selected purposefully for focus group discussions (FGD) and individual in-depth interviews based on the

individual's availability and willingness to participate. Nonetheless, more individuals were subsequently added for interview as a result of snowballing effect - one respondent indicating the other source - to answer queries arising in the mind of researcher during fieldwork and to obtain specific pieces of information. The process for selecting study participants is given in figure 4.3, while the list of participants for interview and FGDs appears in Appendix 4.1 and 4.2 respectively.

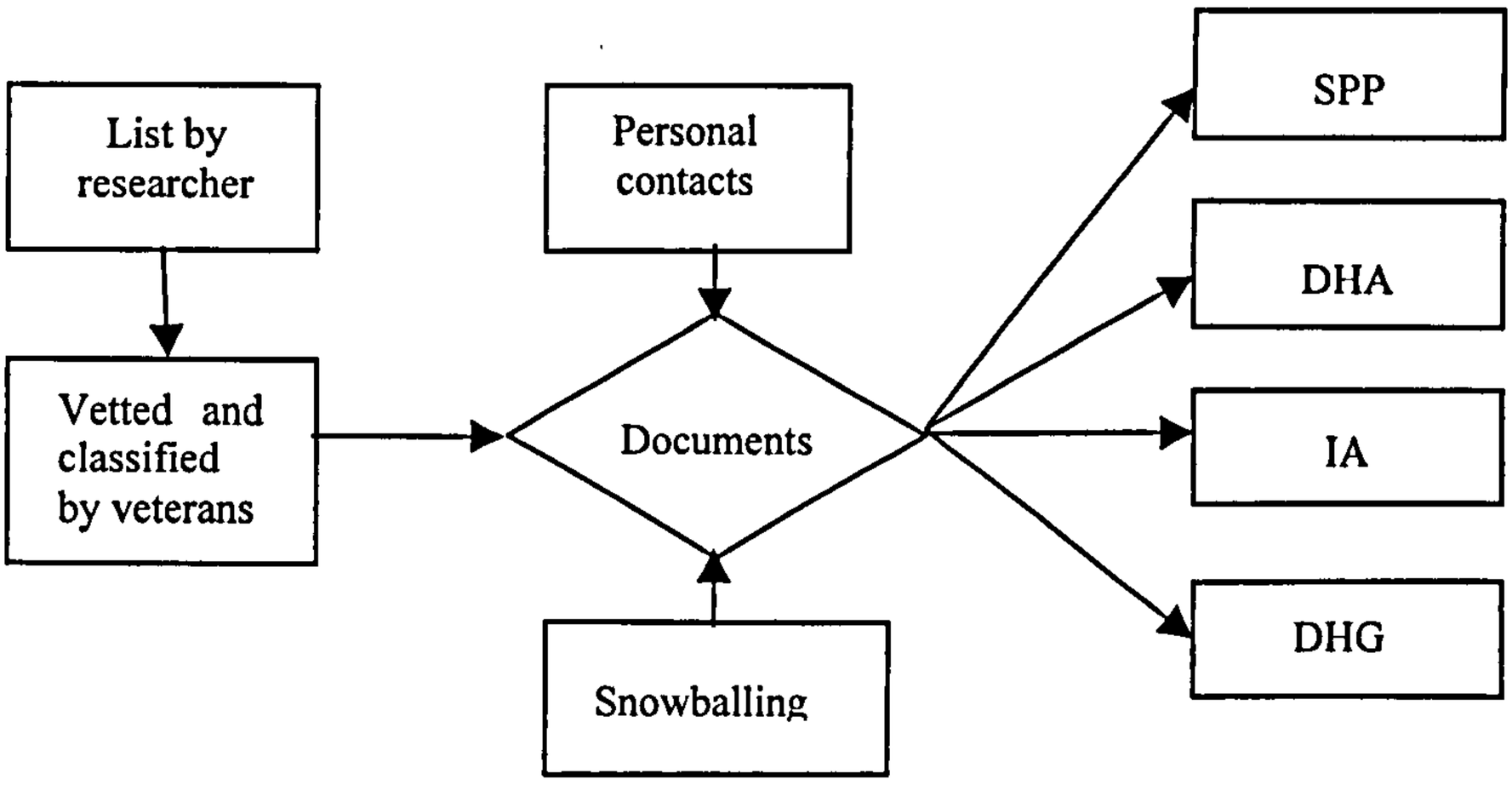
Figure 4.3:- Selection of participants



4.3.2.3. Documents

In the health sector a range of documents is produced by the agencies and sections involved in the reform or by interested groups. These include situation analysis, working papers, minutes of meetings, proposals, review reports, progress reports, memos and correspondence, personal diaries, news items, published and unpublished material, and all sorts of grey literature relevant to the reform initiative. This study envisaged accessing such documents. However, given the enormity of the number and type of documents – documentation is one of the basic features of the bureaucracy – and their location in various sections and offices of the government, the permanent senior staff in the Health Department helped this researcher in drawing up a classification of documents. Based on their indications and armed with the government's permission, the researcher also used his personal contacts, which were often most effective in locating the relevant documents. Added to that list was the snowballing effect – one document pointing to another located in another section or office of the government. Finally, a purposive selection of documents was made, keeping in view their relevance for different interventions. The process for this type of sampling is seen in figure 4.4.

Figure 4.4:- Selection of documents



4.3.3. Instruments

Instruments are tools developed for data collection. Since the qualitative researcher, according to Creswell (1994: 145), is the primary instrument for collecting and analysing data, and given that "data are mediated through this human instrument rather than through inventories, questionnaires, or machines", in the following section, concepts around this term are explored further. However, this is done in the background that the human are 'the initial and continuing mainstay' instrument, but other forms also exist (Lincoln and Guba, 1985: 236).

4.3.3.1. Instrumentation

Earlier in this chapter (4.2.4) an effort was made to draw boundaries for this research. However, it was noted that since qualitative research allows a flexible design, it is liable to instrumentation along the way. Instrumentation, as Miles and Huberman (1994: 35) note, comprises loosely or tightly structured methods for collecting data and in qualitative research this means more than employing device for observing and recording events. That is, not only those initially conceptualised are reconfigured and revised as suggested by data, but also some technical choices may be made during the research process. For example, in the case of an open-ended interview, whether notes will be taken? Or tape-recorded?

However, the question arises, how much "preplanning and structuring of instrumentation" should be done? Miles and Huberman (1994: 35) while providing a useful account of the arguments for "little" vis-à-vis for "a lot" of prior instrumentation, also opine on a third option, "it depends". That is, whereas they argue that "the amount and type of instrumentation" should depend on conceptual framework and research question, the first stance emphasises on certain types of

validity, the second is to ensure internal validity, generalisability and manageability of data. The third stance considers reaching for absolute answers as unhelpful; instead it is both contingent and ecumenical.

4.3.3.2. Researcher as instrument

Human instrument can be used as individual as well as organised into teams. In the current case, however, because this researcher had a role in the policy process for the four health sector reforms being studied, he knew many respondents and most of the documentation. That is, articulating the former attribute, he:

1. led the Sheikhupura Pilot Project (see 5.3.3.1);

2. coordinated the activities of DHA, Multan (one of the two DHAs) (5.4.6.3); and

3. was a close observer (and commentator) of the policy process for IA and DHG (see for details 5.5; and 5.6).

Therefore, as Lincoln and Guba (1985: 39) emphasise, he, acting as a human instrument in the research process, was in a position to influence, e.g. problem definition, design determination, data collection and analysis and reporting of findings. Nevertheless, he took up the role because, as they argue "it would be virtually impossible to devise *a priori* non-human instrument (e.g. paper-and pencil or brass instrument) with sufficient adaptability" required in a qualitative research setting. And given that, as Hofstadter (1979 cited in Lincoln and Guba, 1985: 46) noted, there is a trade off relationship between adaptability and perfectibility, there are chances of biases creeping in, albeit human can recognise and tackle them better. Underlying these observations are the assumptions that "unlike inanimate objects, people think, have feelings, communicate through language, attribute meanings to their environment, and have different beliefs and personal characteristics" (Devers, 1999: 1159). However, how were the biases and other confounders controlled in this research, it is explained in sections 4.6.1 and 4.6.3.

4.3.3.3. Study instruments

Nonetheless, a number of tools were developed as an essential vehicle for eliciting the response of subjects, and to keep a general check on the direction the qualitative inquiry was taking. The instruments, as Warner (1991 cited in Huberman and Miles, 1998: 205) observes, help in maximising construct validity, and minimise the researcher bias or impact on interpretation by connecting him with peoples' experiences. Further, these tools enhance the internal validity, generalisability and better manageability of data (see 4.3.3).

Instruments were developed for gathering in-depth and comprehensive information covering all dimensions of different variables operative in the reform process. For this, a framework established to review the reform initiatives was used. Accordingly, in these instruments, emphasis is laid mainly on gathering views and information both verbal and written about the ideology, principles and purposes; context and rationale; contents and scope; process and methodological considerations in implementation; and the shapers, both protagonists and antagonists. In total five instruments were developed, and their name and purpose is given in table 4.1.

Table 4.1:- Summary of data collection instruments

No.	Name of instrument	Purpose
1.	Interview guide	To facilitate individual interviews
2.	Question guide	To facilitate focus group discussion
3.	Document review guide	To organise document review
4.	Observation Checklist	To structure observing official meetings
5.	Working paper	To guide discussion in meetings and workshops

4.3.4. Techniques

Techniques, in the context of a qualitative study, according to Schwandt (1997), denote the procedures, tools or methods used to generate and analyse data or both. These may be used both in fieldwork or deskwork. Yin (1994) identifies six techniques: documentation, archival review, interview, direct observation, participant observation, and physical artefacts. He notes the strengths and weaknesses in each of these, and advocates the use of a combination of these techniques. This study uses mainly individual interviews, focus group discussions and document review, which are discussed below:

4.3.4.1. Interviews

According to Kvale (1996: 2, 88), "this is the 'inter view' or 'interchange of views' between two persons conversing about a theme of mutual interest". He identifies seven stages of an interview for research: thematizing, designing, interviewing, transcribing, analysing, verifying, and reporting. Thematizing is about frameworks and research questions which have earlier been discussed. This section will discuss designing, leaving the remaining components to be dealt with subsequently.

Interviewing, as Britten (1999) notes, is a well-established technique used in qualitative research. And Patton (1990) identifies three approaches to collecting qualitative data through open-ended interviewing – the informal conversation interview, the general interview guide approach, and the standardised open-ended interview. According to him, these approaches to interviewing differ in determining and standardising the interview questions before the interview actually occurs.

While on fieldwork the researcher discovered various functionaries and civil servants that had been involved, in one way or the other, in the reforming of the health sector. During such a discourse, which is also termed non-standardised interview, frequently an informal conversation took place. This was often a good source of information and notes were taken in such instances. In this study, however, it is mainly the semi-structured interviews or general interview guide approach that was held using an interview guide. The interview guide is an instrument to elicit responses and is a checklist to ensure that all aspects of a particular reform initiative have been explored. In this case, the interviewer works with a list of information required and phrases the wordings and order of questions suitable to the individual respondent. On the other hand, when the interview guide is used in a manner that the wording and order of questions is exactly the same for all respondents, this may be called a standard schedule or standardised open-ended interview. In practice, however, the distinction between the latter two categories depends largely on the interviewee who sets the momentum of the interview (4.4.5.3).

The next question is – who should be interviewed? The issue was touched on earlier (4.3.2.2), specifically for policy studies using a case studies approach there is little literature about the possible interviewees. Therefore, this researcher used his theoretical assumption that the health system is the context of reform and the shapers of the policy process are located within it. Accordingly, the conceptual framework for the health system was used to draw the interviewees from various components of the health system. The other dilemma is that how many individuals may be interviewed. The adequacy of a sample, as Stake (1994) argues, is determined through the researcher's intuition and training. However, the general guidance followed was that (i) all components of the health system are represented; and (ii) until the interviewees yield no new information. The remaining issues, about the actual conduct of the interview, including arranging and logistics for interview, will be discussed in the section on fieldwork (4.4.5.3).

4.3.4.2. Focus group discussions

Focus groups are a "form of group interview that capitalises on communications between research participants in order to generate data" (Kitzinger, 1999). The other forms include brainstorming, nominal/Delphi, and field interviews. Table-4.2 provides a typology of the group interviews comparing their dimensions like setting, role of interviewer, question format and purpose (Fontana and Frey, 1998).

Table 4.2:- Comparing the dimensions of the types of group interviews

Type	Setting	Role of interviewer	Question format	Purpose
Focus group	Formal-pre-set	Directive	Unstructured	Exploratory
Brainstorming	Formal or informal	Non-directive	Very unstructured	Exploratory
Nominal/Delphi	Formal	Directive	Structured	Pre-test exploratory
Field, natural	Informal spontaneous	Moderately non-directive	Very unstructured	Exploratory Phenomenological
Field, formal	Pre-set, but in the field	Somewhat directive	Semi- structured	Phenomenological

Patton (1990) stresses that a focus group does not comprise discussion; instead this is an interview, because there is no decision-making or problem-solving happening in this process. Contrarily, however, it is argued that the participants in this process indulge in a lively and natural discussion amongst themselves. It is important that participants talk to each other about a topic and have an opportunity to agree or disagree with each other (Dawson *et al*, 1992). In a similar vein, according to Khan and Manderson (1992), it is the group dynamics which are important and they emphasise distinguishing the focus group from individual interviews. The group process helps people to explore and clarify their views and this interaction takes the research into new and often unexpected directions (Kitzinger, 1994). However, there is a danger associated with focus groups i.e. due to the group dynamics, if something is of emotional value, it may deflect the flow of discussion (Boeree, 2002).

As to who should participate in a focus group: from a variety of available approaches, convenient sampling is the most commonly employed practice. But it is essential that the characteristics of a group should match with the objectives of the research (Stewart and Shamdasani, 1990). In this regard, composition of the group is important, and homogeneity is often advocated, although a heterogeneous membership may also work. Another factor is the hierarchy within the group and its representativeness. In the former case, a senior or a member with a strong personality may overshadow the juniors, while in the latter not all sections of the population are covered. Accordingly, this researcher, drawing from the conceptual

framework for the health system, selected the participants purposefully and conveniently. Research needs and resources may determine how many focus groups should be organised. However, given that focus groups were held as a complementary tool to gathering data obtained from other sources (Khan and Manderson, 1992), one session for each case was conducted. What was discussed in the focus groups is the next question. The questions, in this case, ordered from general to specific and sequenced according to their importance are preferably less structured. Further, these are fewer in number and are developed to guide the direction of inquiry (Stewart and Shamdasani, 1990).

4.3.4.3. Observation

Interviewing and focus group discussion techniques provide data on 'what people say'. Observation, on the other hand tells the researcher, 'what they actually do' (Pope and Mays, 1999). This is naturalistic and, contrary to its use in natural sciences, the observer is not bound by "pre-determined categories of measurement", but searches for the concepts and categories relevant to his/her subject of study (Alder and Alder, 1998: 81). Observation may be covert when the observer is obscure or overt when the observer and his motives are known. This may be participatory, when the researcher is part of the process and setting, which he intends to observe and non-participatory/direct, where he is a known outsider to observe the subjects under study (Yin, 1994).

Observation was considered an important qualitative technique that could be employed for ongoing or prospective cases. However, since this research is mainly about the initiatives undertaken in the past, this type of technique has a limited role. Nonetheless, for the initiatives which are still ongoing, observation was thought to be a useful tool. Accordingly, the researcher planned to sit in the meetings and observe how the government machinery works to conceptualise, design and implement its decisions. A guide was also developed in order to structure the observations so that no important point was missed.

4.3.4.4. Document review

Lincoln and Guba (1985: 276-79) make a distinction between record and document. The former, according to them, denotes a recorded statement "attesting to an event or providing an account" and includes schedule, audit reports, tax form, certificates, and the like. The latter, on the other hand, denotes any written material other than a record and includes diaries, newspaper clippings, speeches etc. Yin (1994: 81-84), in a similar vein, distinguishes archival records distinct from documents. The former, from the example quoted by him, equals Lincoln and Guba's 'record'.

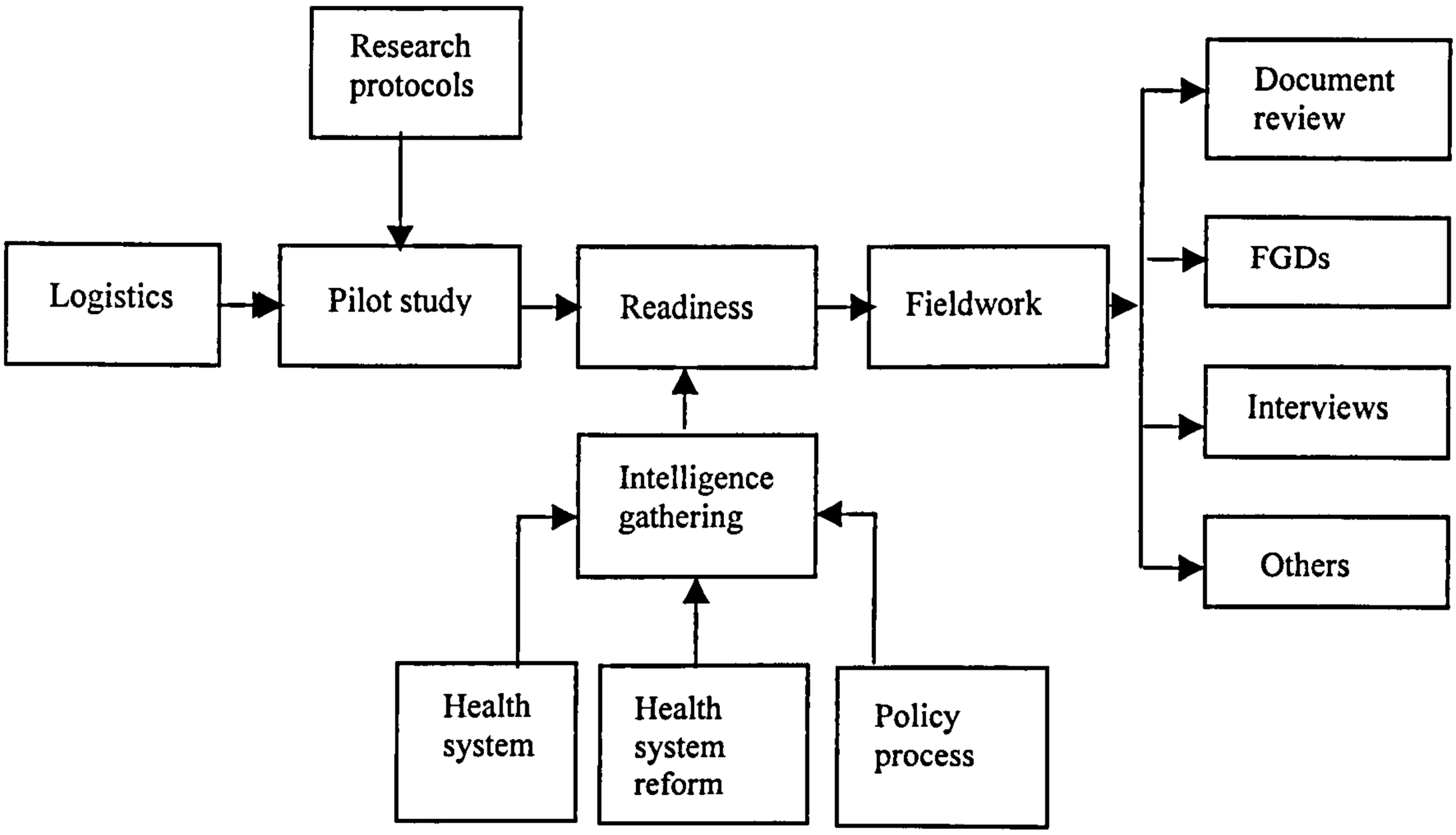
Notwithstanding the above debate, both terms are used interchangeably, and for the purpose of this study no distinction is made, because it was not relevant. All documents fell in the 'document' category. The distinction is about their nature: records are often quantitative or statistical in nature and access to them may not be easy due, for example, to them being confidential or private. Further, these are produced for a special purpose and for some particular audience. Therefore, according to Yin, the usefulness of records varies from case study to case study and while interpreting these, the aforementioned conditions must be kept in mind (Yin, 1994). Documents on the other hand, require contextual understanding prior to their interpretation (Hodder, 1998: 112). According to Yin (1994), documents help in corroborating information from other sources and may lead to inferences. However, he emphasises that such inferences must be made with caution, and treated only as a clue to further investigation, because in his view these could turn out to be false. Therefore, he notes these categories – document and record – need careful scrutiny and use, because these may be wrongly used and are likely to be tampered with and their meanings twisted, while interpreting (*ibid*: 81).

4.4. Fieldwork

According to Yin (1994: 81-84), the case study is among the "hardest type of research". Therefore, he emphasises an intensive plan of training of a researcher prior to his embarking on fieldwork. In his view a researcher should possess or acquire at least five skills to: (i) ask good questions and to interpret responses; (ii) be a good listener; (iii) be adaptable and flexible so as to react to the situation accordingly; (iv) have a firm grasp of the issue(s) being studied; and (v) be unbiased by any preconceived ideas. The first two requirements are the skill and cognitive capacity which any inquirer would need, not only initially, but also throughout the research process. However, s/he must gather intelligence about the case – grasp of the issues – before formally conducting a diligent, ethical and unbiased inquiry.

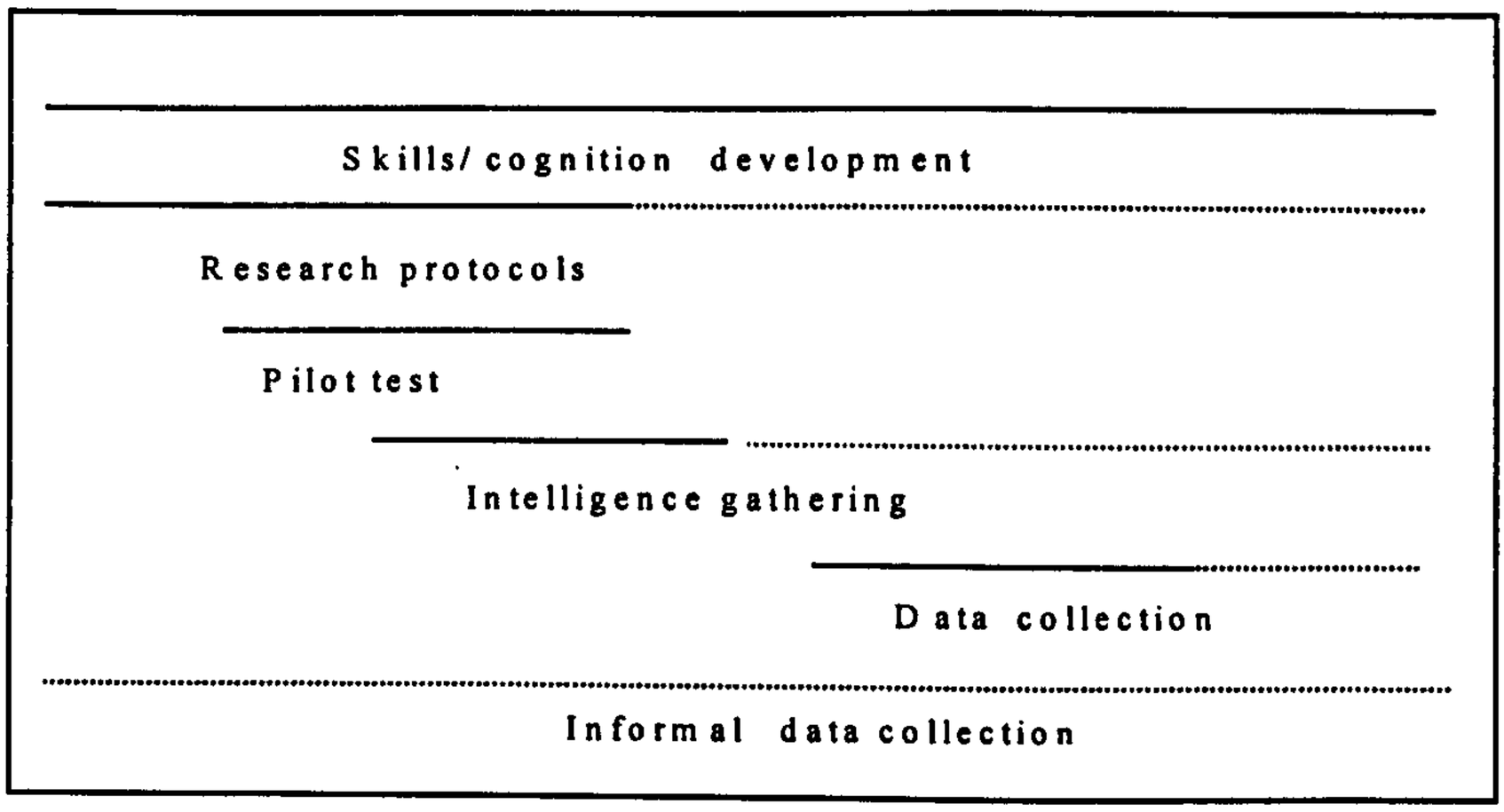
This researcher, after having exercised the skills and cognition in terms of developing conceptual framework, defining the research question and outline protocol, progressed to the fieldwork. Whereas, the literature review, in order to improve research skills and cognition, continued throughout, the fieldwork was conducted in five stages: logistics, pilot study, consolidation, intelligence gathering, and finally data collection. These stages, which essentially document the application of research skills required by Yin (*ibid*) from the researcher, are described in the ensuing pages, but figuratively the fieldwork process is presented in figure 4.5.

Figure 4.5:- Fieldwork process



It may, however, be noted that although the arrows in the figure are unidirectional, the process has throughout been iterative and inclusive. The researcher moved back and forth between various steps in the research process. While the skills and cognitive development was an on-going process, informal data collection and protocol development also continued. Between these extremes a pilot test, intelligence gathering and substantive data collection were conducted (Figure 4.6). Various stages of fieldwork are described in the following:

Figure 4.6:- Research process – overlapping of activities



4.4.1. Stage 1: - Ordering the logistics

4.4.1.1. Permission of the government

1. Authorities in the government were contacted to seek permission to access official records, and interview relevant officers and involve them in research.
2. An initial meeting was held with the selected senior permanent staffs of the Health Department for identifying and mapping the shapers and documents that were needed to be accessed and reviewed respectively.
3. Government allowed this researcher to access and consult any document or official in the Health Department deemed necessary during the research.

4.4.1.2. Organisation of research office and logistics

1. An office was set up ensuring security of data.
2. Adequate stationery and relevant literature were arranged.
3. Recording and computing equipment were purchased.
4. Transport was organised.
5. A telephone was hooked up to the fax, e-mail and internet.

4.4.1.3. Off campus supervision

1. Communication was established with the local supervisor to seek his guidance.
2. A university supervisor visited Pakistan to formally meet the local supervisor and researcher in his fieldwork on August 14-15, 2000.
3. In addition, the researcher, while in Pakistan received two more supervision events from the university supervisors; firstly, in May, 1999 and then in May 2001.

4.4.2. Stage 2: - Pilot study

A pilot study, which is the final stage or test of preparation before fieldwork, was conducted. Yin (1994) emphasises the need for running this exercise, because of its immense role in refining the data collection plan. The DHG case was used as a pilot and the study was sited in the PHDC. Care was exercised in selecting participants so they would not be the informants in the actual case study. Also a meeting of the Departmental Development Working Party (DDWP) was attended in order to pilot the observation guide.

During this stage, conducted in August 2000, different instruments (interview guides; a question guide for focus group discussion; a checklist for document review; and a guide for observing meetings) and arrangements made (as a part of

stage 1) for conducting this study were tested in the field situation. In this regard particular attention was paid to the:

1. respondents' willingness to answer;
2. sensitivity and comprehensibility of questions;
3. flow of questions;
4. time taken to field different question guides;
5. availability of documents;
6. readiness of the respondents for providing access to documents; and
7. comprehensibility and suitability of documents in establishing the setting/ case

Although the interview guide and question guide for focus group discussion are placed in appendix 4.3 and 4.4 respectively, the checklist for the documents review (Appendix 4.5) and the guide for observing official meeting (Appendix 4.6) did not work. Therefore, instead of using these techniques, an alternative means of data collection was employed on account of the following reasons:

1. The grey literature did not conform to any standard; each piece was an entity in its own right – often bearing a number and date, bound in a file. Further, there were certain files containing sensitive issues, marked as "Secret and Confidential". Moreover given the restriction posed by "Official Secrets Act" (GoPb, 1997u), all official files are considered secret and no private person can ordinarily gain access to those[10]. It was, therefore, decided to access the documents under the cover of the government's permission, review them and, if found relevant, notes be taken keeping in view the research question and dependant variables.
2. The utility of observing official meetings as a data collection technique was limited because: firstly, to keep an eye on the meetings (on a particular subject interesting to the researcher), which are often scheduled at short notice (Shaw, 1998), was logistically difficult. Also, to seek information about such meetings beforehand and then to obtain permission from relevant authorities for being in attendance were major hurdles.

   Secondly, given the research agenda, the construct and the guides developed, there was hardly any match with the meetings. Despite the problems faced by the researcher in fielding the observation technique, according to Sofaer (1999) this

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[10] This researcher was denied access to documents in the Finance Department on the pretext, how to ensure that the information collected would not be used for 'anti-state' purposes.

is not a frequently used technique in case study research. Further, as Yin (1994) notes, the case studies need not always include direct, detailed observation as a source of evidence. Therefore, apart from the occasional memos arising from observation, the current study does not rely on this method.

Different instruments, techniques and their field test results are seen in table 4.3.

Table 4.3:- Study instruments

Instrument type	Technique	Piloted	Outcome
Interview guide	Individual interviews	Yes	See Appendix 4.3
Question guide	Focus group discussion	Yes	See Appendix 4.4
Document checklist	Document/record review	Yes	Did not work- Appendix 4.5
Observation guide	Meeting observations	Yes	Did not work- Appendix 4.6
Working paper	Meetings/workshops	No	For example, see Appendix 3.1

4.4.3. Stage 3: - Consolidation

The following activities undertaken, subsequent to the pilot study, marked the stage of consolidation in data collection.

1. A supervisor from the Nuffield Institute for Health, University of Leeds, in addition to assessing the researcher's progress, assisted him in finalising the study design and instruments for use in fieldwork.
2. The gaps and shortfalls, identified in the study design, including instruments and logistics during the pilot stage, were made up.
3. A workshop on stakeholder analysis was organised in September, 2000 to determine and map the shapers that were to be accessed and interviewed.
4. A list of participants was generated and a schedule of events, such as meetings, visits, document review, FGDs and interviews, was drawn up. However, this schedule changed over time due to the snowballing effect and availability/non-availability of participants.
5. Workshops were held to test the robustness of the conceptual frameworks, developed for the health system and health policy process. **NB**: the working papers and reports on these workshops form part of the case study database.
6. A meeting was held with two university supervisors in May 2001, when they were apprised of the progress and also the working of computer software Qualitative Data Processing System was demonstrated.

4.4.4. Stage 4: - Intelligence gathering

1. This stage may also be called pre-fieldwork. Activities, aimed at enhancing the researcher's grasp of the issue, marked this stage. The framework for the health system and policy process for reform tested in the workshop (4.4.3) was applied in reviewing the documents to develop a resumé of the Punjab health sector and health sector reforms (1.3; 1.4; 1.5).

2. The aim of this research is to study the policy process for reforms in the public sector. However, a question haunted the researcher – what is the prescribed and customary policy process in the government? This researcher, based on document review (GoP, 1973; GoPb, 1974; GoPb, 1980; Hussain, 1995; GoPb, 1997u) and the practices[11] for decision-making in the civil services structure, developed a working paper on the public policy process in the Punjab. This was circulated amongst several top officials of the government to receive their comments. Later, a workshop was held to verify and consolidate the contents of the working paper (see Appendix 3.1 for the output of the said workshop).

4.4.5. Stage 5:– Data collection

Although qualitative research designs had been field-tested and subsequently consolidated, unlike the conventional inquiries, as noted by Lincoln and Guba (1985: 267), it is liable to changes during data collection. This researcher was aware of this advice and also conscious of three principles of data collection propounded by Yin (1994): the use of multiple sources of data; creating a case study database (4.4.6.3); and maintaining the trail of evidence (4.4.6.4). An account of how the data was collected is given below, beginning, however, with meetings and workshops as part of pre-fieldwork intelligence gathering activities.

4.4.5.1. Meetings and workshops

In the meetings and workshops the researcher works with groups. In this regard, the Delphi process, nominal group technique or expert panel and consensus development conferences are the group interview methods commonly used for consensus development in health services research. Each of these techniques has strengths and weaknesses: typically certain individual participants or "coalition representatives" are likely to influence the group decision (Jones and Hunter, 1999). Similarly, meta-analysis techniques have been used to measure and develop consensus. But, given the objectives of this study, a modified nominal group

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[11] The researcher worked for the government for several years that accrued him the acumen and experience of the policy process in the civil service structure of the Punjab.

technique was used to validate the predetermined ideas, generate new ones, and aggregate the participant's responses. This technique may, however, be distinguished from focus group discussion, where the aim is to gather data about the opinions, perceptions, knowledge and concerns of the participants about a particular topic (Glitz *et al*, 2001). Different steps for conducting such sessions are as below:

1. A working paper (with an attached worksheet) on the issues to be discussed was developed by the researcher and provided to the participants at the beginning of each session. In certain cases, however, this was given beforehand.
2. The session started with a briefing about the objectives of the meeting. The participants were then requested to go through the paper and raise issues, if any, for clarification. A flip chart was used to record these comments.
3. The participants were then asked to respond to various questions raised in the worksheet, while they wrote their responses in the space provided. Any point arising and the participants voicing views were recorded on the flip chart.
4. The worksheets were collected. And a report, aggregating the responses, was prepared by the researcher and sent to the participants for their comments and validation. However, often no feedback was received and this non-response was taken as the respondents` validation.

On the above pattern this researcher organised meetings and workshops, e.g. on: (i) the policy process in the Punjab public sector (see Appendix 3.1); (ii) initial meeting with the permanent senior staff; and (ii) stakeholder analysis with key informants.

4.4.5.2. Document Review

Notes, in most cases, were recorded directly onto the computer – a laptop was of immense help. Based on these notes, a database was developed. Each document was numbered, borrowed from its origin and placed in the relevant case study file. Initially, recorded at random as the documents were accessed, the database was later organised in chronological order to help establish the story and further analysis. The number of documents consulted for each case is given in table 4.4. It should be noted that there were many documents, including 155 newspaper clippings that appeared during this period, and those, which had overarching relevance for various cases, were categorised as 'general'.

Table 4.4:- Number of documents consulted

Case	SPP	DHA	IA	DHG	General	Total
Number of documents	112	69	75	46	173	**475**

4.4.5.3. Interviews

An interview guide was used to retrieve the responses. However, the civil servants, often despite assurances for confidentiality and anonymity, especially in junior positions, were guarded and even probing questions did little to open them up. On the other hand the non-public participants were frank and even volunteered information with such a flow that often it was difficult to bring them back to the point on the question guide. Overall, it was an oscillation between the 'general interview guides' to a 'standardised open-ended interview'. Certain participants were contacted through email and their responses were received. Further, when agreeing to a schedule, subject to a participant's desire, a copy of the interview guide was provided beforehand. Finally, regarding how an interview should be conducted, Patton (1990) provides a detailed account. Drawing from him, this researcher observed the following protocol for interviewing:

1. The purpose and objectives of the research were provided and consent about the use of the data collecting device was obtained;
2. The anonymity and willingness of the respondents to answer was respected;
3. Confidentiality of the information volunteered was assured;
4. Questions were simple and direct language was used;
5. Questions were clear, specific and one question was asked at a time;
6. No leading question – indicating the answer was asked;
7. No 'why' question was asked – they take the respondents to a defensive position, which is not good for the smooth flow of information;
8. No judgmental remarks were passed as these may offend the respondents and furthermore there is no right or wrong answer;
9. Closed questions, where a response could be yes or no, were avoided – since these limit the information flow;
10. Difficult and sensitive questions were left until nearer to the end of a session;
11. Questions were asked in a logical manner, although the sequence changed depending on the general mood of the respondent and the situation. Often a participant started saying something without having been formally asked. At such a point, as Sofaer (1999) advises, the researcher took advantage of the lead by the participant and guided him/her to the sequence of the guide; and

12. The session concluded with a note of thanks for the participant's time and interest. Further, they were assured of safeguarding their anonymity, interest and choice, while compiling the report.

4.4.5.4. Focus group discussion

Focus group discussions were organised drawing people who had stakes/interest in a case (Grbich, 1999). Usually not more than eight participants were brought together to discuss the different aspects of an issue and were allowed to discuss amongst themselves until they exhausted ideas and came to some agreement – consensus or not to agree (Barker, 1996). Often, a session lasted for no longer than 60-90 minutes, but in certain cases this continued as long as new information continued pouring in and according to the participants' willingness to stay on. The researcher sat in this discourse to facilitate discussion starting with general questions and converging to the specific, ensuring that it was not side-tracked.

Four focus group discussions were conducted using the PHDC, Lahore as the venue, while the protocol followed in conducting the session is given below:

1. Outlined the question, sub-questions or interview guide used;
2. Familiarised with the group participants;
3. Identified the team i.e. moderator; observer; and note taker. They were trained in making sure that the team had required skills and knowledge;
4. Ensured that the meeting venue was accessible, private, comfortable, non-threatening, and the seating arrangement for participants was U-shaped;
5. Before starting the session, the consent of the participants was sought and they were assured of confidentiality and anonymity – unless the participants agreed otherwise, and in certain cases they allowed the researcher to use their name and designation as references;
6. Session was started by an introduction to the researcher's team, followed by the rules for participating, and the particular question or issue for discussion;
7. Conducted the sessions in a manner whereby the moderator guided and steered the discussion; the observer kept silent to note the feelings expressed through body language; the note taker wrote down precisely what was said, without adding his own opinion – although s/he could and did so noting in parenthesis (the note-taker's role became redundant where a tape recorder was used);

8. An informal atmosphere was created in order to facilitate a free flow of ideas and discussion amongst participants, but care was exercised that a particular participant did not dominate the discussion;
9. Effort was made to maintain neutrality – every member of the team performed his/her assigned role and did not opine to become a party or exhibit a favouring bias to certain responses/participant; and
10. Finished the session by summarising the arguments given by the participants during discussion and thanked them.

Soon after the session a debriefing meeting of the team was held to bring together information held by various members and to consider the effectiveness of a particular session. This activity is useful because sometimes another focus group or meeting is deemed essential to further achieve a greater depth in the understanding of an issue(s) (Grbich, 1999). However, such situations did not arise in this study.

4.4.6. Stage 6: - Deskwork (managing the data)

The data collected during the course of a qualitative research study is huge and often unstructured, but is important and valuable material. It is, therefore, essential that it be appropriately organised and managed in order for its subsequent retrieval and usage for analysis. This objective was achieved in the following manner:

4.4.6.1. Recording

Given the experience of the researcher (he is a serving public servant) in a Pakistani situation, tape recording of the interviews was initially considered unfeasible. Government officials, despite permission from higher authority, are often tight-lipped, apprehensive, and reserved in volunteering information. They have developed this trait in response to a law that requires maintaining secrecy of official records and government business. Further, by using a recording device the respondents are likely to become conscious of their response (Rifkin, 1996). This researcher, therefore, planned to mainly rely on logbook notes.

However, during fieldwork it was felt that note-taking had its own limitations. These included that some points were missed; eye to eye contact between the researcher and participant was not possible; and it was difficult to fully arouse the interest of a participant because the researcher may be busy in writing and at the same time thinking and posing probing questions was not easy. Furthermore, quite a significant number of participants agreed to the use of a tape recorder. Therefore, a mini-tape recorder was used to record interviews and focus group discussions. However,

where a participant did not agree, notes were taken. But, nevertheless, this risked data loss, which was avoided by asking the participants to validate the transcription. A note-taker could also have been used, and that was used for one focus group discussion. However, given the secretive and status oriented bureaucratic culture, taking a note-taker along to meetings with officials was thought impractical. Further, this had financial implications, and a risk of the note-taker adding his/her biases.

4.4.6.2. Transcribing

The recorded matter, notes and comments arising from interviews and the focus group discussions were transcribed verbatim and typed in a predefined[12] computer format using 'word processor' MS-WORD. This was done on the same day to avoid forgetting, mixing the events and observations, as time passes and thus losing the information. For workshops and meetings, notes were taken, which were transcribed and typed in a computer format maintaining, however, the originality and exactness of what had been heard, seen and read from the response of the participants. Apart from focus group discussions, the transcribed /typed matter was sent to the participants for their validation. This was likely to generate more data, and, therefore, constituted part of the qualitative inquiry (Mays and Pope, 2000). However, only in a few instances did this researcher receive any feedback from participants. They considered the transcripts of proceedings as their copy.

4.4.6.3. Developing the case study database

According to Yin, the case study database is the organising and documenting of data collected during fieldwork and is essential for increasing the reliability of a case study. Broadly, these may be notes, documents, tabular material and narratives. Contrary to Patton's advice of editing and rewriting such material, Yin (1994: 96) emphasises that the case study data may be systematically organised, categorised and made accessible for later review/ use.

While on fieldwork this researcher gathered and generated a large number of documents. These included literature references and case study documents (hard copies), case study notes, correspondence with participants and different authorities, minutes of meetings, workshop reports, focus group discussions and individual interview narratives and other relevant matter. These were systematically organised

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[12] date and time; place visited; person (s) met; precise narration of whatever listened, read or observed; and if something felt or noticed from the body language or in the surroundings of respondent etc. this be written in parenthesis

and are accessible. In addition, 18 (TDK) standard audio-tapes of over 26 hour's duration containing recorded interviews and FGDs are also available.

4.4.6.4. Maintaining the trail of evidence

The trail of evidence denotes that the evidence provided in a case study report is traceable back to its origin. In other words as Yin (1994: 98-99) emphasises, the reviewer should be facilitated in moving "from one portion of the case study to another, with clear cross-referencing to methodological procedures and to the resulting evidence". This, according to him, increases the reliability of information cited and the overall quality of a case study.

In this study the report makes references to the documents reviewed and where necessary contents have been reproduced. Similarly, for the focus group discussions and individual interviews, the database includes information, *interalia*, on the time, place and mode of record. The report, while referring to the participants, indicates their status, but remains short of citing their name and position, except for those who allowed it. This is due to the ethics binding this researcher, who promised confidentiality and anonymity of participants. Nevertheless, quotations from their narratives have been used to substantiate the evidence presented in the report.

4.4.7. Fieldwork vis-à-vis research question

In the preceding sections, a range of techniques employed in fieldwork to gather data has been given, keeping in mind the study design for responding to the purpose and research question,. However, to present the same in a structured manner, a matrix has been developed outlining the research objectives and variables addressed vis-à-vis different techniques and data sources employed (Appendix 4.7). This matrix proved a useful tool for periodically assessing the progress during the research process.

4.5. Data analysis

It has been shown (4.4) that the research design, data collection and data analysis go hand-in-hand and there is a constant interplay between these elements of qualitative research. However, the question is, when does the researcher get down to data analysis? Pope (2000) notes that the analytical process begins in data collection and continues throughout the research process, because, according to her, "it is impossible not to start thinking about what is being heard and listened". Miles and Huberman (1994: 10), however, go a step further. According to them, the process of

analysis occurs even before data collection, when decisions about framework, case, question, and the data collection approach are made. They call it the 'anticipatory' phase of data analysis. This overlapping contributes to improving the quality of both data collection and analysis, but according to Patton (1990: 377-78), the researcher has to be careful by not allowing "these initial interpretations to distort" the data collection process. Instead, he maintains that the researcher should look for rival explanations in order to "invalidate these initial insights" (*ibid*).

This debate indicates, as Yin (1994: 102) notes, that the analysis, especially of a case study, is the "least developed and most difficult aspect of doing case studies". Responding to this call, this section, after providing an overview of theoretical issues, gives an account of how the data was analysed in this study.

4.5.1. What is data analysis?

Dey (1993: 30) defines data analysis as "a process of resolving data into constituent components to reveal its characteristic elements and structure" in order to "know how and why as well as what". According to him, "data analysis is a related process of describing phenomena, classifying it, and seeing how our concepts interconnect". In a similar manner, Wolcott (1994: 9-55), notes that the data analysis process occurs in three interconnected stages: data processing or description; data analysis; and interpreting or drawing inferences and reporting. He considers data analysis as the "identification of essential features and the systematic description of inter-relationships among them – in short, how things work. In terms of the stated objectives, analysis may also be employed evaluatively to address the questions of why a system is not working or how it might be made to work better". Miles and Huberman (1994: 10) define analysis "as consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification". Given such overlapping views, in the following section the concepts about data analysis are explored in terms of its purpose, strategy and approach used.

4.5.2. Purpose, strategy and approach to analysis

According to Patton (1990: 373), the purpose of the study would largely determine the tone and direction of data analysis. Given this study is primarily applied research, carried out for scholastic purposes, it should exhibit rigour and contribute to theory building. Policymakers are also the audience for this research – it attracted the Alliance for Health Policy and Systems Research, which partially funded this research. Therefore, the end product is also being aimed at for its "relevance, clarity, utility, and applicability of findings" (*ibid*).

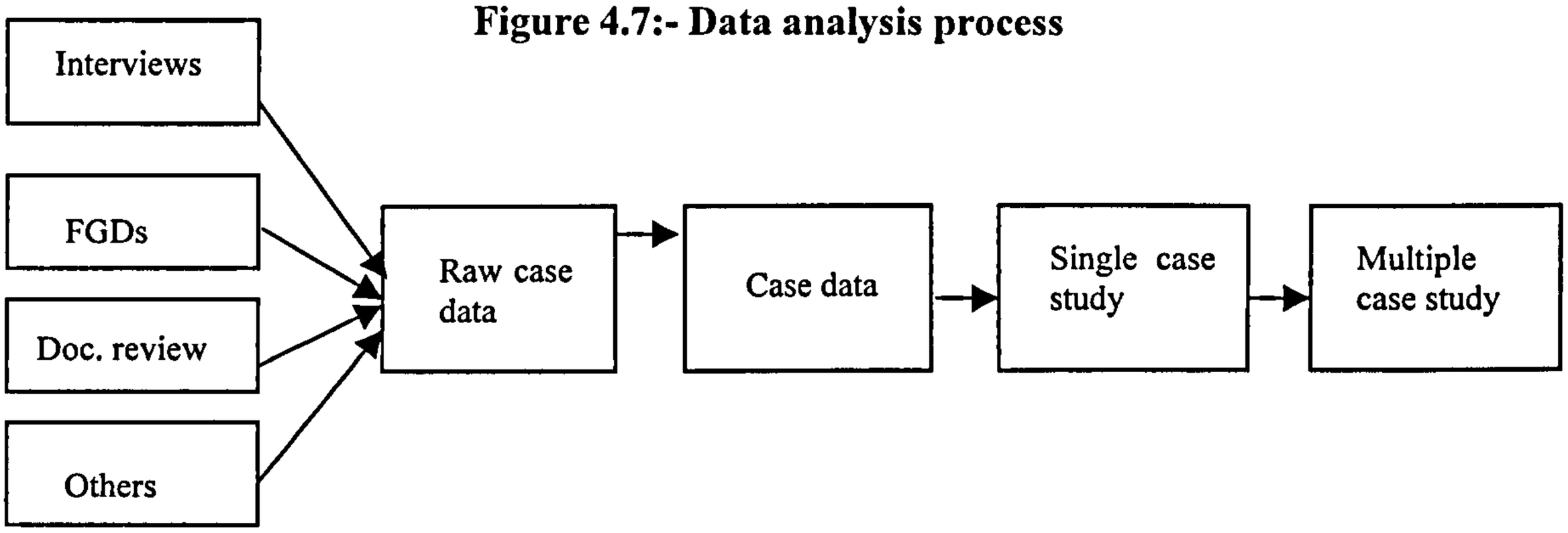
The next issue is concerning the strategy for data analysis. According to Pope (2000), the strategy could either be inductive or deductive. The former, which is considered preferable by social scientists, employs a grounded theory approach, while the later is being increasingly used for the framework approach. The grounded theory, according to Strauss and Corbin (1994: 273-85) is "a general methodology for developing theory that is grounded in data systematically gathered and analysed. Theory evolves during actual research, and it does this through continuous interplay between analysis and data collection". The framework approach, on the other hand, involves sifting, charting and sorting data around the issues and themes arising from data and original aims and objectives introduced in research through, e.g. study instruments. Therefore, although the framework approach is primarily inductive, it begins deductively from *a priori* aims and objectives of the study (Pope *et al*, 1999).

Miles and Huberman (1994: 18) advocate the framework approach, however indicating the trade-offs involved in selecting how tight a framework should be. The solution, in their opinion, lies in a middle of the road position - "avoiding the extremes". The usefulness of this approach is the systematic documentation of analytical process. Since analysis involves the researcher thinking ahead and then returning for reconsidering and reworking the earlier ideas, the framework approach has strength, as Ritchie and Spencer (1994) note, as it allows easy access to the earlier work. Therefore, this study favours employing the framework approach to data analysis. However, before this approach is explained (4.5.5), it is worthwhile considering certain overarching issues such as the analytical unit and use of a computer in data analysis.

4.5.3. Analytical unit

What is to be analysed? To answer this question in the perspective of a case study, as Patton (1990: 384) notes, analysis involves organising data according to cases, which could be individuals or groups, programmes or institutions. Yin (1994: 21-25) adds to this list, rather vague and less clearly defined categories, like events and decisions about programmes, the implementation process, and organisational changes. According to him, "definition of unit of analysis is related to the way the research question has been defined". In this sense, given the research question for this study, the policy process for health sector reform constitutes the main unit of analysis. Within this main unit are the embedded units – the four cases which were the subject of this study. Therefore, analysis is made in two layers: (i) four single-case studies each derived from the case data on individual initiative; and (ii) cross-case analysis to making a case study for the policy process for reforms (Figure 4.7).

Figure 4.7:- Data analysis process



According to figure 4.7, as a result of in-depth interviews, focus group discussions, document review and exhausting other data sources, 'raw case data', all information collected about a specific reform initiative is accumulated as transcripts and logbook notes. This was treated in a way, Miles and Huberman (1994: 10) call data reduction that "sharpens, sorts, focuses, discards and organises data". This process led to constructing a 'case data/ record', for establishing the 'case study', portraying a holistic and narrative description of a particular initiative. In the second analytic layer – cross-case analysis – the case study data is subjected to further analysis in order to develop a multiple-case study for subsequent interpretation (see 4.5.5.5).

4.5.4. Use of computers

There are conflicting views in the literature about the usefulness and effectiveness of computers in analysing qualitative data. Seale (2000) provides an account of the advantages and disadvantages of using computer software, but, in concluding remains short of recommending a particular package. He indicates "there are many such programs available and if you find that a particular one does not support what you want to do, the odds are that another package will contain something more useful if you look hard enough". Earlier, Lewando-Hundt *et al* (1997) comparing manual with software analysis using NUD-IST (Non-numerical Unstructured Data Indexing Searching and Theorising) in qualitative research demonstrated that the software does not replace conceptual thinking. According to them, it is an aid and support, especially when teams of researchers are involved and the challenge is inter-team comparison for enhancing internal validity. Similarly, Aljunid (1996) who used Ethnograph found that subject to structuring the qualitative data in a suitable format, the software facilitates access to data dealing with particular issues and easy retrieval of text for analysis and illustration. However, he faced problems like the absence of the on-line document being coded, lack of options in printing and the tendency for the program to frequently hang.

Nevertheless, this researcher planned to use computer software like NUD-IST or Ethnograph for analysing data. A request was made to the partial financier of this study to arrange the software and necessary training. However, since that request did not materialise, this researcher worked on a tailor-made computer utility, Qualitative Data Processing System (QDSP), and next section demonstrates how it was used.

4.5.5. Framework approach

The framework approach was used for data analysis in this study. This involved five stages: familiarising, identifying the thematic framework, indexing, charting, and finally mapping and interpretation (Ritchie and Spencer, 1994). The step-by-step process for data analysis and how the QDPS software assists is given below:

4.5.5.1. Familiarisation

The raw case data for the individual cases obtained from different sources, e.g. interviews, focus group discussions, document review was organised, source coded and stored in separate computer files for individual participants and sources in different folders. Hard copies of this data were also treated similarly and placed in separate box-files. Although, this researcher himself[13] undertook fieldwork and deskwork, raw data were again read and re-read. This is called 'familiarising' with data. During this process duplications were taken out.

4.5.5.2. Constructing a thematic framework

The immersion in data during 'familiarisation' led to identifying the key concepts and themes, grounded in data and brought about by the participants or by drawing on *a priori* issues and questions derived from the aim and objectives of the study. These concepts and themes were annotated in the margins of the hard copy, and were later organised around the framework developed by this researcher for analysing the policy process for the Punjab health sector reforms. This activity involved ordering the codes, as Bryman and Burgess (1994) call them, logically and intuitively into the headings and sub-headings. This process led to creating a table of contents or an index, which was fed into the QDPS file. This software creates/edits table of contents (TOC) up to five levels or sub-headings. This stage, also called constructing a 'thematic framework', should be able to address the original research question in applied social policy research (Ritchie and Spencer, 1994).

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[13] It was planned to employ a research assistant, but at the advice of University Research Committee, an office assistant was recruited. This arrangement was of immense use, as it added to familiarisation.

4.5.5.3. Indexing

This stage marked the application of an index developed above (4.5.5.2) to the raw case data. The data was again read in its entirety. Whereas more thoughts and themes came up and led to marginal editing of the TOC constructed earlier with the help of QDSP, the codes or index headings were applied to the data in the hard copy. The process was facilitated by the question guide that draws topics from the research question and the conceptual framework developed for analysing the policy process.

4.5.5.4. Charting

In 'charting' the data is cut/lifted from its original context and pasted/rearranged based on the index or the TOC created earlier. According to Ritchie and Spencer (1994: 182), "charts are devised with headings and subheadings, which may be drawn from the thematic framework, from *a priori* research question, or according to consideration about how best to present and write up the study". Bryman and Burgess (1994) note the concern that by removing it from its natural context, data is likely to become de-contexualised. However, it is re-contextualised, i.e. although removed from its original site, it is placed in a new context alongside the similar material in the same categories.

Data can be directly typed or copied and pasted from a word processing package. The data labelled/coded in the previous stage (indexing) was lifted from WORD files and pasted in the QDPS files under appropriate headings in the TOC. Since QDPS can also record references, any data item in the QDPS database can, therefore, be backtracked to its original place in the raw case data. The QDPS file, which forms the output of the charting stage, can be printed in a text format for any headings' level ascribed in the TOC along with their contents and references.

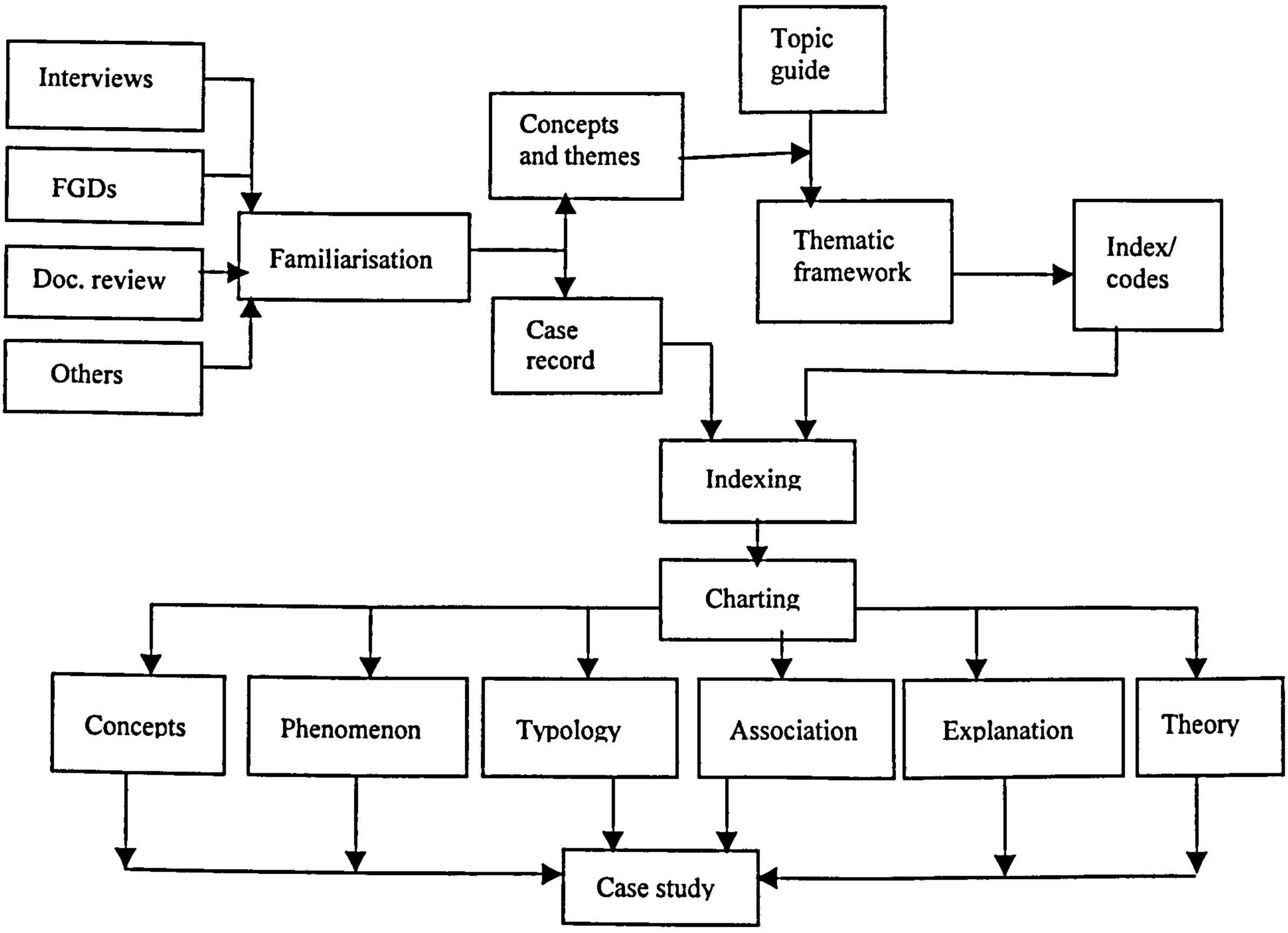
To reinforce the charting stage, the output of this stage was again read, but this time raising questions and seeking explanations. Whereas some more codes emerged, which were annotated on the hard copy and were also added to the framework, gaps were identified in the data. For some of these shortfalls, the researcher returned to the source, while for others new participants and sources were recruited. Such a purposive recruitment of data sources and classification of codes, as Dey (1993: 46) notes, is always the case. Thus, it is seen that the thematic framework developed initially underwent changes, on account of the ever-emerging concepts throughout data analysis. This was finally used to draw an outline for the case study.

4.5.5.5. Mapping and interpretation

This stage involves going beyond data, marking a peak in the thinking process, where the researcher begins to ponder what is to be made out of it (Wolcott, 1994). In this regard, Patton (1990: 324) argues, "interpretation means attaching significance to what was found, offering explanations, drawing conclusions, extrapolating lessons, making inferences, building linkages, attaching meanings, imposing order, and dealing with rival explanations, dis-confirming interpretation". He notes that in this stage, the analyst sets out to map and interpret data as a whole, which is now organised around a thematic framework. In this process, he defines the concepts, maps the range and nature of the phenomena, creates typologies, finds associations, provides explanations and develops theories and strategies (*ibid*: 186).

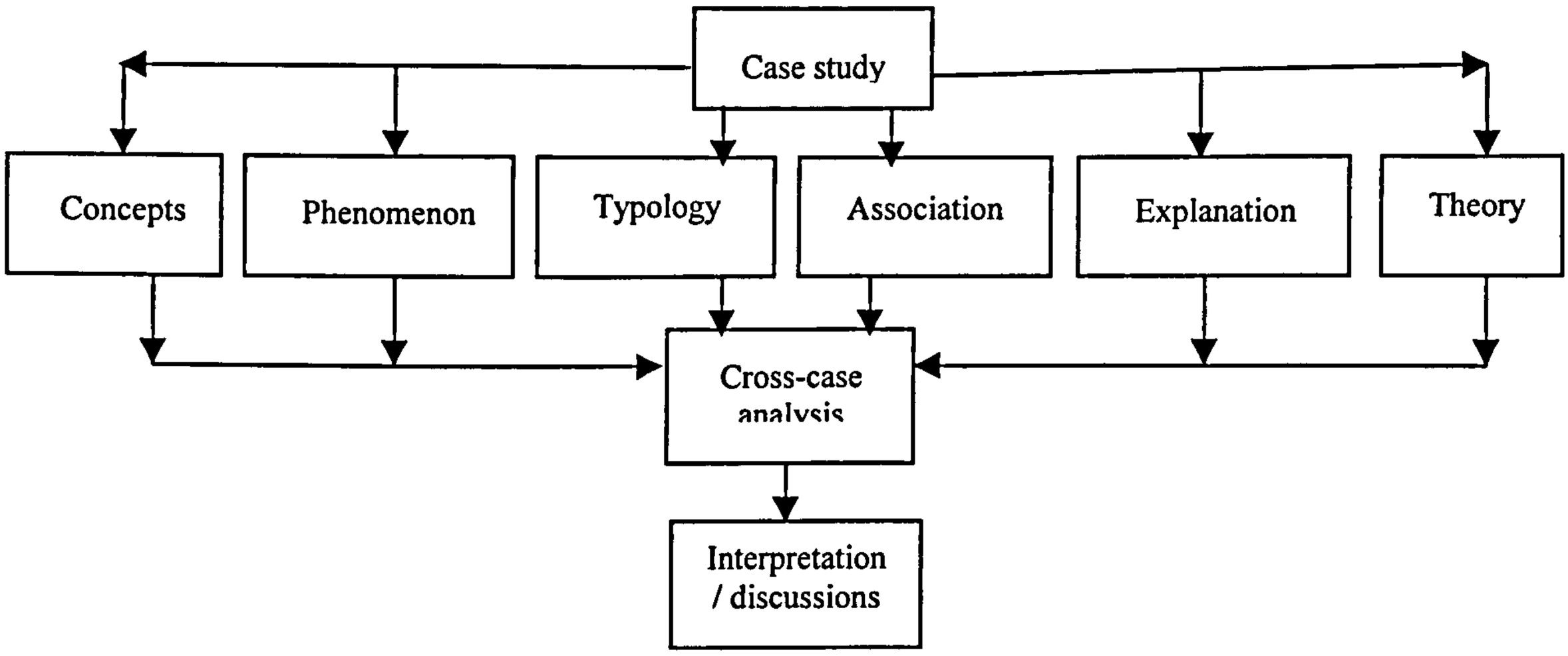
In this stage, reliance was mainly on the charted data, but to substantiate evidence quotes were brought from the case data. The QDPS, by searching a word or sentence in a selected file displayed along with its reference, helped in finding quotes relevant to different case studies. The process of applying the framework approach to analyse data for developing single case studies is seen in figure 4.8. In this way, the pattern evolved for a particular single-case study was repeated for others. In this process, which marks the first analytical layer of this study, the thematic framework evolved further and, accordingly, the earlier draft case studies were revised.

Figure 4.8:- Framework approach to data analysis



In the second analytic layer, the multiple-case study was generated, using the output of four single-case studies as input. Figuratively, extending from the case analysis as seen in figure 4.8, this is shown in figure 4.9. This cross-case analysis process led to drawing out, firstly the factors that influenced the policy process for the government initiatives undertaken in the Punjab health sector during 1993-2000. Secondly, the policy process for the health sector reforms in Punjab was established.

Figure 4.9:- Cross-case analysis



Thus, overall, the analysis of the policy process conducted in this study has three dimensions: policy process for the individual reforms (presented as case studies in chapter 5), the Punjab health sector reforms and factors influencing the policy process (presented in chapter 6).

4.6. Credibility, quality and ethics

Certain measures, which make this study credible, were described earlier (e.g. maintaining the evidence trail). In the following paragraphs it will be seen how the issues of validity, reliability and ethics have been addressed.

4.6.1. Validity and reliability

Validity can be internal and external. The former is concerned with confounders, biases, and criteria for the selection of study subjects. The latter, on the other hand, deals with the notion of generalisation and reproducibility in a population or ecological setting. Reliability is related to the measurement of research variables (Long, 1984: 44, 66). The qualitative methods produce a wealth of data, but its validity and reliability depends mainly on the researcher's skills, sensitivity and integrity (Patton, 1990: 11). This researcher cannot claim to be free of bias, and

section 4.6.3 discusses his role in the research process, and how it was possible to minimise this bias and improve the quality of data collection and analysis.

The researcher rigorously used the research designs as tightly as possible and generated findings through careful observation, interviewing, and undertaking the content analysis of documents. He had adequate knowledge, training and practice, and could put in the required hard work, ensuring that data of high quality was generated. Nonetheless, the trail of evidence (4.4.6.4) maintained as part of this research process provides adequate evidence for these claims.

To reduce the likelihood of errors in the application of research methods, data techniques like triangulation and respondents' validations were used. In triangulation, the researcher corroborated the evidence from various data sources (interview on the same issue from more than one subject) or data collection techniques (interviews, document review, and focus group discussion for the same issue). This was substantiated with the respondent's validation of recorded notes and interviews. The emerging patterns and results were also shared with selected study participants, for instance the then Minister for Health.

The issue of generalisation of results in qualitative methods is of limited value since the study is context specific (Barker, 1995). However, it may "permit the reader to seek patterns that cut across the programme or policies in a number of different places and for a number of different groups" (Patton, 1990: 155-56). Further the case study approach allows the generation of theoretical propositions that may be generalised to other groups either naturalistically or analytically (Grbich, 1999: 188-90). Moreover, as Miles and Huberman (1994: 173) note, multiple (four) cases were used and the cross-case analysis undertaken contributed to further enhancing the generalisability of study results.

4.6.2. Ethical considerations

Long (1984) refers to three guiding principles of ethics in research. These are justice, beneficence and non-maleficence, and autonomy. Justice denotes the general right to benefits, and because the higher-level goal of this research has been to improve the health services of the province, the researcher feels no problem in this regard. Beneficence implies 'to do good' and by the same token non-maleficence means 'do no harm'. Obviously, the current study is likely to contribute to improving the environment of the health system and ultimately the people working in and benefiting from it. Therefore, this study aims to do good and do no harm.

Regarding autonomy, the third concept of ethics, Long (1984) emphasises the informed consent and choice of subjects' participation in the study. Informed consent of subjects was obtained from the subjects as well as from their employer. To protect the participant's rights, they were allowed freedom to join and leave. The research objectives, data collection devices and activities were explained and the transcripts and reports were also made available to them. Similarly, access to the documents was secured after seeking permission from appropriate authorities.

Confidentiality and non-alignment, while collecting data, is important. This was a difficult task to address in qualitative research settings. The information though forms part of the findings and the report, this researcher has asked the University to release the thesis for consultation after three years. Information sources, including those of quotes, have not been explicitly divulged, except where the participants gave their permission. Furthermore, the researcher has ensured his non-aligned position, keeping in mind the interests and choice of the participants.

4.6.3. Role of the researcher

The researcher is an employee of the Government of Punjab currently on study leave and has worked for several years in the Health Department in different clinical and management positions. These ranged from a house officer to a clinical registrar and deputy medical superintendent in teaching hospitals to the assistant project director of the World Bank/DFID funded Second Family Health Project, and project director of an Asian Development Bank assisted Health Care Development Project. The researcher, as such, knew many participants and was also a close observer of the policy process for different reforms undertaken during 1993-2000. Therefore, in this capacity, he can often bring evidence and quote experience in support of the arguments presented in this study.

Since this researcher designed, collected, analysed and interpreted data, one may infer that certain biases might have crept into this study influencing the interpretation of data and how it was reported. Becker (1967: 59) notes that the case study investigation is especially prone to bias, and given that there is a danger that the researcher may use this occasion to "substantiate a preconceived position". In a similar manner, Foltz (1996) views policy analysis as a value-laden enterprise, where the analyst is not neutral. Nevertheless, the existence of bias in the study can also be tested. According to Yin (1994), one assessment of this is to what extent the researcher is open to contrary findings. Further, the rigour adopted during the research process is the key to protecting the researcher and data collection and analysis from bias (Ratcliffe and Gonzalez-del-Valle, 1988).

However, such a situation also bears strength, as Yin (1994) recommends the case study researcher should have a firm grasp of the issues being studied. And this researcher's position of being a close observer of the process provides him with the aforementioned strength. Further, using this opportunity to contribute to data collection and analysis forms a variant of the "participant observation technique", because the researcher has been a participant of events, for example in a neighbourhood or group (as in the case of ethnography) being studied. Barker, commenting on the range of approaches to policy study, also mentions the authorship of a study. According to her this may be the shapers involved in policy making process acting as analysts. This argument provides further support to the researcher's role as a policy shaper. Finally, the objective of this researcher, as Becker (1967) emphasises, has throughout the research process been "to make sure that, whatever point of view we take, our research meets the standards of good scientific work, that our unavoidable sympathies do not render our results invalid".

4.7. Summary and conclusion

Chapter 4 reported the process followed in this research in five sections. Section 1, after defining the purpose and research question, dealt with general issues e.g. significance, boundaries, research type and approach. The rules and procedures for design and methods were laid down in section 2. This dwelt on issues like spatial consideration, inclusion criteria, instruments, and data collection techniques used in this research. In section 3, the process for fieldwork was described to have been conducted in five stages: ordering logistics, conducting a pilot study, consolidating arrangements, gathering intelligence, and collecting and managing data. Section 4 provides details of how data were transformed into results. After defining 'data analysis', issues like purpose, strategy, approach, and analytical unit were considered. Given that the framework approach to data analysis was adopted, its application in this research was also explained. Finally, section 5 presented how the credibility, ethics and quality of this research have been upheld with particular emphasis given to validity and reliability.

To summarise, this chapter has set out the rules and procedures for conducting a qualitative inquiry. However, a conscious effort has been made to respond to the call that the researchers should thoroughly document the research process (Creswell, 1994). In the next chapter, the policy process for individual cases of health reform are analysed following the research rules and procedures set out in this chapter and according to the conceptual framework defined in the last chapter.

5. Case studies

5.1. Introduction

In chapter 3 a framework for analysing the policy process for health sector reform was conceptualised. This instrument was also a key in framing the research question and associated sub-questions. Chapter 4 presented a resumé of how the research methods and techniques were used to address the research question and the data analysed. For this purpose the four cases which were selected are: (i) Sheikhupura Pilot Project; (ii) District Health Authority; (iii) Institutional Autonomy; and (iv) District Health Government. These cases were studied in-depth, and to the data generated the framework approach for data analysis was applied (4.5.5) which led to developing single case studies marking the first analytical layer of this study. The outcome, i.e. the policy process for the four individual cases is presented in this chapter following the conceptual framework developed for this study (chapter 3). Further, since these case studies follow the same pattern, to avoid repetition, their structure is presented below:

1. A brief account of each initiative is given in section 1. In addition, certain issues specific to a particular initiative are also discussed.

2. In section 2, the principles and purposes followed in the pursuit of the initiative are identified. It is explored 'why' the reforms were undertaken.

3. Section 3 examines the role of shapers contributing to the outcome of the reform process. Drawn from stakeholder analysis, they were classified as leader, supporter, bureaucracy, donors, media and civil society; and for the purpose of this study, these are defined as below:

The leader is the front-runner key stakeholder, e.g. head of department, institution or agency that has personal as well as formal institutional interests at stake. The supporter is also a key stakeholder who significantly influences and/or is important to the success of the reforms. Bureaucracy represents the secondary stakeholders, both in the health and other national systems, and is intermediary in service delivery. Donors represent the hegemonic part of the health system, while civil society includes primary stakeholders who are ultimately affected, either positively or negatively. They include service providers and communities or service recipients. Although the media is a part of civil society, it is considered as being separate because of the important role it can play in the policy process for health reforms.

4. The context or origin of the initiative is explored in section 4. It is determined what factors in the health system heralded the reform in terms of issues at three levels: the health sector; the national systems; and international systems.

5. Section 5 deals with the contents of reforms explored at two levels. First, the output of the policy process or the policy *per se* is examined in section 1, and second the policy level is determined in terms of its comprehensiveness.

6. The question, how the initiative was implemented, is addressed in section 6 from two angles: (i) preparedness, and (ii) execution. The former deals with feasibility and the implementation arrangements, while the latter is about determining the fate of the initiative.

7. An overview of how the policy process for a particular reform initiative was undertaken is given in section 7. This inquiry addresses questions how decisions about conceptualisation, design and implementation of reform were made.

Given that the structure for the case studies is provided above, the reader will be presented immediately with the headers for different sections. However, before embarking on presenting the case studies, certain background issues are introduced, which are overarching and common to all the cases.

5.2. Background issues

1. The initiatives under study have a common background. The Government of Pakistan (GoP) launched a Social Action Program (SAP) for improving basic social services. This cross-sectoral programme redirected public expenditure in favour of these services. Under the umbrella of SAP, the Government of Punjab implemented a Second Family Health Project (1993-2001) in the health sector[14]. The case studies for the initiatives presented in this thesis took their origin from this project.

2. The SFHP was a multi-donor project assisted by the World Bank, the UK Department for International Development (DFID) and German Kreditanstalt fur Wielderaufbau (KfW). This aimed to revamp the entire health sector in order to improve the health status of the population of the Punjab. Specifically, its objectives were (i) strengthening health services; (ii) staff development; and (iii) organisational and management development. Of these objectives, the last one required taking

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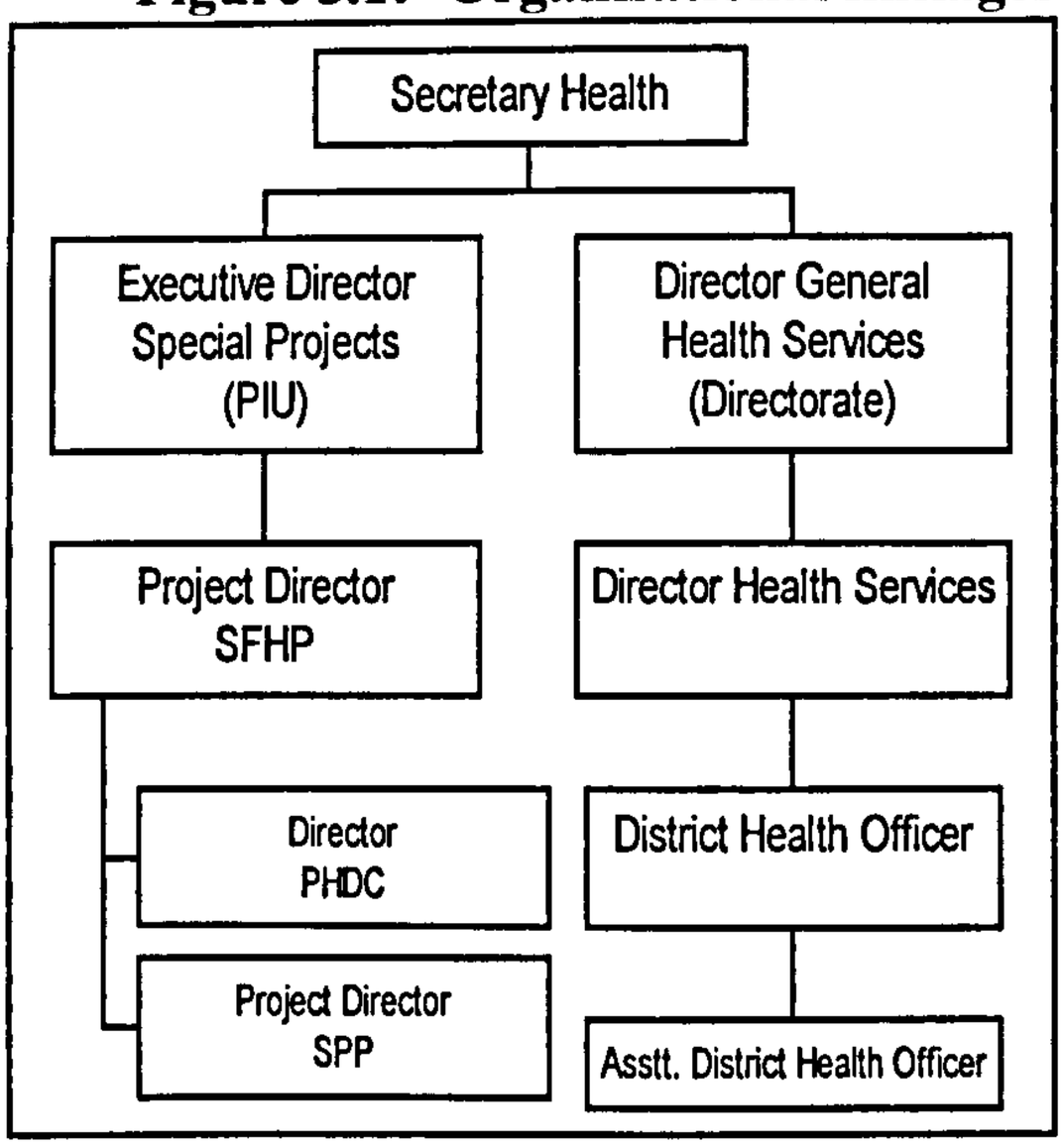
[14] The Baluchistan province also implemented the (Second) Family Health Project concurrently, while the Sindh and Northwest Frontier provinces launched the (First) Family Health Project.

adequate steps for decentralising administrative, financial and legal authority. And to foster this objective, the government of Punjab launched a number of initiatives.

3. DFID provided technical assistance (TA) through a Punjab Health System Strengthening Component (PHSSC) of SFHP. Under the technical supervision of Nuffield Institute for Health, this project was managed by the British Council in Pakistan. The TA was channelled through a Provincial Health Development Centre and attached District Health Development Centres. Later, however, a technical team[15] based in the DGHS undertook it.

4. The organisational linkages established for executing SFHP are given in figure 5.1. A Project Implementation Unit (PIU) of SFHP headed by an executive director of Special Projects (EDSP) was created parallel to the DGHS, Punjab; both reporting to the secretary health. This arrangement had implications not only for SFHP, but also for the initiatives implemented under the project.

Figure 5.1:- Organisational linkages



5. Pakistan inherited a colonial administration, which is characterised by: (i) secretariat and secretaries; (ii) generalist preference; and (iii) cadre system as explained below (Kennedy, 1987):

- The secretariat is the policymaking structure comprising various departments in the provinces[16] that are headed by the secretaries to the government. According to the government Rules of Business, the secretary constitutes the 'government' and is assigned to assist the political executives, i.e. the minister and chief minister in policymaking (GoPb, 1974).

- Bureaucracy in the public sector is both civil and technical. The former is divided into a number of groups or cadres including a generalist or district management group, which is a preferred group for the bureaucrats to join. The

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[15] This team comprised four district co-ordinators, a social development co-ordinator, while an expatriate adviser provided overall support.

[16] In the Federal Government, the counterpart agencies or organisations are called divisions.

Secretaries and certain other bureaucrats in the secretariat are often generalists[17]. According to a senior civil bureaucrat, "they are the managers posted to some department, where they run things for some time before joining another, and have no special vested interest".

- The cadres or groups are the categories assigned to the officials after their selection for the public service. Typically, an official remains a member of such a group throughout his career.
- The technocrats, commonly called specialists or professionals, as compared to generalists, refer to the technically trained officers. They occupy positions in the field formations and institutions in the government department according to their qualification and expertise[18]. Since they belong to a particular department and serve there until superannuating, the technocrats have interests and ownership in the department (Kennedy, 1987).

6. Certain legal terms have been used in case studies. For example, constitution is the most superior which sets the overall direction for the Public representatives/ legislature to formulate Acts or legislation. Not inconsistent with these Acts, the government frames Rules which provide overall guidance for any organisation(s) to operate. Regulations are the next level in the hierarchy that are framed by the organisation itself and approved by the government for carrying out day-to-day functions. Finally, it is the Operational Manual or Routines and Procedures, which are developed by the organisation as a step-by-step guide for undertaking a particular activity or task.

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[17] Although a number of officials came from the Provincial Civil Service and Secretariat Group, but those belonging to the District Management Group were in the senior and effective positions

[18] In the Punjab health sector, the technocrats occupy both the managerial and specialist positions.

5.3. Sheikhupura Pilot Project – a case of prefiguring the Punjab health sector reforms

5.3.1. Account of the project

5.3.1.1. Emergence of the concept

How was the project conceptualised? To answer this question, it is considered fair to directly quote from the first executive director of Special Projects:

> *Yes, I was a practising surgeon till I took over as Surgeon General Punjab. In this capacity, I came in contact with peripheral health services and became aware of the inadequacies in the health sector. ...convinced me that a radical change needs to be introduced and on the other hand my association with rural communities brought out very clearly the total alienation of the end users with all government efforts in the health and other sectors...*
>
> *In addition, I was DGHS when the SFHP and Health Care Development Project came. Seeing the huge amount that was proposed to commit, I was extremely apprehensive that the inputs will not be judiciously used and the end users will be not better off than before. I was naïve at that time that I proposed to the Wold Bank that a Pilot Project be started to test on the one hand the public sector willingness to reach down and the end users' collective ability to act as watchdog. ...this is how the project was conceptualised.*

The document review suggests that SPP was envisaged as a case-control research study. District Sheikhupura served as the case area, while the sub-district Kasur of district Kasur was taken as the control. The project aimed at:

> (i) creating a viable model for primary healthcare that ensured quality of services, which are accessible and, what is most important, sustainable; and (ii) determining the feasibility of community participation including sustainability concerns with special emphasis on replicability (GoPb, 1992).

Accordingly, the project had two sets of interventions, which were designed to address the respective aims:

1. Management modification: (i) decentralising and re-organising district health teams; (ii) integrating the, hitherto, vertically oriented outreach programmes into mainstream primary health care; (iii) activating maternity and child health care; (iv) improving the health management information system; and (v) enhancing the supply of medicine to the health facilities.
2. Community participation as a process involving: (i) selection of villages; (ii) selection of public sector and community animators; (iii) organisation of village

health committees; (iv) selection and training of voluntary village health workers and traditional birth attendants; and (v) identification, development and implementation of small village based projects.

5.3.1.2. Implementation of the project

The assistant district health officers in charge of the sub-districts were granted financial powers (GoPb, 1993c). Later, in partnership with different stakeholders, a set of management interventions was designed. The emphasis was on decentralising powers and creating Tehsil Health Teams, while the District Health Team retained the overall supervisory role (GoPb, 1993a). To orientate district health staff about the project interventions, workshops were held in health facilities throughout the district (EDSP, 1993). The government approved the plans for integration and re-organisation of CDC programmes, decentralisation of powers to the lower levels in the hierarchy, and a career structure for female paramedics to provide incentives (GoPb, 1996; EDSP, 1996). But, these plans were not implemented, because the focus in the SFHP shifted to the wider reform agenda (EDSP, 1998).

For organising communities CARITAS[19] Pakistan guided the process. A core team for the project and district managers was trained in 'community animation' (EDSP, 1993a), followed by a similar exercise for sub-districts (EDSP, 1994b). This cascade continued down to the village level. Trainees in one step identified the participants for the next step, leading to developing a team of animators both from the health facilities and nearby villages. These animators then organised the communities as Village Health Committees (VHC) and the Social Welfare Department registered some of these. The VHCs selected the village health workers (VHW) and identified all practising traditional birth attendants for training, which was conducted in health facilities and villages. The VHCs identified small village based projects and worked out modalities for implementation and maintenance. But, these projects did not take off (Tareen and Omar, 1997). The project authorities attributed this to communities not spending up front (EDSP, 1998a), while a VHW gave another reason, "We continued to chase the project even in Faisal Town (where the Project Management Team (PMT) was located), but nobody co-operated..." But, why did this happen? According to one health worker, this was due to changes in the Project Team.

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[19] CARITAS is an international non-governmental organisation which has experience of working with communities in the Punjab.

5.3.1.3. Fate of the project

While the project was being implemented, expatriate consultants who worked with PHDC suggested different prescriptions for management development in the health sector. This advocacy contributed to the government and the SFHP shifting its emphasis to establishing the DHMTs first (1995-96) and then DHAs (1997-98) (GoPb, 1996a). Later, an anti-tuberculosis project was raised from the remains of the SPP, but the Planning and Development Department did not allow its continuation in the proposed form (GoPb, 1993b). Finally, the SPP was closed in June 1998.

5.3.2. Principles and purposes

The project pursued an ideologically motivated change in the district health system, but this was not clearly documented. There is a consensus amongst the respondents that the project intended to introduce a change, although perceptions differed about its nature and level. The communities thought that it was a vehicle for a change in their life, while for the health sector workers it was a management change. One may argue, therefore, given the objectives, the message of the project was conveyed.

However, what was the motivation for this change? In the opinion of the majority of respondents, the project was ideologically motivated. A VHW told this researcher, "It had no relation to politics. We worked only with the health workers of the Health Department". Augmenting this contention, a senior planner said, "In this country, politically motivated projects are often showpieces like infrastructure projects". However, he comparing the ideological basis of the project with Marxism, Islam or Communism, qualified his statement by saying "it was meant to have a better management of whatever we had. That is, instead of increasing the investment, improve the management practices". Therefore, it is argued that the project was aimed at bringing change to the life of people through their participation and introducing management reforms in the health sector. And it was ideologically motivated, although it was not clearly laid down in the project documents.

5.3.3. Shapers

5.3.3.1. Leader

The (deputy) project director led the project, but selecting such a leader was a mistake, and later dissociating him from the project was also wrong. The majority of the respondents subscribe to the view that he was in the forefront, and that he was dedicated and visionary. However, in the opinion of a respondent, his impatience shown by diving into more intricate details was a shortcoming. But, “by his personal

efforts, he forced the bureaucracy to move the reform process and was the main co-ordinating force", a district officer commented. Paradoxically, a senior officer considered him "too energetic and strong a person to lead a pilot, instead a normal deputy district health officer could have been appointed as its project director". But, documentary evidence suggests that after this project director left, there was little activity in the project. In other words, as an officer in UNICEF commented, "the leader was behind both the success and failure of the project".

5.3.3.2. Supporter

The first executive director of Special Projects was a supporter of the initiative, as the successive executive directors did not support the project[20]. He took decisions and facilitated the leader in implementing the project. According to a senior project officer, he was a dedicated, visionary and an outstanding officer. But, he had shortcoming that he was not a public health person, but a surgeon, and had little exposure to the field and its intricacies[21]. However, he orchestrated the project interventions and laid down such strong conceptual grounds that although he retired after two initial years, the project continued running for at least a further two years.

5.3.3.3. Bureaucracy

Civil bureaucracy in the district was indifferent to the project, while that in the secretariat was slow in making decisions on project issues. The executive director quoted a deputy commissioner saying "well, this is a health problem and nothing to do with us, but any help you need, we are willing to provide". Similarly, almost a consensus opinion emerged among participants of the FGD that civil bureaucracy in the secretariat, although it had an active role, did not do much. They took the project as just another file, because "the staff in the secretariat is trained to deal with cases as another file", one ex-DGHS commented. According to a senior project officer, with few exceptions, they (civil servants) resisted the change and were slow to react. Further, he added that this attitude was perhaps due to the fact that the civil bureaucrats had little understanding of the health system and hence they took a long time to decide on project issues.

Technical bureaucracy did not favour the project either. They were critical of delegating powers to the lower tiers in the health sector hierarchy, an ex-DGHS told this researcher. According to the project proposal, the DHOs were only letting the

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[20] An inter-office note (EDSP) – Re: Problems Faced by the PMT during 5th Joint TBA/VHWs Training Workshop – provides a firm clue to this assumption.

[21] Personal communication of this researcher with one of the contemporaries of the executive director of Special Projects, Punjab

powers go to the lower levels without receiving any incentive from higher echelons in return. Therefore, as one SMO commented, they (DHOs) rallied against the whole process and did not co-operate. For example, after financial powers were delegated, the district accounts staff which was transferred to the sub-districts, was not allowed to take up their new positions. Thus, one way or the other, technical bureaucracy was alienated from the project from its inception. This is inferred from the tone of the officials interviewed, and the memoranda reviewed by this researcher.

5.3.3.4. Donors

The donors initially appreciated and supported the project interventions, but were inconsistent in their approach. For example, DFID which assisted the community participation component of SPP, in parallel espoused the PHDC in establishing DHMTs. Later, they changed their strategy. They pulled out of SPP to support another initiative, the DHAs. Similarly, this researcher knows that UNICEF, which supported the project, withdrew silently in favour of the prime minister's programme. Likewise, the World Bank was supportive, but a review of successive aide-memoirs reveals that SPP disappeared gradually from its agenda.

One may question the response of donors, especially when the project ran into problems. Why did they not emphasise rectification of the problems? Further, if, for argument's sake, as one senior bureaucrat in the Finance Department noted, their interest lay in the disbursement of loans or grants and not in the project objectives, then how did their supervisory missions justify the previous support? It is argued that the donors' support was navigated mainly by factors other than the project objectives and that they were more interested in the disbursement of funds. Therefore, they changed their support according to the government's desires.

5.3.3.5. Media

The media was not used in gathering support for the project, but to only flash up a few news items of a ceremonial nature. This view is subscribed to by the majority of the respondents and is also supported by documentary evidence. The question arises – why was there this gap? A number of reasons were unearthed. For example, a senior medical officer commented that it was due to the misgivings in the public sector about the media, and underplaying the role of the media was a deliberate act of the project authorities. Further, because confidentiality of the official documents is protected under the Official Secrets Act, public servants would not be open to the media. Therefore the media had a weak role in the public sector.

5.3.3.6. Civil society

The community groups received the project well, while the service providers did not adequately co-operate. A general secretary of a VHC reported that the project brought a welcome change to the villages. That is, e.g. despite family feuds, people would come to attend meetings of the VHCs. The respondents are unanimous that the community groups, barring those few with vested interests, were supportive. Opposition to the project was from the health sector workers, who were backed by their Unions. But, different Unions were not organised and united, therefore, they responded differently, and often ineffectively. For example, there is no evidence that the Pakistan Medical Association (PMA) ever took an interest in the project and even its local branch remained dormant. Why was this so – one may question? Because the project was experimenting with a management system for the rural areas that did not affect the teaching and specialist cadres in tertiary and secondary care, one district officer commented. Further, one may infer that given the PMA represents mainly the latter, it considered that the threat was distant. However, this indicates a relatively less developed civil society, as not many groups got involved with the project.

5.3.4. Context

A multitude of factors in all the components of the health sector contributed to the origin of the project. Apparently, the project originated from the SFHP. But, a closer look at the project design reveals this went beyond that premise. An expatriate consultant associated with the project hypothesised that a longstanding malaise reflected in the low utilisation rate and wasteful use of health sector resources led to conceptualising the SPP. Things had gone so bad that one SMO said "the health system was at a crossroads and it was being considered to contract out health facilities, because these were not delivering". The administrative and financial powers were so centralised that, according to a MO, even to replace a burnt out bulb in a facility or to take casual leave, permission of the DHO was needed.

The communities, the executive director argued, were alienated and did not own the public sector. In his words, "...one old illiterate villager told us that whatever the government allocated, out of this, 30% is taken by the politicians, another 40-50% is taken by the bureaucrats and contractors and the last bit is spent to blacken our faces". Primarily a governance issue, this was substantiated by a woman medical officer. According to her, in villages the untrained TBAs conduct more than 80% of deliveries resulting in high maternal deaths due to birth related causes. This state of affairs, in the view of a general secretary of a VHC, was due to:

> *The doctors would mostly be absent and that for a population of 10,000-15000 we don't have a qualified doctor even practising privately in the village. There are a few quacks, like school teachers ...The TBAs were not trained, but were conducting deliveries. The government LHV would occasionally come to the BHU, but if we needed some help at night there would be none and we had to take the woman to some nearby city...*

However, these issues in the health sector were perennial and there was no emergency or crisis and imminent reason for intervention, many respondents noted. But, in the opinion of an aid worker, it was the international interest in the health sector reforms that worked as a window of opportunity and the donor agencies exerted pressure for introducing change. This assumption is validated from the fact that SPP was part of the SFHP, which was a project introduced by the donors.

5.3.5. Contents

5.3.5.1. Policy and its level

From the project proposal, SPP was a comprehensive initiative built incrementally. Further, it was intended to be a research project focused on the district and that too in the domain of primary healthcare. Tertiary and secondary healthcare and support services, such as nursing and blood transfusion services, pre and in-service training institutions etc, were out of its remit. So, one might argue that it was a piecemeal effort. But a rival explanation also exists. A district officer commented that given the envisaged span of activities - management intervention complemented by community participation - the SPP was comprehensive in its own right.

Moreover these interventions were aimed at creating a model of primary healthcare that could address the issues of quality, accessibility and sustainability in the existing system. And given these objectives, the project falls within the ambit of the reform (chapter 2). Further, a retired DGHS supporting this notion viewed SPP as a starter not only for the health sector, but also for the other public sectors in their efforts to reform. It is, therefore, contended that SPP, within the remits of primary healthcare, was a comprehensive reform project.

5.3.5.2. Communications strategy

Many respondents underlined the importance and need for a communication strategy for the project. But, they noted that the traditional mode of communication was used. The plan to publish a newsletter was aborted, because the contributions were not forthcoming (GoPb, 1994a). Nonetheless, workshops, meetings, seminars, circulars, reports and publications were generated, and thus a substantial time was

used in explaining and defending what the project was doing (DGHS, 1995). However, in the absence of a formally defined communications strategy how did the project proposal get approval, one may question. According to a senior planner, "actually SPP was the first project of its kind introduced in the Health Department. Prior to this, there were bricks, mortar and equipment projects". In other words, a formal communication strategy does not form part of the usual project proposal, but in the case of SPP the effort to develop one (newsletter) was not successful.

5.3.5.3. Monitoring and evaluation

The project documents envisaged monitoring and evaluation as its integral part, but it was inadequate and inefficient. A baseline survey to assess the benchmark status of the district health system in the target areas was conducted (PIEDAR, 1994). Then, a mid-term evaluation covering a technical and a field study was also planned. However, only the latter was accomplished (EDSP, 1997). Since it was important to compare the baseline and mid-term situation for learning and adopting the future course of action, the process to launch a technical study was started (EDSP, 1997a). But there is no evidence of this exercise occuring, or a final evaluation survey envisaged at the conclusion of the project having been done. A Steering Committee was organised to guide the project. But, a review of the minutes of successive meetings suggests its ineffectiveness (GoPb, 1994b). The decisions made at this forum would hardly be carried out. Later, the project became an agenda item for the Steering Committee of SFHP (EDSP, 1995), but with the same outcome. Further, there would be review meetings and periodic project briefs were also prepared (GoPb, 1996b), nonetheless with little follow up activity.

5.3.5.4. Management systems

What management systems were developed for the project? To answer this question, a closer look at the project memoranda and the evidence from research participants suggests that a devolved structure for the district health sector was being developed under the project. According to a senior health manager:

> *...this is a model that we can use for establishing the (devolved) district governments at this stage (when the districts are being devolved). ...The project developed everything from community participation to decentralisation; we can use it at best.*

Further, as indicated (5.3.1.2) different systems envisaged were approved by the government, but due to the change in the focus of SFHP these were not followed up.

5.3.6. Implementation

5.3.6.1. Political feasibility

Political feasibility is important for the successful implementation of any reform. Regarding SPP, although most respondents considered that it was a politically feasible time for the project, the executive director did not agree with this. In his view, given the aim of the project, "it was against the interest of the political and feudal leadership of the country. It was, therefore, not a politically feasible time". A senior planner qualified this contention further, "when it (SPP) started (in 1993) there was some political support (available to the project). However, in the post-1994 period, although the civil bureaucracy was supportive, there was no political support (to the project)". It is therefore argued that, although initially it was a politically feasible time, later in the implementation phase there was little political support available to the project interventions.

5.3.6.2. Technical feasibility

Regarding technical feasibility, it is argued that given the flexible nature of the project, it was not needed to 'dry run' the arrangements for ensuring their adequacy before full-scale launching of the intervention. There is a consensus amongst respondents that because the project was itself a pilot, it did not need any field-testing. However, the question arises whether it was essential to pre-test, as in the public sector this is seldom done[22]. Instead amendments are proposed which pass through the usual planning process. Further, one may argue that due to the flexible approach, the project design changed as the implementation conditions required, and it was a continuous learning process. Therefore, a field test was not run.

5.3.6.3. Resources

The project had adequate allocation both from the government and donors at its disposal, but most of that remained unspent (EDSP, 1994). Although a saving for the exchequer, it was at the cost of the project objectives which remained unaccomplished. Why did this happen? A senior planner commented that it was due to a weak team, which was also later changed, that the stipulated inputs could not be made. Further, it is argued that dwindling political support and weak bureaucratic co-operation affected the efficiency of the project team. Another reason was the generic problem of cumbersome financial procedures, which contributed to the low utilisation of funds from government sources (EDSP, 1998a).

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[22] See appendix 3.1 for detail on the Policy Process in the Punjab health sector

5.3.6.4. Organisational support

The organisational linkages developed for the project hampered the introduction of interventions. For implementing the SPP, a PMT comprising two deputy project directors and two office assistants was established under the executive director in the PIU of the SFHP. This team interacted laterally with the District Health Office in Sheikhupura, where a field office was established. These linkages between the PMT and district health staff were informal and personal due to the separate reporting lines (Figure 5.1). Nonetheless, this mistake in the project design was realised during execution, and efforts were made to rectify it. An arrangement was suggested whereby the field team reports to the DHO, who in addition to the DGHS also reports to the executive director (GoPb, 1994b). But, this proposal needed amendments in the rules, which was beyond the purview of the Health Department. Later attempts[23] to link the SPP first with the Institute of Public Health and then with the PHDC failed (GoPb, 1994c; GoPb, 1995; EDSP, 1995a).

However, what were the implications of linkages for project execution? This linkage was important both for the institutions and the project (British Council, 1995). The project could have benefited from the intellectual mass in the institution, while providing a learning ground for the students and faculty. In the absence of such linkages, the project developed its own training team drawn from regular health facility staff and it is argued that this was a drain on the already weak district health system. But, this paid back too as this strategy contributed to building the capacity in the district, as one DHO commented. Further, given that reforms are continuing processes, these should have been geared from a permanent structure and not through a project of limited duration. Moreover, because such initiatives often gather documents and rich experiences, what would be the fate of the archives and human resource developed in this process, after the closure of the project? In the case of the project's linkages with the institutions, the former is likely to be followed up, carried over, and used in furthering the concepts (World Bank, 1995: 6/para 37).

5.3.7. Process

5.3.7.1. Conceptualisation

As indicated (5.3.1.1) the SPP was meant to develop and test the interventions of the SFHP which, in turn, was a part of the larger SAP. Since the latter was a cross-sectoral programme, it can be argued that the SPP was part of the government's

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[23] Executive Director of Special Projects: Note on Association of College of Community Medicine (Institute of Public Health) with Sheikhupura PHC Pilot project – unpublished document

larger agenda. However, this needs clarifying. How did it get on the agenda and who did it? The executive director told this researcher that he took the initiative and convinced the donors to run a pilot alongside the SFHP in order to develop and test the interventions prior to their wider replication. However, according to a senior planning officer, it was team thinking, which led to this decision. Nonetheless, evidence favours that the executive director spearheaded the move to launch SPP, while others supported it.

5.3.7.2. Designing the initiative

The project proposal passed through a lengthy planning process and the highest provincial planning forum, the PDWP, approved it (GoPb, 1993b). However, no in-depth study was conducted to validate the context, instead a top planner commented:

> *the project itself demanded that a deeper study should take place because whichever studies had taken place, pointed to a number of issues and had demanded precise answers. So the project was conceived as an action oriented research.*

Similarly, no technique was used to anticipate consequences in case the project was not launched. Instead, the executive director told this researcher that a sort of apprehension existed that the inputs of the SFHP would not be appropriately used, if these were not pre-tested. According to a top bureaucrat, "... what we were trying to do was to find out the reasons why the available infrastructure was not delivering..." Therefore, as a senior officer in the Health Department commented, "the project was a paradigm shift in the public sector". In his view, "community participation and decentralisation till that time were theoretical issues and to test their operability, the pilot project was initiated".

SPP visualised introducing: management interventions and community participation, and following that, the objectives and priorities for the project were set. There is no evidence, however, that an option appraisal was done. But it is clear from the document review that a flexible approach was adopted, and the project design continued changing as conditions required during implementation. Thus, it is argued that SPP was a software project aimed at developing management systems in the health sector, but no formal study or technique was used in its planning.

5.3.7.3. Stakeholder involvement

The policy process for the SPP was conducted in a hierarchical channel, where its design was extensively discussed involving stakeholders from different public sector departments. Further, given the project proposal underwent several revisions, each

time its contents were discussed amongst stakeholders in the directorate, secretariat and donors. However, although community participation was its major component, none from the communities participated. But, given that it was flexible (5.3.7.2) and its final design bore the impression of stakeholders at various levels, the project had a broad stakeholders' base. Nonetheless, this strength of the project was counterbalanced by its execution in parallel to the mainstream health sector (5.2; 5.3.6.4) and subsequent loss of support (5.3.3.2).

5.3.8. Summary and conclusion

The policy process for the Sheikhupura Pilot Project has been analysed using a framework developed for this study. The project arose initially as a pilot to develop, test and refine the interventions of the SFHP, but later became its vestigial part. Despite the ill-conceived organisational relationships in the health sector hierarchy its management team developed a package for management modification and established a network of organised village communities. Also, the project attracted appreciation and support from the government and donors.

However, because of the dwindling political support and bureaucratic inertia, the required amendments in the rules and regulations took a long time. Further, the PHDC – a subsidiary of the same project as the pilot project – took up a similar agenda as that of the pilot project. This institution launched initiatives: first DHMTs, and then DHAs that received the assent of the government. About the same time, the project team for SPP was changed. Given that with communities it is often the personalities and for management interventions it is the continuing thinking process that is the mainstay for progress, evidence suggests that little progress was registered afterwards.

The Sheikhupura Pilot Project was the first organised effort in the public sector to introduce community participation and decentralisation. There followed several upheavals in the life of the project, and in the words of its director, "half of my time was spent to defend, one fourth to explain and advocate, and the remaining one fourth to work for the project". Although the SPP was gradually lost in this maze, nevertheless, it served to prefigure reforms in the health and other sectors, as a retired director general of health services told this researcher.

> *The Sheikhupura Pilot Project was a leader in introducing the change in the public sector. It was a learning ground, not only for the health sector but also for other sectors as well. Many government departments got inspired and introduced similar interventions.*

5.4. District Health Authority – a case of a neglected initiative

5.4.1. Account of the initiative

5.4.1.1. Emergence of the concept

The idea of the DHA is traced to a report produced by Collins (1995) who proposed advisory groups for different levels of the health system hierarchy, including a District Health Board to work with the District Health Office. Later, in another development, Omar (1996) suggested an 'Inter-sectoral Health Committee' to focus on collaboration. Then, a committee appointed by the government to review these reports recommended the establishment of the DHA. However, it was declined, because its legal implications could not be circumvented by the Health Department.

Later, in 1997 the idea of the DHA emerged again as an item on the election manifesto of the Pakistan Muslim League (PML, 1997). The chief minister constituted a 'Task Force on Health' (GoPb, 1997s)[24], which recommended establishing DHAs initially in two districts, emphasising that "in order to provide legal cover to the DHAs, the department may submit a draft bill. This initiative will be extended to other districts on successful evaluation of the results of these two DHAs..." (GoPb, 1997c). The DHA also figured in the National Health Policy where it was seen as a strategy for management reforms and a means of strengthening the district health system (MoH, 1997b).

5.4.1.2. Establishment of District Health Authorities

Two DHAs were established with the aim "to improve and develop health service for the population residing in the districts". The administrative order for this purpose lays down a list of members, portfolios and a range of functions to be performed by these new bodies. The DHA had thirteen members with the DHO acting as its *ex-officio* secretary. Six members were drawn from allied public sector departments, while the remaining six were non-official honorary persons and the official members nominated three of them (GoPb, 1997b). However, no legitimate powers were delegated to these new bodies.

The mechanism for constituting DHAs had problems: firstly because there was no selection criterion one could expect the will and favour of the officials prevailing in selecting the members. The governor of Punjab, in a similar situation, observed that

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[24] Noted in the file in longhand and comprising: Dr. Amir Aziz; Ayaz Amir, MPA; Zulfiqar Ahmed Khan Khosa; all Principals of Medical Colleges; Deans and Medical Supdts of teaching hospitals

it was against the spirit of decentralisation that the nomination of non-official members should rest on the proposals emanating from the official members. Secondly, certain components of the health system such as patients and communities were not represented (Khan, n.d) and the non-official members, by default, do not represent them. Thirdly, the chief minister nominated the chairperson to honorarily head the authority and a Member of the Provincial Assembly (MPA) as its member. Similarly, the minister for health nominated one notable from the district. This mechanism took a long time to fill vacancies and because the politicians were placed remotely from the districts as the minister for health told this researcher, they could not effectively undertake this exercise. It is, therefore, argued that this arrangement promoted centralisation in the attire of decentralisation.

5.4.1.3. Fate of District Health Authorities

The DHAs were taken over by another initiative. That is, while these bodies were struggling, a delegation comprising the secretary health, two chairpersons of DHAs and the executive director of Special Projects went for a study tour to the UK. This tour was organised by DFID for the participants to learn from the experiences of DHAs in that country. However, the impressions of these study tour participants proved a turning point. The government shifted its emphasis to another initiative – the District Health Government. The new initiative envisaged a paid and full-time district chief executive with full financial and administrative powers to head the proposed structures. The DHAs were left to perish, however as a chairman of a DHA commented "since the order for establishing the DHA has not yet been withdrawn, officially these bodies still exist, notwithstanding being abandoned". So, this was the demise of an initiative in its infancy at the hands of its carers.

5.4.2. Principles and purposes

Insofar as the DHA initiative is concerned, the majority of the respondents argued, this intervention was aimed at bringing change in the district health system, which was not delivering. The question, however, is that what was the motivation for this change? In the opinion of a DHO, the DHA was not ideologically motivated. He argued that in that case the government should have adhered to the initiative and undertaken the needed homework. However, the DHA was abandoned in favour of another initiative.

Then, was it politically motivated? This assumption is supported from evidence that the initiative figured in the election manifesto of the political party in power, and a respondent commented that some MPAs were obliged by inducting them in these bodies. But, the question arises, why did the political bosses allow it to be taken over

by another initiative? Was it the bureaucracy that was responsible for this takeover, and did not translate the political agenda into the operational plans? This assumption is supported by the fact that the chief minister asked the bureaucracy to draft legislation for providing legal cover to the initiative (GoPb, 1997c), but this was not done. Further, the DFID team developed a set of such instruments, but these were shelved (5.4.5.4). However, yet the question remains – who was the custodian of these principle(s) of reforms being introduced under a political agenda, and what did they do for their upholding? Logically, this should have been the minister for health, but he was not mindful in following the progress of reform, the chief minister said.

Thus from the above, it is seen that DHAs visualised a politically driven change. However, the bureaucrats were not enthusiastic in creating an environment conducive for these bodies to operate. Also, the politicians were not vigilant and mindful of their political agenda. Why was this so? One explanation is that they looked for change but not the DHA as the tool for that, because they were not clear about the nature and basis of the proposed change, i.e. the principles and purposes.

5.4.3. Shapers

5.4.3.1. Leader

The secretary health led the reform process, but had doubtful dedication for the initiative and technical capability. He was full of personal traits which distinguished him from his fellow bureaucrats, but as a respondent commented, he seldom used those qualities for advancing the initiative. According to a senior officer, he talked well for the initiative, but practically did nothing to delegate authority to the lower levels. A chairperson of a DHA argued that he was trained under the British colonial style of administration, and would never want to lose powers. But, one may also argue that his failure to delegate was due to his technical weaknesses. According to a politician a person with specifications held by him could not lead the initiative. In his view this was a planner's job, and the secretary health was not a planner. Nonetheless, he was a successful bureaucrat, who despite having abandoned an initiative which was in the political agenda, earned praise from his political superiors – an impression of this researcher after he met the chief minister.

5.4.3.2. Supporter

The chief minister rendered consistent support to the initiative. However, by opening several fronts at a time, he lost control of the process, and hardly anything was achieved. According to a respondent, he was energetic and powerful to the extent that he was a 'democratic dictator'. He wanted things – rather several things –

to be done immediately. Several respondents noted that this haste and urgency which was part of his temperament, led to the problems in the reform process. This attitude, a politician maintained, could work in the manufacturing or construction sector, but not in the social sector. Further, one chairperson of a DHA commented, to bring change, the chief minister depended on those (bureaucrats) who were responsible for the issues in the system. Thus, the chief minister rendered support, but of no avail to the reform initiative.

5.4.3.3. Bureaucracy

Overall, the civil bureaucracy was against DHAs and resisted the envisaged changes, because they did not want to lose power. The reform process could hardly come out of the files in the secretariat, and, once out, it was left unsteered and then shortly after abandoned. They did not respond to at least to one of the two DHAs. A chairperson reported that "they (decision-makers) never responded to any communiqué we made – over 100 letters in about 8 months – and you can well imagine the amount of co-operation we received (from bureaucracy)". Similarly, in districts, according to a DHO, the additional deputy commissioner - a junior civil bureaucrat on the DHA – never came to the DHA meetings. He wanted the DHA to meet in his office. Regarding technical bureaucracy, one chairperson of a DHA told this researcher that those in the secretariat were subservient to their superiors in the civil service, and had attuned to being bureaucrats[25], while the entire line management was against the DHA. According to a technocrat, this was mainly due to the fear of losing power, an uncertain future, and that they were not involved.

But there is another dimension to the role of bureaucracy. They were inefficient in undertaking the policy process for health sector reform. This is evidenced from the process followed for establishing DHAs. A generic notification was issued in April 1997, but the first DHA was created in June the same year. The second DHA was shaped after about one year – in March 1998 (GoPb, 1998w). Such delays were contested on the grounds that bureaucracy in the secretariat was involved in too many assignments in addition to their routine work. This is, however, a weak argument. Why did the bureaucracy not delegate? Is not this itself a case of inefficiency in the wake of decentralisation, one may argue. Instead, bureaucracy took over the responsibility from the PHDC of supporting the initiative (5.4.6.4). One may, therefore, draw a logical conclusion that bureaucracy was inefficient and neither wanted itself nor allowed any other institution to foster the initiative.

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[25] This is also something to do with culture. Technocrats like doctors and engineers once they join the civil service leaving their technical role don't use pre-fix Dr. or Engineer with their name.

5.4.3.4. Donors

The donors inculcated the need for reforms, but were inconsistent in their approach to providing technical assistance. DFID was the main financier, while the World Bank supported the DHA initiative in principle (GoPb, 1997e). It was noted (5.3.3.4) that the donors' support to DHAs was at the cost of pulling out from SPP, and it was uneven. That is, they supported through a technical team, but took eight months to install it, and then operationalised it after another three months. Since the team was there for a short time, i.e. before long it was shifted to work on the DHG initiative, it could not adequately interact with the districts. Why was this so, one may question? A number of respondents subscribed to the view that it was due to the flexibility in the donors' approach that they followed rather than technically guiding the government. However, the fact remains why was the project Logframe not updated, although the project inputs had changed, leading to the project (PHSSC) becoming directionless and technical assistance inconsistent. This was due to, as a senior planner argued, fatigue of donors after following a long-term project.

5.4.3.5. Media

Apart from few news items of a ceremonial nature, the media was not used to gather the support of stakeholders for the initiative. There were some efforts at the local level, but not enough to raise adequate pressure for keeping the initiative on the agenda of the government. This observation is seconded by a majority view. But, the question arises – who could have used the media? The bureaucracy, which did not want to support the initiative, would not have done it. The politicians could have used this forum to promote the political agenda. The chief minister had several items on his agenda, but the minister for health could not take the opportunity, one may conclude. The media did not have a proactive role. This researcher could not trace any news item or report published about the initiatives during those years.

5.4.3.6. Civil society

The PMA did not generate any debate. One could argue that this was perhaps because the local branches were represented on the DHAs. However, if that was an incentive, why did they not take up the issue when the initiative was first ignored and then replaced with another initiative? Logically, it appears that it was because the PMA represents the city doctors and those in tertiary care, while the DHA was about the secondary and primary care in rural areas. Also, it is possible that, as the chairperson and other portfolios on the authority were honorary and no perks or benefits were involved, there was no competition. However, there is no evidence that any other section of civil society took any interest in the initiative.

5.4.4. Context

Many factors embedded in the health sector including its environment led to establishing the DHAs in districts. These are summarised below:

- There were issues in the health sector *per se*. According to a senior health manager, the delayed decision-making coupled with nepotism and corruption contributed to the inefficiency, and the overall perception was that the health services had deteriorated. People would complain about lacking medicine, absentee doctors and missing equipment from health facilities. Complementing this observation, a DHO reported that there were no district plans, and if available, those were inconsistent with the needs and resources of the district. Further, the minister for health added that there was no mechanism for solving the problems locally, therefore, "we established the DHAs ... to supervise and manage the affairs of all health facilities within a district".

- There were also problems in the national systems. According to a donor health is an important and sensitive sector, but the government had run out of remedial options for the ailing health sector. The resources were inadequate and, given the rising inflation coupled with population growth, it was difficult for the government to even maintain budgetary provisions. But, the government was only criticised. Therefore, it wanted to shed off or at least share its responsibility with the public, and the political government introduced the initiative involving the end users in the management of health services. So, both the rewards for improvement and blame for any inefficiency were shared.

- The context also extended to the hegemonic systems. According to a respondent, the DHA was a manifestation of the advocacy for decentralisation that had been there, when healthcare delivery was failing. In this regard, it was noted (5.4.1.1) that the donors contributed to conceptualising DHAs. But, initially due to the lack of political will it did not take shape. However, later the scenario changed. That is, there was political will and also the donors to support it.

The majority of respondents considered that there was no crisis and it was business as usual in districts. However, according to an academic "the government, by and large, has been doing crisis management". Why then did other respondents think that it was the other way? One logical explanation is that such feelings were due to the degenerative process occurring gradually in the health sector to which the people were acclimatised.

5.4.5. Contents

5.4.5.1. Policy and its level

The DHA initiative was part of the government's larger agenda. This is true and is supported by the fact that it was on the government's political agenda. Further, the origin of the initiative can be traced to the SAP, which was a country-wide social sector programme and that several initiatives alongside DHAs were underway. But, a rival explanation from a senior planner is that these initiatives were not part of a bigger picture; instead, each one was an independent entity. In fact, he was indicating the lack of a coherent strategy by the policymakers in reforming the health sector. For example, the Planning and Development (P&D) Department also proposed to establish similar authorities in health and other sectors. Further, several other departments in the social sector undertook the initiatives (GoPb, 1998), but only to follow suit and not as a part of the larger agenda. Thus, the DHA initiative cannot be considered as a part of the government's larger scheme.

The next question is how comprehensive was the policy for the DHA? Insofar as the district went, it was comprehensive. The minister for health noted that within a district all sections of society and allied departments were represented, and the Authority could address issues in the entire district health sector. But, this reason is weak, because the DHA could not appropriate resources from allied sectors to focus on health or vice-versa (DHA, Jhelum, 1997). Further, because no systems were brought into place for operating this body (5.4.5.4), it is difficult to judge the level of policy. Hence from the evidence available, the DHA was not a comprehensive policy. Nevertheless, in the following we discuss important ingredients of the policy.

5.4.5.2. Communications strategy

No communications strategy was defined as a means of consulting and involving the stakeholders. Conventional methods like meetings and discussions had little effect, as observed by a key stakeholder that "2 hours discussion for developing a system is nothing". Some workshops were also organised to involve selected stakeholders, but public dissemination of the initiative was not done. A DHO noted:

> *No, nothing of that sort was there. However, we were in the process and maybe if the DHA was allowed to continue we would have developed a communication strategy. We wanted to work with people making them aware about the DHA. However, this could not happen, because the Authority was abandoned all of a sudden...*

5.4.5.3. Monitoring and evaluation

No system was set up to monitor the progress of the initiative. Reliance was on the informal means of using line managers. Criticising this arrangement, a chairperson of a DHA commented, "When you are replacing a system with a new one and continue to receive reports from people of the same old system, you cannot expect them to provide honest reports. They will never be in favour of change, because they do not want to lose powers". A Monitoring and Co-ordinating Committee was established, which met only once and a review of minutes do not support its role as a monitor. It was a forum used only to criticise the district co-ordinators appointed to assist the DHAs. What the DHA has been doing and how the government could help them, did not figure in its deliberations (DGHS, 1998).

5.4.5.4. Management systems

Every intervention has implications: legal, administrative or financial (2.3.1.2), and so had the DHA, but these consequences were not adequately considered. The civil and technical bureaucracy was to anticipate and accordingly devise systems (Geyndt, 1990), but not much was done. The government notification for the initiative lays down mainly what the new body has to do; however, there are hardly any guidelines as to how to transact business (Griffith, 1997). A DHS in charge of a DHA district furthering this point tells that:

> *...I was DHS... when ... the district was picked up for implementing DHA. I do not remember if I was ever called or consulted (as DHS) in the matter. I also do not know if any administrative guidelines were given to the newly implanted authorities or those who were already working there. ...I do not know if there were any rules or bylaws for the functions of the authority. Similarly, there were no guidelines for the Divisional Director or the DGHS, Punjab for dealing with problems of the District where DHAs were established.*

The new bodies after their establishment were deliberately left on their own without any guidance. The DFID technical team, working with colleagues from the Health Department, developed a 'Health Sector Reform Package' for a decentralised district and presented this to the secretary health in April 1998 (DFID, 1998). It recommended: amending existing rules, developing operational manuals, drafting detailed terms of reference (TORs) and training DHA and DHMT officials. The secretary health informed the team about a draft law "The Punjab Medical and Health Institutions Ordinance, 1998" and asked to draft rules for the DHAs and DHMT (Wildman, 1998). The law was promulgated in May 1998 (GoPb, 1998a) and applied for granting autonomy to the tertiary care hospitals in July 1998 (GoPb, 1998v). However, the draft rules for DHAs and DHMTs, prepared in a series of

workshops, presented to the secretary health in June 1998 were shelved, as being too detailed and liable to work against decentralisation (Griffith, 1999).

However, why did this happen? In the opinion of a bureaucrat, this was deliberate; "let us not limit the body with too many restrictions. Let them devise their own way and channel. ...They (policymakers) gave them a sort of four corners and then left them to work out details on their own". However, people who were put on this work were neither given any orientation or documentation about the issues and the intervention, because there was none, and so these four corners remained hazy. A chairman of a DHA noted:

> *So, everything said and done, I still feel that I was being thrown into deep water with my hands and feet tied and eyes covered. I had no way to go. I was just like a dumb and deaf swimmer, who was trying to paddle his way to the edge of the pool.*

"This resulted in that the same organisation (DHA) in different geographical locations experimented differently and developed different models" one key informant commented. However, why was this allowed to happen? A plausible answer one respondent offered was that "they (policymakers in the bureaucracy) wanted the new system to fail in order to maintain the *status quo*".

5.4.6. Implementation

5.4.6.1. Political feasibility

It was a politically feasible time, but the opportunity was lost. Before 1997, when a coalition led by the Pakistan Peoples Party was in power, the support for the initiative was lukewarm, and civil bureaucracy declined to establish DHAs. This was because constituting this body needed legislation, and the coalition government was not confident to get it passed by the Assembly. After 1997, however, the same political party (Pakistan Muslim League), with an overwhelming majority, was in power both in the province and centre and backed the initiative. However, despite the political will and a clear directive (5.4.1.1), the DHA was not provided with legal cover; instead work was started on yet another initiative (5.4.1.3).

5.4.6.2. Technical feasibility

Although, initially the intention was to pilot test the initiative (MoH, 1997a; GoPb, 1997c), later it was rather an incoherent strategy. DFID committed to support DHAs in four districts: Jhelum, Multan, Sargodha and Gujranwala. But, it was launched only in two districts; Jhelum and Multan. The intention was to extend the initiative to other districts on evaluation of these two DHAs. However, contrarily work was

started to implement the initiative in 15 more districts (GoPb, 1997g). Also at the same time, the P&D Department implemented such bodies throughout the province. Whereas little progress was made to expand, the pilot of the initiative in two districts was also allowed to perish and be superseded by a new movement, the DHG (Abbot *et al*, 1999). Thus, there was no pilot testing of the initiative.

5.4.6.3. Resource

No additional resources were provided to the districts. One DHO commented that the districts, in addition to supporting the new structure, were asked to work better within the same resources. A planning document submitted by one DHA was never responded to[26], while the other DHA was looking for something from outside the Health Department (GoPb, 1998b). This situation occurred, despite the additional provisions promised in the recommendations of the Task Force (MoH, 1997b).

For the capacity building of districts, district co-ordinators tried to develop the DHMTs. One DHO reported that "we were bewildered, but with technical input from DFID we got on track. The technical support was tremendous, because without that assistance we were scattered and lost". But this endeavour was compromised first, as indicated earlier (5.4.3.4), the coordinators had just a few months to work with the districts, as before long they were assigned to work for the DHGs. Secondly, they were not provided with any guidelines, so they did things according to their own preferences and understanding. For example, one co-ordinator, when asked by a top bureaucrat about what he was doing in the district, answered "nothing particular!" The top man enquired, "Why"? "You did not give me any work. So, I did whatever I understood and was appropriate," answered the co-ordinator.

5.4.6.4. Organisational support

There were no adequate institutional arrangements to support the initiative. Initially, the PHDC with the help of donors undertook the policy process including technical assistance. It organised a brainstorming session for sorting the issues particularly related to the administrative structure, financial rules and regulation (PHDC, 1998). Subsequently, DFID shifted its emphasis from the PHDC and based its technical team in the Directorate General of Health Services. By this arrangement, according to a senior officer, the PHDC went into the background, and also the technical assistance escaped control resulting in a lack of ownership of what was delivered. Around the same time, the technical wing of the Health Secretariat and the

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[26] Personal communications of this researcher with the Chairman of the respective District Health Authority

Directorate of Special Projects took over this responsibility. The Health Services Academy offered its assistance by establishing a field demonstration area for its students (HSA, 1998). In response, the Academy was given the status of 'co-opted member' of the DHA (GoPb, 1998c). However, by then, the DHG initiative had taken root, and there is no evidence that the Academy provided any assistance.

5.4.7. Process

5.4.7.1. Conceptualisation

The donors facilitated in bringing the DHA on to the agenda of the government. The expatriate consultant facilitated the introduction of the idea (5.4.1.1), but the then secretary health declined to constitute the DHAs, because the legal implications were beyond the jurisdiction of the Health Department. Nevertheless, DHMTs were established to co-ordinate healthcare activities in the districts (DGHS, 1996a). However, the idea of DHAs came up again in 1997. Politicians had picked it up and this figured in the election manifesto of the Pakistan Muslim League (PML, 1997).

5.4.7.2. Designing the initiative

A number of consultancies were undertaken, but overall the policy planning for the DHA was directionless. In addition, brainstorming sessions were held by a close circle of top technocrats and bureaucrats. The need for an in-depth study was not felt, because, in view of a senior bureaucrat, all issues were known to the people at the provincial level. However, another bureaucrat termed this claim as rhetoric. In his view, they should have undertaken some study and analysis. Also, no projection was made for determining the consequences if the issues were not solved. Nonetheless, there was a strong feeling amongst decision-makers that the system would crumble if these issues were left unresolved.

The objectives laid down in the notification made for the DHAs read "to improve and develop health services for the population residing in the district". This is broad, non-specific, and difficult to measure. The functions envisaged for DHA covered almost the entire health sector. These were too ambitious to accomplish so that one retired army general nominated by the chief minister declined to head one of the authorities (GoPb, 1997f). There is also no evidence that an option appraisal was done. According to a senior officer, it was top-down planning. A remedy was thought through initially and then it was planned how to bring it into place. However, in doing so, the bureaucracy failed to translate political policies into operational instruments. They did not use the archives and expertise available, and they notified a DHA which was different from the one recommended by the Task

Force (5.4.1.1). That is, instead of an autonomous legal entity with full financial and administrative powers (MoH, 1997; GoPb, 1997c), it was only an advisory body.

5.4.7.3. Stakeholder involvement

There was a narrow stakeholder base involved in the policy process for the DHA. Many respondents thought that 'apparently' it was a consultative process. But who were those involved? In the opinion of a senior technocrat, "they were a few bureaucrats, politicians and some technocrats". About this team, one senior planner asserted that they had superficial knowledge and understanding of the health system. Therefore, they could only work out the broad outline of the policy. Since, in his view, the details come from the people working in the system that were not involved, these bits remained unattended to. Regarding, how they contributed to the policy process, it was argued by another senior technocrat that given the bureaucratic culture and the personality of the then chief minister, the entire process was rather dictatorial and people just got on board and carried out what they were asked to do. In other words, it was not a consultative process.

5.4.8. Summary and conclusion

The policy process for the DHA initiative has been examined. Although an in-depth study was undertaken, it was hardly utilised in drawing up the final design of the DHA. Initially declined by the civil bureaucracy, the initiative came on the political agenda and two DHAs were established. The bureaucracy, despite the orders of the chief minister did not arrange any delegation of legitimate power to these bodies.

The British Council, on behalf of DFID, set up its team to support these bodies, and it was located in the DGHS office, hitherto in the PHDC. Since no guidelines were provided, the team was unclear about its functions and so were the DHAs in the districts. The secretary health led the initiative until abandoned, while the chief minister was committed, but could not keep control of the process and the minister for health did not help him. The media was passive and the PMA unconcerned in this attempt to improve the district health sector. Alongside, tertiary care hospitals were granted autonomy, where some gains were observed. Geared by that success, when decision-makers visited the UK health system, they jumped on the idea of DHGs.

In short, after installing, the new bodies were not provided with any structural assistance, and instead emphasis shifted to embark on yet another initiative. Thus, it is argued that establishing the District Health Authorities in this manner was the death of an initiative in its infancy due to the neglect by its carers.

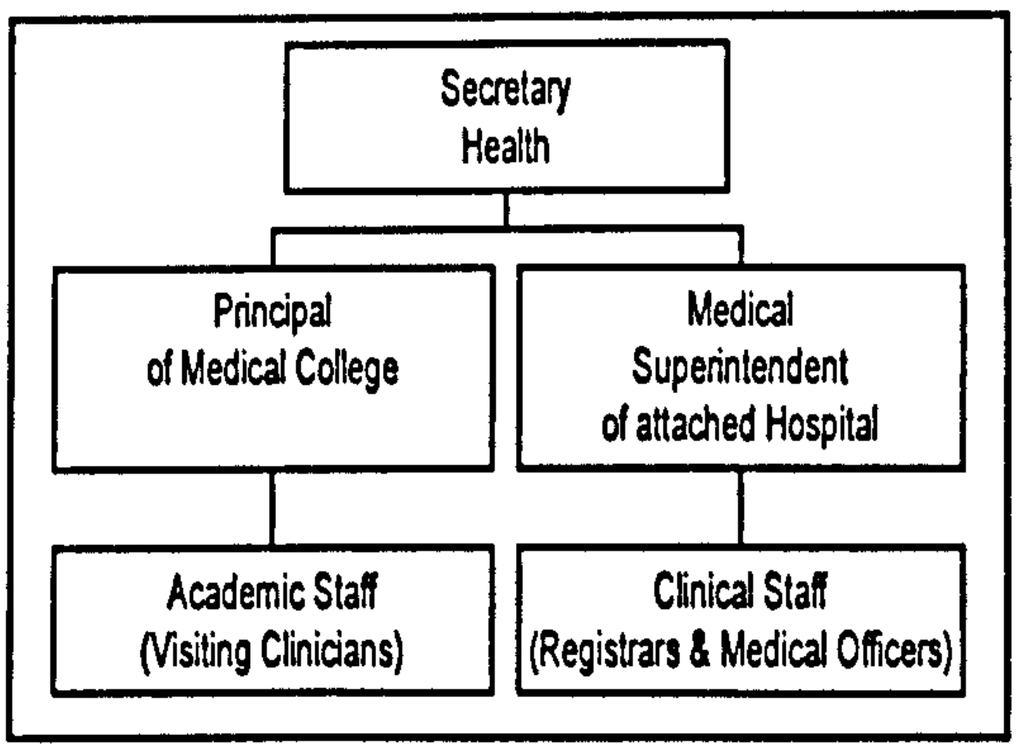
5.5. Institutional Autonomy - a case of mayhem

5.5.1. Account of the initiative

5.5.1.1. General issues

1. The terms 'medical and health institutions' are arbitrarily used in the Punjab context. The former is synonymous for medical colleges with attached tertiary care hospitals, while the rest are health institutions. A principal heads a medical college, while a medical superintendent is in charge of an attached tertiary care hospital. Both are senior in their own cadre, the former in teaching and the latter in the general cadre, reporting directly to the Secretary health (Figure 5.2).

Figure 5.2:- Administrative dichotomy



2. Doctors in the public sector are in three cadres – teaching, specialists and general – and one joins and progresses to seniority in one of these cadres, according to the person specifications.

3. The academics in a medical college are also visiting clinicians for the attached hospital, but they report to the principal. That is, they work in the hospitals, but are not responsible to the in charge medical superintendent. This dichotomy in administration played an important role in shaping the autonomy given to the institutions.

4. The concept of autonomy is not new in the Punjab. A law 'The Punjab Government Education and Training Institutions Ordinance, 1960' was promulgated for granting autonomy to the institutions in the education sector. This law requires establishing a Board of Governors (BOG) comprising majority official and minority non-official members. In addition to the government department implementing the autonomy, other departments, like Finance, are also represented on this body. Further, there is a Board of Management for running day-to-day affairs.

5.5.1.2. Emergence of the concept

In February 1997, the secretary health wrote to a principal of a medical college about the feasibility of introducing autonomy to the medical colleges (GoPb, 1997s: 1). The latter, after consulting the colleague principals and medical staff, recommended that it was feasible under the Punjab Government Education and Training Institutions Ordinance, 1960 (GoPb, 1997h). The new political government

came into office on 17 February 1997 and appointed a Task Force for the Health Sector. At the recommendation of the latter, the chief minister directed that three medical colleges with their attached hospitals are granted autonomy within the framework of the aforementioned law (GoPb, 1997i).

5.5.1.3. Granting autonomy to the medical colleges

The Health Department made nominations for BOGs and asked the Law Department for ratification (GoPb, 1997j). However, the latter objected that as against the provisions of the law the MPAs were members, and the official members were in the minority (GoPb, 1997k). The secretary health tried to resolve the issue, but the Law Department maintained their stance (GoPb, 1997l). The secretary health, however, not agreeing with their view requested the chief minister to approve the proposed constitution of the BOGs. The chief minister approved it and then the permission of the Law Department was asked for the notification of BOGs (*ibid*). However, they refused, indicating flaws and that it was against the constitution (GoPb, 1997m). Thus the proposal to grant autonomy to medical colleges within the framework of the 'Punjab Government Education and Training Institutions Ordinance, 1960' was abandoned and the chief minister directed to draft a fresh law, so the idea of a 'role-model hospital' took birth.

5.5.1.4. Establishing the Role-model Hospitals

A law to establish the role-model hospitals was drafted. To review this, the chief minister appointed a committee which recommended that the concept be tested in three institutions (GoPb, 1997n). Further, it was suggested that the law should envisage delegation of financial and administrative powers held by the Health, Finance and Buildings Departments to the role-model institutions which should be headed by chief executives recruited competitively (GoPb, 1997o).

The draft law was later discussed in the Cabinet which recommended that the audit of the role model institutions be carried out by a third party and the government should not interfere in their day-to-day work. A Cabinet Sub-committee was also appointed to examine the proposed law (GoPb, 1998e). While this Sub-committee suggested certain amendments in the draft law, the Finance and Law Departments expressed their reservations. The former disagreed with the proposed 'indexing' of the financial grant (GoPb, 1998f) and the latter insisted on granting autonomy under the Punjab Education and Training Institutions Ordinance, 1960 (GoPb, 1997p). A Specialist Committee comprising the law, business and medical professionals also discussed the draft law, underlining the "need to have a Board of Governors which will be a supra-body over the chief executive and his Management Committee". The

Health Department was to incorporate these recommendations in the final draft (GoPb, 1998g), but there is no evidence that these recommendations were taken into account in finalising the law.

5.5.1.5. Framing the law for granting autonomy to health and medical institutions

The law, 'Punjab Medical Institutions Bill, 1997" was finalised changing the title of the initiative from 'Role Model Institutions' to 'Autonomy to the Medical and Health Institutions'. The Pakistan Medical Association protested over the arrangements and demanded a comprehensive study be undertaken before autonomy was granted (PMA, 1998; PMA, 1998a; GoPb, 1998h). With disregard to that demand, however, the draft law, the Punjab Medical and Health Institutions Ordinance, 1998 was ratified by the Law Department. Later, the governor of the Punjab assented to the same with certain reservations (GoPb, 1998i). Since it is mandatory under the constitution of Pakistan that an Ordinance should either be re-invoked or placed before the Provincial Assembly for vote within six months, various formalities were rushed through. The Standing Sub-committee on Health considered the Bill on 20-07-98 (GoPb, 1998j) followed by the Punjab Assembly discussing it on 16-17 November when only a few members participated in the debate (GoPb, 1998k). After having been voted on 18th November the Bill was assented to by the Governor of Punjab on 20 November 1998. Finally, it was published in the official Punjab Gazette on 25 November 1998 (GoPb, 1998l).

5.5.1.6. Granting autonomous status to medical institutions

The medical institutions were given autonomy in a phased manner starting in July 1998, within the framework of the 'Punjab Medical and Health Institutions Ordinance, 1998'. Three teaching institutions and six hospitals were granted autonomy in the first phase. A Third Party Evaluation (TPE) of these institutions was conducted, which indicated certain improvements encouraging the policymakers to continue the initiative. One teaching institution with two hospitals in the second phase (GoPb, 1998m) followed in the third phase by another five teaching institutions and eight hospitals were given autonomy (GoPb, 1999).

The chief executives for these institutions were selected through a process by open competition (GoPb, 1998n). They were asked to propose non-official members of their Institutional Management Committees (IMC), according to law (GoPb, 1998o). However, they were late in reacting and with the change of government on 12 October 1999, there was a new scenario. The new governor was not convinced by the way the initiative was handled (GoPb, 1999a). He refused to approve IMCs for

the third phase autonomous institutions. In his opinion, it was against the spirit of autonomy that nomination of non-official members should depend on the proposals emanating from the official members. Later he ordered that until rules were framed, the same powers, as ordinarily applicable, should be exercised by the chief executives (GoPb, 2000). However, when, by the end of 2001, this had not been done, a chief executive in response to this researcher's question, whether under such circumstances autonomy was there, answered "No, not really as yet". In other words autonomy granted with one hand had been taken back with the other.

5.5.2. Principles and purposes

While the purposes for the reform were known, the principles remained unclear. The initiative was on the political agenda of the government in power, and the majority opinion is that it was aimed at bringing efficiency and quality in terms of better availability and accessibility of health services. However, what was the motive behind this change? There are two schools. Firstly, the initiative was to promote local decision-making. Thus, the administrative and financial powers hitherto held by government, were delegated to the institutions. By this arrangement, it was thought that the end-users would finally benefit. In his interview with this researcher the chief minister vehemently emphasised that he wanted the welfare of the patients.

Contrarily, others viewed that the state was introducing corporate management to change its stature in terms of reducing its welfare functions. In their view, fostering quality and efficiency was in order to make the institutions economically viable, so that these were better valued when privatised. The proponents of this idea argue that if the concern was the end-users, then why were the necessary mechanisms for instituting the change not installed? There were no rules for cross-subsidy and utilisation of funds; therefore despite millions of rupees in the institution's account, the chief executives were forced to charge everyone for the services provided. Also, as a senior planner observed, the Finance Department froze the institutional allocations at the pre-autonomy level. This was, in the view of an officer in the Finance Department, "to impel the autonomous institutions to generate resources of their own rather than to look towards government..." Finally the users of the service suffered. It is, therefore contemplated that the political government did not want the state to change its position, but its administrative arm ended up doing so, because the underlying principles for the initiatives were unclear.

5.5.3. Shapers

5.5.3.1. Leader

The majority of respondents viewed the then secretary health as the leader of the reform process, but it is argued that he could not provide ideal leadership. Many respondents avoided commenting on his personal attributes, but according to what this researcher gathered, he was visionary and pragmatic with doubtful planning and implementation capacity. He did not avail himself of the enormous political support in pushing structural issues, like framing of rules, regulations and provision of guidelines, to the institutions. As a result, the status of the reform process was such that the Governor observed, "there are huge voids" (GoPb, 1999b).

5.5.3.2. Supporter

The chief minister provided full support, but lost control over the process. This led the initiative into mayhem. He was accessible, as a senior project officer puts it, "we had a hotline contact with him". According to a senior technocrat, "he took a lot of interest and...mobilised the reform process... He was visionary, dedicated and pragmatic..." Given these attributes, one may question why the initiative was not properly implemented? This is because there is also another side to this picture. One secretariat staff member explained that "he wanted to do things overnight" or as one medical superintendent commented, "he was...instead a non-systematic and pushing administrator... He was short-tempered and very strong". Once, in a seminar, he said, "I am introducing autonomy and I will implement it whether you like it or not and I will see who resists it". These personal attributes notwithstanding, there were reasons for him to push the agenda, as a bureaucrat puts it, "it was political instability in the hindsight, because since 1985 no government could last more than 2-3 years". Nonetheless, in the opinion of most participants, the initiative had strong support, but was badly handled.

5.5.3.3. Bureaucracy

As an institution, the civil bureaucracy did nothing for the reform. This image is drawn from the comments of a senior decision-maker, but there is adequate evidence to support this. In the opinion of the majority of respondents, the secretary health amongst the civil bureaucracy was the major player. As an individual, his role as a leader was not ideal (5.5.3.1). He gathered such people around him, who, as one respondent observed "had a narrow vision ...and they did not involve many stakeholders... They were dedicated, but did what they believed in". The remaining bureaucracy in the health and other government departments played little role in

conceptualising and designing the initiative, one medical superintendent believed. Instead, as one chief executive commented, they created hindrances.

A chief executive noted that out of the technical bureaucracy "a special group worked on the initiative, while leaving many others (stakeholders) behind". Similarly, according to a medical superintendent, "the senior most people in the department, including the principals and even the DGHS were not consulted". Many respondents assumed that just a few technocrats teamed up with civil bureaucracy, but others maintain that the former only carried out what the latter told them to do. A secretariat staff member looked at this issue from another angle. He said, "the technical bureaucracy acted as puppets. They failed to consider alternatives, because they were enjoying foreign excursions at the donors' expense". Nevertheless, they were only a few officials around the secretary health, while the remainder were barely involved and were against the initiative, as a local consultant observed.

5.5.3.4. Donors

Sifting of records reveals that the donors, because they were primarily interested in primary and secondary healthcare, did not take much interest initially. They came in later, when the initiative was in its implementation phase. DFID supported a study tour for two chief executives and a ten days induction course for the chief executives. The World Bank worked to support a 'Learning and Innovation Loan Project'. But, before this project could take off, the government changed and the project was shelved. Nevertheless, there was a great deal of interest amongst donors and they watched the progress of the initiative, as this researcher knows personally.

5.5.3.5. Media

There is almost a consensus of opinion that overall the media was inadequately used, and that too late in the process. Further, as one medical superintendent revealed, this use of the media was necessitated to mainly defend the initiative after a dispute erupted between a chief executive of an autonomous hospital and an influential Newspaper Group. Why was this so, one may question? The chief minister was candid in answering. He told this researcher:

> *I believe the politicians have disappointed people and they don't trust them – things should be done instead. Your action should speak...*

The bureaucracy in the Health Department also did not use the media. Documents indicate that a promotional advertisement was launched and a cell was created under the direction of the chief minister for receiving and collating public opinion (GoPb, 1997q). However, there is no evidence of any activity undertaken by this cell. It is,

therefore, concluded that the media was used only to defend and not to develop public opinion and gather its support for the initiative.

5.5.3.6. Civil society

There are contrasting views about the role of civil society. A senior officer claimed that people were supportive as otherwise the new government would have scrapped the initiative. But a chief executive, differing from the earlier argument, told this researcher that the general public were apprehensive and resented the initiative. In his view, they took it as a step towards privatisation and levying user charges further strengthened their belief. This mixed picture, as a professor told this researcher, was due to the fact that "the poor people became excited and similarly the patients. They were told that once autonomy was launched, they would get better treatment". But insofar as what actually happened, a social welfare officer pointed out that "the patients do come to hospital, but when they come to know that they will have to pay, they disappear". This attitude was a silent protest by the people, because there were no organised groups to protect their rights.

The service providers also did not like the way autonomy was granted. They resisted the initiative and were troublesome, a chief executive informed this researcher. The PMA, on behalf of doctors, declared a dispute by rallying against and resisted the initiative (The Nation, 1999). The academic staff did not co-operate either (Dawn, 1998). In most institutions, the principals led them and often created an unpleasant situation (CE-NMC, 2000; CE-PMC, 2000). But, why did they behave in such a way? An expatriate consultant explained that because autonomy threatened their way of life – salary, pension, responsibility, and corruption etc. Similarly, according to another respondent, with autonomy their private practice had suffered. Contrarily, evidence also suggests that they favoured the concept (Nawa-i-Waqt, 1999), but objected to the way autonomy was implemented and that they were not taken on board. One principal explained that there are rules governing private practice, and it was not the issue. The issue, a top bureaucrat noted, was that the teaching cadre took it for granted that the principal would be the *ex-officio* chief executive. This explains why the principals of medical colleges recommended granting autonomy under the 'Punjab Education and Training Institutions Ordinance, 1960', which provides that the incumbent principal shall be the CE of the autonomous institution (5.5.1.2).

5.5.4. Context

It was mainly the factors in the health sector and the national systems that were the reason for the initiative on the government's agenda. But, there is almost a consensus amongst respondents that there was no crisis. However, feeling existed, as

a senior officer observed, that "things were going from bad to worse and we had reached a stage where things could not be worse than that". But, as a consultant remarked, "there was no apparent big bang". The underlying factors identified by different respondents broadly fall into three categories.

- Firstly, healthcare delivery was ineffective and the communities were dissatisfied. According to a consultant surgeon, the service providers were not punctual, instead working more for their private practice. A chief executive, substantiating this view, commented that consultants were not available; instead house officers were treating patients. Also a medical superintendent noted that equipment was often out of order and visiting staff would seldom visit the hospital in a bid to promote their private practice.
- Secondly, governance and management had deteriorated and there were inordinate delays in decision-making. For example, according to a senior planner, it took a hospital over twelve years to purchase an angiography machine. And in the view of a chief executive and a hospital manager, the public sector institutions were continuously wasting resources, mainly due to the administrative dichotomy in the institutions (Figure 5.2). A surgeon, however, taking the argument further, attributed the failure of hospitals to the generally failed governance system in the country.
- Thirdly, the government wanted to dissociate itself from healthcare delivery and autonomy was a tool used to pull out of the big hospitals, an office bearer of PMA remarked. Augmenting this assumption, a senior officer argued that autonomy was not a felt need of the community; instead it was the wishes and whims of the people at the top. However, given the earlier discussion (5.5.2), it may be true that the political government wanted to introduce autonomy, but to benefit the people, and not to pull out of public welfare.

5.5.5. Contents

5.5.5.1. Policy and its level

The respondents are divided on the question of where did the initiative figure in the government's reform agenda? The majority view is that it was a part of the government's larger agenda. This assumption is supported by the political manifesto of the party in power, which lays down autonomy as a tool for decentralisation (PML, 1997: 22-24). And as earlier noted (5.2) decentralisation was a key objective of a country-wide social sector programme – the SAP. A rival explanation by a donor representative is that by this initiative "only certain components of the (health) sector were being addressed, leaving other sectors in the dark ages of

management". That is, the reform was a piecemeal effort. However, this is considered an extreme view of the situation. The position, as an expatriate consultant noted, was that health led the process, while reforms were underway throughout the government – education, transport etc. A senior technocrat supported this argument by saying that "hospital autonomy steered the process through its results". Whereas this assumption might have substance, a question arises, why was such an impression created? Drawing from the comments of a professor in a medical college, this was because the initiative was not adequately documented and discussed with stakeholders, and also a consultant working in the Health Sector Reform Unit (HSRU) agreed with this inference. Otherwise, it is argued that granting autonomy to the institutions was a comprehensive reform, part of the larger agenda of the government.

5.5.5.2. Communication strategy

No formal communication strategy was drawn up to consult and involve the stakeholders or for public dissemination of the initiative. On this conclusion, there is a consensus amongst respondents. But, a medical superintendent differed. According to him, several seminars and meetings were held to explain and foster support. However, this was not an effective method, as according to a secretariat staff member, "even people in the secretariat (the hub of policymaking) ... did not know what was happening". Similarly, at the institutional level, one chief executive noted, "there was nothing written – this was left to us how we talk to the people". Generally, therefore, as a bureaucrat noted, "...no focused effort was made to take the people (stakeholders) along".

5.5.5.3. Monitoring and evaluation

Although the law required setting up of a monitoring and evaluation system for the initiative, this was not done. In order to monitor the reform process, the law provides undertaking a quarterly TPE of the autonomous institutions (GoPb, 1998d). However, a review of the document indicates that it was done only once (Anjum, Asim Shahid and Co, Lahore, 1999), and then the chief executives themselves reported on their own performance[27]. The validity of these reports was also questioned (Dawn, 1999), as the improvements claimed did not match reality. Further, the whole concept of TPE was challenged. The governor observed how an institution can be evaluated without a legal framework, i.e. the monitoring and evaluation, which was contingent on rules, was void in their absence.

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[27] Personally known to this researcher

5.5.5.4. Resources

Although certain alternative sources for financing the autonomous institutions were made, due to the poor utilisation mechanisms, these could not be utilised. Contrarily, a bureaucrat noted that the Finance Department actually froze the allocation for the institutions at pre-autonomy level, instead of increasing it, as envisaged (GoPb, 1997r). However, they were allowed to open accounts in the commercial banks, thus saving them from surrendering any unspent amount. Also to raise funds, user charges were levied for different services. But, according to a senior audit officer, to use these resources, every institution interpreted its powers differently, because rules were not framed. Thus, he added, there were mountains of audit objections.

Similarly, inadequate arrangements were made to build the capacity of autonomous institutions for managing the change needed for instituting reform. Two major inputs were made. Firstly a finance director was appointed in the institutions. Secondly, a ten days' course was arranged for the chief executives. However, its contents were questioned, given that the new system and the legal framework were absent.

5.5.5.5. Management systems

One chief executive reported that the outcome of the designing phase or contents of policy was an Act of the Provincial Assembly and a Contract document. Nothing was done for their translation into Rules and Regulations. These instruments form the basis for the management systems of an organisation. This deficiency was serious, and the governor observed, "...As I see it, the autonomy has been far from provided. We seem to have freed these institutions from the normal government controls: law, rules and procedures, but we were unable to provide the new charter or an alternate legal framework..." (GoPb, 2000) However, one respondent commented, "in the absence of rules, the institutions in the public service cannot be stopped from working". But, this was an effort to mask the deficiency. That is rather than following such beleaguered examples, why were the essential preparations not made? In the view of a bureaucrat, "you should have done something beforehand, declaring the institutions (in such situation) as autonomous, was not the right way".

Interim financial rules were framed thirty-two months after the first institution was granted autonomy. These rules provide chief executives full financial powers to be exercised through IMCs (GoPb, 2000a). However, given that in many institutions these bodies were not operative, the application of these rules was doubtful. Driven by such complications, the new governor ordered that until rules are framed, the powers as ordinarily applicable should be exercised by the chief executives (GoPb,

2000b). Thus, although certain measures were taken to provide resources to the institutions, poor mechanisms marred utilisation of these funds.

5.5.6. Implementation

5.5.6.1. Political feasibility

It was a politically feasible time for introducing reform. The initiative figured on the political agenda of the government and the chief minister pushed it. According to a chief executive, he was powerful and a "go-getter". Another factor, a bureaucrat remarked, was that he wanted to score points on the political front in order to alleviate the impression that he was there in power due to his brother, who was the prime minister of Pakistan. Nevertheless, respondents' unanimous view was that it was a politically feasible time for introducing reform.

5.5.6.2. Technical feasibility

No field-test was conducted in order to determine the operability of reform, before its full-scale launching. A chief executive, at the core of the policy process for the initiative, told this researcher that pre-testing was not required, because the initiative had been tried all over the world and the government was not re-inventing the wheel. However, documents suggest that autonomy to different institutions was granted in phases, and this might have been a mechanism for learning from the preceding phases. But, an official of a donor agency, not agreeing with this assumption, commented that "in government, lessons are not learnt from a preceding stage or phase of an intervention". Thus, it is concluded that policymakers did not pre-test the initiative and no mechanism was evolved to learn lessons emerging from the earlier phases of the initiative.

5.5.6.3. Organisational support

The organisational support for the initiative changed over time, and the structures brought in place for the purpose were inappropriate. The perusal of records indicates that initially the policy process was based in the health secretariat, where the technical wing played a key role in conceptualising and designing the initiative. The administration wing, with support from the executive director of Special Projects, implemented the reform. Later, a HSRU established in Special Projects supported the initiative, but after the project closed this responsibility was taken over by the health secretariat. This arrangement led to the following complications:

- This researcher had a problem in locating the records of the initiative as it was dispersed in different sections. Further, because the people also changed, it was

difficult to establish the ownership of the initiative. For example, the concerned file kept shuttling for about six weeks till the administration wing owned and took over the subject for developing the details of the initiative (GoPb, 1999c).

- Locating the policy process in the secretariat was challenged. A chief executive questioned how an organisation, which itself was under reform, could implement and also monitor and steer the process. There were other institutions that could undertake this exercise. For example, a medical superintendent identified the PHDC, which could support the reform.

- Since the government, in addition to its regulatory function, took over the role of operator, there was no one to question them, and none to answer for the shortcomings left in the initiative. The concept that started in February 1997 went into the design phase, lasting for sixteen months, till the law was promulgated (May 1998). After another six weeks (July 1998) the first batch of institutions received autonomy. Then, forty-three months later, the rules and regulations for the new system were framed in January 2002.

Who is to be blamed for the delay, one might ask, had the assignment been with a subordinate organisation, would the bureaucracy in the secretariat have tolerated such a situation? Obviously not!

The execution, in general, as the minister for health described, was mayhem. As one hospital manager reported, this was mainly because no roadmap or action plan for undertaking different formalities essential for implementing the initiative was provided. Secondly, as a professor noted and a consultant working in the HSRU seconded, the initiative was inadequately documented. Therefore, utter confusion and disorder prevailed. In this regard, different arguments are as follows:

- For the Children`s Hospital and Institute of Child Health, Lahore, the decision to grant autonomy was made (GoPb, 1999d), but no order was issued. Therefore the institute was still struggling for autonomy[28]. Similarly, in the case of De Montmorency College of Dentistry and Dental Hospital, Lahore, an order to grant autonomy was made, but the chief executive was not appointed, and thus the institution did not obtain autonomy.

- Much more confusion prevailed in constituting the IMCs. In many cases, the chief executives were late in proposing the constituent members, and for the other six institutions, the governor refused to approve the IMCs (GoPb, 2000c). He did not agree with the way the non-official members were proposed.

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[28] Personal communication of this researcher with a Finance Officer of an autonomous institute

- The law requires the government to frame rules and the IMCs to lay down regulations. However, since rules were not framed, different institutions had their own administrative and financial routines, one respondent commented. There was no universality and according to a staff member, confusion prevailed, both in the secretariat as well as in the institutions.

5.5.7. Process

5.5.7.1. Conceptualisation

The initiative was in the political manifesto, but the bureaucracy brought it to the agenda and the chief minister pushed it for implementation. According to a senior technocrat, to identify issues was the responsibility of health sector managers. But they had no structured way of doing so, because the self-perpetuating monitoring mechanism, which throws out issues, has not been in place. However, one DHS, while supporting this notion, took a different view that "it is seldom, almost unknown, that we recognise a problem by ourselves".

The secretary health in his letter of 14 February 1997 asked a principal of a medical college about the feasibility of granting autonomy to the medical colleges (5.5.1.2). The question arises, why did he do so? The new government came into office on 17 February 1997, so there was no obvious political pressure or instructions. The most likely explanation came from a senior technocrat; "I think you know the style and culture of the Pakistani bureaucracy, when they see their boss growing a beard, so they do. If he is clean shaven, they do too. It is the image of the person in the chair, they follow". The new chief minister had been named and the bureaucracy knew his style of work from the previous tenure (1990-1993) of his brother as prime minister. The secretary health judged that the chief minister would espouse this, so he came up with this idea.

5.5.7.2. Designing the initiative

People at the helm of affairs made the decision to grant autonomy in a manner that the design remained incomplete and unsatisfactory for the end-users. These few undertook this exercise, in addition to their routine work. There is no evidence that an in-depth study of the issues was undertaken. Instead, a surgeon noted, "the selected individuals did the opinion-based analysis". In other words, these people had their opinion on issues, which they exchanged. This was because, one chief executive acknowledged, "in this area (of policy research) we lacked". Similarly, respondents are unanimous that there was no projection made as to what would happen if the issues were not addressed. The researcher did not come across any

document indicating the undertaking of this exercise. The policymakers instead relied on their instinct that if no remedial measure was taken, the situation might deteriorate to the extent of total collapse, one task manager told this researcher.

There was no exercise done to formally set the priorities and objectives, one aid worker told this researcher. Criticising the planning process for this initiative, one medical superintendent told this researcher "they (bureaucracy) did not consider the vision, mission and tasks". Also no option appraisal was done, a top decision-maker acknowledged. In fact, as a consultant noted, "a decision to give autonomy was made and then it was done". And one can argue that in planning the policy for autonomy the salient ingredients of good planning were missed.

5.5.7.3. Stakeholder involvement

The policy process for 'autonomy' was undertaken by a few people. A senior planner explained that the process had both technical and legal aspects. According to him, the former was done by a group of 3-4 people in the Health Department. The later, i.e. legal part, a hospital manager told this researcher, was done by a retired Judge. Apparently, therefore, consultation was not intense and broad-based. But, there is a rival explanation to this generalisation. One consultant told this researcher that the methodology was that major issues were extensively discussed first with key stakeholders, and then meetings and question and answer sessions were held with the staff and the general public. Was this an effective method, one may question? In the bureaucratic milieu of the Punjab, as will be noted (5.6.7.3) no junior staff objects to the decisions made at a senior level. That is, the process was dictatorial.

5.5.8. Summary and conclusion

The government of the Punjab visualised the granting of autonomy to the medical and health institutions in the province. The proposal went through different stages of development. Conceptualised initially as 'autonomy to medical colleges', this changed to the 'role model hospital and institutions' and was finally shaped as 'autonomy to medical and health institutions'. A law was promulgated to provide a legal framework for the initiative and in total nine medical colleges and sixteen tertiary care hospitals were declared autonomous.

The chief executives for these autonomous institutions were recruited on higher salaries. While, various sections of the health sector resisted the initiative, the government did not provide a new charter or legal framework to the autonomous institutions. The new governor, concerned by the voids left in the initiative, restrained the chief executives from exercising authority until the rules of business

for the autonomous institutions were framed. However, for this exercise to be accomplished, he relied on the same bureaucracy, which took forty-three months after the first institution was given autonomy in July 1998.

In conclusion, although on the political agenda, the bureaucracy involved few stakeholders in the conceptualisation, formulation and implementation of initiative. And, in this process, they hardly paid any heed to the advice or concern of the few on board. From the word 'go' it was not clear 'why' the institutions were being made autonomous. But, due to the civil services milieu of Punjab, the problems associated with the initiative remained suppressed. However, with the change of government, such voids came into the limelight as the governor of Punjab observed:

> *the more I look at the record of this initiative, the more I marvel at the complications. I feel quite lost in the maze created by the Health Department... Let me say in conclusion that I fully support autonomy and decentralisation of authority at every appropriate level. But, this must be done properly, after due observance of forms and procedures and in a lawful manner. That is the only professional way, I know of doing things.... I regret to say that this is not the way of going about it.*

5.6. District Health Government – a case of miscarriage of reform in gestation

5.6.1. Account of the initiative

5.6.1.1. Emergence of the concept

It was mentioned (5.4.1.3) that DFID organised a study tour to the UK for the participants to learn from the experiences of DHAs in that country. However, upon arrival back, a dialogue began in the Health Department to establish a new structure for the district health system[29]. The chief minister, who was given feedback on the study tour, asked the secretary health to prepare a proposal about the district health care structure (GoPb, 1998p). The proposal indicated some positive changes in service delivery by autonomous institutions, but reported that not much progress was made by DHAs in the districts. This argued for establishing a small management unit like DHG in the district, recommending that unlike DHAs, the new body should be chaired by a paid and full-time chairperson, vested with full financial and administrative powers under a legal authority (British Council Coordinator, 1998).

The secretary health briefed different stakeholders including the minister for health, the chief secretary and the secretaries of the Departments of Population Welfare and Finance about the concept of DHG (GoPb, 1998q), before presenting it to the chief minister. Later, a committee headed by the minister for health with its membership with wide ranging expertise was constituted to examine the proposal (GoPb, 1998r). This committee, agreeing with the concept, suggested the composition of a District Management Committee (DMC) for DHGs, and holding a public seminar to disseminate the concept (GoPb, 1998s). In this seminar, chaired by the chief minister and attended by experts, a concept paper on DHG developed by the executive director was discussed. However, according to many respondents, its contents were approved without taking into account participants' recommendations, as none of these were incorporated into the final draft (Collins *et al*, 2002).

5.6.1.2. Legal framework

The case study on 'Institutional Autonomy' elaborated the manner in which the 'Punjab Medical and Health Institutions Act, 1998' was promulgated (5.5.1.5). Suffice to say here that section 2; clause 1(a)[30] of this law empowers the government to establish a health institution – the DHG for a district, in this case. There is no

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[29] Personal knowledge of this researcher

[30] This clause reads: "establish such Medical Institutions and Health Institutions, as it may deem fit"

explicit definition in the law for the term 'medical institutions'. This shortcoming in the earlier draft of the law was indicated by the governor, but was carried over without rectification in the final Act (GoPb, 1998i; GoPb, 1998d). Nonetheless, the Punjab Medical and Health Institutions Rules, 1999 define the District Health Government as "health institution whose administration and management vests in its DMC, which exercises all powers and does all acts and things that may be exercised or done by the DHG" (GoPb, 1999e).

5.6.1.3. Implementation and fate of the initiative

The chief minister approved the person specifications for the position of the chief executives and the composition of selection committee and the DMC (GoPb, 1999f). Then, the process was undertaken to recruit and select chief executives, establish a support organisation, develop the profile of the health system in ten districts, and accomplish formalities to establish DHG. In this vein finally the Health Department, in consultation with Law Department, prepared the Punjab Health Institutions Rules, 1999 (GoPb, 1999e) and notified the name of districts for establishing DHGs (GoPb, 1999g). Later, a month-long induction course was organised for chief executives. This focused on health management issues, emphasising practical learning tools for operational and developmental management in the organisational context of DHG. However, the Army, which had taken over the country on 12 October 1999, suspended the process for the DHG initiative. Finally, although a 'Social Empowerment Task Force' constituted by the new government advocated for the implementation of DHG (Ahsan, 2000), it was decided to abandon the initiative and instead create the devolved district governments (see 1.3.2).

5.6.2. Principles and purposes

In the case of the DHG, the principles and purposes were clear. The respondents are unanimous that the DHG was launched in order to introduce change in the district health system. However, there are only a few who were sure about the direction of change and the clarity of motives, so therefore contrasting views were obtained. One respondent indicated that the political or ideological motivations are not mutually exclusive, and it is often difficult to differentiate between the two. However, the majority viewed the DHG initiative as an ideological intervention which they thought was carried forward with political support. Nonetheless, the DHG was introduced departing from the DHA initiative which was in the political agenda of the then government in power (PML, 1997).

But, what were the ideology and principles being followed? The concept paper for the DHG contemplates giving a corporate status to the health system, emphasising

the introduction of cross subsidy for protecting poor and improving quality. Similarly, a project officer asserted that, "otherwise equity, quality or other such matters were of secondary nature... It was primarily to improve the efficiency of the health system..." But, if this argument is accepted, then it was also essential to work out the details (Collins and Omar, 1999). However, there is no evidence that this was done. Even gaps left in the concept paper remained, i.e. the bureaucracy, failing to translate political rhetoric into action, poor documentation and dissemination of the initiative, substantiated this assumption. Thus, the principles and purposes of reform were though laid down, remained unclear amongst the stakeholders.

5.6.3. Shapers

5.6.3.1. Leader

The then secretary health led the reform, but left many issues unresolved. He played a key role in conceptualising, formulating and implementing the initiative. Reporting on his personal traits, many respondents found him intelligent, a thinker and a good manager, but someone who had little knowledge of the health system. According to a senior technocrat, he was not pragmatic, instead he worked on an *ad-hoc* basis, and thus could not make any impressive contribution to the Health Department. In the view of several respondents, this was due to those few aides around him who did not have the 'vision and experience' of the district health system.

5.6.3.2. Supporter

The chief minister was a force behind the initiative, but could not take the initiative to its execution. But, given the amount of time he allocated and the priority he gave it, he was dedicated to the initiative. Further, as indicated earlier (5.4.3.2) he was energetic, pushing, and a "go-getter". Then, the question arises, why could the initiative not be executed? This was because he was caught in the bureaucratic traps. That is, one chairperson of a DHA noted that he was misguided, as he relied for change to the system on those from within the same system, who were responsible for the problems. And according to a bureaucrat, he allowed different groups who were opposed to each other to negatively influence the policy process (see 5.6.3.3).

5.6.3.3. Bureaucracy

Bureaucracy, as an institution, was against the initiative. The minister for health told this researcher that "they were upset in this process due merely to selfish reasons. They had personal interests that their role was going to be limited in case the reforms take full shape". However, several respondents considered that the secretary

health, from amongst civil bureaucrats, was committed to the reform. The others, both from within and outside the Health Department, were against the initiative. But, one bureaucrat classified the bureaucracy into three groups - one against, the other in favour and the third wanted granting limited autonomy. These groups were non-resilient in their approach and negatively influenced the policy process. Regarding technocrats, the respondents were unanimous in their opinion that those in the secretariat, being subordinates, just carried out the orders of the secretary health, while those in the directorate and field formations were against, because they felt that they would lose their powers.

5.6.3.4. Donors

Amongst donors, it was mainly the World Bank and DFID that supported the initiative. The former supported in principle and looked for funding government's need for technical assistance (World Bank, 1998a: 5/para-21). DFID, after some reluctance, gave up its pursuit of an already underway programme of supporting the DHA initiative to favour this one (Wildman, 1999). The inputs included establishing HSRU, diverting the technical team from DHA to work for DHG (Wildman, 1999b) and appointment of an advisor to guide the government on health sector reforms (DFID, 1999). However, given the final fate of their support, especially for HSRU, one may question the effectiveness of donor assistance. Establishing this new unit was later condemned by the P&D Department, because it undermined the existing institutions. Further, how would the inputs made into the DHA initiative is accounted for? One donor representative, justifying the assistance in this manner, emphasised, that because a donor agency could not work in a vacuum they were bound to go with the decisions of the government. However, according to a senior planner it was a route with least resistance, i.e. a laid back approach.

5.6.3.5. Media

The media was not proactive, and the key stakeholders made no effort to generate a dialogue to keep the issue alive on the government's agenda. A review of document reveals its minimal use limited to few press briefings, and covering certain seminars and interviews. Also those were rhetoric and held to defend the initiative, and as a respondent noted "to issue strong political statements". However, as a top bureaucrat reported, it was not easy for the government to put across their viewpoint because the opponents took on the government on issues like privatisation and equity consequent to establishing DHGs. Further, in his view, the opposition had more influence on the media than the government. However, the media did not act on its

own also. This researcher could not locate any investigative or analytical report produced by the media.

5.6.3.6. Civil society

The PMA was outspoken. Though not against decentralisation, they resisted the DHG initiative. The major concern was the way the initiative was being developed. They thought that bureaucracy was mishandling the initiative, arguing that not enough preparations had been made, which in their view were essential before embarking on such interventions. Also, they were critical of the disregard of merit in the selection of chief executives (Nawa-i-Waqt, 1999a), or perhaps, their members were not selected. However, documentary evidence favours the former, e.g. in a meeting with director general military services, it was decided:

> ...many eligible retired army personnel have not applied for the position of chief executives of DHG... It was suggested that the GoPb might like to re-advertise such positions so that eligible personnel of army medical corps could also compete with a view to receiving quality managers from a wider group including army as well as the private and public sector... *(GoPb, 1999h)*

This researcher could not find any other section of civil society contributing to the policy process. This was perhaps because the initiative was not executed, therefore other stakeholders were not directly exposed to it.

5.6.4. Context

The health system was on the brink of collapse and needed some radical intervention. The factors, which led to such a situation, were varied and embedded in the different components of the health system, and are analysed below:

- The respondents indicated a plethora of factors perennial in the different components of the district health sector that formed *a priori* reason for establishing DHG. These ranged from poor service delivery, especially in rural areas to the governance issues like inadequate financial and administrative authority at different organisational levels. Inefficient support services and insufficient resources further contributed to the deterioration of the health sector.
- Opinions vary as to whether the situation was critical warranting emergency measures or it was business as usual. The chief minister argued, "the system, in terms of performance, had gone to its lowest ebb. Any intervention would, at least, improve it and not worsen it further". A senior technocrat also had a similar view that "It was quite late. We should have gone for such an initiative much earlier. We had wasted a lot of time".

- A senior planner argued that the earlier intervention – establishing of DHAs in two districts – could not deliver the desired results. And, in his view, DHG was an improvement or a reaction to the failing DHA intervention. However, since there is no evidence suggesting evaluation of DHAs to draw such a conclusion, this is not a well-founded argument. At best, it was a subjective feeling of decision-makers that led to abandoning the DHA to embark on DHG.
- Developments in the health systems around the world also acted as a trigger. A study tour to the UK was a catalyst, as a DFID advisor commented:

> *the decision to adopt a DHG form of organisation and move away from the DHA model appeared to be most influenced by the perception gained through a study tour to the UK in July 1998... In particular, there was recognition that chief executives could be appointed as full-time professional managers to lead the required organisational changes at PHC focused district level...*

Therefore, there are grounds to conclude that the Punjab health sector was in disarray needing urgent intervention and decision-makers jumped to the initiatives in rapid succession without waiting for the outcome and evaluation of the earlier ones.

5.6.5. Contents

5.6.5.1. Policy and its level

There is wide-ranging and contrasting response of respondents about the nature of the initiative. According to many, because the initiative was launched under a country-wide cross-sectoral SAP, the DHG was the government's instrument for decentralisation in the health sector. And, so the initiative was part of the government's larger agenda. A rival explanation by a senior planner is that although a number of interventions were being undertaken in the health sector, the DHG was one of the several pieces that were started simultaneously, but independently. Taking this logic forward, a senior officer commented that because the initiative did not focus on the system in its entirety, hence it was a patchwork. However, a consultant maintained that DHG was part of the government's agenda for decentralisation, but it appeared an isolated effort, because of inadequate documentation by the Health Department (see 5.6.5.2).

5.6.5.2. Communication strategy

Weak support systems were developed. Especially, the communication strategy was not defined for the initiative. A top bureaucrat acknowledged "we did not have a sort of clear communication strategy. It was the weakness that we had identified

ourselves... We should have a better communication strategy". This researcher observed two factors contributing to this outcome:

- There was poor documentation and weak institutional memory. Although there were numerous transparencies indicating that seminars and presentations were held, but when it came to a comprehensive document, apart from (i) a 'concept paper' (GoPb, 1998u), (ii) a 'working paper on HSRO (EDSP, 1999), and (iii) a commentary on the first two by the Nuffield Institute for Health, University of Leeds (Collins and Omar, 1999), there was none.
- Only a few people did all the documentation, which was not disseminated. Confirming this, a task manager in the HSRU commented:

> *Seminars were held to give the stakeholders a clear picture of the DHG. However, this could not be done adequately. A concept paper was also produced, but again, this could not be disseminated to a larger section of the stakeholders.*

Thus, concluding the argument, a senior planner commented that a traditional mode of communication was used and no comprehensive strategy for the DHG initiative was devised to consult the stakeholders.

5.6.5.3. Monitoring and evaluation

The monitoring and evaluation system, specific to the initiative, was not installed and the existing one, according to a technocrat, was inefficient. There is no evidence, except the indicators developed as part of a baseline survey conducted in ten DHG districts, that a system was devised to monitor the progress of the initiative. One request made to DFID by the government, in this regard, was not acceded to (DFID, 1999a). Further, a question arises; what was to be monitored? There were no systems and implementation plans. Although this researcher knows that an effort was made to develop one during the induction course for the chief executives, there was no roadmap or action plan devised for the initiative.

5.6.5.4. Resources

Regarding capacity building of the new institutions to meet the challenge of change, the Army Medical Corps promised ongoing assistance (GoPb, 1999i), while DFID supported a month long induction course for the chief executives (Wildman, 1999a). This course was, however, criticised for its contents. A senior officer argued that the new system, where the participants were going to work, should have been the focus of training, which was not devised by that time. However, this researcher knows that the induction training was used as an opportunity to develop drafts like the service

level agreements, communication strategy, outline of the DHG regulations etc. Further, it was the first of a series and subsequent modules might have seen more developments (DFID, 1999b). Nevertheless, it was argued that "You see, even the Constitutions are amenable to change. There should have been something to guide the institutions, which could have been further built on". Thus in the absence of rules the induction training remained unfocused.

No additional resources were arranged and also no planning done to support the decentralised districts under the DHG initiative. Although the government recognised that decentralisation poses additional constraints on resources including finances (GoPb, 1997r), while drawing up the concept paper, this aspect of the policy process was not taken into account. It visualised the districts receiving the same budget irrespective of their geographical size, population and economy.

5.6.5.5. Management systems

No management systems were designed. The DHG derived its authority from 'the Punjab Medical and Health Institutions Act, 1998'. This law provides broad policy guidelines, whereas according to a senior planner, delegated legislation was needed at the operational level. Under Section 13 of the Act, the government was to formulate 'Rules', while Section 14 demands the DMC to draw 'Regulations' consistent with the 'Rules'[31]. Next in the legal hierarchy are the 'Manuals' that provide operating procedures for different situations. However, except for the rudimentary "Punjab Medical and Health Institutions Rules, 1999", there was nothing. But, defending these shortcomings, a top bureaucrat contested:

> *We did not make rules deliberately. The idea behind was that... By making rules you are actually going into the micro-management. Then you are publicly committing what would be the outcome – which you don't know. First, let the things run as they are, learn from these and then frame the rules, which are practical, realistic and are also in line with the overall spirit of that legislation.*

The proponents of this approach cite several examples where the Acts have been promulgated, but even after years the rules and regulations have not been framed. They propound that the 'Punjab Medical and Health Institutions Act, 1998' provides an adequate boundary for the institution to operate. The opponents, however, are not content with this assumption. They hold that the danger in this approach is that

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[31] These Sections of the referred Act reads: "13- Rules: - The government may make rules for carrying out the purposes of this Act. 14 – Regulations: - The Management Committee may make Regulations, not inconsistent with the provisions of this Act and the Rules, for carrying out the purposes of this Act".

either the districts will adopt restrictive rules limiting their ability to make any change or they will be too loose, causing problems with audit and accountability. Further, different districts might adopt different systems leading to problems like failure to establish a universal monitoring & evaluation system etc (Griffith, 1999).

5.6.6. Implementation

An official notification declaring ten districts for establishing DHG was made (GoPb, 1999e). This researcher could not access the appointment orders for the chief executives, but nevertheless, they attended an induction course, thus assuming their duty. However, as they did not go to the districts, no DMC was established. So the implementation of the DHG initiative remained incomplete. But the following characteristics of the implementation phase of the policy process are identified:

5.6.6.1. Political feasibility

It was a politically feasible time for the DHG initiative till its execution, when the government changed. All participants agree that the chief minister supported the initiative and was proactive. He, being in full control of the political scenario in the province, organised support from other departments of the government, as well. And commenting on the dynamism, an expatriate consultant noted that the Punjab was undertaking "the most ambitious health sector reform programme anywhere in the world, which enjoyed full political commitment" (Wildman, 1999).

5.6.6.2. Technical feasibility

The intention was to launch the initiative in ten districts in order to learn and finalise strategies for implementation in the other districts, but this was not implemented and was finally abandoned by the new government. The concept paper envisaged to "establish DHGs in a phased manner – initially it would be started in pilot districts from where strategies will be finalised for their implementation in other districts" (GoPb, 1998u). Since, it was planned for ten districts, given the population – 34 districts in total – it would have been too big a pilot.

5.6.6.3. Organisational support

The policy process for the initiative was based in the health secretariat. Its technical wing was a key in developing the concept and design, while the administration wing came in later just to issue the appointment letters of the chief executives. The office of the executive director of Special Projects supported the initiative all along, initially through its PIU and later through a HSRU created with the support of DFID, as an interim arrangement before a larger Health Sector Reform Organisation

(HSRO) was established. Support was also negotiated with the Health Services Academy, Islamabad that was tied to a project, which did not materialise (GoPb, 1998t). These arrangements were however inappropriate – an inference drawn from the following evidences:

- The government in secretariat, in addition to its routine functions, undertook the policy process for the initiative. Whereas this may appear a high-profile arrangement, it was criticised on several grounds (see 5.5.6.3). In the view of a politician, instead a dedicated structure like a 'standing task force' should have undertaken the process, while the secretariat should have only regulated it.
- Establishing the HSRU or HSRO to support the DHG also attracted criticism. A working paper contemplating an HSRO in the Special Projects using three different approaches was examined at the Nuffield Institute for Health, Leeds (UK). In their final comment, it was stressed that the choice of approach should rest on an organisational study (Collins and Omar, 1999), which was never done.
- A planning document for establishing the HSRO submitted to the Federal and Provincial P&D Departments was so seriously criticised that the Health Department withdrew it. In their view, the Health Department should focus on developing the capacity in the existing institutions instead of building new structures (GoPb, 1999j).

However, in disregard of the above advice, HSRU was established in the PIU of Special Projects. The question arises, why was this duplication (in the shape of a HSRO) envisaged, while institutions like PHDC, Institute of Public Health or Planning Cell in the secretariat could have supported the initiative? Was it the strong personality and authoritarian director of PHDC and the resultant alienation to this institute (Abbot *et al*, 1999: 1) or an instrument for extending the life of the PIU of Special Projects or the actualisation of an old desire of its executive director? Given that this aspect of enquiry involves personalities, consideration should be given to a document, which the incumbent executive director wrote to the chief minister even before he took over this position and was not part of the reform process. This reads:

> ...It is proposed that a Professional Support Management Group may be formulated with professionals from related fields like project management, finance, procurement, engineering, monitoring and evaluation, human resource development and so on. The services of such persons can be acquired from government departments on deputation wherever available. However, these professionals can also be hired from the private ... (Mian, 1997)

The HSRU, established in the Special Projects, had consultants on its payroll, drawn both from the public as well as private sector (EDSP, 1999a). Further, the HSRU

was not focused in its approach. This unit had a range of activities and accordingly several units. Whereas this structure fulfilled the old desire of the executive director, review of documents suggests that this arrangement resulted in diffusing the efforts and no major gain was made in terms of health sector reforms (HSRU, 1999). Ultimately, the HSRU collapsed when DFID suspended its assistance in October 1999. It was otherwise non-sustainable, because it was based in a project of limited duration and entirely dependent on the donor's assistance.

5.6.7. Process

5.6.7.1. Conceptualisation

Documents suggest that the secretary health identified issues in the health system, and that DHAs were ineffective in addressing these. However, it was the chief minister who decided to act and initiate the process for the DHG initiative. According to a respondent, who was part of the decision-making circle, he did so despite resistance from many stakeholders. But, a question arises why was this done? According to a respondent, the chief minister belonged to a family that was successfully running medical institutions. And the steps he took are mostly explained by the notion that the private sector was doing much better than the public sector. Since, the DHG initiative was propounded as a corporate model, so the chief minister jumped at the idea, one may infer. But, why did the secretary health go for this development, allowing his earlier concept, i.e. the DHA, to perish? It was noted (5.6.1.1) that the UK study tour triggered this, but defending his action, the secretary health told this researcher, it was because the required changes in the system were not possible within the scope of DHAs, so the DHG initiative was instituted. However, this is not accepted as the basis for switching over from DHAs to DHG as a donor noted "if the principle was to devolve powers, then whether DHA or DHG, there should not have been much difference".

5.6.7.2. Designing the initiative

No systematic in-depth study was made to validate the situation and to establish a need for the DHG initiative. Instead, one respondent noted that reliance was on the brainstorming sessions, which another respondent dubbed as superficial intellectual discourse, and the literature review. Further, a top bureaucrat said that "in our system the statistics are not well kept, so we had not launched any study". Supporting this argument, another respondent, close to the decision-makers, said "everybody knew that the system was not working, so conducting a study would have added little to whatever we already know. So instead of wasting time, we decided to go ahead".

There is no evidence that a projection was made to determine the consequences of ignoring the issues. If, at all, as one consultant commented, this was limited to voicing concern that if remedial measures were not instituted the situation might deteriorate to the extent of a total collapse of the healthcare delivery system. Regarding laying down the objective(s) and priorities of DHG, a survey of documents suggests little difference between the aim of the DHG and that of its predecessor DHA initiative. Similarly, there is no evidence that any option appraisal was done for addressing the objectives. To conclude, according to a senior officer, the decision-makers were actually "predetermined just for this initiative and they were only gathering arguments in its favour; no other intervention was considered as an alternative approach to solve the problems".

5.6.7.3. Stakeholder involvement

Only a handful of people undertook the reform process. According to a top bureaucrat, a team of four people, who were identified by a senior technocrat as the chief minister, secretary health, additional secretary (technical) and the executive director of Special Projects were involved. Criticising this team, a senior technocrat said that "there should have been at least twenty persons sitting around debating and using their collective wisdom would have come to a better conclusion". But, a rival explanation by a consultant is that "the process was done at two levels. In preparing the vision and legislation extensive discussions were held with the stakeholders and once decisions were reached, meetings were held with the staff to explain them". Refuting this claim, however, a senior officer noted that in this manner decisions are only conveyed, because in the bureaucratic milieu of Punjab, it is often dangerous for subordinates to disagree with their boss or a senior, especially in the open.

An almost similar situation prevailed in the political bureaucracy. In the Punjab Assembly, while debating the Punjab Medical and Health Institutions Act, 1998, only the leader of the opposition, in addition to the ministers for Law and Health, spoke at the occasion (GoPb, 1998k). The non-involvement of lawmakers, which is evident, resulted in serious flaws being left in the law. One respondent noted that "If you show it to an experienced politician, he would be terrified. All powers of government are transferred to the district. All government controls have been let loose and the Assembly passed it in only a few minutes". Confirming this assumption, a politician told this researcher that during that session of the Provincial Assembly, he asked the minister for law whether due to the serious faults remaining in the law, its assent by the Assembly would be postponed. However, the minister for law expressed his inability to do so on account that the chief minister was pressing hard for the assent of the law.

5.6.8. Summary and conclusion

The government of Punjab undertook an initiative – the District Health Government, abandoning an already underway District Health Authority initiative. With the same aim as that of its predecessor "to improve and develop health services for the population residing in districts" the District Health Governments envisaged small management units at the district level created by decentralising the existing district health sector. Legal cover was provided to the initiative under the Punjab Medical and Health Institutions Act, 1998. After an exercise lasting over fifteen months, ten districts were declared as District Health Government districts. Also the chief executives for these 'health institutions' were selected through 'open competition'.

However, before the initiative could be implemented the government changed. The new government, instead of implementing the initiative, opted to devolve powers to establish district governments with their elected assemblies. The demise of the District Health Government initiative in this way is best summarised by a general secretary of the Pakistan Medical Association. He said:

> *"Thus, for a politically motivated idea, the bureaucratic stoppage was applied. That only delayed the process; otherwise, initiative could have been executed in the districts. ...But, nevertheless, in a modified form, the same idea is currently being introduced as devolution of power..."*

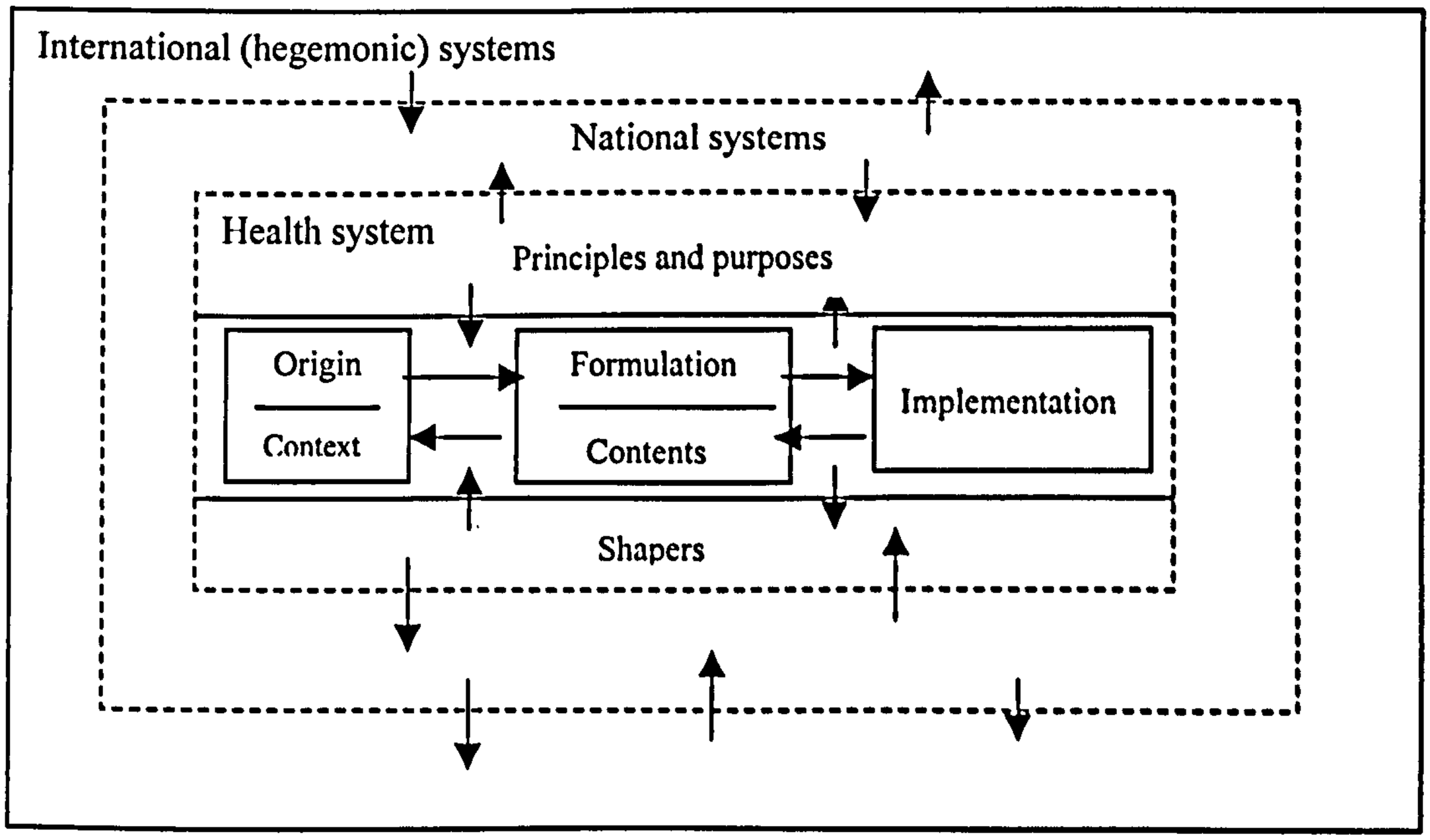
In short, this was a miscarriage of an initiative in gestation, to give way to the devolution of districts. However, how far the seeds sown by the District Health Government and its predecessors Sheikhupura Pilot Project and District Health Authorities had flowered in the new government's Local Government Plan, 2000 for devolution, is yet to be seen.

6. Factors influencing the policy process

6.1. Introduction

Chapter 5 presented the case studies or policy process for the four individual cases as a product of the first level of data analysis. Overall it was a story of demise and struggle for the survival of different reforms. Why did this happen? This is the core issue for this study, and this chapter addresses this question by discussing factors that influenced the policy process. These factors, essentially emanate from cross-case analysis, i.e. the second analytic layer of this study which uses the output of four single-case studies as input. For this purpose, the framework for the policy process developed and the questions raised in chapter 3 serve as a guide. However, in order to situate the discussion, the framework is reiterated below:

Figure 6.1:- Conceptual framework for the policy process



This chapter has seven sections and using the above framework, the first six, with slight variation, follow the same pattern for presentation. That is done by:

1. presenting the findings about a particular aspect of policy process, and then associated factors influencing the progress are hypothesised;

2. discussing the hypotheses, bringing explanations, both rival and supporting, from case data and contemporary literature; and
3. presenting a summary of the section, drawing the main factors influencing the policy process and concluding the arguments.

The final section lists different factors and provides a resumé of the policy process followed for designing the Punjab health sector reforms.

6.2. Laying down the principles and purposes

The principles and purposes constitute the greater 'why' and embody a set of values and direction for the reform (Frenk, 1995), thus providing a map or guide for the proposed system. However, in the Punjab, there was confusion. Why was it so? This section looks for the answer by exploring factors surrounding the laying down of principles and purposes for the health sector reforms.

6.2.1. Findings from case studies

In the case of the Punjab health sector, policymakers worked for the end product, i.e. granting autonomy to the institutions or establishing the DHAs. But why were they doing so? It was not clear to them. To investigate this assumption, an enquiry was made to explore the purposes and principles of the reforms. The underlying understanding and concern was that the system was not delivering services, both qualitatively and quantitatively. Nonetheless, the statement of purposes for the various reforms, deduced from the case studies, are clustered and presented in table 6.1.

Table 6.1:- Statements of purposes

	SPP	DHA	IA	DHG
Purposes	To create a viable model for the primary healthcare that ensured quality of services, which are accessible and, what is most important, sustainable.	To improve and develop health service for the population residing in the districts.	To bring efficiency and quality in terms of better availability and accessibility of health services	Equity, quality or other such matters were of secondary nature... It was primarily to improve the efficiency of the health system...

Table 6.1 provides a summary of the purposes drawn from the findings of the cases. It is seen that overall:

1. The purpose of reform initiatives was clear to the policymakers. It may be noted that purposes are the sub sets of principles and the findings of this study underpin those of Frenk's (1995), i.e. equity, quality and efficiency as the purposes for reform.

2. The stakeholders identified quality, efficiency and sustainability as the major concern for undertaking reforms. Further, it is noted that emphasis on this aspect of the policy process became increasingly more pronounced, and was clearly defined in the successive reforms.

However, what about the principles? These are the important tenets of policy, which are essential to be defined at the very outset of the process. Otherwise, it is argued that in their absence, confusion is likely to prevail about the vision and mission for the proposed system (Frenk, 1995). In the case of the Punjab, there was a similar picture. A respondent working for a donor agency, agreeing to this assumption, attributed this shortcoming to the policymakers lacking the understanding of the policy process. He commented:

> *I think there was an inadequate understanding of how things work. There was a simple belief that autonomy is the answer to all evils without thinking or listening to others that autonomy is a means to something and that something needs to be defined, and also to achieve that something you need to put other things in place. Simply, the whole thing stemmed from lack of understanding.*

Similarly, a Medical Superintendent of an autonomous hospital, supporting the above contention, noted that:

> *In this exercise they (policymakers) did not consider the vision, mission and tasks. In fact, those who were involved were not clear about issues and had little knowledge of the set up they were working to reform.*

This study revealed that the 'desire to introduce change' in the existing system was a common denominator of all health sector reforms. The intention, which is consistent with the aim of the umbrella SFHP, was to improve the health status of the population (5.2). However, why did they intend to change things or what were the underlying principles for different reform initiatives? Drawn from case studies (chapter 5) and following Frenk's (1995) classification (2.4.1.4), these principles are determined by this researcher as below:

> Given that the existing health sector is 'pluralist' (people are free to choose between different options in the public and private sector) and is based on 'citizenship' (access to healthcare is a social right – at least theoretically – see GoPb, 1974), all reform initiatives are intended to address these principles. But, a gradual move towards 'solidarity' [everyone contributes towards healthcare according to his/her capacity, so that each person may receive care when needed (Frenk, 1995)] is also noted. The IA and DHG visualise user charges for those who can afford to pay and a cross-subsidy for the poor. Similarly, the SPP envisaged, in a way, the principle of 'universality' as it intended to develop a model of primary health care that was accessible, affordable and sustainable.

The above is a statement of the implicit principles! However, what were the explicit motives behind the change, which the different reforms looked for? The messages emerging from different cases are summarised in table 6.2.

Table 6.2:- Statements of principles

	SPP	DHA	IA	DHG
Motives	The project was not politically motivated, and its principles were not clearly laid down in documents.	This initiative visualised politically driven change in the health system, but the principles remained unclear.	The initiative was on the political agenda of the government in power, but the principles remained unclear.	The principles and purposes were laid down, but remained unclear to the stakeholders.

From table 6.2, it is seen that:

Based on the political nature of initiatives, there are two groups: (i) DHA and IA, which were on the political agenda of political party in office, and (ii) SPP and DHG, which were not. However, for both these groups, principles remained unclear. But, there is a difference between initiatives in the second group. That is, for SPP, principles were not clearly documented and were also not known, while for the DHG, these were documented, but remained unclear to the stakeholders.

6.2.2. Factors influencing the laying down of principles and purposes

Drawing from the findings presented above, the following hypotheses surrounding the laying down of principles and purposes are conceived: (i) being on the political agenda did not ensure that the principles of reforms were defined; (ii) there is a tendency to consider more tenets of the policy process in the successive reforms; and (iii) the involvement of politicians in conceptualising of reforms is vital for laying down the principles. In the following, I test these hypotheses.

6.2.2.1. Political agenda and the principles

It is argued that in order for perfect implementation, there should be a complete and universal understanding of the objectives of reforms (Hogwood and Gunn, 1984). Otherwise, there is a danger that, in the public sector, there are beliefs about the aims and intentions of the department (e.g. Health Department), which would influence the problem definition and their possible solutions (Gordon *et al*, 1977). For example, according to Headey (n.d), a similar situation was observed in British policymaking:

> In the absence of contrary instructions from their political masters, officials normally frame policy programmes, which fit within the context of the existing objectives pursued in the department.

> Innovations and radical changes are not commonly the product of proposals generated within the civil service.

In the case of the Punjab health sector, the political government, while granting autonomy to the tertiary care medical institutions, wanted to install a mechanism of a safety net for the poor. That is, they emphasised the principle of 'solidarity' and during an interview with this researcher, the then chief minister insisted:

> *Maybe the Rules of Business are not framed, but I got through a Law in the Assembly. It is written there and I ensured that the charges for the poor would not be changed. We will charge the rich and the income so generated will be used for the benefit of the poor. It is explicitly written there. If you have a copy of the law, please read it. It is, however, inscribed in my memory.*

However, if one reads the above Law that was made to institute reforms, there is no mention of the 'poor' or any 'mechanism for protecting' them (GoPb, 1998a). But, why did it happen? The straightforward answer is that bureaucracy in the Punjab Health Department, which was responsible for undertaking the formalities needed for the promulgation of the Law, did not translate the political will into reality. This is because for the bureaucracy, it is always written instructions to which they feel themselves bound for following their routine (Blau and Meyer, 1971). In this case, as revealed from the document review, only verbal instructions were passed. Therefore, it is argued, the bureaucracy followed its own interpretation and accordingly defined the course of action.

The above explanation that bureaucracy influenced the political agenda, nonetheless, raises two questions: firstly, why did politicians fail to clearly define principles? The political manifesto of the government mentions the establishing of the DHAs and granting autonomy to the institutions. But, why did they want to launch the scheme; it was not explicit in terms of laying down its principles. For this shortcoming, an ex-minister for health explained:

> *This is because most of the time our (politicians') academy (assembly and/ parliament) remained closed. There were no elections, training and skill building of politicians. In fact, no one attempted to educate the politicians.*

The above observation by the minister for health also matches reality. In Pakistan, since independence in 1947, for more than half of the nations' life, it was the non-political forces that ran the country. During this period, there were no elections, no parliaments and the political process remained suspended. Further, due to the frequent interruption in the political process, the political executives changed rapidly. Therefore, political forces did not mature to be able to develop a robust political agenda with a sound ideological base.

Secondly, why did not the political executives efficiently follow the implementation of their political agenda – written or verbal? The answer to this, possibly an offshoot of the above argument, is that the chief minister and the minister for health both indulged themselves in deciding the street level issues – where the service providers are in direct contact with the service recipients. The former told this researcher about one such instance:

> *I visited the hospital in June (1997) to see that nothing had been repaired. We, therefore, held a meeting that lasted till 0100 hrs at night, and then it is a long story, but we got everything sorted and straightened in three months.*

When this researcher commented that if the chief minister had been involved in details he would be ignoring the monitoring of government business and work on policy level, he said:

> *I would work both in detail as well as at a philosophical level; the details, because in our culture it is like that... it is the action and not the dialogue that makes the difference. If the chief minister had meetings and talk philosophy but the government department does not act, what is the use of that?*

Similarly, the views of the minister for health on the issue were also not much different. For example, about the problems in a teaching hospital, he explained:

> *...We then started preparing the hospital to provide patient care. First of all we started operating on emergency cases. I shifted my office there and took meetings quite frequently... had I not been a Health Minister, maybe 'the hospital' was still non-operational.*

Peters (1978: 233) terms this phenomenon as 'non-administration', i.e. the politicians were doing something *ultra vires* that they should not have been doing. This does not mean, however, that it was beyond their legal powers. But, the inevitable reality of this "zooming in" is that at the end of the day, the higher stratum of work is neglected (Jaques, 1976). Thus, one of the consequences of the politicians being involved in a street level job was that the principles for reforms were not laid down.

6.2.2.2. Tendency of considering more tenets of the policy process in the successive reforms

Another fact indicated in table 6.2 is that for SPP the principles were not clearly documented and were also unknown to the stakeholders. However, for DHG, which was the latest reform introduced by the government, these were documented, but remained unclear to the stakeholders. Why did this happen? To explore the answer, it is noted (5.3.3.1; 5.3.3.2) that the SPP was both led and supported by technical

bureaucracy, while the DHG was a brainchild of the civil bureaucracy (5.6.3.1). In this exercise, technical bureaucracy worked with the civil bureaucrats to develop the concept, and politicians supported this initiative in designing and implementation (5.6.3.2). One may then conclude that it was due to the civil bureaucracy that the principles were clearly laid down for the DHG. However, this was not the case, because, if that was the case, then why did the policy process for the IA and DHA lack this attribute? In both these cases, the civil bureaucracy was also a partner in conceptualisation. Instead, it is argued that by the time DHG was conceptualised the bureaucracy had started learning and owning the concepts. A respondent from a donor agency commenting on the motivation for the reforms told this researcher:

> *For DHAs, the political or ideological motivation is rather irrelevant, because then there was no sense and belief in decentralisation of powers to the lower levels as far as the district health system is concerned. There was no commitment to the idea.*
>
> *However, for DHG, it was a different phenomenon. By the time the concept of DHG came in, there was commitment to the concept, because by then the Health Department certainly came to believe and own the principle. Otherwise there was not much difference between the two initiatives...*

However, the above explanation raises another question. That is, given the technical bureaucracy was behind the SPP, and as explained earlier (5.2), it had the ownership of the department – why then did it fail to conceptualise the principles? The answer lies in an explanation offered by a respondent working for a donor agency:

> *Another rationale (for the explicit motives of reform) could be that the Health Department learnt lessons through the successive initiatives and there also came more commitment, although designing was done with the assistance of the foreign consultants.*

The SPP, as informed by the document review and endorsed by many participants was the first project (initiated during 1993) of its kind whereby issues like decentralisation and community participation were being tested. On the other hand DHG was quite late in coming (in 1998), and by then bureaucracy had learnt lessons, in addition to owning the concept, as noted above.

6.2.2.3. Involvement of politicians in conceptualising reforms is vital in laying down the principles

The principles and purposes, being a set of values, indicate the political nature of the reform process, and it has been argued that they shape the perception of reality by the policy analysts (Parsons, 1995). Therefore, politicians are considered as key stakeholders and their involvement in conceptualising or the agenda setting stage of reforms is vital. Otherwise, it is likely that the principles will remain unclear. In the

Punjab, however, the politicians had little input into conceptualising the reforms leading to the principles not being clearly defined. This hypothesis is explored by finding 'by whom and how were the reform initiatives conceptualised, and the agenda set in the Punjab? Against different variables for this question, the findings of this study drawn from four case studies are clustered and presented in table 6.3.

Table 6.3:- Conceptualisation – a component of policy process for reforms

	Who identified the issue	How was the issue identified	Who brought the issue on agenda	How was the issue brought on agenda
SPP	Technocrat – the Executive Director of Special Projects	Technical and civil bureaucracy with donors in a hierarchical manner	Technocrats and civil bureaucrats working together in the hierarchy at planning forums	Technical and civil bureaucracy working with donors working in a hierarchy
DHA	Expatriate consultants and technocrats	Donors in consultation with bureaucracy	Politicians in executive position decided to establish DHAs	Politicians – it was on party manifesto that district health system is decentralised
IA	Civil bureaucracy	Civil bureaucracy in consultation with technocrats	Politicians in executive position decided to grant autonomy	Politicians – it was on party manifesto that tertiary care hospitals are given autonomy
DHG	Civil bureaucracy	Civil bureaucracy in consultation with technocrats	Politicians in executive position decided to establish DHGs	Politicians in order to decentralise the district health system

From table 6.3 it is seen that:

In the case of SPP the politicians were not part of the process. For the remainder, however, they joined the civil and technical bureaucracy in bringing the issue on the agenda. But, for the DHA and IA, it was on account of the intervention being in the political manifesto of the party in power, and, as noted above, this does not ensure that the principles of reforms will be defined. In this case scenario, the DHG is distinct. This initiative, despite not being in the manifesto, had political support, and also its principles were documented, but as noted in table 6.3, these remained unclear to the stakeholders.

Thus, given the above findings, overall the politicians were not fully on board for conceptualising the policy for reforms. This inference is drawn firstly by considering that if different cell in table 6.3 are taken as a unit of activity for conceptualisation I do not see much involvement of politicians. Secondly, the DHG initiative was not in their political manifesto, but they became involved, adding their ideology to the initiative. However, a question still remains, why the majority of stakeholders were ignorant about the principles for DHG. This was due to, as seen in table 6.3, the politicians not being involved in identifying the issues which were the cause of concern for different stakeholders. Therefore, they could not trumpet the issues and

the principles for the latter to know. Thus, it is inferred that the full participation of politicians in conceptualising reforms is vital for the laying down of principles.

6.2.3. Summary and conclusion

This section explored the factors that influenced the policy process in terms of the laying down of 'principles and purposes' for health sector reform. It was revealed that although the purposes were clear, the principles were not. This state of affairs led to confusion in the formulation and implementation of reforms in the Punjab health sector. The policymakers worked towards the end product, for example, autonomy; however, why they were doing so, was not clear to them.

To determine the reasons underlying this phenomenon, three hypotheses were formulated: (i) being on the political agenda did not ensure that the principles of reforms would be defined; (ii) there is a tendency for considering more tenets of the policy process in successive reforms; and (iii) the involvement of the politicians in the conceptualisation phase is vital for laying down the principles of reforms.

The above hypotheses were discussed and it is concluded that the principles, as a part of the policy process were not clear and this shortcoming led to confusion about the formulation and then implementation of reforms in the Punjab health sector. Further, although there was a tendency for considering more tenets of the policy process in successive reforms, the politicians joining earlier in conceptualising them facilitated the defining of the principles for the reforms.

6.3. Shapers of the policy process

In the previous section, it was revealed that the principles of reforms were not clear, because the politicians did not fully participate in the conceptualisation phase of the policy process. These principles, according to the conceptual framework of this study, are laid down for directing and guiding the individuals and organisations that shape the policy process (chapter 3). This section examines the role of different shapers, as to how did they influence the policy process?

6.3.1. Findings from case studies

Shapers contribute positively or negatively by the way they conduct the policy process that, in turn, is influenced by their attributes like 'training, experience, interest, preferred management styles, the degree of their knowledge of healthcare systems in other countries, their political commitment or ability to take an apolitical stance' (Dewdney, 1987). To determine the attributes of the shapers in the Punjab they were classified as leader, supporter, bureaucracy, donors, media and civil society (5.1). Their characteristics and the role they played in influencing the policy process, drawing from the case studies, is summarised in table 6.4.

Table 6.4:- Role of shapers in policy process

	Leader	Supporter	Bureaucracy	Donors	Media	Civil Society
SPP	Technocrat - visionary, dedicated and energetic	Technocrat - visionary, dedicated and orchestrated the project	Except few, it was generally resistant and was opposed	Supportive, but not pro-active and changed their alliance to other reforms	Passive, covered news of ceremonial nature	The users passive, providers both medics and paramedics were opposed, but not united
DHA	Civil bureaucrat - talked well, but did not do much practically	Politician with a business background – energetic and a democratic dictator	- do-	Supportive initially, but changed their alliance to other reform	-do-	- do-
IA	- do-	- do-	- do-	Supportive in principle, but came in to be in the process and not singled out	Active, but only to cover the debate	The users passive, providers mainly medics and their body – the PMA opposed
DHG	- do-	- do-	- do-	Supporter, but reduced to disburse and conduct activities	-do-	-do-

From a study of table 6.4, the way different shapers influenced the policy process is that:

Insofar as leadership, the initiatives fall in two distinct groups: (i) SPP, which was led by a technocrat; and (ii) the remaining initiatives were led by a civil bureaucrat who worked in a bureaucratic way. Similarly, there were two types of supporters: (i) technocrat supporting the SPP; and (ii) politician supporting the remaining initiatives. The bureaucracy, except in a few cases, resisted and opposed the initiatives. The donors were supportive in general, but their role changed over time. That is, supportive initially to compete and worked for reforms, before finally going into a laid back position. The media changed over time from being passive to active. Likewise, civil society was passive and is not well developed.

6.3.2. Factors associated with shapers

Given the findings in table 6.4 the following generalisations are made, which will subsequently be discussed individually: (i) the leaders lacked qualities to guide the process to a success; (ii) the support to the reform process was inconsistent and inappropriate; (iii) the bureaucracy resisted the reforms and was inefficient; (iv) the donors changed their role over time; (v) the media was not used and it changed its role over time; and (vi) civil society was passive and not well developed. These factors are discussed below, framing more hypotheses:

6.3.2.1. Leaders lacked the qualities to guide the process

The leader, as defined earlier (5.1) is the front-runner key stakeholder, e.g. the head of the department, institution or agency and has a personal as well as a formal institutional interest at stake. Effective leadership is vital to the success of the reform process (Paul-Shaheen, 1998). However, it was not the case in the Punjab. That is, (i) the technocrat leading the SPP could not effectively harness support for the project; and (ii) the civil servant leading the remaining initiatives led the policy process in a bureaucratic way. In the following, these hypotheses are tested.

Technocrat could not harness support for the initiative

In the case of SPP, a technocrat led the Project Management Team and influenced the outcome of the project (5.3.3.1), but was transferred from the project. Given his personal traits, it is argued that the project became complicated, beyond the capability of his successors to carry it forward. Even, an institution was reluctant to accept the responsibility to manage the project, as, according to a senior officer, it had no capacity and it was being doubted, whether it could do it. Thus, one may praise the leader and also question – why was he transferred from the project? To answer this question, one expatriate consultant working in the PHDC noted that the project leader, while working well with his team, posed threats to his senior colleagues. In his view, they were afraid of being overshadowed by him. In other words, he was too junior to be in the position, and the bureaucratic milieu in the

Punjab (5.6.7.3) would not allow that. In short, the project manager could not harness the support for the project, thus he lacked an important attribute of a leader.

Civil bureaucrat led the reforms in a bureaucratic way

In the case of the DHA, IA and DHG a civil bureaucrat was identified as the leader by the majority of respondents. However, it is argued that ultimately he was ineffective and influenced the policy process in a way that the former two initiatives were abandoned and the third ran into serious problems. What was wrong with his leadership? According to many respondents, this career civil bureaucrat was characterised as the one who talked well, but did not do much practically. This evidence was also substantiated by a politician, who remarked:

> *...We were being hampered by the colonial legacies. Yes, Sir! Yes, Minister! Such characteristics of the civil bureaucracy affected the overall efficiency of the system. I think the biggest hindrance was the bureaucracy itself. They did change the system to the extent they wanted to change. The individuals like ... (name of the leader) wanted to change, but basically still he was a civil bureaucrat trained under the old British colonial style of administration. He would never want to lose all powers.*

In other words, this leader, being part of the bureaucracy, was more loyal to the traditions of his own institution than to the health reforms. He was a generalist who led the reforms in a bureaucratic way, which, as an institution, was opposed and resisted, as a senior project officer told this researcher. Further, remarks of a senior bureaucrat about the way this particular bureaucrat (leader) conducted the policy process, and the advice he rendered, indicate the suit followed by him. He noted:

> One of our problems ... is the reluctance of the government to let go of its hold over the institutions. This is exactly what is happening in this case. ...Either grant full autonomy or do not do it at all. In this situation, the best description of the system will be that it is 'neither fish nor fowl'. Kindly try to give autonomy in the real sense of the word (GoPb, 1997v).

6.3.2.2. The support was inconsistent and inappropriate

The supporters are the key stakeholders who exercise significant influence, and are important for the success or failure of reforms (5.1). They facilitated the process by making decisions and co-ordinating assistance from various sections of the government. In the case of the Punjab, the support to the policy process was inconsistent and inappropriate. To investigate this assumption, two hypotheses are framed: (i) the support for the SPP dwindled over time; and (ii) for the remaining initiatives, the support was incoherent and ill focused.

Support for SPP dwindled over time

The respondents were unanimous in their opinion that the first executive director of Special Projects supported the SPP. Afterwards, there is adequate documentary evidence suggesting that support to the project first became lukewarm and then was almost withdrawn. In fact, no respondent identified anyone else as a supporter. The successive executive directors diverted its resources to the main SFHP, or tried to generate other initiatives out of its remains. Thus, generalising the findings, it is concluded that support to the project dwindled after its initial years of execution.

Support for DHAs, IA and DHG was incoherent and ill focussed

The chief minister of the Punjab was the supporter in the case of DHA, IA and DHG. About him, one of his political colleagues told this researcher:

> *Basically he was enthusiastic in bringing change, but he was more of a dictator than a democratic leader. Well, this attitude did pay off in certain sectors like the roads and bridges, but not in health and education. The social sector was a different ball game. However, unfortunately the same approach was used in these departments. He had approach of an industrialist and could not differentiate between machine and man. I think that was one of the reasons for failure. The people were pushed too hard and too fast. In the thinking process you need time to think, but here people were being forced to think.*

There were several reasons for the chief minister working in this manner (e.g. 5.4.3.2; 5.5.3.2), mainly due to his business like attitude and the political culture of the country. Nonetheless, he ended up having opened many fronts in the Health Department at a time, thus losing the focus. In this regard, a senior planner argued that, although different initiatives were introduced under the umbrella of SAP, there was no coherence between them and each one had its own independent identity. Thus, in his view, the multiplication of efforts resulted in that hardly any reform was taken to its logical conclusion. Instead the leader, a civil bureaucrat, got control of the situation; and it is argued that it was a calculated move by which the bureaucracy kept their political bosses engaged and also maintained the *status quo*.

6.3.2.3. Bureaucracy resisted the reforms and was inefficient

The term bureaucracy is used in the meaning of civil servants, and drawn from Tomlin's (1931 cited in Chapman and Ò Toole, 1995: 4) definition in the British context (Pakistan follows the same model) the latter are "paid wholly and directly out of the money voted by parliament and work in a civil capacity in a department of the government". They are the secondary stakeholders, both in the health and other provincial/national systems, responsible for: (i) assisting the political executives in

policymaking and working out its details in the provincial secretariat; and (ii) in districts, as an essential partner in implementing policy (5.2). However, the bureaucracy resisted the process and was opposed to the reforms. Therefore the policy suffered both in its design and implementation phase. Many respondents subscribed to this observation, e.g. a top technocrat noted:

> *...Pakistani bureaucracy is a staunch disbeliever of decentralisation. ... As the saying goes, a cat cannot see milk, 'while drinking'. So do the bureaucrats. They always amass authority 'beneath them' and want to do everything without accepting any responsibility. They want to remain at the axis and centre of all decision-making. That is the reason that different reform initiatives faced the worst type of opposition from the bureaucracy.*

In addition, the bureaucracy was inefficient. In this respect, Blau and Meyer (1971) note inefficiency in bureaucracy on two accounts. First, given the employment and promotion opportunities in a bureaucratic set up are based on qualification and experience that are protected against arbitrary dismissals, the incumbents hardly attempt to impress their superiors. Second, the rigidity of civil servants in their conducting of official business according to rules that inhibits those exercising judgement needed for efficient performance. In the case of the Punjab, the minister for health seconded the notion of an inefficient bureaucracy, attributing this to its vested interests. He commented:

> *The civil bureaucracy has not been efficient... I am of the opinion that they were upset in this process due to selfish reasons. They had personal interests that their role was going to be limited in case the reforms take shape.*

This inefficiency of bureaucracy due to selfish reasons takes us to another argument i.e. politicising of bureaucracy. And it is on this account that Peters (1978) argues for political appointees with some combination of 'political disposition' and 'administrative talent' however cautions against either of these alone. This observation, it may be noted, is in line with the lesson, this study draws (7.5.1) in respect of policy analysts. That is, bureaucracy should have been explicit in its reservations rather than dragging its feet while working on reforms

However, the question arises, how the bureaucracy was able to manage its position that although inefficient and being opposed to reforms, it was closer to their political bosses. For example, a top decision-maker told this researcher: "We had a hotline contact with the chief minister..." It is argued that this situation had arisen due at least to two factors: (i) 'internal-driven politicisation' of bureaucracy; and (ii) politico-bureaucratic nexus. In the following I explain these factors.

Internal-driven politicisation of bureaucracy

Hojnacki (1996 cited in Moon and Ingraham, 1998: 79) introduced three patterns of politicisation: (i) society-driven, whereby the civil society determines the nature of politics in policymaking; (ii) politician-driven, where the politicians are in control of the process; and (iii) 'internal-driven politicisation', i.e. the bureaucracy works for the survival of its organisation consequent to the administrative reforms. Regarding the last characteristic of bureaucracy, Moon and Ingraham (1998) explained:

> Bureaucrats also actively respond to the administrative reform because they perceive it as a systematic threat to the bureaucracy. Under a bureaucratic-bashing milieu, the bureaucracy protects its organisational interests (i.e. size and budget) by applying new managerial techniques, creating new missions and delaying its implementation procedures to dilute the political urgency. It often internalises reduction pressure by developing training programmes, increasing off-organisation activities, or transferring to quasi-government organisations.

The above observation also corresponds to the Danish experience, where Christensen (1997) noted that the civil servants would defend the formal structure against challenges. In the Punjab, the bureaucracy behaved in this similar fashion. That is, initially they came up with ideas, proposals and arguments favouring an initiative and then either forgetting it or turning against the same and propounding another. For example, the SPP was considered as an "excellent effort, which the Health Department is going to undertake, to address many of its chronic problems... (GoPb, 1992a)" Later, however, this project was allowed to be overtaken by events. Similarly, the DHA was implemented in two districts and preparations were made to extend the initiative to fifteen other districts, but instead the emphasis shifted to instituting yet another initiative, the DHG. By doing so, bureaucracy was seen as an active partner of reforms, in fact, one DHS noted, it was to ensure that a *status quo* was maintained. At the same time, however, they also kept their political bosses engaged and happy that they were doing a lot. This relationship is explored below.

Politico-bureaucratic nexus

Moon and Ingraham (1998) from a study of three Asian countries concluded that government action, e.g. health sector reform, was a product of the interaction between politicians, bureaucracy and civil society. In their view, these forces jointly form a 'Political Nexus Triad'. However, in the Punjab it was a 'politico-bureaucratic nexus', and in that relationship the pendulum shifted towards the bureaucracy. Civil society was hardly seen in the process. In other words, as already noted (6.3.2.2), the bureaucracy was in control of the process.

Why did the above situation arise, whereby the bureaucracy dominated the process? In this regard, Hashmi (1986) noted that bureaucracy, military and the political élite has been governing Pakistan, since its independence. That is, given that for three and a half decades out of the five and a half decades of independent rule, it was the coalition of the former two (bureaucracy and military) that dominated. Therefore, Pakistan has also been called an administrative state or a bureaucratic polity (Islam, 1990). An ex-minister for health, substantiating this point, noted:

> *The civil service is very well organised and well entrenched. Why India is running nicely is because of the stable political institutions. The Congress was quite old when it received power. On the other hand the Muslim League was quite young and a similar debacle happened with the Pakistan People's Party. The civil service used its superiority, while the political institutions unfortunately did not work and the politicians were not trained. In that situation, the civil bureaucracy played well...*

However, the politicians instead of striving to mature themselves and taking the lead, established a nexus with bureaucracy. And also, in this equation, bureaucracy dominated, even when the politicians were in power. For example, during the study period (1993-2000), when a political government was in office, except in 1999-2000, the political élite were in coalition with the civil and military bureaucracy. For example, to benefit the latter, it was decided to re-advertise the positions of CEs, deviating from the procedure laid down for the purpose (GoPb, 1999h). As a result, as drawn from the document review, two out of ten district chief executives and three out of eleven institutional chief executives were retired army officers.

6.3.2.4. The donors were supportive, but their role changed over time

From table 6.4, it is seen that donors were not opposed, but in the course of the policy process, while favouring the reforms, had three milestones in the course of policy process: (i) initially inculcated the ideas and built a critical mass for conceptualising health sector reforms; (ii) competed and actively supported the policy process for certain reforms; and (iii) finally followed suit dictated by the government. In the following, these hypotheses are discussed in detail.

<u>Inculcating the ideas and building critical mass</u>

Foltz (1994) from her comparative study of United State Agency for International Development (USAID) assistance to health reforms in Niger and Nigeria demonstrated that the presence of a strong constituency for reforms in the recipient government facilitated the acceptance and implementation of reforms. Working on this advice, in the Punjab the donors inculcated the concepts and were successful in

developing a critical mass for supporting decentralisation. The civil servants, who were initially against it, appreciated the new paradigm to later become advocates and finally claimed ownership, stating that the initiatives were 'home-grown'. For example, a top technocrat, who was part of decision-making, told this researcher about how he, initially opposed, converted to accept the concept:

> *About decentralisation, I was not convinced. Once an expatriate consultant asked me, what was the one solution to the problems of healthcare in Pakistan? I thought, because there are several issues confronting; there might be several solutions. However, my answer was 'management improvement' and after some discussion, we agreed on decentralisation, as one measure.*

Then, talking about how the grounds were developed in the health sector and that how the donors were instrumental for introducing different reforms, the above-referred technocrat narrated that:

> *Thinking about reforms that started in the early 1990s, the four initiatives can be seen happening in three phases: (i) SPP; (ii) DHA; and (iii) IA and DHG. For SPP, we need to connect its inception with the policy dialogue with the World Bank and other donors. That was the time when the department started thinking about issues like decentralisation and community participation. ...when it came to IA/DHG, the DoH was clear about problems, what to do about those and bringing in the comprehensive solutions that we clearly called as health sector reforms...people say that in the reform process the World Bank and other donors guided us. However, this is not true...*

Finally, about the entire reform process claiming its ownership, he commented:

> *...This reform process did not come in one day – it was after a long process. It was decided, then implemented and then fine-tuned with the help of feedback. It was a dynamic process and home-grown.*

Competing and actively supporting

The governments in developing countries faced with a shortage of funds adopt various strategies in order to compete for donor assistance (Drager, 1996; Sabbat, 1997). Contrarily, in Punjab, for example, in the case of SPP, donors were partners initially, but later they competed for the initiative, firstly for installing DHMTs and then for instituting DHAs.

The DHMTs and DHAs were launched from PHDC, and to secure the identity of these initiatives, the move to link the SPP with PHDC failed (5.3.6.4). Given that the donors worked with PHDC, their role in this decision cannot be ignored. For example, in a meeting of a 'Decentralisation Sub-group' of the 'Planning and Management Interest Group' the project director of SPP presented an analysis of

SPP interventions in relation to the ten-point plan on decentralisation recommended by an expatriate consultant (PHDC, 1995). He emphasised the linking of SPP with PHDC for implementing these recommendations. It was decided that an expatriate management development advisor and Management Development Unit of PHDC would jointly prepare a paper for the proposed linkage to present at the next meeting of the sub-group. While there is no record of this meeting taking place, a review of the proposal developed by them suggests that it was a non-starter (PHDC, 1995a).

Following suit, instead of guiding technically

The last stage of supporting initiatives marks the donors taking a laid back position. May be on account of tiredness, as an expatriate consultant noted, after following a project for seven years (1993-99), they ended up following suit, especially in the case of the DHG. Their role was reduced to directing financial assistance and undertaking different activities for the government. This assumption about DHG is a matter of record, however in the case of autonomy to institutions, the donors got involved only to be in the process, as one of them commented:

> *we wanted to 'keep in there' and not be marginalised, i.e. more or less be completely ignored or excluded – this was one of the many reasons for us in getting involved in the Institutional Autonomy side of things, when the district decentralisation process was going so slowly.*

It may be noted that although autonomy to institutions, a reform in the arena of tertiary care, was beyond the original mandate, DFID helped in organising an orientation course for the CEs and designed a baseline survey of autonomous institutions. Why did the donors behave so subserviently? Sabbat (1997) notes the effect of asymmetry in the donor-recipient relationship. In his view, if recipients are submissive, they lack the ownership of donor supported initiative. Further, when the overall funding by the donors represents only a small proportion of the budget, there is a greater recipient assertiveness. In the Punjab in the initial years of the project a lack of ownership of initiatives is noted, for the government gave up the DHA initiative or for that matter also the DHMTs (both sponsored by donors) to pursue the DHG initiative. Seconding this assumption, a donor representative commented:

> *With DHAs, there was a problem of ownership. That is, someone from outside the Health Department (i.e. the donors) designed it. The health managers did not themselves design the initiative ...*

However, it is argued that the recipient's lack of ownership for initiatives was not due to their submissiveness – they were not. This researcher witnessed tough and often uncompromising negotiations on the part of the recipients, which according to Sabbat should have made a greater partnership with donors. Turning to the other

variable of Sabbat, i.e. the amount of donor contribution, the donor (DFID only) funds constituted about 25% of the total project inputs (GoPb, 1993). This amount was not a small part of the budget the government could afford to lose. Thus, logically, the recipients' could not be assertive in their relationship with donors. Then why was the 'laid back' position taken by the donors? This can be explained only by assuming that the administrative mechanisms of donors had fatigued in supporting the reforms. As a result, they could not argue on issues, and appeared to be following suit. Admitting this conclusion candidly, an expatriate consultant noted that the British Council and DFID took long (an expression of fatigue) to agree contract amendments, which itself had a delayed publication.

6.3.2.5. The media was not used and its role changed over time

The media can play an important role in drawing government attention to the issues (Walt, 1994) and is, therefore, a communication link between public and policymakers (Paul-Shaeen, 1998). However, what was its role in the Punjab? During the study period, the media, and the print-media only, because the electronic media was not involved, gradually changed from being passive to an active player in the process – a generalisation made, based on the evidence from document review corroborated by the personal knowledge of this researcher. Secondly, no effort was made to engage the media in the dialogue for reforms. In the following I test these hypotheses:

<u>The media changed its role over time</u>

Table 6.4 shows that in the case of the SPP and DHA the media was passive. If, at all, it covered mainly political rhetoric, as a senior figure in the PMA noted "only strong political statements' made the headlines in the newspapers". A senior planner conceding to the weakness of initiatives *vis-à-vis* the understanding of civil society about development commented:

> *...because in the minds of the public (and that he meant to include media), any kind of development meant the buildings and such things... As far as the media is concerned we were on a weak wicket.*

That is, for civil society, development meant infrastructure building. Since reforms did not envisage such interventions, these remained unnoticed. Nonetheless, about IA and DHG initiatives, the media was active, but in covering the debate between certain interest groups and government. And during this conflict, a highly placed technocrat told this researcher, "there was an extensive debate in the media, and about 120 items appeared in the press ..." But, there were few instances where the

media itself got involved in keeping an initiative on the government's agenda as this researcher did not find any comprehensive press report about the health reforms.

Policymaker did not use the media

As will be noted (6.3.2.6), whereas civil society was not developed, the policymakers also did not try for that – an observation true for the media as well. Few press releases of ceremonial nature and couple of interviews for defending an initiative cannot be termed adequate. That is, key stakeholders did not actively engage the media in communicating the policy issues to the public. Three reasons for this attitude are identified. Firstly, there was a skewed impression of the media. For example, a senior medical officer working on the SPP commented:

> *This (media) causes more complications than helping. The people in the media...tend to exploit the situation by highlighting the weaknesses and downplaying the positive aspects. In fact, our civil society is not developed to the extent that the media could play a role in furthering the objectives of an initiative like the Sheikhupura Pilot Project.*

Secondly, the mandatory official secrecy inhibited the utilisation of the media. The Official Secrets Act, 1926 prohibits government officials from revealing details about their official business. In addition, there were at least 12 different laws that, in one way or the other, curb the freedom of information (Dawn, 2001a; Dawn, 2002b). As a result, confidentiality became an 'official decorum' in the public sector. In many instances, this researcher was refused access to official documents. Further, because the officials were attuned to be secretive and closed, the document review indicates that, although a cell was created on the chief minister's advice for launching promotional campaigns to receive and collate public opinion (GoPb, 1997q), there is no evidence of undertaking any activity.

Thirdly, the government was weak in putting across its viewpoint. A top bureaucrat, looking for the reasons for non-utilisation of the media, noted that the opponents took on the government on issues like privatisation and equity. Further, in his view, the opposition had more influence on the media than the government. In other words, instead of advocating different initiatives, the government was on the defensive. In this respect, the chief minister vividly commented:

> *We used it (media) to defend. We did not use it to publicize, because I believe the politicians have disappointed people and they don't believe in them. Rather you talk; the things should be done instead. That is, your action should speak...*

6.3.2.6. Civil society was passive and under-developed

Jeffery and Vira (2001: 3) deriving from an earlier work by Pretty (1995) provide a typology of participation by people in externally introduced interventions. From the range of participation types 'passive participation' is relevant in this case. In this kind of relationship "people participate by being told what is going to happen or has already happened (or what they are expected to do). It is a unilateral announcement by an administration or project management without listening to people's responses ..." (*ibid*: 3). In the Punjab people from governance undertook the policy process without particularly involving stakeholders from other components of health sector, i.e. it was mainly the politico-bureaucratic nexus operating, the communities or end-users were passive and no organised effort was made to involve service providers or their representatives. To test this hypothesis, building on findings from case studies, the participation of different shapers in the major tasks of the policy process, i.e. conceptualising, formulating and implementing are given in table 6.5.

Table 6.5:- Role of different stakeholders in the policy process

Initiatives	SPP (1993-98)	DHA (1995-98)	IA (1997-2000)	DHG (1998-99)
Conceptualisation	T	T	C	C
Formulation	CT	CTP	CTP	CTP
Implementation	CTS	CTSP	CTSP	---

Key: **T:** Technical bureaucracy; **C:** Civil bureaucracy; **P:** Politicians; **S:** Civil society

From table 6.5, it is seen that civil bureaucracy took over conceptualising from its technical counterpart in successive reforms. Similarly, politicians who did not participate in conceptualising any reform came into the formulation and implementation phase of the last three reforms. Civil society, in this process, was the most disadvantaged, and figured only during implementation – and that too in the execution phase only. In table 6.5, the implementation cell of DHG is vacant. This is because this initiative, apart from selection of CEs and their induction training, did not really get into that phase.

Thus, while the political and bureaucratic executives were operative throughout the policy process, civil society was confined to the execution phase. That is, this shaper was not on board during the conceptualisation and formulation phase of the policy process. Given that civil society draws from communities, introducing reforms as in the Punjab health sector can be termed as a 'one-hand clap' phenomenon. It was mainly the bureaucracy, and to a lesser extent the political executives were active, civil society or recipients of services were hardly considered. Further, the document review reveals that civil society was involved as members of the Management Committees established under different reform initiatives. Since, such members came through nomination, i.e. the civil servants proposing and the bureaucracy and politicians jointly giving approval, they did not directly represent people.

This kind of relationship extended to the service providers in the health sector as well (see below). But, why was this skewed relationship of civil society *vis-à-vis* the nexus of bureaucracy and politicians? To answer this question, it is argued that: (i) civil society including groups in the professions was under-developed; and (ii) an inadequate and inappropriate effort was made to broaden the stakeholder's base.

Civil society was under-developed

Generally, there was a relatively less developed civil society. This researcher could not identify many interest groups which contributed to the policy process. The PMA came on the scene, but late and ineffectively. For instance, this body was not proactive in the case of the DHA or SPP initiatives, which were about reforming the district health system. They came when the issue of granting autonomy to the institutions and the selection of CEs for the DHGs was raised. Perhaps, it was competition for the lucrative job of the CEs and that the clinical élite were being affected, or this body did not effectively represent doctors in the peripheral areas compared to those from cities and hospitals. In this regard an expatriate consultant observed that "I got the feeling that the PMA was very much Lahore rather than province-wide based" – a point that is also supported by evidence from case studies.

Secondly, the PMA was divided (Niazi, 1999) and the different groups had conflicting views about the reform process. Some groups favoured it (Elahi and Bharwana, 1999), while others were opposed (Rashid, 1999) and yet some changed their stance over time (Bharwana, 1999). Evidence suggests that the PMA was called into certain meetings, but given the internal divide, its representation would not have been effective. This observation conforms to the subscription by the respondents who were unanimous that despite various groups which resisted and were opposed to reforms, they were scattered and ineffective in their opposition.

Inadequate and inappropriate effort to broadening the stakeholders' base

Gerein (1986) reflecting on her personal experiences of working in donor organisations, noted that, in developing countries, the system was not supportive of community participation in the primary health care programmes. In the Punjab, apart from the PMA, there is little evidence that any other group got involved. In addition, bureaucracy and politicians made no effort to involve any that might have existed. Instead, conditions were created that were not conducive to such a partnership. Explaining this situation, the president of a regional 'All Pakistan Clerks Association' told this researcher:

> *...it was at a higher level phenomenon and for the Secretaries and high officials... The seminars were held, but in the Avarai (a five-star hotel) and at the high forums. These should have been held in Basic Health Units or Rural Health Centres. The employees were never involved in decision-making. If it were done properly the people would not have reacted like they did*

Further, according to a respondent who was near to the policymakers, different individuals were consulted, but as an *ad-hoc* arrangement, no formal forum or commission of enquiry with explicit terms of reference was created. In such proceedings, though certain technical managers and professionals were invited, it was not as a technical polity, but as a part of the technical bureaucracy. The latter, given the bureaucratic milieu in Punjab, were subservient to the civil bureaucracy. In short, few stakeholders were involved in policymaking.

6.3.3. Summary and conclusions

This section explored factors concerning the shapers of the policy process. Drawing from case studies, the general features of different shapers were theorised. That is, while the leaders lacked the qualities to guide the process to a success, the support to the process was inconsistent and inappropriate. The bureaucracy, as an institution, was resistant and opposed. The donors were supportive in general, but over time their role changed. Similarly, the media changed from being passive to active, and civil society was not well developed and remained passive in the reform process.

Exploring the above generalisations gave rise to an array of factors surrounding each of the shapers. For example, while the technocrat leader could not harness support, the civil bureaucrat ran the process in a bureaucratic way that was not conducive to introducing reforms. Similarly, the support to the initiatives either dwindled or was incoherent and ill-focused. The donors, who inculcated the reform ideas, fatigued over time. Initially, they competed and actively worked for different initiatives, but ended up in following suit, instead of actively guiding and assisting technically for shaping the reforms. Civil society including the media was not developed and those at the centre made no structured effort to broaden the stakeholder's base.

Overall, after studying the role of different shapers in the policy process, three conclusions are reached: (i) it was mainly bureaucracy and political executives who were involved in the policy process; (ii) the donors fatigued administratively, failing to argue on issues and their colleagues in the government overwhelmed them; and (iii) given the shapers are spread throughout in the health sector, there was a narrow stakeholder's base, and the process for involving them was not efficient.

6.4. Context analysis

In the preceding section it was examined how different shapers contributed to the outcome of the policy process. This section looks at how did the context analysis influence events? That is, the concern is to examine the nature of 'context' and to consider how to analyse it as part of a health policy process. Dewdney (1987) divides health policy into two major areas: (i) health issues proper; and (ii) the machinery for coping with the health issues. While the latter is taken up next, this section is concerned with the 'health issues proper'. According to the framework for this study, this concerns the 'context', and in the following paragraphs I examine how the inadequate analysis of context influenced the policy process?

6.4.1. Findings from case studies

The case studies in chapter 5, drawing from various sources, presented the contextual factors that were the *raison d'être* for different initiatives. Here, firstly these factors, as perceived by research participants, are clustered according to their association with different components of the health sector (6.4.1.1). Secondly, evidence is brought from documents for determining to what extent the context was analysed in actual practice (6.4.1.2). In this regard, it may be questioned that all contextual factors may, but may not be documented due to being, for example, politically sensitive. However, it is argued that such factors are accounted for in the participants' responses.

6.4.1.1. Participants' perspective of the context

Using his judgment this researcher marked the contextual factors in table 6.6 as '+', if identified by the respondents contributing to instituting a particular reform. Similarly, if for a health sector component no contextual factor was identified, it is keyed as '-'. Additionally, the context was explored in terms of the severity of different factors and likewise the response of participants was clustered and keyed in the table 6.6. It may be noted that different variables in the horizontal column of table, plotted against the four initiatives in the vertical column, are drawn from the framework employed for context analysis (3.3.3).

Table 6.6:- Factors preceding the reform initiatives

	Internal environment					External environment		Gravity of situation
	Governance	Providers	Communities	Support services	Resource generators	National systems	Hegemonic systems	
SPP	+	+	+	+	+	+	+	+-
DHA	+	+	+	+	+	+	+	+-
IA	+	+	+	+	+	+	+	+-
DHG	+	+	+	+	+	+	+	+-

Key: Contextual factor identified: - '+' Contextual factor not identified: - '-'

Table 6.6 reveals that:

1. Respondents perceived that there were issues at all levels of policy context, i.e. all three layers of the environment for different initiatives; and
2. A mixed situation emerged regarding the perception of the respondents about the gravity of the situation confronting the Punjab health sector.

Substantiating above findings, the chief minister observed, the working of the health system, on the whole, was so bad that any intervention would not make it worse, but in his view, would improve it. One of his Aides noted:

> *Some people suggested to him (chief minister) that Sir don't tinker with the system, because if you would the system would become worse. He said, 'the system has become so bad that any tinkering would not make it further worse and if anything perhaps it will improve it'. So we must tinker with the system.*

In a similar tone, another respondent told this researcher that not only health but also other national systems, including the political system were in disarray:

> *All our systems are broken, and this situation prevails since 1988... there has been mismanagement. The Members of Provincial and National Assemblies and political parties were pushing and getting the transfers and postings (people of their choice) – thus the whole thing broke. Such a situation prevailed not only in the health department, but also in every government department...*

However, to what extent the above situation was taken into account and that a comprehensive context analysis was undertaken in developing policy, the evidence is sought from the review of the documents and is presented below:

6.4.1.2. Documentary evidence of context analysis

Table 6.6 above reveals that the respondents viewed factors in all components of the health sector. This demanded a review of the entire sector, while analysing the context. However, in actual practice, inadequate attention was given to establishing the policy context for the Punjab health sector reforms. While this is a hypothesis, how was the context established for the interventions? To answer this question, findings related to the launching of an in-depth study of the situation for determining the context and the documentation produced about the selected initiatives are clustered and presented in table 6.7.

Table 6.7:- Means and evidence of context analysis

	In-depth study/situational analysis	Documentation
SPP	Baseline survey, discussions in the *ad hoc* committees and bureaucratic hierarchical decision making	A project document with detailed activity plan and financial layout. In addition, a series of documents including consultancy reports were created during the life of project.
DHA	Consultancies, discussions in the *ad hoc* committees and bureaucratic hierarchical decision making	An (3-page) administrative order provides a constitution and a range of functions without any guideline. In addition, a number of consultancy reports were generated both prior to launching the initiative and during its implementation.
IA	Brainstorming in the *ad hoc* committees and bureaucratic hierarchical decision making	Two documents – an (2-page) Act and a (4-page) Contract, laying down what is expected, but not how to do it.
DHG	Baseline survey, brainstorming in the *ad hoc* committees and bureaucratic hierarchical decision making	In addition to a concept paper, two documents – an (2-page) Act of assembly and the (2-page) preliminary rules

Table 6.7 indicates that:

1. In the case of the SPP and DHG a baseline survey was conducted, while in the case of the DHA, expatriate consultants undertook a number of consultancies. Otherwise, in all cases, prior to launching, only discussions were held in the *ad-hoc* committees and decisions were taken in a bureaucratic hierarchical channel.
2. A number of documents were generated during the life of the initiatives, but overall different reforms were not rich in this respect. This researcher could not find much documentation on the background and about various phases of the policy process.

6.4.2. Factors related to the context analysis

From the above findings, drawn from the participants and the documentary evidence for context analysis, it is assumed that: (i) a non-holistic analysis of context was made; (ii) non-holistic view of context led to more problems; and (iii) critical situation alone did not serve a window of opportunity for introducing reforms. In the following, I discuss these assumptions:

6.4.2.1. A non-holistic analysis of the context was made

A point is made in the findings above that discussions were held in the *ad hoc* committee, but the focus in these deliberations remained mainly on the issues surrounding governance, resource generators and service delivery options. The role of the communities, the support services and the influence of other national and international hegemonic systems were ignored. While this generalisation is validated from the document review, the comments of an ex-minister for health are relevant. He emphasised that unless some time is spent with the common man taking into account his needs and suggestions, the outcome of policymaking cannot be perfect:

As far as the reforms that have taken place in the recent past, I don't have reason to doubt the honesty, intention and motive of the originators. However, if I have any objection rather reservation is that while formulating those policies, what we political workers say is that ground realities were not kept in view. That is, unfortunately, when we formulate policies, even while our party was in power and I was the minister for health this exercise was done in Islamabad (capital city, remote from the context). ... So, when policies are made in this manner, these cannot be accepted as perfect or even closer to being perfect for delivering healthcare to a common man.

Further, the document review suggests that during the life of the initiatives a number of documents were generated. But these were only bits and pieces. This researcher could not locate and access any document in the Health Ministry at any level – federal, provincial, regional, district or below, which describes the health system (for a particular level) in its entirety. Furthermore, the ones which were available were not comprehensive. For example, as seen in table-6.7, to establish a benchmark situation of the district health system a baseline survey was conducted in the case of the SPP and DHG. However, if the survey report is analysed using the framework for the health sector (1.2.2), this did not address all components, specifically the resource generators, the national and international systems were ignored.

Similarly, for DHAs, expatriate consultants undertook a number of consultancies, but the documents so produced lacked comprehensiveness. Review of these documents reveal that mainly these were concerned with the issues surrounding governance, service delivery, communities and national systems, while resource generation, support systems and the international hegemonic systems were omitted. Why did this happen? As noted above, given that no comprehensive document about the health system existed for the consultants to base their understanding on, they faltered in their recommendations. An academician and author of a book on health services in Punjab, while indicating this shortcoming, noted the importance of a holistic view of the context. He told this researcher:

> *...the expatriate consultants do not know the situation, and yet they analyse it and even offer recommendations for improvement. ...you have to target issues in their holistic context and not in a piecemeal fashion, making an isolated effort.*

Thus, from the evidence presented, although the problems were identified and analysis done, this was only a part of the situation, failing to holistically view the health sector. This shortcoming, it is argued, led to policy not only failing in addressing the issues, but also giving rise to more problems. This hypothesis is explored in the ensuing pages.

6.4.2.2. Non-holistic view of the context led to more problems

In the case of the Punjab, as noted in table 6.7, the inadequate context analysis led to instituting poorly designed reforms. For example, the secretary health, when asked about the reason for switching over to DHG, told this researcher that this was due to the DHA initiative not addressing the issues it was aimed at. In his words:

> *We changed from DHAs to DHG because we thought that the amount of legal support that was available to DHAs was very limited. It was still an appendage to the Health Department. We wanted to devolve all powers for decision-making to the district itself. But, it was not possible within the existing legal framework and the (new) legislation gave us the powers ...however, these changes were not possible within the scope of DHAs...*

Since this study did not envisage undertaking evaluation, there is no empirical evidence to indicate the impact of reforms arising from a policy process with a non-holistic view of the context on the overall health sector. But, this can be inferred from similar situation during the earlier developments in the health sector. For example, a former planning chief, Government of Pakistan, explained that because the situational analysis, i.e. the working paper or project documents prepared in the public sector, did not adequately investigate the existing capacity and failed to foresee the expansion needs in the other sub systems *vis-à-vis* those envisaged for the service delivery component, the balance or equilibrium of the system was disturbed:

> *During the 1980s, emphasis was on infrastructure (service delivery) development. The concurrent inputs needed for developing management, support, and resource development/generating systems were minimal. This skewed development, more in favour of bricks and mortar, created governance problems for the expanding health system. Consequently, the health system remained technically weak and the health managers and decision-makers had to mainly rely on the advice of the technical agencies and donors.*

Similarly, a senior manager in the Health Department commented:

> *One thing is obvious that, until 1980, we did not have any big problem in terms of health services. Our health outlets were providing services with which people were satisfied. When, however, the services expanded, the bureaucracy did not visualise the commensurate expansion in the supervisory capacity of the system. For example, before the 1980s the DHO supervised about 10-15 health facilities in a district. Now these have expanded to over 100, whereas the financial and administrative powers and the resources of the DHO office remained the same. This resulted in the system, which was providing services, crumbling.*

Another manifestation of the skewed developments was the creation of a number of vertical programmes within the health sector, which a planner in the Punjab Health Department noted, causing fragmentation of the health services, especially in districts. In his view, this situation was a reason for the government to again embark upon reforms in the 1990s. Ham (1997: 135) noted similar phenomena in the case of five developed countries, where it was primarily economic concerns that underlay the reform efforts made cyclically over time (see 2.2.5).

Thus, it is seen that a reform initiative designed and based on a non-holistic analysis of context led to the same issue presenting in a different manner and the reformer also prescribed a similar reform in a different wrapping. In the Punjab, as gathered from the evidence presented above, whereas certain components of the health sector were overlooked, the impact of other national and international systems was not taken into account in analysing the context. Therefore, it is noted that while the issues persisted, different reforms with a common strategy were introduced in succession.

6.4.2.3. Critical situation alone did not serve a window of opportunity for introducing reform

Determining the gravity of the situation is another aspect of the context analysis, because, as noted earlier (3.3.3), crisis serves as a weapon in the hands of interest groups. In the case of the Punjab health sector, however, the critical situation alone did not serve as a window of opportunity for introducing reforms; someone charged with action was also needed. In the following, I discuss this hypothesis, first by determining the nature of the situation and then how this opportunity was used to introduce reforms.

A mixed situation emerged about the nature of the situation in the case of the Punjab, given the response of participants (Table 6.6). Many thought that it was business as usual and there was no crisis. But, a strong realisation existed that if the prevailing deterioration continued unabated the health system would soon collapse. On the other hand, others thought that the government had for sometime been doing 'crisis management'. This variation in the perception of the situation held by respondents is due to the degeneration in the health system which was gradual spreading over many years past. Therefore, it is argued, people became acclimatised and took it as the norm. Furthermore, what is regarded as critical and most important is a matter of opinion and subjectivity, which may vary from individual to individual.

However, despite the critical situation, either an initiative was launched but forgotten, or it was launched only when someone proactive supported the move. To exemplify this, the SPP was launched without political support, but was forgotten. The establishment of DHAs was considered technically desirable, but given the then

wavering political feasibility, its implementation was deferred (DGHS, 1996a) till a particular politician took over the office of the chief minister. That is, although it is maintained that an opportunity for intervention arises when a longstanding problem is perceived and a solution to address the same is evolved (Paul-Shaheen, 1998), in the Punjab the bureaucrats were alive to the necessity, but could not implement the initiative until a politician willing to support it came on the scene.

The above situation indicates another dimension to the debate. Various writers on policy term its making predominantly as a political process (Hill, 1997; Walt, 1994; Reich, 1995; and Barker, 1996). However for this study, views held by Barker are subscribed to. According to her, while undertaking policy analysis, one must take into account the broader context of the health system and the political context beyond that. In other words, policymaking, as Lee and Mills (1982: 31-32) argue, is concerned with 'political feasibility' as well as 'technical desirability'. That is, whether the political environment was conducive and that the bureaucracy was also willing. The latter is dealt with elsewhere (6.3.2.3). Regarding the former, it was not the political party in power determining feasibility; instead it was a particular politician who mattered. Otherwise, this researcher noted that despite the same political party in power, i.e. the Pakistan Muslim League, in the Baluchistan province, where a similar situation existed, no structural reforms were introduced.

Thus, it is argued that in the Punjab health sector, the issues were there and according to a project officer, the urge to decentralise had been simmering for a long time. Further, the document review suggests that the donors were also around, but then came a political will and a proactive chief minister. This changed the scenario and several reforms were introduced. Thus, it is concluded that although the situation in the Punjab health sector was critical, it needed someone (chief minister) to react. The critical situation on its own did not serve as a window for introducing reforms.

6.4.3. Summary and conclusion

This section examined the role of context analysis in the policy process. It was seen that a comprehensive analysis of context is possible when the analyst places himself in relation to the health system. Given that the context of health reforms has three layers: the health sector, the national and international hegemonic systems, for the holistic view of the context it is essential to examine all these three layers one by one.

However, this study revealed that in the case of the Punjab, a non-holistic view of the context was taken in conceptualising and formulating reforms. But, this shortcoming extends to the literature as well. Several authors did not take into account the health sector *per se* in its entirety while discussing the context or offering a reform package

(2.2.4). Another dimension of the context analysis is the relative severity of the contextual factors. It was found that the critical situation alone did not serve as a window of opportunity; some agent was needed to introduce reforms.

In conclusion, the overarching factor in relation to the policy context was that a non-holistic view of the situation influenced the reform process in the Punjab health sector. That is, what is needed more is whether the policymakers know the health system in both its depth and breadth? This question, however, hinges on considering the external environment and the national and international hegemonic systems operating out there. But, the policymakers in the Punjab hardly exhibited such characteristics.

6.5. Contents of policy

In the last section, I discussed policy context and how its analysis influenced the policy process. This section is about policy contents or set of decisions forming the body of a policy. The contents are aimed at transforming the contextual grounds to the desired future, including the identification of the means to achieve that future. But, it is also important to consider that the nature of policy contents hinge on the performance of the 'machine' that conducted the policy process, because the strengths and weaknesses of the latter are reflected in the former. Therefore, in the following both policy contents and policy machine are examined focusing on the influence of the latter on the former. However, I start with policy *per se*.

6.5.1. Findings from case studies

The policy contents denote the design of policy *per se* and the preparedness or securing an environment conducive to implementing the policy. In the case of the Punjab, the design was not robust, i.e. (i) the policy design was not comprehensive; and (ii) to implement policy, inadequate arrangements were made. In the following discussion these hypotheses are tested from the evidence brought from the cases.

6.5.1.1. Policy design

Four inter-related policy levels (systemic, programmatic, organisational and instrumental) were identified (2.4.1.4) and it was argued that comprehensive reform must contemplate all these levels. Yet, a specific initiative may begin at any of these levels and subsequently grow to extend to the others (Frenk, 1994). The policy, according to Webb and Wistow (1986), may be communicated to implementers through government circulars, orders, plans etc. Furthermore, a policy document may identify: (i) the services to be made available and the possible impact to be achieved; (ii) inputs in terms of resources to be devoted to the intervention; and (iii) the guiding philosophy i.e. the ideology and values that underpin the policy (*ibid*: 91). Whereas the last one has already been discussed (6.2), the former two are discussed here. That is focusing on the first component of the Webb and Wistow model, if the policy documents for the initiatives undertaken in the Punjab health sector are judged for their comprehensiveness, the results from case studies can be clustered and tabulated as below:

Table 6.8:- Design of the reform initiatives

	The policy contents	Comprehensiveness
SPP	A project document with a detailed activity plan and financial layout. There is a series of documents reviewing the background and progress on various project components.	Looking forward to developing and testing a comprehensive model of Primary Health Care for Rural Areas. There were legitimate powers, but environment was non-conducive.
DHA	An (3-page) administrative order providing constitution and a range of functions for the new bodies, but without any approved guidelines and action plan. There is a series of documents generated by consultants.	Envisaged a comprehensive reform package, outlining a decentralised district health system including secondary and primary health care, but had no legitimate powers to implement different activities.
IA	Two documents – an (2-page) Act of the Provincial Assembly and a (4-page) Contract document for the Institutional CEs, laying down what is expected, but not how to do that. Many transparencies and presentations.	Envisaged a comprehensive reform package at the tertiary care level, backed by legitimate powers to implement the same. However, the absence of rules led to problems in realising these objectives.
DHG	In addition to the innumerable transparencies and presentations, there are three documents – (2-page) Act of the Provincial Assembly; (2-page) preliminary rules; and an incomplete concept paper that explains the initiative. Also a district baseline survey report produced by consultants is available.	Envisaged a comprehensive reform package at the secondary and primary care levels, backed by legitimate powers to implement the same. However, the new government abandoned the initiative in favour of district government that involved devolution of all government functions including health.

Table 6.8 indicates that:

1. There were two categories of initiatives in terms of documentation. Firstly, the SPP and DHAs were relatively well documented, and there is a series of documents regarding both the background and progress on different components. Secondly, the IA and DHG had relatively fewer documents, albeit innumerable transparencies and presentations were found. But, there is no comprehensive document providing the background and activity plan for these initiatives.
2. All initiatives envisaged comprehensiveness, albeit, within a particular component of the health system. However, given their focus, the initiatives were of three types: (i) the SPP aimed at developing a comprehensive package of primary health care, (ii) the DHA and DHG visualised a decentralised district health system, and (iii) the IA aimed at granting autonomy to tertiary care hospitals.
3. All these initiatives, except DHAs, were granted legitimate powers. However, either a conducive environment was not created (e.g. SPP) or inadequate arrangements were made resulting in the under-utilisation (notably IA) of available authority and resources.

Thus, as seen from table 6.8, the reform initiatives were aimed at establishing either a decentralised institutional or district health system. Therefore, these interventions were potentially structural in nature and were at a systemic level that also could have implications for other policy levels (Gonzalez-Block, 1997). However, since the overall design of the reform was not complete and that too poorly documented, it is difficult to identify the policy levels addressed by a particular initiative.

6.5.1.2. Preparatory arrangements

This aspect of analysis is about the second component of Webb and Wistow's model that deals with the state of preparedness for implementing the policy. Drawing on the variables derived from the framework for the health sector (1.2.2), focusing on governance, resource generators and support services, findings from different case studies are clustered in table 6.9. It should be noted that service providers and communities – the other components of the health system – were the target of these reforms. Hence these components had no role in preparedness except the communication strategy that is discussed under support services.

Table 6.9:- State of preparedness for launching the initiatives

Variables		SPP	DHA	IA	DHG
Governance systems	*Financial*	Government rules	No legitimate powers	Interim financial rules	Interim financial rules
	Administrative	Government rules	No legitimate powers	Interim rules	Interim rules
	Legal	Government rules	No legitimate powers	Not defined	Not defined
Resource generators	*Financial*	Adequate, from government	Philanthropic and informal means	User charges and locally generated	User charges – a corporate model
	Human Resource	Adequate, from donor's assistance	Adequate, from donor assistance	Inadequate	Inadequate
Support services	*Communication*	Informal	Informal	Informal	Informal
	Information/ Monitoring	Yes – as part of the project plan	Informal, existing hierarchy	Inefficient third party monitoring	Inefficient third party monitoring

For the individual variables, the following situation is noted from table 6.9:-

Governance has three elements: financial, administrative and legal. The administrative systems are concerned with human resource management, institutional record and organisational plans. Such systems form the hub of the organisation. For undertaking SPP government rules and procedures were followed, but there is progress over time so that DHG was seen as a corporate model eligible to outsource and undergo performance based contracts with various service providers. DHA, in this scenario, was a transitional stage – the government procedures were followed in transacting official business, but this body could advise and facilitate the execution of its decisions. The IA was a step forward, and a fully authorised IMC was instituted. However, the needed legal systems were not adequately worked out for using the authority available to the system.

There is a mixed picture regarding mechanisms for resource generation and human resource development. The SPP had adequate resources from the government and donors, and also an in built system for human resource development was put in place. For DHAs there was adequate technical assistance, but for financial resources it was dependent on philanthropic contributions or certain ad-hoc arrangements. However, in the case of IA and DHG, there is a clear move towards self-sufficiency. In addition to the regular government grant,

institutions were authorised to levy user charges and use the income so generated on their own. But, non-framing of rules hindered effective utilisation of these funds; and there was no system for human resource development.

Regarding support services, communication and information systems have been studied. The communication was informal and no strategy was formally developed to consult and involve the stakeholders and for the public dissemination of the initiative. However, developments are seen in respect of the information and monitoring system. The SPP had these systems, as part of its plan, while for DHA it was informal monitoring – there were neither indicators nor any information system. In the case of IA and DHG the law provides instituting a regular third party evaluation, but this was not properly conducted.

Thus from table 6.9 a mixed picture of preparedness emerges, but on the whole, the preparatory arrangements made for implementing the policy were not robust. Not only the governance systems, but also the support and resource generation systems were not well developed. Further, it was noted that the overall design for policy was not complete (6.5.1.1). Why was this so? This question is the central point for this section, as this takes us to a further depth of analysis. To answer, as indicated in the beginning of this section, this was due to the factors infesting the machine responsible for designing policy. In the following paragraphs, this assumption is discussed in detail, but the policy machine is introduced first.

6.5.1.3. Policy machine

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The 'policy machine', for the purpose of this thesis, is the organisational framework within which the policy for the health sector reform was formulated. This machine is comparable to Easton's "black box", where different state institutions come together for policymaking. However, it is called so metaphorically deriving from the commonly used "government's machinery" which processed the policy contents for the Punjab health sector reforms. But, there is a caveat. First, the operations performed by this machine may not be taken as mechanical. It is emphasised that this study examines the health sector reform as a social phenomenon, and the stakeholders and their relationships and the overall performance and the outcome or the policy contents are considered accordingly. Second, the policy machine may sound equivalent to bureaucracy, but it is not – the latter is a part of the former. The bureaucracy was discussed as a shaper, acting as one of the stakeholders of the policy process (6.3.2.3). The policy machine is a decision-making system, where all shapers including bureaucracy come together for designing a policy.

6.5.2. Factors associated with the policy contents

What were the factors associated with the policy contents? To answer this question, it is observed that: (i) there is a skewed understanding of the concept of policy analysis; (ii) there is a weak institutional arrangement for policy analysis; (iii) there

is an *ad-hoc* mechanism for consultation; and (iv) political arrogance is essential for facilitating the reforms. These hypotheses are discussed below:

6.5.2.1. Skewed understanding of the concept of policy analysis

In chapter 2 the concept of policy analysis was introduced (2.4.2). It was noted that especially in the health sector this concept has not received the importance it deserved. In the case of the Punjab, the situation was no different, i.e. various echelons in the hierarchy had varying and skewed understanding of the concepts of policy analysis. For example, I referred to Lipsky's (1980) idea of 'street level bureaucracy', i.e. those that are in active contact with the clients. In his view, these individual civil servants contribute to policymaking (3.3.5). Contrarily, however, in the Punjab, a top trainer of the civil servants, when asked about the role of the civil servants in policymaking, told this researcher:

> *Policymaking comes much later in the service of a civil servant. You cannot impart this type of training at this level. ...Such decisions are taken at a much higher level i.e. ministerial, and it is always the cabinet under the chief minister or the governor that decides on the policy issues.*

Barker (1996: 4) would also receive the same answer from her students. But, according to her "the day of passive administration seem to be numbered" and "in many ways policymaking is the stuff of good management, and characterises the manager, a proactive, strategic thinker, over and above the administrator, a servant of the policies elaborated by others". This message, however, seemed to have been taken in the Pakistani context. That is, when a top generalist civil servant of the country was asked about the training opportunities for civil servants on policy development, he replied that because such facilities have so far been deficient, the arrangements were being made for this purpose.

In other words, a difference of understanding existed about the role of civil servants in policymaking and the need for their training within the top echelons of those responsible for organising and imparting training. But the state of affairs became more confusing when the political boss in the provincial health sector termed this question as "funny". He saw no need for such an exercise, because in his view:

> *Framing policy is the result of a conglomeration of the intellect and other faculties of a human being that develop over time. There is no mathematical way of achieving that faculty. There could be schools of drama, music, and medicine, but not that of how policy is made. Can you teach the king how to make policies? This is his job and he learns it through experience. The great leaders of the world have never been trained in policymaking. This is the ultimate faculty of the human mind*

> *that is gained by gaining and imbibing experience. You cannot teach them how to make policies.*

Thus, it is seen that in the Punjab there was a skewed understanding of the policy analysis held by different parts of the policy machine. Also the apparatus needed for building the policy skills of civil servants did not exist. Such a structure is important for the civil bureaucrats, both upon induction and refreshers, especially for the generalists who move, quite frequently, from one department to the other. Dror (1968: 246-59) argued that the quality of personnel determines the quality of policymaking. In his view, to achieve this aim the policymakers need to be equipped with good education in policy knowledge. However, in the Punjab the situation was compounded, because there was no institution for undertaking policy research, which could advise the policymakers and contribute to policy development.

6.5.2.2. Weak institutional arrangement for policy analysis

The policy machine was drawn primarily from the top echelons in the governance component of health system, which networked mainly with Departments of Finance, Planning and Development, Law and Services and General Administration. Representatives from these provincial departments, appointed part-time on various *ad-hoc* committees, often steered by the chief minister or minister for health, would discuss issues relating to the reforms. But, as inferred from the response of a senior bureaucrat, there was a core group occupying the governance positions in the Health Department, which took part in the policy process:

> *We formed a nucleus group of 4-5 people within the Health Department, where forward-looking people were assembled as a team. This core group, which was to initiate and then submit their products to the government that means the chief minister who was taking interest himself and through him we established structures for the larger and broader consultation within the health sector itself and outside the sector.*

The above arrangement indicates that the policy machine operated at two levels. First, in a smaller group an idea was formulated and sold to the chief minister, and once espoused then in the second stage other stakeholders were involved. However, given the administrative milieu in the Punjab, the second level hardly operated. That is, the process would go unhindered in the meetings, because the chief minister wanted the issues discussed and decided for action in the meeting called for the purpose. As a politician remarked, he was enthusiastic in bringing change, and was more of a dictator than a democratic leader (6.3.2.2). Also, the comments of a technocrat are noteworthy:

> *There might have been some meetings of some experts, but you know there has never been a question of any dissent in such meetings, and especially at such a time when there was a very powerful and arrogant*

> *chief minister supporting this idea (reforms). You can well imagine the response of the bureaucracy and our experts.*

However, after such meetings there would be a backlash. The bureaucrats tuned to making decisions in the hierarchy would seldom agree with such a mechanism. Explaining this phenomenon, the executive director of Special Projects commented:

> *... It is the bureaucratic culture, which led to this thinking. The Finance Department was perhaps thinking by the analogy of PC-1(Planning document) that after approval by a development forum (provincial or national) of which they are part, they would again do its post-mortem. Such an attitude was unacceptable to the political leadership, who asked for the decisions there and then...*

Thus the hegemony of the above group, which had designed the idea and sold it to the chief minister, prevailed. Further, this group operated parallel to those formally envisaged in the SFHP documents, e.g. the Project Steering Committee and the Technical Committee. The former was meant to foster intersectoral collaboration to bring relevant government departments on board facilitating project implementation. Similarly, the Technical Committee was to deal with matters concerning reforms and related issues (GoPb, 1993). However, in the words of a donor representative, this forum was reduced to almost a nonentity.

> *The Technical Committee was not functioning in this respect, and in my time was merely used as a forum for choosing master candidates for training abroad... and commenting on the choice of short-term international experts.*

In other words, the above referred group that was informal in nature (because, it was never formally recognised with specific terms of reference) took over the functions of the formally constituted group. On this situation, a senior politician commented, "people on the group worked on different assignments at a time ...including the purchase of equipment through the donor agencies ... (the result, in his view) was a mumble jumble". Further, this group was impermeable and difficult to access by other stakeholders. Several authorities are given in case studies, but remarks of an expatriate consultant are pertinent at this point: "when life got difficult there, I just went to the secretary health for approval". This donor representative was part of the international hegemonic system and on the Technical Committee of the project.

6.5.2.3. *Ad hoc* mechanism for involving the stakeholders

There was a narrow stakeholder's base due to the *ad hoc* mechanism for involving them in the policy process. The stakeholders can be individuals or groups of people, organised or unorganised who are affected by, or can affect and influence, a decision or action (Dick, 1997). The stakeholder analysis is needed as part of the decision-

making process to know who the stakeholders are, and how they are likely to be affected, in case the system was reformed. This exercise is also helpful in planning strategies for approaching various groups and individuals in order to gain their support or alleviate their opposition (ODA, 1995).

In the Punjab, however, there was no formal mechanism for identifying the stakeholders at any level of decision-making. There is no evidence that any available tool such as 'stakeholder analysis' was employed while undertaking any initiative. Instead, participants for different committees were selected informally on an *ad hoc* basis. In this regard, a chief executive of an autonomous institute told this researcher that "…every time there would be different people in the meetings and this was not a standing group". Therefore, it is argued, this shortcoming affected the way the policy process was undertaken – especially, because a particular group (6.5.2.2) dominated the policy process, excluding many stakeholders and alienating others. For example, when this researcher asked about the government's process for policymaking, a senior technocrat commented:

> *In my view if put in one sentence, this process was agency directed and most secretive. In this process the stakeholders whether the consumer who in our meaning is the patient in a village or the top-level manager whether in service or retired, none of them were involved. All of them were ignored.*

Similarly, another technocrat commented about the level of consultation and the involvement of stakeholders in the policy process for the reforms, that:

> *All documentation and planning whatsoever were done by few people and never saw the light of the day and remained within the close circle. It was never made public to the stakeholders. I mean if you ask (34) DHOs and (34) medical superintendents, and (8) DHSs, you will be surprised to know that none of them was ever involved in these activities. Resultantly, hostilities and a sort of antagonism remained in the managers and fieldworkers ...*

6.5.2.4. Political arrogance is essential for the success

Despite the shortcomings in the policy process as described above, a stream of changes is seen happening in the Punjab health sector during the 1990s. Several respondents subscribed to this observation. That is, the SPP visualised devolution of a district health system within the government's control, but gave way to the semi-autonomous structure of DHAs. Then, autonomy was granted to the institutions, and a DHG reform was initiated to run a functionally deconcentrated district health system in a corporate manner. Contrarily, however, the top bureaucrat in the Punjab government described the outcome of the reform process as 'neither fish nor fowl'. That is, as discussed earlier (6.3.2.1; 6.3.2.3), bureaucracy behaved in this manner

while working for decentralising powers under different reforms. However, to qualify his observation, I examine the policy process for the Punjab health sector reform in a framework suggested by Dunleavy (1995). According to him, five factors contribute to generating the policy disaster. In table 6.10, the Punjab situation is contrasted against these factors.

Table 6.10:- Characteristics of the policy process in Punjab

Dunleavy Factors	Punjab situation
Scale aggregation	Apart from SPP, there is adequate evidence to suggest this factor was operating in the Punjab scene. There was a tendency to go in a 'big way' – even the piloting of DHG in ten (or 30% of) districts.
Overly speedy legislation and policy process	This was the most obvious phenomenon associated with the policy process in the Punjab. The majority of respondents cited this fact. The Bill was passed by the Provincial Assembly after two day's discussion in which only a few legislators participated.
Political hyper-activism	This factor was most pronounced. The DHG, for example, was started in disregard of the political manifesto, which promised the DHAs. The chief minister was hyperactive and also arrogant – a factor that also surmounted the bureaucratic arrogance.
Arrogance of bureaucracy	The civil service in the Punjab is generally arrogant, but also behaved subordinate in the hierarchy. The generalists commanded the technocrats, but were often careful with the political bureaucracy, especially the chief minister.
Ineffective checks and balances	This factor was a quite obvious shortcoming – some reforms forgotten, others abandoned, often overlapped each other, some survived and yet there was no accountability of the core executives.

From table 6.10, one may conclude that the policy process for different reforms in the Punjab health sector was a 'disaster'. However, the question arises, why were there some successes? Not only did successive reforms evolve in their concepts and contents, but also some survived even though the government changed. The answer to this question lies in revisiting the above table. It is seen that the political arrogance surmounted the bureaucracy, which worked for the reforms, although often dragging its feet. In this context, the chief minister told this researcher:

> *They (bureaucrats) were not very cooperative. But, with stick, I got it done from them. When they came to know that I meant business, they started working. They would otherwise obstruct. But, I had to be hard on them.*

Thus, although the policy machine in the Punjab had several deficiencies, some successes were registered. It was due, it is argued, to the political arrogance overpowering that of the bureaucracy. Otherwise, the policy machine in the Punjab health sector not only needed an overhaul in terms of creating an environment for policy analysis, but also some additional parts, especially a policy research unit,

were required. Akin to this structure a Health Sector Reform Resource Centre was suggested by an expatriate consultant, but the policymakers in the government did not pay heed to the same (Wildman, 1999c).

6.5.3. Summary and conclusion

This section was about the contents of reforms in terms of design and the policy machine. The former denotes the set of decisions or policy that is the output of the process. The latter, on the other hand, is the machine or set of individuals and organisations that undertook the process. In this section, in addition to examining the contents, the nature and attributes of the policy machine were also studied.

It was revealed that the design was incomplete and arrangements to implement the same were not robust. However, the underlying shortcoming was that the policy machine had skewed understanding and the arrangements for policy analysis were inadequate. Further no structured efforts were made to broaden the stakeholders' base. Nonetheless, political arrogance pushed the process and certain successes were therefore also registered. Overall, however, it is argued that in the Punjab the policy machine faltered.

This study established that incomplete design and inadequate implementation arrangements stemmed from the shortcoming of the policy machine. It needed not only overhauling, but also required installing some additional parts.

6.6. Implementation

In the preceding section I discussed policy contents in terms of policy design and policy machine. The design meant the policy and arrangements for its implementation, while the policy machine is the organisational arrangement brought together to formulate policy. The focus of this section is the implementation of the policy. Implementation is a complex and iterative process, and given that the implementers contribute to policy formulation, it is difficult to draw a boundary between formulation and implementation. Nonetheless, following the framework for this study, a distinction is made between these two phases of the policy process. Accordingly, the implementation phase begins once the policy design and implementation arrangements are ready and handed over to the implementers for execution.

6.6.1. Findings from case studies

Implementation is studied from two aspects: the operative feasibility and execution of the initiative. The former is about 'implementation strategies' that are sensitive to the needs, interests and perspectives of implementers themselves, while the latter concerns the 'implementation process' (Webb and Wistow, 1986). In the case of the Punjab, however, there was confusion, i.e. implementation of various health sector initiatives was not smooth. Based on this generalisation, in the following sections I explore: (i) the operative feasibility; and (ii) the execution of different reforms.

6.6.1.1. Operative feasibility

Feasibility, according to Walt (1994: 55) refers to 'the potential for implementing policy'. In other words, the question is whether the state has the capacity to implement a particular policy. This aspect of the policy process was tested by enquiring whether the initiative was pre-tested and accordingly strategies were adopted for wider implementation. Further, what was the political environment like, and the agency brought into place for executing the initiative? To answer such questions, the following hypothesis that, in the Punjab poor feasibility rating of initiatives marred the policy process is tested. And for this purpose, findings from case studies for the variables: technical feasibility; political feasibility; and executing agency are clustered and presented in table 6.11.

Table 6.11:- Operative feasibility of initiatives

	Technical feasibility	Political feasibility	Executing agency
SPP	Given the incremental approach to develop a PHC model , it was not needed to 'dry run' the arrangements for ensuring their adequacy before full-scale launching of the intervention	Initially for a brief period it was a politically feasible time, but later in the implementation phase, there was not much political support available for the project interventions.	Management teams at district and sub-district level drawn from health sector were visualised. However, there is no evidence of these teams having been operated at any level.
DHA	Phased approach, but whereas not much progress was made to expand, pilot of the initiative was allowed to perish and be superseded by a new one, the DHG.	Initially a lukewarm political support, but later the same political party was in power, both in the province and centre backed the initiative - it was on its political agenda.	Management structure as DHA with membership drawn from a range of public sector departments and different sections of civil society who were honorary.
IA	Phased approach was used, and a third party evaluation mechanism invoked to learn, but was ineffective and lessons were not fed into the subsequent phases.	It was a politically feasible time, the initiative figured on political agenda of the political government and the provincial chief minister pushed it.	Management structure as the IMCs comprising 2 official and 5 private members and a paid chief executive in chair.
DHG	Phased approach, to learn from experience, but was not executed. So, this aspect cannot be commented on.	It was a politically feasible time till its execution, when the government changed.	Management structure, as DMC comprising 2 official and 5 private members and a paid CE in chair

The salient findings from the above table are as below:

1. About testing the operability of initiatives, a mixed situation is observed. The SPP envisaged an incremental approach, while implementation of other initiatives was planned in a phased manner. However, the researcher could not find from the archives of the initiatives any protocols or arrangements that were made for such an exercise.
2. The political feasibility for implementing the initiatives was the main environmental factor influencing the policy process. This is revealed that apart from certain hiccups in SPP and DHA (initially) politicians were supportive and proactive. However, with the change in government, it changed and the IA was kept, while DHG was scrapped.
3. In respect of execution a development is noted in the organisational characteristics of the agency for the successive initiatives. There is a gradual shift from the central bureaucratic control to a management structure with public-private partnership. That is, there is evolution in the concepts and design of initiatives, but evidence suggests that the executing agencies remained far from performing adequately.

6.6.1.2. Execution of reforms

Execution is not a straightforward process, but according to Backoff (1974) it "begins with clarifying and checking on the ideas for logic, consistency and the meaning. The ideas may have to be reordered for better understanding and may have to be tested by common sense based on actual administrative experience and

behavioural insights". Further, it requires considering: "What steps are involved? What kind of institution or structure is required? What kind of skills is assumed? What kind of communication, instruction, forms is needed? Will attitude need to be changed? What is implied for staff training and education?" (*ibid*) While some of these issues have been dealt with elsewhere (6.5.1.2) it is argued that in the Punjab different initiatives were inefficiently executed. Whereas this generalisation is supported by the argument that the executing agency remained far from being ideal, findings from the table (placed at Appendix 6.1) verify it further. That is, inferred from this appendix/table, the following chronology of the execution phase of the reform in the Punjab is identified:

> The Second Family Health Project overarches all the reforms, indicating being the mother project. The SPP was launched to test different interventions envisaged under this project. However, before its completion another initiative – District Health Authority, essentially a variant of one of the interventions of SPP, was initiated. While the structure of these new bodies was yet to be properly developed and legalised, a new concept, DHG was initiated. The IA was launched alongside the DHA. In the end, whereas the SFHP closed, the IA initiative continued, while the remaining were either abandoned or allowed to perish.

The findings in Appendix 6.1 can also be translated figuratively. Accordingly, figure 6.2 presents different reforms on a vertical axis plotted against the time (in years) on a horizontal axis. That is, the area covered by different initiatives on a vertical axis depicts the amount of activity under way during the corresponding period on the horizontal axis.

Figure 6.2:- Chronological progression of reform process (1992-2000)

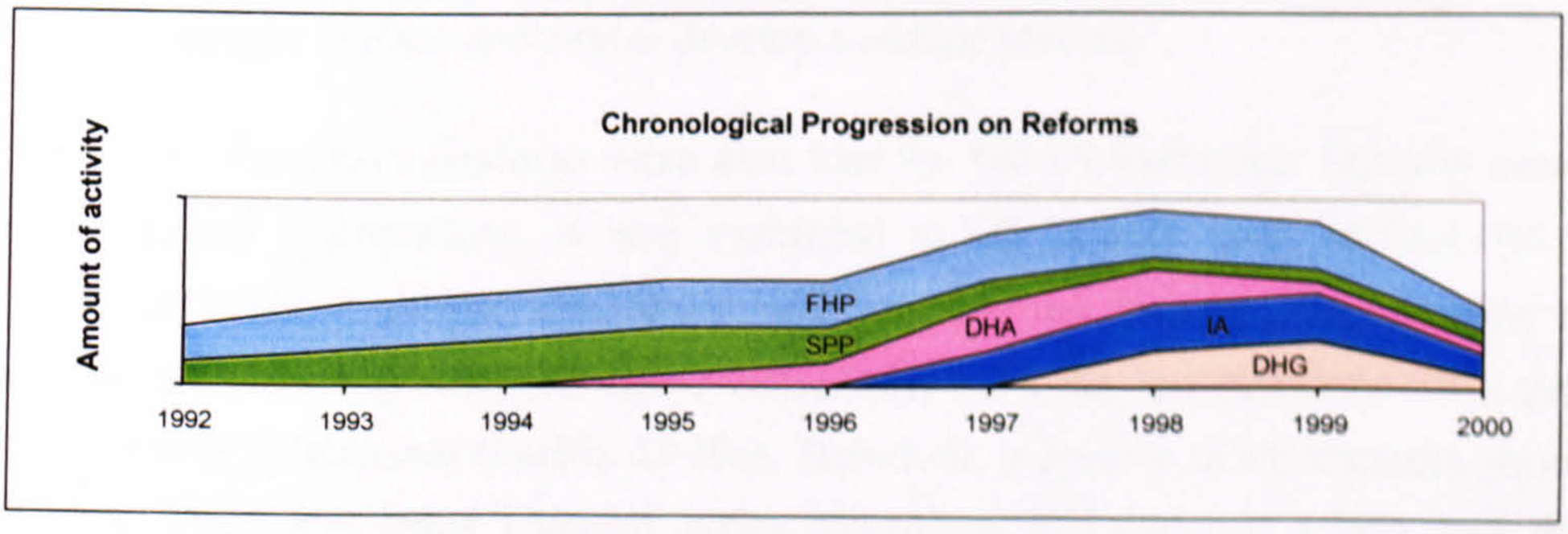

Figure 6.2 reveals that:

> SPP was launched almost alongside the main Second Family Health Project. When its implementation was attaining its peak, the DHA initiative started taking shape and there is almost a proportionate decline in the emphasis on SPP. The IA initiative started almost alongside DHAs, while the DHG began at the expense of the latter. At this point, the SPP attained a plateau followed by a decline indicating its closure, but continuity of its interventions. A similar situation is observed with the DHA and DHG, which were abandoned, but not withdrawn officially. Therefore, the graph does not touch zero.

6.6.2. Factors surrounding the operative feasibility

From the above findings (6.6.1.1), the factors surrounding the operative feasibility are that: (i) technical feasibility was not judged for any initiative; (ii) the successive initiatives had increasing political feasibility; and (iii) the executing agency was far from ideal. In the following section these factors are discussed at greater length

6.6.2.1. Technical feasibility was not judged for any of the initiatives

Zwi and Mills (1995) emphasise pilot testing focusing particularly on perception, attitude, process, systems and institutions. It is essential to conduct this exercise before actually commencing or executing any initiative. However, in the case of the Punjab, although it was intended to undertake such an exercise, the policymakers faltered. This notion was seconded by a donor and also from documentary evidence. It was noted that in the public sector there is hardly any culture of learning from the experience – even, the advice and observations made by different forums were not carried over (Collins *et al,* 2002).

> Nevertheless, organisational learning is not a highlight of the reform process. Two important pilot projects have been undertaken in the Punjab – the Sheikhupura pilot project and the pilot on DHAs established in two districts: Multan and Jhelum. Yet the evaluation of the Sheikhupura project was incomplete. In the case of the DHAs pilot, before any proper structure of these new bodies had been developed and legalised for their legitimacy or powers essential for their operation were delegated, a new concept, the DHG started taking place. The pilots were abandoned before the DHAs were actually brought in place and able to develop a change process.

Similarly, the above findings were also true for the IA initiative. Initially conceived as a phased intervention, it was extended to all tertiary care institutions in the province without proper evaluation and learning of lessons. To monitor and to extend the reform process, as noted earlier (5.5.5.3), the law provides for a quarterly Third Party Evaluation (GoPb, 1998a). However, a review of documents shows that it was done only once (Anjum Asim Shahid & Co Lahore, 1999) and that too attracted serious objections (GoPb, 2000). Finally, the chief executives themselves reported on their performance[33]. About DHG, because this initiative could not be executed, its evaluation and testing its technical feasibility cannot be ascertained.

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[33] Personally known to this researcher

6.6.2.2. Successive initiatives had increasing political feasibility

Glassman *et al* (1999) demonstrated that the feasibility of health sector reform is affected by its political timing. In the case of the Punjab for the successive initiatives there was increasing political support. That is, political leadership was committed and prepared to expend political capital to manage powerful stakeholders associated with the reforms. Initially, however, this was not the case. The SPP had little political support, because in view of the then executive director of Special Projects, its components, i.e. community participation and decentralisation, were against the interests of the (then) political and feudal leadership. Similarly, in the initial phases of the policy process for DHAs, there was lukewarm political support. However, later on there was strong political support, and this momentum was also maintained for the remaining initiatives. Even, the new government maintained this interest and the move for decentralisation continued. For example, the IA initiative was kept intact, although certain restraints and efforts were made to bridge the gaps left in designing the initiative.

This phenomenon of increasing political feasibility for decentralisation can be explained by assuming that political support to the health sector reforms was subject to political stability. And one parameter to adjudge political stability was whether the same political party was in power both in the centre and provinces. Two quotes are relevant here. First, given the fact that two different political forces were governing in the centre and province, it was one of the most unstable political periods in the country's political history. Narrating the then scenario, one senior technocrat commented:

> *I think, the worst time in Pakistan's history for the Health Department, in particular and for all public sector departments in general, was during the period from 1988-1997. Two different political parties had governments in the province and centre. In these years, the entire structure and functioning of the system was destroyed. Corruption became rampant that no one could work in a rightful manner. Rules were violated and the district health system was totally eliminated. This was the situation in 1997, when we analysed and saw that the system had totally crumbled...*

Second, with the same political force in power both in the centre and province, a situation was observed whereby (6.4.2.3) a string of reforms was introduced during the period 1997-2000. Regarding the political feasibility of introducing reforms during this time, one senior politician commented:

> *It was the best time in Pakistan's political history especially in the Punjab. There had been times in Punjab like Kalabagh, Zia-ul-Haq[34] etc, but this time, the political government was in a position to make laws, to implement the new system and new ideas. It was the best time possible.*

The above observations can also be tested empirically by depicting the position of different political forces in the government and the Punjab health sector reforms launched during the 1993-2000 (Table 6.12).

Table 6.12:- Governments in power during 1993-2000 in Pakistan

Punjab Health Sector Reforms	Period	Government in Power	
		Punjab province	Centre (Pakistan)
SPP	1990-93	Pakistan Muslim League	Pakistan People's Party
DHMT (instead of DHA)	1993-97	Pakistan People's Party led coalition	Pakistan Muslim League
DHA, IA, DHG	1997-Oct. 1999	Pakistan Muslim League	Pakistan Muslim League
IA, Devolution	Oct. 1999 – 2000	Military Rule	Military Rule

From table 6.12 it is seen that:

1. During 1990-97 two different parties were in power in the centre and province. During this period SPP was launched. Also the implementation of DHMTs instead of DHAs was allowed, but work was done for conceptualisation and formulation of the latter.
2. After 1997 till the military takeover in October 1999 there was a single party in power both in the centre and province. During this period implementation of DHAs, IA and DHG was allowed.
3. After October 1999 there was military rule both in the centre as well as in provinces. While the IA as a move for decentralisation of institutions was kept intact, districts were devolved, i.e. a radicalisation of reforms is seen during this period.
4. Further, the four initiatives under study can be divided into two sets, based on their political timing: the SPP and the remainder with DHAs overlapping the two sets.

Thus, from the findings in table 6.12 the assumption made above is verified. That is, the two initiatives launched, when both in the centre and province the same political party was in power, received further political support. This support continued afterwards, i.e. the military government upheld the reforms, but abandoned the DHG in favour of devolution of powers to the districts.

6.6.2.3. Execution agency was far from being ideal

Executing agency means the individual or organisation responsible for executing policy. According to Van Meter and Van Horn (1975) the following characteristics have a bearing on the capacity of the agency for implementing policy: '(i)

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[34] During the 1960s, it was the same political force in power both in the province and centre, the Kalabagh was the then Governor of Punjab. Similarly, Zia-ul-haq (1978-88) was a military ruler i.e. the same political forces was in power in the country.

competence and size of the agency's staff; (ii) degree of hierarchical control and processes within the agency; (iii) political resources; (iv) vitality of an organisation; (v) degree of open communication within the organisation; (vi) the agency's formal and informal linkages with the policymaking or policy-enforcing body.

Contrarily, in the Punjab as seen from table 6.12, a mixed picture is noted regarding the nature and the structure of the agency visualised or established to execute the policy, but overall, the arrangement was far from ideal. To substantiate this argument, the remarks of a consultant regarding DHA are the most representative and true for all initiatives (Griffith, 1997):

- ...DHA acts as a decision making body;
- Although the DHA has been notified, the actual and practical functions and role of the DHA is not at all clear and the Chairman of the DHA says he has "...been charged with a mission to test the system and to set the parameters (of the DHA)..." ... there is little evidence of a real sense of direction for and clarity about the DHA; and ...
- The DHA appears to have management and executive authority.

6.6.3. Factors associated with the execution of reforms

From the findings in section 6.6.1.2 two major generalisations are made: (i) parallel and diverse attempts were made to introduce reform; and (ii) it was a story of the struggle for survival and demise in the majority of reforms. I discuss these below:

6.6.3.1. Parallel and diverse attempts were made to introduce reforms

There were parallel and diverse attempts at reforming the health sector. But, the question arises – why was this happening? Three reasons are worth considering:

First, there was a dire need and desire for change and to introduce this, the decision-makers tried one intervention after the other. This need can be of two types: system need; and political need. Regarding the former, when a technocrat was asked whether there was any crisis in the system that acted as a prelude to the introduction of reforms, he told this researcher:

> *It (introduction of reforms) was rather quite late. We should have gone for such initiatives much earlier. We had wasted a lot of time...things that we should have done 2-3 decades earlier, we were thinking at this stage...*

Introducing reforms was also a political need. The Pakistan Muslim League came into power in early 1997 and (Figure 6.2) peak activity is seen during this period till the military takeover in late 1999. This was due to the political party in power

wanting to register some success to its credit, a desire attributed to the continuing instability and frequent change of governments in the political history of Pakistan. Therefore, it tested various prescriptions for the intended change in the health sector.

Secondly, the lack of or a poor information system installed for monitoring reforms led to making frequent interventions. The system was informal and, as one chairman of a DHA commented, this was the main weakness of the reform process. Therefore, those who managed change subsequent to intervention could not objectively gauge the progress of different initiatives. Further, since the decision-makers relied on their subjective assessment, which they were not sure of, the review of documents reveals that no intervention was officially closed. This was, perhaps with hindsight that if the new endeavour failed, there could still be a fallback position; and the earlier reform will be reactivated without again going into the (formal) process.

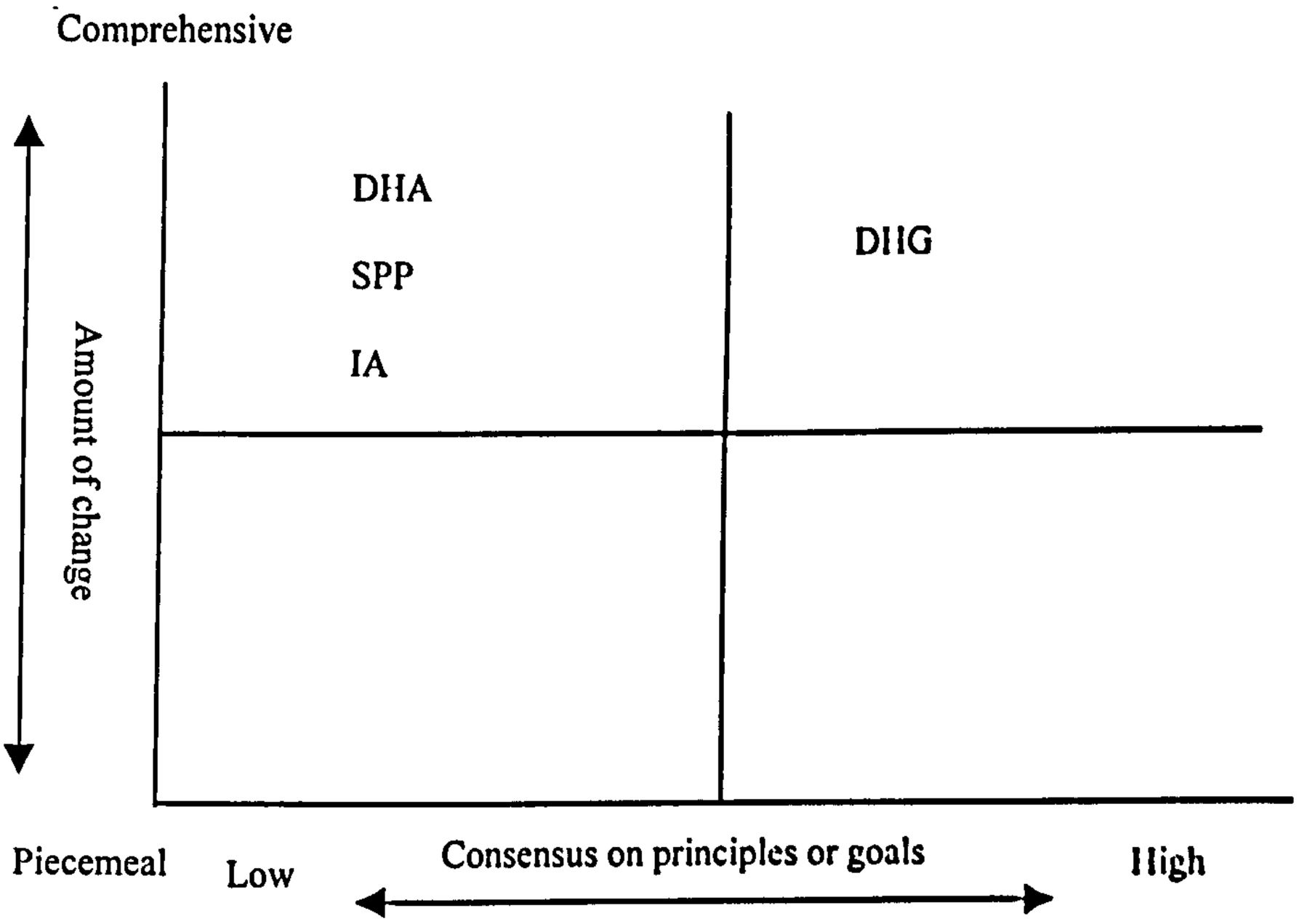
Thirdly, introducing reforms one after the other was a phenomenon of maintaining the *status quo*. This assumption may appear contradictory to the earlier argument, but it is not. There was a dire need (of the system) and the desire of various stakeholders to introduce change, but bureaucracy used a ploy. The bureaucracy, who led the reform process, came up with the ideas and proposals one after the other, which the political bosses espoused. Each of these went through a process. However, at the end of the day no structural change occurred and the same old system prevailed. This was due to the bureaucracy, being keen on guarding its system, and never wanting to lose powers. Therefore, in figure 6.3, the activity graph dips with the change of political government. This finding seems contrary to the military government advancing the reform agenda (table 6.12), but it is not. That is, since the policy for the devolution of powers to the districts was processed at the Federal level by the 'National Reconstruction Bureau', there is little activity in the province.

6.6.3.2. A story of the struggle for survival or demise of reforms

Different models for the policy process, particularly Hogwood and Gunn (1984), after evaluation of policy, visualise its maintenance, succession or termination. In the Punjab, as seen from figure-6.3, except for IA all initiatives met a fatal outcome. First, why was this exception? That is, while other initiatives were either abandoned or allowed to perish, the IA survived. It is argued that this was because the chief executives of autonomous hospitals had taken over their jobs, and given they are highly paid, out of vested interest they remained in position, contributing to the continuity of reform. Further, this initiative was backed by an Act of Assembly and rudimentary Rules that provided legal structure to this initiative. Second, why did other initiatives meet the untoward fate? Two reasons are hypothesised: (i) shunning

change/high consensus reform and is mapped accordingly. However, given this reform was not implemented, it is not possible to comment about this aspect of the policy process.

Figure 6.3:- Dimensions of policies affecting implementation



After: Van Meter and Van Horn (1975)

6.6.4. Summary and conclusions

This section was about the implementation phase of the policy process and, in this regard, operative feasibility and the execution of reforms were studied. A number of hypotheses were generated, which were then tested drawing evidence from the case studies and raw case data.

It revealed that technical feasibility was not tested for any of the initiatives and the agency brought into place for executing reform was far from ideal. Similarly, though the reforms were executed inefficiently, increasing political feasibility underlay the success of certain initiatives.

In conclusion the policy machine was inefficient in implementing the different reforms. The political feasibility was important, but did not materialise into any real success. A number of interventions initiated in parallel led to the loss of focus and the *status quo* was maintained.

6.7. Process

In the last section, implementation of policy was discussed. Here, in this section the process as a component of the policy process will be explored. The process overarches the entire phenomenon of policymaking (chapter 3), and concerns not only the whole chain of decisions and course of action for translating the context into contents which are implemented, but also how the shapers and principles affect this. Thus exploring the process requires looking into the "black box" in order to know 'how decisions are made'. It is different from the question 'what decisions are made' which concerns the design. It is also distinct from the 'policy machine' where focus is on the nature and attributes of different shapers undertaking decisions. Both these questions have been dealt with earlier (6.5). In other words this is about the entire policymaking process including how the shapers and principles influence this.

6.7.1. Findings from case studies

In the case of the Punjab the 'process' for health sector reform was marred with several shortcomings, which influenced the overall outcome. To test this hypothesis, findings of this study drawn from various cases against different variables relevant to 'process' are clustered and tabulated in table 6.13.

Table 6.13:- Process for the health sector initiatives

	In-depth study	Forecasting	Objectives and priorities setting	Option appraisal	Planning process
SPP	Brainstorming, working papers and a baseline survey conducted	No formal technique used; impressions were based on the subjectivity of decision-makers.	Limited objectives were set by bureaucracy and no priority setting	The optional appraisal done in the planning forums	Planning was done at the planning forums in a hierarchical decision channel with limited stakeholder involvement
DHA	Consultancy and brainstorming sessions conducted and working paper developed	-do-	Limited objective set by the bureaucracy and politicians who assented for the initiative. No priority setting	The initiative conceived, planned and implemented without appraisal	Went through a hierarchical decision making with a limited stakeholder involvement in ad-hoc committees
IA	Brainstorming sessions conducted and working paper developed	-do-	-do-	-do-	-do-

	In-depth study	Forecasting	Objectives and priorities setting	Option appraisal	Planning process
DHG	Brainstorming sessions, working paper developed and also a baseline survey made	-do-	-do-	-do-	-do-

It is seen from table 6.13 that the process for different initiatives, with few marginal variations, was almost similar. Nevertheless, salient findings are described below:

1. To validate legitimacy of intervention, techniques such as brainstorming were held in the *ad-hoc* committees and also working papers were developed. For DHA, however, donors undertook consultancies. But, as noted earlier (section on context), these cannot be termed in-depth studies, as these were based on a non-holistic view of the situation.
2. No formal projection technique was employed to determine the possible situation if the issues were not addressed and forecasting of the likely future if otherwise. Instead impressions were formed based on the subjectivity of the decision-makers.
3. Generic objectives were laid down for various initiatives. If one surveys different planning documents in the Health Department, they do not differ much from those laid down for these interventions. No alternative objectives were considered; and also no priority setting was done.
4. Similarly, option appraisal was done formally only in the case of SPP by the planning forum. For the remainder, the decision to undertake a particular initiative was made first and then planning for its implementation was done in a hierarchical manner, involving limited stakeholders. These proposals were also discussed in certain *ad-hoc* committees.

6.7.2. Factors influencing the process

Given the above findings, the assumption made at the start of this section is confirmed to the extent that the process was riddled with shortcomings. However, how was the overall process and its outcome influenced? It is argued that: (i) overall, the process was inefficient and there was no proper planning for policy; (ii) the lack of learning culture led to the shortcomings that perpetuated; and (iii) the inappropriate arrangements for support hindered the reform process. These hypotheses are tested in the following sections:

6.7.2.1. The process was inefficient

From table 6.13 it is seen that a hierarchical decision making channel was followed for policymaking. But the question arises – what is the normative process? To understand this, as explained earlier (4.4.4) this researcher developed a working paper followed by a workshop with senior officials in the government. The outcome of these deliberations is available in appendix 3.1. This exercise of developing an ideal model dictated by the books and experts in the government was run with hindsight to compare and establish how best it was practiced for the reforms under study. However,

it was helpful in enriching the researcher's acumen for the policy process. It was noted that in actual practice there were many deviations for the different initiatives. The most glaring was that all initiatives had administrative, financial and legal implications, but apart from SPP, none were considered in the process. Thus, many stakeholders were excluded and plans remained incomplete. For example, the Finance Department commented on the law promulgated to provide legal cover to the IA and DHGs, as follows:

> *The Finance Department has first of all to point out that as the law, Punjab Medical and Health Institutions Act, 1998 had major financial implications and restructuring involved for the health sector and in that the organisational structure was also being changed, the summary floated to introduce the new Law should have been moved through the Finance and S&GA Department, as provided under the Rules of Business.*
>
> *(However) the draft law was neither shown to the Finance Department nor to the S&GAD. The contribution of the two departments may have avoided a rather very "different" (and in a way an incomplete) piece of legislation as now being perceived... the flaws being inherent, it may not even be possible to fill in the gaps or rectify the errors left in the Act... (GoPb, 2000d)*

Similarly, the scheme for DHAs was not shared with the P&D Department, and then this department also developed such bodies in the entire province. On a summary note submitted by the chairman P&D Board, the chief minister approved establishing District Health Committees in addition to those for development, education and agriculture and irrigation sectors. Later, however, this order was withdrawn at the request of the Health Department (GoPb, 1998).

Actually, in the Health Department people were not much aware of the normative policy process. For instance, the chief secretary questioned "why the draft notification (of BOGs) was sent to the Law Department" after approval of the chief minister (GoPb, 1997v). According to the Rules of Business (GoPb, 1974), it was not needed, but this move by the Health Department jeopardised the whole initiative of autonomy to medical colleges (5.5.1.3; 6.7.2.2). Likewise, while processing the case for nominating the chairperson for the DHA, Multan the same person was also notified as a member (GoPb, 1997d). Similarly, in the case of the appointment of chief executives, the Law Department indicated the shortfalls in the contract drafted by the Health Department (GoPb, 1998x). Further, such omissions meant, no details like framing of rules, regulations, manuals and defining of routines and procedures for new bodies established under different initiatives were worked out. Across the board such shortcomings were observed in all initiatives, which many participants noted – the most representative from the governor of the Punjab – are:

I am afraid I am not willing to accept a *fait accompli*. I would like comprehensive answers to the issues raised here. Could the chief secretary invite the secretaries of Health, Finance, Law, P&D, Regulations to layout what has been done, what remains to be done and how we can extricate ourselves from the total legal chaos that is at best obvious to me? I am also uncertain if it is fair to have a Third Party Evaluation. Have we put up a framework on the ground, which can now be evaluated? As I see it, there are huge voids and in the presence of these, we cannot in all fairness evaluate what we are only claiming to have introduced... (GoPb, 2000c)

Another aspect of the process for the Punjab health sector reform was that it was a case of 'planning follows policy'. This does not mean however, as Walt (1994: 7) argues, that the policy was first formulated and the planners were helping to put it into practice. The issues or problems in the health sector, whether of a high or low political nature (2.4.1.3), were not on the policy agenda. Instead the 'policy ideas' such as 'establishing DHAs' or 'granting autonomy' were agreed and then details were planned. This finding substantiates the earlier argument (6.2.3) that policymakers worked towards the end products. Why they were doing so, was not clear to them. In other words, the 'policy ideas' were not the result of situational analysis, which has a critical role in policy formulation (Green, 1999). This assumption is supported by findings in table 6.13 that the process for different reforms was hardly helped by the planning process, and instead these were picked up from contemporary practices. For example, in a summary note for Cabinet, the secretary health wrote:

> The chief minister brought in an idea of Role Model Institutions to provide standard and quality health delivery services to the people of the Punjab. He directed the secretary health to prepare a plan on this concept (GoPb, 1997a).

Similarly, about DHAs, one senior official in the Health Department commented:

> *The chief minister had since spent his period of exile in the UK, where he saw DHAs, which left imprints on him and he was fascinated that he bought the idea and ordered its immediate introduction in the Punjab.*

Likewise, a minister for health commenting about the policy process for different reforms told this researcher:

> *We did not have to reinvent the wheel, instead we could have gone to the internet or some measure like that and pulled out the international experience and learnt from that to develop a workable model.*

Barker (1996: 27) indicates a managerialist approach taken by some authors e.g. Abel Smith (1994), 'who talk of planning health policies as though the planners were able to formulate policy unrestrained by the politics of the health sector'. In

this manner, she reiterates the limitations of managerialism as an approach to practice public policy (Minouge, 1983). Following such an approach it is seen that in the Punjab mainly the health managers controlled policymaking; in practice, however, they could not (6.7.2.3). Neither the policy contents (6.5) nor its execution (6.6) was ideal.

6.7.2.2. Lack of a learning culture led to the shortcomings that perpetuated

It was noted (6.2.2.2) that policymakers have a tendency for considering the increasing number of tenets of the policy process in the subsequent reforms. Equally, however, evidence points to a lack of learning culture in the public sector. These two observations are apparently contradictory, but are not. The former concerns the 'knowledge in the policy process' while the latter is about 'knowledge of the policy process' (2.4.2.2). That is, the policymakers were impressed by the advocacy, but it remained unclear to them how to systematically undertake policy analysis. In this regard, a representative of a donor agency noted:

> *Even lessons from similar interventions were not learnt. Lessons are not learnt even from a preceding stage of an intervention. There is a lack of learning culture both in the government and in donor agencies.*

This characteristic of public sector culture led to shortcomings in policymaking perpetuated throughout the process. There is a huge body of evidence that different authorities advised the Health Department on certain issues, but the weaknesses indicated were never rectified and were consequently carried over in the process. For example, while assenting to the Punjab Medical and Health Institutions Ordinance, 1998, the then governor of the Punjab observed (GoPb, 1998i):

> 1. The ordinance does not define...medical institution or ... health institution.
> 2. The ordinance is silent with regard to properties both moveable and immovable and assets and liabilities of the institution. In the absence of such provision these will continue to rest in the government, while administration and management of these institutions is transferred to institutions that are corporate bodies i.e. separate legal persons ... cause administrative, financial and other problems.
> 3. There is also in-sufficient provision with regard to provincial government servants who continue to serve in the notified institutions. Will they have the option to become employees of the institution? Lacunae like these may lead to avoidable litigation...
> 4. ...should be urgently attended to in the rules to be framed under the ordinance..."

However, none of the above advice was heeded to by the Health Department in drafting the Punjab Medical and Health Institutions Act, 1998. The new Governor,

therefore, took on the bureaucracy for the shortcomings left, and finally the rules were framed in January 2002 – forty-two months after the first institution was granted autonomy in July 1998. Likewise, a review of the communications between the Law and Health Department about the BOGs for autonomous institutions is a proof of the above observation. For drawing up the membership of BOGs, the Law Department suggested that some criteria be evolved for the selection of non-official members to avoid discrimination and that the public representatives be kept away to preserve the principle that government is responsible to the Provincial Assembly. They advocated that (GoPb, 1997m):

> A fair criteria/process is evolved for making appointment of non-official members to avoid objections on the grounds of discrimination. Further, since Members of Provincial Assemblies are members of the legislature, it would look better if they are kept away from the membership of bodies, which are subordinate to the government. By doing this they would contribute to the preservation of the principle that government is responsible to the Provincial Assembly.
>
> ... It would be observed that according to Article 63(1) (c) of the constitution, a person is disqualified if he is in the service of a statutory body regardless of whether or not the office which he is holding is office of profit. In the instant case the BOG...shall be a body corporate. In other words, the proposed BOGs are statutory bodies. Persons joining as members of the Board would be deemed to be in the service of a statutory body. Considering the risk of incurring disqualification of the Members of National and Provincial Assemblies under Article 63 (1) (e) of the constitution cannot be ruled out."

However, if one visits the membership of the Institutional Management Committees (IMCs) that were constituted instead of the BOGs, several of them had MPAs on them and also the Health Department did not lay down any criteria for the selection of members. Instead, it was left to the non official members of the IMCs. This led to the new governor of the Punjab refusing to approve the IMCs, and he commented:

> ...I think, it seriously detracts from the spirit of autonomy that the nomination of all (5) non-official members should depend on the proposals emanating from the 3 official members. In other words, the 5 non- official members owe their membership of the Committee to the proposal of the official members. This militates against the very purpose of having non-official members... (GoPb, 2000e)

On the whole, therefore, it can be generalised that the Punjab health sector lacked the learning culture, which led to the shortcomings being perpetuated even in the new set up attracting criticism (Dawn, 2002c).

6.7.2.3. Inappropriate support structure

In order to support the policy process for reforms an inappropriate structure was instituted. The support structure is a focal point relating to different components of the policy machine in order to process policy for a particular reform initiative. The shape of the support structure for various initiatives in the Punjab drawn from the relevant findings from the case studies clustered is tabulated below.

Table 6.14:- Support structure/organisation for initiatives

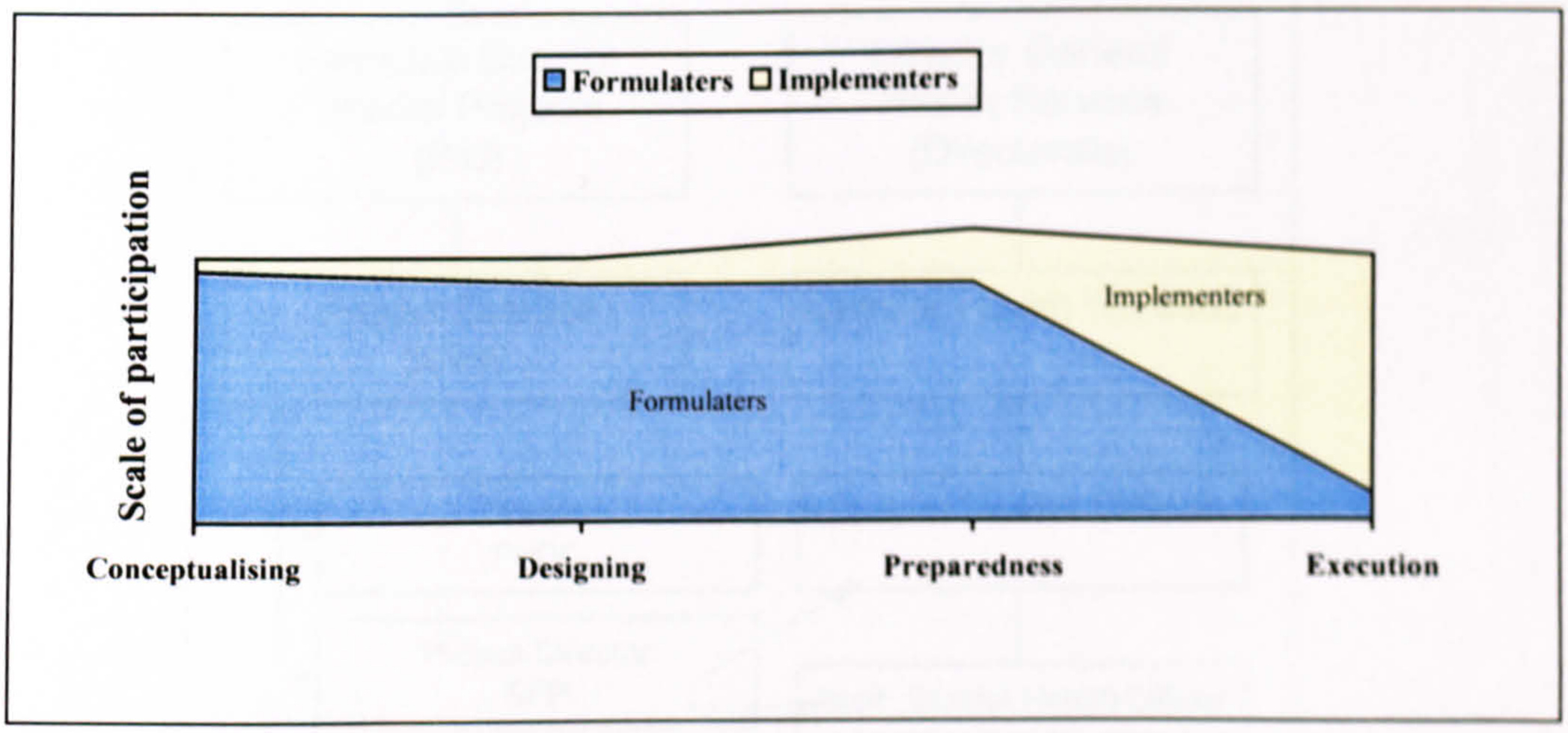
	Support structure
SPP	A temporary structure created in the Project Implementation Unit of the Second Family Health Project as a Project Management Team. This related laterally with the district health staff, who otherwise reported to the DGHS.
DHA	It was initially the Provincial Health Development Centre – a subsidiary of the Second Family Health Project, which supported the initiative, but later the technical wing of Health Secretariat took over this function.
IA	The technical wing of Health Secretariat had a key role in conceptualising and designing the initiative. The administration wing, with support from the executive director of Special Projects, implemented the reform. Later, a Health Sector Reform Unit established in the Special Projects supported the initiative, but after the closure of the project the Health Secretariat again took over this responsibility.
DHG	The technical wing of Health Secretariat and executive director of Special Projects jointly conceptualised the initiative. Later, a Health Sector Reform Unit established in the Special Projects supported the initiative till it was abandoned.

Given the nature of the support structure, as inferred from table 6.14, it is seen that the reform initiatives under study are of two types: (i) autonomy to the medical and health institutions (IA), and (ii) establishing a decentralised district health system (SPP, DHA, and DHG). Both categories of reforms, however, were aimed at bringing structural change into the health sector, for which involvement of several public sector departments like the Finance, Law, Planning & Development and Services and General Administration etc. was essential. In other words, this was a case of 'planning for change' as against the 'planning of change' where the health sector could itself manage (Hogwood and Gunn, 1984: 209). Whereas for the latter a hierarchical structure will do, the former would need an organic structure with flexible tasks and relationships. Such structures are also called the 'implementation structures' (Hjern and Porter, 1981).

However, as noted earlier (6.5.2.2), it was a group of four people as individuals and not representative of different organisations who supported the process. In fact, structures akin to implementation structures like the 'Steering Committee' and

'Technical Committee' meant to support process were taken over by this group. They conceptualised, formulated and handed over the policy – e.g. outlined as an Act of Assembly– through a Contract to the executers – the street level bureaucrats. Thus the relationship which existed between the formulators and implementers can be drawn as in figure 6.4.

Figure 6.4:- Interaction between implementers and formulators



Source: Adapted from Green (1999)

That is, as seen in figure 6.4 the implementers are pushed out by the formulators, who undertook most of the policy process including the preparedness part of the implementation process. The implementers were reduced to execution only due to the inappropriate arrangements made for supporting the reform process in the Punjab health sector. This generalisation is made on account of two reasons: (i) a parallel and temporary organisation was created; and (ii) the policy machine itself supported the process for introducing these initiatives. In the following sections, these two assumptions are discussed in further detail.

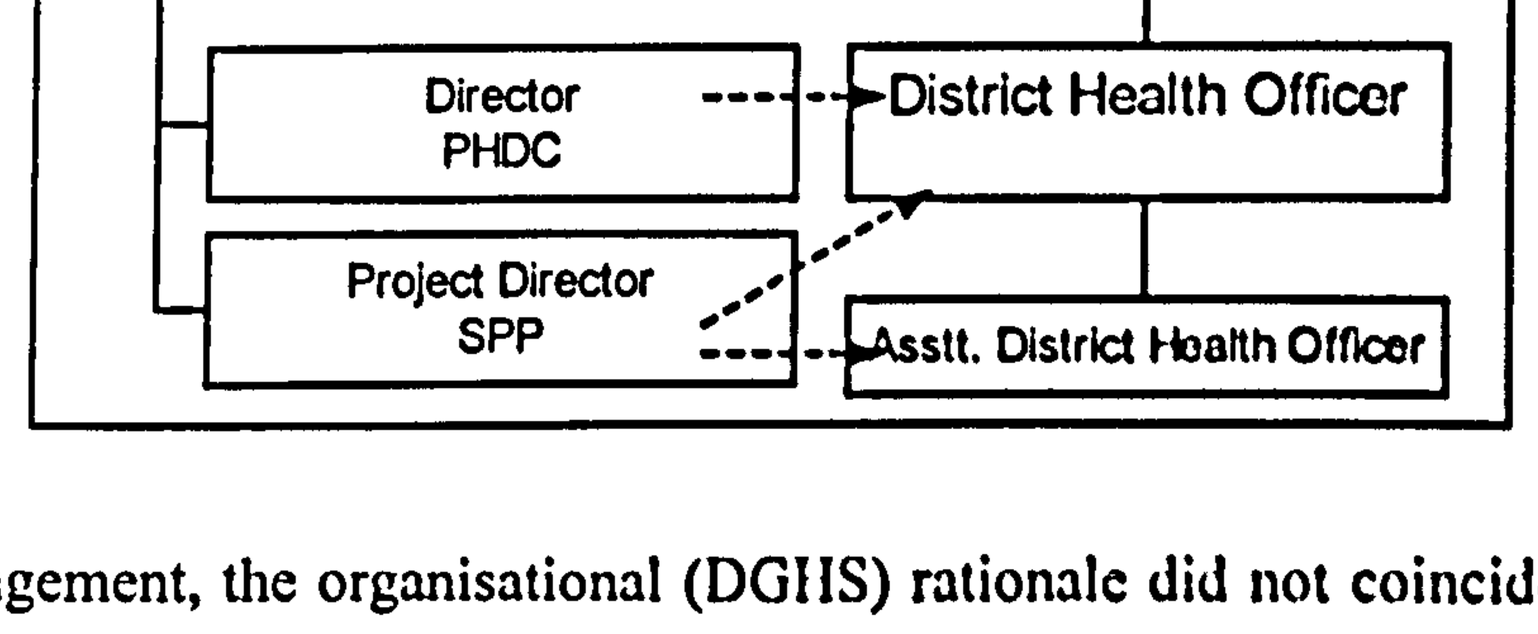
Parallel and temporary organisation

Bossert (1990), from his 'five country studies' provides a list of characteristics as the guidelines for a sustainable donor assisted project. Two of these, relevant in this case, are to: (i) integrate activities into the established administrative structures; and (ii) gain significant levels of funding from national sources in order to ensure operation beyond the project's life (7.5.7). In the Punjab, neither of these guidelines was adopted. Specifically, looking at the first, the following picture emerges:

From table 6.14 it is seen that a Project Management Team established in the Project Implementation Unit of SFHP managed the SPP. This team reported to the executive director of Special Projects through the project director of SFHP, while it worked

laterally with field formations in the district that was under the control of the DGHS through a DHS (Figure-6.5). These relationships, as noted earlier (5.3.6.4), since inconsistent with the organisational lines of reporting, were informal and personal.

Figure 6.5:- Organisational relationship of support structures



In this arrangement, the organisational (DGHS) rationale did not coincide with the programme (EDSP) rationale (Hjern and Porter, 1981) and as already identified (5.3.6.4), led to several issues. There was no flexibility in this structure and it was marred with bureaucracy and stringent administrative and financial procedures (EDSP, 1998). Further, both DGHS and EDSP served as masters in the respective organisations reporting separately to the secretary health. As a result, symbiotic relations could not develop between the two. Instead, at times, a tension was observed, e.g. one ex-EDSP quoted an ex-DGHS as saying to the then EDSP in a meeting, "Either I work under you or you work under me: only then the project can move". Given such a situation, a top planner in the Health Department argued that the linkages for the SPP were wrongly designed:

Creating a separate set up of the executive director of Special Projects was a mistake. Taking it away from the DGHS, who was the main stakeholder of the process, was not right. At times we (decision-makers in the secretariat) felt this shortcoming in meetings and while interacting with the mainstream Health Department. They did not know what was happening. Therefore, they would not own the results of the project. The DGHS and his line management would not feel the strong stakeholders of the project, whereas they were. So I would say that something went wrong in the design...

Similarly, for DHAs, the PHDC initially provided organisational support. However, based on the above logic, it was also not an appropriate arrangement. The PHDC reported to the EDSP, while the DHA was established in the district field formations – in the control of the DGHS (Figure-6.5). Later, a new structure, the Health Sector Reform Unit, was established in the PIU of Special Projects for supporting the IA and DHG initiatives. However, it was also far from an implementation structure. A mix of private and civil servants were hired temporarily as consultants in realisation of the then executive director's proposed scheme of a 'Professional Management Support Group' (5.6.6.3). This arrangement was doomed, as a representative of a donor agency commented:

> *...to make a new set up like HSRU with advice from 'somewhere' and implement reform from a de-institutionalised structure – again a simple individualistic power game... 'someone' who wanted to take the lead made sure that the technical assistance was moved from an institutional set up to a temporary unit that collapsed soon (after the donor support was withdrawn).*

Given the analogy of the PMT for SPP and the PHDC supporting DHAs, establishing a temporary structure – HSRU – in another temporary structure – Special Projects – was not the right arrangement for policy succession (Hogwood and Gunn, 1984). The P&D Department highlighted this shortcoming, and the Health Department, in the wake of severe criticism, withdrew the proposal it had submitted for seeking funds for the HSRU (5.6.6.3). Further, in such an arrangement for the policy process there was loss of institutional memory and this researcher faced immense difficulty in locating the reform archives.

Policy machine itself supporting the initiative

Findings in table 6.14 reveal that the technical wing of the health secretariat (the government) took over the policy process for DHAs from the PHDC and subsequently it also undertook the policy process for DHG and IA initiatives. This policy planning and implementing in the core of government (health secretariat) can be advocated, but it is also contestable. That is, how an organisation itself in need of reform can undertake to steer reforms, a chief executive, a chairman of DHA and the P&D Department commented. This was also in defiance of the principle of planning for change, which cannot be implemented by the organisation itself undergoing a change (6.7.2.3). Hjern and Porter (1981: 211-27) elaborate the implications of such an approach, as follows:

> Failure to identify the implementation structure as administrative entities distinct from organisations has led to severe difficulties in administering the implementation of programmes. When a new programme is enacted, it is assigned to a single organisation, and

> everyone walks away secure in the belief that somehow it will be implemented. If there is a failure, the programme is assigned to another organisation, or the department head is fired, or both.

Precisely the same situation happened in the Punjab. DHG was first suspended and then abandoned by the new government. The comments of the new governor about the conduct of the IA initiative were harsh (5.5.5.5). The secretary health who led the process, according to one of his close associates, was first subjected to several serious examinations and was finally transferred out of the Health Department. Nonetheless, besides these complications, the policy machine itself supporting the process that led to these deficiencies (absence of rules and regulations) perpetuated for some time (see 6.7.2.2).

6.7.3. Summary and conclusions

This section studied the process, as a component of the policy process, and was concerned with 'how did the policy machine work'. It was revealed that whereas, on the whole, it was inefficient, the individuals and organisations comprising the machine lacked a learning culture. Underlying this characteristic, however, was the absence of an appropriate implementation structure. Instead reliance was placed on certain temporary structures created parallel to those established formally or the policy machine itself undertaking the process. This arrangement led to complications, including the non-development of institutional memory and so the experience or lessons were not passed on to successors.

With this section I conclude exploring different factors that influenced the policy process. The next section, to recapitulate, enlists these factors portraying the policy process for reforms as practiced in the Punjab health sector.

6.8. Policy process in the Punjab health sector

So far, drawing from case studies, I have discussed a variety of factors associated with different tenets of the policy process. This section summarise these factors in Table 6.15, and then provide a comprehensive picture of the policy process for the Punjab health sector reforms.

6.8.1. Summary of factors influencing the policy process

Table 6.15:- Factors influencing the policy process

Tenet of the policy process	Features of reforms and factors influencing the policy process	Major theme emerging
Principles and purposes		
	Being on the political agenda did not ensure the laying down of principles	The absence of clearly defined principles
	Tendency of considering more tenets of the policy process in the successive reforms	
	Involvement of politicians in conceptualisation of reforms was vital in laying down the principles	
Shapers		
	Leaders lacked the qualities to guide the process as: • technocrat could not harness support; and • civil bureaucrat led the reform in a bureaucratic way	There was narrow stakeholders' base or the policy process was a 'one-hand clap' phenomenon
	Support for reform was inconsistent and inappropriate as: • support for SPP dwindled over time; and • support for the other initiatives was inconsistent and inappropriate	
	Bureaucracy resisted and opposed reforms as there was: • an internal-driven politicisation of bureaucracy; and • a politico-bureaucratic nexus	
	The donors were supportive, but their role changed over time – a conclusion drawn from: • inculcating the ideas and building the critical mass; • competing and actively supporting the policy process for reforms; and • following suit, instead of technically guiding	There was fatigue of administrative mechanisms of the donors.

Tenet of the policy process	Features of reforms and factors influencing the policy process	Major theme emerging
	The media changed its role from being passive to active, but to only cover the debate The policymakers did not use the media	
	The community was passive and under-developed Inadequate and inappropriate effort was made to broadening the stakeholders' base	
Context		**Lack of a holistic view of the context**
	A partial analysis of context was made	
	The interventions designed subsequent to non-holistic analysis of the context led to more complications	
	Critical situation alone did not serve as a window of opportunity for reform	
Contents		**Shortcomings of the policy machine**
Design		
	The design of policy was incomplete	
	The preparatory arrangements were not robust	
Policy machine		
	There was a skewed understanding of policy analysis	
	There was weak institutional arrangement for policy analysis	
	There was a an *ad hoc* mechanism of consulting stakeholders	
	Political arrogance was essential for the success of reforms	
Implementation		**There was a lack of proper implementation structure**
	Operative feasibility was poor as: • technical feasibility was not judged; and • agency responsible for execution was far from ideal, but • successive initiatives had rising political feasibility	
The execution was ineffective		

Tenet of the policy process	Features of reforms and factors influencing the policy process	Major theme emerging
	Parallel and diverse attempts made to reform because: • there was a dire need and desire for the change; • there was a lack of or poorly developed information and monitoring system; and • it was a phenomenon of maintaining the *status quo* and inefficiency marked the process.	
	It was a story of demise and struggle for survival of reforms because: • subordinates were shunned of from the policy process; • of certain policy attributes i.e. comprehensiveness and consensus of stakeholders on principles.	
Process		Shortcomings of the policy machine
	The process was inefficient	
	There was a lack of learning culture that led to the shortcomings perpetuated in the process	
	There was an inappropriate support structure as: • parallel and temporary organisation were established; • the policy machine was itself supporting the initiatives.	

Table 6.15 classifies different factors according to the tenets of the policy process. In addition, presents the common themes, judged by this researcher, emerging from the combination of various factors.

6.8.2. Salient features of the policy process for the Punjab health sector reforms

In table 6.15 various factors influencing the policy process were given, leaving the question – what was the policy process like? To deal with this question, the salient features of the policy process for the Punjab health sector reforms are given below, essentially building on the conceptual framework (chapter 3) for this study:

1. The principles for different initiatives were unclear, which contributed to the confusion and lack of direction in the policy process. However, a tendency was observed for considering all tenets of the policy process in the subsequent reforms. That is why, for DHG, the latest initiative in the study period, principles were documented but remained unknown to the stakeholders. This study underpins that this shortcoming was due to the non-involvement of politicians in conceptualising reforms. Contrarily, the purposes for different reforms were clear, and were common to most developmental proposals.

2. The different shapers had a varying role in the policy process, as:

a. The leaders, who were the bureaucrats, did not guide the process to success; either they failed in harnessing the required support or it was the bureaucratic attitude that got in the way. Similarly, support was inconsistent and mostly incoherent. In fact, the supporter ended in opening up several fronts, thus losing oversight and focus. But the most important factor was the absence of mechanism for identifying the stakeholders. Both the leader and supporter did not employ 'stakeholder analyses' technique. Thus, whereas many stakeholders were precluded, no appropriate strategy was developed to harness the support or alleviate the opposition of others. This resulted in a narrow stakeholders' base.

b. The technical bureaucracy was subservient to its civil partners; and will be referred to as a part of the bureaucracy. Its role in the policy process for reforms was the 'internal – driven politicisation', i.e. as an institution, it was working to maintain the '*status quo*' and not to bring change in the health system. And in this purpose they were successful; particularly due to their technical superiority and that their political counterparts were not politically mature. It was, therefore a politico-bureaucratic nexus, where both bureaucrats and politicians were engaged in policymaking and also concerned about politics. In this relationship, the bureaucracy defied and often downplayed the orders of their political executives, but it was due to the arrogance of the political chief executive that certain successes were also registered.

c. Civil society was not developed, and the policymakers made no significant effort to either develop or actively involve it in the policy process. Official confidentiality and the prevalent administrative milieu further added to the exclusion of many groups. The media, which was initially passive, became active, but mainly to cover the debate between government and one of the newspaper groups. Of the others, it was only the Pakistan Medical Association, who participated, but it was ineffective due to internal splits. Similarly, the health service providers were either not involved or, if at all, not as a technical polity, but as a technical bureaucracy – a role that was indistinguishable from the bureaucracy. There is no evidence that the health service recipients were effectively involved at any stage of the policy process. In short, because the shapers were mainly from the governance components of the health system, and both the service providers and recipients were poorly represented in the policy process, it was a one-hand clap phenomenon.

d. The donors operating from the outer orbit of the external environment form part of the international hegemonic systems. However their role changed over time. They inculcated the concepts of decentralisation. As a result, the civil

servants, who were initially opposed, appreciated the new paradigm to later become the advocates and finally claimed the ownership of the reforms. The donors competed for reforms and drove the move for design and execution. However, ultimately their role was reduced to mainly directing the financial assistance, while technical assistance became minimal. They appeared to be following the recipients rather than guiding or technically assisting the project. This may be attributed to the effort of donors to go with the government, but it was also the manifestation of a different phenomenon - 'aid fatigue'. This syndrome exists increasingly and concerns the weariness of aid in kind. In the Punjab, however, the money was there and the donors were also willing to pay, but it was the administrative mechanism of donors that fatigued.

3. The context was explored, while preparing the case for reform, but only partially. This was on account of the inadequate understanding of the context and lack of its systematic analysis. This led to the interventions remaining defective in their design, which upon implementation, not only failed to adequately address the problems, but also gave rise to some others. According to the framework used in this study (chapter 3), the context has three inclusive levels: the health system; the national systems; and the international hegemonic systems. The outcome of the context analysis would therefore largely depend on where the analyst positions himself. A holistic view will, however, require studying the context at all these three levels. But, in the Punjab, it was not the case. Another related feature of the policy process was that, although the situation in the health sector was critical, someone needed to react. The critical situation alone did not serve as a window of opportunity for reform.

4. Different reforms were aimed at establishing a decentralised institution or a district health system. Therefore, these were potentially structural in nature and were at a systemic level that could also have implications for the other policy levels. However, since the design was incomplete, it is difficult to pinpoint which policy levels were addressed by different initiatives. As conjectured above, the contents or design were deficient, and the preparatory arrangements made to implement reforms were not robust. Such an outcome hinged on the performance of the 'policy machine' that churned out reforms and conducted the process for them. There was an inadequate understanding of the concept and no specific institutional arrangement existed for undertaking policy analysis. This 'machine', in other words, was not only inefficient and needed overhauling, but certain 'additional parts' were also required.

5. Implementation denotes the execution of reforms subsequent to determining their operative feasibility. However, there were shortcomings in both these areas.

Reforms were introduced in rapid succession. This indicated the dire need for initiatives by the health system, but equally important was their skilful execution. That was not the case, however. Technical feasibility was not judged for any of the initiatives and the envisaged executing agency was far from ideal. Nevertheless, some reforms were executed with limited success, which was consistent with the increasing political feasibility for successive reforms. Also the chief executives had taken over and given that they were highly paid in-charges of the autonomous institutions, they remained in position, i.e. the vested interest contributed to the continuity of the reform.

6. Overall, the process for reform was inefficient and there existed no culture of learning from the experience or listening to the advice of different stakeholders. The shortcomings were therefore carried over, leaving voids in the policy process. This was mainly due to the absence of an apparatus like an 'implementation structure'. Either the 'policy machine' itself or some temporary structure coordinated the policy process. This led to some reforms being forgotten, others abandoned or overlapping each other, some survived and yet there was no accountability. Further, the institutional memory for reforms was fuzzy and this researcher had difficulty in locating the archives for building the case studies for this research.

6.9. Summary and conclusion

This chapter discussed the policy process for the Punjab health sector reforms, unearthing a variety of influencing factors. Viewed retrospectively, it was not a rosy picture; however, limited progress was also registered. Underlying this situation, a number of factors were revealed, influencing the policy process. However, keeping in view the thematic commonalties emerging, six of these stand out prominently. These are: (i) the absence of clearly defined principles; (ii) insufficient involvement of stakeholders; (iii) the lack of a holistic view of the context; (iv) the shortcomings of the policy machine; (v) the need for a proper implementation structure; and (vi) the administrative fatigue of donors leading to their adopting a laid back position.

In the next chapter I relate these factors to the existing material on the subject and draw implications of this study for the policy process in the Punjab health sector. Further new venues for research into the subject are also identified.

7. Conclusions

7.1. Introduction

In the last chapter, the policy process for the Punjab health sector reform was discussed. Drawing evidence from four individual case studies described in chapter-5 and the raw case data it transpired that many factors contributed to the outcome. However, keeping in mind the common themes emerging, six factors stood out prominently. This chapter aims to conclude this study by:

1. presenting a retrospective overview of whether the research question and the surrounding sub-questions have adequately been answered;
2. identifying the contribution of this study to the existing body of knowledge;
3. relating the findings to the existing material and insight on the subject;
4. indicating the lessons or implications of this study for the Punjab health sector policy process;
5. revealing the limitations and the measures taken to circumvent those; and
6. identifying new venues in the research arena.

7.2. Overview of achievements

This study was launched with the following aim and objectives (Box 7.1):

Box 7.1: – Aims and objectives

This study aims "to explore factors that influenced the policy process for the government initiatives undertaken in the Punjab health sector during the period 1993-2000". Drawn from this aim, the major objectives of the study are:

1. to develop a framework for analysing the health sector;
2. to describe the changing structure and functions of the Punjab health sector;
3. to establish a framework for analysing the policy process for reforms;
4. to analyse the policy process for the health sector reforms undertaken in the Punjab health sector during the period from 1993-2000;
5. to explore the factors that influenced the policy process for reforms; and
6. to draw lessons for the ongoing and future reforms.

Within the remits of the above aim and objectives, it was to address the research question, "what factors influenced the policy process for the government initiatives undertaken in the Punjab health sector during the period 1993-2000". Since this

question has several facets; more questions and sub-questions (Box 7.2) surround it. Accordingly this study was designed and conducted.

Box 7.2: - Research question

1. What is the changing structure and functions of the Punjab health sector?
   - 1.1. What is the organisation of the health sector?
   - 1.2. What is the role and functions of various components of the health sector?
   - 1.3. What are the status, issues and problems in the Punjab health sector?
2. What was the policy process for the health sector reform initiatives undertaken in the Punjab health sector during the period 1993-2000?
   - 2.1. Which reform initiatives were undertaken during the period 1993-2000?
   - 2.2. Who and how did they influence the shaping of reform initiatives?
   - 2.3. What were the principles and ideology behind the reforms?
   - 2.4. Why were the reforms introduced or what factors preceded their introduction?
   - 2.5. What were the scope and proposal in terms of concepts and design?
   - 2.6. How did the government conceptualise and design the reforms?
   - 2.7. What was the process for implementing reforms?
   - 2.8. What was the eventual fate of the reform initiative?
3. What were the factors that influenced the policy process and lessons for the ongoing or any future reform initiative in the health sector?

To what extent have the above aim and objectives been achieved? To answer this question, a retrospective overview of the study process is presented below, which may be best read alongside Appendix 4.7. This appendix outlines the research objectives and dependent variables (Box 7.3) addressed by applying different data techniques and sources in a matrix structure (4.4.7).

Box 7.3:- Research variables

1. Theoretical framework for health system
2. Organisation of Punjab health sector
3. Roles and functions of various components of health sector
4. The status and issues in the health sector
5. Reform initiatives undertaken in the health sector during the 1993-2000
6. Theoretical framework for the policy process for health sector reforms
7. The ones who shaped the reform initiatives
8. The ideology behind the reforms
9. The factors that preceded the reform
10. The government's process for conceptualising and designing reform
11. The process and methodology for implementing the reform
12. The scope and particular proposal of different reforms
13. The eventual fate of different reform initiatives
14. Factors in the health system that influenced the process of reforms
15. Features of policy process that influenced the outcome of reforms
16. Measures or lessons facilitating the ongoing or future health sector reform

Chapter 1 addressed research question 1 and its related variables. That is, a theoretical framework formed the basis on which the structure and functions of the Punjab health sector were reviewed. In addition, the status, problems and a brief resumé of the reforms (other than those studied in-depth) undertaken during 1993-2000 were reported. Thus, first two objectives and five dependent variables of research question 1 were addressed.

Chapter 2, by a literature review, prepared the ground to partially respond to research questions 2. A framework was developed in chapter 3 for analysing the policy process for four selected cases to address the research objectives 3 and research variables 6. But, how was this analytical framework applied to the selected cases? Chapter 4 reports the process that was followed in this research. It was the laying down of rules and procedures and their application for conducting a qualitative inquiry, while upholding ethics, credibility and quality.

Chapter 5 replies to the remaining part of research question 2 and the associated sub-questions. Four health sector reform initiatives were studied using the analytical framework developed in chapter 3. Individual single-case studies were presented in chapter 5. Thus, research objective 4 and variables 7 to 13 were addressed.

Chapter 6 answers research question 3. The factors influencing different tenets of policy process were hypothesised and tested. This was building theories using the common themes emerging; and six factors were identified that influenced the policy process for the Punjab health sector reforms. However, lessons for the ongoing or future initiatives in the health sector are left to be dealt with in this chapter. Thus, research objectives 5, 6 and variables 14, 15 and 16 are achieved.

7.3. Contribution to the knowledge

While justifying the need to carry out this research, it was noted (chapter 4) that despite a great deal of interest in health sector reforms all over the world, few systematically planned studies have been undertaken (Gross *et al*, 1998). This notion is also true for the Punjab, and this study, by analysing the policy process determined the factors that influenced the output of reforms, breaks new ground. It is an original work and "like many qualitative researches" opens up new venues, adding to the body of knowledge (Health Services Research, 1999) in terms of: (i) conceptual framework for the health sector; (ii) conceptual framework for the policy process; (iii) documenting the research process, especially through use of a computer utility "Qualitative Data Processing System"; (iv) introducing new terms on the subject; and (v) identifying factors that influenced the policy process for the

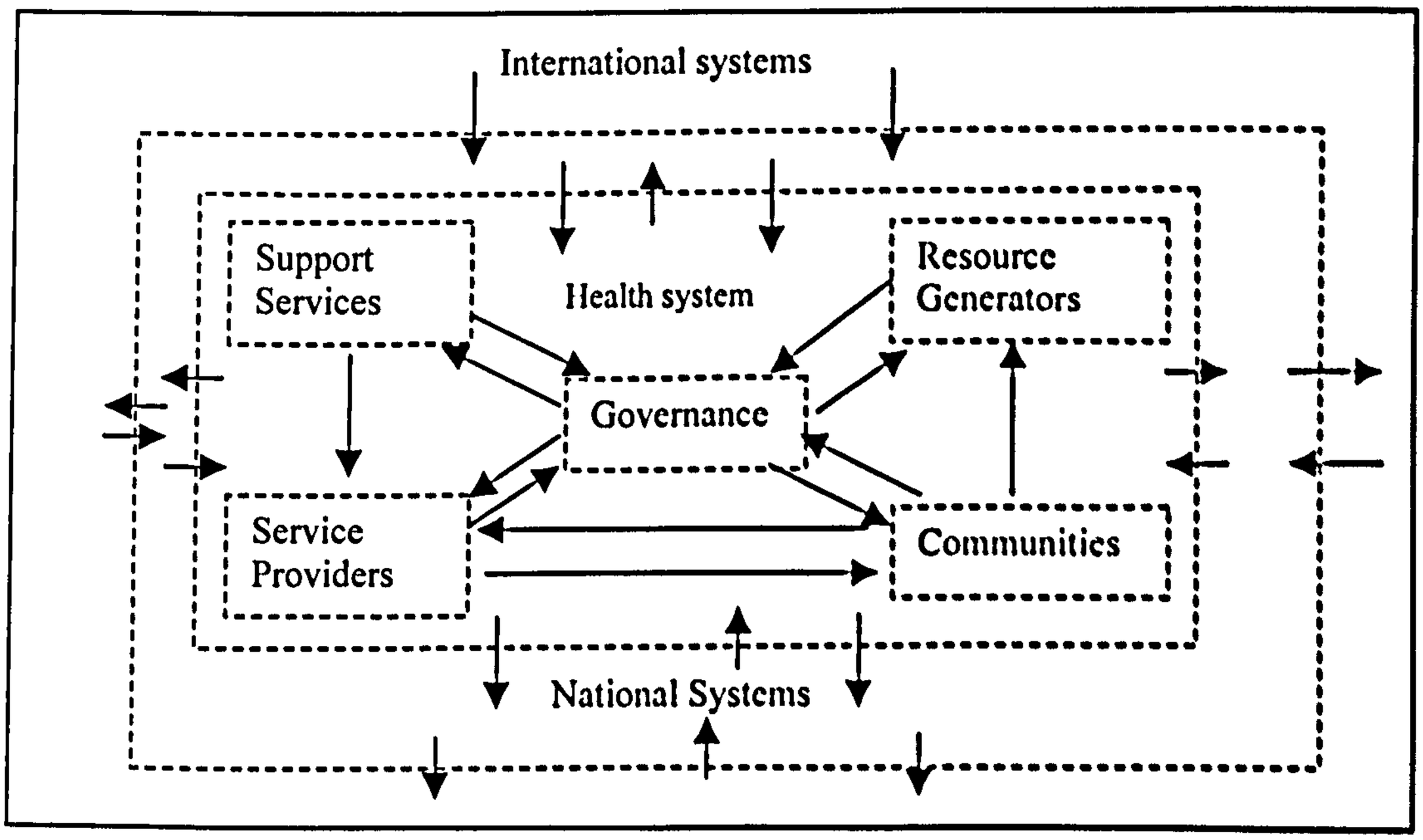
Punjab health sector reforms. In the following section, these contributions made by this research are explained.

7.3.1. Conceptual framework for the health sector

Many authors have provided frameworks for the health system (e.g. Roemer, 1991; WHO, 2000; Frenk, 1994; and Tareen and Omar, 1998). However, as noted in chapter 1, these models had one or other deficiency. Specifically, it was difficult to apply them in the public sector perspective. Given this challenge, the current study established a framework for examining the public health sector (Figure 7.1).

This framework helped in relating the public health sector to other provincial or national systems and international systems operating in the social world of the Punjab. Whereas, the details about the framework are available in chapter-1, it was applied successfully in the Punjab perspective, particularly:

Figure 7.1:- Conceptual framework for the Punjab health sector



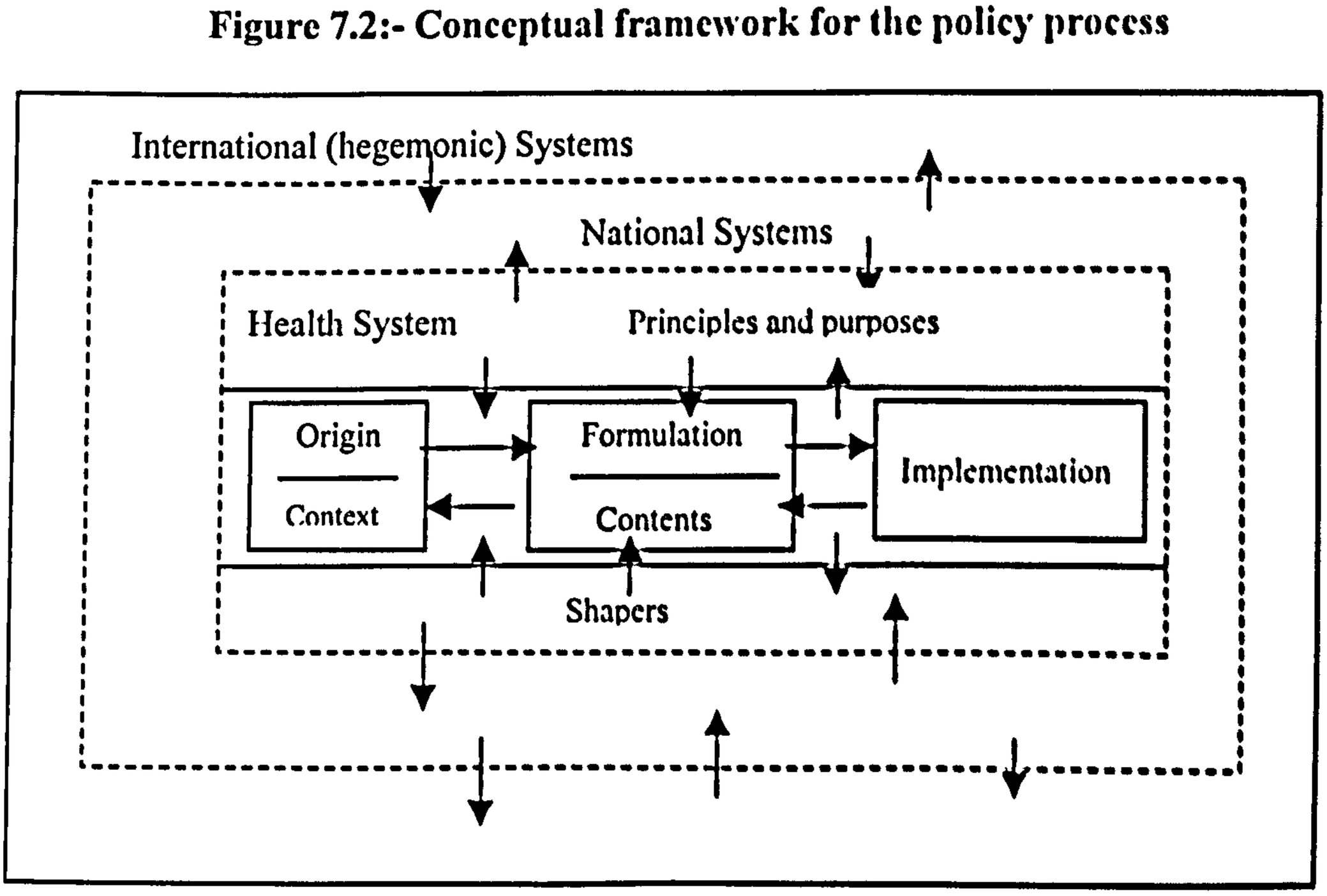
1. the health sector forms the context of the policy for reforms, and the framework was usefully employed in exploring its changing structure and functions. This structured approach to context analysis helped understand how the partial view of context contributes to the defective design of reform.
2. because the shapers of policy, as individuals or organisations, are present in different components of the health sector, this framework helped in their location. They are the stakeholders, and their exclusion from the process affects the ultimate design and implementation of policy.

3. the study participants belonged to the health sector. The framework was useful in locating and developing an inventory of those key informants that were later validated in a stakeholder analysis workshop. Since they shaped the policy process it was possible to construct a comprehensive view of the policy process.
4. the framework was also helpful in data collection and analysis. By applying this framework, it was possible to locate and draw from the material used in the study and then the information so obtained was re-contextualised in the thematic framework developed for analysing the findings.

7.3.2. Conceptual framework for the policy process

Like the health sector, a number of authors have developed frameworks for analysing the policy process (e.g. Barker, 1996; Parsons, 1995; Hogwood and Gunn, 1984; Walt and Gilson, 1994; Frenk, 1995; Gonzalez-Block, 1997). However, as indicated in chapter-2, these models lack comprehensiveness, i.e. they do not address all tenets of the policy process. Therefore, in chapter 3, a framework based on a working definition of the policy process for health sector reforms, was developed (Figure 7.2).

Figure 7.2:- Conceptual framework for the policy process



The above framework proved robust, because:

1. the health sector forms the context of the policy process, a point where this framework relates to the framework for the health sector. In this manner, it was possible to holistically analyse the policy context.
2. it is comprehensive which brings into its remit all tenets of the policy process, and was successfully used in defining the research question posed by this study. It was used to design research protocols, especially data collection instruments.
3. it helps in establishing a thematic framework used as a tool for organising findings from raw case data and analysing and interpreting data. Thus, it was possible to answer the research question from various perspectives.
4. nonetheless, in determining the factors influencing the policy process, although the framework of this study was followed, evidence were brought from across its components, necessitated due to its being at the second analytical level.

7.3.3. Research process

This study, responding to the call by the 'qualitative research authorities', in chapter 4 not only lays down the rules and procedures, but also provides an account of 'how' these methods were used in the actual research (Yin, 1994; and Creswell, 1994). That is, contrary to what Creswell noted, different steps of research have not been truncated; instead this thesis gives them a due share of space and emphasis. That is,

1. a detailed presentation is made on how the research was designed and qualitative data collected, analysed and processed, to enable the study to be replicable by a third party. This was to demonstrate the rigour in the case study research and as Yin (1994: 9-10) emphasises, "every case study investigator must work hard to report all evidence fairly".
2. a concept of 'pre-fieldwork' is introduced. This activity is necessary to gather intelligence about a particular case in a structured fashion. Pre-fieldwork was helpful in determining the policy process normally practiced, and to identify any deviation occurring for the Punjab health reforms.
3. further, for the convenience of readers, the narration of different research steps is augmented with appropriate visuals. While reading the account, the figures present the steps in a logical sequence and were appreciated as an aid to communication and flow of ideas[35].

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[35] Informal comments of a senior colleague who very kindly reviewed the chapter 4 of this thesis.

7.3.4. Introduction of new terms in the literature on policy

This study introduced new terms to the literature on policy, e.g. shapers, policy machine, pre-fieldwork and donors' fatigue. Although used in the text, these are explained as,

1. the 'shapers' denote the stakeholders shaping the policy. Unlike the actors (the term in the contemporary literature) who play a pre-defined role, the shapers are proactive in forming part of, and influencing the direction of the process and the consequent output. They may be individuals, organisations and groups.

2. the 'policy machine' is the organisational framework, within which the policy for the health sector reform is formulated; and is comparable to Easton's "black box", where different state institutions come together for policy making. It is, called so metaphorically, deriving from the commonly used term "government's machinery", which processed the policy for the Punjab health sector reforms.

3. the 'donors' fatigue' is different from the classic phenomenon of 'aid fatigue' that exists increasingly and its manifestation and aetiology are concerning the weariness of aid in kind (Burnell, 1997). That is, the money was there and the donors' willing to pay, but it was the administrative mechanisms that fatigued leading to the donors adopting a laid back approach vis-à-vis the recipients.

4. the 'pre-fieldwork' connotes intelligence gathering, and is conducted prior to the fieldwork proper. More than a pilot case study (Yin, 1994: 74-76), this stage in the research process helps not only in having a fuller grasp of the case for adding robustness to the design and establish the direction of enquiry, but also to identify/ determine the location of the study participants. Further, in many ways the pre-fieldwork is also useful in data analysis (4.4.4).

7.3.5. Factors influencing the policy process

The policy process is influenced by a range of factors (Gilson and Mills, 1995; Chinitz, 1995; Bloom and Xingyuan, 1997; Oliver and Paul-Shaheen, 1997; Paul-Shaheen, 1998; and Glassman *et al*, 1999). This study identifies different factors that influenced the policy process for government initiatives undertaken in the Punjab health sector during 1993-2000. Since, this study is the first of its kind ever carried out, contributes to the existing body of knowledge.

Different factors that influenced the Punjab policy process are:

1. the absence of clearly defined principles;
2. insufficient involvement of stakeholders;
3. lack of a holistic view of the context;

4. shortcomings of the policy machine;
5. the need for a proper implementation structure; and
6. the donors' fatigue in supporting the reforms.

7.4. Relating findings to the existing material and insight into the subject

This section attempts to place the findings of this study i.e. the six factors that were identified, as influencing the policy process, in the international perspective.

7.4.1. Absence of clearly defined principles

It was found (6.1) that in the Punjab health sector no attempt was made to clearly lay down the principles for these health sector reforms, mainly because the politicians were absent from the conceptualisation phase of the policy process (6.2.2.3). Clearly, this issue hinges on broadening the stakeholders' base by including politicians. However, given its importance, it is discussed separately.

This study argues that the principles serve as spectacles for assisting in searching and identifying the issues and helping in agenda setting. By this, it means that the principles and purposes, although not predating a particular policy, indicate a course of action for drawing a policy. In other words, they should not be confused with 'policy advocacy' (2.4.2.2). The latter is used in the sense that a particular policy or a group of related policies are advocated for adoption. The proponents, in this case, argue for a particular recommendation (Gordon *et al*, 1977).

For the principles to be clearly defined, it was noted (6.2.2.3) that the participation of politicians in the conceptualisation phase of the policy process was vital. This fact might explain the anxiety as to why certain issues get placed on the agenda and others do not (Hogwood and Gunn, 1984) and also highlights the importance of the involvement of politicians in the policy process. Because politicians bring ideology to the process, it is urged that the policy analysts should benefit from such spectacles (principles) – perhaps they bring their lenses (of ideology) from Marxism, pluralism, élitism or structuralism.

The above approach may be called the reformist's way (Gordon *et al*, 1977), but several authorities subscribe to this view. For example, the WHO made a similar call. In its charter on 'Reforming Health Care', a set of principles has been articulated for the member countries to follow, while embarking on health reforms (WHO, 1996). Such considerations, as Dougherty (1996: viii) notes in the American context of health reform, are essential, because in his view:

> ...the market changes tend as a rule to be unconscious of moral values – sometime supportive, sometime inimical, and generally unaware. Reflection of moral values is therefore critical for two reasons: to curb the worst excesses of the directionless change that is reshaping the system and, most importantly, to set the stage for renewed efforts to reform the system consciously.

7.4.2. Insufficient involvement of stakeholders

In the Punjab case, there was a narrow stakeholders' base and, further, those involved were there for a relatively short period. But, how does this situation compare with the observations of authorities in the literature on policy? Jordan (1981) identifies three types of images for decision-making: (i) iron triangle, (ii) policy network, and (iii) corporatism. The 'iron triangle' in the American context 'comprises the interest groups, relevant government agency and the congressional committee, and is difficult to be accessed'. According to him, the 'cabinet government' demonstrates an authoritative alternative to 'corporatism'. In a similar way he advanced his earlier work with Richardson (1979 cited in Jordan, 1981: 105) on policy communities as a comparatively smaller circle of participants that a civil servant might define for a particular policy. This concept was further developed by Marsh and Rhodes (1992 cited in Hill, 1997: 72) who characterised the policy community by: their limited membership sometimes consciously excluding others, sharing values, exchanging resources with the group leader able to regulate, and having a relative balance of power amongst members. Hill (1997), however, advocates that, while networks and policy communities are closely related, the latter are a stronger version of the former.

In the case of Punjab it is argued that both the 'policy communities' and 'policy networks' were operating – the former was at the first level and the latter at the second level of decision-making (6.5.2.2). To substantiate this assumption the response of a top technocrat to the question, as to how reforms were formulated, is worth mentioning. His remarks indicate the nature of cohesion in the group – an identifier of being a policy community. According to him,

> *We had a hotline contact with the Chief Minister. The Chief Minister, Secretary Health, Additional Secretary (Technical), Executive Director of Special Projects and others working together and then making presentations to the Chief Minister.*

The policy networks, on the other hand, are larger in size and are drawn from the lower level agents in the system with a fluctuating degree of contacts among them. They have varying amount of resources, but are unable to regulate their use on a collective basis, and also have unequal power (Hill, 1997). In the Punjab, according

to a bureaucrat, there were conflicts in this stratum of policymaking, mainly due to the inflexibility of network incumbents.

7.4.3. Lack of a holistic view of the context

According to Hogwood and Gunn (1984: 197), "The reason, which is less commonly – or at least less openly – offered in explanation of policy failure is that the policy itself was 'bad', in the sense of being based upon inadequate information, defective reasoning, or hopelessly unrealistic assumptions". In other words, policies are sometimes inefficient; not because they are badly implemented, but because they are bad policies. That is, the policy may be based upon an inadequate understanding of a problem to be solved (*ibid*). In this regard, Seedhouse (1995: 1) noted that "transformations are undoubtedly taking place, but they are almost always based on incomplete thinking, and are often on account of reasons which do not make sense". By this, he emphasises the need for taking into account the context or 'where' the reforms are introduced, and lays down the conditions for the systematic reform of any system in terms of a number of questions essentially aimed directly and indirectly at exploring the context.

However, what is context? In the contemporary literature the health sector *per se* seems to be excluded. It is mainly the external environment that is taken into account (Frenk, 1995; Collins *et al,* 1999; Cassels, 1995). Similarly, Buse and Walt (2000) noted a tension between global prescription and local diagnosis and solution in the World Bank's Agenda for change (World Bank, 1987). In their view, drawing from Gilson *et al* (1995), "without proper regard for ensuring local, facility-level retention of fees (to improve quality), developing adequate capacity and systems for protecting the poor, the service utilisation for various ... groups and illness categories were adversely affected, placing public health at risk". Likewise, Qadeer *et al* (2001) noted that the governments exerted little effort to evaluate these global prescriptions. The case in point is the 1993 World Development Report that was taken as the guideline for planning for health and the proposed interventions were implemented in the Third World without scrutiny and critique as to what extent it was relevant to the local conditions (*ibid*). About this, Uglade (1995) concludes that "as a guide to health policy makers it is of little value and could be used to deny essential health services to the poor of the third world".

This study, as explained in chapter 3, argues that the context has three layers with the health sector occupying the innermost layer. The enquiry about this layer can be extended to a further depth, taking into account the individual components, i.e. governance, providers, communities, resource generators and support service. The

next two layers correspond to the external environment that has two orbits, accommodating the national and international systems respectively. The former refers to the nation state and people in terms of their demography, history, culture, health problems, economics, welfare and political systems, media and information. The latter, on the other hand, includes bilateral and multilateral aid organisations, international economic agreements and non-governmental organisations, which often influence developing countries by setting controls and laying down boundaries. Hence, these are also called hegemonic systems (Twaddle, 1996).

The inclusion of all three layers in the context analysis acknowledges the fact that the reforms are located in the health sector, which itself needs to be understood if it is to be reformed. That is, it is "ensuring that the process and context of policymaking is sensitive to the local context is likely to be the key to success" (Social Science and Medicine, 2002). However, it hinges on the question where the analyst places himself while analysing the context. In the case of the Punjab, while drawing up the initiative, the context was not viewed holistically. As a result a range of reforms were undertaken by the successive governments, but despite substantial inputs, a number of these were abandoned, others forgotten while some remain.

7.4.4. Shortcomings of the policy machine

It was concluded (6.5.3) that mainly the bureaucracy and political executives were the main players who undertook the policy process. In order to explore the kind of relationship between politicians and bureaucracy, Aberbach *et al* (1981) describe four images in the European perspective. Accordingly, in image I or 'policy/administration' policymaking is the domain of politicians, while the bureaucrats are charged to administer it. Image II or 'fact/interest' perceives both the bureaucrats and the politicians participating in policymaking. The former bring forward the facts and information, while the latter contribute through the interests and values or political sensitivity in the society. Image III or 'energy/equilibrium' considers that both the bureaucrats and politicians as engaged in policymaking and both are also concerned about politics. The latter energize the policy system, while the former bring equilibrium. This phenomenon is also called politicising bureaucracy or bureaucratising the politics. Finally, in image IV or 'pure hybrid', the distinction between the politicians and bureaucrats virtually disappears. The bureaucrats, in this form, are closer to power and are key in the policy making game.

Where did the bureaucracy stand in the Punjab? When this researcher asked the top bureaucrats in Pakistan about their role in policymaking, the majority claimed to work in a Weberian style or as image I above, but came to acknowledge having

operated within an image II environment after some discussion. However, review of documents reveals that in the administrative milieu of the Punjab health sector, it was the image III. That is, whereas the politician especially the chief minister was strong, but bureaucracy was maintaining a middle of the road position. Further, evidence suggests that there was a tendency for the relationship between bureaucracy and politics to be moving towards pure hybrid. That is, the former were also involved in politics.

Why was there such a relationship? It has been noted that it was nurtured by the factors like (i) the politico-bureaucratic nexus (6.3.2.3) operative in the Punjab; (ii) both politicians and bureaucracy were subject to frequent changes in their positions (6.3.2.2; 6.3.2.3); and (iii) it was the tiny group drawn from this nexus who undertook the policy process in addition to their routine work (6.5.2.2; 7.4.2). But, the next question is; who should otherwise have undertaken this aspect of the policy process? Gordon *et al* (1977) identify the research branch in the government department, some government-funded consultant, an independent or funded individual or organisations, and professional bodies could also undertake this. According to him, this exercise may be limited to organising the information, which could also go beyond this to defining the relationships and proposing various policy options. However, in the case of the Punjab, there was neither such a unit to assist the policymakers in policy formulating, nor was any external agency involved.

7.4.5. Need for a proper implementation structure

Implementation is a complex and iterative process, and it is difficult to delineate a clear boundary between the policy formulation and its implementation. According to the top-down approach expounded by Hogwood and Gunn (1984), formulation continues into the implementation, which embodies also monitoring and control. The latter is important, in order to keep progressing according to schedule and specification, and to ensure that timely remedial measures are taken. Evaluation is undertaken at some point in time to decide whether policy be maintained or terminated or succeeded with amendments or started afresh. The proponents of the bottom-up approach argue that the implementers play an active role to the extent that there may be some redefinition of objectives and goals of the policy (Elmore, 1978). In this regard Lipsky (1980) propounds the idea of a 'street level bureaucracy', i.e. those individual civil servants that are in active contact with the clients. According to him, they, out of their routine and devices to cope with their work pressures, contribute to this policymaking.

Comparing the two approaches, Hill (1997) identifies the former (top down) as rigid and prescriptive, which takes policy as an input for the implementation process. The latter (bottom up), on the other hand, is adaptive to user needs and the policy is considered as an output. Lane (1987) in this scenario proposes a third approach; the implementation comprises a coalition of actors, which is a learning process and involves responsibility and trust. He argues that responsibility characterises the top-down approach, while trust forms the basis of a bottom-up approach. In his view, in the case of the former, there is little space for the implementers to use and develop their faculties, while with the latter option there is a danger of losing sight of even the objectives and the goals. He, therefore, proposes the implementation process as an advocacy coalition, evolutionary learning and a combination of accountability and trust. Similarly, in the planner's terms implementation requires continuing dialogue and the involvement of managers in the planning process (Green, 1999).

However, in the Punjab no appropriate implementation structure was established for the planning and implementation of the reform initiatives. Instead, reliance was on the bureaucratic hierarchy in the central ministry or in some temporary structure (6.7.2.3). This fact also verifies the earlier assumption about the narrow stakeholders' base, i.e. there were few that were involved and so the hegemony of the policy community over the policy process was demonstrated. This is, however, a phenomenon, that Kennedy (1987:162) referring to PAEME (1969) notes, has been there for a long time, and has often been criticised by the professional bodies. But, why did it happen? Two explanations exist. Firstly, policymaking in the Punjab is a top-down phenomenon (6.5.2.1; 7.4.4). As a result, every civil servant looks to the upper echelons in the hierarchy for approval. Secondly, the policy formulators saw implementation as a means to demonstrate their role (6.2.2.1).

Hjern and Porter (1981) argue that no programme is fully implemented by a single organisation; instead a cluster or parts of both public and private organisations come together to form an implementation structure. According to them, the implementation structure is less formal in that there are fewer authoritative relations. The actors comprising the structure do not represent a legally defined entity and their decision to participate in a programme is based on the consent and negotiation, i.e. they do not essentially belong to the organisation formally responsible for implementing the programme. In the case of the Punjab, as seen earlier (6.7.2.3), an effort was made to establish a structure akin to the implementation structure. However, firstly these structures were temporary, and secondly they were overtaken by the 'policy community'. That is, to conclude, there was no proper structure for implementing the reforms.

7.4.6. Donors' fatigue in supporting reforms

The donors, as part of the international system, lie in the outer environment of the health sector (Figure 7.1). They influence the health sector directly as well as indirectly through other systems, which may also be receiving foreign aid. This influence, Buse and Walt (2000) found, has grown due to enhanced lending by the World Bank. This increased flow of resources has also raised the profile of health on the international and national development agenda drawing the focus to issues like financing, priority setting and systemic reforms. The health sector reforms in the Punjab were supported by the donors (5.1), mainly DFID. However, as noted earlier (6.3.2.4) they expressed signs of fatigue and went into a laid back position. That is, the money was there and also the will to pay, but the 'donors fatigued' in supporting reforms. This phenomenon was different from the classic 'aid fatigue' that increasingly exists, but its manifestation and aetiology concerns the weariness of aid in kind (Burnell, 1997).

The SFHP was initially a five years (1993-98) project that was extended for another two years. This long duration may on its own right be the cause of fatigue as this extended to the donors failing in adequately undertaking their assignments. A senior bureaucrat in the Finance Department noted that the donors failed to properly monitor the project's performance. In his view, "the donors were only unloading their monies..." Similarly, Buse and Walt (2000) noted the salience of loan disbursement in donor assisted projects. Akin to this observation, a senior official in the government painted the picture, "...people (donors) attempted to please everyone (in the government that mattered) and followed a route of least resistance".

This 'laid back' phase of the donors (6.3.2.4) was not confined to the front running individuals in the project, but extended to the administrative mechanisms. The policymakers in the Punjab had 'ready access' to the higher levels of the donors' hierarchy. The latter, however, could not argue, e.g. when the interested individuals deinstitutionalised the technical assistance first by moving it from the PIDC to the DGHS without establishing the reporting and monitoring channels, and finally to a temporary structure – the HSRU (6.7.2.3). A donor representative argued that they (donors) could not be blamed for the "fiasco" that was there in the project – they were flexible and wanted the Health Department to use technical assistance to their advantage. However, this contention, if accepted, takes the discussion back to the initial argument of a 'laid back' approach taken by the donors in aid disbursement.

7.5. Implications of study for the Punjab health sector

This study indicated several issues confronting the policy process, and to remedy those, emphasis is placed on the system physician (reformer) to 'heal thyself' by instituting the discipline of policy analysis and broadening the stakeholders' base. Particularly, as Zwi and Mills (1995) note for decentralisation to be successful, and that is the case in point, "a longer period of planning, defining and clarifying responsibilities, training, preparation and implementation is required". How should this advice be homed in the context of the Punjab health sector? It is not an easy objective to achieve because of the challenges confronting the researches influencing decision-making. The most prominent of these challenges as Trostley *et al* (1999) indicate in the case studies of Mexican policies is that the "researchers are but one of the many interest groups, and the research but one input among many equally legitimate elements to be considered by the policymakers".

Nonetheless, informed by the literature (e.g. Haines and Donald, 1998; Madhok, 1999; Black, 2001; and Donald, 2001), the following are a number of suggestions, which although dispersed here and there in this thesis, are reiterated for making the policy process a robust phenomenon for any future undertaking.

7.5.1. Laying down the principles and purposes of policy

The politicians should be on board in the conceptualising phase and then should remain involved throughout the policy process. It is assumed that they would, by their ideological input, assist in laying down the principles and purposes for reforms. Also, the other partner i.e., policy analysts should be explicit in their position, as Foltz (1996: 214), referring to an earlier work by Lindblom and Cohen (1979), advocates that:

> ... the policy analyst is viewed as just another actor with his own set of values and biases. Policy analysis is a value-laden enterprise and it is not neutral. Therefore, policy analysts, to be useful to the policymakers, must incorporate their values and speak to them in their language.

In other words, as proposed earlier (7.4.1) the policy analysts should put on their 'spectacles' with whatever (ideological) lenses and give clear guidance and direction to the policy process. That is, the greater 'why' of the reform should be known loud and clear. In this regard guidance can be had from the 'Ljubljana Charter on Reforming Health Care'. Accordingly, in order to articulate principles that emerge from the experience of countries implementing health reforms, the Charter lays

down two sets of principles: the fundamental and those for managing change consequent to reforms (WHO, 1996).

7.5.2. Broadening the stakeholders' base

The stakeholder's base undertaking the policy process is broadened using some structural approach such as undertaking 'stakeholders' analysis' (Brugha and Vavasovsky, 2000; Dick, 1997 and Vavasovsky and Brugha, 2000). This is a sort of policy toolkit developed to identify stakeholders, and assess their attitude and influence, and the manner in which they participated in the origin, design and implementation of the initiative. Further, it is a tool for knowing the positions the stakeholders would take in the event of launching an initiative; and understanding their views while devising a plan and strategies is likely to ensure the longer-term success of policy. The implementation unit (7.4.5) may organise this activity in collaboration with the formulators of policy i.e. the key stakeholders in the health secretariat. This exercise is done in a group and the politicians, i.e. the political executives, who form part of the governance set up, should also be on this group. Further once selected the stakeholders should remain part of the policy process to play their defined roles.

7.5.3. Analysing the context holistically

Building an understanding of the policy context has been emphasised (Collins *et al*, 1999). This study reinforces these views and suggests the following measures to the policymakers in the Punjab (Pakistan) for analysing the policy context, which can also be generalised to similar situations.

7.5.3.1. Adopting a system thinking approach

It was earlier conjectured (2.2.5), as Fraser and Wilson (2002) argue that for bringing change – and reform is a change – the stakeholders need to change the way they think and work. For this purpose, they proposed a 'systems thinking technique'. According to this technique, it is relevant to understand, in entirety, the complexity involved in health care and the basic tenet of this approach is to involve all those who are part of the system being explored. In their view, it is essential to understand two features of how the systems work, i.e. reinforcing and balancing. In the former case, there is a vicious cycle – one event, giving rise to more of the same output. For the latter case, however, after triggering, the resulting event will give rise to an event, which will in turn limit the first event (*ibid*). Disregard of the basic tenets of how the systems work is likely to give rise to complications and to avoid those, this study underlined the essential nature of context analysis that the system under

reform should be examined in its breadth and depth as part of the policy process. For this purpose a scheme is outlined (3.3.3), but to carry out that, it requires a reference document be developed.

7.5.3.2. Need for a comprehensive document

Conyers (1982) identifies the need for 'data collection and analysis' prior to the policy formulation for social planning, and emphasises determining the situation of the existing provisions, while projecting future requirements. Similarly, Gordon *et al* (1977) see the importance of information as a case for action to introduce a new policy or revise an existing one – or perhaps to maintain the *status quo*, i.e. 'deciding not to decide'. In addition to placing the reform initiative in its right context, it is argued that undertaking a situational analysis will broaden the policymaker's acumen. In this context, Green (1999), while advocating the running of this exercise, views it as an educational process for participants. He considers it like establishing a baseline that can be referred to for subsequent monitoring of progress. Further, this document, which may be termed as a health system profile, serves as a ready reference for consultants and donors.

7.5.3.3. Establishing the health system profile

The next logical question is – what should constitute the health sector profile? Gonzalez-Block (1997) suggests a 'minimum data set' for developing the health system profile. Given the conceptual framework for context analysis suggested by this study (3.3.3), this data-set does not address certain components of the context, e.g. the international systems. Nonetheless, this can still serve as a starting point. Most of Latin American countries are engaged in developing their health sector profiles (PAHO, 2000). However, for countries like Pakistan with a weak indigenous capacity, where there is no comprehensive document about the health sector, this exercise can be built progressively. For this purpose, the 'minimum data set' in table-7.3 can be tailored to the local needs and agreed by the policymakers. This exercise, which requires periodic increments, may however require some institutional arrangement for their maintenance.

7.5.3.4. Organisational responsibility for maintaining the health sector profile

Parsons (1995) argues that possible candidates for developing the suggested database are of two types: those inside the government and others outside the government. However, since, in his view, the latter are to a certain degree partisan, there is a danger of a clash of ideas, which may limit the policy options. The former,

on the other hand, are drawn from within the government structure and in some organisational form they are already engaged in drawing up working papers or context analysis. However, in the Punjab, this activity is not institutionalised, and given that there is no research branch, some organisation needs to own the developing and periodic updating of such a document. It is, therefore, suggested that the PHDC (a unit for the management development and in-service training in the Punjab Health Department) be assigned to develop and periodically update the document. Further, since the PHDC has a chain of DHDCs attached to it, the exercise is extended to the districts as well. This is important, because the districts have been devolved and the elected District Assemblies manage the affairs with little interference from the centre (1.3.2). However, it is pertinent that such profiles are placed in the public domain and kept open to the inputs from other sources.

7.5.4. Establishing a policy research unit

A policy research unit (for example, as part of the Planning Cell) is needed to assist the policy machine in the Ministry of Health to develop policy options and an outline design. The importance of such a unit was conjectured earlier (7.4.4). Further, the reforms are for a longer term and essentially require developing a vision and an ability to build the institutional memory of 'what works and what does not'. Therefore, continuity of both the personnel and the institution involved in the process for an adequately longer time is important. For example, Walt *et al* (1999), for personnel, advocate an incumbency period of five years as the breaking point. Contrarily in the Punjab the average stay of the secretary health and executive director of Special Projects responsible for steering the health reform was about one year. Actually, it was the saying in the Health Department that the Secretary to the Government for Health – a generalist civil bureaucrat – who often had little idea of the working of health sector takes six months to understand and before he starts implementing policies he is transferred to another sector. Therefore, this unit would serve at least two purposes.

First, it is assigned to organise orientation sessions for the new in-comers to the bureaucracy in the health sector. Foltz (1994) noted that in the case of Niger a lack of indigenous capacity in policy analysis led to few of the technical assistance skills being transferred and the implementation of reforms was also difficult. Thus, in order to institutionalise and further build the capacity for such skills in the Punjab this function may be extended to the other components of the policy machine. Second, acting as a linchpin this unit will organise information, and go beyond defining relationships and proposing various policy options. Such policy units, as Prince (1983 cited in Parsons, 1995: 387) advocates, contribute to improving the

effectiveness of organisational decision making. However, for longer-term sustenance, according to him, this unit would need pre-requisites, at least:

1. being headed by a strong and influential patron;
2. being taken seriously by the senior officers as a unit and the views expressed;
3. being staffed by experienced and high status personnel; and
4. being capable of undertaking reviews and research on various issues.

7.5.5. Establishing a reform implementation unit

A permanent structure for undertaking the implementation of the policy process, mainly its preparedness and then carrying out the monitoring of the execution of policy is established in the health secretariat. This structure has two components: (i) an implementation unit; and (ii) an organic structure. The former is a nucleus responsible for coordinating all related activities, including organising meetings and establishing liaison with the organic structure. A structure akin to the implementation unit created in the PIU of SFHP (HSRU) was criticised. It was advised that "instead of creating another empire, the Health Department should focus on the conceptual resource development and capacity building in the existing infrastructure"[36]. Similarly, Glassman *et al* (1999) noted that locating the reform group outside the Health Secretariat in the Dominican Republic allowed it to be seen as an outsider by the bureaucracy and was linked symbolically with donors weakening the groups' legitimacy. This researcher, therefore, suggests that given both the physical and administrative proximity of the Planning Cell to the decision makers it should host the 'Reform Implementation Unit'.

The organic structure is a standing body that draws from different components of the health system and the national and international hegemonic systems that are partners in the policy process. However, its membership can be determined by using a policy toolkit like a stakeholder analysis, but should be high level in the hierarchy to ensure the representation of the interests of those affected. Further, this group, called the 'Reform Steering Group' ensures an effective coordination and close integration between different structures participating in the policy process. The constitution of this group would differ depending on the nature of reform being introduced and its implications for the remaining system(s). However, its core membership would remain the same and include: Finance, Law, Regulation, Planning and Development, and Services and General Administration Departments.

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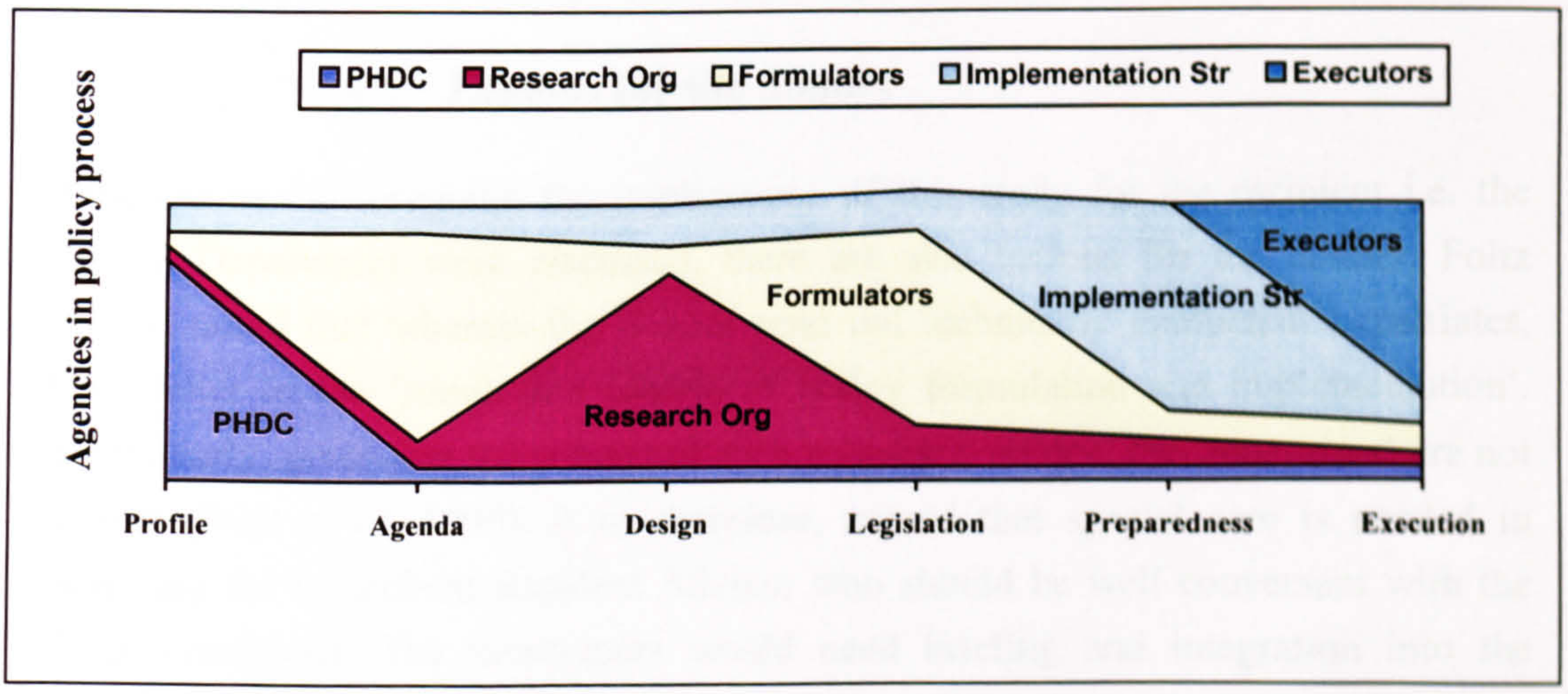
[36] From the observations of the Punjab Planning and Development Board put forward for the PDWP

7.5.6. The new paradigm

This study reinforced two concepts. First, a systematic approach to policy formulation and implementation is advocated (Bloom and Xingyuan, 1997). The process begins by identifying the problem the proposed reform is intended to address and exploring the context holistically. For this, an in-depth study is needed, otherwise there is no point introducing change merely for the purpose of change. Then policy options are considered, assessing the potential impact of each of these. Once a particular option is agreed, interventions are formulated and implemented. During this process, however, constructing a coalition of stakeholders is essential, otherwise pressures by the powerful are likely to influence the ultimate outcome.

Second, as Massey (1995) notes, there is an increase in the agencification of government as a common structural product of the reforms; and so is suggested by this study. In this regard figure 7.3 provides an overview of the proposed structures and their roles envisaged for the policy process.

Figure 7.3: - Relationship of various agencies in the policy process



Accordingly, different activities carried out as part of the policy process are seen on the horizontal axis, while the extent to which different structures participate in the carrying out of these activities is measured on the vertical axis. Thus, the area covered in the graph by each structure represents the amount of involvement by the particular shaper in the specific phase of the policy process. However, it may be noted that, although different organisations appear one after the other, they relate to each other through the implementation structure. In this manner different structures remain part of the policy process throughout, albeit, with varying intensity.

There is a caveat, however; the relationships and the extent of responsibility endowed to each structure should essentially be defined clearly. If this is not done,

there is a danger of introducing nothing less than a toothless tiger, and an extended bureaucracy or the agencification in the Health Department. It is not, as Jordan (1994 cited in Massey, 1995: 72) argues 'simply a championing of the virtues of organisational plurality'. Further, drawing from Peter and Pierre (2001) and Massey (*ibid*) this proposal is defended on the grounds: (i) the existing monopoly of the civil service in the policy process will be broken, i.e. they will confine themselves to a supervisory and monitoring position; (ii) in this manner decentralisation will also be introduced in the health secretariat; (iii) such an arrangement frees-up resources through greater efficiency; and (iv) it is likely to develop accountability through small identifiable units.

However, the above constellation of organisational structures is also fraught with risks; particularly losing the ownership of policy, and given the likelihood of interest groups with vested interests as indicated above (7.4.2), there is a potential danger of them hijacking the entire process. Nonetheless, the mechanism suggested above in terms of establishing a strong steering group should safeguard against such eventualities. Further, coordination between these agencies could be another issue, which can be circumvented by the Reform Implementation Unit.

7.5.7. Lessons for the donors

Whereas in the foregoing the implications of this study for the recipient i.e. the Health Department were discussed, there are also lessons for the donors. Foltz (1994) noted that whereas the donors send out technically competent expatriates, they falter in the 'rough and tumble of policy formulation and implementation'. Particularly, given that the context of each country is unique, the 'blueprints' are not useful (Walt *et al,* 1999). It is, therefore, argued that special care is needed in selecting the incumbent Resident Advisor who should be well conversant with the local conditions. The newcomers would need briefing and integration into the ongoing process. For that, however, the stability of key players in their positions for a sufficiently longer period is crucial, as they carry institutional memory (Pavignani and Durao, 1999). About the particular initiative and its successful implementation assuring sustainability, this study reinforces the findings of Bossert (1990) that 'the donors should design and manage the project in a manner to: (i) demonstrate effectiveness in reaching clearly defined goals and objectives; (ii) integrate activities into the established administrative structures; (iii) gain significant level of counterpart funding; (iv) negotiate project design with mutual give and take, and respect; (v) include a strong training component for building local capacity'.

7.6. Limitation and delimitation

There have been arguments and counter arguments about the biases, generalisability, possible lack of rigor, purposive sampling and so on, in undertaking qualitative research, and that such limitations are considered inherent in the case study approach. Nevertheless, qualitative methods were used, because these are flexible, innovative, iterative, allowing the researcher to study issues in depth and detail (Patton, 1990). It is argued that this debate of 'quantitative versus qualitative' is rather tired and possibly dead, and especially after the arguments presented by Baum (1995), this controversy should come to an end. She provides the basis for public health researchers to move on, using appropriate (qualitative) methods for particular research agendas in public health. Nonetheless, this researcher faced certain limitations. For example, despite having laid down *a priori* boundaries, the overlapping of purposes, approaches and techniques could not be avoided. That is, it was not possible to draw demarcation lines between the dimensions of this research.

The unit of analysis in this study is the policy process for health sector reform, and embedded within this unit are four cases, which have been subjected to inquiry. The policy process has six dimensions which have been contrasted in the preceding pages for the four reforms undertaken in the Punjab health sector during the period from 1993 to 2000. For this purpose, empirical evidence was gathered from the purposively selected individuals and a range of documents. This was to ensure that all components of the health sector were represented and that no information gap was left in developing a case. But, in some cases, the same participants were used for more than one case. In such a situation, the challenge was how to ensure that the response was relevant and that they did not mix their views on different cases? This problem was circumvented by mutually defining the context and through a guided questionnaire. Where this arrangement was not possible, the participant was classified as being in a general category, and the information was used to fill the knowledge gap left in different case studies.

Another limitation was that a number of participants did not allow the use of a tape recorder. This risked data loss and the researcher's bias creeping in firstly while note-taking and then drawing the findings and interpretation. To overcome that bias, the researcher sent transcripts to the relevant respondents for their validation. However, given that only rarely was a response received, this researcher planned a workshop for the policymakers, especially those who participated in this research. The intention was to share the preliminary results and receive feedback to further augment the information database of this research. This opportunity was envisaged as the culmination of a process whereby the participants were involved in policy

research. But lack of resources became a problem. As an alternative, however, major findings of this study were emailed to the key informants for their comments. It was encouraging that about two thirds of them responded validating the findings.

Access to official documents was problematic. Despite the researcher having the permission of the relevant authorities, the gatekeepers would not allow him access, on one ground or another. However, if there were some personal contacts, then no matter how big the lock was, it opened instantaneously, and did not need any key in terms of permission. The alternative scenario was that, if the output of the review was linked to the need of the authorities, then the documents would walk to the researcher. For example, the secretary health liked the idea for developing an institutional memory of different reform initiatives, and then all the documents were made available. Nonetheless, poor record keeping and lack of interest by the staff in reforms was an overarching factor, which hindered access to the relevant information. This limitation might have compromised this study.

This research was an in-depth study of the policy process for the Punjab health sector reforms, starting from agenda setting, their conceptualisation through formulation to implementation. Therefore, study participants were required to be drawn from a range of polity representing different components of the Punjab health sector. Also, there was a similar problem with documents. This challenge was met by conducting a stakeholder analysis workshop, which helped in identifying key informants, who were engaged through various means in an active dialogue in order to unearth their views. Likewise, for locating documents a meeting with the senior staff of the Health Department was useful. They indicated the offices and organisations holding archives of various initiatives. But, access to the participants as well as documents was costly, both monetarily as well as in terms of time. Sometimes, for example, the Leader of the Opposition in the Punjab Assembly lingered on making time for an interview and finally refused to be seen. Similarly, a senior bureaucrat initially resisted, but, when the interview started he offered all out help and asked this researcher if anything else could be done. In the researcher's view, this is due to the lack of exposure of public servants to academic discourses and a sub-conscious inhibition due to restrictions by the Official Secrets' Act.

The researcher had earlier (4.6.3) defended his role as a close observer of the policy process for the reforms studied in this research. Those arguments will, therefore, not be repeated here. Nevertheless, this role risked adding the researcher's biases to the findings and interpretations made in the study. Also, given that the data was being collected from more than one case, there was a danger for the researcher that he himself could mix the findings and analysis and interpretation of one case with

others. This limitation was overcome by, first developing individual single-case studies, and then developing a comparative case study. Further, given that the policymakers, who served as key informants, were also the key stakeholders for various reforms, they could have considered the analysis of the policy process as a threat to them. There was, therefore, a danger of their bias coming through their responses, and also influencing the analysis and interpretation by this researcher. However, this was overcome by validating the research findings, employing triangulation, methodological rigor, and the integrity of this researcher.

Finally, four cases were selected based on the logic explained earlier (4.3.2.1). The in-depth study of these cases accrued a huge body of evidence, which was used in unearthing the factors influencing the policy process. Whilst this approach to design enriched the research, enhancing its validity and reliability, quite a significant amount of raw case data remained unutilised. This limitation was mainly due to space constraints and to avoid labouring various points made in this study.

7.7. The way forward

According to Hyder (1999 cited in Bryant, 2000: 70) for identifying specific areas, where further research would make a difference, at least five questions need answering. These are: (i) what is the magnitude of the problem? (ii) how long has the issue/problem persisted? (iii) what is the existing knowledge base? (iv) cost-effectiveness of the proposed research? and (v) the current status of inquiry. This research has provided an insight to the policymakers regarding what has been going on in the Punjab's health sector reforms in terms of the policy process. Given that some of them were involved in different stages of this research, a foundation has been laid for developing a critical mass to promote the culture of a critical approach to health policy development. Therefore, seizing the opportunity, the research agenda can be carried forward. In this regard, it is proposed that:

> A decision-making instrument as an aid to policy analysis is developed. This tool may consist of a checklist of issues to be addressed while undertaking reforms as well as a systematic way of analysing the policy process for reforms. Zwi and Mills (1995) suggest that developing such methods would assist in agenda setting, policy formulation, policy implementation and evaluation.

The Punjab (Pakistan) has recently undergone a devolution process by establishing district governments through elected district assemblies. In such a situation, to avoid any complication, this study reinforced the need for developing the capacity of the

policymakers for policy analysis (Collins *et al*, 2002). Within this background it is worth exploring, retrospectively that:

> How far the shortcomings of the policy process observed during the reforms of 1993-2000 have been avoided in the policy process for devolution of powers and whether there is a need for introducing the measures suggested by this research.

This study has indicated a number of shortcomings in the policy process, and the implications for the Punjab health sector have been highlighted (7.3). However, in continuity to the above proposal, prospective research is needed. That is:

> The suggestion made by the current research study may be considered as an agenda for action research and tested in the Punjab health sector. However, as Walt (1996) notes, this type of research should be carried out by involving interest groups, ensuring that policymakers take responsibility for designing an appropriate policy response and implementation strategy.

In addition to advancing knowledge, the above proposal would also help in the development of capacity for policy analysis amongst policymakers in the Punjab. However, there is a caveat. Given the limitations encountered (7.6); this study reinforces the observation that different sections of the government in developing countries are not 'sanguine' about policy process research (Foltz, 1996). Therefore, it would be advisable to solve such issues by agreeing modalities with stakeholders at all levels of the health sector before embarking on the assignment.

7.8. Final comment

The analysis of the policy process for the Punjab's health sector reform undertaken by the government during 1993-2000 revealed many loopholes. Several initiatives were implemented in rapid succession. Some of these were abandoned, while others were forgotten, and yet others are still struggling to survive. This study, by revealing the factors responsible for this outcome, underpinned the importance of developing the capacity of policymakers for policy analysis, overhauling the policy machine and broadening the stakeholder's base.

This thesis began with a quote by a senior bureaucrat, *"It was a very exciting time, I must say"*. In retrospect, given the challenges posed by the Punjab health sector reforms, it was undoubtedly an exciting time for the policymakers. But, had the policymakers paid some heed to the above-referred factors and made some endeavour in analysing the policy and involving more stakeholders, the time would have really been productive and beneficial, as well as, exciting.

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Authorship

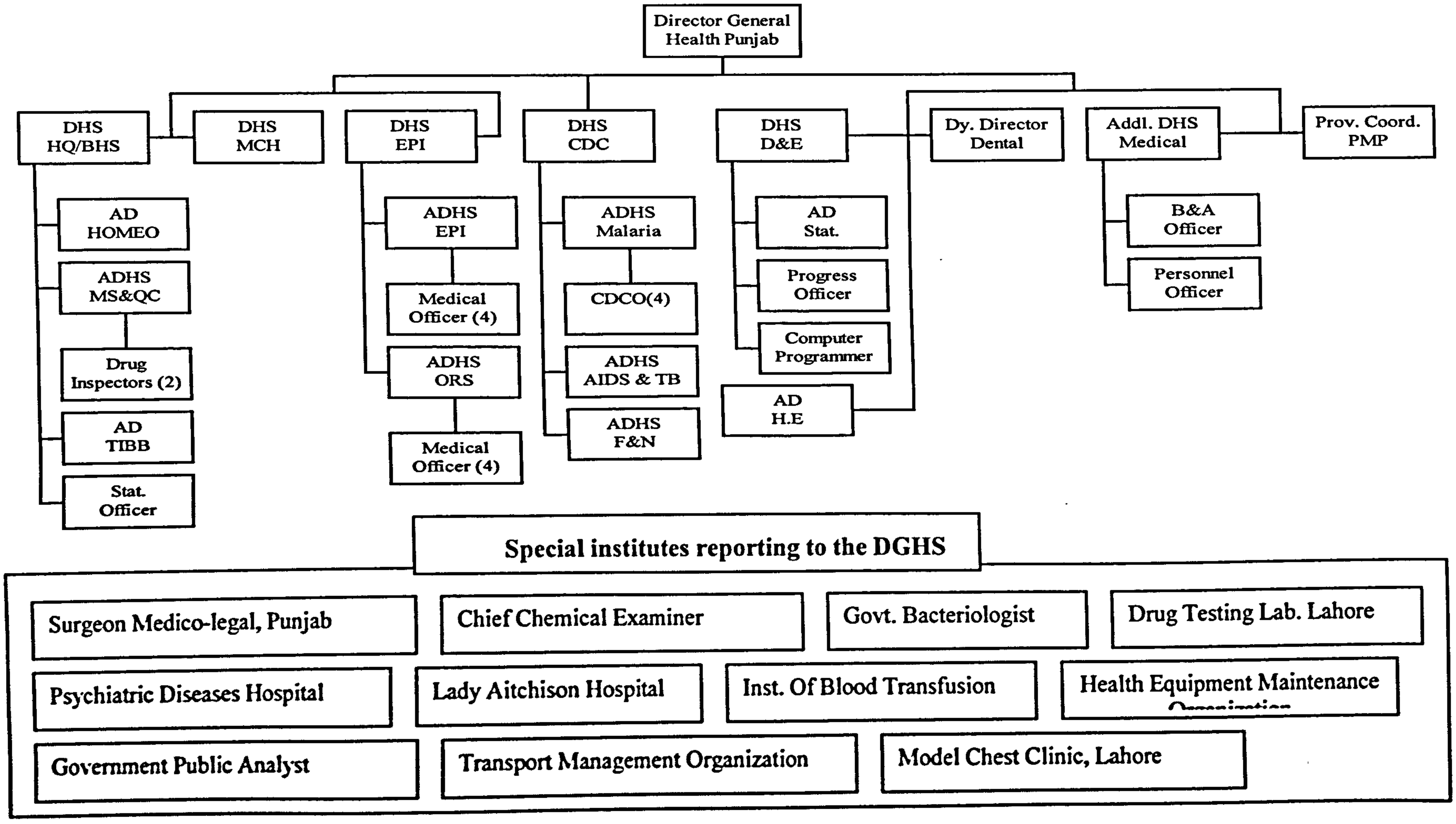
Following four multi-authored papers, which this researcher co-authored, have been cited in this thesis. His role vis-à-vis the co-authors is identified as below:

Table Ref-1 Role of researcher vis-à-vis the co-authors in papers cited in this thesis

Paper co-authored	Role of this researcher vis-à-vis the co-authors
Tareen EU and Omar MA (1997) Community Entry – An Essential Component of Participation, Health Manpower Management, 23 (3): 97-99	Fieldwork needed and the first draft of paper was developed by this researcher. The co-author, Omar MA elaborated certain points and did final editing.
Tareen EU and Omar MA (1998) Empowerment at Village Level Through a Workshop Method, Development in Practice 8 (2): 221-225	Fieldwork needed and the first draft of paper was developed by this researcher. The co-author, Omar MA elaborated certain points and did final editing.
Tarin EU and Thunhurst C (1998) Community Participation – with Provider Collaboration, World Health Forum 19: 72-75	Fieldwork needed and the first draft of paper was developed by this researcher. The co-author, Thunhurst C elaborated certain points and did final editing.
Collins CD, Omar MA and Tarin E (2002) Decentralization, Health Care and Policy Process in the Punjab, Pakistan, International Journal of Health Planning and Management 17 (2): 123-146	First draft of background information for the paper was developed by this researcher. The co-authors: Collins CD and Omar MA contributed to the analyses, including commenting on the 'Concept Paper for District Health Government' and editing.

It is confirmed that the material used by this researcher in this thesis out of the above referenced papers is his, and the co-authors bear no responsibility.

Appendix 1.1: – Organisational structure – Directorate General of Health Services, Punjab



Appendix 3.1 – The Punjab public policy process

The researcher, based on document review and norms practised for decision-making in the civil service structure, developed a working paper. This was circulated among the top officials of the government of Punjab. Later a workshop was held with a group of them to discuss the contents of the working paper and receive their comments. The outcome of these deliberations is given below:

The Punjab public policy process – prescribed and customary

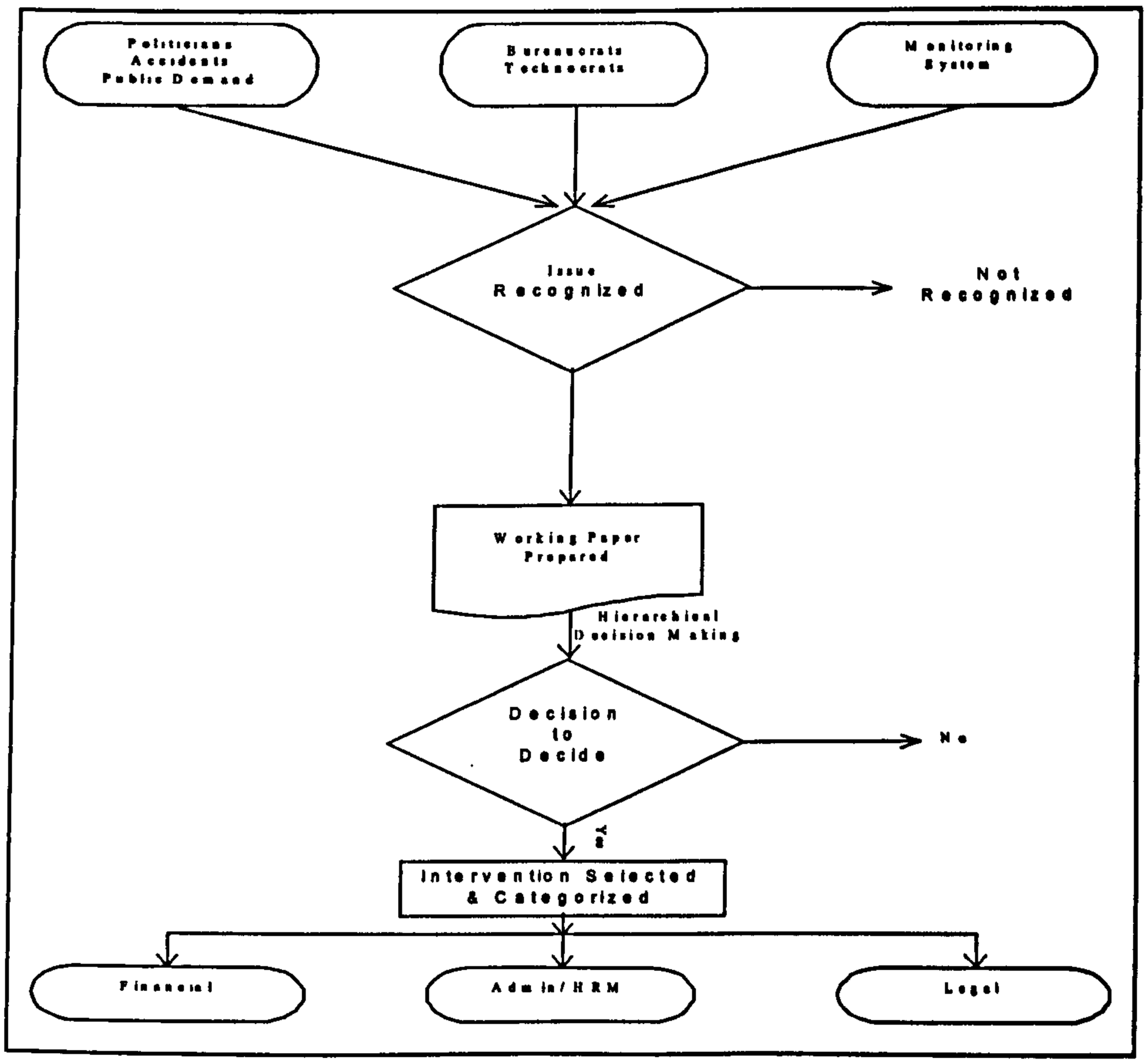
The key stakeholders often identify the issues or some influential technocrat feeds them. Sometime, politically driven – from within the department or by the popular politicians, this may also be evoked accidentally or a natural calamity becomes a cause. Public demand or unrest could be another reason and occasionally the routine monitoring system is the source for identifying and defining the issues. However, considering the issues for action and bringing them on the active agenda of the government depends on a number of factors: What is the extent or population affected? Epidemic would readily attract attention compared to a problem, which is endemic or pandemic. How severe is the problem, is another consideration. The issues, which are chronic and long standing, may be allowed to simmer, while those acute in nature are attended to immediately. Availability of the remedial measure is another factor that plays a significant role for the issue taken up for action. Finally, public concern is important to the 'decision for deciding'.

A working paper providing the background information and situational analysis is prepared. This is often done by a technocrat and may envisage, *inter-alia*, the proposed interventions to address the issues. This working-paper, subject to the assent of the decision-makers, and depending on the extent and range of implications – legal, financial or administrative, passes through an approval or decision-making process before it is implemented. This phenomenon may take place at any level in the organisation. However, in the civil secretariat, the following course of action is adopted:

The issue once on agenda, the concerned section officer takes it up in 'a file' as a 'paper under consideration' (PUC). S/he 'puts it up' – providing a gist of contents, relevant rules and laws, past precedents, and suggestions for the deputy secretary to facilitate the decision. The latter may agree to or seek further clarification from the

section officer and forwards it to the additional secretary. S/he, in turn, considers the issues in the light of the information provided and using his own acumen; offers his/her comments and passes it on to the secretary health. If the issues and the suggested intervention fall within the purview of the Health Department, the secretary health will pass orders on the case. However, in case it is beyond his jurisdiction, the matter is then referred for advice to the relevant department or to the governor/ chief minister as a 'Summary'. And for that depending on the nature and implications of the case, it is routed through the Departments of Law, Finance, S& GAD, P&D, the minister for health, and chief secretary (figure 3.1.1). Apparently, this is a long and protracted course, but it is often the actors, who determine the pace of this process. The case is then processed further, according to its implications.

Figure 3.1.1: Agenda setting in the public sector



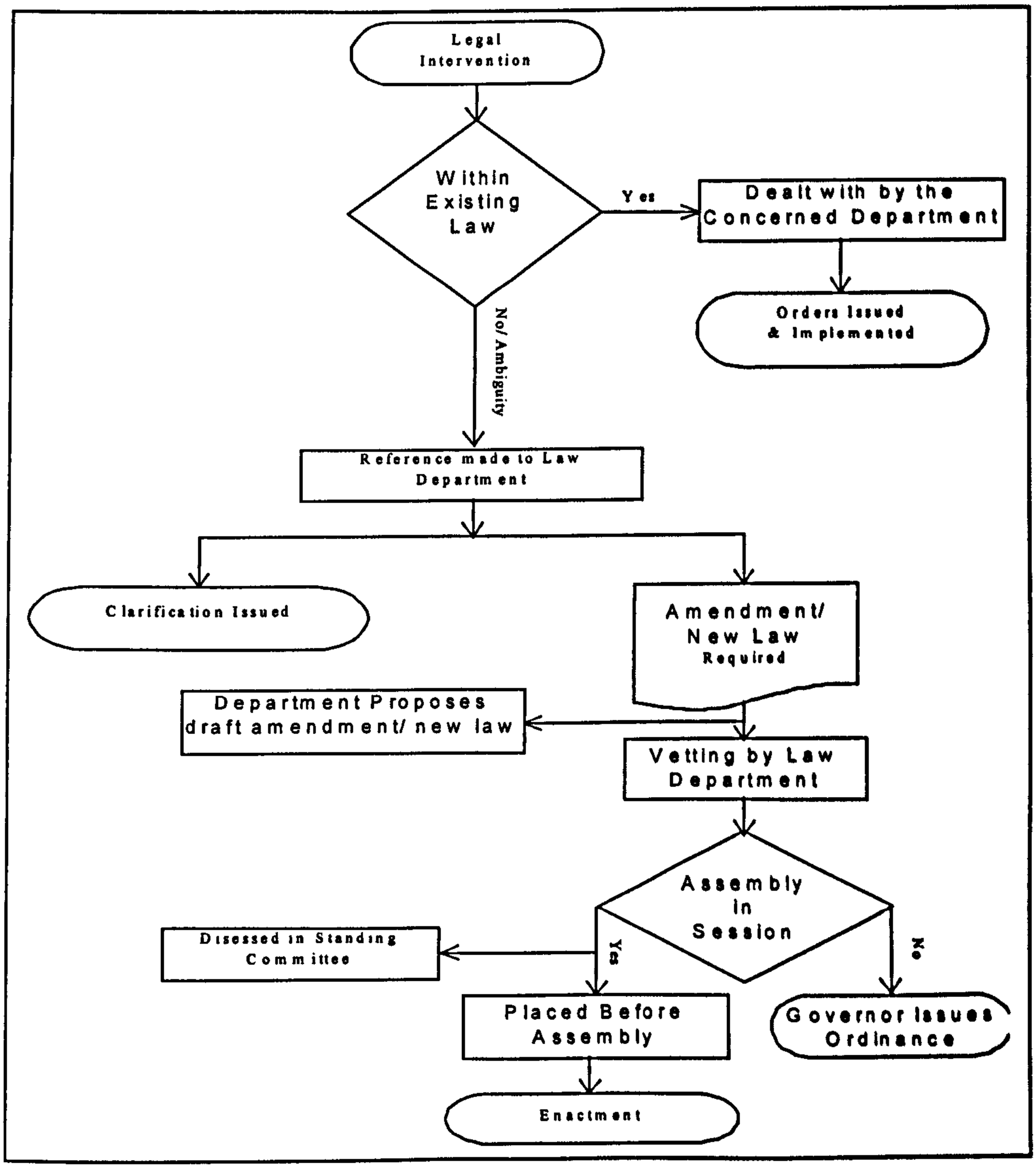
Legal implications

The issue in the working paper, after having been discussed at various levels in the Health Department, is decided exercising the delegated powers within the provisions of existing Laws. Otherwise, it is sent to the Law and Department, which processes the proposal and the draft Bill. It is *inter-alia*, examined whether the proposal is within the remits of the constitution and that it is not contradictory to the existing

laws. Following that, the cabinet and or cabinet sub-committee consider the draft law before approval of the governor/chief minister. If the Assembly is in session, the draft Bill is placed before it, where it is scrutinised at two levels: in the standing committee on health followed by a clause-by-clause reading in the house, before it is tabled for vote. In case the Assembly is not in session and the issue is considered of public concern, the proposed law is placed before the governor for approval as an Ordinance. However, this is done with the concurrence of the relevant minister, chief secretary and the chief minister/ governor in a hierarchical manner.

Often an intervention may require framing of rules/regulations under existing laws or certain modifications therein. In such cases the issue instead of referring to the Assembly is decided in the government. In this discourse, if the proposal has a bearing on other sectors, those are also consulted (figure-3.1.2).

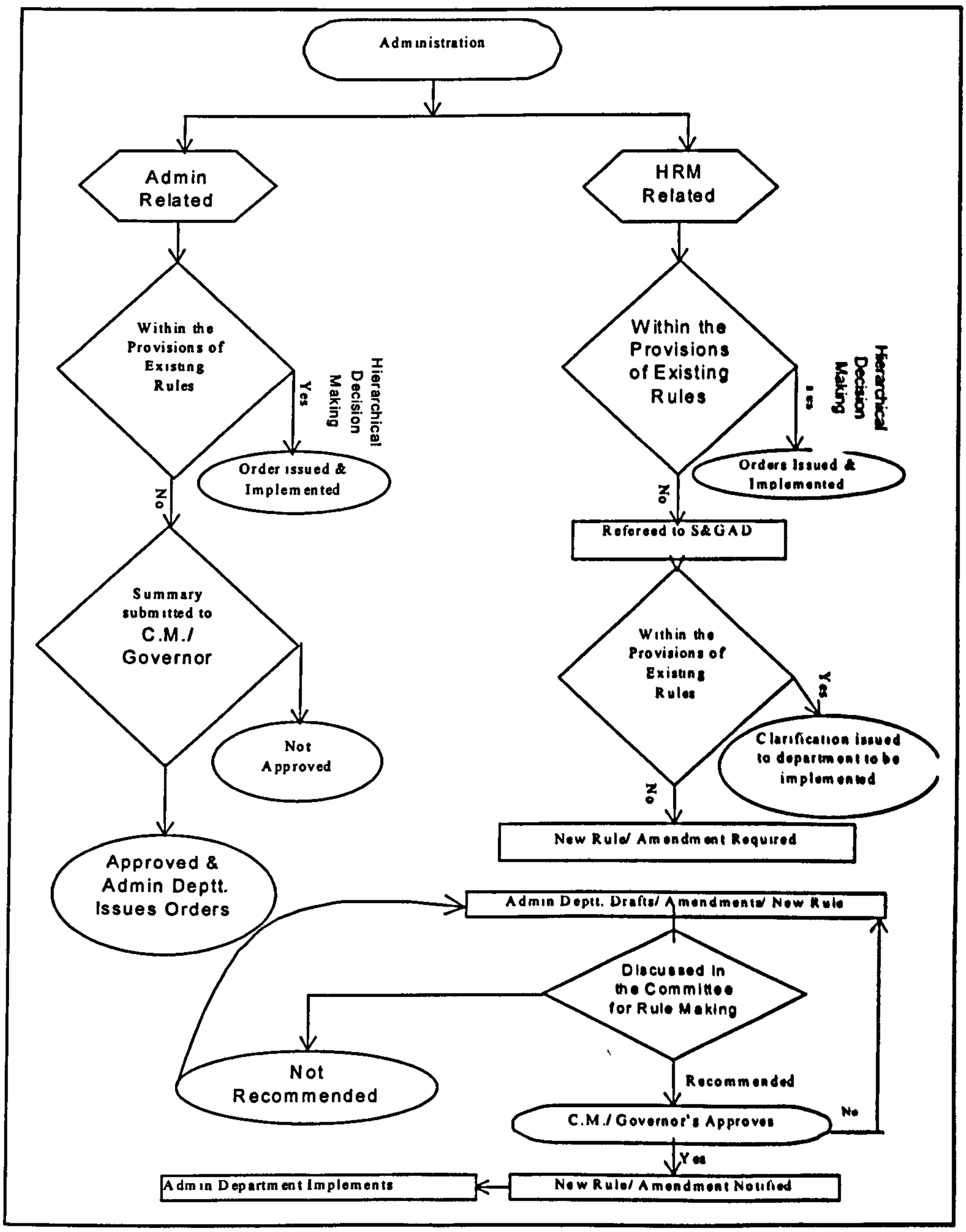
Figure-3.1.2: Public policy process for legal interventions



Administrative Implication

For the administrative interventions, having intra-sectoral implication, the proposal is dealt within the Health Department in a hierarchical fashion and if the solution lies within the provisions of the existing policy, an administrative order may be deemed sufficient. Otherwise, it is submitted to the chief minister/governor via the minister for health and chief secretary and any subsequent action is contingent upon their agreement. In case there is some ambiguity in the interpretation of existing rules pertaining to the human resource management or there is cross-sectoral effect, this is referred to the Service & General Administration Department.

Figure-3.1.3: Public policy process for administrative interventions



In the above situations, this department may clarify the issue through an advice or a Rulemaking Committee examining the proposal for amendments or framing of new rules. Its recommendation after the approval of the chief minister/governor becomes law, which is notified and published in the 'Estacode' (figure-3.1.3).

Financial Implications

Where the financial matters are involved, then the Finance and or the Planning & Development Departments/ Board become stakeholders. In case the concern is about the recurrent budget, this may be resolved within the Health Department. However, when the implication exceeds the delegated powers for incurring the expenditure or any deviation from the existing financial rules is involved, the proposal is sent to the Finance Department. Here, it is subjected to a hierarchical decision-making process and an advice given is finally translated into 'audit-copy' by the Health Department. The Finance Department authenticates this instrument, as without this formality, the Accounts Office may not allow the payment to the office incurring the expenditure.

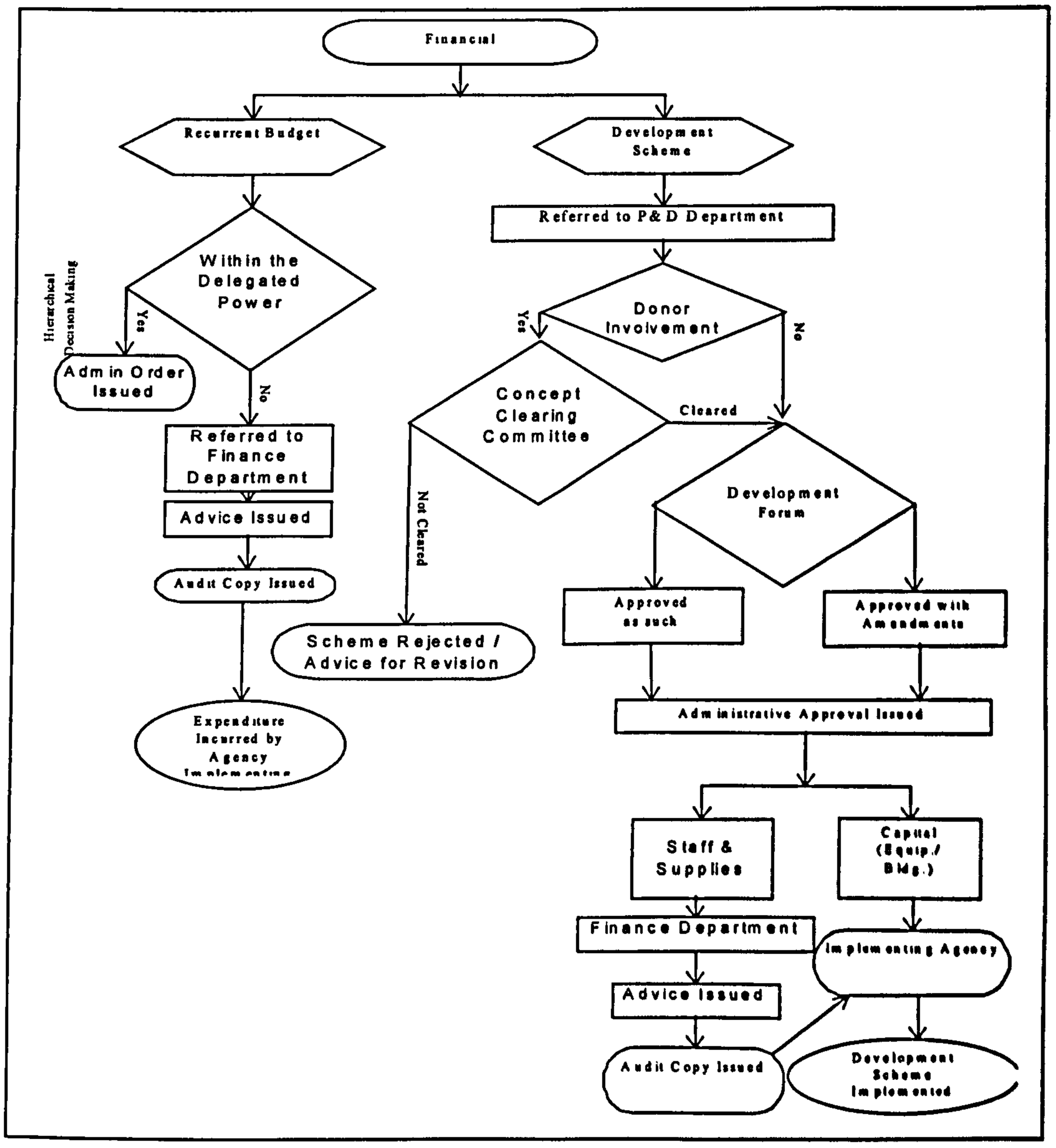
On the other hand where the intervention implies a new scheme/project, this is taken up at the multilevel 'Developmental Forum' in the public sector and is decided, depending on the cost of the scheme. However, if co-financing of project by a donor is proposed, then it is got cleared from a 'Concept Clearing Committee' established at the federal level in the EAD, before the Development Forum takes it up for allocating the resources. The amount of foreign exchange involved is another determining factor for decision-making on financial issues (table-3.1.1).

Table-3.1.1: Decision threshold in a multilevel 'Developmental Forum'

Sr. No.	Organisational Level	Developmental Forum	Head/ Developmental Forum	Decision threshold
1.	Institution	Drawing and Disbursing Officer in Category-1	Head of the Institution	Rs. 1.5m
2.	District	District Development Committee	Deputy Commissioner in district	Rs. 5m
3.	Division	Divisional Development Committee	Commissioner of division	Rs. 10m
4.	Administrative Department	Departmental Development Sub-Committee	Secretary of the department	Rs. 20m
5.	Planning & Development Board	Provincial Developmental Working party	Chairman P&D Board	Rs. 200m
6.	(Federal) Planning Commission	Central Developmental Working Party	Deputy Chairman Planning Commission	Recommends > Rs. 200m & approves if foreign exchange > 25%
7.	National Economic Council	Executive Committee of the National Economic Council	Federal Finance Minister	Schemes recommended by the Central Development Working Party

The minutes of the proceedings at the Developmental Forum of any level form the basis for the issuance of 'administrative approval'. For the decisions made within the Health Department, the department itself issues it, while for the higher levels of 'Development Forum' the Finance Department endorses this. Similarly, where the creation of staff positions is involved, this is referred to the Finance Department for their concurrence and an audit copy is issued. The capital for construction and infrastructure development is authorised to the Buildings Department, while for the equipment and revenue, it is allowed to the Health Department (figure-3.1.4).

Figure-3.1.4: Public policy process for financial interventions



After a decision on an issue has been taken, the line management is then asked to implement it. For the projects, however, a special body may be established for coordinating/implementing the activities. In case of financial intervention, there is a

prescribed system of monitoring and evaluation. Accordingly, for the recurring expenses periodic statements of expenditure are submitted and an annual audit is instituted. However, in the case of developmental schemes, there is a system of PC-forms (Planning Commission Forms). The PC-1 – denotes project proposal; PC-II is the feasibility study of the project; PC-III is the project monitoring proforma; PC-IV or Project Completion Report (PCR) is a project completion report; and PC-V is a project impact report. The P&D Department is responsible to institute the aforementioned monitoring mechanism.

The above arrangements are, however, seldom brought in place for legal or administrative interventions. Instead, reliance is made on the existing set up, even the physical and financial resources are not provided to implement and sustain these. The existing set up, according to the secretary health is that "every issue is dealt with on a file. This has two parts – note portion and correspondence. The section officer takes up the issue and decided at appropriate authority level. This arrangement ensures that the decisions are timely and right. However, this process is not done in isolation, but is amenable to judicial scrutiny". In addition, as deduced from the evidence gathered by this researcher, hardly any strategy is evolved to effectively involve the stakeholders and little effort is made to train or orientate those who are responsible for implementing the policies.

In the case of the foreign aided interventions, it is often imperative for the government to follow donors' procedures. Since, the national managers, especially the account managers are not familiar with these guidelines; there is often confusion in implementing such projects. In certain cases, however the donor agencies install their own implementation arrangements. Similarly, there could be variations in the federal projects or programmes implemented in the provinces. However, since beyond the scope of this study, such interventions will not be discussed.

Appendix 4.1: – List of interviewees

Case Studies	Participants
Sheikhupura PHC Pilot Project	1. Director General Health Services, Punjab 2. Executive Director, Special Projects, Punjab 3. Additional Secretary (Dev) Health Department 4. Project Director, Second Family Health Project 5. Senior Planning Officer, Health Department 6. District Health Officer, Sheikhupura 7. Deputy District Health Officer, Sheikhupura 8. Programme Director, DHDC, Sheikhupura 9. DFID/SFHP Project Director 10. Caritas Pakistan/NGO 11. Senior Medical Officer, Rural Health Centre 12. Chairman, Village Health Committee 13. General Secretary, Village Health Committee 14. Village Health Worker
District Health Authority	1. Minister for Health, Punjab 2. Parliamentary Secretary for Health/Chairman, DHA 3. Chairman, District Health Authority 4. District Health Officer/Secretary, DHA 5. District Health Officer/Secretary, DHA 6. District Health Officer/Secretary, DHA 7. DFID/Health Planning & Management Advisor 8. Director, Health Services Academy 9. Director Health Services (DHA, District) 10. Director, Provincial Health Development Centre 11. Project Director, Second Family Health Project 12. World Bank, Consultant 13. DFID/District Health Management Coordinator 14. Senior Planning Officer, Health Department
Institutional Autonomy	1. Additional Secretary (Tech) Health department 2. Chief Executive, Autonomous Hospital - male 3. Chief Executive, Autonomous Hospital - female 4. Chief Executive/Principal, Autonomous Hospital 5. Senior Health Specialist, World Bank 6. Senior Health Specialist, World Bank 7. Medical Supdt, Autonomous Hospital (male) 8. Medical Supdt, Autonomous Hospital (female) 9. Professor of Orthopaedic Surgery, KEMC 10. DFID/Health Planning and Management Advisor 11. DFID/Consultant 12. Executive Director, Special Projects, Punjab 13. Task Manager, Health Sector Reform Unit 14. Task Manager, Health Sector Reform Unit 15. Section Officer, Health Department

Case Studies	Participants
	16. Staff Officer, Chief Secretary, Punjab 17. Project Director, Second Family Health Project 18. Statistics Branch, Mayo Hospital 19. Social Welfare Department – to represent the patients
District Health Government	1. District Chief Executive (select) – male 2. District Chief Executive (select) – female 3. District Chief Executive (select) – female 4. Director, Provincial Health Development Centre 5. Task Manager, Health Sector Reform Unit 6. Project Director, Second Family Health Project 7. Senior Planning Officer, Health Department 8. DFID/District Health Management Coordinator 9. Director, Health Services Academy 10. DFID/Health Planning and Management Advisor
General	1. Chief Minister, Punjab (ex) 2. Minister for Health, Punjab (ex) 3. Minister for Health, Punjab (current) 4. Chairman P&D, Government of the Punjab 5. Patron, Pakistan Medical Association 6. President, Pakistan Medical Association 7. Member, Institutional Management Committee 8. Deputy Secretary, Finance Department 9. Additional Secretary, Finance Department 10. Director General Health Services, Punjab 11. President, All Pakistan Clerks Association, Lahore 12. Additional Secretary (Admn) Health Department 13. Secretary Health (current) 14. Secretary Health (ex) 15. Secretary Regulations 16. Professor of Urology/Author on Health Issues 17. Director Audit and Accounts, Health Department 18. Director General, Civil Services Academy 19. Director General, National Institute for Public Administration 20. Secretary Government of Pakistan (Establishment) 21. Director Health Services (DHA, Districts) 22. Dean, Lahore University of Management Sciences 23. Chief Inspector of Treasuries, Punjab

Appendix 4.2: – List of focus group discussion participants

Case Studies	Participants
Sheikhupura PHC Pilot Project	A. Senior Planning Officer, Health Department B. Assistant Chief, PHDC, Lahore C. Deputy District Health Officer, Sheikhupura D. Programme Director, DHDC, Sheikhupura E. Women Medical Officer, Sheikhupura F. SMO, RHC, Warburton, Sheikhupura G. Lady Health Visitor, Sheikhupura
District Health Authority	A. Director Health Services (Development & Evaluation) B. Senior Planning Officer, Health Department C. Assistant Chief, PHDC, Lahore D. Programme Director, DHDC, Jhelum E. Under Secretary, Health Department F. DFID/District Health Management Coordinator
Institutional Autonomy	A. Assistant Professor, KE Medical College B. General Secretary, PMA, Lahore C. Task Manager, Health Sector Reform Unit D. Medical Superintendent, Autonomous Hospital E. Senior Planning Officer, Health Department F. Staff Officer to CE, Autonomous Hospital
District Health Government	A. District Chief Executive (select), DHG B. Director, Provincial Health Development Centre C. Task Manager, Health Sector Reform Unit D. Project Director, Second Family Health Project E. Section Officer, Health Department F. DFID/District Health Management Coordinator G. General Secretary, Pakistan Medical Association H. Programme Director, Management Development Unit, Provincial Health Development Centre

Appendix 4.3: – Interview guide

NB: The following is a generic question guide which was adapted to the individual case studies. Further each of these questions was supplemented with more questions for an in-depth enquiry, particularly if a response was not satisfactory.

1. How do you see the establishment of (name of initiative) in the health sector – was this aimed at some change?
2. What was the motivation behind undertaking the (name of initiative) – was it motivated politically or ideologically?
3. What were the factors or issues that necessitated the government to introduce (name of initiative)? Whether any crisis acted as a prelude or catalyst to the intervention?
4. Who identified the (aforementioned) issues and how did they do it – what was the mechanism that was adopted for identifying issues?
5. Who decided to bring the (aforementioned) issue on to the agenda and how was this done?
6. Was any in-depth study or analysis of the selected issue (for introducing reform) undertaken and how was this carried out in the case of (name of initiative)?
7. Whether the (aforementioned) analysis involved any projection as to how the situation would develop if it was allowed to continue? [and the (name of initiative) initiative was not introduced]
8. How were the objectives/ priorities fixed in the wake of situation and who set those?
9. How were the objectives and priorities addressed – who prepared and approved the plans, and what was the planning process for the (name of initiative)?
10. Whether any alternative approaches to achieve the objectives were considered and was any analytical technique used to appraise the alternatives for (name of initiative)?
11. What was the communication strategy as a part of any consultation and public dissemination process? Was this strategy used to consult and involve different stakeholders?

12. How was the operability of intervention field tested – as a pilot for testing the ground and learning lessons for the full-scale introduction of (name of initiative)?
13. How was the initiative (name of initiative) received by people (different interest groups) – was there any opposition and whether those in opposition were all united or divided i.e. had they different stances on the issue and what was their position?
14. What was the role of civil bureaucracy vis-à-vis technical bureaucracy in conceptualizing, designing and implementing the (name of initiative)?
15. Politically, how was the timing for introducing the (name of initiative) – was it at a feasible time i.e. was there a strong political backing to support the initiative?
16. How do you see the introduction of (name of initiative) in relation to the government's agenda – was it (initiative) part of a larger agenda (of comprehensive reforms) or it was a stand-alone piecemeal effort?
17. Who was the leading figure in the entire process for introducing (name of initiative) and what were his/her personal attributes e.g. individual with vision, pragmatism and dedication to guide the way forward for the initiative?
18. Who else supported the leader in the process for introducing (name of initiative) and what were his/her personal attributes e.g. individual(s) with vision, pragmatism and dedication to guide the way forward for the initiative?
19. How were the media used to develop public opinion and gather its support and what efforts were made to keep the issue alive on the policy agenda including defending the (name of initiative)?

Appendix 4.4: – Focus group discussion guide

1 Why was the (name of initiative) introduced? What was the ideology behind introducing the (name of initiative)?

2 What were the factors or issues that preceded the (name) initiative?

3 How was the (name) initiative designed? What influenced this process?

4 How was the (name) initiative implemented? What influenced this process?

5 Why did the (name) initiative have such fate (status of the initiative)?

Appendix 4.5: – Document review guide

Section-I: (General Information)

Doc. #. | | | | | Subject/Title: #. |

Nature: | | | Type: | |

Physical Location: |

Section-II: (Findings)

(Attach additional sheets if required)

1.	What was the idea behind the reform initiative?
2.	What were the imminent factors or issues that prompted?
3.	What was the government's process for designing the reform initiative?
4.	Who were the shapers of reform initiative?
5.	What was the scope and the particular proposal of the initiative?

Also particularly answer the following:

5a.	What were the support mechanisms that were installed to manage the resulting change and to build the capacity of the implementing agency?
5b.	How was the operability of the intervention field tested – pilot for learning the lessons?
5c.	What were the implementation arrangements brought in place or which resources were allocated out of the existing set up in the health sector?
5d.	What was the information system to monitor the process for implementing the reform?
5e.	What were the mechanisms that were brought into place to keep the reform process on track i.e. as planned and how did they function?
6.	What was the process and methods for implementation?
7.	What was the eventual fate of the reform initiative?
8.	What were the features of reform and factors in the health system that enabled the reform to proceed?
9.	What were the features of the reform and factors in the health system that hindered the pace of reform?
10.	Other and Miscellaneous?

CODING REFERENCE

Doc. # A unique No. allocated to each document reviewed

Nature

Nature	Code
Administrative	01
Planning & Development	02
Technical	03
Financial	04
General	05
Others	06

Physical Location (Name and address of office/ department/ section where document is available)

Type

Type of document	Code
File	01
Situational/ baseline Report	21
Review Report	22
Progress Monitoring Report	23
Evaluation Report	24
Other report	25
Memo	03
Unofficial Letter	41
Semi-Official letter	42
Official letter	43
Office order	44
Notification	45
Resolution	46
Circular	47
Press/News Item (complete reference)	05
Published Material (complete reference)	06
Grey literature	07
Other	08

Appendix 4.6: – Official meetings guide

Section-I: (General information)

Session #.		Subject/Title:	
Nature:		Type:	
Organizer(s):			
Venue:			
General:	Subject session/ meeting was held on _____. Mr./Ms./Mrs. _____ chaired the meeting. A total of _____ participants attended this meeting.		

Section-II: (Findings)

(Attach additional sheets if required)

1.	Who identifies the issues and how – what is the mechanism or process that is adopted for this?
2.	Who decides to bring the issue on agenda and what is the process involved for this?
3.	Is there any mechanism for undertaking in-depth study or analysis of the selected/identified issue and how is this carried out?
4.	Whether the aforementioned analysis involves also speculating as to how the situation will develop if it was allowed to continue as such?
5.	How are the objectives and priorities fixed in the wake of situation and who sets these?

6.	How are the objectives and priorities addressed –who prepares the plans, who approves these and what is the planning process involved?
7.	Whether any alternative approach is considered to achieve the objectives and any analytical technique used to appraise these?

CODING REFERENCE

Session #
A unique No. allocated to each session/ meeting

Nature

Nature	Code
Administrative	01
Planning & Development	02
Technical	03
Financial	04
General	05
Others	06

Type

Type of Session	Code
Meeting (Closed)	01
Seminar	02
Workshop	03
Public Meeting	04
Other	05

Appendix 4.7: – Fieldwork vis-à-vis research question

Objective (1)	Research Variable (2)	Data Source (3)	Indicator (4)	Technique (5)	Remarks/Checklist/interview schedule (6)
1. To develop a framework for analysing health system	1. Theoretical framework for health system	International experience/literature	Theoretical framework for the health system defined	Literature review	This formed part of improving skill and cognition in order to prepare for conducting research
2. To describe the changing structure & functions of the PPS, HS	2. Organisation of health sector	Documents/literature	Organisation of health sector defined	Document/literature review	Questions 2, 3 and 4 (column-2) required a review of the documents and archives in the DoH, for intelligence gathering to improve the researcher's grip over the issue.
	3. Roles and functions of various components of health sector	Documents/literature	Role & functions of components of health sector defined	Document/literature review	
	4. The status, issues & problems in health sector	Documents/literature	Status, issues & problems in the health sector defined	Document/literature review	Research variable--5 addressed in two parts: • In an initial group meeting with the permanent senior staff (veterans) of the DoH an inventory of reform initiatives developed. • Review of relevant documents to verify findings of the initial meeting and to develop a brief resume of the reforms as part of intelligence gathering.
	5. Reform initiatives that were undertaken in health sector during the 1993-2000	Documents/ Health managers	Descriptive inventory or a brief resume of the reforms those were undertaken in the health sector	Initial group meeting Document/literature review	

Objective (1)	Research Variable (2)	Data Source (3)	Indicator (4)	Technique (5)	Remarks/Checklist/interview schedule (6)
			established.		
3. To establish a framework for the process of health sector reform	6. The theoretical model for analysing the policy process for health sector reform initiatives	Literature	Theoretical model for analysing process for various reform initiatives developed	Literature review	This formed part of improving skill and cognition in order to prepare for conducting research
4. To explain features of the reform process undertaken in the PPS, HS.	7. The ones who shaped the reform initiatives	Key informants	Shapers/stakeholders of reforms identified	Initial group meeting and Stakeholder analysis workshop	For question-7, a stakeholder analysis workshop was organised to determine/verify the players of reforms identified in the initial group meeting – for whom the success and failure mattered.
	8. The ideology, which was behind the reforms	Shapers/stakeholders/ documents	Principles and purpose of reform established	Focus group discussions /individual interviews/ document review	Question-8 to 11 addressed using the following techniques: ❖ Focus group discussion sessions (one for each case under research) held with the selected stakeholders and key informants to address the questions 8,9,10 & 11 in column-2 of this matrix. ❖ Individual interviews were held with selected key informants with a focus on a question guide. ❖ Review of relevant documents in the DoH also addressed questions 7, 8, 9, 10, 11 & 12.
	9. The factors or issues that preceded the reform	Shapers/stakeholders/ documents	Context and rationale of reform is defined		
	10. The government's process for conceptualising and designing the reform	Shapers/stakeholders/ documents	Process and methods for policymaking in govt. is defined	-do-	
	11. The process and	Shapers/stakeholders/	Process and method	-do-	

Objective (1)	Research Variable (2)	Data Source (3)	Indicator (4)	Technique (5)	Remarks/Checklist/interview schedule (6)
	methodology for implementing the reform	documents	for implementing the policy is determined		
	12. The scope and particular proposal of reform	Documents	Contents and scope of reforms found	Document review	
5. To explore factors that influenced the output of reforms.	13. The eventual fate of the reform initiative	Documents/health managers	Output of reforms are known	Documents review/ initial group meeting	Question-13 was addressed alongside objective-3 and question-5 in two parts: ❖ In a meeting (initial) with permanent staff of the DoH eventual fate of the reform initiatives was determined. ❖ Review of relevant documents/department files in the DoH was made to verify the above finding.
	14. Factors in the health system that influenced process of reforms	Shapers/stakeholders/ documents	Factors and features of reforms that influenced reform process known	Focus group discussion /Individual interviews /document review	
	15. Features of policy process that influenced process for reforms	Shapers/stakeholders/ documents	-do-	-do-	Questions 14 & 15 addressed as below: ❖ FGDs (one for each initiative) were held to address these questions alongside objective-4 and questions 8,9,10, 11 & 12. ❖ Individual interviews held with key informants ❖ To supplement and triangulate results

Objective (1)	Research Variable (2)	Data Source (3)	Indicator (4)	Technique (5)	Remarks/Checklist/interview schedule (6)
					documents reviewed to address questions-13, 14 and 15.
6 To draw lessons to contribute to the reforms; both ongoing and the future undertakings.	16. Measures to facilitate the ongoing or any future health sector reform initiative	Findings of this study and literature on international experience	Lessons for application to the ongoing reform and a model for the future course of action is defined	Literature review/ Workshop with health managers and participants of this study	Review of contemporary literature together with findings of study and themes emerging contributed to the development of insight for policy process in Punjab health sector. A workshop was planned to be held with health managers and selected participants of this study to: ❖ Share results and present preliminary report of study; ❖ Receive participants' comments and any additional information to supplement the findings; and ❖ Record answers in response to the question, 'how can the findings of this study contribute to reforms; both ongoing and the future ones? However, the same could not be organised due to lack of funds and time constraints.

Appendix 6.1: - Chronological progression of reform execution

	1992	1993	1994	1995	1996	1997		1998		1999		2000
Granting Autonomy to the Medical Institutions						Role model hospital conceptualised	Autonomy to medical colleges conceptualised and abandoned	Law framed and Autonomy to medical and health institutions	Institutions granted autonomy	More institution granted autonomy	Rules not framed	New govt. stops institution to exercise autonomy till rules are framed
District Health Authorities	**District Health Government takes over District Health Authorities**			DFID supports the PHDC	DFID supports DHMT /PHDC	DFID supports the DHA concept and shifts to DGHS and districts		DFID supports the DHA concept and shifts to DGHS and districts		DFID supports the DHG through HSRU established in EDSP		DFID pulls out its support
				District Health Boards suggested and debate between the SPP and PHDC is generated	DHA/ DHMT conceptualised .	Notification for DHAs issued		Study tour to UK and DHG concept develops		DHG district and Chief Executives selected		New Government abandons DHG
					Govt. refuses DHA	First DHA established in Jhelum		Second DHA established in Multan		Both DHAs abandoned in January, but not withdrawn		
					DHMT established	DHMT established in 17 districts and latter abandoned		Aborted exercise for DHAs is 17 districts				
Sheikhupura Pilot Project		UNICEF supports Community development	PM's and VBFPWs program with paid workers	UNICEF reduces support to the SPP	UNICEF withdraws support from SPP							
		Community development started with voluntary workers	SPP denied funds for health workers' pay, but continues	Community development continues with voluntary workers	Community development continues with voluntary workers	Follow up is discontinued						
	SPP conceptualised and designed	SPP launched. Financial autonomy granted. A package of management Modification agreed.	Essential Drugs List and management tools developed	Essential Drugs List replicated for province. Work on mgt. Mod. package continues	PMT is partially changed. Work on management modification package continues	PMT is completely changed Major part of management interventions approved, but not implemented		Approval of DOTS and MCH proposal is refused and project is merged in the main SFHP, but certain interventions e.g. Essential Drugs List continue				
SFHP	SFHP conceptualised	SFHP launched				Mid-term review of SFHP						SFHP closed
	1992	1993	1994	1995	1996	1997		1998		1999		2000