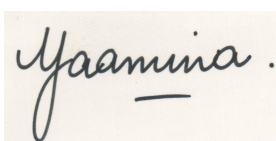# THE UNIVERSITY of EDINBURGH

Public management reforms in developing countries: The case of health sector reforms in Punjab, Pakistan

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Declaration

This is to certify that that the work contained within has been composed by me and is entirely my own work. No part of this thesis has been submitted for any other degree or professional qualification.

Signed:

Yaamina Salman

Preliminary findings of this research were presented at two conferences:

1. Salman, Y. (2012). "Health Services Reform in Pakistan" at Annual Conference of International Research Society for Public Management (IRSPM), 10th – 12th April, 2012, Rome, Italy.

2. Salman, Y. (2013) "Trajectories of Health Services Reform in Pakistan" at Annual Conference of International Research Society for Public Management (IRSPM), 10th – 12th April, 2013, Prague, Czech Republic.

Abstract

In developing countries healthcare reforms are increasingly advocated and implemented in association with global developmental agendas. This thesis analyses the process of health sector reforms in Punjab by looking at the reform drivers, strategies and implementation and examines the elite motivation to reform.

Responding to the empirical gap, one underlying objective is to map health sector reforms in Punjab at the primary and secondary level health facilities with respect to drivers, content, design and implementation. Bureaucrats and administrative elite hold a central role in the design and implementation of public management reforms, but in the context of developing countries with political instability and chronic budget deficits; it evaluates how the bureaucratic elites adopt, design and implement reforms.

An abductive research approach is used, to investigate Punjab as a case study of health sector reforms at the primary and secondary level health facilities. The organisational context of the study enables the investigation of seven health reform programmes in Punjab, managed and implemented at the provincial and district level.

The *central argumen*t of the thesis is that the process of reforms in developing countries is a political one. Administrative elites, central to the design and implementation of reforms tend to focus more on the reform trajectory and "what" to implement, and underemphasise implementation. Using data from an in-depth case study of Punjab with two embedded subunits of Lahore and Kasur selected on the basis of urban and rural demographics, this research triangulates between different datasets (bureaucracy, professionals, staff and service users) and documentary sources such as reports, documents, legislation etc. in addition to locating findings and arguments in public management, as a field of literature.

The study provides evidence that devolution and the United Nations Millennium Development Goals largely drive health care reform in Punjab. Both reform and

development agendas are funded by financial assistance from international financial institutions and donor organisations, and the implementation is top-down with little or no engagement with professionals, staff and service users. There is lack of motivational engagement with professionals and staff, who have no input in decision-making. The reform process lacks citizen engagement (ignorant service user) and accountability from the citizens. The adoption of reform agenda is highly driven by the fact that reforms consistent with global development agendas like UNMDGs bring in funds and resources in economically unstable environment faced by the country in general. Findings suggest that the reform process in developing countries needs to be understood in a much broader context and needs to incorporate the role international organisations play in determining the reform agenda. Reform adoption is highly dependent on the political activity and motivations of the administrative elites. *Firstly*, the existing models of reform are inadequate and focus on the institutional forces, rather than the individual motivations of the policy makers. *Secondly*, developing countries facing fiscal and economic stresses as well as unstable political institutions suffer from a skewed power imbalance where the power is concentrated in elites that results in a self-serving bureaucracy. This study contributed to the literature on reform process in developing countries by suggesting implications for research on reforms in the developing world, which includes the political and tactical motivation of the key actors in the reform process.

Dedication

This thesis is dedicated to my parents, Rahim Khan and Nikhat Rahim.

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The completion of the thesis would not have been possible without the guidance and support from my supervisors Prof. Stephen Osborne and Dr. Tony Kinder. I really appreciate and value their patience and compassion that they have shown throughout the journey. Special thanks to Dr. Tony Kinder for being such a good mentor and friend during the last year, and for all the golden words of wisdom that will last me a lifetime. He is indeed an invaluable resource for all the PhD Students in our school. I also wish to thank all my colleagues at the Business School who have shared their thoughts with me on various issues. Thanks to Wendy, Bing, Sidra, Ally, Denis and Katharine for being patient listeners throughout the journey.

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Abbreviations

ADB	Asian Development Bank
BHU	Basic Health Unit
CAQDAS	Computer-Assisted Qualitative Data Analysis Software
CIDA	Canadian International Development Agency
CMIPHC	Chief Minister's Initiative for Primary Health Care
DEG	Digital Era Governance
DFID	Department for International Development, United Kingdom
DGHS	Director General Health Services
DHIS	District Health Information System
DHQ	District Headquarter Hospital
EDO	Executive District Officer
GDP	Gross Development Product
HDI	Human Development Index
HMIS	Health Management Information System
HMIS	Health Management Information Systems
IMF	International Monetary Fund
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MCHC	Maternal and Child Health Centres
MDG	Millennium Development Goals
MoH	Ministry of Health
MoU	Memorandum of Understanding
MS	Medical Superintendent
MSDS	Minimum Service Delivery Standards

MSDS	Minimum Service Delivery Standards
NPG	New Public Governance
NPM	New Public Management
ODGHS	Office of Director General Health Services
OECD	Organisation for Economic Cooperation and Development
PDSSP	Punjab Devolved Social Services Programme
PHSRP	Punjab Health Sector Reform Programme
PHSRP-PMU	Punjab Health Sector Reform Programme – Programme Management Unit
PLGO	Pakistan Local Government Ordinance
PLGO	Pakistan Local Government Ordinance
PMDGP	Punjab Millennium Development Goals Programme
PovRSP	Poverty Reduction Strategy Papers
PRSP	Punjab Rural Support Programme
RHC	Rural Health Centre
RHC	Rural Health Centre
SOHIP	System-oriented Health Investment Project
SOP	Standard Operating Protocols
THQ	Tehsil Headquarter Hospital
UNDP	United Nations Development Programme
UNMDG	United Nations Millennium Development Goals
WHO	World Health Organisation
WOG	Whole-of-Government Approach

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Chapter 1
Introduction to the Research Study

Chapter 1   Introduction to the Research Study

In developing countries, public sector reforms esp. in health services are increasingly advocated and implemented in association with global developmental agendas. This research study analyses the process of adopting, designing and implementing health services reform in Pakistan. The underlying objective is not only to map out health service reforms with respect to content, design and implementation but also to show how *reforms* and *change* occur in public sector institutions, and what motivates the decision-makers. Public sector institutions, especially in developing countries, are thought to be change resistant, however, the reform trends of the recent years have shown many radical change initiatives introduced through reform practice like for e.g. New Public Management (NPM). Research on NPM reform suffers from a skewed case selection with majority of the evidence reported from the advanced market economies (Christensen and Lægreid, 2007; Joshi and Houtzager, 2012). But despite its origin in the western world, NPM has reached the developing countries under global pressures. Studies on NPM reforms in developing countries are fragmented and sparse, with mixed evidence showing the adoption of NPM reforms within the context (Manning, 2001; McCourt, 2002).

The underlying objective of this research study is to conceptualise the role played by bureaucracy/administrative elites in adopting, designing and implementing the reforms. Bureaucrats and administrative elites hold a central role in the design and implementation of public management reforms, but in the context of developing countries with political instability and chronic budget deficits, it will be interesting to look at how the interests of citizens, governments, and elites play out in the reform process.

Since it would not have been able to capture the entire process of health service reforms in Pakistan in a single research study, this study specifically focuses on evidence from Punjab health sector reforms. The public health infrastructure is organised under three tiers: primary, secondary and tertiary. The Punjab health sector

case study, conducted to answer the research questions will only cover health sector reforms introduced in primary and secondary health care facilities.

The current agenda of health service reforms in Pakistan revolves around Devolution (Local Governments Plan of 2001)(Government of Pakistan, 2001f) and United Nations Millennium Development Goals (UNMDG). The Government of Pakistan has written two National Health Policies (2001 and 2009) during the last fifteen years, to provide a policy framework for provincial governments to design and implement reforms. Additionally, the government has also been writing Poverty Reduction Strategy Papers with IMF and World Bank that have served as a policy framework. Health sector reforms in Punjab are based on Punjab Health Sector Reform Framework, which was prepared by the provincial government in 2005 and is based on the National Health Policy of 2001.

1.1   Research Context

The research is situated within the context of two policy decisions of the government: Devolution and adoption of UNMDG. In recent years, one of the most important legislative measures that have impacted the service delivery structures and performance has been the Local Government Ordinance of 2001. The Pakistan Local Government Ordinance enforced in 2001 resulted in a third tier of district governments with devolved social services. The new local government structures and newly elected local government officials took office in 2001 and posed a number of challenges to service delivery. The resulting devolved social sectors of health, education, and water sanitation needed to witness a number of structural and processual changes to accommodate the new system.

Secondly, Pakistan signed the United Nations' Millennium Development Goals in 2000. In addition to the challenges of the newly formed local government system Pakistan had to show progress towards the achievement of UNMDG. The plans for the achievement of UNMDG were backed with financial support from International Financial Institutions in the form of financial and technical assistance.

Decentralisation (devolution) and UNMDGs were instrumental in acquiring financial and technical assistance under reform packages in a country, facing chronic budget deficits, ineffective service delivery mechanisms, natural disasters and security crises. These resulted in reform programmes and interventions, which were matched with financial and technical assistance of multilateral and bilateral financial institutions (ADB, DFID).

1.2   Research Gap, research questions and significance

The research study seeks to address the gap of missing research on health sector reforms in Pakistan from a public management perspective. A review of the literature revealed that majority of the research in health services reform in Pakistan is from a public health perspective and less on the management of health services. The scant literature available in the management of reform in the health sector only examines one aspect i.e. non-state provision of health services (Palmer et al., 2008; Batley, 2006).

In response to the empirical gap identified, the study aims to examine the nature and process of reform in Pakistan in the health sector. The study also seeks to examine the process as a whole by drawing an analytical framework based on Pollitt and Bouckaert's (2004) model of public management reform and Christensen and Laegreid's (2007) transformative theoretical approach to analyse reforms within Punjab Health sector. Both the frameworks have been used for comparative research studies on reforms across twelve OECD countries (Pollitt and Bouckaert, 2004) and five countries from Europe and Australia (Christensen and Lægreid, 2007). These research approaches can serve as unbiased instruments to examine reform experiences, producing results that can be analysed using different theoretical approaches. The main research objectives are:

- *To map out health sector reform initiatives with respect to drivers, strategies and how they were implemented*

- *To explore the motivation to reform from the perspective of administrative elites*

- *To add to existing knowledge on public management reforms in developing countries for theory-building*

This research study aims to extend knowledge by investigating the motivation of elites in reform adoption, by examining the reform process in health sector. Elite decision-making, even though its centrality to the reform process is well acknowledged in literature (Grindle, 2000; Pollitt and Bouckaert, 2004), is not well understood within the context of developing countries. Developing countries present a unique context to administrative elites who function within powerful bureaucratic structures, and in an environment where there are chronic budget deficits, unstable political institutions and international financial institutions. Politics of service delivery reform has been receiving attention in public management literature, and is being recognised as an important determinant of the success and failure of reforms, but so far has not received much attention in the reform design and adoption phase (McLoughlin and Batley, 2012).

The research questions guiding the research project are as follows. The evolution of research questions is discussed in detail in Chapter 4.

This research study has been guided by two main research questions. The two research questions are followed by sub-questions that help in operationalising the broad research questions by identifying themes and outlining the scope of the study:

Research Question 1: What model of public management guides health sector reforms in Pakistan?

- What are the main reform drivers' and strategies' and how have they been implemented?

- To what extent has NPM been the dominant reform paradigm in health service reform trajectory?

Research Question 2: How are public management reforms being adopted in a developing country context?

- What motivates and drives administrative elites to adopt and implement health service reforms in Pakistan?

    What role do professionals, health care managers and service users play in the reform process?

1.3   Delimitations of Scope and Key Assumptions

The research study employs an analytical framework that draws upon the models of Pollitt and Bouckaert (2004) and Christensen and Lægreid (2007) . While a variety of definitions of public management reforms have been suggested in the literature, this research will borrow the definition from Pollitt and Bouckaert (2004:8) , who define it as **_"deliberate changes to the structure and processes of public sector organisations with the objective of getting them (in some sense) to run better"_** **_(2004:8)._** The empirical area to which this definition is applied is Punjab Health Sector, and it covers the health sector reforms introduced and implemented by the Punjab government only. Thus, obviously, it does not deal with reforms at the central level. Therefore, the definition for health sector reform used for this research will be **_"deliberate changes to the structure and processes of health service organisations working in the public sector in order to bring about an improvement in service delivery"._**

In order to investigate the direction of reform, and to infer the governing model of public management in the health sector, using Pollitt and Bouckaert's (2004:65-69) classification that reform has two main components "what" and "how". For the purpose of this study, the _"what"_ component of reform is defined as _reform strategy_

which outlines the scope and content of reform e.g. finance, personnel-related, organisational or performance measurement (2004:67). The *"how"* component of reform refers to the process of *implementation* i.e. whether the reform implementation has been top-down/bottom up, involves legal dimensions and if it has resulted in creation of agencies or task re-allocation.

Within the context of this study, the term '***administrative elite***' refers to the senior civil servants and health department officials that are involved in formulating and implementing reform strategies within the province. Chistensen and Laegreid (2007) and Pollitt and Bouckaert (2004) have both reiterated that public management reforms are a product of elite decision-making , which is at the hear of the entire reform process.

Reforms in developing countries have been in response to external pressures. In order to get an insight into why and how the reforms are adopted by administrative elites, it is important to understand the process of adopting the reform agenda. Reform adoption, therefore means what motivates the elites to adopt and implement health sector reforms in Punjab. What drives them to initiate reform proposals and how is the process carried out? Therefore, ***reform adoption*** refers to elite motivation, reform drivers and other contributing that can influence or initiate reforms in the health sector.

The empirical focus of the research study is on the primary and secondary level health facilities that fall under the purview of provincial and district governments. The study does not include the tertiary level health care facilities that comprise up of medical colleges, universities and specialised care institutions; neither does it include the private health care institutions and facilities. Moreover, the scope of the research also does not cover vertical programmes run by the federal government, which are being implemented in the provinces. This has been done to refine the research focus and to manage the time and resource limitations.

1.4 Methods

The study is designed as qualitative case study of Punjab with two embedded sub-units of Lahore and Kasur, investigated to get further insights into implementation of reforms. The study is conceptualised based on the relativist ontology and within the interpretive paradigm.

The time scale selected for studying the reforms was decided after the initial key interviews were conducted. Following the military coup in 1999, Pakistan faced a period of unrest and security crises. 2001 saw the passage of Pakistan Local Government Ordinance, subsequently resulting in devolved health services. The system was faced with the challenge of consolidating and strengthening the system, and a number of reform programmes were introduced from 2004 onwards to strengthen health services. Additionally, Pakistan had also signed on the United Nations Millennium Development Goals and due to political uncertainty, was lagging behind on MDG targets. The government committed itself, with participation from the provincial governments to take on measures for the achievement of MDG targets resulting in reform interventions and programmes.

The research focus became progressively narrowed and more focused during the research process. The questions stated above have been refined and have become more focused during the research process. The case study comprised of elite interviews, interviews with implementation partners, management consultants, district government officials, doctors and service users. Data was collected from multiple sources, and due to inconsistencies and discontinuities observed in primary sources of information i.e. interviews it was supplemented with documentary sources in the form of policy documents, reports and evaluations.

1.5 Contribution

This thesis argues that previous studies on reform process in general, and developing countries reform in particular, have neglected the politics and motivation to reform of the central actors in the reform process. Most research models on public

management reform process (Pollitt & Bouckaert, 2004 or Christensen and Laegreid, 2007), utilize post-hoc evaluation of reform experiences and despite acknowledging the centrality of the elite decision-making, do not consider an actor-based perspective to delineate the reform process. This thesis instead explores the reform process in health sector from 2004-2011, in Punjab (most populous province of Pakistan), by looking at the socio-economic and institutional forces (top-down look at reform process) and supplements the findings with an actor-based perspective (bottom-up actor perspective on reform process).

The research focus of the thesis explores the reform process in health sector in Punjab, by looking at the reform experience in primary and secondary health care facilities from 2004 till 2011, thereby making an empirical contribution to the research on health sector reforms in developing countries in general and Pakistan in particular.

The thesis makes a distinctive contribution to the field of public management and international development management by contributing to our understanding of the reform process. The findings of an in-depth case study of health sector in Punjab are used to extend the existing theory and knowledge about public management reforms in developing world. The thesis contributes to the research in the following ways:

Firstly, it makes an empirical contribution by mapping health sector reforms in Punjab from 2004 till 2011. Reform drivers, strategies and implementation practices are mapped. It also finds the relative salience of reform drivers in the context where internal pressures are a much weaker influence on the reform process when compared with international pressures exerted through global development agendas and donors. Findings of the research study also raised issues like *inadequate political inputs in the reform process, insufficient stakeholder involvement* and *lack of citizen engagement*, and may have implication for future research centring on the themes of reforms and development.

Secondly, the research confirms adoption of NPM-like reform practices but here the researcher would like to argue that adoption of practices resembling NPM does not necessarily mean adoption of NPM in health sector but rather this can be explained by examining the motivation of elite actors in the reforms, who adopt these practices in order to gain legitimacy in the eyes of donors and political elites.

Thirdly, this research will make recommendations for theoretical development of research on public sector reforms by stressing upon the political nature of the reform process and stress for a political economy analysis. It also suggests that reform process in developing country context is political in nature and its analysis should go beyond the analysis of external and internal pressures to reform, by analysing the elites' motivation to reform.

1.6   Thesis Structure

The thesis has been divided into nine chapters. Chapter 2 provides a background and research context to the research on health services reform in Pakistan. Chapter 3-4 review the existing literature around the research topic. Chapter 3 reviews literature on theoretical approaches to public management reform. Definitions and theories/models of public management reform have been discussed. Chapter 4 specifically discusses the developing country context. Developing countries' experiences and models on reform are also discussed with special reference to the overall themes and paradigms governing the reform processes. Existing literature on health services reform in Pakistan and other developing countries is also reviewed, followed by identification of research gaps leading to research questions of the study.

Chapter 5 covers the methodological issues, choice of research strategy, ethical issues and data analysis strategies. Chapter 6 and 7 present findings from the case study in light of the conceptual framework and research questions drawn at the end of literature review. Chapter 8 discusses the finding in light of the existing research. Chapter 9 concludes the study by answering the research question in light of findings and discussion, and also highlights the empirical and theoretical contribution of the

research. Research limitation, methodological challenges and future publications from this research project are also discussed.

Table 1-1: Overview of thesis structure and contents

Chapter	Contents
Chapter 1 Introduction to the research project	• Brief overview of the thesis • Research Questions • Contribution to knowledge
Chapter 2 Health Service Reform Context	• Global and National Policy Context • National Administrative Context
Chapter 3 Theoretical Approaches	• Traditional Public Administration, • New Public Management • Post-New Public Management
Chapter 4 Reforms in developing countries	• Reform Models in Developing Countries • Role of International Organisations • Politics of Reform • Research Gap, Research Questions and Conceptual Framework
Chapter 5 Research Methodology	• Research Philosophy • Case Study as a Strategy • Data Collection, Presentation and Analysis • Quality of research findings
Chapter 6 Case Study - I	• Reform Programmes In Punjab • Strategies used and their implementation
Chapter 7 Case Study - II	• Findings from Lahore and Kasur • District health administration, staff and service users' perspective
Chapter 8 Analysis and Discussion	• Applying the analytical framework • Triangulating findings with literature • Answering the research questions
Chapter 9 Conclusions and Reflections	• Evaluating the contribution to knowledge • Evaluating the findings with research questions and research objectives • Implications

Chapter 2
Health Service Reform Context

Chapter 2   Health Service Reform Context

The need for health sector reforms in Pakistan has been triggered by a number of factors including emphasis on better health services for better health outcomes through poverty reduction and global development agendas, devolution of health services to districts and participation in the United Nations Millennium Development Goals. This chapter sets out important contextual factors affecting health sector reforms in Pakistan.

The chapter is divided into three sections. **Section 2.1** sets out the global context influencing policy choices in Pakistan and discusses Poverty Reduction Strategy Papers (PovRSP) and United Nations Millennium Development Goals. Poverty Reduction Strategy Papers although are written by national governments, but are prepared in accordance with the guidelines of IMF and World Bank, as a conditionality for financial assistance. United Nations Millennium Development Goals are also a global development agenda for poorer countries, with health and education as its main focus areas. Adoption of UNMDGs results in conformance to the global development targets and agencies like Asian Development Bank and Department for International Development (DFID), UK have ben lending financial and technical assistance to many developing countries for achievement of MDG targets.

Section 2.2 outlines the national policy context and presents the National Health Policies of 2001 and 2009. Since health was mainly a provincial subject later devolved to districts, these National health policies give broad aims and goals to the provinces and lists the policies regarding national vertical programmes. These national health policies have been instrumental in guiding the provincial health policies, which in the case of Punjab is Punjab Health Sector Reform Framework. **Section 2.3** explains the national administrative context, public health care organisations, devolved health services. Key issues affecting health service delivery

are also identified. The purpose of the chapter is to set the backdrop of the research, and not to provide an analysis.

2.1 Global Policy Context

Pakistan is classified as a low-income country (World Bank, 2010; WHO, 2007), and is placed at 146 out of 187 developing countries based on its Human Development Index (HDI) of 0.515. There has been an increase of 53% in HDI since 1980 and an annual increase of 1.3% (UNDP, 2013). The government is also dependent on the assistance of multilateral and bilateral financial institutions for loans and grants, in order to run the development programmes.

2.1.1 Poverty Reduction Strategy Papers

Poverty Reduction Strategy Papers (PovRSP) approach was initiated by the World Bank and IMF in 1999, after a mixed response to the Structural Adjustment Programmes developed in the 1990s.The strategy results in a country-based strategy for poverty reduction, which aims to provide the crucial link between national public actions, donor support, and the development outcomes needed to meet the United Nations Millennium Development Goals. The PovRSPs help guide the policies of concessional lending associated with International Monetary Fund and World Bank, and are a tool to ensure that Pakistan continues to receive the financial and technical support from international financial institutions. According to IMF and World Bank, the Poverty Reduction Strategy Papers (PovRSPs) should be country driven, result oriented, comprehensive, partnership-oriented and based on a long-term perspective for poverty reduction (Foster, 2005; ActionAid, 2003).

Individual country governments that are also responsible for commissioning and organising technical and donor input into it, write their own papers. Pakistan receives a mix of concessional and non-concessional lending from World Bank and IMF, and PovRSP acts as a basis of their assistance programmes. The Government of Pakistan has written three poverty reduction strategy papers: Interim PovRSP in 2001(Government of Pakistan, 2001a), PovRSP-I in 2004(Government of Pakistan,

2004b) and PovRSP – II in 2010 (Government of Pakistan, 2010b). According to PovRSP I and II, the poverty reduction strategies have been based on the government's learning from the earlier ones. The PovRSP show that the strategies have been formulated after dialogue with the provinces, districts and the relevant stakeholders as per the World Bank and IMF Guidelines.

The core principles of the policy paper are engendering growth, implementing broad based governance reforms, improving social sector outcomes and reducing vulnerability to shocks. The papers show that they have been prepared after "a comprehensive process of consultations at the district, provincial and national levels" (Government of Pakistan, 2001a:11) but the overall response indicated otherwise (discussed later in Chapter 7 and 8).

Interim Poverty Reduction Strategy Paper (2001)	Poverty Reduction Strategy Paper - 2004	Poverty Reduction Strategy Paper - 2010
Engendering growth Implementing broad based governance reforms Improving social sector outcomes Reducing vulnerability to shocks	Accelerating economic growth and poverty Improving governance Investing in human capital Targeting the poor and the vulnerable	Macroeconomic stability and real sector growth Protecting the poor and the vulnerable Increasing productivity and value addition in agriculture Integrated energy development programme Making industry internationally competitive Human development Removing infrastructure bottlenecks through public private partnerships Capital and finance for development Governance for a just and fair system

Table 2-1: Pillars of Poverty Reduction Strategy Papers

Table 2-1 and 2-2 show some common themes regarding health sector policy guidleines in PovRSP: strengthening of the devolved structures, encouraging public-private partnerships, increasing public health expenditures and evidence-based policy making. These guidelines have been instrumental in determining the tone and direction of national health policies.

Interim Poverty Reduction Strategy Paper (2001)	Poverty Reduction Strategy Paper - 2004	Poverty Reduction Strategy Paper - 2010
Increasing public health expenditure Strengthening of primary health care facilities Training of medical staff through DHDC/PHDC Instituting public private partnerships Administrative autonomy in teaching hospitals Establishment of Health Boards and Village and Health Committees	Programmes for achievement of MDGs Health sector investments Raising public sector health expenditures Strengthening of primary health care Preventive and promotive health programmes Strengthening the district health system Behaviour Change Communication Strategy Increase outreach of public health facilities Development and implementation of HMIS Encouraging public-private partnerships for service delivery	Evidence-based decision-making, capacity development and health information infrastructure Intersectoral support for health policies Health promotion for social and environmental issues Leadership and governance-accountability measures and evidence-based policies Increase in public health financing Increase the outreach of basic health services Develop a health workforce Developing technological capacity – medicines etc.

Table 2-2: Policy guidelines for Health Sector in Poverty Reduction Strategy Papers

2.1.2 United Nations Millennium Development Goals

In September 2000 United Nations Millennium Summit was held where the world leaders agreed upon a set of eight specific goals called the Millennium Development Goals (MDGs) to be achieved by 2015 (Government of Punjab and UNDP, 2012; UNDP, 2003).The eight goals are: *eradicate extreme poverty and hunger; achieving universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases ;ensuring environmental sustainability; and develop a global partnership for development.* Three of the eight UNMDG are related to health (boldface).

Pakistan is also a signatory to the MDGs. The Poverty reduction strategy papers and national health policies are aimed towards the achievement of the goals. Punjab has set up a separate unit within the Planning Commission to monitor and evaluate the performance of various social sectors towards the achievement of the goals.

UNMDG 4: Reducing child mortality	UNMDG 5: Improving Maternal Health	UNMDG 6: Combating HIV/AIDS, Malaria and other diseases
Under 5 Mortality Rate (Deaths per 1000 live births)	Maternal Mortality ratio	HIV prevalence among 15-24 year old pregnant women (%)
Infant Mortality Rate (Deaths per 1000 live births)	Proportion of births attended by skilled birth attendants	HIV prevalence among vulnerable group (e.g., active sexual workers) (%)
Proportion of fully immunized children 12-23 months	Contraceptive Prevalence Rate	Proportion of population in malaria risk areas using effective malaria prevention and treatment measures. (%)
Lady Health Worker's coverage (percentage of target population)	Total Fertility Rate	Incidence of tuberculosis per 100,000 population
Proportion of children 12-23 months immunised against measles	Antenatal Care Coverage	Proportion of TB cases detected and cured under DOTS (Direct Observed Treatment Short Course). (%)
Proportion of children under 5 who suffered from diarrhea in the last 30		

days (percent)		

Table 2-3: Health-related UNMDGs: Indicators and Targets (Source: UNMDG 2000 at www.undp.org.pk)

The UN Millennium Declaration set out eight millennium development goals, which were to be achieved with the help of 18 targets and 48 indicators (Table 2-3). Pakistan has adopted 16 targets and 37 indicators to be achieved by 2015. Three of eight United Nations Millennium Development Goals (UNMDG) are directly related to health and correspond to four targets and sixteen indicators. The health-related UNMDGs are: reducing child mortality, improving maternal health, and combating HIV/AIDS, Malaria and other diseases.

2.2   National Policy Context

Two national health policies were formulated by the Ministry of Health in 2001 and 2009, and act as guiding policy frameworks for all four provinces. Punjab has prepared a Punjab Health Sector Reform Framework based on the National Health Policies and Poverty Reduction Strategy Papers to serve as a basic framework for introducing health sector reforms in the province (Government of Punjab, 2006a).

2.2.1   National Health Policies

Traditionally, the strategic policy role was performed by the Planning Commission and was communicated through the instrument of five-year plans/development plans to the various social sectors. The country had no comprehensive national health policy till Ministry of Health prepared its first National Health Policy in 1990, followed by one in 1997, 2001 and 2009. These national health policies serve as a policy framework for the provincial governments and are also used as a toll to communicate the government's stance on health sector to the world. The key policy objectives of the two most recent of the four health policies are given below.

The National Health Policy of 2001 was developed by the Ministry of Health and had health sector reforms at its core. The overall vision for the National Health Policy is based on the "Health for All" approach. The National Health Policy of 2001 identified ten areas of reform in the health sector, which were also in line with the Millennium Development Goals (MDGs). The key reform areas are given in Table 2-1. *The National Health Policy of 2009* emphasized on the need to improve the health and quality of life of women and children by improving access to facilities. The policy was also in line the Millennium Development Goals (National Health Policy 2009).

National Health Policy 2001	National Health Policy 2009
Reducing widespread prevalence of communicable diseases;	Development and provision of an essential health services package
Addressing inadequacies in primary/secondary health care services;	Human resource development and management
Removing professional/managerial deficiencies in the District Health System;	Generate reliable health information to manage and evaluate health services
Promoting greater gender equity;	Acquire and adopt appropriate health technology to deliver quality services
Bridging basic nutrition gaps in the target population;	Enhancement of health budgets and provision of social safety nets
Correcting urban bias in the health sector;	Improved governance & accountability
Introducing required regulation in private medical sector;	
Creating mass awareness in Public Health matters	
Effecting improvements in the drug sector; and	
Capacity-building for health policy monitoring	

Table 2-4: Comparison of Key Policy areas of National Health Policies of 2001 and 2009

Both the national health policies stress upon the need to improve access to health services to the population especially women and children, strengthening the district heath systems, human resource development and regulation of the medical sector. These national health policies and poverty reduction strategy frameworks serve as policy frameworks for provincial health policies.

2.2.2 Punjab Health Sector Reform Framework

The Punjab Health Sector Reform Framework is a document that has been prepared with the help of Punjab Resource Management Programme (a technical assistance programme of the Asian Development, to help the government with a comprehensive reform package to improve service delivery across social sectors by managing resources effectively) to serve as a policy framework for Punjab health programmes. Health sector reforms in Punjab from 2006 onwards are based on this guiding framework (Government of Punjab, 2006a).

The Health Sector Reform Framework takes stock of the issues facing public health services in Punjab. Before 2006, the Punjab Health Department had established Punjab Health Sector Reforms Programme (PHSRP) in 2005 whose agenda was to improve the missing health facilities in the province. Another initiative that was happening at that time was the Punjab Devolved Social Services Programme (PDSSP), which was working for capacity building of devolved social services. PDSSP was set up with technical and financial assistance from Asian Development Bank (ADB) and Department for International Development (DFID), UK. Punjab Health Sector Reform Programme (PHSRP) and Punjab Devolved Social Services Programme (PDSSP) were launched by the Health Department in 2005 and 2006 respectively to introduce health sector reforms in Punjab. PHSRP works as the implementation and monitoring arm of the Health Department to institutionalize the reforms. PDSSP helped the Health Department, Punjab in capacity building of district governments to plan and implement reforms. The framework identifies the themes and issues affecting public health services, maps out the existing work being done under various reform programmes, and proposes reform interventions. The

purpose is to give a direction to the upcoming health sector reforms. It defines the strategy and milestones for improvements in health service delivery.

According to the Health Sector Reform framework, the proposed reform programme under this framework was designed to achieve results by making improvements in the following ways (Government of Punjab, 2006a) :

Punjab Health Sector Reform Framework – Key issues
• Improving Performance of health management system;
• Improve access and quality of trained manpower, drugs and technology;
• Review existing policy framework for health service delivery
• Improve health service delivery infrastructure
• Health Mass Awareness
• Introduce Public- Private Partnerships
• Broaden Health Financing Mechanisms

Table 2-5: Key policy issues in Punjab Health Sector Reform Framework

These reform programmes were to be developed with the help of PDSSP and Health Department. PHSRP will implement, monitor and evaluate the implementation of the reforms, and act as the implementation arm of the Health Department of Punjab.

2.3   National Administrative Context

Pakistan is a strategically important country with one of the largest Muslim populations comprising of four provinces: Punjab, Sindh, Khyber Pakhtunkhwa and Balochistan. There are four provinces constituting 116 districts, a capital territory – Islamabad, and federally administered tribal areas. In 2001, the federal government abolished the administrative entities called "Divisions", which was the third tier of the government. The entities called "Districts" which used to make the fourth tier became the third tier. The change was made to facilitate the implementation of Local Government Ordinance of 2001. The government is based on the 1973 constitution of Islamic republic of Pakistan. The country has a bicameral legislature that consists of the Senate (Upper house) and the National assembly (lower house).

The country has had a turbulent political history where successive governments have been elected but have failed to complete their term due to party politics, corruption and military takeovers. A military coup was witnessed by the country on October 12, 1999 and the Army Chief became the head of the state. In October 2002, elections were held resulting in an elected government and the Army Chief was controversially elected as the President of Pakistan. The government was democratically elected but was under heavy influence of the President who was also an Army Chief.

The government is based on the 1973 constitution, which has not only seen a number of amendments, but has also been suspended twice under military rule. According to the Constitution of Islamic Republic of Pakistan, the country follows a federal parliamentary system having President as Head of the State and Prime Miister as head of government/executive.

Punjab is the Pakistan's biggest province by population, accounting 55.6 percent of the country's total population. The province has a substantial industrial and agrarian base, and it contributes 58% to GDP. Any changes in development indicators have a significant effect on weighted national indicators (Pakistan Census 2011).

2.3.1 Basic political/administrative structure and recent reforms

2.3.2 Health Status and Demographics

Pakistan is the sixth most populous country in the world, with a population of more than 185 million (Government of Pakistan, 2011b). Pakistan's *health profile* characterises high population growth rate, high infant and child mortality, high maternal mortality and burden of communicable and non-communicable diseases. High burden of infant and perinatal mortality can be traced back to malnutrition, diarrhoea and respiratory illnesses, while high maternal mortality ratios can be associated with high fertility rates, low skilled birth attendance, illiteracy and lack of access to emergency and obstetrics. Only 40% of the childbirths are attended by skilled birth attendants, and 30-40% of the children are being lost to malnutrition (WHO, 2007).

2.3.3 Key issues affecting Health Service Delivery

The following key issues have been found to affect health service delivery in Pakistan. The following key issues have been widely established in the academic literature (Khan, 2009; Nishtar, 2010; Nishtar and Bile, 2010) government policy documents (Government of Punjab, 2006a; Government of Pakistan, 2001d; Government of Pakistan, 2009b) and in reports made by international organisations (WHO, 2007)

1. Low utilisation of health care facilities due to absence of staff, lack of trust and poor physical infrastructural facilities.

2. Lack of staff and non-availability of doctors in remote areas.

3. No accountability mechanism in place and the system's inability to take any sort of remedial action against absenteeism, medical negligence.

4. No evidence based public health research despite a full fledged Health Management Information System being in place.

5. Shortage of female doctors and staff particularly in rural areas and small towns.

6. Absenteeism of health care personnel in primary and secondary health care facilities.

7. Shortage of professional health care service managers.

8. Health care infrastructure in the urban areas has not been expanding in the urban areas encouraging private health care institutions.

9. No standards of performance measurement. Although the systems are now in place but are still in the initial phases of implementation

10. Lack of medical regulation where services are provided by a range of professionals or quasi-professionals ranging from quacks, dispensers, Hakims, chemists etc.

11. Chain of command and reporting relationship are confusing after the devolution of social services to social governments.

12. The public health sector spending is mostly concentrated on buying equipment and building hospitals in larger cities.

2.3.4 Healthcare System and organisation

The health system of Pakistan consists of both public and private sectors. The Ministry of Health (MoH) at the federal level is responsible for developing national policies and strategies. According to the constitution of Pakistan, health is primarily a provincial subject, except in the federally administered areas. Minister of Health heads the ministry of Health at the Federal level, and Federal Secretary (Health) heads the bureaucracy and is assisted by Director General (Health) and two joint secretaries (WHO, 2007). (See appendix for national, provincial and district organisational structures)

Provincial Health Departments perform two main functions: 1) policy-making and regulation, and 2) operations and management of health service delivery (Government of Pakistan, 2009a). *Policy-making and regulation* is the responsibility of Secretary, Health supported by an Additional Secretary, Deputy Secretaries, and other departmental staff. *Operations and management* of health service delivery is done by Director General – Health who reports to the Secretary (Health). During the time of fieldwork 2010-11, the Office of Director General (Health) was still working

but was later abolished by the Punjab Government in 2012. The human resource functions of recruitment of staff in BPS-17 or above were the responsibility of ODGHS.

Each province has its own provincial health department. The Provincial health secretaries are responsible for translating the national health policies into provincial health policies, controls the budgetary resources and has direct control over teaching hospitals and other specialised care institutions. Majority of the teaching hospitals and specialist health care institutions within the province a fall under the purview of the provincial government, with a few exceptions where they are being managed by the federal government.

Although, health care delivery is a provincial subject, it is still being administered by both federal and provincial governments. The district governments are responsible for service delivery and implementation at the district level. Since the local government system is fairly new, the provincial health department is still actively involved with the district governments. The organisational charts for the Ministry of Health at the federal level, Health Department at the provincial level, and the District Health governments are given in the appendices.

Public Health Delivery System

The public health delivery system is administratively managed at the district level. 36 of the total 136 districts across the country are in Punjab. The state provides public health services through a *three-tiered* delivery system in conjunction with other public health interventions. The three tiers correspond to the *primary, secondary and tertiary care public health facilities/institutions*.

Primary health care facilities include Basic Health Units (BHU) and Rural Health Centres (RHC). *Secondary health care* facilities are the District Headquarter Hospitals (DHQ) and Tehsil Headquarter Hospitals (THQ). These secondary facilities are also responsible for first and second level referral facilities, indoor

patients and ambulatory care. Tertiary care institutions include the teaching hospitals and specialist care institutions, mostly in larger cities only. (Figure 2-1)

A limited number of *Maternal and Child Health Centres (MCHC)* are also part of the integrated health system. These centres work with primary level health care facilities and assist them in providing basic obstetric care. Ladies Health Workers Program is a vertical programme managed by the federal government that works with the provincial government to improve maternal and child health services in the province.

Service delivery is organized as *preventive, promotive, curative* and *rehabilitative services*. The curative and rehabilitative services are mainly provided at the secondary and tertiary level. The preventive and promotive services are provided through national/vertical programmes where community health care workers interact with communities and work along with primary health care facilities. The examples of such programmes are Ladies Health Worker Programme and National Aids Control Programme.
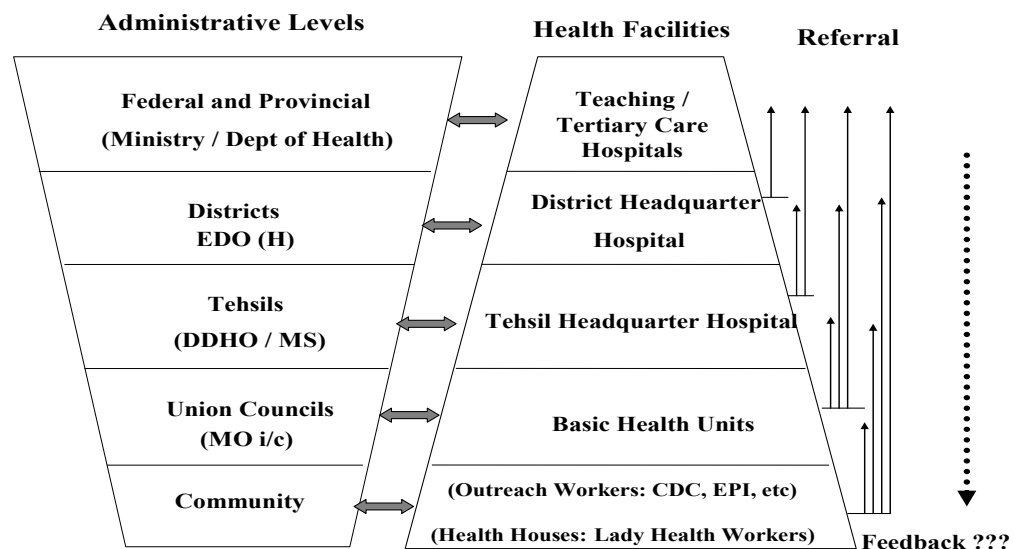
Figure 2-1: Organisation of Public Health Care System (Source: WHO, 2007)

Decentralised service delivery framework under PLGO 2001

The Devolution plan was announced in March 2001 to replace the existing, highly centralised and control-oriented government with a three-tiered local government system, as part of a broader strategy of the military government to "reconstruct the institutions of the state". The elected local governments took power on August 14th, 2001 in all the four provinces. The system also provided a number of institutionalised opportunities for citizens to participate in decision-making and policy formulation eg. Citizen Community Boards. The official goals for devolving social sectors has been put forward by National Reconstruction Bureau (specially constituted by the military rulers to plan and implement reforms), and are popularly known as the five Ds:

1. Devolution of political power – elected politicians articulating the goals of their communities;

2. Decentralisation of administrative authority – autonomy of district departments;

3. Decentralisation of resources to districts – taxation powers and transfers;

4. Decentralisation of management functions – specialisation of staff and performace-based appraisal;

5. Diffusion of power authority nexus – checks and balances through monitoring by citizens.

(Taken from National Reconstruction Bureau, 2000 in Nayyar-Stone et al. 2006)

Health, literacy and primary and secondary education were devolved to the districts as a consequence of Devolution of 2001. As for health services, Executive District Officer EDO (Health) is in charge of all the primary and secondary health care facilities of the district. The EDO has the authority to make appointments up to a certain level. Annual budgets, day-to-day affairs, monitoring and evaluation of health services and implementation of directives from the provincial health department were responsibility of the district office.

According to Pakistan Local Government Ordinance of 2001 (Government of Pakistan, 2001f), health services concerning the functions of basic & rural health, child & maternal health, population welfare, tehsil and district headquarter hospitals was transferred to district governments (Figure 2-3). The staff working in the districts and tehsils was transferred to their respective district governments, but the transfers and postings of medical staff was controlled by provincial governments. Procurement of medicines was also done by the provincial government which should have been transferred to the districts, but was still carried out by the provincial health departments which often delayed the procurement, availability and provision of medicines at the health facilities. The legal and institutional authority regarding procurement of medicines, and appointments, postings and transfers should have been transferred to the district governments but was retained by the provincial government (World Bank et al., 2004; Cyan et al., 2004).

Funding of all health services was retained by the provincial government, in addition to the vertical health programmes which are financed by the federal government (e.g. Lady Health Workers Programme, National Tuberculosis Programme). The funds are not physically transferred to the district governments and are transferred in the form of grants, being paid by the Accountant General's Office based on approved invoices forwarded by the respective district governments (Nayyar-Stone et al., 2006). Health facilities also collect various nominal fees from outpatients and for services like X-rays etc. The fee is nominal and is not at all representative of the costs incurred. These revenues are not retained by district governments, but are deposited with the provincial governments who then allocate it to the districts based on the Provincial Financial Commission's Award (formula-based grants). (Government of Punjab, 2012; Cyan et al., 2004)

Province	District	Tehsil, *taluka,* or town[a]
Education	**Education**	
Primary education	Primary education	
Secondary education	Secondary education	
Colleges (non-professional)	Colleges (non-professional)	
Professional colleges		
Teacher education		
Health	**Health**	
Basic and Rural Health	Basic and Rural Health	
District and *Tehsil* (HQ) hospitals	District and *Tehsil* (HQ) hospitals	
Provincial hospitals		
Medical colleges		
Population Welfare		
Agriculture	**Agriculture**	
Agriculture extension	Agriculture extension	
On-farm management	On-farm management	
Soil conservation	Soil conservation	
Fisheries	Fisheries	
Forests	Forests	
Water Supply and Sanitation		**Water Supply and Sanitation**
Sewerage		**Sewerage**
Transport	**Transport**	**Transport**
Inter-district roads		
Intra-district roads	Intra-district roads	
Intra-tehsil roads		*Intra-tehsil* roads
Street lighting		**Street lighting**
Parks and playgrounds		**Parks and playgrounds**
Municipal regulation		**Municipal regulation**
Irrigation		
Police		
Mines and mineral development		
Industrial and labor regulation		

——————— Fully devolved　　— — — — — Partially devolved

a. In urban areas, city districts, not the city towns, undertake these responsibilities.

Figure 2-2: Reassigning functions from provinces to local governments after devolution of 2001 (World Bank et al., 2004)

Health services were the responsibility of the provincial governments before devolution, and the provincial governments' managed it by posting staff at district and sub-district levels. The medical staff appointed at the health facilities reported to Office of Director General, Health Services (ODGHS), which operated with Directors (Health) performing different functions. After the Local Government Ordinance of 2001, health was devolved to districts with the exception of medical and dental colleges, postgraduate medical institutes, teaching hospitals and specialized care institutions. The control over medical staff, and reporting mechanisms for monitoring and evaluation in 2010 indicate the control of both

ODGHS and district health administration i.e. Executive District Officer – Health (EDO – Health) at the district level. (Figure 2-3)
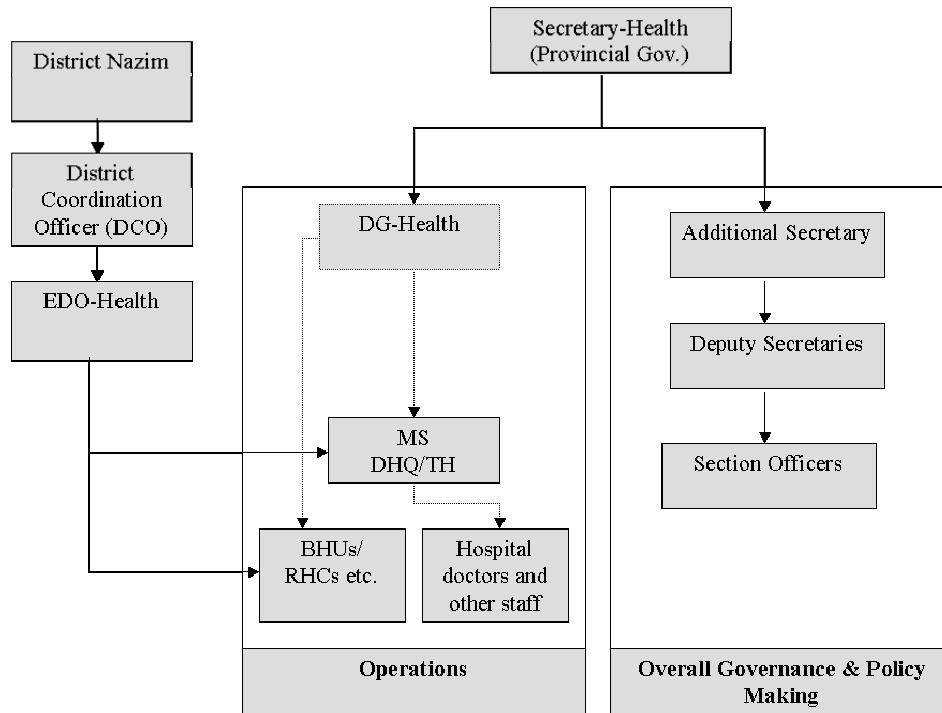
Figure 2-3: Intergovernmental relations in Health Sector (Source: Nayyar-Stone et al., 2006)

Key: MS-Medical Superintendent, DHQ-District Headquarter Hospitals, THQ – Tehsil headquarter Hospitals, BHU – Basic Health Unit, RHC – Rural Health Center

Chapter Summary

This chapter gives the background to health sector reforms in Punjab and gives an overview of the policy context (globally and nationally), administrative structures, and health service delivery organisation. At the global level, the policy context is determined by WorldBank and IMF prescribed Poverty reduction strategy papers,

which ensure conformance with their favoured policies. United Nations Millennium Development Goals are a global poverty alleviation agenda adopted by most poor and developing nations of the world, to achieve health and education targets till 2015. The national context comprises of National Health Policies of 2001 and 2009. The National Health Policies provide the provinces with a policy framework within which to set their own implementation plans. Punjab Health Sector Reform Framework is one such instrument, which has been prepared by Punjab Health Department to set the tone and direction of health sector reforms in Punjab. Administrative structures and organisation of health service delivery is also discussed to provide an understanding of the overall health infrastructure within the province. Devolution of 2001 serves as an important backdrop of recent health sector reforms. The newly devolved health services need consolidation, strengthening and sustainability, while at the same time it is also integral to the achievement of Millennium Development Goals.

The next three chapters (Chapters 3 – 5) review the existing research on public sector reforms, identify research gaps and formulate research questions for this study.

Chapter 3
Approaches to Public Sector Reforms – From *administration*, to *management* and now *governance*

Chapter 3 Approaches to Public Sector Reforms – From *administration*, to *management* and now *governance*

The literature review is divided into two chapters. Chapter 3 reviews the theoretical approaches to public management reforms by focusing on the reform context, strategies and implementation. Chapter 4 discusses the literature on public management reforms in developing countries followed by a review on scant literature on health sector reforms in Pakistan. This chapter also identifies the research gaps based on the literature review and defines the research questions for the study.

This chapter intends to review the literature on public management reforms. It is divided into three sections that trace the theoretical evolution of the field of public management with respect to the different approaches to public sector reforms. Literature on traditional Weberian Bureaucracy, New Public Management and New Public Governance is discussed.This section explains the theoretical evolution of public management reforms and is further divided into three subsections: Weber's Rational Model, New Public Management and Post-NPM Models. Under these three subsections, reform drivers, strategies and implementation and their critique is discussed.

Public sector reforms have been a topic of interest for those associated with public offices since the early twentieth century. Though, they are not a new phenomenon but have certainly become more significant than what they were around fifty years ago. The reforms have changed focus, from simple reforms aimed at introducing procedural changes with public administration offices in 1950s to reforms in 1980s-90s responding to pressures of globalisation, by redefining the role of state and government. The last thirty years have seen public sector reforms become a matter of national interest, which regularly features on national policies and party manifestos.

It is now "a global movement seeking to urge recalcitrant governments to modernize, to transfer, and adopt 'best practices' (Pal and Ireland, 2009)".

Within public administration and management literature, three periods of reforms can be identified. Osborne (2010:1) refers to these as *'policy and implementation regimes'* denoting design and delivery of public services through the governing paradigms of Public Administration, New Public Management and emergent New Public Governance. Pollitt and Bouckaert (2011:10-12) have categorised them as reform thinking on a temporal dimension (see Table 2.1 below) where the mid 1960s-late 1970s were dominated by rational decision-making and hierarchical planning, the late 1970s to late 1990s were dominated by New Public Management which essentially meant the introduction of business-like processes in the public service delivery and late 1990s till present as an era where there was no single dominant model but some governing themes like governance, networks and partnerships. Goldfinch (2009:1) argues that there are two major periods of reform. The first is seen as a revolution in the field of public administration and can be called as "progressive era public administration (PPA)" (Hood, 1994 as cited in Goldfinch, 2009:1) or the "Weberian, bureaucratic or traditional model". This period of reform originated in Great Britain and is associated with Northcote and Trevelyan Report of 1854 (1954), and influenced by Indian Civil Service and Prussian traits, and was seen in the earlier parts of the twentieth century in industrialized and colonialized nations. The second period of reform is the New Public Management, the most widely researched phenomenon, which arose in the 1980s and 1990s and was primarily to address the shortcomings of the previous models.

Period	Characteristics of Dominant Discourse
Mid 1960s to late 1970s	Rational, hierarchical planning and cost-benefit analysis. Science and expertise will produce progress.
Late 1970s to late 1990s	New Public Management. Business techniques to improve efficiency. Rise of

	'better' management' as the solution to wide range of problems.
Late 1990s - 2010	No dominant model. Several key concepts, including governance, networks, partnerships, 'joining-up', transparency and trust.

Table 3-1: Three phases of reform thinking (Source: Pollitt and Bouckaert, 2011:11)

The academic commentary on the periodization of reform broadly categorises the reforms to fall into three dominant discourses/models: Traditional Public Administration, New Public Management and Post-New Public Management. These models have manifested themselves in the public service systems of developing economies of the west. Whether these are the dominant reform models in the developing world is going to be explored in Chapter 4. The following sections will explore the drivers, strategies and implementation practices of Traditional Public Administration, New Public Management and New Public Governance.

3.1 Traditional Public Administration

The term 'Traditional Public Administration' refers to the period of reform in public sector till the 1980s. While some have frequently regarded it as the "golden age of planning" (Pollitt and Bouckaert, 2011:9), others have termed it as "the bureaucratic paradigm", "old orthodoxy", "old-time religion" or "traditional public administration" (Lynn, 2001). Reforms during this period were of a 'technical' or 'legal' nature, and were a national matter handled by the national or subnational governments (Pollitt and Bouckaert, 2011:5). They were introduced to improve the overall functioning of the public offices and were not a political matter or used to gain political mileage (Pollitt and Bouckaert, 2011:6).

Theoretical foundations of this reform period can be traced to Woodrow Wilson in United States, Max Weber in Germany and the Northcote-Trevelyan Report of 1854 in United Kingdom (Hughes, 2003:17). The Northcote-Trevelyan Report attacked patronage and is regarded as the first contribution towards merit-based, non-partisan

and neutral systems of administration (1954). The main propositions include "the abolition of patronage and the substitution of recruitment by open competitive examinations under the supervision of a central examining board; reorganization of office staffs of central departments in broad classes to deal with intellectual and mechanical work respectively; and filling higher posts by promotion from inside based on merit" (1954; Hughes, 2003: 20). These personnel-related reforms of the mid-nineteenth century in United Kingdom influenced subsequent reforms in the United States targeting the "spoils system". Traditional Public Administration discourse draws on the works of many contemporaneous authors of that time, but the most significant influences have been those of Woodrow Wilson, Frederick W. Taylor's Scientific Management and Weber's Rational Model. The works of these authors and how it contributes to the traditional public administration period is discussed in the following sections.

3.1.1 Woodrow Wilson

In 1887, Woodrow Wilson proposed the politics-administration split in public services. Woodrow Wilson believed that in order to address the evils of the "spoils system", a distinction in the spheres of politics and administration was needed. The main propositions were that policy was to derive from the political sphere and execution to be handled by the administration in a way so that partial and arbitrary decisions are addressed by the split. The traditional model was influenced by the politics-administration dichotomy where policy making was the function of the elected politicians and the administration was seen to be as a 'technical task' which was left to the professional officials who out the policies in action. The officials would use their technical expertise to bring the policies made by the elected officials. Woodrow Wilson was seen as the originator of the concept, which was later also used by Max Weber to explain an ideal-type bureaucracy(Lynn, 2006; Hughes, 2003).

The split espouses a clear relationship between politics and administration, where the department or the executive agency plays an advisory role to the political leadership

on development and implementation of policy while managing the resources to ensure its implementation. Accountability is exercised through hierarchy, where the administration is answerable to the Cabinet, who is ultimately responsible to the citizens. The politics-administration dichotomy is a milestone in the field of public administrations and marks the development of the discipline independent of law and political science (Hughes, 2003; Olsen, 2007).

3.1.2 Taylor's Scientific Management

Deriving from the management theories of that time, the public sector by the start of the twentieth century had enough theoretical foundations of bureaucracy and political control developed. What the bureaucracy lacked was ways to work and organise, which they derived from contemporary management theory at the time. Taylor's Scientific Management provided the 'one best way' of doing things. It propagated standardisation and control within the public sector organisations, by emphasizing standard operating procedures, division of labour, specialisation of tasks and managerial control to ensure adherence to the standard rules and procedures (Hughes, 2003; Lynn, 2001). Characteristics of this management theory, were found in Weber's theory of bureaucracy which will be discussed in the following section.

3.1.3 Weber's Rational Model

Bureaucracy existed before Weber proposed the theory but in the words of Ostrom (1974, as cited in Hughes, 2003) was "fully congruent with the traditional theory of public administration". Weber identifies three types of authority – traditional, charismatic and rational/legal within the context of administration and proposed six principles of bureaucracy based on rational/legal authority that he believes is the basis of neutral and impersonal administrative action by individuals (Weber, 1946).

- The principle of fixed and official jurisdictional areas, which are generally ordered by rules, that is by laws or administrative regulations.

- The principles of office hierarchy and of levels of graded authority mean a firmly ordered system of super- and sub-ordination in which there is a supervision of the lower offices by the higher ones.

- The management of the modern office is based upon written documents ('the files') which are preserved. The body of officials actively engaged in 'public' office, along with the respective apparatus of material implements and the files, make up a 'bureau' ... In general, bureaucracy segregates official activity as something distinct from the sphere of private life ... Public monies and equipment are divorced from the private property of the official.

- Office management, at least all specialised office management – and such management is distinctly modern – usually presupposes thorough and expert training.

- When the office is fully developed, official activity demands the full working capacity of the official ... Formerly, in all cases, the normal state of affairs was reversed: official business was discharged as a secondary activity.

- The management of the office follows general rules, which are more or less stable, more or less exhaustive, and which can be learned. Knowledge of these rules represents a special technical learning which the officials possess. It involves jurisprudence, or administrative or business management.

> (Gareth and Mills, 1970 as cited in Hughes, 2003,p.21-22; Weber, 1946)

Therefore, an ideal type bureaucracy relied on rational decision making for the pursuit of organizational goals. Adherence to laws, rules and regulations would result in standard procedures, impersonality, fairness and equity while giving an overall 'stability' and 'permanence' to public administration systems.

The bureaucracy also favoured appointment of officials based on their abilities and expertise. Merit based recruitment was in direct contrast to the previous appointments based on nepotism and favouritism where a candidate's expertise to perform the job was not of interest. The merit-based appointees were offered a *'tenure'*, which offered the security of long-term employment and advancement based on seniority and merit. The officers working in these organisations were deemed to be a "high-status group, somewhat apart, and with strong values and *espirit de corps"*. (Goldfinch, 2009, p.3)

Prevalence of rule of law over impersonal relationships between members of the organisation and the officials were to put their organisation over their own personal interests. Decision-making was seen to be completely rational, as the role of the officials did not harbour any personal loyalties or influences but relied on rules, laws and procedures. Impersonal relationships with citizens also helped in impartial and fair decision-making (Goldfinch, 2009:3).

The main argument for bureaucratisation of public sector institutions has been that it is the best form of organisation which provides "stability, consistency, continuity, efficacy, easily replicable performance of repetitive activities, equity and professionalism" (Goldfinch, 2009:4). It minimises the potential influence of 'politics' and 'personality' on the organisational decisions by discouraging political patronage in appointments and also fosters accountability by having a clear chain of command and hierarchy.

Summary

In conclusion, Traditional Public Administration period was governed by some key principles such as "dominance of rule of law, focus on administering set rules and guidelines, central role for the bureaucracy in making and implementing policy, politics-administration split within organisations, commitment to incremental budgeting and hegemony of professionals in public service delivery" (Hood, 1994 as cited in Osborne, 2010:3). Administrative institutions were organised to pursue the values of 'neutral competence, representativeness and executive leadership' (Kaufman, 1956 as cited in Lynn, 2001).

The essence of traditional public administration has been captured by Dunsire (1995) as "paternalist, statist cannon, with emphasis on collective action and faith in bureaucratic rationality and professional autonomy; its leading values were equity, justice, impartiality and conspicuous uprightness, with liberty and participation relegated to representative organs". Dunsire (1995) has adequately captured the essence of this period and discusses the implication for public administration by

discussing the following "taken-for-granted" assumptions that governed the public services system during this period:

- public provision of a function is more equitable, reliable and democratically accountable than provision by a commercial or charitable body;

- where a ministry or other public body is responsible for a function, it normally carries out that function itself with its own staff;

- where a ministry or other public body provides a service, it is provided uniformly to everyone within its jurisdiction;

- operations are controlled by a hierarchy of continuous supervision;

- employment practices including promotions, grading salary scales, and retirement are standardized throughout the public service;

- accountability of public servants to the public is via elected bodies.

(Stewart and Walsh,1992:509 as cited in Dunsire, 1995)

Despite the popularity of Traditional Public Administration and Weber's Rational Model, there is much literature examining the shortcomings of this era. The bureaucratic model was criticised for financial extravagances, being unresponsive with overly centralised bureaucracies and having too much emphasis on rules and regulations (e.g.Parker and Bradley, 2004; Hughes, 2003; Osborne and Gaebler, 1992; Osborne and Plastrik, 1997). The model was used as a base line for developing the public administration systems on the post-colonial world. The criticism on the model coincided with the economic depression of the 1970s in the industrialised democracies and served as a strong impetus to the economic liberalisation that followed, discussed in Section 3.1.2.

3.2 New Public Management

The term New Public Management (NPM) refers to a general wave of reforms, originating in late 1970s within practitioners (Thatcher and Reagan administrations')

in UK and US respectively. It is an administrative philosophy, which was adopted by governments in UK and US, and later adopted by Australia and New Zealand. During 1990s it was adopted by many other European countries and later guided reforms in many developed and developing nations of the world (Polidano, 1999; OECD, 2005).

NPM is a departure from the basic assumptions of Traditional Public Administration and provides a new way to manage public services. This reform period characterised as New Public Management has been "distinguished by an international character and a degree of political salience which mark them out from the more parochial or technical changes of the preceding quarter century" (Pollitt and Bouckaert, 2011:31). It revolves around the overall theme of improving efficiency of public sector organisations by modelling public sector organisations after the private sector, providing autonomy to top management in public organisations, and focusing on performance and quality improvement (Hood, 1991; Dawson and Dargie, 1999; Dunleavy and Hood, 1994).

Despite a debate on the nature, content and variation in NPM in academic literature, NPM has been widely accepted as a dominant paradigm in public management during the last two decades. Despite the differences, there is a broad consensus that NPM does exist and is responsible for public sector change in not only the developed economies but also in the developing world.

(Aucoin, 1990)	(Hood, 1991)	(Dunleavy et al., 2006)	(OECD, 1995 as cited in McCourt, 2002)
Public Choice Theory Reinforcing power to the executive structures by Centralisation, Coordination, and Control	Hands-on professional management, Explicit standards and measures of performance, Greater emphasis	Disaggregation: Splitting large public sector organisations and using information technology systems for control Competition:	Devolving authority Ensuring performance, control and accountability Developing competition and

Managerialism	on output controls,	Purchaser/Provider Separation and competition among potential providers	choice
Changes in organisational design by deconcentration of power by Decentralisation, Deregulation and Delegation	Shift to disaggregation of units in the public sector,	Incentivization: Performance-based incentives	Providing responsive service
	Shift to greater competition in the public sector,		Improving the management of human resources
	Stress on private-sector styles of management,		Optimizing information technology
	Stress on greater discipline and parsimony on resource use		Improving the quality of regulation
			Strengthening steering functions at the centre

Table 3-2: Comparing NPM features

NPM has undergone many iterations since Hood coined the term to label a genre of reforms around marketization and performance in his iconic article. As the discipline of New Public Management developed, it was observed what was initially termed as a universal reform movement, was diverse and differentiated with differences to be observed not just across countries/nations (Peters, 1996) but also across sectors (Ferlie et al., 1996). Academic literature on different occasions has indicated towards different models of NPM, evidentially supporting the existence of several movements within NPM. It has even been termed as a "shopping basket" for reformers, and some have even gone as far as saying that "If NPM is now everything, maybe it is nothing – certainly not a distinctive way of managing organisations" (Dunleavy and Hood, 1994, p.10). In sum, public sector changes brought about by NPM may have the same underlying ideas but the reform agendas and interventions used have varied across sectors and countries. This is evident from the academic literature surrounding NPM, which defined, categorised and presented various models of NPM (see for example Lane, 2000; Hood, 1995; Hood, 1991; Gruening, 2001; Dunleavy and Hood, 1994). These models have noted the diversity in interpretation and how different analytical lens have been used to examine NPM.

Hood (1991) is his most widely cited article refers to NPM as a group of ideas that have been the most influential in the field of public administration for the last ten years. The author attributed the popularity of the trend to four "administrative megatrends" emphasizing reduction in public expenditures, shift towards 'privatisation' and 'quasi-privatisation', information technology and the increased 'inter-governmental cooperation' due to globalisation. The author further argued that in response to these global trends, the governments have taken multiple reform measures that can be collated and explained as seven doctrines of new public management (Table 3.2).

3.2.1 Theoretical Foundations

New Public Management in its initial stages was essentially practitioner-driven, and the theoretical evolution to the discourse came much later (Aucoin, 1990; Dunsire, 1995; Gruening, 2001). The initial accounts tracing the theoretical evolution categorised NPM reforms as being influenced from two schools of thought: public choice theory and managerialism (Aucoin, 1990; Hood, 1991). Public Choice theory is based on the assumption that individuals "maximize" and their actions are based on their aims and preferences. These aims and actions are based on the individuals knowledge of the situations, which for the public sector means that bureaucrats endeavour to maximise their 'agency budgets' as a means to enhance their power and income (Peters, 1996). Managerialism, on the other hand, is based on the belief that public and private sectors are generally alike, and should follow the same principles of management (Boston, 2011: 20).

The varied intellectual origins of NPM reforms have been adequately captured by Boston (2011: 20) in his commentary on NPM ideas and their theoretical origins. Since, NPM has been more practitioner than theory driven, NPM ideas draw from a variety of theories. Boston (2011) argues for three distinct "analytical traditions" to form the bases of NPM ideas: the managerialist tradition; 'new institutional economics' or 'new economics of organisations' and its sub-branches like agency

theory, transaction cost economics, and comparative institutional analysis; and finally public choice theory.

Managerialist tradition, contributes to NPM by propagating ideas abolishing the difference in management practices in public and private sectors. It also argues for shift in management focus from 'process' to 'results', resulting in performance management reforms that aim to establish a performance culture that thrives on quantifiable performance targets and outcome measures. An increased emphasis on output and performance while creating a culture for accountability but has resulted in a shift from the basic ethos of public administration of equity and responsiveness (Table 3.3).

NPM Principles and Assumptions	Theories that informed NPM
Ignoring the differences in public and private sectors and using the same management principles to manage	Managerialism
Shift in emphasis from 'process accountability' to 'accountability for results'	Managerialism and Agency Theory (Principal-Agent Theory)
Preference for 'straight-line acccountability' e.g. vertical rather than horizontal accountability, unitary rather than collective leadership	Managerialism and Agency Theory
Emphasis on management rather than policy (generic management skills)	Managerialism
Devolution of responsibilities and management control (improved management control and reporting mechanisms)	Neo-liberalism, Public Choice Theory, Agency Theory, and Transactional Cost Economics
Preference for specialised, single-purpose organisations (disaggregation)	Neo-liberalism, public choice theory and managerialism
Independent public bureaucracy (agencies) over classic public bureaucracy (ministerial departments)	Managerialism, Agency Theory, and Transactional Cost Economics
Preference for private over public ownership (privatisation, corporatization, and use of independent organisations)	Neo-liberalism, public choice theory and transactional cost economics
Short-term and highly specified contracts, preference for classical over relational modes of contracting	Agency theory, Transaction Cost Economics (also support relational contracts)
Preference for contracting over in-house provision	Neo-liberalism and public choice theory
Competition within public sector (multiple suppliers over single source suppliers)	Neo-liberalism and Public Choice Theory, Agency Theory and Transactional Cost Economics
Preference for fixed-term labour contracts over tenures	Agency Theory

| Preference for monetary incentives over non-monetary incentives such as ethics, professionalism and status | Managerialism |
| Cost-cutting, efficiency and discipline in resource use | Neo-liberalism and managerialism |

Table 3-3 Origins of NPM Assumptions and Principles (Adapted from Boston, 2011: 20-21

3.2.2 Models analysing reforms

NPM literature suggests different models that capture the essence of NPM reforms. These models have different emphasis and help us in understanding the complex and varied nature of NPM reforms. Two such models of Dunleavy and Hood (1994) and (Ferlie et al., 1996) are discussed below.

Based on criticism surrounding the clear distinction between state and the market, Dunleavy and Hood (1994) proposed four alternative future models to new public management to take into account the intermediary possibilities existing between the extremes of state and the market. The authors argue that contrary to Osborne and Gaebler's claim of a universal movement towards New Public Management and a 'single' NPM model, there are multiple 'plausible' trajectories towards NPM, and the reform issues go much beyond the outcomes of 'cost effectiveness' and 'quality'. Analysing the public service systems on two dimensions: 'degree of generalised rules' and the 'degree of separation of public and private sectors', four alternative models of public management are proposed in a 2x2 matrix. These model address constitutional and political issues and refer to four different models that may denote the future of reforms. These models are 'Gridlock Model', 'Public Bureaucracy State', 'Minimal Purchasing State' and 'Headless Chicken Model', and can used to analyse public management reforms in a constitutional context.

Degree of generalized rules	High	'Gridlock Model' Private Providers, 'iron rule book', no political mediation Example: US Health Care in 1980s	'Public Bureaucracy State' Extended public provision by distinctive public sector organization Example: Traditional German Public Sector Style
	Low	'Minimal Purchasing State' Maximal corporate presence, state as an intelleigent consumer. Example: Los Angeles Government	'Headless Chicken Model' Distinctive but turbulent public sector. Example: UK Higher Education.
		Low	High
	Degree of separation of public and private sectors		

Table 3-4 Public Management Models. Source: Dunleavy and Hood, 1994

Ferlie et al. (1996) has suggested four ideal type NPM models in an attempt to build a typology. These approaches are 'The Efficiency Drive', 'Downsizing and Decentralization', 'In Search of Excellence' and 'Public Service Orientation'. These models of reform are driven by the shortcomings of public services and are based on public sector diagnoses of problems.

NPM Model I – The efficiency drive	NPM Model II – Downsizing and Decentralization
earliest model that desired to make public sector more business-like	more elaborate and developed quasi markets
financial control, cost and information systems	management by hierarchy to management by contract
clear target setting, monitoring of performance	contracting out of strategic functions
transparency in performance reviews	de-layering and downsizing
responsiveness to customers, customer orientation, market-like experiments	shift from 'command and control' to new management styles and 'management by influence'
deregulation of the labour market	split between public funding and independent sector provision; emergence of separate purchaser and provider organizations
shift in power from professionals to management	
less bureaucratic and more entrepreneurial management	more flexibility and variety in service systems
new forms of corporate governance	
NPM Model III – In Search of Excellence	**NPM Model IV – Public Service Orientation**
Management of change	major concern with service quality (TQM)
Bottom-up form: organizational development and learning, recognition of organizational culture and radical decentralization	concept of citizenship
	shift of power from appointed to elected bodies
Top-Down Form: attempts to secure cultural change, top-down vision, stress on charismatic forms of top-down leadership, training programs etc.	development of societal learning
	collective provision, participation and accountability

Table 3-5 NPM Models (Source: Ferlie et al., 1996)

The diverse nature of NPM can be attributed to a number of factors. Firstly, NPM has been known to originate from practitioners and public officials in Anglo-American countries in late 1970s following the economic downturn. The theoretical exploration of the field came much later in the 1990s, when academics started

researching the causes and outcomes of this new phase of public administration (Dawson and Dargie, 1999), thus making NPM more "practitioner-driven" rather than "theory-driven". Drawing upon 'managerialism' and 'new institutional economics' and influenced by neo-liberalism in the 1980s and 1990s, gave NPM a 'multifaceted' nature that had been widely recognised. It has been widely criticised for not having a sound philosophical and theoretical basis, but NPM has been found to be influenced from well-established theories in management and economics (Aucoin, 1990). Secondly, NPM has also been influenced a number of political, social and environmental factors which have influenced the way these ideas have been applied in different countries (Boston, 2011:18-19). Therefore, it can be concluded that NPM reform practice can be examined by looking at the recent reform measures like structural devolution to agencies, managing and auditing performance, privatisation, public-private partnerships and adoption of private sector management practices.

3.3 Post-NPM Reforms

> *"Most of us could write the New Public Management's post mortem now."(Lynn, 1998d, p.232)*

> *"The intellectually and practically dominant set of managerial and governance ideas of the last two decades, new public management (NPM), has essentially died in the water." (Dunleavy et al., 2006, p.467)*

The literature is abundant with examples of New Public Management being in the past simultaneously with some scholars also writing about it not being over and very much "alive and kicking". The paradoxes and contradictions embedded in the NPM philosophy (Hood, 2004) with unintended consequences of NPM reforms have forced the reformers to rethink the paradigm which was unquestionable at one time and was claimed by some to be the best thing that has happened to public management discipline. The research focus shifting from a description of NPM features and characteristics to the NPM aftermath, marks the beginning of a new stream of burgeoning literature, which has been labelled by some as "New Public Governance" (Osborne, 2006), Whole of Government Approach (Christensen and

Lægreid, 2007; Christensen and Laegreid, 2007), Public Value Pragmatism (Alford and Hughes, 2008), New Weberian State (Pollitt and Bouckaert, 2011; Drechsler, 2009). These different schools of thought and approaches are broadly working towards a reassertion of the role of the state with an increased emphasis on collaboration and cooperation by governance of inter and intra-organisational relations, asserting efficiency along with effectiveness. The post-NPM literature features overlap in themes in some instances while being inconsistent with others.

Christopher Hood, a strong proponent of NPM and author of the seminal NPM article, acknowledged the 'middle-aging' of NPM in a 2004 article. Hood identified the paradoxes and unintended consequences of NPM reforms(Hood, 2004). The author is somewhat defending these surprises/unintended consequences by attributing them to limitations of human knowledge and administrative reform history while at the same time writing a critique of NPM. According to the author, these paradoxes and contradictions present an opportunity to researchers to further investigate and explore the reform process. Hood identified seven paradoxes emanating from NPM reform practice (summarised below from Hood, 2004) leading to the negative criticism and unintended consequences of reforms characteristic of NPM paradigm.

Firstly, it is argued that more emphasis on output levels manifested in performance contracts and indicators are a concept, which is more suited to production and manufacturing where products are easily quantifiable. This concept is difficult to apply to public services and where it is not always easy to measure output, and increased emphasis affects the service quality and also defeats the basic purpose of NPM reforms.

Secondly, delegation and autonomy to public service managers were an attempt to depoliticise but have resulted in increased politicisation. In an effort to regain and remedy the loss of control over the implementation process, politicians indulge in hiring and firing, which they are required to do in order to monitor performance. This interferes with the resultant managerial autonomy of NPM reforms.

Thirdly, NPM was a response to address the shortcomings of the traditional public administration regime, but, in instances, it has been the reason for further development and grounding of those practices. The idea behind NPM reforms has been to decrease 'processual' controls by focusing on results. It was believed that this will result in increased discretionary space to the managers and they will be free to add value to the process. But in practice, a decrease in processual controls led to instances of corruption and hence was reverted back.

Fourthly, another main premise of NPM reforms has been that they have been driven by fiscal stresses globalisation and non-performing administrative systems. Hood (2004) points to evidence from OECD (1995) that contrary to the claim above, some of the weak administrative systems like Egypt, Italy and Greece have been the slowest despite the presence of the above drivers. On the other hand, some of the effective administrative systems like Netherlands, UK and Australia have been quick to adopt substantial NPM reforms.

Fifthly, a broad vision of NPM change can be translated into different implementation practices at different levels of organisation or in a different cultural environment. This means differences and variation across reform practices across sectors and countries. It may also yield variation in the implementation style of public service managers.

Sixthly, due to an increased presence of consultants and epistemic communities in determining the agenda and direction, reforms that have yielded disappointing results in the past may be repeated e.g. repeat instances of e-governments.

Finally, NPM reforms also increase system complexity. Service delivery through agencies (fragmentation) may result in uninformed citizens who find it hard to understand the new bureaucratic structures and thus compromises the informed citizen understanding of the system which is essential to problem-solving.

The NPM reforms increased fragmentation and ignored cross-sectoral relationships among public service organisations. These reforms focused more on the internal mechanisms of the public service organisation with a focus on performance contracts and outcomes. The reforms in post-NPM era of public management comprising of horizontal, cross-government and inter-agency reform measures aimed at enhancing control and coordination (Halligan et al., 2011 p.74). Approaches that characterise the post-NPM reforms in literarature have been reviewed below:

3.3.1 Joined-up Government or Whole-of-government Approaches

The term "Whole-of-Government" is fairly broad and signifies reforms that have a 'horizontal focus'(Christensen and Laegreid, 2007). It has also been termed as "Joined-up-Government" in earlier versions of these second generation reforms.The reforms within this approach overlap with other contemporaneous approaches favouring collaboration and coordination, while also being inconsistent within a variety of contexts. For example, 'joined-up-government" reforms in UK focus on interdepartmental and intergovernmental relations that span across the public, private and third sectors(Ling, 2002) while those in Australia are more systemic and broad government initiatives (Halligan et al., 2011, pp.74-80). This has also resulted in subsequent literature on collaboration, as horizontal government reforms become the mainstream topic in public management reforms (O'Flynn, 2009).

The Whole-of-Government Approach (WOG) was a response to the negative implications of NPM reforms of 'structural devolution, single-purpose organisations, and performance management According to Halligan et al. (2011, pp.76-82), Whole-of-government approach has been driven by four factors: reversal of agencification measures taken under NPM to reduce fragmentation, to address 'wicked' problems that require a concerted effort among government and agencies, external pressures like terrorism and security issues that require system-wide coordination and collaboration for long-term learning and goals.

WOG approach has empirically manifested itself in a number of forms. Four dimension of these reforms have been suggested following an empirical analysis of these reforms is UK, Australia and New Zealand (Halligan et al., 2011). These reform practices are: Integrating Service Delivery by bringing together government services in one place e.g. one stop shops or single window services, 'collaboration' and 'clustering'(Kernaghan, 2005), Horizontal government approaches like traditional coordination mechanisms, reorganising, restructuring and coordination resulting in integrated governance structures (Bogdanor, 2005 as cited in Halligan et al., 2011), developing a supportive culture that values exchange and collaboration across boundaries such a encouraging teamwork, information sharing and incentivising working together.

Likewise, another contribution having similarities to WOG approach, but focusing on the use of Information and Communication Technologies (ICTs) and e-government is Digital Era Governance (DEG). Dunleavy et al. (2006) state that NPM has indeed ended and make an argument for Digital Era Governance. Based on a study conducted in some "leading-edge" economies of the world, which were seen as primary proponents of NPM like United States, United Kingdom, Canada, Australia, New Zealand and Netherlands, they conclude that some of the NPM ideas might be there but the NPM wave has ended and a reversal of key NPM ideas has occurred. It is also added that these NPM practices cannot be completely reversed as they have become institutionalised and compare them to the characteristics of traditional public administration, which were also not completely replaced.

3.3.2 E-Governments

Dunleavy et al. (2006) proposes Digital Era Governance (DEG) to replace NPM. The NPM themes of Disaggregation, Competition and Incentivization are to be replaced by DEG characteristics of reintegration, Needs-based Holism and Digitization processes. The idea is to trigger a reversal of the NPM practices, which have become institutionalised over time, but have led to unforeseen consequences. According to the authors, 'reintegration' will require policies directing rollback of

agencification practices, reassertion of the centre, reducing production costs, and network simplification. Likewise, 'needs-based holism" will require a change in focus with more client-based/needs-based organisation with simple, fluid and responsive government processes and one-stop provision of services. Digitization Processes will use information and communication technology for automated and simplified processes, reducing intermediaries, and ensuring simple, fast and efficient service delivery while ensuring an "open-book government".

3.3.3 Public Value Pragmatism

Public Value Pragmatism also emerged in the post-NPM period with a focus on outcomes and how actions create public value, while challenging the "one-size-fits-all" approach by criticising the universality of the reform models. The concept of 'public value' applies to consumption by the collective 'citizenry' rather than individual value it provides to its clients. This is a departure from "one best way" orientation in all the previous reform models, whether it was traditional public administration or new public management or collaborative governance. This approach is more flexible and considers the role of contextual factors and the local contingencies in reform decisions.

3.3.4 New Public Governance

New Public Governance (NPG) is another approach which has been put forward as a critique to NPM, and which acknowledges networks and multiple actors in the process. According to Osborne (2006), this approach to public services management and delivery draws on a range of existing approaches that mark the post-NPM period. Drawing and building on the different theoretical constructs and use of governance and networks in the literature, a model of public service delivery and implementation is suggested. The model "posits both a *plural state*, where multiple inter-dependent actors contribute to the delivery of public services and a *pluralist state*, where multiple processes inform the policy making system" (Osborne, 2006, p. 384).

Chapter Summary

This chapter has located the research study within the field of public management, and reviewed the dominant theoretical approaches informing reforms worldwide. Three main approaches were reviewed: *Traditional Public Administration, New Public Management* and *Post-NPM Reforms.* The relevance of the given approaches to reforms in developing countries will be discussed in Chapter 4.

Chapter 4
Reforms in Developing Countries

Chapter 4   Public Sector Reforms in Developing Countries

Developing country reform experiences are quite complex due to the peculiarities and challenges the context holds for them. There is an additional set of actors for the governments to cope with i.e. International Financial Institutions (IFIs) and development partners (multilateral and bilateral) financial institutions. Additionally, the government are also faced with contextual challenges from within i.e. capacity constraints, national disasters, and poor economy. This chapter reviews public sector reforms in developing countries and is organised as under:

Section 4.1 explains the administrative context of public sector reforms in developing countries by arguing that developing countries have continued with the Weberian model of public administration systems despite introducing market-based reforms, and this serves as an important contextual challenge to reforms in developing countries. This section also establishes the centrality of elite decision-making to the reform process in developing countries. **Section 4.2** reviews the reform models by categorising reform experiences in developing countries into three phases: Washington Model of public management, New public management, and post-new public management reforms in developing countries. **Section 4.3** establishes the context for reforms, and identifies contextual factors that may influence reform trajectory. **Section 4.4** reviews research on the role of international organisations in the reform process, and discusses the role of development organisations and international financial institutions in reforms. **Section 4.5** reviews the literature on politics of service delivery reform and establishes its relevance to the process of reform adoption. **Section 4.6** reviews the state of available research on health sector reforms in Pakistan, thus identifying a major empirical gap. **Section 4.7** articulates the research gaps in the literature, leading to the research questions of the study in **Section 4.8.**

4.1 'Weberian' Model of public administration

The public administration model in developing countries bears a close resemblance to the Weberian Bureaucratic model discussed in Section 3.1.The organisation of public sector in the developing countries is highly bureaucratic and hierarchical (Manning and McCourt, 2013), where the institutions are highly developed but resistant to change. The bureaucracy forms the core elite that enjoys status and power and cherishes their status, while being highly resistant to change. There are few explanations for this: *first,* the inherent elitism in the colonial structures of administration pre-independence provided a familiar ground to the new systems post-independence; *second,* the time frame for independence to these developing countries coincided with the traditional model being in fashion everywhere else like for example France and United Kingdom were both proponents for the statist model in the mid twentieth century (Hughes, 2003, p.220) and *thirdly*, the developing countries found it re-assuring to replicate the western models of public administration, which were believed to be successful (Pollitt and Bouckaert, 2011, pp. 15-19).

> *"The new interventionist credo had its counterpart in the development strategy of the day, adopted by many developing countries at independence, which emphasized the prevalence of market failures and accorded the state a central role in correcting them. Centralized planning, corrective interventions in resource allocation, and a heavy state hand in infant-industry development were part and parcel of this strategy. Economic nationalism was added to the mix, to be promoted through state enterprises and encouragement of the indigenous private sector. By the 1960s, states had become involved in virtually every aspect of the economy, administering prices and increasingly regulating labour, foreign exchange, and financial markets." (World Bank, 1997, p.23)*

The bureaucratic model in developing countries has largely not been able to deliver. Turner and Hulme (1997, pp.220-224) argue that the administrative laws and institutional structure in South Asia were introduced by British before independence, and is the reason for the public service failure. The civil servants, who were lower in the hierarchy before independence, due to apparent seniority levels became senior level civil servants after independence.

> *"In countries such as Bangladesh, the current administrative laws are usually those introduced by the British 50 to 100 years ago. South Asian civil servants commonly claim that 'their system' follows 'the British system': such claims are made with pride and are to demonstrate the pedigree and quality of their civil services. They fail, though, to note that they are based on a British colonial model (rather than the British domestic model) and that, 50 years on, modifications might well be desirable." (Turner and Hulme, 1997, p.222)*

Such characteristics have led to a few shortcomings in the prevailing administrative setups in these countries and has implication for reform and development. McCourt (2013) believes that this has left the system to be 'highly centralised' with a continuous chain from top to the bottom administrative tier, focusing more on 'inputs' rather than 'outputs' and with no concern for 'outcomes'. The civil servants did not have the capacity to perform tasks that were demanded of them, thus having an overall effect on state capacity. The bureaucracy was the main source of 'expertise' and had a central role in decision making in the developing countries. Due to lack of political stability and democracy, the political input to decision making in reforms was negligible. Ill-equipped civil servants who rejoiced in seniority, prestige and elitist culture stemming from the colonial legacy, proved to be a strong pillar in public administration.

Although the term bureaucratic structures carries negative connotations for development and performance, a study commissioned by World Bank in 1997 (World Bank, 1997), has found a positive relationship between hierarchical "bureaucratic structures" and "economic growth". Rauch and Evans (2000), in their study of 35 less developed countries, have found that characteristics of public bureaucracies like merit-based recruitments, career stability and internal promotions lead to effective bureaucracies that can be instrumental to economic growth and development.

Along with a bureaucratic approach to management and administration, the developing countries also opted for a strong state-sector, which was in alignment with the ideas of Socialism and Marxism. The governments during the 1960-70s

believed that government ownership of enterprise will lead to economic growth and stability which was the need of the hour for the newly built states wanting to strengthen their state apparatus and start their journey towards economic growth, e.g. Pakistan started nationalisating enterprises that established themselves during the industrial boom period in the 1950s, but was met with intense criticism. It did not even go well with labour unions and labour working classes who started complaining about their working environments and intense labour conditions (Islam, 1989).

As is evident from the above argument, developing countries are home to a very unique implementation habitat when compared to the Anglo-Saxon advanced economies. Public management capacity, markets, resources, political and economic stability are few variables that signify the unique case of the developing world (Batley and Larbi, 2004, p.1). Post-colonial states in the developing world house a very strong bureaucratic organisational structure, which even after years of independence from the colonial rule, is strongly embedded in the politico-administrative structures. The institutional conditions of the public services in developing countries are quite from those present in developing countries and are insufficient for the implementation of the western models of public management reforms.

Most developing countries followed the traditional model of public administration after independence from the colonial rule (Hughes, 2003: 218). There was a prevalent trend towards traditional bureaucracies, rigid rules, and recruitment of staff through examinations to make an elite workforce of bureaucrats that was well paid and prestigious. Almost all the developing countries who were under colonial rule before independence followed the traditional bureaucratic model for governance (Hughes, 2003, p.218). Post-independence, the developing countries while having a traditional bureaucratic structure, adopted the statist model for economic growth and development where the state was responsible for service provision and nation-building measures (Hughes, 2003, p.219; Batley and Larbi, 2004). It was believed

that in order to achieve economic growth and development, the state should intervene and dominate public service provision.

> *"The Third World was saddled with what Caiden calls "law and order administrations" which lacked the experience, resources, and trained personnel to perform competently, much less to switch directions suddenly; rule was autocratic and personal, backed by force."* (Caiden 1991 as cited in Lynn, 1998a,p.108).

Corresponding to the period of traditional public administration and the Weberian bureaucratic model in the developed world, the first three quarters of twentieth century in the developing world witnessed states where the governments were strong, authoritative and performed a number of functions themselves. The last quarter of the twentieth century saw an emerging towards 'minimalism', where state performed fewer functions themselves and more in 'partnerships' with other actors. 1950s and 1960s saw the more developed capitalist and socialist countries filling the post-colonial vacuum of the newly independent states by propagating the idea of a state bureaucracy with the help of aid programmes and academic advisors (Stone, 1965 and Siffin, 1976 as cited in Batley and Larbi, 2004).

In developing countries, the period from 1980s till to date is believed to be a period of radical public management reforms. The earlier periods have established the role of state for the provision of many public services. South Asia and Africa saw this period during the 1950s.

> *"Post-colonial governments added redistributive and nation-building intentions whose interventionism was often enhanced by commitments to reversing colonial inequalities, to state socialism and national planning."* *(Batley and Larbi, 2004, p.8)*

These 'nation-building' measures were soon found to be infeasible because of the worldwide economic crises, and provided a string impetus for change. The powerful bureaucratic structures resisted change as they served as a source for power and patronage for the politicians and the civil servants. After the end of cold war and socialist regimes, most of the developing world, with some exception like for

example, North Korea, started adopting market based reforms under the encouragement of international financial institutions like World Bank and International Monetary Fund. These reforms were adopted amidst academic commentary on the implications of adopting these reforms. While there were proponents of the market based reforms that claimed universal applicability (Osborne and Gaebler, 1992) there have been arguments against the reforms being too "sophisticated" to be applied to the developing country context (Minogue et al., 1998, p.34).

4.1.1 Colonial legacy and the administrative structures in Pakistan

Pakistan has been known as an administrative state and a bureaucratic polity (Islam, 1989) where political power is exercised through "administrative elites, institutions and structures" (Islam, 1989:271). The political system since the independence has been biased towards the administrative elites, who have been civil servants and army officers (during military rule) due to the absence of any effective political institutions since independence. Pakistan is a federation with a federal form of government, but has been predominantly functioning as a unitary system in the past. Administrative decentralisation in the social services through Pakistan Local Government Ordinance of 2001 was implemented initially by the military government, which met with resistance when a democratic government was elected in 2008.

Pakistan has administrative structures that are reminiscent of the colonial legacy, political power is fragmented and concentrated in the centre, and there is absence of effective political institutions since its independence with intermittent military rule. Reforms have been hard to implement in the past, especially those that change service structures and affect the power interests of the bureaucracy (Islam, 1989). Pakistan's administrative system is based on the administrative system developed by the Moghul emperors which was later transformed by the British during the colonial rule. In order to manage the hostility and resentment of the population, the British officers enforced strict law and order in revenue collection etc. and at times resorted to violence for enforcing the laws and extracting revenues from the people.

The administrative elites belonged to the Civil Services of Pakistan (CSP), which was modelled after Indian Civil Service (ICS). The entire bureaucratic structure, and the provincial services worked under Imperial rule with complete disregard towards public interest in the absence of political will to do so. The British designed ICS to exercise control over Indian population that were resistant to the British rule and as a first step towards the development of representative democratic institutions in India (Khan, 1999). The theme of organisational control was evident in the organisational structures that were created to minimise the resistance from the employees and to make them obey the rules and regulations.

Post-independence in 1947, India and Pakistan inherited one of the most developed civil service systems in the world. Pakistan's initial years saw unstable political institutions which resulted in strong bureaucratic and military structures with little or no judicial and internal accountability (Nadvi and Robinson, 2004). This period was followed by a "bureaucratic-military oligarchy" from 1958 -1971, in which bureaucracy was able to create a 'restrictive political environment' where bureaucracy dominated with having ties with the few leading business groups. Developmental policies that were adopted during the period also served the bureaucratic interests making them socially and economically powerful (Nadvi and Robinson, 2004:55). This period was followed by democratic elections being held resulting in Zulfiqar Ali Bhutto's government who introduced administrative reforms in 1973 and also enforced the current constitution. The administrative reforms of 1973 resulted in a unified grade system called 'All Pakistan Unified Grade System' which enhanced the political control over the bureaucratic institutions with an intention to contain the bureaucratic influence. As a consequence, the bureaucratic employment embodied nepotism and political patronage in appointments (Nadvi and Robinson, 2004).

The democratic phase was replaced by another military rule which was imposed by Gen. Ziaul Haq in 1997. A number of administrative reforms and bureaucratic appointments of the last period were revoked as illegal. In an attempt to exert

political control over the bureaucracy, many departments and ministries were created causing political fragmentation (Nadvi and Robinson, 2004). Military rule was followed by a democratically elected government in 1995. No government completed their tenure and elections were held prematurely due to political and economic instability till 1999, when the country was again taken over by a military coup.

Soon after the military coup in 1999, the military government constituted a National Reconstruction Bureau (NRB) mandated with the task of setting up local governments. The Pakistan Local Government Ordinance was promulgated in 2001, which administratively devolved the social sectors of health, education and water sanitation to the local governments in the four provinces. The local governments were set up to further the interests of the military rulers, who saw the local tier as crucial to the exercise of power in the absence of democratically elected governments. Administratively decentralised social sectors and local governments were initially met with a number of teething problems and required a lot of consolidation which was done through reforms and capacity building initiatives by the government. Following devolution and setting up of local governments, the provincial bureaucracy was divested of powers, which due to structural impediments and path dependent behaviours led to confusion and ineffective implementation of the Local Government Ordinance of 2001.

4.2   New Public Management in Developing Countries

There is a broad consensus among the scholars that developing country reform experiences have demonstrated NPM practices (McCourt, 2002; Batley and Larbi, 2004; Batley, 1999; Larbi, 1999). However, there have been differing accounts on the why and how these reforms have been adopted, and how they have been implemented. Additionally, as compared to research on NPM reforms in developed countries, NPM reforms in developing countries are under-researched. McCourt (2002;2013) considers the material on NPM reforms as 'sparse' and 'fragmentary', attributing it to the lack of research culture among developing country governments

and increased donor presence in reform programmes. New Public Management in developing countries have encountered different arguments from scholars, where some argue for convergence and policy transfer (Common, 1998b), global public management revolution (Kettl, 2000) after an increasing number of 'crisis' and 'developing' countries have adopted elements of new public management (Larbi, 1999).

The driving forces for public management reforms in both developed and the developing world have primarily been the economic and the fiscal crisis faced by the countries. The difference in both the context lies in the fact that owing to the financial and economic crises, the impetus for reform in developed economies came from within i.e. they were pushed by the politicians (Aucoin, 1990; Aucoin, 2011), while in the developing countries, these reforms emerged as a response to conditionalities that came with the financial assistance from international organisations e.g. structural adjustment programmes of 1990s or Poverty Reduction Strategy Papers (Larbi, 1999).

Table 1 Summary of incentives for public management reforms in developed and developing countries	
Developed market economies	**Crisis and adjusting economies**
Economic and fiscal crises in the 70s and 80s	Economic and fiscal crises of greater magnitude, plus increasing debt burden in the 70s and 80s
Quest for efficiency and effectiveness in public services	IMF/World Bank-supported structural adjustment lending conditions; efforts to reduce public deficits and redress balance of payments problems
Ascendancy of "New Right"/neoliberal ideas in policy making in the 70s and 80s; belief in markets and competition and minimal role for the state	Structural adjustment and economic liberalization policies in the 80s and 90s; efforts to reduce size and role of government
Change in political context — coming into power of Conservative governments, e.g., in the United Kingdom and United States in the late 70s through the 80s	Political and policy instability; failure of public administration institutions and the need to reform them and build their capacity; collapse of communism and central planning
	Good governance requirements and its link to public administration and management reform; donor pressures
Development of information technology to facilitate and support change	Learning from the experiences of developed countries; the demonstration effects of reforms in the United Kingdom and other developed market economies; policy transfer
Growth and role of a network of international management consultants who believe in the tenets of NPM	Technical assistance and the influence of international management consultants as advisors on reforms

Source: Larbi, 1998a

Table 4-1: Comparison of driving forces behind NPM reforms (Source: Larbi, 1999)

Following McCourt's (2008) classification of two phases of NPM reforms, NPM reforms in developing countries are discussed below under a 'Washington Model of Public Management' featuring decentralisation reforms, and a second phase of both NPM and non-NPM reforms, following the demise of Structural Adjustment Programmes of IMF and World Bank.

4.2.1 "Washington Consensus" in public management

Developing country governments started experimenting with NPM reforms in the 1990s, as a result of the Washington Consensus. "Washington Consensus" is a label, originally attached to a set of policy reforms that were argued by Williamson (1990) as a solution for Latin American countries. Ten propositions for economic growth

were proposed: "fiscal discipline, redirection of public expenditures, tax reforms, interest rate liberalisation, competitive exchange rates, trade liberalisation, liberal foreign direct investment flows, privatisation, deregulation and secure property rights". The Washington consensus propagated economic growth as the overriding goal of development actors (World Bank and IMF). The economic growth agenda of Washington Consensus implied an increase in the role of private sector in developing countries, which has chronically under-performing state institutions. The reforms taken up by the developing countries in this phase of market reforms resulted in privatization, downsizing and corporatisation in the developing countries (Polidano, 1999). The concept of minimalist state gained importance but was slow to materialize in the developing world, supported by the World Bank's Structural Adjustment Programmes in 68 developing countries (Nunberg, 1997 in McCourt, 2008). These downsizing and retrenchment programmes had mixed results mostly unsuccessful, and the Washington Consensus period was termed as over by the World Bank in late 1990s. The poor results achieved in developing countries in addition to the East Asian financial crisis of 1997, apparently triggered by Washington's advice, transferred the development roles of the World Bank to United Nations. Human Development Paradigm started gaining credibility, through Human Development Reports and the initiation of United Nations Millennium Development Goals (McCourt, 2008; McCourt, 2001). The failure of the reforms under Washington Consensus was explained by lack of political will and commitment to reform (Nunberg, 1997 in McCourt, 2003).

The reforms that were taken up during this phase have been privatization, retrenchment and corporatization. Decentralisation was pursued in the developing countries in an attempt to "debureaucratise" the public services (Ingraham, 1997). McCourt (2002:229) adds that decentralization was not new to developing countries, but most developing countries have seen decentralization reforms in 1970s and 1980s (Elcock and Minogue, 2001). According to McCourt (2002:229) NPM-style devolving authority involved top-down delegation of central administrative functions while retaining accountability within the centre. These decentralization efforts

focused more on performance contracts between 'centre' and 'agencies', rather than use of legal instruments to ensure compliance and 'lawfulness'. Examples of such decentralization can be seen in countries like Jamaica, Ghana and Tanzania with a modest impact in the performance (Polidano, 1999).

Polidano and Hulme (1999) find that developing countries also experimented with corporatization during the 1990s by converting their civil service departments into autonomous agencies, authorities or corporations, which was commonly observed by forming revenue authorities, essentially a merger between custom and income tax departments into *national revenue authorities as done in Ghana, Tanzania and Pakistan.* During the same period, another set of reforms around the themes of capacity-building were also being adopted by the developing countries. These reforms were also instituted in most countries with financial and technical assistance from donors. A number of reforms in developing countries were initiated in the developing countries under the capacity-building programmes with technical assistance from multilateral and bilateral financial organisations. These capacity-building reforms happened at the same time as many NPM reforms were being implemented. Developing countries have been found to have low administrative capacity and lack of political neutrality. *The mixed results of initial NPM reforms in the developing countries were blamed to be because of the low administrative capacity (Schick, 1998).*

4.2.2 Post-Washington Consensus: NPM and Non-NPM Reforms

The developing countries for the last three decades have seen a wave of public management reforms that has swept through the developing, transitional and crisis states. The last two decades, in particular, have seen a shift towards a more market-oriented private sector based reform package for the developing countries under the pressure of IMF and World Bank. This phase of reforms in the developing world corresponds to the market-based reforms introduced in the advanced western economies to combat the economic and fiscal stress faced by them. In a similar vein, the developing countries, who were also engulfed in the economic and fiscal crisis,

esp. for Asian countries, it was the East Asian financial crisis of 1997, adopted a number of reforms inspired from the NPM paradigm. This led to a rethinking of the role of the state and government, which has resulted in a plethora of reforms in developing countries for almost two decades.

McCourt (2008) auggests that Washington Model of Public Management and this era of reform should be considered distinct from each other. The lack of results following such reforms forced the researchers to think about the factors that constrain implementation and outcomes, thus resulting in a shift in research focus towards contextual factors (Flynn, 2002) and political economy of reforms (Batley et al., 2012; Andrews, 2012; Andrews, 2013c; McCourt, 2013). (unpack and expand).

For example, Sri Lanka undertook economic reforms on its own initially and then with the support of international financial institutions in 1987, and launched a reform programme to encourage privatisation and foreign investment by economic liberalisation. On similar lines, Ghana instituted an Economic Recovery Programme with the support of IMF and World Bank for economic stabilisation by reducing the public sector control of exchange and interest rates to reduce public expenditure and public ownership (Batley and Larbi, 2004: 10).

India started an 'Economic Reform Package' in 1991 following an economic crisis supported by IMF. The reform package was not intended to reform the public administration and focused on "macro-economic management" and liberalisation of trade regulations (Batley and Larbi, 2004: 10).

4.2.3 Applicability of NPM reforms

The argument about whether NPM reached the developing countries and to what extent it has been applied to public services in developing countries is contradictory. Manning (2001) in a widely cited publication of 2001 has termed NPM as an out-dated and slippery label. Manning further adds that NPM reforms have undoubtedly been adopted by the developing countries but with partial implementation and

coexistence with other reforms. Adding to the same line of argument, Polidano and Hulme (1999: 123-4) term the partial implementation and adoption as "sampling items from the NPM menu" while, whereas regarding outcomes Manning (2001) notes that "victory" of NPM reforms outside the OECD countries has been partial, because they have not been applied extensively with positive results, while even proving detrimental to public service delivery in some settings. NPM reforms were considered 'desirable' but whether they were 'appropriate' and 'applicable' to the developing country context has been questioned in the academic literature. The academic literature suggests that NPM is "culturally bound" (Hughes, 2003: 218), and its victory has been very 'partial' (Manning, 2001).

Following civil service reforms resulting in downsizing and post-Washington Consensus, governments in developing countries started re-thinking their roles in public service provision in response to globalisation, and internal pressures like citizen pressure and a desire to improve public services. Under the prevailing assumption, that developing countries follow international models of best practice under aid conditionalities (see for example Common, 1998a: 62-65), I would like to argue that some NPM reforms were adopted by the developing countries, with evidence of reforms being implemented on small scale and within some sectors.

Another line of discussion has been pursued by Polidano and Hulme (1999), who argue for New Public Management as the dominant theme in the study of reforms during the 1990s but also points out towards lack of sufficient empirical evidence on NPM in developing countries. Polidano and Hulme (1999) using the concept of reform "laggards" (Pollitt and Bouckaert, 2011), finds that there have been few cases of reform "stars" or "enthusiasts" like Uganda who have undertaken retrenchment, as the authors believe that privatisation and downsizing are the first steps towards NPM reforms. McCourt (2008) also argues for new public management reforms pertaining to private sector management techniques to strengthen public service delivery systems arising out of privatisation and downsizing initiatives.

Another line of reforms characteristic of NPM have been that of 'agencification'' and 'corporatization' resulting in autonomous agencies and authorities, which claims to be free from the constraints imposed from civil service systems. The instances of such corporatization efforts have been few with Pakistan, Ghana, Kenya, Uganda and Tanzania having merged customs and income tax departments into National Revenue Authorities (Polidano and Hulme, 1999).

Contradictory arguments about NPM has reached the developing countries or not can also be explained with lack of research on developing country reform experiences. McCourt (2013;2002) have noted at multiple instances that there isn't enough research on NPM reform experiences in developing countries. Most of the research around NPM reforms were found to be in Ghana and Tanzania (McCourt and Minogue, 2001; Minogue et al., 1998).

Reforms in developing countries may be pursued for entirely different objectives as compared to the developing countries. Polidano and Hulme (1999) explain that NPM reforms in developing countries are instituted for different objectives as compared to the developed countries. Taking the example of corporatization reforms in both the developed and developing countries, Polidano and Hulme (1999) note that reforms around corporatization are feared to have resulted in corruption in the developed countries while in the developing countries they are introduced to curb corruption e.g. Tanzania.

Capacity constraints to implement NPM reforms with the intended outcomes have also been blamed for the half-hearted attempts towards NPM by governments. Batley and Larbi (2004) and Batley (1999) while discussing agencification at Ghana's Ministry of Health have observed that the new structures as a result of agencification were marred by the lack of governmental capacity to operate them.

NPM has been criticised for its universal applicability (see for example Schick, 1998; Bale and Dale, 1998). The argument has been the inability of the public service systems and infrastructure in the developing economies to enforce and

implement NPM reforms. Contract-based and result-oriented management envisioned in public sector reforms require robust public sector institutions with mechansims to enforce contracts and evaluate performance.

Batley (1999) in a commissioned research for DFID explored the applicability of NPM reforms in developing countries in South Asia and Africa. He argues that governments in these countries explored alternate modes of service delivery in the sectors of water and health, with great fervour but the changes seen are slow. Governments in these countries are only attempting to re-structure the process rather than bringing about a real change in the service performance. More attention and support is needed to fully adopt and bring about change in the service delivery performance of these sectors.

NPM reforms have occurred in developing countries where there is critical economic crises, and governments heavily rely on borrowing from multilateral lending agencies rather than local political processes. Batley (1999) explains that reforms imposed under economic crises through radical reform programmes may not follow successful implementation. Since these reform policies will be imposed top-down through national politicians, they may not get the relevant support required from the sub-national and local levels required for implementation. Local ownership of reforms will be missing which accompanied with negative connotations of the reforms conceived by higher level political echelons under external influence will serve as a major constraint to successful reform implementation.

New Public Management has now been replaced with a post-NPM period of reforms addressing the criticisms and problems of NPM. New Public Management was believed to have universal applicability and was implemented with an enthusiasm and fervour that was transferred to the developing countries through different modes. Firstly, NPM was considered "the" thing for public management systems for the developing countries. Secondly, the international organisations also propagated an overall sympathetic notion towards NPM and this translated into country policies by the bilateral and multilateral aid agencies. This section aims to develop an argument

that will help us in answering that whether NPM made its place in the developing countries and improved the public sector performance and whether it was ever applied to the developing world in its true essence or not.

Reforms in the developing countries have not entirely been New Public Management. Manning (2001) argues that applicability of NPM in the developing world has been very patchy and does not have extensive application outside the OECD countries. He further notes that NPM has not been able to replace the hierarchical bureaucracies by 'interlinked contracts' and the governments functioned more or less in the same manner as specified by Weber. NPM was not able to bring about drastic changes in the public sector as initially espoused in its philosophy.

Another argument for mixed results in NPM implementation is because of the different social and cultural dynamics. Public's expectations from the governments are very low and the public does not pay heed to the government initiatives. Corruption and unstable governments also affect the public's indifferent response towards the government initiatives.

Manning (2001) has provided three explanations for mixed results in NPM reforms in developing countries: different public expectations, lack of accountability form the public, flimsy contracts and interference from the government and the pervasive influence of the donor conditionalities on the government drown the public voice. Contracting, as seen in the New Zealand Model was employed in the developing countries but with mixed results. The lack of regulation, and the interaction of the public sector purchasers with their providers in the same domain resulted in disputes which could not be handled judicially. The contracts drawn proved to be flimsy, and the needed a watchful public to sustain them which was either unaware or uninformed or had lost trust in public institutions.

Many developing countries followed the path set out by the developed world by introducing NPM reforms. These countries implemented the reforms with the intention of improving service delivery by engaging others (private sector and other

civil society organisations). The assumption was that these non-state providers have the expertise and will be more efficient in providing these resources to the people. NPM came to the developing countries with a promise to address the criticisms relating to the traditional models of public administration. Economic problems and budget deficits were a strong motivating factor for such reforms in the developing countries also.

The reforms under the NPM philosophy started reaching the rest of the world by mid-1990s. NPM was confined to developed countries like United Kingdom, Australia and New Zealand till the early 1990s (Pollitt and Bouckaert, 2011).

As Manning (2001) writes

> *"....measured against its self-proclaimed universal relevance, NPM has undoubtedly not become the only public management paradigm in developing countries. Any review of public management developments in any developing country in any region demonstrates beyond doubt that hierarchical bureaucracies have not been substantially replaced by chains of interlinked contracts.....But most government functions remain performed by vertically integrated bureaucracies functioning pretty much as Weber might have intended". (Manning, 2001: 300)*

NPM reforms were considered 'desirable' but whether they were 'appropriate' and 'applicable' to the developing country context has been questioned in the academic literature. The academic literature suggests that NPM is "culturally bound" (Hughes, 2003: 218), and its victory has been very 'partial' (Manning, 2001).

Research on NPM reforms and their outcomes has led us to the conclusion that NPM is a viable model of public management for the countries where there are well-developed public administration systems that can support horizontal fragmentation of public services by having well-developed mechanisms for accountability. Schick (1998) argues that that formal contracts and internal markets would only be feasible for the developing economies if they have a strong market sector and mechanisms for enforcing contracts. Most developing countries lack the capacity and

infrastructure to administer and enforce contracts due to the absence of formal procedures to regulate economic activity.

The literature discussing NPM reforms in developing countries can be summarised to arrive at some conclusions:

Polidano (1999) argues that the developing countries have adopted reforms that are characteristic of NPM but finds it different from NPM reform experiences in the developed economies. The author is of the view that reform packages in developing countries are composed up of different types of reforms, not just NPM and it is only one of the many 'currents' of reforms on the developing world. Corruption and lack of capacity make NPM reforms unsuitable for the developing countries. Localised contingency factors are more influential in determining the outcomes of reforms rather than national characteristics.

NPM reforms have also been imposed on the developing countries by the international donor agencies. Abu Elias (2006) while comparing NPM reform programmes in Singapore and Bangladesh has argued that reform initiatives are influenced by factors like nature of politics, institutional development and socio-economic dynamics.

According to (Batley, 1999), New Public Management in the developing countries is 'idiosyncratic'. McCourt (2002) notes that empirical evidence on NPM in developing countries is sparse and fragmented with few analytical accounts. There is lack of independent academic research and most of the research is commissioned by donors or independent evaluations rendered to ensure transparency of the financial institutions.

The developing country experiences of NPM refute the universality of NPM. For (McCourt, 2002: 234), that implementation of NPM reforms in the developing world have been modest, and have encountered a number of difficulties. One of the problems facing NPM implementation has been the "top-down" approach to

implementation, with other factors worsening the situation like corruption and lack of capacity. McCourt (2002) argues that NPM reforms when subjected to the local context and contingent factors may not give the intended results that they are designed for.

Academic literature on New Public Governance reforms is still very scant. Due to the turnaround time for journal publications, and the time taken to research and prepare the manuscript, the next few years may see much academic research being published on NPG. McCourt (2008) also notes the lack of empirical evidence evaluating the NPG reforms in the developing countries. According to McCourt (2008), Brazil can be seen as one of the adopters of NPG reforms in the developing world.

4.3   Role of international organisations

There is a growing body of literature on the role of international organisations and how they support reform initiatives in developing countries. The impact of the international organisations in determining the reform agenda is unmistakable. International Monetary Fund (IMF) and World Bank have been supporting reforms in developing countries for more than three decades, and not only act as faciltiators but also for pressuring governments in adopting reform packages under loan conditionalities and Poverty Reduction Strategy Papers. During the 1980s, IMF and World Bank being the "decisive development actors" (McCourt, 2008), defined the overarching development goals to focus on economic growth with the belief that economic development will result in growth and development in other sectors. In this section, I intend to argue that the international organisations have influenced the reform agenda of the developing world, with different instruments like Washington Consensus, Structural Adjustment Programmes and Poverty reduction Strategy Papers. These have been used by the World Bank and IMF to administer financial aid with conditionalities in place to ensure good governance and improvement in public services.

4.3.1 Development Consensus Agendas

One of the tools for influencing the reform patterns in the developing world has been with the help of the global development agendas. Two development consensus have been witnessed since 1980s: Washington Consensus and United Nations Millennium Development Goals. Washington Consensus dominated the lending policies of IMF and World Bank for almost twenty years. The main premise of the Washington Consensus has been the economic growth can lead to improvements in public service delivery. IMF and World Bank were the decisive development actors of that time for the developing countries. As McCourt (2008, 2013) argues, that the state-owned enterprises in post-colonial independence nations, under-performed in the initial decades, and the economic crisis in these nations led the development actors to think on bringing in the private sector for the job, and ensue privatisation. Cook and Minogue (1990) examine the privatisation in developing countries and conclude that it has been slow due to the political and administrative limits to effective implementation. Drawing on research materials from India, Pakistan, Thailand and Sri Lanka, the slow results were attributed to political and bureaucratic resources available to the decision makers rather than economic criteria. IMF and World Bank lost credibility because of the East Asian financial crisis of 1997, rise of East and South Asian Economies (Japan, 'Asian Tigers', China and India, and the increased foreign direct investment in developing countries. An overall shift in the poverty and development arena also happened as a consequence of Human Development Reports published by United Nations, which later culminated in a full-fledged development consensus in the new century under the name of United Nations Millennium Development Goals. The World Bank (1998) has blamed 'political commitment' for the failure of the reforms following assessments like Nunberg (1997 as cited in McCourt, 2008) that forty percent of the Bank's civil service reform projects were deemed unsatisfactory at completion. Additionally, 'Democracy' and 'Good Governance' were the central elements of aid policy embraced by international donors and financial institutions during this time. It served as a 'political conditionality' for providing development assistance to the developing world with primary focus on the development and strengthening of development institutions

(Robinson, 2002: 249). The focus later shifted to include the civil society and to move away from the technocratic interventions to strategies improving public service delivery (include World Bank citations).

By late 1990s, the World Bank experiences with the Washington Consensus were giving way for new ideologies like New Public Management. New Public Management seemed desirable to the developing world, which McCourt and Minogue (2001) and McCourt (2008) view as not been taken up like downsizing was during the Washington consensus period. McCourt (2008) also notes that there have been support for NPM reform programmes within the World Bank circles (see for example Bale and Dale, 1998) but were dominated by those against its universal applicability (Schick, 1998 and Nunberg, 1997 as cited in McCourt, 2008).

4.3.2 United Nations Millennium Development Goals

The United Nations' Millennium Development Goals have become the effective agenda for public sector development in the developing countries. UNMDG have a focus on health, education and water sanitation with a goal to drastically improve the indicators by setting out goals to achieve by 2015. United Nations have produced studies and reports on the role of public administration in achieving the goals and to encourage the participating governments to reform their public services for improved access and public services (World Bank, 2004).

Hollowing out of the state and reduction in government's role in redefining public services has not happened in the case of social sectors. There has been a change in the role the government has played by involving itself "indirect provision" (Batley and Larbi, 2004:15-16), which involved decision pertaining to the policy and standards of service, organisational arrangements, coordination, financing and regulation. These indirect government roles became more important in light of the reforms.

Andrews (2013a) examines the literature surrounding the role and influence of international organisations categorises it into two streams: firstly, there is literature that criticises the role international organisations' play by imposition of common models of governing while disregarding the local context; secondly, there are studies suggesting the forced adoption of new public management practices in developing countries which the author notes is not supported by enough empirical evidence.

United Nations' Millennium Development Goals (UNMDG) adopted at the United Nations Millennium Summit 2000 has become the effective agenda for reforms and development in the developing world. The main focus of the UNMDG is on improving the education and health indicators implying more reforms and spending in these sectors. The adoption of the UNMDGs resulted in a substantial increase in the development aid disbursed to the developing countries (Collier, 2008; Batley et al., 2012).

External influence exerted by international organisations can be observed in developing countries and is increasing in the number of projects that are supported and initiated by international organisations. During the 1990s, World Bank and IMF have played an important role in disseminating market-based and economic reforms through Structural Adjustment Programmes (SAPs) and economic stabilisation strategies (Haggard and Webb, 1994). According to World Bank (1997), World Bank and its associate agencies have focused on administrative reforms like civil service reforms, downsizing, service delivery and contracting out, capacity building and institution-building. While, on the other hand, the bilateral development agencies like Department for International Development (DFID) have focused on democratic governance reforms like electoral systems, parliament and legislature, judicial and anti-corruption reforms.

Brinkerhoff and Brinkerhoff (2002) identify the key lessons that can be drawn from public management and governance reforms in the failed states. These lessons centre around the themes of institutional strengthening, capacity-building, and policy reforms. The key lessons are: firstly, commitment, ownership, skill-building are

crucial for success; secondly, public sector capacity-building will be more sustainable if it is met with informed citizens (citizen demand-making); thirdly, existing level of state capacity is important for sustaining reforms, which in case of corrupt and authoritarian systems may result in collapse and failure of governmental institutions.

4.3.3 Poverty Reduction Strategy Papers and Donor Conditionalities

Organisations like IMF and World Bank are influencing the governments in developing countries by shaping the reform programmes, and using instruments like donor conditionalities and poverty reductions strategy papers. Donor conditionalities and poverty reduction strategy papers are an instrument used to make the developing countries conform.

In 1999, World Bank and IMF announced a Poverty Reduction Strategy Paper approach, to "poor countries and their development partners strengthen the impact of their common efforts on poverty reduction" (Craig and Porter, 2003). Poverty Reduction Strategy Papers have been used as a tool for ensuring adherence to certain policy recommendations made by the World Bank and IMF. These papers aim to describe a country's macro-economic, structural and social policies and programmes over a three year or longer period, to promote pro-poor policies, that will result in reduction in poverty. These poverty reduction strategy papers were followed by external financing through multilateral and financial institutions. By design, PovRSP's are a country-driven approach requiring participative consultative process, and a favourable neo-liberalism economic attitude (Santiso, 2001; Craig and Porter, 2003).

4.3.4 Adoption of Best Practices

The developing and transitional economies around the world have been adopting the western models of public administration and reform. There have been two reasons for adoption of 'best practices': firstly, these models come with a promise for

improvement in public service systems as seen in the developed economies and it takes less effort to convince the others of the positive outcomes that the 'best practices' have to offer, and secondly, these western models and approaches come as part of the package offered with financial aid and loans granted by international and multilateral financial organisations. The 'one-size-fits-all' approach fostered by the developing and the international organisations, have been imposed on the developing countries but has come up with mixed results. As McCourt (2013) argues that the reason for failure is "donors and reform advocates can take the horse to water, but they can't make it drink" (Nunberg, 1999 as quoted in McCourt, 2013).

Good practices or the international best practices in public sector management comes from the advanced western economies and are inappropriate for the developing country context. The developed economies of the world where the practices originated are very different to the administrative and institutional context for the developing countries. For example, Andrews (2012) while examining public financial management reforms in African developing countries, urges to look at the degree of difference between the 'proposed adoption contexts" and the context of the country in which the practice originated. Implementation failures of reforms initiated by World Bank in developing countries based on international best practices has been attributed to the willingness and readiness of the governments of those developing countries, thus highlighting the importance of problems and context of the country (McCourt, 2013).

4.4 The politics of reform adoption

Recent policy and academic debates on reform thinking in developing countries have seen an emphasis on the effects of politics and governance in developing countries. Batley et al. (2012) have explored the effects of 'politics' and 'governance' on public service provision in developing countries by arguing that politics and governance may determine the provision of public services (to whom, where and how well). Therefore, their relationship is at the heart of diagnoses and widespread under provision of public services in developing countries making them as a 'cause' and 'consequence' of reforms. Acknowledging the role of external actors in the reform process, Batley et al. (2012) explains that reform experiences in both developed and developing countries have seen change in the reform agenda, which has shifted from an emphasis to minimalism to a reassertion of the government's role in partnership with the market and civil society. The changes in the reform strategies have been abrupt due to the external agents having a significant presence in the reform process.

The ideology of the 'minimalist state' was disseminated to the developing world through a host of economic policies under 'Washington Consensus' during the 1990s. Carothers (2011) and (Williamson, 1990) explain that it became the 'one best way' to do things, and was used as a tool to ensure the effective use of financial grants and aid in the developing world. The reforms under this period were followed by evidence about failure of reform due to the impeding political-administrative contexts, which the importing models were unable to overcome (Whitehead, 1990) . The interests and priorities of the local political actors conflicted with the development agenda, resulting in implementation gaps and failures (Nunberg, 1999 as quoted in McCourt, 2013). World Bank in a 1998 publication (World Bank, 1998) acknowledges the impediments to reform failure and acknowledge contextual significance by noting that conditionalities and lending would only work if they are met with political and administrative support.

A number of studies have attested that reform proposals are generated by the 'executive' rather than 'legislature, political parties, interest groups or think tanks' in

developing countries (Grindle, 2000; Krueger, 2002; Williamson, 1994; Waterbury, 1992). This holds particularly true in the case of developing countries that have post-colonial administrative structures, that embody a strong bureaucratic setup, strict rules and procedures with weak political institutions. According to (Waterbury, 1992), in most developing countries, executive-based "change teams" guide reform proposals from adoption to implementation, while having a long history of dominating the legislature over the years. Grindle (2000) argues that the process of policy and institutional reforms especially in developing countries is a political one, and finds that the power relationships among 'executives, legislature, leaders, party elites, national institutions and international institutions' are an important determinant for the success and failure of reform. Looking specifically, at how reform proposals emerge, the findings confirm that most reform proposals are produced by the executive rather than by legislature, think tanks or interest groups. The centrality of elite decision-making is reinforced by Grindle (2000) in her analysis, which has already been quite evident from the literature reviewed. Leftwich and Wheeler (2011) stress the critical role played by 'leaders, elites and coalitions' as crucial to the reform and development outcomes. Although the authors contribution is pertinent to the outcomes of reform and development efforts, it is equally relevant to the reform adoption and design stage.

In another instance, Batley (2004:54) analyses the politics of service delivery reform, and analyses the interests involved in reform, and also indicates that the interests and influences may vary from sector to sector. The policy makers and service users/citizens in developing countries have been found to be non-instrumental in 'demanding, designing and directing' reforms. Reforms within the institutional context of developing countries, due to the presence of an additional set of actors i.e. IFIs and donors is more complex and has significant 'political salience' (Batley and Larbi, 2004). Batley and Larbi (2004) has evaluated the reform process in social sectors, by identifying the 'principals' and 'agents in the reform process, and to what extent the agents are motivated to act in the interests of citizens.

Grindle and Thomas (1991, in Batley, 2004c) have distinguished between two types of reform initiatives: reform interventions requiring wider *public mobilisation*, and reforms requiring *bureaucratic responses and restructuring*. Reforms that require wider public mobilisation have high political stakes, while those requiring bureaucratic responses call for 'bureaucratic compliance'. The factors identified by Grindle and Thomas (1991) are summarised in Table 4-1. Batley (2004) have added on to Grindle and Thomas's (1991) argument, by arguing that in weak political economies, bureaucratic structures are highly politicised, and those reforms that have low 'political salience' in advanced economies may be highly political in nature. Moreover, in case of externally-led reforms the policy-making process excludes the broad public arena and is a closed process.

Characteristic of reform	Features of reforms in the public arena, requiring political support and stability	Features of reforms in the bureaucratic arena, requiring bureaucratic compliance
Dispersal of the costs	Costs have wide impact among the population	Costs focus on government institutions
Dispersal of the benefits	Benefits are focused on government	Benefits are not immediately felt by bureaucracy and only in long term by public
Technical and administrative complexity	Reforms have low administrative content and can be done quickly	Reforms are administratively complex
Level of public participation	Reforms require wide public involvement and are 'visible'	Reforms require limited public involvement and are 'invisible'
Duration and visibility of reform process	Reforms can be achieved quickly and are visible	Reforms require sustained effort with few immediate visible returns
Examples	User fees. Privatization of services	Contracting out. Decentralized management

Table 4-2: Public and bureaucratic arenas of response (Source: Grindle and Thomas, 1991 in Batley, 2004)

The author concludes that the interests involved in reform are affected by institutional factors including administrative structure, international influence, economic and fiscal crises, and sector characteristics. Organisation of service

delivery is of little interests to users and change only affects the bureaucratic arena. Developing countries also low levels of political engagement in the reform process with political leadership concentrated at the highest levels. Moreover, the international lenders push reforms through the political leaders giving a false impression of consensus and representation (Batley, 2004:59).

Some of the major trends in the field of international development and public management in developing world during the last decade has been an increase in the emphasis on 'politics and governance' rather than 'management and professional practice'. Batley et al. (2012) argue for a shift in thinking about the role of government in public services, and how this can be seen as cause and consequence of public service performance. As a consequence of this emphasis, politics and governance are now seen as a cause and consequence of performance of public services. The studies discussed above discuss politics of *service delivery reform* and are considering politics as an important variable in determining the outcomes of the reform process. Here, I would like to argue that politics plays an equally important role in adoption of reforms in developing countries. What motivates the elite to reform determines the type of reforms to be implemented, and will later also determine the political and administrative commitment to reform.

4.5   Health Sector Reforms in Pakistan

Academic literature discussing health sector reforms in Pakistan is scarce. An initial literature review before the start of fieldwork revealed no published research on health sector reform *process* in Pakistan. Little literature that is available from a public management perspective is found to concentrate along the themes of health sector post-decentralisation, non-state provision of health services and on some vertical donor-funded programmes e.g Lady Health Worker Programmes. These have focused more on the output that is improvement of health indicators and the different programmes that have been instituted, but with very little commentary on the management of health services of these programmes.

Decentralisation has featured on Punjab Health Sector reform agenda since 1990s. Despite the argument that there is lack of managerial capacity in the districts (Islam, 1989; Islam, 2001) coupled with political and bureaucratic resistance (Collins et al., 2002; Collins et al., 1999), decentralisation has been a prominent feature of the provincial reform packages. Collins et al. (2002) has argued that the quality of change is highly dependent upon the process leading to that change and hence stressed for the need for research in this area in developing countries.

 Policy making in the health sector was quite complex. Tarin et al. (2009) have elaborated on the policy process in health sector reforms in Punjab and have observed a difference between 'formal policy procedures' and actual process that leads to development of health sector reforms in Punjab. The researchers observed that the entire reform process was highly driven by bureaucrats who based their decisions on missing and deficient data, thus indicating a largely top-down exercise. Health care managers were not involved in the policy process thus resulting in resistance and lack of capacity during implementation (Table 4-1).

Elements of policy process	Formal procedures	Actual processes practiced for Health sector reforms
How issues get on the agenda	Bureaucrats monitoring the health situation or politicians driven by the public demand should recognize importance and get issues on agenda	Except for SPP, the bureaucrats came up with interventions which the politicians endorsed for political advantage
Development of working paper	This document is required for providing background information on the issue, situation analysis and the possible interventions to address issues recognized as worthy of action	Except for SPP, this exercise was done retrospectively, with deficient information provided and little analysis to justify intervention
Approval process	Before adoption, depending on implications, the working paper passes through the hierarchy, usually bottom up, in government departments for approval and the pace of this process is contingent on the nature of the issue	Except for SPP, this process was often top down and did not follow the required process, and the pace for approval depended on the actor with power and influence
Implementation	The policy as an order, notification or circular is given to line managers, who are required to implement the intervention with the help of resources provided for the purpose, guided by the rules and regulations	The line managers were required by order to implement policy but, except partially for SPP and AMI, no appropriate rules, regulations and instructions were given

Figure 4-1 Difference between formal policy procedures and actual reform process in Punjab Health Sector (Tarin et al 2009: 316)

Within the academic literature, an extensive commentary was also found on inter-sectoral collaboration and outsourcing of public health care facilities in Punjab. A research project was conducted by International Development Department, University of Birmingham resulting in a published report and publications in academic journals, which had some relevance to the research project. The research project analysed inter-sectoral collaboration for public service delivery, with Punjab Health as one of its case studies (Palmer et al., 2008; Bano, 2011). The project discussed Punjab Rural Support's Programme's take-over of government facilities at primary level. The primary purpose of the project is to provide an understanding of the nature and relationship between the non-state provider and Punjab Health

Department, identifying key factors shaping the relationship and whether and how the relationship has affected the working of these organisations. The main findings of the research implied that the reform was adopted by the Punjab Government in response to the political pressure, rather than its intended benefits, and was vulnerable to changing political alliances. The findings also suggest that the government was more interested in demonstrating their willingness to modernise and exhibit a 'reformed model of governance' rather than developing 'a long-term relationship' with the non-governmental organisation for improvement in service delivery(Palmer et al., 2008). In an other article culminating from this research, Batley (2006) also finds that the success of such reform programmes favouring alternate modes of service delivery will require commitment and facilitation from the government in order to make them successful, while also sustaining them in the long run. Zaidi et al. (2011) has also pointed out towards the limitations of the contracting process, and have argued that the public sector is not capable of managing and initiating tight performance contracts, thus making a case of large NGOs as better managers of such contracts.

Devolution and its impact on health services has also been explored by Aslam and Yilmaz (2011) and (Ansari et al., 2011). Ansari et al. (2011) reports a general dissatisfaction of the people with decentralised health services, and also added that there is a general distrust in public health facilities. From the users viewpoint, the users were found to be dissatisfied even after provision of medicines and availability od staff because of the general perception that surrounds the public health infrastructure. On the other hand, Ansari et al. (2011) also reports the dissatisfied district health administration because of partial implementation of devolution programmes especially with respect to the transfer of funds to the districts.

A review of the literature reveals that there is a significant empirical gap on health sector reforms in Pakistan. No research outlines the health sector reforms with respect to reform drivers, reform strategies and how they were implemented thus

justifying the choice of research questions, and Punjab as a case to add to the knowledge on health sector reforms in developing countries.

4.6 Research Gap

In the context of developing countries, it is very much evident that NPM reforms have made their way to the reforms agendas of the developing countrie . The proposition prevails that the developing countries have followed what the developed countries have done because of the pressures and aid conditionalities imposed on the developing countries through International Financial Institutions (IFIs) and global development agendas. The literature suggests that international organisations and development agencies are an important *stakeholder* and *actor* in public sector reforms and development initiatives.

The literature on public sector reforms suffers from a skewed case selection (Joshi, 2006; Joshi and Houtzager, 2012)with more emphasis on developed economies where these reforms originated. If NPM has to be hailed as a universal paradigm, we need to provide more accounts of its application and implementation in developing countries to enhance our understanding of the reform process. The absence of a consensual body of knowledge has been noted by Marsh and Sharman (2009) who have drawn our attention towards the absence of around the drivers, content and consequences of reform worldwide. (Lynn, 1998a) while noting Ingraham (1994) comments that commonalities are more important than differences in the patterns of reforms, points out that if this was the case then the states worldwide would look alike eventually, and emphasises researching reforms across different contexts, countries and sectors to explore and understand the dynamics of reforms. At another instance, Lynn (1998a) writes:

> *"We argue that institutional dynamics of reforms can best be interpreted as a complex mixture of environmental pressure, polity features ad historical institutional context. These factors define how much leeway political leaders have in making choices about reforms – that is, they both further and hinder reforms, resulting in complex patterns of influence, learning and effects."* *(Lynn, 1998)*

Pollitt and Bouckaert (2004) have argued that reform practices or NPM reforms may be a product of diffusion of ideas from the outside or it may be a product of the local initiatives and citizens pressure, making it a local phenomenon. This calls for research into the reform processes across countries, contexts and sectors, to add to the literature specific to developing countries. Another explanation for variation in reform processes across countries is given by Brunsson (1989), who has argued that adapting to external pressure does not only signify environmental determinism, but is connected to the political-administrative leadership, professional organisations and management consultants, which that make certain types of reforms acceptable and feasible to the context reflecting 'hypocrisy' or 'double talk'. Christensen et al. (2002) have found that the structure of 'polity' and 'administrative structures' also determines the types of reforms that are adopted, and explains the adoption of reforms within contexts. Therefore, the need to research reform process across contexts and countries and to explain the variation in the process across developed and a developing country establishes the rationale to study the reform process in Pakistan. Developing countries present a unique and interesting context with multiple actors, local peculiarities, and an uninformed public. The peculiar context to study reforms that have originated in the developed world, and have now been diffused to the developing countries through international organisations and globalisation. Since elite decision-making has been established as central to the reform process in developing countries, it will be interesting to study how the elites pull the reforms under pressure to their context.

Despite the availability of evidence that reforms are usually generated by administrative elites with political support (Grindle, 2000), their importance to the reform process remains understudied and underappreciated. Most political economy analyses of reforms esp. within the developing world are focused on the motivation of political leaders, electoral campaigns, party political manifestos as important determinants of reform agenda (Pollitt and Bouckaert, 2004). As a consequence, reforms on public management reform are generally seen as correlation of factors or

actors within political regimes, international financial institutions and service users (Pollitt and Bouckaert, 2004; Christensen and Laegreid, 2007).

The empirical gap in the field of health sector reforms in Pakistan was quite obvious from the start of the research project, as there was very little published research available on health sector reforms in Pakistan from a public management perspective. Available research on health sector reforms in Pakistan, did not have the public management lens, and was done by public health officials. Keeping in view the empirical and theoretical gaps in research, this research study was designed to capture the process of health sector reforms with Punjab as a case. Theoretical gaps in the literature on reform process on developing countries and how reforms are adopted across countries with different contexts have also been addressed with the help of research questions drawn for this research.

4.7 Research Questions and Conceptual Framework

For the purpose of this research study I would like to argue that reforms in developing countries entail an increasingly complex process due to the presence of additional set of actors i.e. international organisations. These international organisations push certain reform agendas in addition to financial and technical assistance.

In developing country context, international organisations' role in the reform cannot be ignored, as they are a permanent actor and stakeholder in the reform process. Reforms are *pushed* to the developing countries with the help of development agendas, and conditionalities (Section 4.6). The institutional environment of reform is composed up of endogenous and exogenous influences, which together influence the policy agendas resulting in reform in public sector. Political and administrative elites of developing countries in response to these influences *pull* the reforms into their context.

Comparative public management reforms studies like Pollitt and Bouckaert (2004) and Christensen and Lægreid (2007) have used analytical frameworks to capture the reform process across countries. I will discuss both the models and how they have informed this research and then draw a broad analytical framework based on these to guide the empirical framework of this study.

4.7.1 Pollitt and Bouckaert's Model of Public Management Reform

Pollitt and Bouckaert's (2004) model of public management reform has been used to compare reforms in twelve OECD countries. The model is presented as a 'conceptual tool' and a 'heuristic device' for capturing forces that 'drive' and 'restrain' change (2004:25).
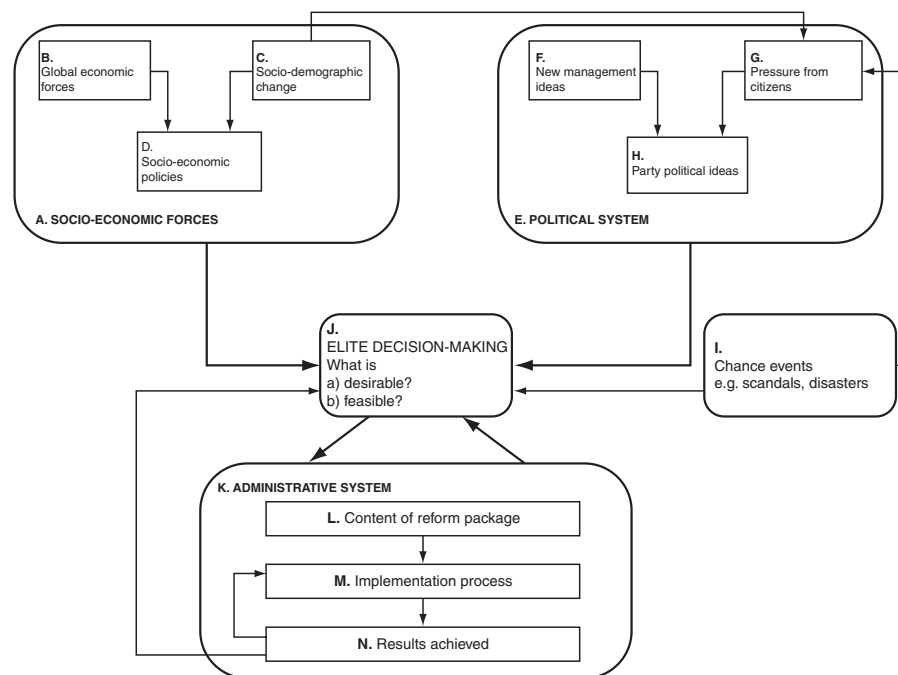
Figure 4-2: Pollitt and Bouckaert's (2004:25) Model of Public Management Reform

The forces at work can broadly be defined to be composed of three sets of factors: Reform drivers, Reform Content and implementation, and Result achieved achieved. The model regards elite decision-making as central to the reform process. The

process model is a conceptual map that identifies the important forces that shape and affect the process of reforms in most of the countries. The model is a detailed set of typologies and can help in building theories as more and more empirical evidence is collected from the countries and arguments developed. Pollitt and Bouckaert (2011) arrived at the model by synthesizing their experiences of reforms in twelve countries. This model provides a framework for collecting empirical evidence and also provides basis for subsequent discussion of findings. It considers public management reform as a process of change, and identifies the sources restraining and shaping change. Three large groups of elements affect the process of elite decision making. The first of these groups is the socio-economic forces. The socio-economic forces are made up of global economic forces, socio-demographic factors and socio-economic policies. These will include population, globalization demands, competition, international trade and many other such global economic trends. This group of factors provides the impetus for reform rather than the agenda for change.

The second important group of factors is the Political System. The political system can either aid the process of reform or can also create hurdles or make the process of change more difficult. The countries that have rigid constitutional laws face difficulties in the process of reform like Germany while countries like UK have been good at introducing reforms at the government level. The political system is important because it also takes into account the voice of the citizens of a country and at times pressures from other international organizations also. Politicians also try to fulfill the political agenda of their parties while trying to reform the institutions for good.

The third important set of factors is the administrative system. An administrative system is a set of corresponding factors which is also closely linked to the political system. The administrative system ensures the implementation of the reform efforts and also determines the content of the reform package. The rules and regulation, degree of decentralization and the accountability mechanisms all affect the process

of reform. The implementation of reform is also very important and needs to be carefully monitored so that they can guide the reform efforts in the future.

This model of public management reform entails the relationship between socio-economic factors, political pressures and the administrative system and how this affects the process of elite-decision making which results in public management reform programmes. This model has not only identified the factors responsible for bringing about administrative change but also the ones that can resist change.

Additionally, the authors have also provided another conceptual by introducing concept of reform trajectory to help us in drawing interpretations from reform practices observed. Reform trajectory is defined as "*an intentional pattern – a route that someone is trying to take. It leads from a starting point (alpha) to some desired place or state of affairs in the future (an omega)....consists of three basic elements, an initial state, a trajectory and a future state*" *(2004:66).* The reform trajectory is composed up of two components "what" and "how" of reform. Four main components define the substance of "what" of reform, and three for the process of "how". The scope of these reform trajectories and what this would entail is govin the following table.(Table 4-1).

What/Content	Finance: budget, accounts, audits
	Personnel: Recruitment, Posting, Remuneration, Secure Tenure Etc.
	Organization: specialization, coordination, scale, (de)centralization
	Performance Measurement Systems: content, organization, use
How/Process	Top down/Bottom up
	Legal dimensions
	Task allocation: (new) organizations

Table 4-3 : Aspects of reform trajectory: "What" and "How"(Adapted from Pollitt and Bouckaert (2004:67)

4.7.2 Christensen and Laegreid's Transformative Approach

In a similar vein, Christensen and Laegreid (2007) have also conducted a comparative research on reforms using a transformative theoretical approach as basis for comparing reforms in five countries: Australia, Denmark, New Zealand, Norway and Sweden. The main argument of this approach is that 'institutional dynamics of reforms' can be best understood as a complex mixture of "environmental pressure, polity features, and historical-institutional context" (2007:4). These factors both facilitate and hinder the reform process within the political and administrative elites, while exerting a complex pattern of "influence, learning and effects". Reforms are considered as a response to three types of contextual processes: (i) environmental pressure, (ii) national historical/institutional context, and (iii) political-administrative structures. In the words of the authors (2007:7)

> *"the transformative perspective is not only about combining and blending different perspectives but also about translation: co-evolution, dynamic interplay and processes of mutual dependency between reforms, structural features, culture and environmental pressure. If we regard administrative reform purely as a meeting between external pressure and national constraints and strategies, we lose sight of important aspects of the process."(Christensen and Laegreid:2007:7)*

The reform process is termed as a complex process by the authors which cannot be captured in its true essence by having specific conceptual frameworks. Therefore, in line with the arguments of Christensen and Laegreid (2007) and Pollitt and Bouckaert (2004), the need for a broad analytical framework that can capture the contextual peculiarities, while enumerating the reform practices in health sector will be most suited to this research study. The next section presents the research questions and broad framework to guide empirical framework of the study.

4.7.3 Research Questions

The research study will answer the following two main research questions, based on the research gap identified in Section 4.6. The main research questions have been further broken down into sub-questions in order to operationalize the concepts and demarcate the scope of the study.

Research Question 1: What model of public management guides health sector reforms in Pakistan?

- What are the main reform drivers' and strategies' and how have they been implemented?

- To what extent has NPM been the dominant reform paradigm in health service reform trajectory?

Research Question 2: How are public management reforms being adopted in a developing country context?

- What motivates and drives administrative elites to adopt and implement health service reforms in Pakistan?

- What role do professionals, health care managers and service users play in the reform process?

These research questions will be answered with the help of a conceptual framework, which will answer the research questions by insights from public management literature. The conceptual framework will identify the variables/dimensions that will guide the collection of empirical data. The empirical data will then be subjected to critical analysis with insights from the literature to answer the above research questions. By synthesising the research findings according to the analytical framework guiding data collection, we will be able to conclude how the different

models of public management have manifested them empirically in the context of Pakistan.

Drawing on Pollitt and Bouckaert's (2004) model of public management reform and Christensen and Laegreid's (2007) transformative approach, a broad conceptual framework was made across three dimensions found crucial to the reform process: reform drivers, reform strategies and how they were implemented. The reform process will also look at the impact of reforms on service delivery, people working within health sector, and service users. This framework will be used to guide the case study of Punjab Health Sector. An interview guide was prepared by using this model as a broad conceptual framework.

Dimensions of Reform Process		
Reform Drivers	**Reform Strategies**	**Reform Implementation**
Endogenous: Political and administrative Structures Economic and fiscal crises Socio-economic conditions **Exogenous:** International Best Practices Global development agenda International Financial Institutions and Donors	**Personnel-related** strategies e.g. Recruitment, Posting, Remuneration, Secure Tenure Etc. **Performance management** e.g. content, organization, use of performance management techniques **Organisational** strategies e.g. specialisation, coordination, scale, (de)centralization **Financial management** e.g. budget, accounts, audits	**Top down perspective** Top-down/Bottom up Legislation New agencies and structures **Bottom up Perspective** Impact on service delivery Impact on people working within health sector Impact on service users

Table 4-4 Conceptual Framework

Chapter Summary

This chapter has reviewed the literature on public management reforms in developing countries by focusing on issues of contextual importance like the importance of context, role of international organisations, politics of reforms in developing countries. Research gaps, research questions and conceptual framework for the research study are outlined. The next chapter discusses the research methodology adopted to answer the research questions.

Chapter 5
Research Methodology

Chapter 5   Research Methodology

This chapter presents the methodology used to examine the health sector reform process in Pakistan. As demonstrated in the literature review, public sector reforms feature prominently on the agendas of developing country governments. Pakistan has also initiated a number of reforms in public services with an added emphasis on education and health. Health care reforms in Pakistan remain under-researched and under-theorised especially in the public management literature. No holistic attempts to map the health services reform trajectory and to explore the role of key actors in the reform process have been made. This study intends to rectify the empirical gap in health services reform in Punjab by mapping the nature of health service reforms in Pakistan. By taking Punjab (largest province by population) as a case, this research methodology endeavours to contribute to the theoretical development of reform models in developing countries. This chapter outlines and justifies the methodological approach taken in the thesis.

This chapter has been divided into *nine* sections. Section 5.1 is about the research questions and gives us the overall research design for the study. Section 5.2 describes the underlying philosophical assumptions of the research design, discussing the ontological and epistemological assumptions, research approach and research strategy guiding the research process. Section 5.3 discusses case study as a research strategy, rationalises it and addresses the main criticisms on case study research. Different types of case studies are defined and the type of case study for this research is defined. Section 5.4 discusses the population and sampling strategies and justifies the selection of Punjab as case. Section 5.5 explains the data collection and fieldwork during the research process. Section 5.6 discusses data presentation and data analysis employed in the research. The quality of research findings is evaluated by addressing the reliability and validity of the research in Section 5.7. Ethical considerations of the research process are elaborated in Section 5.8. Section 5.9 gives an overall summary of the entire research process.

5.1 Research Questions

The study investigates the following research questions and objectives based on the research gaps identified in the literature review. The research gaps are discussed and research questions are formulated in Section 4.7.

Research Questions	Research Objectives	Sub-questions
What models of public management guide health services reform in Pakistan?	To map out health sector reform initiatives with respect to drivers, reform strategies and implementation practices To see whether the reforms are consistent global reform paradigms e.g NPM, etc To look at the contextual factors shaping the reforms	What are the main reform drivers' and strategies' and how have they been implemented? To what extent has NPM been the dominant reform paradigm in health service reform trajectory?
How are public management reforms adopted in a developing country context?	To explore the values and motives of the executives and government in adopting the reform agendas and their implementation	What motivates and drives administrative elites to adopt and implement health service reforms in Pakistan? What role do professionals, health care managers and service users play in the reform process?

Table 5-1: Research Objectives and Research Questions

5.2 Research Philosophy and Approach

5.2.1 Ontological and Philosophical Stance

The process of research design in qualitative research starts with researchers' philosophical assumptions that form the basis of the research study. These philosophical assumptions shape the research by bringing in *worldviews* or *paradigms*. These paradigms or worldviews can be defined as "a basic set of beliefs that guide action" (Guba, 1990:17). The paradigms used by qualitative researchers depends on their belief set, and these paradigms have continually evolved in the field of qualitative research (Creswell, 2010:19; Guba and Lincoln, 2009). Using Schwandt's (2000) identification of three epistemological stances in qualitative research (interpretivism, hermeneutics and social constructionism), this research study has been conceptualised as based on *relativist* ontology and within the *interpretive* paradigm.

Relativism is a general term, which emerged during the anti-positivist movement in social science research. It challenges the positivistic assumption that "scientific knowledge is cumulative, unmediated, and complete representation of reality" (de Ven, 2007:47). The relativists believe that reality is 'socially constructed' and it is important how people construct/interpret/understand reality. The *interpretive* epistemological perspective differentiates human and social action by considering it meaningful and enables understanding of events and behaviour by 'grasping the meanings' that constitute them (Schwandt, 2000:191). Interpretivism values 'human agency' and is based on the assumption that social world is not government by 'law-like' rules but is 'mediated through meaning and human agency'(Ritchie and Lewis, 2003: 17). Relativism is based on the premise of subjectivity, meaning that similar situations or events can be described differently and is based on the experiences and subjectivity of the researcher. It also emphasises that social world needs to be understood from an 'actors' point of view as they are directly involved in the events that need to be investigated (Burrell and Morgan, 1979).

This study seeks to understand the drivers of health sector reforms in Punjab and motivations of the reform process, which has been undertaken by the elites, managers and policy makers taking part in this research. The knowledge this research intends to seek is the reality that is constructed by the actors in the reform process. The research questions cannot be answered by empirical observations alone but it also needs to supplement the observations with the meaning and insights that individual informants bring to the process. The researcher agrees with the view that Saunders et al. (2003:84-5) hold that:

> *"It is necessary to explore the subjective meanings motivating people's actions in order to be able to understand these...role of the interpretivist is to seek to understand the subjective reality of those that they study in order to be able to make sense of and understand their motives, actions and intentions in a way that is meaningful for these research participants." (Saunders et al., 2003: 84)*

This research study supports the focus on actors' perspectives in the research process. Elite interviews in the research study are instrumental in providing an insight into the process of health sector reforms, and are used to complement the shortcomings of discontinuous and missing data, and to further provide an insight into elite motives to reforms.

5.2.2   Research Approach

The research methodology for the thesis is based on qualitative research design. The justification for the use of qualitative research lies in it being data-driven, flexible and provides a way to navigate through 'rich, complex, context dependent sources of data'(Yin, 2003) all of which are fundamental for a research project that maps the reform process while looking at the role of key actors in the reform process. Moreover, qualitative research uncovers the underlying dynamics of reform while helping the researcher to establish a narrative for addressing the research problem. This research involves human agents who, George and Bennett (2005:129) consider reflective because they *"contemplate, anticipate and can work to change their social*

and material environments and they have long-term intentions as well as immediate desires or wants".

Qualitative research has a long, distinguished history (Denzin and Lincoln, 2003:1) and has been increasingly used in the field of social sciences. Denzin and Lincoln (2003:5) view the qualitative researcher as a *'bricoleur'* and a *'quilt maker', adding to our view of research as bringing together different pieces of the story to make sense and weaving different pieces of information together.*

Keeping the researcher' ontological and epistemological stance in view, qualitative research approach was an appropriate choice. Qualitative research is based on the assumption that there can be different ways interpret and make sense of the world and those being researched (Miles and Huberman, 1994). For the purpose of this research, qualitative research was adopted to because of its ability to provide insight into the reform process. This research therefore is in agreement of van Maanen (2000:9) appreciation of interpretive research:

> *"… an array of interpretative techniques which seek to describe, decode, translate and otherwise come to terms with the meaning, not frequency of certain… phenomena in the social world."*

The researcher also chose qualitative research approach because of the peculiarities of the research context. Research is not valued, neither is considered important within the administrative and bureaucratic organisations in Pakistan. There is no culture for valuing research projects and facilitating researchers. Questionnaires or other quantitative research approaches may have resulted in very low response rates. Health sector reforms is a matter of public policy and merely enabling access to governmental documents and resources may have helped the researcher, but in order to get an insight into why reforms are undertaken and what motivates the policy makers, a qualitative case study method was adopted as a research strategy.

5.2.3 Abductive Research

This research uses abductive research strategy with induction and deduction carried out throughout the study. Abductive research strategies build upon existing concepts and theories, and attempt to reconstruct theory, by developing it in different contexts and environments (Thomas, 2010; Mantere and Ketokivi, 2012; Blaikie, 2009). Abductive research can provide new insights to the researcher on the existing research, and can supplement the existing knowledge by adding findings from different context and environment.

Sociological and management researchers have suggested at least three different relationships between data and theory: *inductive, deductive* and *abductive* (Blaikie, 2009; Patton, 2001). Inductive research strategies are used to research new phenomena, where little existing research is available and aims to build theories and propositions (Patton, 2001; 2004). Deduction, on the other hand, is appropriate where the existing research and theories are well developed, and is used for testing some aspects of theory, in different samples, contexts and datasets. Abduction aims to understand, build and add upon existing theories, and encourages logical inferences during research (Thomas, 2010; Mantere and Ketokivi, 2012).

In other words, this current research investigates the reform process in developing countries and the role elites play in designing reforms. This can be characterised as *theory developing* (abductive) rather than *theory building* (inductive) and *theory-testing* (deductive). Since the basic premise of this research is that reform process in developing countries is different to the developing world, and the existing research in public management has mainly originated in advanced market economies, this research attempts to extend our understanding of the reform process in the developing world and emphasise the political nature of the process. By identifying unobserved patterns within exiting theories, the use of abduction will generate explanations and add on to the existing research, by provide contextual explanations and extending it to different and unique contexts. It will also denote a reconstruction

of the reform process, which can help the researcher to propose informed reconstruction of concepts and theories (Hoffmann, 1997; Yu, 1994)

5.2.4 Linking relativism, interpretivism and abductive research strategy

The research follows relativist ontology within the interpretive paradigm. Relativism, is a broad term and challenges the concept of absolute reality. Relativism believes in socially constructed reality and stresses the importance of human subjectivity, while interpretive epistemology acknowledges the human subjectivity of agents/research participants in shaping social reality. Relativism and interpretivism both coincide with the researcher's belief that similar situations can be described differently by different research participants because of the subjective nature of truth. The researcher attempts to investigate the political processes and administrative elites in the public management reform process, by examining individuals as members of organisations. The chosen paradigm will help the researcher in an in-depth exploration of the motivation and driving forces in health sector reform agenda and how they have resulted in various reform strategies and programmes. This also means that the data/responses obtained may differ due to the individual nature of the respondents and their organisational context. This paradigm also appreciates the data that has been obtained from a variety of sources like bureaucracy, health care managers, consultants and service users. This has helped the researcher in identifying the different phases of the reform process, both formal and informal, and how this has affected the direction of reform.

Interpretivism places the respondents, whether they be actors or institutions as different from objects in natural sciences , therefore requiring a different way to research them (Silverman, 2009; Schwandt, 2000; Patton, 2001). The interpretivist view has guided the choice of research strategy for this study based on the view that "reality is created and given meaning by individuals" that are "restrained by the goal that the actors' want to achieve" (Easterby-Smith et al., 1994). Moreover, interpretive approaches are considered to be more apt for context-rich qualitative

research studies. This research study provides a contextual explanation of health sector reforms in developing countries in light of the western models of public management and also adds to the research on developing countries that provide a completely different habitat for public management theories that have been written in the West. Therefore, interpretive approach will assist the researcher in understanding the activities of key actors in the reform process over a period of seven years (2004 – 2011). Essentially, this implies that the role of key actors and service users will be derived from their meanings and interpretation that they will provide during data collection.

The choice of research strategy as abductive has mainly been because of the fact that this study is a step towards theory-building. According to Blaikie (2007:89), abductive reasoning is "advocated as the appropriate method of theory construction in social science". Since this strategy involves deriving meaning from social actors' accounts and experiences within the context of their everyday activities (2007:89), which is suitable for this research study attempting to generate scarce empirical evidence within the context of public management in health sector in Pakistan.

5.3 Case Study as a Research Strategy

Given the nature of research, with the intention to map health sector reforms in Punjab, where little prior research was available and to explore the role of key actors in the reform process, a case study approach was chosen. The case study design will provide the researcher with the flexibility and rigour this research requires, to carefully investigate the reform process and to draw generalisations about health care reform. The theoretical and conceptual framework guiding the research study is grounded in the public management and organisation theory literature (Pollitt and Bouckaert, 2011; Greenwood et al., 2008).

5.3.1 Case Study: Definitions

The researcher agrees with the rationale given by Ritchie and Lewis (2003:76) as follows:

"The term case study is used in various ways, but the primary defining features of a case study are that it draws in multiple perspectives (whether through single or multiple data collection methods) and is rooted in a specific context which is seen critical to understanding the researched phenomena".

The case study as a research study has been employed because it will enable me to research a "bounded system" or case and will make use of the contextual data to interpret my findings about the research problem in question (Creswell, 1998;Flood as reported in Fals Borda, 1998). According to Stake (2003:135), a case has parts that are 'purposive' and denote a 'self' , making it an 'integrated system' whose behaviour can be 'patterned'. Stake (2003) further adds that some features of the case maybe inside (i.e. within the boundaries of the system) while some may exist outside and are significant as its 'context'. It may be difficult for the researcher to define the boundaries of the case but the "boundedness" and "behaviour patterns" can acts as important tools for specifying the case. This has been sufficiently defined by Yin (2003:13) as:

"A case study is an empirical inquiry that investigates a contemporary phenomenon with its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident."(Yin 2003;13)

5.3.2 Justifying case study as a research strategy

As elaborated upon by Yin (2003), case studies are used when the researcher specifically wants to cover the contextual conditions in which the phenomenon occurs. Based on the research questions and research objectives of the thesis specified in Section 6.1, case study as a research strategy was chosen over other alternate research strategies because of the following reasons given by Yin (2003), Stake (2003) and Flyvbjerg (2011):

- Case studies give the researcher an opportunity to study/observe/investigate the phenomena within the context, which is pertinent to the type of research questions investigated for this thesis

- Case studies are ideal for those research projects where it is difficult to distinguish between the phenomenon of interest and the context.

- Experiments and surveys focus on the control and influence of few variables and more focused on the number of informants

- Case studies are more dynamic and have the potential to uncover interesting findings due to the flexibility and comprehensiveness of the data collection process.

- They rely on multiple sources of evidence, resulting in data triangulation, cancelling out any biases or limitations of a particular data set.

Stake (2003:136) defines a case study as "both a process of inquiry about the case and a product of that inquiry". Case studies are generally considered a strong alternative to research problems where there is little room for applying statistical methods (George and Bennett, 2005:19) and where the nature of research is exploratory and intends to understand the findings in light of the context they are observed in (Yin, 2009). The case study method is widely used in social science research especially in the areas where there is little prior research and context and setting plays an important role in determining the phenomena in question. George and Bennett (2005) have listed four strengths that case study methods have and are also significant for social science research problems: *conceptual validity, generating new hypothesis/propositions for further testing, to study causal mechanisms in the context of individual cases,* and *the capacity for addressing causal complexity.* Case studies allow the researcher to conduct the research in a manner that unravels the indicators that are best suited to theoretical constructs that the researcher is there to measure, thus increasing the conceptual and theoretical rigour of the findings.

5.3.3 Types of Case Studies

Case study research can include two different types of case studies. Broadly defining, there are two main variants: single or multiple case studies Yin (2003). Yin (2003:40) has defined case study designs based on two criteria in a 2X2 matrix:

number of cases and units of analysis. Two types of single case studies are defined: holistic and embedded. Holistic case studies have a single unit of analysis and focus on analysing a single case within its context. Embedded case studies also use a single case but they have more than one unit of analysis, e.g different units or subunits within the case. These studies are used when the researcher is interested in drawing conclusions and wants to capture the variation that may or may not occur in different types of subunits.

This research study employs a single case study design with embedded units. Province of Punjab is the case and since the province has both urban and rural cities with a vast difference in the demographics and lifestyle in both, it will have two embedded subunits i.e. cities of Lahore and Kasur, where Lahore can be classified as highly urban, metropolitan provincial capital, and Kasur is a comparatively small rural city.

This study employs a single case design with multiple units of analysis for the following reasons:

- **Critical case:** Punjab represents a 'critical case' in explaining health sector reforms in Pakistan. It is the largest province in terms of population and has 148 of the 342 national assembly constituencies making it highly representative and influential in the Parliament (Government of Pakistan, 2011b). Highly populated also means that it is rich with examples, stories and experiences that can provide the researcher with insights into the data. Moreover, the researcher also belongs to Punjab which makes it easier to access hard to reach rural establishments due to prior knowledge and familiarity. 56% of the total population of Pakistan resides in Punjab making it more suitable as a case that can be used to draw generalisations from (Government of Punjab, 2012).

- **Representativeness:** Since Punjab is the largest province of Pakistan in terms of population and has a wide public health infrastructure, a case study

of Punjab health care reforms will be representative of the reform experiences in the other provinces as well.

Three types of case studies based on the purposes they are going to serve have been identified by Stake (2003:136): *Intrinsic, Instrumental* and *Collective. Intrinsic* case studies are those where the researcher seeks to better understand a particular case, where the particular case does not necessarily represent other cases in the population, but is of interest because of some unique and peculiar characteristics relating to the research problem. Theory-building is not the main objective of such case studies but they may result in some theory building. *Instrumental* case studies are conducted to draw insights or to redraw a generalisation. The case is studied in-depth with regards to their context and such studies help to draw generalisations and are usually representative of the other units in the population. *Collective* case studies study more than one case in order to find answers to the research problem, where the cases are considered representative of the overall population. The rationale behind such case studies is that having a closer look at multiple cases will help in better understanding of the phenomena in question and will result in better and more reliable theory generation. This case study can be termed as having features of both instrumental and collective case studies, as it is an in-depth and can be used to generalise results for the country (instrumental) and because of the overall population and representativeness in the assembly, this can also be termed as a collective case study.

5.4 Population and Sample

Social inquiry requires the researcher to define the population and select samples for their study. Single case studies also require sampling decisions. Qualitative research requires non-probability sampling (Ritchie and Lewis, 2003:78) where the units are 'deliberately' selected because of the specific features that they embody of groups located within the population. Qualitative research sampling is often criticised for the lack of rigour in sampling strategies which some believe are integral to determine the quality of research findings. The different characteristics of the population are used to select the sample that is not statistically representative. According to Ritchie and

Lewis (2003:78), the following sampling approaches can be used in qualitative research.

Criterion-based or purposive sampling: Sampling units or participants are chosen because features or characteristics that they possess which will help the researcher in understanding and exploring the main research questions of the study e.g. socio-demographic characteristics, experiences, roles, positions held etc.

Theoretical Sampling: The term, initially used by Strauss and Corbin (1997) and Glaser and Strauss (1970), is a type of purposive sampling where the researcher selects the samples based on the potential contribution they can make to the development and testing of study's theoretical constructs or hypothesis. It follows an iterative process where the researcher will pick an initial sample, analyse data and based on the results will select another sample to refine the findings of his study. The process goes on till no further insights can be obtained and the researcher reaches a stage called 'data saturation. The criteria for selection in this type of sampling is purpose and relevance to the theoretical constructs in question.

Opportunistic Sampling and Convenience Sampling: These two types of sampling techniques are most commonly used in qualitative research. Opportunistic sampling has been defined by Patton (2002) as when the researcher takes advantage of the unforeseen opportunities, taking a flexible approach and samples informants as the fieldwork unfolds in the relevant context as the events and opportunities arise. It is not as systematic as the previous two approaches and has been criticised by authors (for example Patton, 2002).

5.4.1 Purposeful sampling

The sampling strategies used for this research are purposive or criterion-based sampling, opportunistic and convenience sampling. Purposive sampling serves two key objectives of the sampling: *relevance* and *diversity* (Ritchie and Lewis, 2003:79). Relevance pertains to comprehensiveness so that all the key constituents of

the subject matter are covered. On the other hand, diversity helps in exploration so that the characteristic in question can be explored.

The overall population in this research would comprise of all the four provinces in Pakistan; Punjab, Sindh, Balochistan, and Khyber Pakhtunkhwa. Punjab was selected on the basis of population, representativeness, and ease of access. 148 of the total National Assembly seats are from Punjab (Government of Pakistan, 2011b) with 56% of the total population of the country residing in Punjab (Government of Punjab, 2012). It has 36 total districts that are both urban and rural. Selection of Punjab as a case was thus justified on the basis of relevance (population) and diversity (urban and rural components).

In the first phase, semi-structured interviews were conducted with the administrative elites at the federal and provincial level. The justification for interviewing the administrative elites is given by Snow and Hrebiniak (1980) referring to them as the best 'vantage' point for viewing the organisation as a whole. This has been criticised by Bowman and Ambrosini (1997) and (Walker, 2004) who have suggested that information gathered from single informants is unreliable attributing it to the variation in the responses and have suggested the use of multiple informants in any research. Walker (2004) specifically emphasises the use of multiple informants in public management reform research which he believes is under-researched and has mostly relied on surveys from single informants who happen to be the administrative elites (for example Pollitt and Bouckaert, 2002). Therefore, based on methodological insights from the literature the data was collected from 'multiple informants' i.e. administrative elites, middle management, district health management, doctors and health care facility in charge, paramedical staff and service users to gain insights into health care reforms in Punjab.

Another important issue which has been raised by Walker (2004), is the problem of recalling information. Many informants had trouble recalling events which had happened two three years ago. They refused to mention some health care reform initiatives that had been implemented in the past but were now more integrated with

the health care system. The researcher had to give them cues in order to enable them to respond to these. These problems were handled by the use of multiple informants and also by sending them the interview guide before hand so that they could spend some time before the interview to recall important information.

The data collection in this research study started with four key interviews with the civil servants belonging to Planning & Development Department, Punjab Resource Management Programme, and Health Department. These key interviewees were selected after informal conversations with officials from the Health Department, which happened at the time of enabling access to departmental documents and reports about health sector reforms in the province. An initial list of potential informants covering important aspects of health sector reforms in Punjab was prepared. In addition to people belonging to the Health Department, Government of Punjab it was observed that Punjab Devolved Social Services Programme, Punjab Resource Management Programme and Planning & Development Department also have a role in the design and implementation of health sector reforms in the province. Representatives from all these departments were interviewed. Interviews were also conducted at Punjab Health Sector Reform Programme, which is a specialised unit within the Health Department and is mainly looking after the reforms under UNMDGs. Other interviews comprised of interviews in Punjab Rural Support Program (Chief Minister's Primary Health Care Initiative) and at CONTECH, which have been the management consultants for a number of health reforms discussed.

Opportunistic, convenience and snowball sampling occurred when during the course of fieldwork, there were some instances where the informants mentioned other colleagues that might be useful for the research. Those names were noted and were contacted later to arrange interviews, which proved to be very relevant to the research.

5.5 Data collection

The process of data collection spans over a period of 10 months from May 2010 till February 2011. The process started off by sending introduction letter and a letter explaining the research objectives of the study asking for access to documentary sources and interview officials from the Health Department and associated health care facilities. The interview guides and case study protocols were sent to Ministry of Health, Islamabad and Health Department, Government of Punjab. The permission was granted two weeks later and initial key interviews were scheduled in the month of June. The department granted limited access to documents and reports and a letter was circulated in the relevant departments to facilitate the researcher.

The initial four key interviews scheduled did not happen in the month of June because of the floods in Punjab and the non-availability of the Health Department officials as they had cancelled all their prior appointments and were engaged in relief work. No other interviews were scheduled till September 2010.

Phase I: Initial key interviews

The initial key interviews were exploratory in nature and served two purposes: to establish a relationship with the Health Department, and to gain access to some documents so that the researcher can refine the interview guide and revisit the research to see if they are appropriate for the research problem in question. Four interviews of 45-60 minutes duration were conducted. Two of the four interviewees were currently posted in the Health Department, while the other two had worked with the Health Department and Ministry of Health during the last four years, for more than a year at a stretch. The informants were chosen because of their involvement with health sector reforms in Punjab and at the federal level.

The research questions and conceptual framework of the study were revisited and with some slight changes, the interview guide was refined. Policy documents esp. Punjab Health Sector Reform Framework (PHSRF) which was not publically available at that time and documents about Punjab Health Sector Reform Programme

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(PHRSP) were shared. These documents were carefully analysed and also served the purpose of data triangulation (Mathison, 1988).

Based on this phase of data collection, it was observed that PHSRP and PRSP are two main reform initiatives that are being implemented at primary and secondary level health care facilities. Insights gained from this phase reinforced the conclusions drawn from the literature review that public sector reform process is highly context-dependent, and is consistent with Miles and Huberman's (1994) view that a process only has meaning when observed within a specific social and physical setting. The interview guide used for the interviews has been attached in the Appendix.

Phase II: Semi-structured Interviews

The second phase of interviews included a more diverse set of informants than the first one. Opportunistic and snowball sampling techniques were used to identify informants (insert citation). The first phase informants were all government officials. The informants in this phase were management consultants, people working in Punjab Health Sector Reform Programme- Programme Management Unit, Punjab Rural Support Programme, Punjab Devolved Social Services Programme and officials from Office of Director General-Health Services. 12 interviews of 45-60 minutes were conducted in this data collection phase.

Phase III: Interviews within two embedded case units (Lahore and Kasur)

The third phase of the data collection was an in-depth study of two districts in Punjab: Lahore and Kasur which were selected based on the urban and rural composition. District Health Administration of the two districts was interviewed. Health care facilities in these districts are organised under three tiers: primary, secondary and tertiary care institutions. One health care facility at each level was selected. Two-three days were spent at each selected facility to interview the management, doctors, paramedical staff and service users. The following health care facilities in each district were visited.

	Lahore (Urban District)	Kasur (Rural District)
Primary level health care facility	Rural Health Center, Burki Basic Health Unit, Mozang	Basic Health Unit & Dispensary, Chak 16, Kasur Dispensary Rural Health Center, Mustafabad
Secondary level health care facility	District Headquarter Hospital, Mozang	District Headquarter Hospital Kasur
Tertiary level health care facility	Punjab Institute of Cardiology, Lahore	No tertiary care institution.

Table 5-2: Health Care Facilities Visited and Interviewed in Lahore and Kasur

Phase I: Initial Key Interviews	Informants identified by documentary analysis, initial study of health reforms. Research questions and interview guides refined. Access obtained to policy documents. Informants belonged to Ministry of Health and Health Department, Government of Punjab
Phase II: Semi-structured interviews	Interviews with more Health Department officials, management consultants, Punjab Health Sector Reform Programme (PHSRP) and Punjab Rural Support Programme (PRSP) officials
Phase III: Semi-structured interviews within the two embedded case units of Lahore(urban) and Kasur(rural)	District Health Administration and management and doctors of one health care facility at each level was visited (Service users on the day of the visit were also interviewed informally at each health care facility.

Table 5-3: Data Collection Phases

5.6   Data Presentation & Analysis

Data analysis in qualitative research converts data into findings. For the purpose of this research study, the term data analysis refers to *transforming* interviews, observations, documents, filed notes and memos collected during fieldwork. The

researcher has tried to make sense of large amounts of data accumulated by *reducing* the volume of raw data into meaningful chunks by *identifying patterns and emergent themes*, which are *presented* using the analytical framework of the case study. The analytical framework acts as a 'moulding tin' that gives meaning to raw information and data and addresses the initial propositions of the case study.

The overall data analysis strategy in a qualitative study requires the researcher to make a few important decisions: when to start the formal analysis, how open-ended or pre-configured the analytical framework is, and the overall theoretical framework the study relates to (Rossman and Rallis, 2012:264-5). The following pointers drawn from Rossman and Rallis (2012) guided the data analysis phase of the research:

- Refer regularly to the conceptual framework but also be open to new insights which might not be in your framework initially.

- Keep your research questions in your mind and the qualitative genre the study is influenced by

- Asking analytic questions of your data and modifying them based on the learning

- Log the entire process and important decisions as you move along the process

- Writing descriptive and analytic memos.

- Share your findings to get back, refer to the literature and visualise your data using concept maps etc.

The theoretical framework that guides the research shapes the data analysis strategies employed by the researcher (Patton, 2001:434). In this research study, the data analysis phase required revisiting the research questions and refinement of the conceptual framework so that it adequately captures the essence of finding relating to the overall research objectives of the study. Data collection and data analysis phases in qualitative research are rarely mutually exclusive, but are rather complementary and serve the purpose of providing rich and thick data descriptions. For the

researcher, during this study, an initial preliminary analysis was conducted after the first four key informants' interviews' to improve the interview guide and develop case study protocols. The preliminary analysis and interview transcripts' were shared with the key informants to enable 'member checking' (Creswell and Miller, 2000), which is considered a measure for validity.

Actual in-depth data analysis started after fieldwork, which had drawn upon two primary sources which also later served as a tool for organising the analysis: research questions and framework generated prior to fieldwork, and the analytical insights obtained during fieldwork (Patton, 2001: 437)

5.6.1 Documentary Analysis

In order to answer the first research question about models of public management guiding health sector reforms, a mapping exercise was required to identify the reform measures relevant to the study. Lack of research on health sector reforms in Pakistan, required the researcher to conduct a detailed examination of health sector reform programmes in Punjab. This task could not be accomplished alone with interviews and required a detailed examination of official documents, policy documents and reports. The interview responses lacked minute details required by the researcher, and many a times the informants themselves were unsure about the details of the programmes under question. Documents, reports, and policy frameworks and documents were frequently referred to by the informants, which were analysed based on their "content" and "functions".

The analysis initially involved publically available data on the websites of health Department. There were hardly any information available publically, and whatever was available was old and dated. Health Department, Punjab was requested that access be provided to the official documents, which was made available partially. Official correspondence and letters were not enabled access.

5.6.2 Data Management

Data management is an important issue for qualitative researchers as there is usually large amounts of data coming from different sources, sites or cases (Miles and Huberman, 1994:45). Interviews were digitally audio-recorded on an electronic device wherever the informants' permitted. There were some informants who did not want the interview to be recorded. Hand-written notes were taken in such cases, which were transcribed by the researcher at the earliest. All the interviews were transcribed in a word-processor and imported in NVivo 10, which was used for data management and thematic coding of the interviews. The documents, reports and official documents were also stored in NVivo.

5.6.3 Coding

Coding is termed as analysis and is defined as "tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study…attached to chunks of varying size-words, phrases or sentences, or whole paragraphs, connected or unconnected to a specific setting" (Miles and Huberman, 1994:56). Multiple codes can be assigned to data reflecting different analytical insights of the researcher.

Following Miles and Huberman (1994:55-72) guidelines, coding was done at two levels: a more general 'etic' level and a specific 'emic' level, which are more closer to the participants' views and nested within etic codes. Etic codes can be defined as constructs, descriptions and content that are closer to the theoretical constructs of the study, while emic codes are meaningful accounts, events that are considered important to the participants of the research study (Lett, 1990) . List of codes were developed pertaining to the conceptual framework of the study. Interview transcripts were transcribed by the researcher themselves, because interview transcription done by the researcher themselves provides an opportunity to the researcher to immerse in the data and provides useful insights to the researcher (Patton, 2001:441).

Descriptive codes were assigned to the interview transcripts, documents, and reports in the first instance which were later supplemented by inferential and pattern codes (Miles and Huberman, 1994:57-72). These pattern codes indicated the emergent themes that were emerging from the data in light of the research questions and framework. 190 codes were generated in the first 'descriptive' coding exercise, which were later reduced to identify themes from the data.

The coding phase of the analysis was also supplemented by 'memoing' by the researcher. Memos are the 'theorising write-up of ideas about codes and their relationships as they strike the analyst while coding….it can be a sentence, a paragraph or a few pages…it exhausts the analysts momentary ideation based on data with perhaps a little conceptual elaboration" (Glaser, 1978 as quoted in Miles and Huberman, 1994:72). Memos were written during fieldwork and analysis phases, and were the first piece of analysis written by the researcher during the fieldwork. These memos tied together different pieces of data together into a cluster for a more in-depth analysis later. They were also written during transcription and assigning of codes to the data post-fieldwork. NVivo was only used to code and manage the interview data, documents and reports. The researcher found the traditional method of coding in the word processor (although the transcripts were coded in NVivo initially).

5.6.4 Thematic Analysis

Some of the themes emerged out of the coding exercise. According to Bazeley (2009), themes often turn out to be labels assigned to 'metacategories' or 'a classification of codes into different types of categories'. Codes are then grouped together to bring out themes or patterns, constituting a thematic structure. Bazeley (2009) is of the view that description is part of the analytic journey but is not sufficient, therefore the data should be challenged, extended and linked together to make the findings valuable. Using Bazeley (2009) three-step formula was used to work through and record results during data analysis. The three-step model suggests the researcher to *'describe-compare-relate'* for each theme the researcher needs to

write about and helps in structuring the data. Describing stage often means laying out the context of the study and providing details about sources of data and how they are interrelated. In this study, health care reforms are *described* and mapped within the context in which they have taken place and how they are linked with other health care interventions. The responses of health care managers, service users and civil servants have been *compared* to capture the variations and commonalities in their accounts and why. The data has also been *compared* to the available documentary evidence to validate and fill in the missing information in the informants' accounts. Possible relationships among themes and categories is also explored while writing the analysis by *relating* them to each other, also paying attention to the particular circumstances in which they might have occurred.

5.6.5 Using NVivo

Before data analysis, interviews were transcribed by the researcher for import into NVivo. Qualitative data collected during the field is unstructured and huge, which is transcribed and imported into NVivo where it can be stored, retrieved and coded for further analysis. NVivo can help to develop associations and cross-references between categories and codes which can later help with the development of propositions and theory.

Most of the researchers working with qualitative data in social sciences have been using Computer-assisted qualitative data analysis software (CAQDAS) to aid the process of data analysis. The researcher also find useful in the initial data management, storage and retrieval phases where the data was transcribed, coded, relevant documents coded and stored. But during the actual analysis phase where the researcher actually had to engage and go over the data again and again, the software seemed difficult and obtrusive for the researchers thoughts. The researcher particularly found it difficult to handle a case study that has multiple sources of evidence and not very useful in establishing associations, relationships and propositions. The researcher later did this in a traditional manner by using word-processor, post-it notes and highlighters. NVivo was useful for my research for

storing and managing data, easy retrieval and coding data chunks, which were later, used in traditional manner to write the analysis.

5.7   Quality of research findings and limitations

"The criteria for judging a good account have never been settled and are changing". (Clifford, 1986)

"Words like 'validity' and 'reliability' are markers of an earlier, now largely discredited (or at least no longer fashionable) 'moment' in the short history of qualitative social research". (Seale, 1999:2)

For the purpose of ensuring quality of research findings, tests of validity and reliability are commonly used in qualitative research. Since qualitative research is dependent on the subjective interpretations of the researcher done in an objective manner, there are procedures that ensure the credibility and trustworthiness of the results drawn from the research. Various procedures can help in establishing the validity of the research study. Qualitative research literature provides a number of procedures to counter the limitations and subjectivity of the researcher. Concepts like validity (Yin, 2003; Denzin and Lincoln, 2003), reliability (Yin, 2003; Yin, 2011), trustworthiness (Creswell and Miller, 2000; Patton, 2001) and rigour (Lincoln and Guba, 1986) are commonly used to test and consider in qualitative research.

Interpretive, constructive and constructionist perspectives have been seen as prone to the inherent limitations and subjectivity of qualitative research. Lincoln and Guba (1986) have argued that qualitative research falling under this paradigm should use criteria different from qualitative research under other competing paradigms (Guba and Lincoln, 2009). The authors have suggested "credibility as an analogue to internal validity, transferability as an analogue to external validity, dependability as an analogue to reliability, and confirmability as an analogue to objectivity". (Lincoln and Guba, 1986:76-78). Further emphasis has been placed by the authors on the researcher being reflexively conscious about his/her own perspective and being appreciative of the informants' accounts.

Researchers following the interpretivist/constructivist philosophy "view the social world (as opposed to the physical world) as socially, politically and psychologically constructed, as are human understandings and explanations of the physical world"(Patton, 2001:546). The researcher agrees with Patton's (2001) view that the case study conducted in this research is intended for a more deeper understanding in a particular context and does not aim to produce generalizations and causal relationships across time and space. This case study offers a perspective and encourages dialogue with other perspectives rather than emergence of a 'singular truth' and 'linear relationships'

The researcher follows Yin's(2003) four tests that have been commonly used in social research studies and are equally applicable for the conduct of case study research. The four tests used are construct validity, internal validity, external validity and reliability, and are discussed below.

5.7.1 Construct Validity

Case studies and other forms of qualitative research have faced criticism over subjectivity, and lack of operational definitions of the concepts and phenomena under study. Construct validity is a test to ensure that the researcher clearly knows what is to be studied and why. According to Yin (2003: 33-36) this requires the researcher to clearly specify the parameters of the study(what is to be studied) and relating them to the overall objectives of the research. The researcher should be able to demonstrate the relevance of the dimensions/variables/concepts under study by relating them to the overall research objectives.

In order to ensure the *construct validity* in this research, the initial key interviews were used and the interview questions were changed and refined several times in the initial phases of data collection. Initial key interviews helped the researcher to refine the overall research questions and specifically point to the relevant actors in the field. The transcripts of the initial key interviews with a preliminary analysis were also shared with the interviewees. Multiple sources of evidence were used e.g.

documents, reports, interviews from managers as well as service users to validate the responses obtained. Access to documents, reports and official documents were requested in the initial key interviews, which made available documents which were otherwise not publicly accessible. Data triangulation was used to enhance the quality and credibility of the findings Yin (2003:35). The interview responses were supplemented with documentary evidence, reports and official documents which corroborated the research findings obtained from interviews. A "chain of evidence" of evidence was also maintained by using NVivo, which also helped in recording memos and notes, and also served as a research diary for the fieldwork phase. In addition to this, some key informants were requested to review the case study summaries before the initial coding phase, known as respondent validation (Yin, 2009; Miles and Huberman, 1994; Huberman and Miles, 2002).

5.7.2 Internal Validity

Internal validity tests are important for experimental and quasi-experimental research. In qualitative research, internal validity is of significance if the researcher is undertaking causal or explanatory case studies espousing causal relationships among variables. If the studies are descriptive or explanatory in nature, internal validity is not of surmount importance. Internal validity needs to be ensured during the data analysis stage and can be done through pattern-matching, addressing rival explanations and using logical models (Denzin, 1978 as cited in Patton, 2001:247). Although, the research did not require testing of causal relationship, but it did require an understanding of the reform process which required pattern matching, and corroborating accounts of reform across informants. The partial use of NVivo in data analysis phase helped in establishing relationships among the responses of the key informants, which helped in aggregating the responses of the informants, and validating it with different sources of data like reports and documents, which helped in further validation of the patterns and themes observed with respect to the objectives of the study (Bazeley, 2009; Eisenhardt, 1989). The internal validity was also strengthened because of the longitudinal aspect of the study which studied health sector reforms from 2004 till 2011. Conflicting explanations and accounts of

reform were better investigated across time and helped in contextually clarifying these accounts over time. If some ambiguities were observed, and clarifications were required the respondents were contacted again by the researcher to clarify their responses.

5.7.3 External Validity

External validity refers to generalizability of the research findings. Single case studies have been criticised for lacking the ability to be generalizable. In order to ensure external validity the research study draws upon Pollitt and Bouckaert (2004), and Christensen and Lægreid (2007) models of public management reform. The models have been used to guide research and data collection from twelve countries on public management reform. The framework acts as an empirical framework specifying the broad areas/phenomena of interest and has guided the data collection process. These frameworks along with other relevant studies from public management have helped the researcher in drawing insights from the results of the study. Analytically, this study uses the institutional theory literature to further the research findings and to draw implications for future research.

In order to increase the generalizability of case study research, literature suggests that the researcher should provide thick descriptions of events and phenomena in question Seale (1999). Sufficient details were provide regarding the reform interventions and the background and context to the initiation of these reforms were also examined. The case study findings were enriched with the help of two embedded case units within the larger case to validate and provide an insight into the overall reform process.

5.7.4 Reliability

Reliability refers to minimising errors and researcher biases during the conduct of research. Reliability does not mean replication of the results but is about the robustness and rigour of the research which ensures that if the study is repeated again

with a different researcher it will yield the same results Pollitt and Bouckaert (2011). A case study protocol was prepared before the start of the case study which specified the interview guides for the different interviewees (civil servants, consultants, healthcare management and service users). The initial key interviews were done with a broad semi-structured interview guide, which was refined after a preliminary analysis of the interview data obtained. The case study protocol also identified the relevant reform programmes to be covered and to ensure that at least one interview is conducted under each reform intervention in Punjab.

Tests used	Measures taken by the researcher	Stage of Research
Construct Validity – developing operational measures	Using a guiding empirical and analytical framework that draws upon existing research on public management reform and has been used to collect empirical evidence from twelve countries Multiple sources of evidence – interviews from diverse informants, documents, reports and official sources(Yin, 2003:38) Preliminary analysis shared with key informants or Member checking (Yin, 2003)	Literature review Initial Key interviews Summaries shared with key informants before data analysis for validation purposes
Internal Validity	Analytical techniques used Multiple sources of evidence	Pattern matching and generating themes during data analysis Use of notes and memos Data verification by using multiple sources of evidence Partial use of CAQDAS – mainly used for storage, retrieval and coding
External Validity	Rich, story-like descriptions recorded based on multiple sources of evidences to provide an insight into the reform phenomenon	Literature Review and Data Collection phase
Reliability	Case Study Protocols Interview Guides	Pre-data collection phase and initial key interviews Informed Consent Case study database prepared including important documents, interviews and researcher memos

Table 5-4: Validity and reliability tests of this research project

5.8 Ethical Considerations

Ethical considerations are considered an integral component in the design of any qualitative research study because of the tensions that may arise between aims of the research study and participants' rights. Ethical considerations may be defined as steps taken by the researcher to maintain the privacy and rights of the participants of the research study. Ethical considerations are important not only when doing field work but are also important while designing the research process and making sure that the researchers' goal does not conflict with rights of the study participants. As Yin (2003:33-35) notes the importance of using ethical principles by saying that applying appropriate ethical principles can prevent any harm to the research participants, therefore making it imperative for any qualitative research.

Orb et al. (2001) have suggested two main dimensions of ethics in qualitative research: "procedural ethics" which involves acquiring approval from a relevant committee to carry out research involving human participants, and "ethics in practice" referring to the everyday ethical issues that arise during research fieldwork. These two dimensions are used to guide the ethical considerations of the research design of the thesis.

For the purpose of procedural ethical considerations, an ethical approval was obtained from the Research and Support Office, University of Edinburgh. Ethical issues that arise during research fieldwork were countered with the help of Orb et al. (2001) three types of ethical considerations: informed consent of informants, confidentiality of data and consequences of research. The research study was designed by keeping in view the ethical considerations required in qualitative research. A *letter of introduction* from the University of Edinburgh and University of Punjab, Pakistan was obtained to facilitate the data collection process. The letters were sent to Federal Ministry of Health and Health Department, Government of Punjab to gain access to the informants. The informants were assured while

scheduling an interview and requesting access to documentary sources that an official permission to do so has been granted.

Many of the informants in the research were bureaucratic elites, and were quite hesitant in giving interviews and letting go of too much information, which maybe used against them later. Kvale (1996) suggests the principle of autonomy for conducting ethical research, which can be honoured by using informed consent giving participants the right to accept or decline to be a part of the study. *Informed Consent* forms were given to the informants along with a copy of interview guide, and were assured both verbally and in writing about the confidentiality of the interview data and anonymity. Informed Consent Form used during fieldwork is attached in the Appendix. Confidentiality and anonymity were assured to the informants. A copy of the Informed Consent form and the interview guide with researchers' contact details were left with the informants, if they need to refer to it in the future. Identities of the informants are kept confidential and pseudonyms are used to identify the informants in the thesis. Confidentiality and anonymity refer to (Orb et al., 2001) second principle of beneficence which prohibits the researcher from publishing any data that can potentially harm the respondent in the future or may reveal his/her identity. The third principle of justice Orb et al. (2001) was observed by not discriminating between any informants whether it be administrative elites, health care managers, professionals or service users.

5.9 Chapter Summary

The research methods, research philosophy and data collection & analysis procedures are summed up in the table below:

Summary of Research Methodology	
Research Paradigm	Interpretivist/Constructivist
Research Approach	Abductive approach with elements of induction and deduction throughout the research study
Research Design	Case study of Punjab Province, with two embedded district sub-units
Data Collection	Triangulation of data by collecting evidence from multiple sources: Documents and Official reports, Interviews with bureaucratic elites, district health management, professionals and service users Government records and figures compiled under HMIS and DHIS Public sources of information like newspapers, public documents, web.
Data Analysis	Thematic analysis using codes and Bazelay's (2009) 3-step model for generating themes, iterative process between theory and data by using analytical techniques like notes and memos
Data Presentation	Data organised according to the analytical framework developed in Chapter 5 after literature review, triangulated with literature in Chapters 9 and 10.

Table 5-5: Summary of the research methodology

This thesis takes an interpretivist/constructivist stance recognising that reality is socially constructed and appreciates the construction, meanings and experiences of its informants (Patton, 2001; Burrell and Morgan, 1979). The research used case

study as a research strategy and collected qualitative empirical evidence about health sector reforms in Punjab. Data collection involved in-depth interviews from multiple informants from the Punjab government, management consultants, implementation partners and district health management of two districts. Health care facilities in both the districts were visited, where observations were made and service users interviewed to validate the responses from the informants. Multiple sources of data (documents and reports) and informants enhanced the validity of the research findings by corroborating them with each other. Access to documents, reports, official documents and secondary sources enabled the triangulation of data sources enriching and validating the results. The data analysis involved thematic analysis relating to the research questions and conceptual framework of the study. The data was categorised into variables and categories for pattern-matching, supporting the abductive research approach adopted for the study.

The next chapter present the findings from the case study based on the analytical framework of the thesis. The case study findings are presented in two chapters. Chapter 7 maps health sector reforms in Punjab, and draws upon documents and interviews. Motivation to initiate reform, is also reported. Chapter 8 is a bottom up approach to reforms with findings from two case units researched: Lahore and Kasur. This chapter mainly reports the perspective of district health administration, people working in health care facilities and service users and gives us an insight into reforms.

Chapter 7
Case Study - I

Chapter 6   Case Study – I

The findings of Punjab case study are organised in two chapters. Chapter 7 maps health sector reforms in Punjab. It describes the reform programmes, strategies and their implementation. It also examines the motivation behind reform initiatives and how this relates to the internal and external pressures for reform. The chapter draws healvily on documents and interviews to present a validated account of reform in health services in Punjab. Chapter 8 describes the two case studies of Lahore and Kasur, with respect to the reforms and their implementation by drawing on the perspectives of district health administration, people working in health facilities and service users. It a bottom up perspective on reforms in the health sector which focuses on views of informants during reform implementation (district health administration, professionals, staff, and service users.

This chapter reports the findings of the case study of health sector reforms in Punjab in light of the thesis' research objectives. The chapter intends to capture the reform process in health sector: drivers, strategies and implementation in health services during 2004-2011. Organised under four sections, Section 6.1 is an assessment of the Punjab Health Sector; Section 6.2 outlines the aims and objectives of the reform programmes in the health sector; Section 6.3 identifies the themes emerging from data collected during fieldwork and Section 6.4 explains how it was implemented.

The chapter draws heavily on policies, official documents, reports, evaluations and interviews with key informants. Officials are posted in different departments very frequently, and changes in government also resulted in political appointments in the Health Department. In order to make most of the informants' institutional memory, access was requested to official reports, documents and policy frameworks which were not publicly accessible. The information retrieved from these is supplemented with interview responses' to present an accurate picture of health sector reforms in Punjab. The discontinuities and inconsistencies in the responses were complemented with policy documents and reports.

6.1 Punjab Health Sector Assessment

Pakistan is a federation divided into four provinces: Punjab, Sindh, Balochistan, Khyber Pakhtunwa; while Islamabad (the capital territory) and Federally Administered Tribal Areas (FATA) are separate administrative units operating under federal government. Punjab is a strategically important province to the country as 56% of the total population lives in Punjab (Government of Punjab, 2012). Any changes in the social indicators in Punjab have an effect on the overall country indicators.

Pakistan has a mixed health system where the privately financed health delivery system coexists with public health care facilities. Punjab health sector has an extensive network of public and privately managed health infrastructure. The public health sector facilities are primarily financed from public revenues while the private sector is funded through out-of-pocket household expenditure.

The public health delivery system is a three-tiered structure: (i) Primary or First-level health facilities which include Basic Health Units (BHU), Rural Health Centres (RHC), dispensaries and out-reach and community based activities, (ii) Secondary level health facilities include Tehsil Headquarter Hospitals (THQ) and District Headquarter Hospital (DHQ) for inpatient and outpatients, and (iii) Tertiary care facilities include hospitals and specialised medical care institutions present in major cities only (Table 7-1).

Tiers of Public Health Infrastructure	Facilities	Services
Primary or First-level Health Facilities (FLHF)	Basic Health Units, Rural Health Centres and Dispensaries	Preventive, Outpatient and basic inpatient care Out-reach and community-based services for immunisation, malaria control, sanitation, maternal and child health and family planning
Secondary Level	Tehsil Headquarter Hospitals and District Headquarter Hospitals	Outpatients, inpatients and specialist care by referrals or otherwise
Tertiary level	Hospitals, teaching hospitals and specialist care institutions in major cities	Outpatients, inpatients, and specialist care provided

Table 6-1: Tiers of public health infrastructure

The province has an extensive network of health care facilities but service utilisation is very low. In 2011, as many as 74% of those seeking health care services, have accessed private health care facilities in Punjab (Government of Pakistan, 2011a) . Primary health care includes 2,456 Basic Health Units (BHU), 293 Rural Health Centres (RHC) and 188 maternal and child health centres. Secondary health care institutions comprise of 89 Tehsil Headquarter hospitals (THQs) and 36 District Headquarter hospitals (DHQ). In spite of the extensive network of health care facilities, service utilisation is very low.

	Facilities	Number
Primary health facilities	BHU	2456
	RHC	293
	Maternal and Child Health Centres	188
Secondary health facilities	DHQ	36
	THQ	89

Table 6-2: Numbers of health facilities (Source: Health Department, Government of Punjab, 2012)

6.1.1 Key issues and challenges

The overall public health structure is plagued with a number of problems and challenges (Figure 1). Some of the key issues that have a bearing on the reform initiatives of the government can be clustered around the following themes:

Governance and Management of Health Service Delivery

The 2001 devolution of social sectors (education, health and water & sanitation) was not supported by sufficient structural changes and capacity building efforts of the Punjab Health Department. There was ambiguity in terms of roles, policy issues and responsibilities, leading to confusion in chain of command and multiple reporting relationships (Siddiqi et al., 2006; Islam, 2002). Budget planning and execution was transferred to district governments, but they lacked the planning and management capacity at district health departments. The district governments were neither had the capacity nor the political support from the current government. This resulted in lack of adequate funds and decision-making delays. The district governments could only make appointment to lower level posts while the appointment of health care workers largely remained with the Provincial health Department. There was no internal monitoring mechanism to monitor the performance of district health departments.

Federally financed vertical health programmes had their own reporting mechanisms and their integration with provincial health programmes was far from ideal. Their coordination with district health departments was limited and they often worked in isolation from the provincial and district health governments.

Human Resources

The primary health care facilities suffer from many personnel-related problems. While there is shortage of trained staff, there is also a serious problem of staff absenteeism. Low salaries, no residence or transport for health service providers, and weak internal monitoring mechanisms serve as a disincentive to health care workers. Lack of training, medicines and equipment also contribute to making the public health facilities less attractive to doctors and paramedics (Government of Punjab, 2006a). The number of female doctors in the available work force is too low and they are unwilling to work in less attractive rural health facilities. Shortage of female doctors also has an effect on the health-seeking behaviour of women, refraining them for accessing public health care due to cultural conservatism (Government of Punjab, 2006a; Government of Punjab, 2006i).

Health Care Financing

Low levels of public financing gives rise to many problems. Due to this, staff working at public health institutions are not paid at market rates. Better incentives in private health care institutions lead to public health care workers holding dual jobs. Private health care facilities also employ the best in the market and well-qualified, trained health care staff prefers to work in private sector. On the other hand, limited resources also result in poorly maintained public health facilities forcing the users to make out of pocket expenditures at private health care institutions (Nishtar, 2010).

Regulation

Absence of regulatory mechanisms for the public and private sector also affect the quality of health care. Weak regulatory environments also let the private sector to flourish. Due to a proper incentive package for health care workers they set up

private practices resulting in staff absenteeism. The private sector is also home to many quasi-professionals like hakims, chemists, quacks etc., who also provide services resulting in mishaps and negligence (WHO, 2007). Although, Pakistan Medical and Council is responsible for regulating the private health care establishments, its national status and lack of presence in the districts has made it an effective regulatory body.
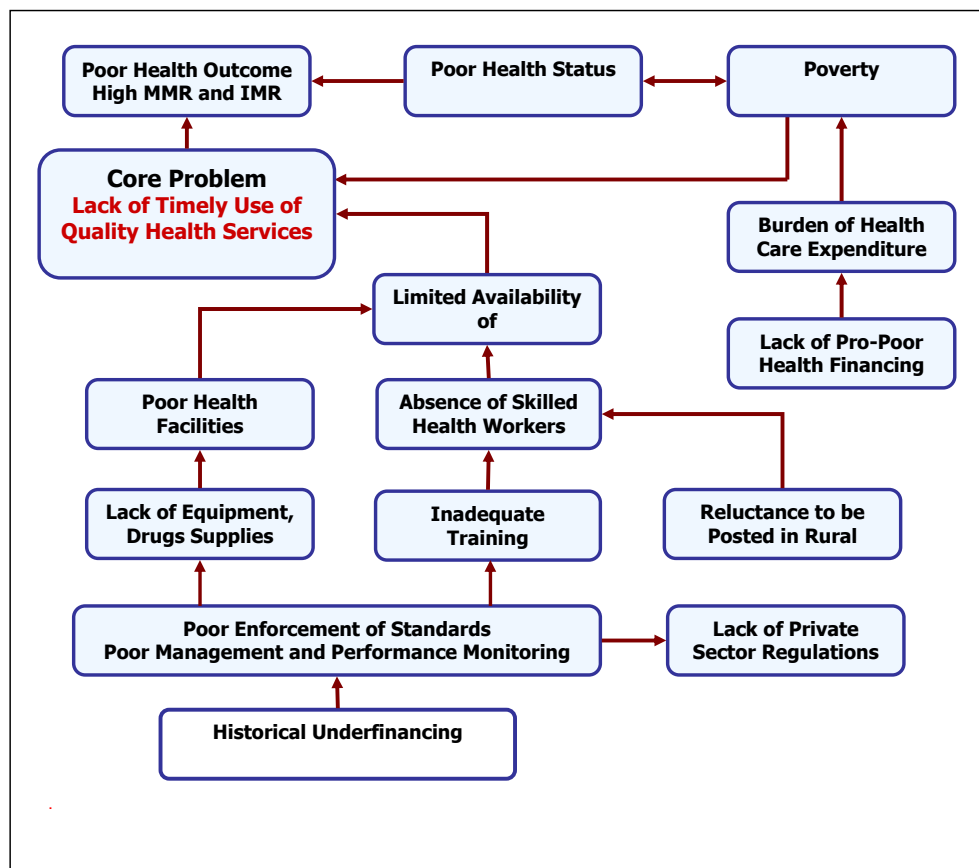
Figure 6-1 Key issues governing poor service delivery mechanisms in Punjab Healthcare System (Source: PMDGP documents of ADB)

Decentralisation and health service delivery

The Government of Pakistan introduced a devolution programme to bring decision-making closer to the public and ensure their involvement in local accountability and improvement management of social services. The local government system was

promulgated in August 2001 through the Local Government Ordinance of 2001. The local governments elected form the third tier of the governance structure.

The local governments are further divided into three tiers: district, tehsil and union councils from the highest to the lowest tier respectively. Each tier has its own council which is headed by a mayor (called Nazim) and a deputy mayor (called Naib Nazim), who are elected from within the council on a joint ticket (Government of Pakistan, 2001f). The district mayor (called Zila nazim) is the head of the district administration. A civil servant is appointed by the district government who serves as the District Coordination Officer (DCO), and reports to the district mayor. The local councils also have the authority to form committees to monitor the performance of executives.

The major source of local government revenue is through inter-governmental transfers made from provincial to the local governments. Provinces transfer the funds to the local governments through a Provincial Finance Commission, and parallel transfers. Parallel transfers are made by federal and provincial governments under specific programmes for example, funds were transferred to the district governments for implementation of reform programmes like Punjab Millenium Development Goals Programme by Punjab Health Sector Reform Programme. Many of these funds transferred are for specific programmes and are conditional grants subject to adoption and implementation. The local governments also have the authority to hold the district executives accountable. The structure for the district health system is given in the figure in the appendix.

Punjab Health Sector Reform Framework

Punjab Health Sector Reform Framework is the policy framework for health sector reforms in Punjab. It maps out the problems affecting health service delivery, the current programmes of the government and proposes strategies and interventions for health care reforms.

> *"The Health Sector Reform Framework seeks to set the tone and direction for comprehensive health sector reforms by clearly defining the strategy and milestones for enhancing service delivery systems in the health sector."(Punjab Health Sector Reform Framework 2006, p.1)*

According to the framework documents', the government believes that reform is essential for the achievement of millennium development goals and to strengthen the devolved health services.

> *"There has been a broad consensus in Punjab that the health sector is in need of fundamental reform in order to reach the Millennium Development Goals and a better impact on the health status of the population, particularly the poor and vulnerable segments in the society". (Punjab Health Sector Reform Framework 2006, p.i)*

The framework also acknowledges lack of resources to realise its objectives and seeks assistance from development partners of the provincial government.

> *" The [Government of Punjab] has instituted a number of reform programmes with the active assistance of the domestic and international partners". (Punjab Health Sector Reform Framework 2006, p.i)*

The proposed reforms are expected to have a positive impact for the Millennium Development Goals with an overall improvement in the quality health care by introducing reforms aimed at strengthening health systems and improving access. The expected outcomes and 'ingredients' of reform as set out in the document are given in the table below (Table 7-3). The policy framework details out each of the issues in the health sector, maps out the current programmes and proposes interventions. For example, in order to address staff absenteeism in the primary health care facilities, it was proposed to design differential incentive packages for health services in hard and in-accessible areas, do incentive-based career planning and increase mandatory period of service for fresh graduates from one to two years. (Punjab Health Sector Reform Framework, p. 7-9). None of the proposed interventions were implemented by the Health Department until 2011.

Expected Outcomes	Ingredients of Reform
Measurable impact on MDGs	Improve performance of health management system
Improvement in health delivery services	Improve access & quality of trained manpower, drugs and technology in health sector system
Significantly reduced instance of disease	
Better Health Management Systems	
Reduction in poverty	Review existing policy framework Health Service Delivery
Social protection for vulnerable population groups	Improve Health Service Delivery Infrastructure
Improved Primary/Secondary and tertiary health care	
Enhanced utilisation of BHU/RHC	Health Mass Awareness
Optimal utilisation of facilities	Introduce Public Private Partnerships
Effective and quality referral system	Broaden health financing mechanisms
Enhanced capacity for planning, costing and budgeting	
Improved capacity for data analysis and research	
Evidence and outcome based planning	
Better patient management	
Community participation and public private partnership	

Table 6-3: Outcomes and Ingredients of Reform (Source: Punjab Health Sector Reform Framework, 2006)

6.2 Reform Programmes in Punjab

The Punjab government has introduced a number of reform programmes aimed at strengthening and improving service delivery in the health sector. The devolution of social services to the districts and the global health agenda under the United Nations Millennium Development Programme has been an important catalyst for reform programmes in health. The following reform programmes were found in the health sector.

6.2.1 Chief Minister's Initiative for Primary Health Care (CMIPHC)

Chief Minister's Initiative for Primary Health Care (CMIPHC) is an initiative by the provincial government to improve service delivery in first level health care facilities. Absence of health care staff and doctors, non-availability of medicines and poor conditions of health care facilities contributed to the widespread failure of these facilities' to deliver.

The management of the primary health care facilities in 12 districts[1] was handed over to a government operated non-governmental organisation Punjab Rural Support Programme (PRSP). PRSP is a provincial rural support programme which was established by the provincial government in 1997 as a not-for-profit 'parastatal' organisation(Batley, 2004a). PRSP was established in 1998 by the provincial government and is working in primary education, basic health, and income generation through micro financing. It is a member of Rural Support Network at the national level, which also supports ten other rural support programmes across the country (CMIPHC, 2008).

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[1] PRSP is managing the first level health care facilities in twelve districts of Punjab, which are Rahim Yar Khan, Chakwal, Vehari, Lahore, Faisalabad, Sahiwal, Kasur, Mianwali, Toba Tek Singh, Hafizabad, Lodhran and Pakpattan.

Punjab government provided the initial endowment fund of Rs.500 million to serve the objective of poverty alleviation through social mobilisation, empowerment and institution building. These funds were invested and the return on investment was used to meet the operational expenditures(Palmer et al., 2008). PRSP has government representation on its Board of Governors and considers itself as a community mobilisation arm of the provincial government. All executives working in the programme (both in Programme Support Unit and District Support Managers) are sent on deputation from the provincial government (CMIPHC, 2008; PRSP, 2013).

CMIPHC started off with contracting out of 104 Basic Health Units in Rahim Yar Khan to PRSP in March 2003. The agreement to contract out the services was between the district government and PRSP. The contracting process was not competitive and an MOU was signed for five years.

6.2.2 Punjab Devolved Social Services Programme

Punjab Devolved Social Services Programme (PDSSP) was a multi-sectoral initiative, launched with the help of funding from Asian Development Bank (ADB) and Department of International Development (DFID), UK[2]. According to the PDSSP mandate, the initiative was to help the government in achievement of Millennium Development Goals by 2015, by strengthening the service delivery mechanisms in the devolved social sector. As per their documents, their main objective was to re-align intergovernmental relationships, establish minimum service delivery standards to support social sectors, strengthen public accountability mechanisms, enhance community participation, promote public-private partnerships

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[2] PDSSP was founded with a loan from Asian Development Fund ($150m), DFID ($25m) and Punjab government's own resources ($5m) PDSSP. 2010a. *Financing* [Online]. Available: http://www.pdssp.gop.pk/financing.asp [Accessed 10th June 2013].

and innovations, and enhance social sector financing (PDSSP, 2010b). 65% of the work done by PDSSP was in the health sector.

Asian Development Bank (ADB) approved the programme on 20th December, 2004 for a $180m equivalent assistance. ADB organised this as a $75m loan from Asian Development Fund, $75m equivalent loan from ordinary capital resources, and $30m grant from Department for International Development (DFID), UK. The Punjab government provided $5m. The duration of the programme was four years and was wrapped up in October 2010.

PDSSP worked on a number of projects, which are laid out in Table 7-4. The most significant contribution of PDSSP has been the Minimum Service Delivery Standards. The programme was adopted for implementation by the Punjab government under Punjab Millennium Development Goals Programme. PMDGP is being implemented by PHSRP. PHSRP is also implementing three year rolling plans for districts and has also incorporated the Costed Monitoring Strategy for internal monitoring purposes.

Strategies and Programmes Proposed	Adopted for Implementation
Minimum Service Delivery Standards (PDSSP, 2008a)	MSDS adopted for implementation under PMDGP by PHSRP
Standard Medical Protocols (PDSSP, 2008e)[3]	Implemented to help achieve MSDS
Standard Operating Procedures for Primary and Secondary Health Facilities (PDSSP, 2008d)	Implemented to help achieve MSDS
Job descriptions and Performance Evaluation Criteria for Medical, Nursing and Paramedical Staff (PDSSP, 2009e)	Under consideration.
Guidelines and formats for five year plans, three-year rolling plans and annual sectoral plans	Revised and adopted for implementation by PHSRP (PHSRP, 2011)
Early childhood care and development(PDSSP, 2009d)	Not adopted for implementation till December 2011
Urban integrated Health Facility Model (PDSSP, 2009h)	Not adopted for implementation till December 2011
Mental Health Care Model for Secondary Health care (PDSSP, 2009g)	Not adopted for implementation till December 2011
Costed Monitoring strategy for social sectors (PDSSP, 2009b)	PHSRP is implementing internal monitoring mechanisms and managing DHIS
Medico-legal system in Punjab:	Not adopted for implementation till

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[3] Standard Medical Protocols and Standard operating Procedures complement the Minimum Service Delivery Standards and were adopted for implementation.

Prospects for Improvement (PDSSP, 2009f)	December 2011
Behaviour Change Communication Strategy (PDSSP, 2009a)	Health Department, Punjab has created an independent Health Education Cell
Public Private Partnership Strategy for Social Sectors (PDSSP, 2009i)	Not adopted for implementation till December 2011

Table 6-4: Status of proposed programmes under PDSSP

6.2.3 Punjab Health Sector Reform Programme (PHSRP)

Punjab Health Sector Reforms Programme (PHSRP) started in 2005 for the uplift and maintenance of physical and infrastructural facilities in first and second level health care facilities throughout Punjab. Later it was brought to assist the Health Department in achieving the United Nations Millennium Development Goals. PHSRP is housed within the Health Department, and helps in implementation of reform programmes. According to PHSRF, it is the implementation arm of the Health Department. PHSRP & Punjab Health Department are implementing the work of Punjab Devolved Social Services Programme (PDSSP), Punjab Millennium Development Goals Programme (PMDGP), School Health and Nutrition Programme, and Punjab Health Care Commission.

6.2.4 School Health and Nutrition Programme

School Health was an important component of health service delivery in Punjab till the 1980s. A need for Health and Nutrition Programme for the school children in rural areas was realised by the PHSRP and its relevance to the achievement of UNMDG. United Nations International Children Emergency Fund (UNICEF) provided the financial and technical assistance for the programme (PHSRP, 2010c). The main objectives of the programme centred around the overall well being of school children by detecting common health problems. For this purpose, a dedicated post of School Health & Nutrition Supervisor was created at every BHU. The staff was also responsible for capacity building exercises for school teachers, to promote hygiene education in school children.

This program is a multi-sectoral initiative and is being implemented with the help of Health Department, Education Department, District Governments and UNICEF. The training manuals for these supervisors were prepared and they were given training at District Health Development Centres.

6.2.5 System-Oriented Health Investment Programme (SOHIP)

SOHIP was a project funded by the Canadian International Development Agency (CIDA) aimed at strengthening the health system. According to the partnership agreement between PHSRP and CIDA funded SOHIP dated 5th September 2008, the programme was for "strengthening of district health management systems and capacity in the province of Punjab, through the development and provision of management training for health and allied managers in province of Punjab."

PHSRP and SOHIP agreed to partner for the following objectives: i)to develop a detailed 'District Health Management Strengthening Implementation Package' which defines and describes district health management functions and provincial support mechanisms for strengthening district health management, and (ii) to develop and implement a province-wide district health management strengthening training programme, based on capacity needs identified by the special committees to enable district health management practice in Punjab.

According to the terms of agreement, SOHIP provided technical and financial assistance including provision of temporarily engaged consultants for the accomplishment of the agreed objectives of the agreement, while PHSRP provided guidance, advice and facilitation for the development of a district-wide health management strengthening training programme. PHSRP will appoint one focal person for each of the objectives from its staff to work with SOHIP and will ensure that they are well-represented in all the relevant meeting and committees in Health Department. With an initial demonstration in two districts of Pakpattan and Mianwali, it was extended to the other districts and was successfully wrapped up on 31st December, 2010.

6.2.6 Punjab Health Care Commission

Punjab HealthCare Commission (PHC) is an independent regulatory authority established after Punjab Health Care Act 2010 was passed in the Punjab Assembly in 2010(PHC, 2011). The government under PMDGP was planning for such a commission to facilitate the implementation of Minimum service Delivery Standards (MSDS) in the province. The main objective of the commission is to regulate the medical practice within the province. Punjab Health Care Commission is also ensuring the standards of medical practice according to the Minimum Service Delivery Standards (MSDS). The Commission is being set up with the Technical Assistance provided by Department for International Development's (DFID) Technical Assistance Management Agency (TAMA). It has evolved after a rigorous consultative process with the stakeholders that included the Health Department, Allied Health Organisation, and Punjab Health Sector Reforms Programme (PHSRP). The inception phase of PHC was implemented with the PHSRP, the implementation arm of the Health Department, Government of Punjab. (PHC, 2011).

6.2.7 Punjab Millennium Development Goals Programme (PMDGP)

Punjab Millennium Development Goals Programme (PMDGP) was initiated by the Punjab government to help them attain health related UNMDGs 4 and 5, which seemed difficult to achieve without wide ranging reforms in health service delivery and pro-poor health financing. The goal 4 and 5 of UNMDGs are aimed at reducing the Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). Public health spending in Punjab was low as compared to other countries in the region. Per capita public health spending in Punjab for year 2009 is about $6.4 which is significantly low than per capita spending of $18.4 in Bangladesh and $74.1 in Sri Lanka(ADB, 2010b).

Pakistan signed the Millennium Declaration in 2000 and committed itself towards the achievement of Millennium Development Goals by 2015. The UN Millennium Declaration set out eight millennium development goals, which were to be achieved

with the help of 18 targets and 48 indicators. Pakistan has adopted 16 targets and 37 indicators to be achieved by 2015. Three of the eight United Nations Millennium Development Goals (UNMDG) are directly related to health and correspond to four targets and sixteen indicators.

The health-related UNMDGs are: reducing child mortality, improving maternal health, and combating HIV/AIDS, Malaria and other diseases. The following table explains the targets for the three health related UNMDGs adopted by Pakistan.

UNMDG 4: Reducing child mortality	UNMDG 5: Improving Maternal Health	UNMDG 6: Combating HIV/AIDS, Malaria and other diseases
Under 5 Mortality Rate (Deaths per 1000 live births) Infant Mortality Rate (Deaths per 1000 live births) Proportion of fully immunized children 12-23 months Lady Health Worker's coverage (percentage of target population) Proportion of children 12-23 months immunised against measles Proportion of children under 5 who suffered from diarrhea in the last 30 days (percent)	Maternal Mortality ratio Proportion of births attended by skilled birth attendants Contraceptive Prevalence Rate Total Fertility Rate Antenatal Care Coverage	HIV prevalence among 15-24 year old pregnant women (%) HIV prevalence among vulnerable group (e.g., active sexual workers) (%) Proportion of population in malaria risk areas using effective malaria prevention and treatment measures. (%) Incidence of tuberculosis per 100,000 population Proportion of TB cases detected and cured under DOTS (Direct Observed Treatment Short Course). (%)

Table 6-5: Health-related UNMDGs: Indicators and Targets (Source: UNMDG 2000 at www.undp.org.pk)

The Punjab Millennium Development Goals Programme is designed around three core policy areas: i) improve the availability and quality of primary and secondary health services, (ii) improve the management of health service delivery, and iii) develop a sustainable pro-poor health financing system.

Punjab Millennium Development Goals Programme is funded by the Asian Development Bank. The programme has been further sub-divided in three sub-programmes for loan disbursement and monitoring purposes. The first sub-programme was completed by 2009 and focused on planning, stock-taking and piloting of the strategies for MSDS implementation. The subprogram 2 focused on implementation and was completed by the end of 2010. The subprogram 3 is currently under implementation, and consolidates the implementation of MSDS and Punjab Health Care Commission. The loan was released upon successful completion of the targets set out for each programme.

6.3 Reform Interventions used in Health Sector

6.3.1 Alternative modes for Health Service Delivery

Pakistan, in principle, favours policies fostering partnerships within social sectors. National priorities regarding alternate methods of service delivery e.g. public private partnerships and non-state provision through non-governmental organisations have been derived from Poverty Reduction Strategy Papers, papers written by Social Policy and Development Centre under the John Hopkins Comparative Non-profit Sector Project (Batley, 2004a), Local Government Ordinance of 2001(Government of Pakistan, 2001f) and National Health Policy (Government of Pakistan, 2001d; Government of Pakistan, 2009b). The Poverty Reduction Strategy Papers (PovRSP) of 2004 and 2010 show government's commitment to stakeholder participation and public-private partnerships. Two pillars of the PovRSP refer to removing infrastructural bottlenecks through public private partnerships and improving governance (Government of Pakistan, 2004b; Government of Pakistan, 2010b). The National Health Policy of 2009 and the Local Government Ordinance both

encourage entering partnerships for health service delivery, wherever the government lacks capacity.

Punjab Health Department has entered into partnership on two programmes. CMIPHC is an example of non-state provision of health services through public health infrastructure. The Punjab Government contracted out the first level health care facilities (Basic Health Units, Rural Health Centres and Dispensaries) in 12 districts to Punjab Rural Support Programme (PRSP). Punjab Rural Support Programme is a government established non-governmental organisation and it is Punjab government's own parastatal organisation(Palmer et al., 2008). The programme has a semi-government status which gives them the advantages of being private sector without the disadvantages associated with public sector institutions (CMIPHC, 2008).

CMIPHC is managing the first level health care facilities in Punjab in partnership with district governments. The district government transfers the physical assets and allocated budget to CMIPHC. A District Support Manager is appointed in each CMIPHC district, who has the autonomy to source drugs, hire and pay doctors on contract. Other than the doctors the rest of the staff working at the first level facilities is paid by the district government.

In order to address the shortage of doctors at the health facilities, CMIPHC came up with a new model and arranged the health care facilities in clusters of three each. The doctor was paid a higher remuneration package (three times the salary as before), and had to allocate and divide his/her time between three health facilities. The District Support Manager had the autonomy to hire doctors on contract with CMIPHC rather than Punjab government. The doctors were hired on a one-year renewable contract. Female doctors were also appointed on contract which increased the number of female patients seeking health care at public health facilities. A cluster of five BHUs was assigned to each Female Medical Officer. Shortage of female doctors especially in remote rural areas kept women from accessing public health facilities due to cultural conservatism.

Although there was no monitoring mechanisms or criteria laid out in the Memorandum of Understanding (MoU), which can help in evaluating the performance of the initiative, it was considered successful by third party evaluators of the World Bank (Loevinsohn et al., 2009)in 2006. A significant increase in the number of people seeking health care at the first level health care facilities was observed. For example, the following table shows an increase in the number of patients treated in the two districts after CMIPHC took over the management of health care facilities.

Districts	Out patients treated in 2003 (before CMIPHC)	Out patients treated in 2007 (after CMIPHC)
Lahore	452, 939	1,476, 341
Kasur	501, 764	1, 668,164

Table 7 -5: Comparison of the number of patients treated at First Level Health Care Facilities in Lahore and Kasur (data obtained during fieldworks from the district governments of Lahore and Kasur)

Managing the staff and operations differently was what made the initiative successful. The overall incentive structure for district support managers (offices, vehicles, running costs and managerial autonomy), was more favourable and conducive to deliver the targets and goals set out to them. This was felt by the District health care managers too and they were of the view that if they were given all these, they would be able to deliver too. The district health government officers pointed it out on more than one occasion.

> *"...if we were given the autonomy to hire doctors and pay them as we want, these health units would definitely have performed"(INT-DHDC-15)*

> *"...they can hire doctors on their own without involving the Health Department...they can obtain drugs and use their annual budgets accordingly as and when the need arises....they get paid three times more than us....if we are given autonomy and an enhanced pay package, we will deliver."(INT-LAH-18)*

Civil servants working in the Health Department were of the view that CMIPHC is not a solution as they are nurturing the curative bias that we have in our programmes. Similar remarks were recorded from the district government offices of Lahore and Kasur, who believed that CMIPHC is not doing anything which was impossible otherwise. They just have the right mix of incentives and autonomy (District Officer Health, Lahore). They were of the view that CMIPHC is only giving results because of their ability to make decisions on their own and a reasonable compensation package.

CMIPHC is a government-sponsored non-governmental organisation, but is dominated by the civil servants from the Punjab government. The rationale behind hiring them was because of their familiarity with the system which will help to reduce the resistance and reluctance the bureaucracy has with such providers. But this initiative has come to a halt after 2008. It is not being extended to other districts as the current government has reservations (Health Secretary, Punjab). As per the government and PRSP secretariat the Chief Minister is not supportive of the initiative anymore (Interviews in Health Department and PRSP Secretariat). The support to the programme has been withdrawn, although it is still functioning in the twelve districts, but is not being extended to other districts.

Punjab government entered into another partnership with National Commission For Human Development (NCHD) for providing integrated primary health care in five districts in Punjab. The program was a pilot testing of a proposal developed in SP1 of PMDGP. The government with the help of ADB and UNICEF was carrying out a third party evaluation of both initiatives during 2010-11 to decided if the initiatives will be extended to other districts.

6.3.2 Community Mobilisation and Empowerment

In line with PRSP philosophy of community mobilisation, CMIPHC organised 'Support Groups' attached to each first-level health facility. The Support Group comprised of people from the local area who were teachers, students, peasants, councillors etc. The group helped in maintaining the health facility, integrated it with the community and also acted as monitors. They met at least once a month and attended the Monthly Review Meetings arranged by CMIPHC at district level. The meeting were well attended by CMIPHC executives, staff, doctors and support groups. As part of the Health Department's Behaviour Change Communication Strategy to create health awareness, some of the district governments arranged walks and health awareness campaigns for the community.

6.3.3 Capacity Building

Capacity building efforts have featured in a number of reform initiatives in Punjab. A grave need for capacity building was identified in a number of government documents and independent evaluations (Government of Punjab, 2006a; Government of Punjab, 2006h; Government of Pakistan, 2010b). Capacity building initiatives have been carried out under various reform programmes. Provincial Health Development Centres and District Health Development Centres conducted training of health care workers. CIDA funded SOHIP conducted training of district health managers and the project was completed in 2010. The district health officers found the training useful and termed it 'as their first comprehensive interface with the system'. The trainings conducted by the Provincial Health Development Centre were more generic and covered all social sectors, while SOHIP training sessions were more focused towards issues specific to health service delivery.

The need for capacity building was also recognised by CMIPHC. Due to the shortage of trained health care workers, CMIPHC did not always have the best in terms of human resource. Another serious limitation for capacity building was that it was very difficult to take the staff away for training and development purposes. The Monthly Review Meetings were taken as an opportunity to address this by inviting one or two resource persons to every meeting to deliver interactive capacity building sessions with the doctors. CMIPHC, Kasur arranged resource persons from a leading teaching hospital in Lahore to conduct a session on recent techniques in gynaecology and obstetrics. Another session was arranged to apprise the doctors about widespread dengue in Punjab, and how to diagnose and refer it to the district hospitals.

In addition to these capacity building efforts, the Health Department and District Health Development Centres also conducted capacity building sessions for the doctors and paramedical staff on regular basis.

6.3.4 Planning

PDSSP developed guidelines for Three-year rolling plans for district governments. The purpose was to strengthen the devolved social services and gear towards the achievement of UNMDG, by engaging the district governments in only planning for things that are actually going to happen and continuously revise and update. The three-year rolling plans are now being implemented by PHSRP, who have made some modifications to the guidelines developed by PDSSP (PHSRP, 2011).

From the PHSRP executives' perspective, they were of the view that it was a good step to engage the district governments to think about their local area and the exercise required an updated statistics, which if they were unable to gather, should be taken from community organisations working in the area.

The district health government staff felt that they are doing similar exercises for a number of purposes, resulting in duplication. They were of the view that a lot of time was spent in preparing reports and meeting deadlines etc. For example, three year rolling plans are monitored and compiled at PHSRP, but the Office of Directorate General of Health Services fulfilled the capacity component of three year rolling plans. Fulfilling the requirements of two offices was reported as 'cumbersome' for district health care managers.

6.3.5 Monitoring and Evaluation

Prior to the PHSRF interventions to improve monitoring mechanisms, Punjab Health Department was responsible for province-wide monitoring of health facilities. A commonly recorded observation was that monitoring activities lacked rigour and were not good enough for evaluation purposes. This was endorsed by Health Department Officials (Interviews with Special Secretary Health & Joint Secretary Health). The Health Department used to conduct monthly, quarterly and annual monitoring of development schemes and public health interventions on a prescribed format designed by Planning & Development Department. The focus of these

monitoring activities was on the utlilisation/non-utilisation of funds and providing justification for purchases made. Some monitoring activities of certain health care facilities were also carried out by the department on special directives issued by the Chief Minister or the Prime Minister, usually in response to issues brought to their attention by politicians or media (PDSSP, 2009b). Information was also collected through Health Management Information Systems (HMIS) in Office of Directorate General of Health Services Punjab. HMIS was introduced in 1990s with the help of USAID, and was used for collecting data from primary health facilities. The system needed revamping after the devolution of health sector.

PHSRP introduced two major Monitoring & Evaluation interventions proposed by Punjab Devolved Social Services Programme: Internal and external monitoring conducted by government officers, and District Health Information Systems (DHIS). Internal monitoring was carried out with help of directors of District Health Development Centres[4]. As District Monitoring Officers, they visited the health facilities and evaluated them on the basis of Clinical Performance Indicators (13 clinical performance indicators for BHU and 19 clinical performance indicators for RHC). Administrative inspections were also done by the District Coordination Officer's[5] Office (PHSRP, 2010b).

The external monitoring of health facilities was done by Chief Minister's Monitoring Force (PHSRP, 2010a). District Monitoring Officers were appointed in districts to conduct monitoring with the help of Monitoring & Evaluation Assistants. The monthly monitoring reports were shared with PHSRP's Programme Management

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[4] District Health Development Centres are district hubs for training health care workers and strengthening the devolved health services. They are present in all 36 districts in the Punjab and work closely with the Executive District Officer (Health).

[5] District Coordination Officer is the head of district administration.

Unit (PMU) who shared the reports with district for feedback or any relevant action. The reports and statistical indicators are compiled and analysed at PHSRP for further use and action.

Internal monitoring exercise was quite comprehensive but their emphasis was on physical and human resources. Notes of the monitoring report of District and tehsil Headquarter Hospitals of Kasur have pointed out staff-absenteeism, vacant posts, punctuality of health care workers, overall condition of the facility like for e.g. landscape around the hospital, cleanliness of toilets, sign boards and directions to the facility (Field notes of district Kasur, March 2009). In Lahore, hundreds of posts were found vacant in the hospitals (Field notes of district Lahore, April 2009). From the tour notes, and the guidelines issued to the monitoring officers it is apparent that the overall focus of the monitoring exercise turns out to be more on the missing facilities like staff, physical infrastructure, drugs and equipment, and less on the quality of service provided.

Director, Monitoring and Evaluation of PHSRP also indicated the lack of capacity, sufficient, and resources to carry out the monitoring and evaluation exercise.

> *"Due to capacity constraints of the monitoring staff, we are not able to evaluate as many aspects of health care as we want to… Something is better than nothing, maybe some day we will have the resources to do a state-of the art monitoring and evaluation exercise"(INT-PHSRP-4)*

District Health Information Systems (DHIS) were introduced in all Punjab districts in 2008. The system was introduced with technical and financial assistance from Japan International Cooperation Agency (JICA). JICA implemented a study on improvement of MIS in health sector (2004-2007) in four districts in Pakistan. The study culminated in a DHIS and a National Action Plan for the nationwide implementation of DHIS. The plan was enhanced for nationwide implementation under a new project funded by JICA in 2009 for a period of three years. JICA was responsible for installation and maintenance of DHIS software and to provide adequate training to the staff responsible for entering data and generating reports. It

will oversee the overall implementation of the project and provide technical assistance for smooth and effective implementation.

DHIS has been implemented and has received a positive evaluation from an appraisal done by World Health Organisation. Majority of the staff at health facilities have been provided the relevant training for the software. The reports are submitted to PHSRP on monthly basis. The implementation of the programme has been done effectively in all 36 districts of Punjab.

6.3.6 Hiring consultants for Technical Assistance

Almost all the technical assistance components carried out in the Punjab Health Sector (for example PDSSP) were carried out by consultants contracted by the Punjab Health Department. Health Consultants were hired through a competitive process, and should comply with the requirements of the development partners. According to the Loan Negotiation minutes of PDSSP with ADB, Government of Pakistan has assured the development partners of only hiring consultant that meet their seal of approval. In another instance, under the Programme Agreement of Punjab Millennium Development Goals Programme, ADB has urged the Health Department to bring in consultants for capacity building.

> *" In carrying out of the Programme, Punjab shall employ competent and qualified consultants and contractors, acceptable to ADB, to an extent and upon terms and conditions satisfactory to ADB" (Section 2.03 of the Programme Agreement) (ADB & Government of Punjab 2008)*

CONTECH International (a health management consultancy firm) was contracted to work in 90% of the projects in Punjab. Almost all ADB-funded and DFID-sponsored projects worked with CONTECH.

6.3.7 From 'Quantity' to 'Quality' of Health Care

The UNMDG and the government's commitment towards achieving them by 2015 have forced the government to make a major priority shift in their programmes. The

programmes are now designed for quality of health care rather than multiplying the quantity of health care facilities. Punjab Government notified minimum Service Delivery Standards (MSDS) for implementation in December 2007. The objectives of MSDS are to "provide a common set of requirements applicable to the whole health care system, provide a framework for continuous improvement in overall health care and identify mandatory system requirements to ensure the delivery of quality health services" (PDSSP, 2008a).

MSDS is a set of interventions, which address the major causes of the burden of disease, primary health care provision and will be used to determine allocation of public funds and inputs. This will eventually lead to public heath spending according to the needs and priorities of the area, and will specifically address the local problems. The services package covers preventive and curative services, promotive services and rehabilitation services. MSDS includes the provincial as well as the vertical programmes in Punjab. The standards will be applicable to both provincial and vertical programmes (PDSSP, 2008a). Obligations for health care providers' obligations', patient's rights and obligations, minimum human resource requirements and essential drugs and supplies etc are specified. Minimum Service Delivery Standards are complemented by two important document 'Standard Medical Protocol' and "Standard Operating Procedures'.

Under PMDGP, the government has started implementing maternal, neo-natal and child health related MSDS for general public and health care workers by completing an awareness campaign across Punjab. In addition to this the districts have updated their three year rolling plans, which were prepared under SP1 of PMDGP. So far, seven districts have conformed to the MSDS, and PHSRP expected more districts by the end of SP2. All 36 district have signed a MoU with the provincial government to reach MSDS by 2012 (ADB, 2010b). The provincial government is also addressing the staffing concerns of the health facilities. While there has been an improvement in the condition of the paramedical staff available, there is still a serious shortage of

Female Medical Officers. According to PHSRP, 60% posts of gynaecologists and 48% for anaesthetists were vacant in June 2010.

6.3.8 Motivation to reform

For CMIPHC, the bureaucracy on the whole was not very keen on pursuing the proposal made by the district government of Rahim Yar Khan in 2003. But the Chief Minister of Punjab, pushed the project forward and implemented it, because of government's inability to deliver in the first level health care facilities. It is apparent from the Chief Minister's decision that he wanted to bring in a new management culture into the state working and resort to non-state providers.

Almost all the respondents identified PHSRF and UNMDG to be the reason for health reforms. According to Punjab Health Sector Reform Framework, it is a document that maps the existing reforms in health sector, lists the key issues affecting health service delivery and intends to set the 'tone' and 'direction' for reform. This document has been prepared by the Punjab Resource Management Programme and the Health Department, Government of Punjab.

The respondents also argued that the government's desire to achieve Millennium Development Goals by 2015 is also guiding the current reforms. The respondents shared that it was clear from the federal government that they wanted us to show some substantial progress towards Millennium Development Goals.

> *"...Punjab as you know is the most populated and if there is an improvement in indicators and services in Punjab it affects the country indicators too…. the government wants to show its commitment towards achieving the MDGs by introducing the health reforms."(INT-PDSSP-3)*

Majority of the respondents also argued that devolution of health and other social services to local governments has also been the reason for many capacity building reform initiatives in the health sector. They shared that the health sector reforms were a much-needed step to consolidate the devolved social services. The Local Government Ordinance of 2001 introduced a third tier of government at the district

level. Health, which was a provincial subject, was handed over to the district governments. Since local government system was fairly new, a number of teething problems were experienced and there were issues of coordination, and a general confusion among the newly elected and appointed district government officials regarding the responsibilities they will assume.

> *"…local governments are good but the system needs to be developed more and issues of coordination need to be sorted out…we don't have trained people to run the executive branch of the district governments….these executives were not ready….and a lot of money was pouring in to strengthen devolution efforts." (INT-MOH-2)*

A small number of those interviewed were also of the view that these reform programmes were a way to serve the interests of the civil servants whose pay packages were enhanced as a consequence of reform. They were of the view that the reform agendas are being pursued because these result in new structures and departments and provide better pay packages to those working in them. The example quoted was that for Chief Minister's Initiative for Primary Health Care and Punjab Devolved Social Services Programme where the government had been appointing its staff on deputation (CMIPHC) with an enhanced salary package, or Punjab Devolved Social Services Programme where the positions were advertised and filled from executives from the Punjab government.

> *"…and then these reforms they bring in opportunities for top executives also. They work in newly created departments and units with the donors and development partners and they get an enhanced pay package….take for example the CMIPHC…they get three times the salary that we get…if we are given the autonomy and money they are getting, we may do it better." (INT-LAH-19)*

Interview respondents also argued that the reforms were a genuine interest of the government to improve health service delivery across the province. The politicians know that health and education are the two most talked about mandates when the elections are approaching. They need something to show to the public. They were of

the view that the governments irrespective of their party affiliation are always looking to improve the social sectors of education and health.

> *"....education and health have been near and dear to the governments I have worked with during the last ten years of my service…..these are the things that give politicians mileage during elections."(INT-PDSSP-1)*

Some respondents expressed the belief that the reform efforts were a way to lure donors to invest funds in your programmes. They argued that the reforms agendas were a way to get loans and assistance from the development partners of the government. The government has a budget deficit every year and they need such development assistance to function. The condition of the health services is deteriorating rapidly due to a rapid increase in population.

> *"we do not have a public health infrastructure that can cater to the needs of the entire population….the trust issues that people have with our institutions are a blessing in disguise… private health care institutions are flourishing because we have failed the public by not providing what they want."(INT-KAS-20)*

Some of the respondents also expressed that the current reforms are due to the special interest of the Chief Minister. The Chief Minister of Punjab did not appoint a Health Minister in his cabinet, because he was especially interested in improving heath services in the provinces. He looked after the Health Department himself, and as one respondent pointed out:

> *"CM is very passionate about health and spends a considerable amount of his daily time looking after Health Department matters. He wants to make a difference in health services."(INT-PHSRP-3)*

The most striking observation to emerge from the comparison of responses of different groups of respondents is the responses from top executives who in the beginning completely ruled out any role of the developmental organisations in setting the reform agenda. But on further probe, and reference to Punjab Health Sector Reform Framework which indicates the donors involvement in the reform process, they did acknowledge that these reform have been funded with the help of

development assistance from Asian Development Bank and DFID. They were of the view that we decide what needs to be done under the reform programmes i.e. executives working in Health Department and the Chief Minister, and these organisations only provide funds and assistance to implement them.

The Health Consultants that were contracted to work on technical assistance components of the projects were of the view, that the Health Department does not have the capacity to do research and devise comprehensive programmes. According to one of the consultant interviewed, who was an ex- government executive working with the Health Department "the reason I am doing well is because I know the system inside out". But he also pointed out that the international best practices that have given good results globally should be adopted. One of the Health Consultant who had worked on the preparation of standard medical protocols and other performance related exercises responded

> *"...international practices are where we start....we see what is happening in for example United Kingdom, eastern Asian countries...I have a team and I make sure they know what is happening all over the world, so that we can introduce similar programmes here in our country."(INT-CONT-10)*

During the visit to health care facilities in Lahore it was observed that people being treated at the health care facilities were ignorant about any reform initiatives or programmes that have been introduced in the health sector. As one of them responded to a question as to whether the services have improved during the last few years,

> *"we don't know of any reforms programmes that may have improved service...I haven't seen any change lately, except that I think there are more doctors in the hospital now, but the waiting times are the same.....otherwise, I visit this hospital almost every two weeks and it has been the same."(INT-KASU-21)*

On the other hand, a patient at the first level health care facility in Kasur (rural), when asked about the reforms responded in affirmative and replied:

"things have greatly improved since these new people have come in ...we have medicines here....we are even trying to build a wall around the health centre...they regularly visit here too....we have a female doctor who comes every week."(INT-KASU-24)

The patients being treated at a BHU in Kasur were quite happy because they now were sure of the doctors presence at the health care facility. One of them was quick to point out at the complaints/feedback register and said that he could record any complaints if he wanted and the District Support Manager took notice of it.

6.4 Implementation

6.4.1 Establishment of new structures

Punjab Health Department created new units and structures to help with reform implementation. Punjab Health Sector Reform Programme's Programme Management Unit was created to work on the missing infrastructural facilities throughout the province. Later in 2006, it was declared as the implementation arm of the Health Department and was mandated to implement PMDGP and PDSSP-led initiatives. PDSSP was also a separate unit that was set up for capacity building purposes. PDSSP worked with the Health Department but was not a subsidiary of the Health Department.

Punjab Health Care Commission was created to regulate the public and private health facilities and to ensure effective implementation of MSDS in both public and private facilities. PHSRP has helped the Health Department in establishing the Commission.

Health Education Cell was created within the Health Department to work on Behaviour Change Communication Strategy proposed by PDSSP. The strategy focuses on preventive care and health education by circulating leaflets, holding walks and campaigns within the districts. The District governments are responsible for holding and coordinating the activities.

6.4.2 Legislation

Three important legislative measures, were taken to support reform efforts: Pakistan local Government Ordinance of 2001, 18th Amendment to the Constitution of Islamic republic of Pakistan and Punjab Health Care Commission Act. Pakistan Local Government Ordinance 2001 was promulgated in 2001 for the new local government system throughout the country. It devolved the social sectors of education, health, and water and sanitation.

In April 2010, 18th amendment to the Constitution was passed in the Assembly which devolved the health sector completely to the provinces (Government of Pakistan, 2010a). As a result, federal Ministry of Health was abolished and the health functions were to be transferred to provinces. The public health intervention programmes managed by the Federal Ministry of Health were to be handed over to the provinces in 2011.The Federal Ministry of Health has been abolished, and the transfer of functions and programmes is still in process.

Punjab Health Care Act 2010 (Government of Punjab, 2010)was passed in Punjab Assembly for the regulation of the public and private health care facilities. Private health care facilities are an important part of the health care system, but due to lack of licensing and registration practices, it was difficult to oversee the performance. Regulation of the private sector was also important for the implementation of MSDS. Two of the three important legislation measures by the governments have decentralized health services to provinces and districts.

6.4.3 Conditional Grant Mechanism

Conditional grant mechanism for release of funds for implementation of MSDS was in place for districts health budgets under PMDGP. As per Programme Agreement signed between Asian Development Bank and Government of Punjab (2010a) , the conditional grants will be disbursed within one month subject to the conditions met as set out by the provincial government. The grants were in addition to the district

health budgets for the implementation of MSDS and other related activities. A 10% of the conditional grants was allocated for capacity building activities (Punjab Health Department, 2008).

6.4.4 Top-down implementation

It was commonly recorded that decision-making and implementation around reform programmes is done by the senior bureaucrats in the Health Department and Planning & Development Department. Representatives of Pakistan Medical Association (association for doctors and professionals) and Young Doctors Association (Professional association for younger and junior-level doctors) were of the view that the system lacks the capacity to involve stakeholders in decision-making.

> *"At times we are called to meet and to attend meetings, but what happens eventually is what is decided by these bureaucrats. We are only called to one or two meetings probably just to show that the process specified in the guidelines issued by donors was followed…honestly I don't even remember if I ever went to one either."(INT-LAH-26)*

The senior civil servants were of the view that there are so many factors that need to be taken into account while planning for important structural reforms, which cannot be captured and visualised, by the service users or the professionals in our organisations. The representatives from the community and professional associations have a very myopic view of the problem, and although there are better solutions to the problem at hand, but we have to see what is feasible and can be implemented e.g. availability of resources is an issue. Planning and capacity building initiatives under PDSSP were claimed to be a product of consultations and feedback from all the important stakeholders.

6.4.5 Structural Impediments to implementation

Prior to devolution, health service delivery was the responsibility of provincial governments. The provinces provided these services by appointing staff throughout

the province at all levels. The medical staff reported to the Director General (Health Services) through various Directors (Health). After devolution, the control over the staff is now exercised by Director General (Health) at the provincial level and Executive District Officer (Health) at the district level. This has resulted in dichotomous relationships for the staff working in districts. There is duplication of functions for example, during 2010-11, two HMIS were being maintained and operated: one in PHSRP called the District Health Information System, and the other one was in HMIS Cell in Director General Health Services. The districts were providing data to both the systems till the successful transition to DHIS.

The district governments only had the authority to appoint medical staff in the district up to Grade 16. This included the paramedical staff, administrative staff and other miscellaneous staff within the health facilities. The appointment of doctors and other specialised health care workers was the responsibility of the Provincial Department. This was reported as a cause for delay in implementation of MSDS by the EDO(H). The lack of capacity among the district governments has also been identified as a hinderance to the implementation of local government systems in third party evaluations (Nayyar-Stone et al., 2006).

6.4.6 Fragmented Implementation

The overall implementation of the district health system and the subsequent reforms was reported as fragmented. One of the main reason contributing to this was lack of capacity of the Executive District Officers EDO(H). There is no management cadre within Health. The appointees are medical graduates who have a diploma in Public Health & Management and they are posted in different districts. They do not have any prior management experience. There is lack of management education and since the district systems are still in the process of evolution, this leads to fragmented implementation.

Successful implementation examples were attributed to two factors: high literacy rates and the management skills of EDO (Health). The districts in Northern Punjab

with higher literacy rates were better in terms of sector-wide implementation of newly devolved systems. The respondents also attributed this to the Executive District Officers (Health).

> *"This can easily be linked with EDO (Health) in these districts. There is one officer who has served in two places very close to each other in Punjab. Both these districts were not doing well in terms of BHU and RHC indicators, and one of them was doing too badly. The way he raised these districts clearly showed that it's because of him. The day you pull him out it will all go down."(INT-PDSSP-1)*

6.4.7 Lack of ownership

Implementation has been pre-dominantly top-down and this has resulted in lack of ownership in reform. The district governments were seldom involved in formulation of plans and strategies. The elected government did not support the local government system fully and the district health officers felt that "the fate of the system was hanging in balance". This contributed to lack of interest and general lack of ownership among the district health officials.

> *"we are trying our best to implement the MSDS, despite the situations like floods and dengue. Lack of proper staff at the health facilities is a major obstacle to effective implementation and we can do nothing about it."(INT-LAH-18)*

Tour notes of monitoring of health facilities in Kasur reported that the Radiology Department of a hospital in Kasur was working without a Radiologist and an untrained technician was technically the incharge of running the entire department. The Monitoring Officer urged the Hospital Incharge to report the matter to provincial health department, which till now was not done. The hospital incharge was of the view that these matters will be resolved in their own time. My requests will be filed and will be of no use(Tour notes of Kasur, April 2009).

6.5 Chapter Summary: The Reform Process

Looking at the evidence from health sector, an overall picture of the reform process emerges. Due to the fiscal deficit and the economic condition of the country, Pakistan is highly dependent on foreign aid and development assistance. All except one programme, have been funded with loans and development assistance from the development partners of Punjab Government. Department for International Development (DFID), UK and Asian Development Bank have been the prominent development partners in health.

The health sector reforms are products of decisions that are highly centralised. The bureaucrats and senior civil servants in the Health Department dominate the centralised decision-making. Despite having a local government system in place, and devolving the health sector to provinces and governments, formulation of development plans in health is concentrated in the provincial Health Department. This has been a reason for lack of ownership among the health care managers in districts. While there was a lack of ownership and enthusiasm was observed in the district health care managers, the officials working at the Health Department were quite optimistic about the reform initiatives and improvement in service delivery.

Punjab Health Sector Reform Framework is the core policy framework for the current phase of reforms in Punjab health sector. PHSRF is based on Poverty Focused Investment Strategy of Punjab (the provincial strategy for National Poverty Reduction Strategy Paper). Poverty reduction Strategy Papers and UNMDG are the core national policy framework for development plans in social sectors.

The reform interventions have been varied, but an overall shift towards improvement in quality of health care can be seen. Benchmarks for good quality health care have been developed under MSDS with the implementation of 'Standard Operating Procedures' and 'Standard Medical Protocols'. An overall shift towards service quality is evident from MSDS and other PMDGP reform interventions. Capacity building has also featured on multiple reform programmes. Regulation of the private

sector health facilities has also been a theme realised under Punjab Health Care Commission.

Implementation has been predominantly top-down with directives coming from the Punjab Health Department. PHSRP serves as the implementation arm of the Health Department with a few dichotomous relationships and duplication of functions was observed with Office of Director General Health Services. Due to the absence of efficient monitoring mechanisms the implementation of reforms was patchy and fragmented with some districts giving better results than the others. Literacy rates and EDO (Health)'s capacity to manage have an affect on the implementation progress.

Different motives for public action were observed in the responses. It was widely recorded that the formulation and implementation of reform was done by bureaucrats with Chief Minister's support. The decision-making process of the elite/top bureaucrats is influenced by a number of factors like securing development loans for the social services, bringing in money to reduce the effects of fiscal deficit on quality of social services, and at times their own personal interests like for example reform programmes with development assistance usually gives them opportunities to work for a better incentive package. Bureaucrats almost always enjoy the support of the Chief Minister in office. It is a well-established fact that the appointments to these positions are done by the political party in office, and they appoint like-minded bureaucrats.

Development partners were integral to the reform process. The financial and technical assistance of development partners came with a few conditions. Establishment of separate Programme Management Units and hiring of consultants was set in programme agreements. A review of the loan negotiation minutes and documents showed that the loans and development assistance programmes were approved because of the country's commitment towards UNMDG (which also features on ADB's agenda for development) and Poverty Reduction Strategy.

Chapter 7
Case Study – II

Chapter 7   Case Study – II

The previous chapter maps health sector reforms in Punjab by reporting drivers, strategies and implementation practices in the Health Department by drawing upon interviews of administrative elites, implementation partners and management consultants in addition to documents, legislation and third party evaluations. This chapter reports the findings from the two case units examined within Punjab. The case units were investigated with the following objectives:

- To investigate the implementation of health sector reforms and their impact on service delivery arrangements

- To delineate the role of district health management, see the working and implementation of reforms and to look for any implementation gaps

- To get the perspective of service users

- To capture any implementation differences between rural and urban reform implementation within the district

The findings are reported with respect to the research questions and also include the service users' responses. Results reported also draw on monitoring reports and views of the district health administration, health care managers and service users from the following health facilities. The responses are organized under the emerging themes with respect to the research questions.

Lahore and Kasur districts were selected based on the urban-rural component. Lahore being the provincial capital and a metropolitan city, exhibits a different health-seeking behaviour than Kasur, which is primarily a rural district. (District maps with health facilities attached in the Appendix)

7.1 Impact of devolution on healthcare – emerging district health administrations

One of the most significant government reforms in recent years has been devolution in Pakistan. Devolution is a reform initiative that began in 2001 when the Local

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Government Ordinance was passed. Local government elections were held in between December 2000 and September 2001 which resulted in appointment of approximately 200,000 new officials in district governments across the country (Nayyar-Stone et al., 2006). A discussion paper "Local Government Plan", was written by National Reconstruction Bureau (NRB), specially constituted to plan and initiate the reform for the military government. This document suggested a "top-down" devolution exercise led by the Federal Government, with elements of (i)"bottom-up involvement" of citizens to be carried out through elections at various levels (ii) the establishment of Citizen Community Boards to initiate local capital investment projects, and (iii) establishment of monitoring committees to oversee service delivery under devolution (Government of Pakistan, 2000).

The official goals for devolution, as put forward by the National Reconstruction Bureau were popularly known as "Five D's" referring to (i) Devolution of Political Power (ii) Devolution of administrative authority (iii) distribution of resources to districts (iv) deconcentration of management functions, and (v) diffusion of the power-authority nexus (Government of Pakistan, 2000).

In the current administrative setup, districts are key to public service delivery especially health and education, given the broad functional assignments. The districts are important, as they signify an intermediate level of government that can reflect and voice citizen preferences and differences. The provincial government departments are too remote to accomplish the achievement of responsive and effective service delivery mechanisms. Moreover, the assignment of health and education to the district level is also crucial for the achievement of Millennium Development Goals and other poverty reduction strategies of the government as given in the Poverty Reduction Strategy Papers (Government of Pakistan, 2004a).

Health service delivery was the responsibility of the provincial government before devolution. Staff was posted at the district and sub-district levels by the provincial governments, while the medical staff reported to the Director General (Health) through Directors (health) responsible for various functions. All the tiers of health

service delivery infrastructure except large teaching hospitals with attached medical or dental institutions were devolved to the districts. At the time of the fieldwork for this research project, control over medical staff was exercised by Director General Health's Office and the district health administration (see Figure 8-1).
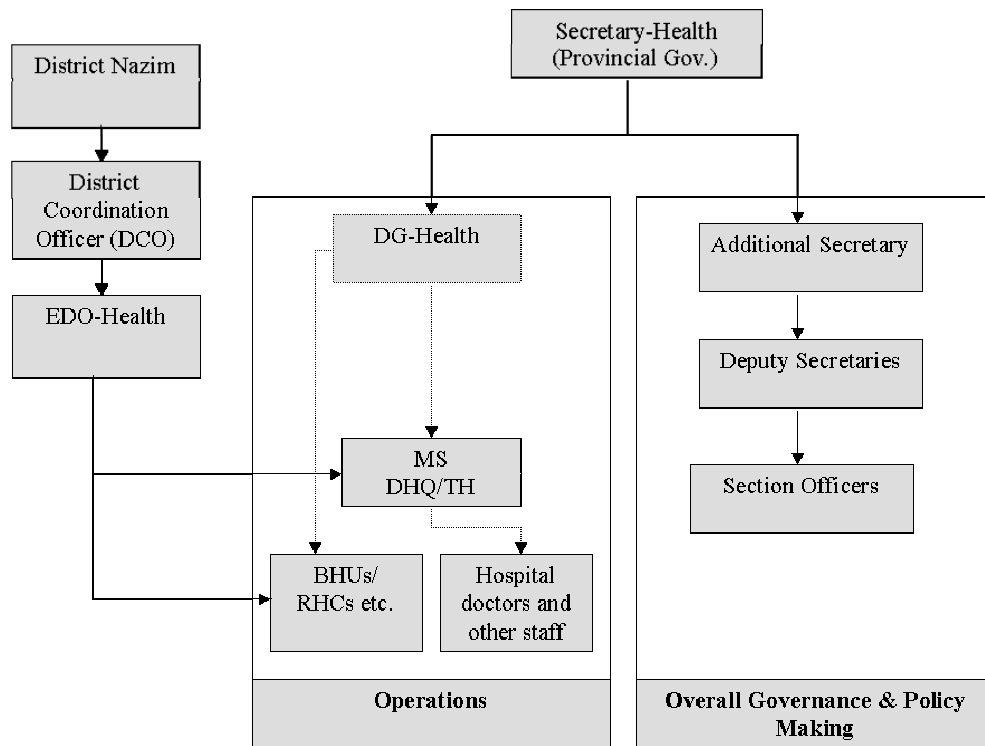
Figure 7-1: Overview of the intergovernmental relations in the health sector (Source: Nayyar-Stone et al., 2006)(repeated from Chapter 2)

Key: MS – Medical Superintendent, DHQ – District Headquarters Hospital, THQ – Tehsil Headquarters Hospital, BHU – Basic Health Unit, RHC – Rural Health Center

According to the Local Government Ordinance of 2001, the health service functions transferred to the district governments are basic & rural health, child & maternal health, population welfare, and tehsil and district headquarter hospitals (Figure 8-2). Executive District Officer (Health) is the person responsible for the execution of these functions. The staff working with the provincial Health Departments in the

filed in primary and secondary health care facilities was transferred to the district governments. It was learnt that the transfers and postings of medical staff working in the districts is still handled by the provincial health departments. The district health administrations of both the districts (Lahore and Kasur) were keen in pointing out and felt that this was a major hindrance in smooth functioning of the district health governments.

> *"....We should be dealing with the transfers, postings and other day to day affairs pertaining to the staff within the districts, but Health Department is reluctant in letting go of the power this brings to them. We on the other hand are left with autonomy in dealing in staff issues of people working in the lower grades....Power is hard to let go of ...."(INT-KAS-17)*
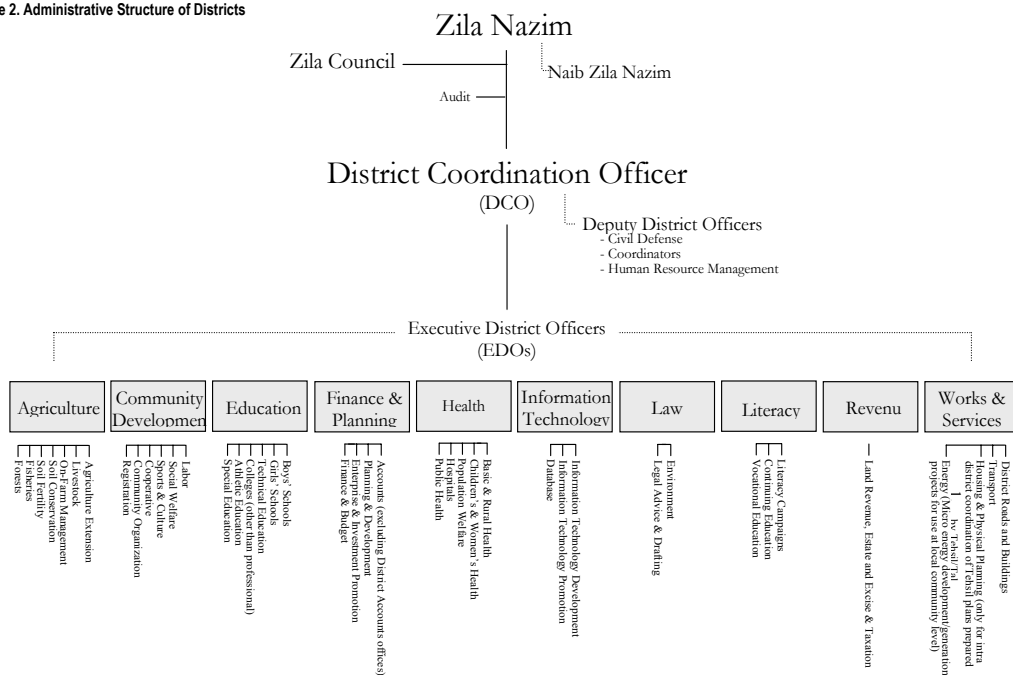
Figure 7-2: District Administrative Structure (Source: Nayyar-Stone et al. (2006))(repeated here from Chapter 2)

7.2 Embedded case unit I - Kasur

The district Kasur is a rural district with almost 69 % of the population living in rural settlements. For the purpose of research, the following were interviewed within Kasur:

1. District Coordination Officer (DCO)

2. Executive District Health (Officer) Health

3. Director, District Health Development Center (DHDC)

4. District Support Manager – Chief Minister Initiative for Primary Health Care (CMIPHC)

5. Doctor-In charge at BHU

6. Doctor In charge at dispensary

7. Female Medical Officer at BHU

8. Medical Officer Incharge at Rural Health Center, Mustafa Abad, Kasur

9. Female Medical Officer at Dispensary, Kasur

10. Deputy Medical Superintendent, DHQ, Kasur

11. 5 service users (2 at BHU, 2 at dispensary, 1 at DHQ)

7.2.1 Themes from Kasur Case

Forming district governments and district health administration was one of the most significant reforms implemented in Kasur. The district health administration along with the provincial health department and Punjab Health Sector Reform Programme's Project Management Unit (PHSRP-PMU) was implementing reforms towards the achievement of United Nations Millennium Development Goals (UNMDGs). The district health administration was constituted and brought in the office with the objective of more responsive, and efficient and service delivery, which will also help in the implementation of reforms to help the achievement of MDGs. The following themes emerged from the interviews, observations and documents obtained during Kasur visit.

Limited authority

Executive District Officer (Health) was of the view that the devolution plan was not perfect but it was good compared to the other reforms the governments have introduced over the years.

> *"...the devolution plan isn't the best our country can have but I would say that still it can do a lot of good for our system. In the past, health service delivery was captive in the hands of provincial health departments and they hardly had any idea what was going on in Southern Punjab or other remote districts. They were drowned in paper work, day to day affairs of the department, paying salaries etc. to actually be bothered about what is actually happening in the province....In my opinion, district governments have really covered the health facilities all over Punjab, but in order for them to be effective and bring about a change, they should be given more empowerment financially and in other routine matters too. It seems that the only thing they want us to do is appoint peons, chowkidars, janitors etc"(INT-KAS-17)*

The above quote reflects that the district health administration, which has been formed with people who previously had no experience in running district functions and most of them were doctors with no background training wanted power and authority, which in their view was enjoyed by people in Health Department.

> *Procurement of medicines has a very long procedure...though, not just medicines but other goods too...budgets are not physically transferred to us...we have to provide the department with invoice and get approval...a very lengthy and time consuming procedure which could have been handled at district level. (INT-KAS-20)*

Budgets were not physically transferred to the districts, which led to delays. EDO (H) Kasur also reported that approved invoices need to be sent to Accountant General's Office in Lahore, to pay for medicines, contingencies or other routine equipment.

The District Coordination Officer of Kasur was also of the view that some sort of managerial authority should have been given to the district health administration esp. regarding appointment of doctors and para-medical staff. Shortage of staff and staff

absenteeism were quite common within the district health facilities, and human resource issues are dealt with by the provincial Health Department causing substantial delays and gaps in service delivery.

> *I wish they had at least transferred some of the authority to the districts…I have approximately 13 vacant posts at DHQ, Kasur….and there are a few locals who are interested in applying… but it is all up to the Health Department, they will advertise it and the procedure will take months…eventually the people hired will come from all over Punjab, and may not be true for all the cases, but we will encounter turnover and absenteeism.(INT-KAS-20)*

Training and capacity building

The district health administration, in addition to consolidating health care management under devolution was also responsible for training and development of the doctors and paramedics. These training were held under the District Health Development Center (DHDC) which was also training doctors for Minimum Service Delivery Standards. DHDC was regularly running training programmes in the district, which ranged from a one-day crash course wanting to create awareness (e.g. Dengue Awareness) or also engaged specialised doctors from Teaching Hospitals in Lahore to deliver short training courses for as long as seven days.

Lack of administrative support to reform

The primary health care facilities in the district have been transferred to Punjab Rural Support Programme under the Chief Minister's Initiative for Primary Healthcare (CMIPHC). A District Support Unit was established in Kasur, which worked closely with the district administration. The district government fulfilled the office space and other infrastructural requirement of the support unit.

According to the District Support Manager, they were facing some problems like delay in release of funds, delay in payments for procurement of medicines which was still dependent on release of funds from the provincial government. District Support Manager, Kasur quoted a recent incident where they had outstanding payment of

medicines worth Rs. 1,30,000 due to administrative delay in releasing funds. Researvations about the fate of the programme and whether it would continue or expanded in other districts was observed in interview responses of the provincial government officials (see Chapter 7) and even in the district health administration.

> *"...it is very unfortunate that the government is even thinking about discontinuing CMIPHC....the figures clearly show the difference this programme has made in the districts especially in the number of patients treated".(INT-PRSPK-14)*

CMIPHC and PRSP were started during the government of an opposing political party than those in the office during fieldwork. The civil servants interviewed also had some reservations about the programme, as they said they are more curative-based management of health services and they are not doing anything on the preventive side. CMIPHC and PRSP responded to this by saying that this was the mandate that they were given, and they would need resources, access and vertical coordination with the national programmes for preventive health care in the province, which they don't have.

> *"...we were asked to manage the primary health care facilities in the province and were given the budget to run those health facilities, which we did. If we need to expand our scope, we would need government support and resources, which we currently don't have....the government is still undecided over CMIPHC. Let them decide whether they want to keep us or not and we can talk about this later. We have delivered on what we have done and this is clearly reflected in the numbers."(INT-PRSPK-14)*

Participation in decision-making

Another theme that emerges especially from the key informants in the district was that they had little or no involvement in planning or initiating reforms in service delivery.

> *"...there is no one better than the district health administration to tell the government about what is needed for improving the quality of health services....I approximately see 100-150 people from the district every week. These people are staff working at health care facilities, citizens, local*

political personalities etc. and hey came up with all sorts of issues like complaints about absence of staff, non-availability of medicines, negligence of doctors, problems with staff working in vertical health programmes. I can deal with some of the issues by themselves but then there are others that I cannot do anything about for e.g. vertical health programmes."(INT-KAS-17)

The district health administration was of the opinion, that they should be the first point of contact when they are planning strategies for the health sector, but this is actually not the case. Under Punjab Devolved Social Services Programme (PDSSP), which prepared guidelines for preparing three-year rolling plan, which is now being implemented by PHSRP, the districts were asked to prepare three year rolling plans for the districts, which lays down the road map of the district towards the achievement of Millennium Development Goals (MDGs). District Kasur prepared their first three-year rolling plan in 2010, but the administration was of view that this needs to be done more intensively. They needed more training and resources to effectively carry out the task.

They district administration also shared that input from the district level administration is not integrated into the overall system. Devolution is fairly new, and although it is now a permanent constitutional feature, the current government still does not support it fully *(INT-DHDC-15)*. The provincial health department still wants to enjoy the power and control that they used to enjoy before and have not accepted the assignment of functions to the districts fully. The district health administrations are not fully trained and are learning the new system, and therefore seek help from the provincial health departments quite often.

7.2.2 Role of Key actors

The term key actors' is used in the case study to identify informants ordered by their roles in the reform process. Key actors within the two embedded case units, denote the district health administration, medical officers in charge of primary and secondary health care facilities, staff and service users.

District Health Administration

The district health administration of Kasur was asked questions about reform implementation and their role in the reform process. The following themes emerged. The district health administration believed that devolution required consolidation and the system was still evolving. The informants attributed this to multiple reasons: one, the current government does not fully *support* the system, second, devolution was a *donor-led initiative* and has brought in a lot of financial resources which have been sent on training and development programmes like System-oriented (SOHIP) by Canadian International Development Agency and Punjab Devolved Social Services Programmes (PDSSP) by Asian Development Bank and thus the half-hearted support the government gives to these programmes, third, there was *lack of specialized and trained staff* to look after the functions at district level. Fourth, there is hardly any *bottom-up communication/information flow* from the districts to the provincial health departments, which is crucial for such a system to work.

Medical Officers and Staff at Health Care facilities

The Medical Officers and Staff at the facilities complained about lack of involvement in any sort of decision-making at reform with the Health Department. They shared that they were not treated as part of the system. They complained about human resource issues like low pay rates, lack of training and development opportunities, and poor working conditions. The health care facilities usually were in a quite dilapidated condition, with no personal office and staff facilities. Medical Officers, in charge, of primary health care facilities were given accommodation, near the facility, which they reported was in poor condition, and not maintained properly. Things if brought to attention to the district health administration are taken care of, and ultimately sorted but this took time, and meant repeated visits at the district offices. When asked about the training opportunities and regularly-run training programmes within DHDC, they responded that the programmes are good and much-needed, but they want more opportunities for professional and post-graduate training *(INT-KAS-29; INT-KAS-28)*. The doctors were also of the view that working in remote/rural districts ultimately becomes a disadvantage, because there are not

teaching hospitals or postgraduate medical institutes in the city, which makes it really difficult to acquire any further qualifications *(INT-KAS-34).*

Service Users

The service users gave us an interesting insight into health service delivery. The service users at primary health care facilities (a dispensary and basic health unit) were quite appreciative of the recent improvements in health services during the recent years. Women at the basic health unit were really happy with the presence of a female doctor at the facility two days a week. Comparing the level of service delivery over the last four years,

> *"...the medicines are available now and good quality medicines...there are times when the doctor has run out of them, but this is very rare...there was a time when the doctor would be absent and we would have to walk to the BHU from far away and then go back and return another day due to the absence of doctors..."(INT-KASU-21)*

> *"...we also can write comments in the register and the manager (DSM – CMIPHC) reads them, and it is taken care of very soon...we can write about anything...non-availability of medicines, staff etc.." (INT-KASU-24)*

Citizens at the primary health facilities visited were very enthusiastic to talk and share their experiences. The primary health care facilities in the district were under CMIPHC, and DSM also talked about ensuring the presence of a female doctor and availability of quality medicines as his first priority in the district.

Service users in the dispensary (primary facility) talked about how functional this dispensary has become during the last few years. They couldn't exactly remember which year the dispensary became functional but the time scale mentioned matched with the transfer of primary health care facilities to CMIPHC. The dispensary had an old broken boundary wall that was being reconstructed with the help of community mobilization (another intervention implemented by CMIPHC). People at the facility also mentioned planting trees next to the boundary wall, and how they are doing it all together.

Citizens present at the Rural health Center, Mustafabad (secondary health facility) were quite uninterested and gave neutral responses to the researcher. They complained about waiting time and absence of doctors. The researcher had to try and make them talk about their experiences at the facility. The said health care facility was unclean and mismanaged as compared to the primary health care facility.

> *The doctor I have come to see today is good as compared to the one who was here before. But who knows how long before he is changed or he leaves…I normally have to wait for around half an hour before my turn. I am not given an appointment if I have to see a doctor. I am just asked to come in during the day between 9-1 pm. I prefer going to DHQ, but at times it is too busy there, and I have to wait a long time..thats why I come here. (INT-KASU-38)*

7.3 Embedded case unit II – Lahore

Lahore is the most populous city of Punjab with a population of 8,109,421 and a population density of 8200 persons per sq.km. The district has a literacy rate of 74% much higher than the national average of 26%.

There are a total of 37 Basic Health Units, 6 Rural Health Centers, and 2 District Headquarter Hospitals in Lahore. The following informants were interviewed in Lahore district for our study.

1. Executive District Officer (Health), Lahore

2. Deputy District Officer (Health), Lahore

3. District Support Manager, CMIPHC-Lahore

4. Medical Officer, Basic Health Unit at BHU Lidher, Lahore

5. Medical Officer, Rural Health Center, Burki, Lahore

6. Medical Superintendent, District Headquarter Hospital, Mian Munshi, Lahore

7. 3 staff interviewed (paramedical and administrative staff – 1 at each facility)

8. 5 service users (2 at BHU, 1 at RHC, 1 at DHQ)

7.3.1 Themes from Lahore Case study

The following themes emerged from the interviews of the key informants.

Limited authority and multiple channels for coordination

The district health administration of Lahore also pointed out that this new system is still in its infancy stage and a lot needs to be accomplished especially in terms of strengthening the system and role definition.

> *"its still a long way to go to see the districts as a service management unit for health….we have been assigned some core functions at the district level, but do you think this can be done effectively, if we cannot even procure medicines*

and we have to reach out to the provincial government to that…delays from the Health Department are a routine matter, whether it be medicines or appointments and transfers."(

According to EDO(H), they have learnt by doing. He acknowledged that there have been training programmes and they have been very beneficial in letting them know how the system works, but the trainers who have never been in the field themselves, were unable to provide them with real examples and situations that would experience in the field. They also felt that one-two day training programmes (short duration) did not prepare them enough for the field.

> *"…the training programmes, I am not saying were bad, they were really good but they only told you about the new system, our responsibilities, what we have to do, our responsibilities etc, but it did not really tell us what to do if you cannot sit in your office for a week because the CM has suddenly decided to have a meeting regarding Health, and has to meet some donors and development partners, and he wants you there…I have to ignore my day to day affairs and report there….what to do if the procured medicines are late by three-four months, what to do if you need to appoint doctors in your DHQ hospital and you have to remind Health Department again and again."(INT-LAH-18)*

They had the autonomy but some core functions, which are important for smooth functioning of health services in the district, were still with the provincial Health Department.

The informants were also of the view that the channels of coordination were multiple and confusing. They referred to the implementation of Minimum Service Delivery Standards, and the monthly monitoring and evaluation reports that have to be sent by the district every month to PHSRP. They were being asked for the reports monthly (staged implementation of MSDS in the district which enabled the districts to request additional grants for the district) by the Punjab Health Sector Reform Programme's-Program Support Unit, but if there is a discrepancy or if they need further clarification regarding something, it was the office of Director General Health Services Punjab, who will do the correspondence and communication. This was confirmed by Director General (Health Services) in the interview that the PHSRP

does not have the authority to do that, as they have been established recently, and they can only go through us if they wanted any correspondence with the districts *(INT-DGHS-36)*.

Uncertainty

The district health administration and the District Support Manager CMIPHC expressed concerns over the administration's lack of support and uncertain stance towards the new system. CMIPHC contracts were under discussion and a serious debate over the renewal was going around in the provincial administration. Similarly, devolution and district governments initiated under the military rule, were also a bitter pill to swallow for the current provincial setup. Pakistan Local Governments Ordinance of 2001 was now a part of the constitution and almost impossible to revoke but the party in office did not lend it its complete support. CMIPHC and devolution were both in a "limbo" *(INT-LAH-18)*, and informants were of the view that government should clearly state its stance on these programmes *(INT-PRSPL-9)*.

It was interesting to note that Lahore's District Health Administration (EDO-H and DO-Health) did not complain lack of involvement with the Health Department in policy issues, and rather expressed being frequently called to important meetings at the Health Department. Lahore is the capital of Punjab, and Health Department is also located in the provincial capital.

7.3.2 Role of key actors

District Health administration

The district health administration of Lahore was asked questions about reform implementation and their role in the reform process. Like, Kasur's district administration, they also believed that devolution required consolidation and the system was still evolving. But unlike, Kasur's district administration they were called to important meetings in the Health Department, and felt that they had a fair amount of representation within Health Department *(INT-LAH-18)*.

They were also aware of the strong presence of donors in the reform process. Since they were based in the capital city, they had a chance to interact with them on visits, during meetings and often were asked to provide them with information, arrange visits.

Medical Officers and Staff

The Medical Officers and Staff in Lahore's health facilities complained about human resource issues too. The Medical Officers and Staff at the facilities complained about lack of involvement in any sort of decision-making at reform with the Health Department. They shared that they were not treated as part of the system. They complained about human resource issues like low pay rates, lack of training and development opportunities, and poor working conditions. The working conditions in Lahore facilities were found to be in a much better physical condition than Kasur. The facilities but were found to be much cleaner, and a good overall physical condition. The Medical Officers in Lahore shared that there was no accommodation next to the facilities, but if required the Health Department would provide them with one. Training and development opportunities were missed by the doctors, but the paramedical staff (nurses) were pleased because of the Nursing College within the city which also offered training, courses and diplomas that they could manage with their jobs *(INT-LAH-34)*. In general, doctors were happy to have been posted in Lahore and not in some remote rural area but still felt that the reforms on paper and actual reforms implemented had little in common, and these reforms would never work if they (government) do not 'include' or 'engage' us in the process *(INT-LAH-27)*.

Service Users

The service users in Lahore were completely indifferent to any reform programmes implemented during the last five years. They were not aware of the contracted basic health care facilities in the district. They also expressed that they would opt for private health care as they were sure that the quality of service provided at public health facilties is not good. The only reason that they would come to public faciltiies

is if they are coming for a minor illness *(INT-LAH-40)*. One of the users was there for vaccination of her child, and she shared that she would always take her child to private practice, but since the vaccination programme is free in public hospitals and dispensaries, she has opted to come here. *(INT-LAH-39)*

7.4   Within case analysis

7.4.1   Dual management control and multiple coordination channels

A number of informants pointed out towards multiple reporting and coordination channels. Monitoring reports input into the District Health Information System (DHIS) follows a confusing procedure. Health Management Information System (HMIS) now known as District Health Information System (DHIS) was initially part of the Office of Director General Health Services (DGHS). With the new service delivery infrastructure, the Office of DGHS should have been abolished. At the time of fieldwork in 2010-11, the office was still there. Punjab Health Sector Reform Programme was handed over the HMIS, which was improved, revamped, customised and renamed as DHIS. A special unit was established. The complete transfer of data had occurred but there were still two units performing the same task

7.4.2   Funding

The provincial government is still providing the funds for health services, and the federal government is financing the vertical health programmes (e.g. Lady Health Worker Programme which is one of the largest and oldest vertical health programmes funded by USAID in Pakistan). The researcher was informed by the district health governments that the budget released for the fiscal year are sometimes not enough e.g. more than 75% of the budget is spent on salary of medical and other staff, and the remaining gets spent on consumables and medicines (no figures were shared, as the informant insisted on complete anonymity). They also shared that these district funds are not transferred in the bank accounts of the district, but

payments are made on approved invoices and bills by the Accountant General's Office.

The health facilities in the districts collect a nominal fee for the use of health services from the users which are not reflective of the cost of medicines or other services provided to the user e.g. laboratory tests etc. These fee are collected and go in the provincial accounts, and are further allocated to the districts through the Provincial Financial Commission (PFC) Award, which has its own criteria for collection but is not based on the amount collected from each district.

7.4.3 Differences in service users attitude

Both in Lahore and Kasur, the service users interviewed in the primary health care facilities seemed more satisfied and have felt the difference in service quality over the last few years. People interviewed at secondary health facilties complained about lack of doctors/absence of doctors, waiting times, non-avalability of medicines. Contrary to this, the service users in the health care facilities at the primary level (Basic Health Units and Dispensaries) in both districts were satisfied with the service provided to them. They appreciated that the doctors' availability and presence has drastically improved and the availability of quality medicines. Primary health care facilities in both the districts were transferred to Punjab Rural Support Programme under CMIPHC in both the districts. The primary health care facilities had also witnessed an increase in the number of patients treated, since PRSP took over.

	2003	2004	2005	2006	2007
Lahore	452939	509434	1240077	1295809	1476341
Kasur	501764	542923	967143	1564685	1668164

Table 7-1 Number of people receiving curative services at primary health care facilities in Lahore and Kasur from 2003-2007

7.4.4 Uncertainty and confusion – Lack of administrative support

Due to the uncertain nature of local governments, and current government's confused stance over some reform programmes, the district health administration and the management of reform programmes were unclear about future course of events. Devolution and establishment of local governments, and Eighteenth amendment to the constitution has made it clear that health service delivery is going to be a district level function, but the uncertain climate and lack of administrative support from provincial government affects the morale and motivation of the staff working at all levels.

7.4.5 Human Resource Development and Motivation

All the doctors and staff interviewed presented a unanimous view that none of the reforms, addressed the human resource problems. They were also of the view that the administration had no motivational engagement with the staff. They complained of being underpaid, and the absence of training and development opportunities for them. MSDS and other training run by the government, were seen to be as steps taken by the administration to fulfil the conditions for obtaining funds and loans. It was also evident from their responses that they were not involved in any phase of the reform process.

	Implementation	Role of key actors
Lahore	Multiple channels for coordination Confusion over the fate of devolution and CMIPHC Three-year rolling plans made for the first time MSDS and PMDGP are the main reform interventions	District Health Administration: *'it can be called limited input. I think because of my being in the capital, I do get more chances to be with the CM."* Doctors and Staff*: '... PRSP is very organized, streamlined, and we know who to contact if there is a problem, and it's taken care of quickly. Even a phone call at times fixes the problem. No lengthy paperwork if it would have the district health administration'.* Service Users: preference for private health care facilities, ignorant about CMIPHC and other reforms and no knowledge of any community participation efforts
Kasur	Limited authority Too many places to report to Too much paperwork (fulfilling donor requirements)	District Health Administration: *'.no input from us, call us glorified clerks for the government'* Doctors and Staff: Vacant posts, no motivational engagement by the administration, lack of training and development opoortunties Service Users: satisfied consumers in primary level facilities run under CMIPHC Absent doctors and staff at DHQ Hospital under district health administration reported by

| | | users |
| | | Badly maintained secondary health care facilites |

Table 7-2: Collating themes from two districts for within case analysis

Chapter Summary

This chapter provides a bottom-up view of the reform process reporting on the themes emerging from the case studies of Lahore and Kasur. These findings will supplement our research findings about reform process by and help us in analyzing and discussing our findings. Tehh researcher found the case very enlightening, as they cleared the discontinuities in data already collected. The next chapter will further analyse the findings according to the research questions and triangulate it with existing research to draw conclusions and implications for this research.

Chapter 8
Analysis and Discussion

Chapter 8   Analysis and Discussion

This chapter seeks to analyse and discuss the findings of the case study with existing research. Section 8.1 analyses the findings presented in Chapters 6 and 7 by using the analytical framework as a template. This helps in summarizing the research findings and avoids replication of data. Findings are discussed, compared and contrasted with the existing research on reforms in Section 9.2. Section 9.3 synthesises the research findings in order to answer the research questions of the study. Section 9.4 outlines some theoretical implications of the research study.

Chapter 2 sets out the health sector reform context and introduced how the health sector is organised, the key issues affecting health service delivery, and policy frameworks affecting the reform agenda. Chapter 6 and 7 present the findings from the case study organised under the analytical framework developed in Chapter 4. The initial literature review in 2009 had revealed that there in an empirical gap on health sector reform literature on Pakistan from a public management perspective (Chapter 4). Chapters 6 and 7 map health sector reforms in order to bridge this empirical gap. A theoretical and empirical gap on the process of public management reforms in developing countries was also noted in the literature review (Chapter 4), as most literature on reform process and implementation suffers from a skewed case selection focusing on advanced Western economies (Haque and Ko, 2013; Haque and Turner, 2013).

This chapter would like to argue that the key to health service reform lies in the dominant administrative elites in the bureaucracy, who face internal and external challenges to the power configuration. These administrative elites are driven by the circumstances that force them to realign their goals and agenda and reconfigure the system in order to maintain their legitimacy and power in the overall administrative system. Chapters 3, and 4 set out the basic framework for analysing the case of health sector reforms in Punjab during 2004-2011.

8.1 Analysis – Applying the analytical framework

The main overarching research questions examined in the study is:

Research Question 1: What model of public management guides health sector reforms in Pakistan?

Research Question 2: How are reforms being adopted in a developing country context?

The first research question aims to address the empirical and theoretical gap in public management research in Pakistan. It generates empirical evidence to examine the reforms in Punjab health sector and determine the health service reform trajectory across three dimensions of the reform process: drivers, strategies and how they were implemented. This research question seeks to address the following sub-questions: What are some of the main reforms in health sector in Punjab? What are the main ideas and theories that have guided the reforms? How do they appear in reform practice and what influence do the endogenous and exogenous forces have on the reform design? To what extent has NPM been the dominant model of reform? And how have the reforms affected the service delivery, people and service users?

The second research question is based on the hypothesis that elite decision-making is central to designing of reforms in developing countries, and aims to understand the motivation for the political and administrative to initiate reform in the context where international organisations also play an important role in the design and delivery of public administration systems. This question aims to understand how reforms are adopted by the administrative elites? What role do elites play in pulling the reform agenda to a developing country? What motivation do they possess and how does it affect the reform agenda? The question will provide an actor-based perspective on how reforms are pulled in light of the actors' motivation to reform.

A framework was developed after reviewing the literature to act as a heuristic device for gathering empirical evidence during fieldwork (Chapter 4). Considering the institutional diversity and complexity involved in developing country reform experiences, the framework is built around three factors crucial to designing reforms: *reform drivers*, *strategies* and how they were *implemented*. The framework draws upon Pollitt and Bouckaert's (2004) model of public management reform and Christensen and Lægreid (2007) transformative theoretical approach to public management reforms. Both the models, give a central role to elite-decision making, and considers it to be at the heart of the reform process. While Pollitt and Bouckaert (2004) focus more on the institutional forces driving reform, Christensen and Laegreid (2007) argue for a transformation in reform agendas when they are subjected to the political, administrative and cultural contexts. The following analytical framework identifies they key dimensions to be investigated within Punjab health sector reform, and the data gathered will seek to answer the research questions of the study.

Health Service Reform Trajectory in Punjab		
Reform Drivers	Strategies – "What" of reform	Implementation – "Process" or "How"
Exogenous Influences: Global development agenda in the form of UNMDG, Donor Influence and Poverty Reduction Strategy Papers, International Best Practices, and Globalisation Endogenous Influences: Under-utilisation and poor services of public health care facilities, health indicators, deteriorating health service delivery mechanisms, medical negligence	Organisational: Contracting-in of primary health care facilities, devolution of health services, capacity-building for devolved health services Performance: Minimum Service Delivery Standards, training Personnel: Hiring on contracts, short training and development initiatives for doctors and paramedics, Incentives in the form of Health Sector Reform Allowance for	Legislation: Pakistan Local Government Ordinance 2001, Punjab Health Care Commission Act 2010 Creation of agencies and structures: Punjab Health Sector Reform Programme – Programme Management Unit for monitoring, evaluation and implementation Top-down/bottom-up: Predominantly top down mechanisms of policy making and implementation with

	working in remote rural areas Other: Community empowerment through Rural Support Programmes, encouraging local accountability mechanisms,	political support; reform proposal, initiation and implementation controlled by the top bureaucratic tier in Health Department, Punjab.

Table 8-1: Health Service Reform Trajectory in Punjab

Seven reform programmes were identified in Punjab Health sector, either fully implemented or currently undergoing implementation. These reform programmes were managed and implemented by the Punjab Health Department and district health administration. These seven programmes are discussed in detail under Section 7.2.

Pollitt and Bouckaert (2004:67) have divided the concept of reform trajectory into components of *"what"* and *"how"*. The 'context' and 'substance' of reform has been further divided into four types: organisation, finance, personnel, and performance. The 'process' or 'how of reform' constitutes three types of processes: 'top-down/bottom up', 'legal dimensions' and 'organizational processes' (Table 9-2).

What/Content	Finance: budget, accounts, audits
	Personnel: Recruitment, Posting, Remuneration, Secure Tenure Etc.
	Organization: specialization, coordination, scale, (de)centralization
	Performance Measurement Systems: content, organization, use
How/Process	Top down/Bottom up
	Legal dimensions
	Task allocation: (new) organizations

Table 8-2: Aspects of reform trajectory: *What* and *How* (Adapted from Pollitt and Bouckaert, 2004:67)

To supplement our findings of the case study, the findings of the two embedded sub-units within the case were analysed with respect to the effects/change the reforms are having on service delivery, people, and service users. The health care managers, doctors and paramedical staff, and service users were interviewed in two districts of Punjab.

Impact/ Change/Effects	Service Delivery (Health care management as key informants)	Multiple channels of coordination Improvement in the number of patients treated Availability of staff and medicines Community involvement and feedback
	People (Doctors and staff as key informants)	Incentives in the form of Health sector Reform Allowance, Opportunities for training, alienation and felt not being part of the system, training under MSDS considered a gimmick to conform to donor conditions, lack of motivational engagement during reform implementation
	Users (service users at health facilities as key informants)	Improvement in the level of service, availability of medicines, and better condition of health facilties

Table 8-3: Implementation: Effects on service delivery, people and users

8.1.1 Reform Drivers

Drivers of reform have been classified into two categories: endogenous and exogenous forces. Endogenous forces are internal factors affecting the reform trajectory and design, comprising up of all influences and forces that emanate from the internal context of the region in question. Poor socio-economic conditions, under-utilisation of public health care facilities and quality of health care provided was identified as a key issue driving health sector reforms. Urban cities like Lahore have a wide network of private health care facilities, but poor quality of health services in rural districts affected the users. Key issues affecting health service delivery have been discussed in greater detail in Chapters 2 and 6.

The exogenous influences on health sector reforms can be identified as UN Millennium Development Goals and Poverty Reduction Strategy Papers at the policy level. Multilateral and bilateral financial institutions were found to be involved in all reform interventions because of the technical and financial assistance they provided to the reform programmes. Management consultant also brought in the influence through suggestion if internal best practices in the reform plans.

8.1.2 Reform Strategies and Implementation

Organisational Reforms: According to Pollitt and Bouckaert (2011:95-97) organizational reforms are based on decisions regarding specialisation, coordination, centralization/decentralization and scale of the organisations. Applying this to our findings, we can see that health sector reforms do not show any specific intent towards creating specialized or multi-purpose organisations. The Office of Directorate General of Health Services was to be abolished after the setting up of Punjab Health Sector Reform Programme's Programme Management Unit. The monitoring an evaluation functions of the office were transferred to Punjab Health Sector Reform Programme. Health Management Information Systems (HMIS) were also revamped and handed over to them. The human resource and personnel related function were retained by the Health Department.

Alternate modes of service delivery are explored with the help of partnership with non-state providers in the province. Vertical health programmes working at the national level with donor support like National AIDS Programme and National Tuberculosis Programme were already working with non-state providers across all the four provinces. At the provincial level, this was done for the very first time by transferring the Basic Health Units at primary level to these non-profit organisations. National Commission for Rural Development (NCHD) and Punjab Rural Support Programme were transferred the primary health care facilities of twelve districts. 24 out of 36 districts' primary health care is being managed by non-state providers.

Coordination was handled in a typical top-down fashion. A recurrent theme that emerged from the interviews of district health administration and professionals was the multiple channels of coordination and duplication in reporting mechanisms. The district health administration often encountered situations where they were reporting to two different offices for the same thing e.g. monthly district reports to be fed into the district health information systems were sent to Punjab Health Sector Reform Programme and Office of Director General of Health Services.

Personnel: Personnel-related reforms were very few to be seen in the current health sector reforms. An incentive to work in rural areas was offered to Doctors that meant an additional payment of Rs. 12000 over and above their salary and allowances to work in the rural area. No significant reforms relating to recruitment, and compensation were observed. Capacity development programmes were implemented to strengthen and prepare the professionals and staff for the devolved health services. (Section 6.3)

Performance: *Performance management* practices were seen in the form of Minimum Service Delivery Standards (MSDS), and they were in the process of implementation. The districts were subjected to training programmes and successful adoption of the standards were rewarded with the help of incentives in the form of additional district budgets. (Section 6.4)

Financial Reforms: No financial management reforms were found in the period 2004-2011. Transparency and open government reforms were also not found. However, district health information systems and the availability of district health service delivery data on the website since 2012 can be counted as government's first steps towards public disclosure of data.

Implementation (How): Reforms were implemented with help of new legislation where required: Pakistan Local Government Ordinance of 2001 and Punjab Health Care Act 2010. In addition to the required legislation, a Programme Management Unit under Punjab Health Sector Reform programme was established to act as an implementation arm of the Punjab Health Department. Section 7.4

8.1.3 Effects on Service Delivery, People and Users

Two embedded case units of Lahore and Kasur yielded evidence that led the researcher to the following effects the reform had on service delivery, people and users. With regards to service delivery, significant increase in the number of patients treated was observed in primary level health care facilities that were contracted out to Punjab Rural Support Programme. This can be attributed to presence of staff and availability of medicines. The primary level health care facilities were now in better physical condition, and were maintained up to a certain minimum level with available resources. The district health administration felt that the devolution plan, which was not fully implemented, was constraining their performance and ability to work effectively in the districts. They also mentioned that the powers were not fully transferred to districts, which kept them from solving routine problems at the district level. Human resource issues like lack of staff and vacant posts, in addition to multiple channels of coordination was also highlighted.

The people working within health sector complained of low pay, lack of motivational engagement and lack of training opportunities provided to them. They also indicated that they were not included in the reform process at all. The service users, on the other hand, were ignorant of any reform programmes being implemented within the

districts, but did notice any improvement in the level of service provided to them, after the contracting of primary health care facilities.

These summary findings are just a brief recap of the detailed research findings discussed in Chapters 6 and 7 to avoid duplication of data in the discussion sections.

Reform Programmes/Interventions	Reform trajectory	
	What (Context and Content)	How (Implementation)
Establishment of local governments, and devolving the management of primary and secondary health facilities to the local level	Administrative decentralization of health at primary and secondary level from the provincial health department to district governments.(Organisational/decentralization)	New Legislation – Pakistan Local Government Ordinance of 2001 Establishment of National Reconstruction Bureau to aid the process – policy making, evolving the new system and supporting the government in design and implementation f the new system
Chief Minister's Initiative of Primary Health Care under Punjab Rural Support Programme (CMIPHC)	Contracting-in of management of primary level health facilties to a government-run NGO (Punjab Rural Support Programme) in twelve districts of Punjab. (Organisational/Competitition)	Establishment of Punjab Rural Support Programme by providing seed money, and to take up uplift project in health, education and microfinance.
Punjab Health Sector Reforms Programme (PHSRP) Punjab Millennium Devlopment Goals Programme School Health and Nutrition Programme District Health Information Systems	Information and Communication technologies used in the form of District Health Information System for Monitoring and Evaluation, and to ensure implementation of programmes run with financial and technical assistance of development partners. (Organisational/ District Health Information Systems/ Coordination)	Establishment of a separate agency to be housed within the provincial health department. Primary purpose was to improve the infrastructural facilities of health facilities across the province. Now acts as a Programme Management Unit for health services regarding Punjab Millennium Development Goals Programme, monitoring and implementation arm of the health Department, and also acts as a liaison between the Health department and development partners
System-Oriented Health Project (SOHIP)	Training and development programmes run for district health management by development	Technical assistance of CIDA

Reform Programmes/Interventions	Reform trajectory	
	with the help of financial and technical assistance from Canadian International Development Agency (CIDA). Purpose was strengthening the evolving district health management within Punjab. (Capacity-building/Personnel related)	A temporary unit setup within Punjab Health Department International management consultants hired for planning and conducting the training programmes
Punjab Devolved Social Services Programme (PDSSP)	Capacity building and strengthening, needs assessment, and preparation of implementation plans for the province. Purpose was strengthening of devolved health services. (Planning/ Capacity-building)	A number of projects were undertaken and implementation plans prepared. Minimum Service Delivery Standards (MSDS) and Three-year Rolling Plans for health were adopted, as they directly contributed towards the achievement of Punjab Millennium Development Goals (PMDGP). Selectively implemented.
Punjab Health Care Commission	Regulation	Legislation – Punjab Health Care Act 2010 Technical assistance by DFID for thee establishment of Commission
Complete devolution of health to provinces and local governments (18th Constitutional Amendment)	Administrative decentralisation	Legislation- Constitutinal Amnedment

Table 8-4: Health Sector Reforms in Punjab - Reviewing the empirical evidence

8.2 Determining the health sector reform trajectory

This section will evaluate the research findings with existing research on public sector reforms in developing countries. In doing so, it seeks to find if NPM is the dominant paradigm governing the health sector reform trajectory, what drives health reforms in Punjab, and what facilitates or constrains the reform process?

8.2.1 Interpreting the reforms in health sector

New Public Management has been a common explanation of reforms during the last decade, and has been well articulated in public management literature (Hood, 1991; McLaughlin et al., 2002; Lane, 2000). The prevailing assumption about reform in developing countries is that they have followed the developed countries in bringing about NPM reforms under aid conditionalities and donor pressure (Ingraham, 1997; Common, 1998b; Andrews, 2013a). But studies have also found that NPM in developing countries despite donor pressure has taken its own form and has been translated into the local context, thus challenging the universality of NPM (Manning, 2001; Haque, 2003). In this and the following sections, I would like to argue, in light of research findings from this case study, that NPM-like practices have been adopted in Punjab Health Sector, not because of the universal application the paradigm holds, but because of a complex interplay of forces driving reform.

New Public Management as a paradigm, is synonymous with reform measures centering around the themes of decentralization, performance management, managerialism, competition and disaggregation (Table 9-5). Applying Hood's (1991) seven administrative doctrines as a framework, the reforms are to an extent drawn from the NPM style practices. Not all seven administrative doctrines were evident, but we the evidence only covers health sector. *"Explicit standards and measures of performanc*e" and *"greater emphasis on output controls"* have to some extent been established under Minimum Service Delivery Standards (MSDS) and Standard Operating Protocols (SOP) for doctors and para-medical staff. The Punjab government notified MSDS for implementation in 2007, which were later associated with an increase in the district health budget subject to successful adoption of the

standards and the required training. MSDS was an important milestone for the Punjab Millennium Development Goals Programme. In order to ensure effective MSDS implementation and to respond to some medical negligence cases at the same (although medical negligence cases were not the stimulus for introducing PHC, a Punjab Health Care Commission was setup in 2011.During fieldwork, Punjab Health Commission Act 2010 was approved by the Punjab Assembly and was adopted for implementation by PHSRP-PMU.

'Disaggregation' of public sector units has also been undertaken by transferring the management of primary health care facilities to government-run NGOs in Punjab, but has not been extended to all the districts. The management of the primary health care facilities was given flexibility and autonomy to spend the same allocated annual budgets as per the needs requirements of their local facilities.

'Competition', on the face of it, was ensured by giving fixed term contracts to Punjab Rural Support Programme (PRSP) and National Commission for Human Development (NCHD) for the districts transferred, but the provincial government and PRSP/NCHD did not have a purchaser-provider relationship, neither the process of recruitment was competitive. The process did not go any competitive process of recruitment as PRSP and NCHD are both government-run organisations, but more autonomous in their role and functioning. The organisations managed to get their contracts because of the political support of the Chief Minister in office at the time. "Private sector management practices" were only found in the form of contract appointments being made by district health administration (Executive District Officer – Health) and under Chief Minister's Initiative for Primary Health Care (CMIPHC), where they were allowed to hire for fixed term contracts of up to one year. EDO (Health) was only authorized to make appointments up to BPS-16, while PRSP under CMIPHC could appoint doctors and paramedical staff. The province overall had put an overall ban on new recruitments, which resulted in more contract-based recruitments but this was not by design but was because of the recruitment ban on new appointments.

(Aucoin, 1990)	(Hood, 1991)	(Dunleavy et al., 2006)	(OECD, 1995 as cited in McCourt, 2002)
Public Choice Theory Reinforcing power to the executive structures by Centralisation, Coordination, and Control Managerialism Changes in organisational design by deconcentration of power by Decentralisation, Deregulation and Delegation	Hands-on professional management, Explicit standards and measures of performance, Greater emphasis on output controls, Shift to disaggregation of units in the public sector, Shift to greater competition in the public sector, Stress on private-sector styles of management, Stress on greater discipline and parsimony on resource use	Disaggregation: Splitting large public sector organisations and using information technology systems for control Competition: Purchaser/Provider Separation and competition among potential providers Incentivization: Performance-based incentives	Devolving authority Ensuring performance, control and accountability Developing competition and choice Providing responsive service Improving the management of human resources Optimizing information technology Improving the quality of regulation Strengthening steering functions at the centre

Table 8-5: Comparing NPM features (Table 3-2 repeated)

Developed Market Economies (Larbi, 1998)	Crisis and adjusting economies- developing world (Larbi, 1998 and Batley, 1999)	Case of Punjab Health Sector – Motivation for reform (Research Findings)
Economic and fiscal crises of late 1970s and 1980s	Economic and fiscal crises – debt burden	Poor state of health care facilities
Quest for efficiency (NPM reforms) and effectiveness (Post-NPM period)	IMF and World Bank supported reform programmes for e.g structural adjustment programmes to address balance of payments	Adoption of Poverty agenda in the form of United Nations Millennium Development Goals
Neo-liberalism in policy making in 1970s and 1980s: minimalist role of the state	Lending conditions	Conditional loans and financial assistance extended for Punjab Millennium Goals Development Programme
Change in political context (parties favouring minimalism in office)	Political instability, policy instability, failure of public institutions, need for reform and capacity-building, central planning fails to deliver, good governance agenda to realize public management reforms, donor pressure	International Management Consultants hired directly by the international financial institutions/governments' development partners for reform planning e.g. PDSSP, PMDGP
Development of information and communication technologies to consolidate change	International best practices	
Influence of international management consultants supporting NPM reforms	Technical assistance and the influence of management consultants as advisors for reforms	Technical assistance from DFID under PDSSP for strengthening and capacity building

Table 8-6: Comparison of NPM Reform Drivers

8.2.2 Is it really NPM? – rhetoric or reality

After analyzing the reform interventions, there is no doubt that Punjab Health sector has been introducing *NPM-like reforms* in health sector. Batley (1999) and Batley and Larbi (2004) have argued that within the social sectors , alternates modes of service delivery have been explored via reform efforts in developing countries. Such

initiatives are backed by donor assistance, are introduced in social sectors like health, education, and water sanitation because of the poor standards and governments' failure in these sectors (Batley, 1999). These reforms are designed to bring in advantages in terms of 'efficiency', 'reducing the burden on government', and 'give choice to citizens'. Reforms in Punjab health sector were mainly introduced to align the departmental priorities with the Millennium Development Goals and to strengthen the devolved health sector. The Punjab Millennium Development Goals Programme was bringing in financial assistance to the Health Department, which was instrumental in bringing about an improvement in the health services of the province. The pressure from IFIs and donors was

(Batley, 1999) and Batley and Larbi (2004) find that NPM experience in developing countries has mainly been concentrated in rethinking the role of government in service provision. The government rethinks their role in service delivery, making itself responsible for 'enabling' and 'regulating' the private sector, community organisations, or 'arms-length' public agencies' rather than directly providing services. They have also argued for donor involvement and drive towards rethinking of the government's role. Alternate modes of service delivery were pursued by the Punjab government in primary level health care facilities which were outsourced to government-run non-governmental organisations, and the management of these facilities was handed over to government civil servants, on a special deputation. At the primary level, the main reform intervention has been the contracting of primary level healthcare facilities to Punjab Rural Support Programme and National Commission for Human Development. The facilities were contracted-in to a government run non-governmental organisations run by an "independent" but government-appointed Board of Directors, but operating outside the core government. The officials were also government appointed bureaucrats sent on a deputation for a fixed period of time. As rationalised in the official documents, the government officials knew the system well and would face minimal resistance and would understand the system well. Contracting-in resulted in outsourcing of these

facilities to government officers who were now getting three times the pay, which they used to get, but were also more autonomous and resourceful than before.

Reforms have usually been perceived as a loss of power in developing countries. The market-based reforms are perceived by the administrative elites as an infringement of power and results in power-sharing. This results in support for reform which is only a façade and a show for the donors as the bureaucracy is unwilling to let the power dilute. This has been particularly true in the case of decentralisation in developing countries. In the case of devolved health services, it was found that devolution has not been fully implemented. District health budgets were still with the provincial Health Department, and were not physically transferred to the districts. Procurement of medicines and equipment was a lengthy process, which not only required approval by the Health Department, but payments were also released after an invoice was sent to the Accountant General's office. Similarly, recruitments and hiring of staff was also retained with the Health Department, which was very slow to respond to missing or absent staff.

Batley (1999) has also argued that drastic reform programmes have been undertaken in countries that have had acute economic and fiscal crises, and have looked to multilateral and bilateral financial institutions for assistance. Pakistan has suffered acute economic crises, and additional security crises, which led to an inflow of foreign assistance, resulting in a number of reform initiatives. Such reform initiatives when implemented suffer from lack of local ownership of the reform programmes. The health administration especially at the district was quite complacent and unenthusiastic about the on-going reform programmes. They also shared that they were only being part of all these reforms because it is important for them to be compliant with the provincial health department, and they don't see if this will actually bring about any change in the service delivery.

It is evident from the findings that before deciding on the universal nature of NPM, we need to see that there is much more to the story than just NPM as a universal paradigm. Externally conceived and propagated reform agendas are *pulled* in by

administrative elites and these reform agendas suffer from lack of input from the masses. This results in "capture" of the reform process by the donors, consultants and the political and administrative elites which constitutes a self-serving bureaucracy in the developing countries. Elites are motivated by the inherent incentives that are hidden in the proposal, adoption and implementation of a reform programme. (discussed later in Section 8.2.5)

Cheung (2011) writes about an Asian model of NPM reform, which he terms as "fundamentally alike in all the unimportant aspects" (2011:132) with NPM of developed economies. Asian NPM is termed as a 'hybrid' of 'state-led development strategies' and 'instrumentalities of public administration' under the influence of two paradigms NPM and Good Governance. NPM, has been discussed before, and Good Governance refers to eight values that governments should follow i.e. accountable, consensus-oriented, effective and efficient, equitable and inclusive, participatory, following the rule of law, responsive and transparent (UNESCAP, 2006 in Cheung, 2010). Cheung (2011) suggests that these two paradigms have been influential in determining the Asian reform trajectory and identifies four types of country reform experiences (based on agenda setting and speed of reforms) in Asia: *bureaucrats-led modernisation agenda, politics-led political agenda, a party-state-led legitimacy and capacity-building agenda* and a *politics-led politicians-bureaucrats modernisation agenda.* Punjab health sector reform can be termed as a 'politics-led politicians-bureaucrats modernisation agenda', with a generally slow pace to reform, taking into account the power configurations of the politicians and the elites.

The case study clearly demonstrates that the reform initiatives in health sector bear a close resemblance to NPM menu of public sector reforms. Turner (2002) has identified three types of NPM reform adopters: 'enthusiastic diners', 'cautious diners' and 'unfamiliar diners'. The Punjab health sector can be labelled as a 'cautious diner' which does possess knowledge of the NPM menu but is reluctant to implement type reforms, where decentralization and some systemic NPM-style changes are evident but the adoption of NPM style reforms have been slow. This can

also be attributed to the lack knowledge about NPM because for e.g. decentralisation has been externally imposed and disturb the power relationships or contracting-in of management services has faced resistance because of the power-sharing it brings to the district health management. Bureaucrats are suspicious of the reforms and are wary of the consequences these reforms might have on the changing power configurations in the future.

To conclude, whether health sector reforms in Punjab are influenced by NPM or not, I agree with Cheung's (2011) argument for an Asian hybrid NPM-model, which is influenced by global pressures where reforms are policy instruments of developing country governments to acquire financial assistance and development funds. In doing so, they take up reform practices that conform to the global 'reform practices', but they do not let reforms reconfigure the pro-bureaucratic system of administration. These reforms are only pursued and adopted to protect and preserve the pre-existing interests of the politicians and administrators, which due to the absence of a true democratic polity, are not effective representations of the public interest.

8.2.3 Context matters: the system of governance and administration

The trajectory of administrative change in Pakistan cannot be fully understood and appreciated without an insight into the system of governance and administration in Pakistan. The administrative system has changed little in appearance, since inheriting post-colonial administrative structures in 1947, and has not undergone any considerable reorganization and restructuring, which has resulted in strong institutional rules and practices.

Pakistan's inherited a well-organised bureaucratic setup after independence in 1947. These administrative structures are built on traditional bureaucratic principles, which at the time of independence were essential to state-building (Islam, 1989). Asian countries gaining independence from the colonial rule depict post-colonial administrative structures different from the "British Domestic Model" (Turner and Hulme, 1997). The colonial administrative structures of the British were designed

with the purpose of exercising authority and control over the political and civil forces in these countries. These administrative institutions were well developed and were passed over to the independent countries that chose to retain it over the years. Initially these structures were the only well-developed institutions the newly independent countries possessed thus making them inevitable for the stability and development of the state. As (Hughes, 2003) notes, this resulted in a strong 'state sector', which coincided with the prevailing Socialist and Marxist philosophies of the time.

Pakistan, gained independence in 1947 and inherited the British system of colonial governance, which is still intact. Devolution as a result of Pakistan Local Government Ordinance of 2001 (see also Chapter 2, 7 and 8) is the most significant administrative decentralization that the country has seen since independence. The system of governance in Pakistan can be best described as an "administrative state" and a "bureaucratic polity"(Islam, 1989).

Smith (2003:181) argues that " a universal feature of colonial government was that it developed bureaucracies while neglecting legislatures, parties, local councils and other bodies able to maintain control and accountability". This has been true for Pakistan where the bureaucratic nature of the administrative setup, coupled with political instability, security crises and military rule led to underdeveloped political institutions that failed to fulfil their functions, despite being democratically elected. To illustrate, Pakistan has been under military rule and dictatorship for almost 36 years since its independence and only one democratically elected government has been able to complete the tenure since 1947.

In case of Pakistan, the bureaucracy is considered to possess expertise and knowledge both of a professional and technical nature. It continues to dominate even in the presence of strong democratic governments (Islam, 1989; Islam, 2001). Pakistan has had a turbulent political history, with intermittent military rule resulting in underdeveloped political institutions. Over the years, bureaucracy who started off as a strong institution post-independence became stronger due to instability of the

political institutions resulting in an imbalance between politics and administration. This corroborates Hughes (2003:223) argument that the administrations in developing countries are true bureaucracies resulting in " government by bureau, government by officials" or a "bureaucratic mode of production". Our findings also align with Smith's (2003:233-36) argument:

> *"The bureaucracy controls and manages the means of production through the state. It provides the necessary organization. It proliferates opportunities for bureaucratic careers by the creation of public bodies needing public managers - marketing boards, development corporations and other parastatal organizations and their subsidiaries. It articulates an ideology of state ownership and planning. It organizes the means of its own reproduction by passing on to the offspring of bureaucrats disproportionately advantageous opportunities to obtain the qualifications needed for entry into bureaucratic occupations and therefore the new class."*

The research also showed that bureaucracy and the top administrative elites within the health department were quite independent in making reform decisions with political support from the Chief Minister. The Chief Minister had not appointed a Health Minister intentionally and wanted to look after the affairs of the Health Department himself (Source: Interview with Secretary Health, Government of Punjab). The key informants from the Health Department, Government of Punjab added that the ideas and planning for the reform was primarily done within the Health Department with assistance from management consultants appointed under the technical and financial assistance programmes of donors. When the Chief Minister's Secretariat was contacted for arranging an interview and an introduction letter with project details sent to the office, the researcher was asked to contact the Secretary Health or Health Department officials as they would be better able to give an interview regarding health sector reform than the Chief Minister, despite his looking after the Health Ministry by intention.

On the other hand, politics in Pakistan characterizes chronic instability and repeated military intervention in its history of 67 years. Military rulers have favoured measures undertaken in the form of constitutional amendments and special ordinances concentrating powers in the executive, making political institutions

weaker by devolving power from provincial to local governments. The Local Government Ordinance of 2001 is one such example executed under Pervez Musharraf's military rule. Otherwise, the reforms were mainly driven by the administrative elites (senior executives in Health Department and Ministry of Health) with political support with the exception of devolution of 2001, which was driven by the military government with support from administrators.

India, Bangladesh and Sri Lanka still have post-colonial administrative models, as is the case in Pakistan. The power and influence of the administrative elites and political instability create an imbalance in developing countries. Woodrow Wilson's politics-administration dichotomy where the politicians devise policy to be implemented by a neutral civil service is a concept alien to majority of the developing countries. It can be concluded that the administrative elites exercise a great deal of influence in the reform process and the political input to the reform process is very negligible. It was evident from the case study that administrative elites possess a great degree of influence in determining the reform trajectory in health services in Punjab.

8.2.4 Donor influence and global development agenda

Exogenous variables are defined as forces external to the national context and exert an influence on the reform trends and trajectory e.g. *globalization and international best practices, global development agendas, and donor influence*. International organisations like IMF and World Bank have been assisting developing countries in initiating reforms since the 1980s. The literature around the role these organisations play have criticized these organisations and blamed them for imposing reform models e.g. new public management on developing countries. This research confirms that the international organisations do shape the reforms in developing countries. This study found a strong presence of international organisations in all reform programmes in the health sector at primary and secondary level health care facilities in Punjab. In Punjab Health sector, multilateral lenders (IMF and World Bank) have played a key role with bilateral donors (ADB and DFID), and have not only come as

advisors in the form of technical assistance but also as financial sponsors of the reform package.

The findings suggest that there are limits to the internationalisation of reform practices. Following the international *best* practices does give the reformers and national governments, the legitimacy that they require (Hood, 2000; Cheung, 2005). But the adopted international practices are filtered through national characteristics and administrative traditions, and get translated into the local context by the political and administrative elites. For example, contracting of primary health care facilities was indeed the government's intention to extend the public health service provision but these contracts were given over to a government-run NGO which was financed with seed money from the Punjab government. The District Support Managers were civil servants appointed on deputation, to make the transition easier and also because they understood the governmental processes better than anyone else.

In developing countries, reforms are influences by external organisations like the World Bank, IMF and other bilateral and multilateral financial lending institutions like DFID and ADB. The health sector reforms in Punjab are externally influenced by Asian Development Bank and DFID through financing, technical assistance and conditional grant mechanisms.

Donor involvement and international influence was observed in almost all but one reform intervention. International financial institutions like Asian Development Bank and Department for International Development (DFID) are actively engaged with health Department, Punjab in the reform programmes. Both these financial institutions are lending technical and financial assistance to the Punjab government for programmes instituted under Punjab Millennium Development Goals Programme, that has been initiated for the fulfilment of UNMDG. Punjab Millennium Development Goals Programme worked under Conditional grant Mechanism and money was disbursed in three tranches.

Polidano and Hulme (1999) are of the view that governments favour the reform proposals which are backed by donor assistance because of the financial gain it brings to them. Hirschmann (1993) while using evidence from Malawi also reports that civil servants do not raise objections towards reform because they do not want to be the ones 'blocking' or 'refusing' aid. This research study confirms Polidano and Hulme (1999) and Hirschmann's (1993) argument. The bureaucracy and politicians seemed especially keen in lending their support to reform programmes that bring in financial assistance. The informants even went to the extent of saying that *"you won't call it reform, if it isn't sponsored" (INT-CONT-10).*

Developing countries are encouraged by the international organisations to adopt reform practices that are considered "best". Pritchett and Woolcock (2004) have argues that mimicking the organisational forms of a certain country has been the root cause of a number of problems faced by developing countries. A number of studies have also criticised the approach that has been adopted by international donors and financial organisations, that exports the reforms and practices successful in a developed country and encouraged the developing country governments to adopt these (see for example Grindle, 2004; Andrews, 2008).Hiring of management consultants for technical assistance programmes was true for all reform interventions. PDSSP, PHSRP and PHC were conceptualised by management consultants hired according to the guidelines of Asian Development Bank and DFID, UK. MSDS and SOP were also prepared by management consultants. CONTECH Management consultants prepared the MSDS and SOP, and were ADB-approved management consultants. Capacity building reforms like in the case of SOHIP-CIDA were run by a Canadian-based local consultant. The management consultants interviewed referred to the international best practices as the starting point of their work. When further probed about the importance of context the informants responded that *'they are local and they would obviously know what's going to work and what's not'. (INT-CONT-10, INT-SOHIP-11).* Andrews (2012) has argued that the international best practices are adopted in countries where the commitment to reform is weak. In the context of this research, there was no direct evidence that

showed weak commitment to reform. The informants within the Health Department seemed optimistic about the reform programmes, and their outcomes in the future, but the action showed otherwise. Retaining power that should have been fully transferred to the district administratice structures, delaying the renewal of contracts in CMIPHC and lack of motivational engagement with the professionals and staff indicated otherwise.

The international development debate during the 1990s linked public sector decentralization reform to poverty alleviation in developing countries, and also provided a rationale for international donor agencies to support many decentralization and local government reforms in the developing world. According to Romeo (2003), if decentralisation is not mainly driven by external pressures rather than local service delivery issues, it is predominantly a political intervention by the central governments to extend and reinforce their control over local jurisdictions. Recent decentralisation analyses in developing countries have shown that in Africa, these political motives have helped the dominant political party or military rulers to extend their control over the local jurisdictions within the country e.g. in Nigeria and Angola (Crook, 2003; Crook and Sverrisson, 2001). In Pakistan, the military rulers in an effort to reconstruct the state and with similar political motives to legitimize their rule and control over the public, introduced local government reforms in 2001. Decentralisation in Pakistan was not only under the need for improved service delivery combined with external pressure but was encouraged by the military rulers to provide them with the power base and legitimacy to extend their rule in the country devolution(Cyan et al., 2004; Nayyar-Stone et al., 2006; Mohmand and Cheema, 2007). Decentralisation is also considered as a first step by the multilateral lenders towards introducing NPM reforms to public sectors in developing countries, which in the context of our research was implemented by the government, for subsequent NPM style reforms in health sector under PMDGP. To conclude, donor involvement (financial and technical assistance) was present in all the reform programmes found in Punjab.

8.2.5 The politics of health sector reform

Recent developments in literature on public sector reforms have established that the process of reform in developing countries is a political one (Grindle, 2000; Batley et al., 2012). 'Politics' and 'governance' are increasingly becoming the explanation of under-performing public services in developing countries (Batley et al., 2012; McLoughlin and Batley, 2012). A political analysis of the reform process and why reforms have been adopted in the context of a developing country can enable us to look at the reform process in developing countries and compare it to the experience of the developed world. In this section, I would like to argue that reforms in developing countries have been largely driven by 'pragmatic rationales'(Batley and Larbi, 2004:38) than the drivers enumerated in intellectually stimulating theories discussed in our literature review (Chapter 3 and 4).

A number of studies have attested that reform proposals are generated by the 'executive' rather than 'legislature, political parties, interest groups or think tanks' in developing countries (Grindle, 2000; Krueger, 2002; Williamson, 1994; Waterbury, 1992). This holds particularly true in the case of developing countries that have post-colonial administrative structures, that embody a strong bureaucratic setup, strict rules and procedures with weak political institutions. According to (Waterbury, 1992), in most developing countries, executive-based "change teams" guide reform proposals from adoption to implementation, while having a long history of dominating the legislature over the years. In the case of Pakistan, it has been found to be particularly true because of the technical expertise that the bureaucracy possesses, coupled with the political instability, ineffective legislature and political turmoil, the bureaucracy emerges as the main players in initiating change and reform proposals in the public sector (Islam, 1989; Islam, 2001). Bureaucratic elites within health department were found to me the main proponents of reform proposals and reform implementation in Punjab.

One of the most important driver of reform in public sector globally has been the economic and fiscal stresses that the governments face (Aucoin, 1990; Manning,

2001). The fiscal stresses establish urgency for change in both developed and under-developed economies paving way for public sector reforms. For developing countries with unstable and under-performing political institutions, political elites transfer this urgency for change to the bureaucratic elites and form teams and 'coalitions' to draw proposals for change (Leftwich and Wheeler, 2011). Leftwich and Wheeler (2011) stress the critical role played by 'leaders, elites and coalitions' as crucial to the reform and development outcomes. Although the authors contribution is pertinent to the outcomes of reform and development efforts, it is equally relevant to the reform adoption and design stage. This research study found that reform proposals were purely a product of a few select elite teams selected and appointed by politicians. Appointments in the public sector are highly political in nature and *like-minded* bureaucrats are appointed to important positions. The reform proposals were generated by Health Secretaries with the help of management consultants, and were prepared in light of the *national policy frameworks.*

Grindle (2000) in her analysis of three decentralisation initiatives also suggests that reform proposals emerge when political leaders become concerned with poor state of the public administration systems, thereby resulting in constitution of special teams and committees to review the situation and develop policy recommendations, which ultimately result in reform. Pakistan Local Government Ordinance of 2001 (Government of Pakistan, 2001f), is one such example, that illustrates Grindle's analysis. A National Reconstruction Bureau (NRB) was instituted by the military rulers to improve the dismal state of public administration in the country, which resulted in creating local governments and devolving social services. The military rulers did have other political motives for introducing decentralisation (Cyan et al., 2004), where they wanted to dilute the power of the bureaucratic structures and establish power and control. The motivation for decentralisation was a combination of political and international influences, in a time of crisis-ridden and poorly managed public administration system.

When the researcher asked the Health Department officials about the origins of the reform proposals, there were divergent responses.   The proposals and reform initiatives are presented to Health Minister or the Chief Minister after a plan has been chalked out, and mostly these reform proposals are taken as given. The reforms suggested are assumed by the executives and politicians as solutions to some pressing problems with health service delivery. The informants in the Health Department were of the view that recently, the pressing problem has been 'slow achievement of Millennium development goals' and preparing reports for the donors so that the next tranche could be released (INT-PDSSP-1;INT-MOH-2).

Being part of these teams also served as an *incentive for the elites*. The informants were of the view that being part of these committees and being responsible for initiating and presenting the reform proposals, mostly meant being part of the implementation phase. Additional Secretary, Health who presented the idea and made the program proposal for PDSSP was later made the Programme Director of the programme for a period of three years and was also compensated for this, as it was a special position created for the purpose. The goodwill that he built with the donors during his time at PDSSP, helped him gain an important position with another ADB-funded position. These positions One of the informants shared that *"Since it was a programme that was sponsored by 'development partners' they wanted someone who knew it inside out, and who better than ABC as he wrote the proposal"(INT-MOH-2).*

Batley et al. (2012) find that international policy in the form of UN Millennium Development Goals and the subsequent emphasis of UN on public administration and its role towards the achievement of MDGs, have driven the recent reforms in health, primary education, water supply and sanitation (United Nations, 2011). The 'thrust' of the international development agenda resulted in an increase in the 'development aid spending' by the richer countries, which confirmed their support at the G8 summit in Scotland in 2005. This led to an increase in the developing country government's motivation to initiate reforms as they were matched with financial

assistance from the international multilateral and bilateral donor organisations. Following the signing of Millennium Development Goals, the governments faced a period of uncertainty and instability owing to the military rule and lack of immediate bureaucratic support extended to the military rulers. Following the election of a democratically elected government in 2004, reform programmes were initiated in health services in 2004. The very first reform initiation efforts were seen in the form of Punjab Health Sector Reform Programme, which was setup as a Programme Management Unit within the Health Department to work with the financial assistance from Asian Development Bank for the uplift and provision of missing health care facilities in the province. The project was funded with the help of financial assistance from Asian Development Bank.

The policy makers and service users/citizens in developing countries have been found to be non-instrumental in 'demanding, designing and directing' reforms. Reforms within the institutional context of developing countries, due to the presence of an additional set of actors i.e. IFIs and donors is more complex and has significant 'political salience' (Batley and Larbi, 2004). Batley and Larbi (2004) has evaluated the reform process in social sectors, by identifying the 'principals' and 'agents in the reform process, and to what extent the agents are motivated to act in the interests of citizens.

Grindle and Thomas (1991, in Batley, 2004c) have distinguished between two types of reform initiatives: reform interventions requiring wider *public mobilisation,* and reforms requiring *bureaucratic responses and restructuring.* Reforms that require wider public mobilisation have high political stakes, while those requiring bureaucratic responses call for 'bureaucratic compliance'. The factors identified by Grindle and Thomas (1991) are summarised in Table 9-5. Batley (2004) have added on to Grindle and Thomas's (1991) argument, by arguing that in weak political economies, bureaucratic structures are highly politicised, and those reforms that have low 'political salience' in advanced economies may be highly political in nature.

Moreover, in case of externally-led reforms the policy-making process excludes the broad public arena and is a closed process.

Most health sector reforms in Punjab for like contracting-in of health care facilities, decentralisation are not very likely to generate a public response. The reform initiatives have an impact on service delivery mechanisms but they can only seen in the long run, and would not manifest themselves in providing immediate benefit to the service consumers. This explains the ignorance and lack of substantial service improvements experienced by the users in Lahore and Kasur districts. The users were only able to report the availability of medicines and staffed medical facilities in their districts. According to Grindle and Thomas (1991) classification, health sector reforms in Punjab will fall in the 'bureaucratic arena', having an effect on the *working* and *behaviour* of professionals, healthcare managers, and officials.

Characteristic of reform	Features of reforms in the public arena, requiring political support and stability	Features of reforms in the bureaucratic arena, requiring bureaucratic compliance
Dispersal of the costs	Costs have wide impact among the population	Costs focus on government institutions
Dispersal of the benefits	Benefits are focused on government	Benefits are not immediately felt by bureaucracy and only in long term by public
Technical and administrative complexity	Reforms have low administrative content and can be done quickly	Reforms are administratively complex
Level of public participation	Reforms require wide public involvement and are 'visible'	Reforms require limited public involvement and are 'invisible'
Duration and visibility of reform process	Reforms can be achieved quickly and are visible	Reforms require sustained effort with few immediate visible returns
Examples	User fees. Privatization of services	Contracting out. Decentralized management

Table 8-7: The public and bureaucratic arenas of response and resistance to reform . Adapted from Grindle and Thomas (1991 in Batley,2004)

Due to the nature of health sector reforms introduced during 2004 -2011, focusing on decentralisation, contracting-in of health care facilities, and minimal involvement of

public, these reforms can be categorised as virtually 'invisible' to the public. Their effects are also not short-term. They can easily be classified as administratively complex, with few immediate visible outcomes. Decentralisation, contracting-in of management services and regulation of MSDS through PHC, require 'bureaucratic compliance'. The nature of the reforms also explains the lack of bottom-up accountability mechanism and ignorance of the service users about health sector reforms.

Elite motivation to health sector reform can be analysed using Feigenbaum and Henig (1994) typology. Three types of motives for reform can be found when reforms are introduced as technical and administrative solution to some pressing problems: pragmatic, tactical and systemic. *Pragmatic* motives to reform are discrete and context-dependent episodes to reform, carried out by bureaucratic units that are insulated from the push and pull of normal political pressure. These reforms are usually undertaken in areas, which are 'apolitical' or 'depoliticised', and are considered as a tool among many others to solve managerial/social problems. Punjab Millennium Development Goals Programme, which focuses of improving the health indicators around maternal and child health, and also comprises of MSDS and Punjab Health care commission can qualify as showing pragmatic motivation to reform.

Tactical motives to reform result in reforms initiated to serve short-term goals of politicians, parties or interest groups and are introduced to reward supporters and attract allies and is "political product differentiation" strategy. Decentralisation of health services, post-devolution is one illustration of this type of reform in the health sector. Decentralisation was a politically motivated reform, carried out by military government to attract and reward supporters. The reforms were done by the military regime to create local government structures, which would help them counter-act the power bureaucracy holds (Cyan et al., 2004).

Systemic motives to reform intend to reshape the society by altering the economic and political institutions and by transforming the economic and political interests e.g.

private sector management practices, or contracting out. None of the reform interventions discussed explicitly exhibit systemic motives to reform, however, contracting-in of management services to a government-run NGO can fall in this category.

Motives to reform	Examples
Pragmatic – discrete and context-dependent, carried out by bureaucratic units insulated from political pressures	Punjab Millennium Development Goals Programme, Minimum Service Delivery Standards, and Punjab Health Care Commission
Tactical – reforms intended to serve short-term goals, rewards supporters and attract allies, political product differentiation strategy	Decentralisation of health services
Systemic – intend to reshape the society by altering the economic and political institutions' and interests.	Alternate modes of service delivery

Table 8-8: Feigenbaum and Henig's (1994) typology of motivation to reform applied to health sector reforms in Punjab

8.3   Synthesis: Reform Model and Reform Adoption

The section will synthesize the arguments presented in Section 8.1 and Section 8.2 to answer the research questions of the study. At the end of the literature review, based on the empirical and theoretical gaps in the literature, following research schema was outlined to guide our research of health sector reforms in Punjab. The study set out to determine the answers to the following research questions.

Research Question 1: What model of public management guides health sector reforms in Pakistan?

- What are the main reform drivers' and strategies' and how have they been implemented?

- To what extent has NPM been the dominant reform paradigm in health service reform trajectory?

Research Question 2: How are reforms being adopted in a developing country context?

- What motivates and drives administrative elites to adopt and implement health service reforms in Pakistan?

  What role do professionals, health care managers and service users play in the reform process?

This section seeks to answer the research questions by synthesising our findings and discussion from Chapter 6-8 and will now present an overall synthesis of the main findings of the research study.

8.3.1 Reform model guiding health sector reforms

New Public Management has suffered from a 'self-proclaimed universality' (Osborne and Gaebler, 1992; OECD, 2005; Manning, 2001) but is not the only paradigm governing reforms in developing countries (Manning, 2001). A review of public management literature on developing countries reveals that despite the introduction of NPM-like reforms in selective instances, the traditional bureaucracies have retained their power and structure, and have not been replaced and extended with contracts and agencies (McCourt, 2002). This research study confirms the findings of authors, and reports that traditional administrative structures have been retained with a powerful bureaucratic structure that has been instrumental in adopting reforms but is also acting as a barrier to successful implementation.

Punjab Health Sector is faced with some key challenges to health service delivery (Section 6.1 and 6.2). Given the backdrop of UNMDG and Devolution, the government is keen to reform the health sector. Pakistan, being a developing country,

is reliant on financial and technical assistance of multilateral and bilateral financial institutions that have been instrumental in bringing public sector reforms in developing countries. In line with the policy frameworks and global health development agendas, reform programmes in health sector have been introduced from 2004 till 2011. Seven reform interventions were identified in the Punjab Health Sector, which, on the face of it, have resembled the reform practices of OECD countries. Using Pollitt and Bouckaert's concept of reform trajectory, *organisational, performance* and *personnel-related reform trajectories* were found (Section 8.1). These reform trajectories were implemented in primarily a top-down fashion by bureaucratic elites with political support. The reforms implemented have required legislative measures, like passage of two new acts in National and Provincial Assemblies (Government of Pakistan, 2001f); Government of Punjab (2010), but the design and implementation part of the reform process was concentrated within the bureaucratic elites. The reform programmes were found to be driven a number by exogenous and endogenous influences, like poor public health service delivery mechanisms, health indicators, financial stress, and globalisation. Development agendas like Poverty Reduction Strategy Papers and UN Millennium Development Goals are also criteria for extending financial assistance to the developing countries. The government and the key actors in the reform process, predominantly top-down, are forced to adopt these development agendas because of the anticipated financial and technical assistance that comes with it. The government on the other hand feels that it adds legitimacy in the eyes of citizens, but also in the eyes of its development partners, and also shows that the government is trying to do something which otherwise on its own would not be possible. Health and education are usually the most talked about and crucial services that can add weight to the political manifestos.

This current research has also found that NPM reforms in developing countries do not follow the same political-administrative design (Aucoin, 2011), that has been observed in OECD countries. *The reforms are not primarily introduced with the objective of achieving efficiency and improving service delivery, as in the developed economies, but are adopted in response to economic and fiscal pressures, motivating*

the political and administrative elites to design reform proposals, which will potentially meet the donors' seal of approval. Therefore, this suggests that reform process is complex and is not driven and determined by the internal and external institutional forces, rather it is a complex interplay of elite motivation combined with the internal and pressures to reform.(Section 8.2.5 and Section 8.3.2)

The reform strategies as discussed in Section in 8.2.1 and Section 8.2.2, bear a close resemblance to NPM confirming the findings of Manning (2001), McCourt (2002) and Batley (1999) that NPM practices have been selectively adopted by the developing world. However, the study does not support the research that claims universal applicability of NPM reform models irrespective of the context. The researchers stance aligns unequivocally with the findings of McCourt (2013) and Batley and Larbi (2004), who give preference to context over best practices. The study agrees with the findings of Manning (2001) and McCourt (2002;2008;2013) that developing countries started adopting reforms with NPM elements after the financial crisis of 1997 in East Asia under donor pressure, but does not consider donor involvement as the most influential driver for health sector reforms in Punjab. Reforms in health sector may look like NPM reforms but actually these are reforms imposed by the international organisations and translated into our local context by the political and administrative elites.

Using Pollitt and Bouckaert's (2011) concept of reform trajectory, we can clearly conclude that reform trajectories in Pakistan are clearly not done with a clear omega in mind. The departing point of these reforms may have been the key issues in health service delivery but this intention on part of the government then gets matched with financial and institutional constraints. Financial constraints in the form of budget deficits and the commissioned budgets just being enough to pay salaries and cover routine expenses, the governments then look for financial assistance from development partners and donor organisations. The preoccupation of the donor organizations with current models of public management that have been successful in the developed world, are then used as a criteria to judge the proposals and

programmes proposed by the developing world.

The bureaucracy on the other hand, core administrative elites back these reform agendas because of the prosperity, power and financial well being these projects bring to them. These programmes are usually implemented with the help of special agencies and administrative units that are specifically built for this purpose, confirming Grindle (2000) and Leftwich and Wheeler (2011) analysis. Being part of these teams, ultimately means that elites get a chance to be paid more than they were previously by working as project directors or as officers on deputation on special donor-assisted projects.

The documentary analysis suggested participatory evolution of research proposals by involving professionals, staff and service users (Government of Pakistan, 2001a; PDSSP, 2004) but the research findings suggested otherwise. The professionals, doctors and staff argued against any sort of involvement or input into the policy process, and also indicated lack of motivational engagement by the Health department during reform implementation. They feel that they are being underpaid, with no avenues for training provided to them. The government may be undertaking reforms but they had serious doubts about the impact it has on service delivery outcomes. *'Our health care system needs an overall revamp not incremental change that can be reversed by the new party in office'. (INT-KAS-32)* Service users interviewed at health facilities were found to be ignorant of any recent reform interventions in the public sector. The service users interviewed at contracted health facilities appreciated the recent improvement, by saying that there has been an improvement in availability of staff and medicines. (INT-KASU-24;INT-KASU-22)

Many reforms in water, health and primary education have been drawn from NPM practices in the developed world (Batley and Larbi, 2004; Batley, 1999) but have failed to alter the powerful bureaucratic structures. There is selective adoption of NPM-like practices in Punjab Health sector reforms but these reforms have been introduced for two reasons: *firstly,* as a response to strengthen the devolved health services and *secondly*, to align the goals and strategies so they can help in meeting

the donor requirements for financial assistance for the achievement of Millennium Development Goals.

The research findings corroborate Cheung's (2011) suggestion of a hybrid NPM model in Asian countries which thrives on nation-buiding, steering the economy, within a predominant role of administrative reorganisation and reform Cheung (2005). The reform practices and strategies have been around the themes of performance management, decentralization, alternate service provision, community mobilisation and empowerment and capacity-building. The overall reform fabric bears close resemblance but does not have the political-administrative design of NPM reforms.

Additionally, I would like to argue that relative salience of the reform drivers. The research findings suggest that endogenous forces e.g. bottom-up pressures from citizens and service users, party ideologies, and socio-economic forces are only a weak factor in determining the reform design and implementation. This implies that NPM-like reforms, which by design are introduced to achieve efficiency in public services, are only adopted but do not serve the purpose they are intended for, but the entire process is coloured with incentives, ideologies, and vested interests of political and administrative elites.

8.3.2 Reform Adoption

This question about how reform are adopted does not have a straightforward answer, but the findings indicate a number of factors influencing the adoption of reforms in developing countries. The findings of Section 8.2 and Section 8.3.1 in response to the first part of our overarching research question confirm the centrality of administrative elites in driving, designing and implementing reforms in Punjab health sector. Moreover, generating reform proposals, building consensus, drawing implementation plans and dealing with international financial institutions is dominated by elites. Reforms are perceived by elites as an opportunity to secure incentives in various forms. If reform proposals are able to secure financial

assistance from the "development partners" and IFIs, it is highly likely that the officials will be associated with the project under its implementation phase. This means, 'special deputation' appointments with additional perks and allowances. Although the recruitment process is transparent by design with advertisements in leading newspapers, but is open to public servants working with the government. The positions are rarely filled with someone from the private sector, because it is believed that in order to understand the governmental structures it is important to have an 'insider', who understands the rules of the game.

Tracing the origins of the reform interventions and how they were introduced (Section 7.2 and Section 7.3) the reform programmes tell a consistent story about the interplay of elite interests and financial gains associated with reform, as an important factor in adopting reforms. In most cases, a small group of elites was assigned the task of making recommendations about improving health service delivery by the political leaders (Chief Minister or Health Minister). The political executives did not articulate or define problems within health sector that required solutions, and gave broad scope to the administrative elites to explore various paths to reform public services and build consensus around them. The process of consensus involved making presentations to the cabinet at the provincial and the federal level, but hardly any informants referred to evidence, or involving professionals or citizens to the process. This confirmed the lack of motivational engagement during reform implementation, lack of participation in deciding reform agenda, and ignorant service users.

From the perspective of the elites and executives undertaking the task to design reform packages and programmes, they were considerate of how the reforms would affect the various economic and political interests. There were very few disagreements and conflicts within the administrative arm of the government because of the appointment of like-minded bureaucrats to the office as soon as a new government takes office. The international actors engaged with committees and teams appointed by the Chief Minister to negotiate the reform proposal and loans

that follow. Multilateral and bilateral development agencies during the negotiations and as part of the contracts encouraged governments to hire management consultants for needs assessment and technical assistance. CONTECH, a management consultancy firm was found to be particularly favoured within the bureaucratic circles, because of their previous experience with ADB and DFID.

The existing models that capture reform processes across countries and that form the basis of our research questions have shown that the reform adoption patterns vary among countries. Christensen and Lægreid (2007) argue for a transformative theoretical approach to studying reforms, where the reforms are transformed in their tone and meaning as they interact with political, cultural and administrative contexts. Additionally, Pollitt and Bouckaert (2004) have demonstrated with evidence from twelve advanced countries finding selective adoption of reform elements, making governments an important actor in the reform process (see also Turner, 2002). What these reform models fail to capture is the elite motivation to reform, and how their interests' interact with external pressures to adopt reform practices.

We have emphasised the centrality of decision-making throughout the reform process, but what is interesting is why do the elites' adopt NPM-like reforms (or any other reforms) that challenge their right to retain power or dilute the power they hold over institutional structures? This contradiction can be explained, in Punjab Health Sector, by devolution and contracting-in of primary health facilities. This research study found the devolution had not happened the way it was envisaged in Local Government Plan of 2001. District health budgets were retained by the provinces and so were the rights to hire and post staff within the districts. Similarly, CMIPHC's status was undecided as their contracts had expired but the government was still undecided about whether to renew their contracts or not. This implies that under external pressure or 'pragmatic rationales' that may have governed decision-making, led to the adoption of reforms but proper implementation of reforms did not happen because of conflicting interests of the governments and elites.

Punjab Devolved Social Services Programme (PDSSP) was a technical assistance programme to strengthen the devolved social services. According to the Secretary Health, this programme was designed and approved because of the financial assistance that came with the programme. Punjab Millennium Development Goals Programme (PMDGP) is another example that brought in financial aid and technical assistance and was adopted for implementation because of the multi-tranche loan that ADB could extend to the programme. PDSSP was a technical assistance programme and many of its programmes have not been adopted for implementation, and were even considered too ambitious for the Punjab Health Sector (Interview with Programme Director, PDSSP), and the implementers knew beforehand that not all of the programme proposals prepared under PDSSP would not be adopted for implementation.

Chief Minister's Initiative for Primary Health Care (CMIPHC), used the services of department civil servants on special deputation, as district support managers. These civil servants were the same who were considered to be ineffective managers of the public health care facilities, but when appointed on deputation, on thrice the salary, and with more managerial autonomy were considered successful. Punjab Health Care Commission is a regulatory body which has been conceptualised and implemented with the help of technical assistance from DFID and later has been implemented by PHSRF. Therefore, we can conclude that designing and adopting reform proposals not only brought in financial and technical assistance to the government, but it also resulted in elite incentives.

8.3.3 Theoretical Implications

This section will summarise the answers to the research questions of the study and draw some theoretical implications.

Firstly, most research on public sector reforms focuses on the institutional forces and their effect on the reform agenda and process (Pollitt and Bouckaert, 2004; Christensen and Lægreid, 2007) . The current models of public management reforms

de-emphasise the political dimensions of reform decisions that are rooted in the conflicting interests of politicians and bureaucrats. Politics of service delivery reform have recently been receiving attention as an important determinant of reform outcomes (Batley et al., 2012). The findings of the research study have enabled me to argue for a political analysis of the reform adoption process (actor-based perspective).

Secondly, Public management reform prescriptions or models originate in the Advanced Western economies that have well-developed market economies which prove to be sufficient for effective implementation of NPM reforms. Developing countries, on the other hand, are politically unstable, with strong bureaucratic institutions, and provide an ineffective habitat for implementation of reform ideas and practices originating in the West (Schick, 1998). Based on the experience of health sector reforms in Punjab and the findings of the case study, the researcher's stance aligns with those researchers who give precedence to context over best practice (Andrews, 2013c; McCourt, 2013). The characterization of health service reforms as instruments of change to bring about an improvement in the state of public health service delivery is overly deterministic and understates the motivation to reform in political and administrative elites, which may or may not align with the social and demographic needs of the region in question. The current models of public service reform fail to embody the administrative culture that post-colonial administrative structures embody, shaping beliefs of key actors, their desire to retain and use power and serve their own interests. Moreover, I would like to argue that reforms in developing countries is more of a 'political process' than a 'structural one'. My views concur with those of Batley et al. (2012), (Leftwich and Wheeler, 2011) and McLoughlin and Batley (2012), in considering development and public sector reform process as a political one. The motivation to reform in health sector, seems to be a complex process which did not have the single answer it ought to have provided the researchers, that it was an effort to improve service delivery in public health care facilities for the good of the citizens.

Thirdly, the degree of social consensus shown in the policy documents and claimed by the policy makers is over stated. Citizen engagement and motivational engagement of people working within the health sector is absent resulting is islands of decision making dominated by the political and administrative elites. These administrative elites are at best responding to two types of pressures: the pressures of the political elites to come up with projects and programmes that can bring in financial assistance through multilateral and bilateral financial institutions, while conforming to the global development agendas, and secondly, the administrative elites want to initiate reform proposals and programmes that can help them secure special deputations and appointments, resulting in incentives and will keep them away from the routine matters of the office. This not only makes them popular with the current political setup, but may also result in being the favourites of a certain political regime in office.

Chapter 9
Conclusions and Reflections

Chapter 9   Conclusions and Reflections

This chapter will conclude on the research study elaborated in this thesis: firstly, it will assess the extent to which the research aims and objectives have been achieved, and will evaluate the contribution to knowledge. The contribution is evidenced empirically and theoretically through the study of health sector reforms and the application of public management theories and concepts to the understanding of them in relation to reforms undertaken in health sector during 2004 till 2011. Mapping the health sector reform in Punjab across reform drivers, strategies, and their implementation addresses the empirical gap identified in the literature review. In addition, recommendations are made for studying reforms in developing countries based on the findings from this research and avenues for theoretical development towards reforms in developing countries for further research are proposed. The findings are discussed under relevant research objectives and questions.

9.1   Research objectives

This section concludes and examines the research by examining to what extent the research objectives have been achieved, and the research questions have been answered. The research objectives identified are:

- *To map out health sector reform initiatives with respect to drivers, strategies and how they were implemented*

- *To explore the motivation to reform from the perspective of administrative elites*

- *To add to existing knowledge on public management reforms in developing countries for theory-building*

The first research objective is based on the empirical gap identified after literature review indicating lack of research on health sector reforms from a public management perspective (Section 4.5). Scant research reform in health sector has been within the public health domain focusing on health indicators and clinical

outcomes and processes affected by health sector reforms. This research responds to the empirical gap identified on health sector reforms in Pakistan by taking Punjab, most populous province, as a case from 2004-2011. Health sector reforms applicable to primary and secondary health facilities were mapped with respect to drivers, strategies and how they were implemented (Chapter 6). The case study provides a top-down approach to reforms, and supplements it with bottom-up evidence from professionals, district health administration, and service users in two case units: Lahore and Kasur (Chapter 7). Seven reform programmes in health sector have been identified from 2004 till 2011 (Section 6.2). The implementation of these reform programmes via legislation, creation of new structures, and implementation constraints have been discussed in Section 6.4. The reform programmes are then subjected to a theoretical analysis, and interpreted with respect to the dominant public management paradigms, to add to the relevant existing literature on developing country reform experience.

9.2 Research Questions

The overarching questions guiding this research are:

Research Question 1: What model of public management guides health sector reforms in Pakistan?

- What are the main reform drivers' and strategies' and how have they been implemented?

- To what extent has NPM been the dominant reform paradigm in health service reform trajectory?

Research Question 2: How are public management reforms being adopted in a developing country context?

- What motivates and drives administrative elites to adopt and implement health service reforms in Pakistan?

What role do professionals, health care managers and service users play in the reform process?

The findings of the research study suggest that NPM-like reform practices are adopted in health sector reforms in Punjab, but the traditional bureaucratic structure retained their power and structure, and have not been replaced with market-based mechanism or private sector-based practices. The findings align with the McCourt (2002; 2013) and Manning (2001) who have reported selective adoption of NPM practices in developing countries. The research study also finds that traditional bureaucratic structure have been instrumental in adopting NPM reforms in health sector but also act as a barrier to effective implementation.

Influence of multilateral and bilateral financial institutions was present in all the reform programmes and interventions found in Punjab. The policy frameworks guiding reforms like Poverty Reduction Strategy Papers, National Health Policy and Punjab Health Sector Reform Framework also indicated conformance to donor-led reform agendas. Federal government urged the provincial governments to design their policy frameworks according to Poverty Reduction Strategy Papers which later formed the basis of Punjab Health Sector Reform Framework.

The theoretical approaches to public sector reforms for e.g. NPM suggest that reform practices are primarily introduced by governments to achieve efficiency and improve public service delivery. But this research reports otherwise. . *The reforms are not primarily introduced with the objective of achieving efficiency and improving service delivery, as in the developed economies, but are adopted in response to economic and fiscal pressures, motivating the political and administrative elites to design reform proposals, which will potentially meet the donors' seal of approval.* This suggests that reform process is complex and is not driven and determined by the internal and external institutional forces, rather it is a complex interplay of elite motivation combined with the internal and pressures to reform.

Additionally, I would like to argue for the relative salience of reform drivers. The research findings suggest that endogenous forces e.g. bottom-up pressures from citizens and service users, party ideologies, and socio-economic forces are only a weak factor in determining the reform design and implementation. This implies that NPM-like reforms, which by design are introduced to achieve efficiency in public services, are only adopted but do not serve the purpose they are intended for, but the entire process is coloured with incentives, ideologies, and vested interests of political and administrative elites.

The reform programmes tell a consistent story about the interplay of elite interests and financial gains associated with reform, as an important factor in adopting reforms. In most cases, a small group of elites was assigned the task of making recommendations about improving health service delivery by the political leaders (Chief Minister or Health Minister). The political executives did not articulate or define problems within health sector that required solutions, and gave broad scope to the administrative elites to explore various paths to reform public services and build consensus around them. The process of consensus involved making presentations to the cabinet at the provincial and the federal level, but hardly any informants referred to evidence, or involving professionals or citizens to the process. This confirmed the lack of motivational engagement during reform implementation, lack of participation in deciding reform agenda, and ignorant service users.

9.3 Evaluating the contribution to knowledge

This research project makes a significant contribution to our understanding of reform process, new public management and the politics underlying reform adoption in developing countries. The research makes an empirical and theoretical contribution as under.

9.3.1 Empirical Contribution

The research study makes an empirical contribution by mapping health sector reforms in Punjab at the primary and secondary level health facilities. The study

responds to an empirical gap in the literature on public sector reforms in general and health sector reforms in particular in Pakistan and other developing countries. Health sector reforms in Punjab are mapped from 2004 till 2011, by using a case study approach to reconstruct the reform process by looking at drivers, reform strategies and how they were implemented. The research reported in the thesis leads us to the following empirical findings about health sector reforms in Punjab.

- Health sector reforms are shaped by domestic conditions, institutional dynamics and global pressure. These reforms bear resemblance to the common *NPM rhetoric,* but act as policy instruments for the elite to secure financial assistance from multilateral and bilateral lending agencies. The reforms do not threaten the pro-state and pro-bureaucracy model of public administration, which is reminiscent of the colonial legacy. Reforms have donned the NPM fabric but weak links between policy-making and implementation have failed to change the pre-existing political and administrative interests' and institutions. Reforms have been politically motivated e.g. decentralisation of social services, and half-hearted implementation efforts by succeeding governments have failed to consolidate the system.

- *Relative salience* of reform drivers is observed in designing reforms. Endogenous influences e.g. socio-economic conditions and citizen pressure exert a weaker influence on the reform process as compared to the exogenous influences of globalisation, international best practices and international financial institutions.

- *Elite motivation* to reform the health sector was mainly governed by the impending fiscal deficits faced by the government, resulting in generation of programmes, proposals and interventions that can help them in gaining financial loans and grants from lending institutions. Reform proposals were mainly generated by the 'executive' rather than the 'legislature, political

parties, interest groups or think tanks', which was contrary to the policy formulation process. The technical expertise possessed by the bureaucracy in an environment of political instability, ineffective legislature and political turmoil, the bureaucracy dominates the in initiating change proposals. The reform programmes also served as an *incentive* to the administrative elite, as they resulted in creation of special agencies and programme management units (PMUs), giving them more power and thus resulting in enhanced perks and salaries. The empirical data suggested that reform proposals were only generated by elites to serve their own interests or to please their bosses in the executive, who wanted to acquire as much financial loans and assistance as possible from the multilateral and bilateral funding organisations.

- The *service users'* were found to be non-instrumental in 'demanding, designing or directing' reforms. The service users were not aware of any reform programmes except for CMIPHC where the management of some primary health care facilities were being handed over to PRSP. The service users' were not involved whatsoever in generating reform proposals, despite the establishment of governments at the local level. This indicated lack of user involvement and participation in any stage of the reform process.

9.3.2 Theoretical Contribution

The literature review chapters for the thesis were particularly challenging to construct, as there are competing views on public management reforms in developed and developing countries. The study contributes to existing theoretical knowledge by recognising the conceptual confusions and simplifications surrounding reforms in developing countries.

In doing so, the study makes a small contribution to the development of theoretical knowledge on reforms in developing countries. Currently, the models of public management reform used to capture the reform process do not take into account elite motivation to reform. They acknowledge the centrality of elite decision-making and

how it is crucial to effective implementation and reform outcomes but do not acknowledge the interests and politics that may be influential especially in the developing country context (Pollitt and Bouckaert, 2004). models of public management reform widely cited in literature focus on the institutional forces and do not take into consideration the *actors' perspective.*

Elite decision-making or administrative elites in the context of developing countries are which are found to be an important determinant of reform agenda in developing countries. Unstable political institutions have resulted in a powerful bureaucracy, which operates in a complex environment. If the effects of reform, with regards to services users, are visible in long-term, and the reforms are more about bureaucratic restructuring and compliance, reform agendas tend to be influenced more by elite actors' incentives and motivation.

Currently, the reform process in developing countries is mainly seen as driven by socio-economic, institutional and global pressures. This research contributes by adding another sphere of analysis to developing country reform experiences. i.e. political analysis of motivation to reform.

The main recommendations for theoretical development concur with those of Batley et al. (2012) who have stresses upon the political nature of the reform process and have stresses for a political economy analysis. A small but burgeoning literature on service delivery in developing countries has started focusing on how political economy factors – 'actors, institutions and incentives' influence service delivery mechanisms. Political economy factors have recently been used in the literature surrounding reform outcomes, and have been used to explain the successes and failures of reform programmes (McLoughlin and Batley, 2012; Leftwich and Wheeler, 2011). This stream of literature on political economy factors and their effect on successful public service delivery adds to the previous literature, which claimed lack of political will and commitment as the only factor explaining reform failure in developing countries (Crook, 2010). The findings of this study suggest that reform process in developing countries is political in nature, and analysis of the

reform process should go beyond the analysis of external and internal pressures to reform, but should also look into the complex interplay of the pressures to reform including the elites' motives to reform.

9.4 Implications

The research study has provided a comprehensive account for reform process in health sector in Punjab and added to the existing literature on health sector reform in developing countries. The results of this study can be used to enhance our understanding of the reform process in developing countries and how it is different to the reform experience in advanced Western economies. The main findings of the study endorse the importance of politics in determining the reform agenda in developing countries. Future research needs to give special importance to an actor-based perspective acknowledging the interplay of interests and incentives, in addition to the internal and external pressures, leading to reform strategies and implementation in developing countries.

Models for capturing reform process like for example Pollitt and Bouckaert (2004) and Christensen and Laegreid (2007), do acknowledge the important role of elite decision-making, but these models de-emphasise the political processes underlying elite decision-making in developing countries. Reform proposals, policies and implementation are not an all-inclusive process that involves service users, people working in organisations. On he other hand, politicians are not representing the true interests of the citizens, resulting in policies and implementation practices that are not representative of public interest. Models of public management reform in developing countries should assess actor motivations and influences, in order to identify the forces that can enable or constrain the reform process in developing countries.

The research also has implication for donors and other financial lending institutions who have been a key player in the development process but have failed to achieve the results they had aimed for (McCourt, 2013; Manning and McCourt, 2013).

International organisations like World Bank and IMF have accepted their inability to effectively reform the developing countries and have indicated the inability to contextualise their development efforts, and have started looking beyond 'lack of political will' as their explanation for failing reforms efforts in the developing world.

9.5   Limitations of the research study

9.5.1   Limitations of the theoretical and analytical framework

The theoretical framework for the study draws from public management literature that was written and developed as a response to the New Public Management (NPM) trends introduced by governments in advanced western economies. Although the theoretical frameworks are mainly drawn from NPM, but they have been mainly designed to be general heuristic devices aimed at collecting empirical evidence that can be useful for single country and comparative studies. Organisational theories e.g. institutional theory could have been used to explain elite motivation to reform and could also have explained the organizational structures and associated elite behaviours in post-colonial developing nations. Due to the limited time available and lack of necessary empirical evidence that can provide holistic view of the reform process in Punjab health sector, the theoretical framework was limited to public management literature and literature on reforms in developing countries. Institutional theories can provide useful explanation to explaining the behavior of administrative elites in post-colonial administrative structures, and will be explored to produce research articles using data from this research.

A large amount of data was collected, which later had to be excluded from the research project. Data was also collected from service users that could have been analysed to gauge the public engagement in the policy process. Owing to time and resource constraints, within the scope of the study, this data was only used to supplement our findings, and to provide any missing links and evidence that can help us to explain our findings in a better way.

9.5.2 Research Limitations and Methodological Challenges

The researcher has tried to ensure adequacy and soundness of empirical and theoretical contributions, some limitations during research were inevitable, but can be used to inform future research. Firstly, the findings of this research are based on the case study of one of four responses in Punjab. Although, it was possible to conduct case studies of all the four provinces, but it may have taken a very long time, and the time and resources available for research was limited. Pakistan also experienced one of the worst floods of its history in summer of 2010 causing massive devastation across Punjab province. This caused a delay in the fieldwork by four months. Additionally, was forced to select two districts that were in close proximity to each other and where the administration agreed to give interviews and facilitate fieldwork. The southern districts of Punjab could not be included in the fieldwork, due to relief efforts in progress at the time of fieldwork.

Secondly, owing to the security situation in Pakistan, the donors and international organisations did not reply to the phone calls or email requests for interviews. The initial design of the study had to be altered as no representatives from any donor agencies responded to requests for interviews. An ideal qualitative study, whose findings show a strong donor presence in all the reform interventions, should have been validated with respondents from donors and other international organisations.

Thirdly, the tertiary care facilities were not included. District Kasur did not have any tertiary care facilities but Lahore had tertiary facilities, which were visited and some interview were conducted but due to the complexity of medical education and dual reporting mechanisms like federal cabinet and the provincial health department, they were excluded from the scope of this research.

Publication Plan

The researcher plans to extract at least two publications from this research study. The first research publication will evaluate the impact of New Public Management on

Public Sector Reforms in Pakistan. Currently, we are five colleagues from University of Punjab who are pursuing their doctorates in UK, and we are all working on reforms in different sectors: Higher Education, Taxation reforms, Public-private partnerships, water sanitation and health. All are either in the writing up stage or have completed. The plan is to write about Impact of New Public Management on reforms in Pakistan. Potential journals that can publish the research are *International Review of Administrative Sciences* and *Public Administration and Development*.

The second article that I intend to write is about the politics of health sector reforms in Punjab and express it as a problem of collective action using Olson's theory of collective action. I would like to evaluate the behaviour of administrative elites by applying theories of collective action by Olsen, and explain elite behaviour in the reform process in developing countries (Olson, 2002). Potential journals that might publish such are International Public Management Journal and Governance.

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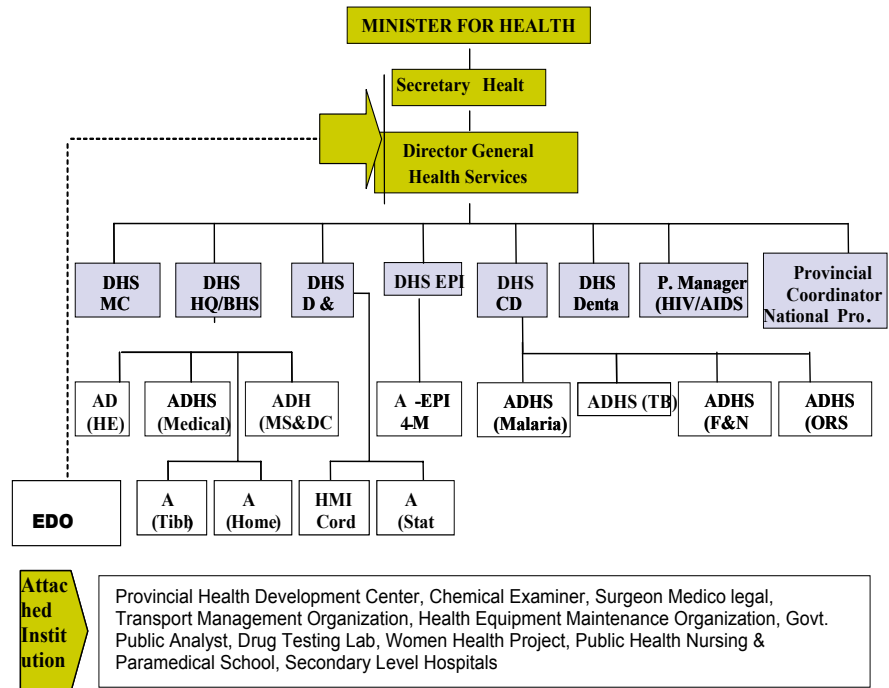
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Appendices

Organisational Chart for the Ministry of Health

Federal Minister

Minister of State

Secretary Health (BS-22)

SR J. S (Admin) (BS-21)

SR. J. S (F&D) (BS-21)

Chief (Health) (BS-20)

D. G. (Health) (BS-21)

Technical Wing

Drugs Wing

D.S. (A) (BS-19)

D.S. (E.stt.) (BS-19)

D.S. (Per.) (BS-19)

D.S. (B.) (BS-19)

D.D.G. (P&D) (BS-19)

Nursing Advisor (BS-20)

D.D.G. (MER/IH/PH) (BS-19)

D.D.G. (PHC) (BS-19)

D.C. (L&QC) (BS-20)

Cost Accountant (BS-20)

D.C. (Reg&Evol) (BS-20)

S.O. =02
A.D.=02
Librarian=1 (BS-18/17)

S.O. =02 (BS-18/17)

S.O. =03 (BS-18/17)

S.O. =03 (BS-18/17)

S.O. =2
R.O. =01
St.Off.=01 (BS-18/17)

S.O.=01
ADG=01 (BS-18/17)

A.D.G =02
Dy.N.P.D=01 (BS-18)

H.E.A. (BS-18)

ADG=01
C.S.Off. =01
S.T.O.=021 (BS-18/17)

DDG/
CQC
(QC) (BS-19)

DDG
(R&D) (BS-19)

D.D.G.
(E&M) (BS-19)

D.D.G.
(Reg) (BS-19)

D.D.G.
(D.I)
(BS-19)

DDC /
ADC=2 (BS-18)

DDC /
ADG=2 (BS-18)

DDC /
ADG=2 (BS-18)

DDC /
ADG=2 (BS-18)

DDC /
ADG=2 (BS-18)

ADC /
VCQC=3 (BS-17)

ADC=01
S.T.O=01
A.O. =01 (BS-17)

ADC=01 (BS-17)

ADC=03 (BS-17)

ADC =2 (BS-17)

C.Prog. (BS-17)

Attached Deptt.

Pakistan Institute of Medical Science (PIMS) Isbd

Directorate of Malaria Control, Islamabad.

Federal Government Services Hospital Isbd.

Jinnah Postgraduate Medical Centre (JPMC) KHI.

National Institute of Child Health (NICH) KHI

Directorate of Central Health Establishment KHI

Organizational Set-up: Provincial Level

MINISTER FOR HEALTH

Secretary Healt

Director General Health Services

| DHS MC | DHS HQ/BHS | DHS D & | DHS EPI | DHS CD | DHS Denta | P. Manager (HIV/AIDS | Provincial Coordinator National Pro. |

AD (HE) | ADHS (Medical) | ADH (MS&DC | A -EPI 4-M | ADHS (Malaria) | ADHS (TB) | ADHS (F&N | ADHS (ORS

EDO | A (Tibb) | A (Home) | HMI Cord | A (Stat

Attached Institution

Provincial Health Development Center, Chemical Examiner, Surgeon Medico legal, Transport Management Organization, Health Equipment Maintenance Organization, Govt. Public Analyst, Drug Testing Lab, Women Health Project, Public Health Nursing & Paramedical School, Secondary Level Hospitals
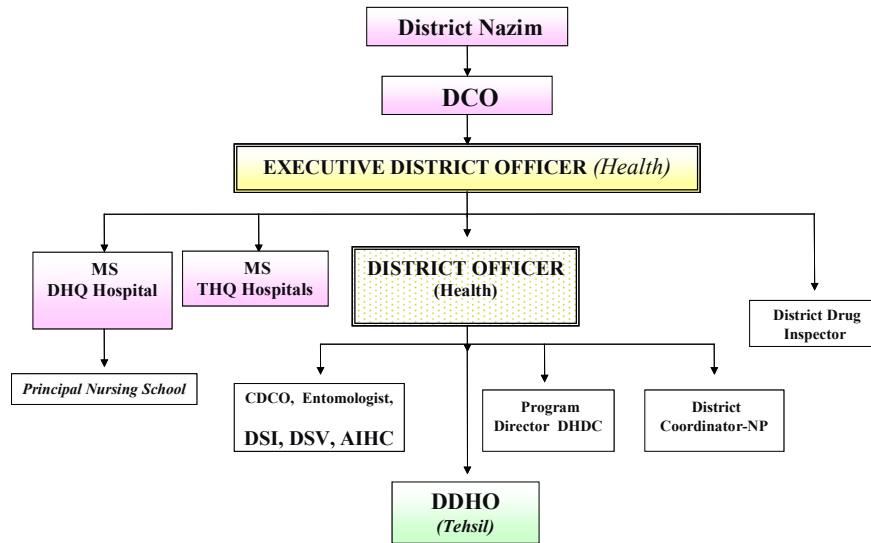
Source: Inventory of Health and Population Investment in Pakistan, WHO

Organisational Chart for Health Department, Government of Punjab

Source: Health Department, Government of Punjab

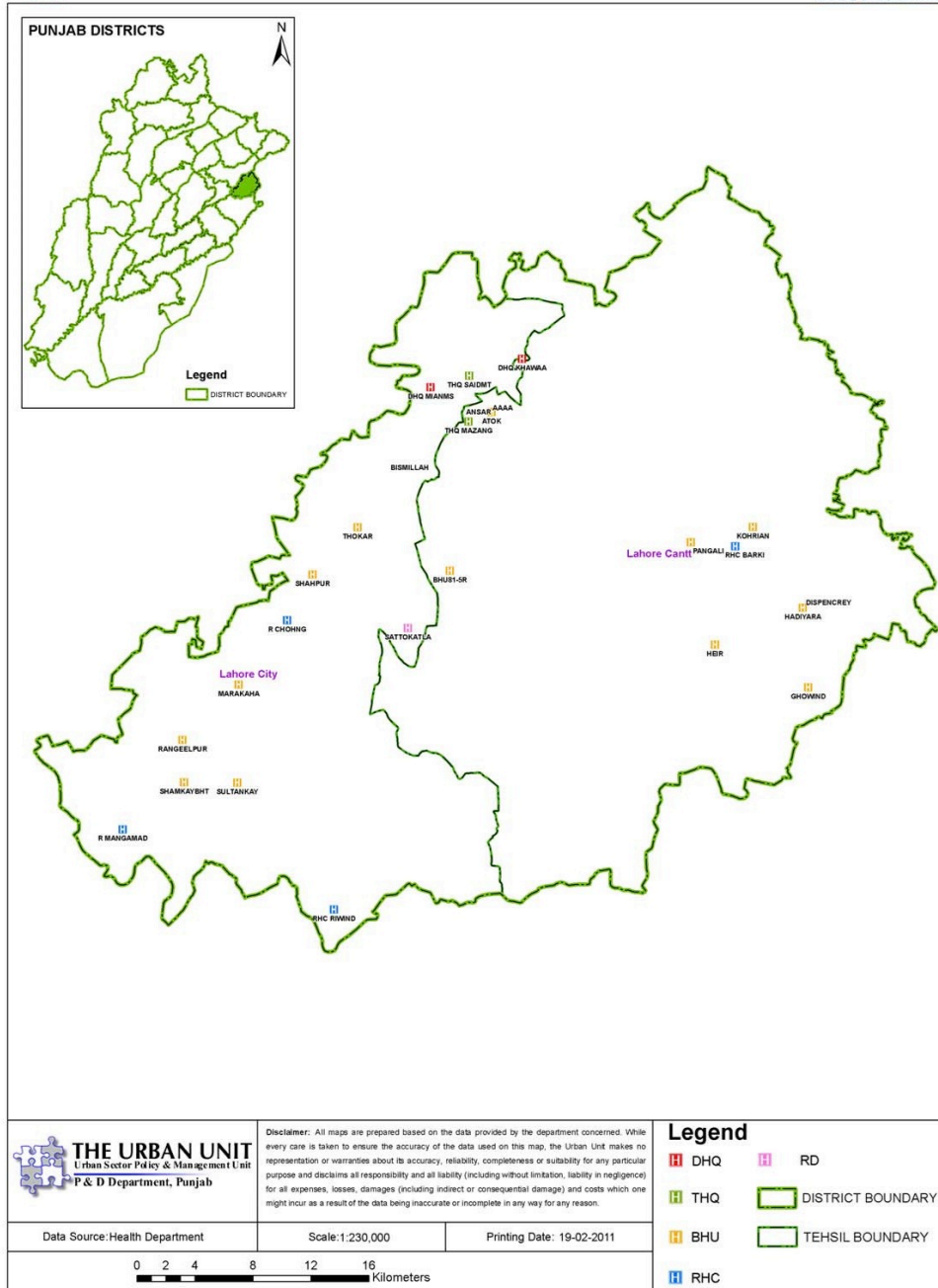# Organizational Set-up : District Level

```
                    ┌──────────────────┐
                    │  District Nazim  │
                    └──────────────────┘
                             │
                    ┌──────────────────┐
                    │       DCO        │
                    └──────────────────┘
                             │
        ┌────────────────────────────────────────────────┐
        │  EXECUTIVE DISTRICT OFFICER (Health)            │
        └────────────────────────────────────────────────┘
```

District Nazim

DCO

EXECUTIVE DISTRICT OFFICER *(Health)*

| MS DHQ Hospital | MS THQ Hospitals | DISTRICT OFFICER (Health) | | District Drug Inspector |

Principal Nursing School

CDCO, Entomologist, DSI, DSV, AIHC

Program Director DHDC

District Coordinator-NP

DDHO *(Tehsil)*

Organisational Structure at District Level

Source: Health Department, Government of Punjab

District Lahore – Public Health Care Facilties

DISTRICT KASUR HEALTH SECTORS
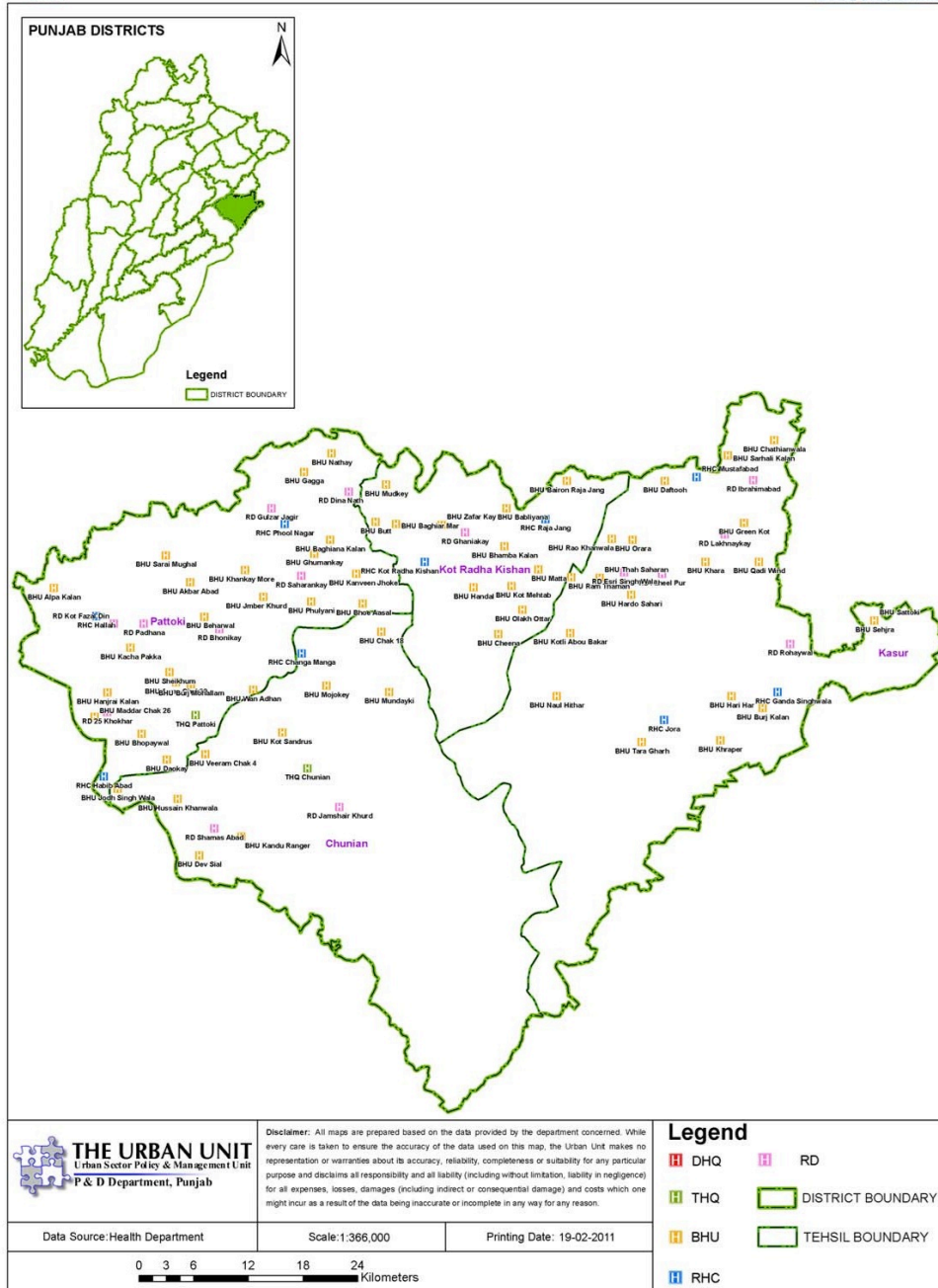
District Kasur – Public Health Facilities

Informed Consent

Thank you for agreeing to this interview. I am a PhD student at The University of Edinburgh Business School. I am conducting interviews for my PhD research titled " Health Sector Reforms in Pakistan - The Case of Punjab". The main objectives of the study are to investigate the reform process, type and content of reform interventions in the health sector, how they were implemented and your individual experiences.

This interview is completely voluntary and you have been asked to participate in this interview to describe your experiences in the implementation of health sector reforms. You may decline to answer any question or stop the interview at any time for any reason, without explanation.

The interview is confidential and your anonymity will be maintained throughout my research project. I will not include any information in my thesis that will identify you. Your participation in this interview is completely voluntary and you will not receive any compensation for your time. You may refuse to participate in this interview or discontinue participation at any time without penalty.

The interview will last approximately one hour. I would like to tape record your responses to my questions so I can listen carefully to what you have to say and not have to take notes. I will destroy the audio recording of this interview as soon as my thesis is completed. If you do not want me to audiotape your responses, then I will just take notes.

If you have any questions about this project, you may contact the researcher Yaamina Salman, PhD Student, The University of Edinburgh Business School at +(44) 77 350 91330 / 0321-4002089 and Y.Salman@sms.ed.ac.uk or alternatively you may contact my supervisor, Prof. Stephen Osborne, Professor of International Public Management - University of Edinburgh Business School at +44-131-650-8358 and stephen.osborne@ed.ac.uk.

I have read the above information and I voluntarily agree to participate in the interview described herein.

Print Name: _____

Signature: _____

Date _____

Consent for Participation in Interview Research

I volunteer to participate in a research project conducted by Yaamina Salman from University of Edinburgh. I understand that the project is designed to gather information about Health Sector Reforms in Punjab (process, content and implementation). I will be one of approximately 30 people being interviewed for this research.

My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty. If I decline to participate or withdraw from the study, no one in my organization will be told.

I understand that most interviewees in will find the discussion interesting and thought-provoking. If, however, I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview.

Participation involves being interviewed by the researcher. The interview will last approximately 45-60 minutes. Notes will be written during the interview. An audio tape of the interview and subsequent dialogue will also be made. If I do not wish to be audio-taped the researcher will only take notes.

I understand that the researcher will not identify me by name in any reports using information obtained from this interview, and that my confidentiality as a participant in this study will remain secure. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals.

Colleagues, staff and supervisors from my organization will neither be present at the interview nor have access to raw notes or transcripts. This precaution will prevent my individual comments from having any negative repercussions.

I have read and understood the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

I have been given a copy of this consent form.

Signature _____

Name _____

Date _____

For further information, please contact:

Yaamina Salman

PhD Student

The University of Edinburgh Business School

email: y.salman@sms.ed.ac.uk

cell: +(44) 77 350 91330

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Interview Guide

(note these were not necessarily all the questions asked nor were all questions necessarily asked of each respondent. This serves as a broad discussion and interview guide)

CONTEXT and DRIVERS (Bureaucrats, District health managers, Consultants)
- What is the current state of health sector reforms in Pakistan?When did it all start?
- What has been happening previously? Have there been eras or regimes where the reforms have been pursued enthusiastically?
- Can we identify different phases of health sector reforms in Pakistan?
- When did this current phase of health reform start? What makes it different from the previous reform efforts?
- Have certain types of reforms been specific to the type of government/party in office?
- What drives the reform design? How are reform proposals made?

REFORM PROCESS
- Can you briefly explain the policy process of health sector reforms? Who initiates the reform proposals?
- What is the role of Ministry of Health, Planning Division and other departments in the reform process?
- Where does the reform idea/agenda come from? Is it from the legislature?
- Who are the important stakeholders in the reform process other that the Ministry of Health and Provincial Health Departments? Are there any local/third sector organizations who are part of the reform process?
- What type of interdepartmental relations exist between the Ministry of Health at the Centre and Health Department?
- Which departments are involved in the overall reform process (both at policy making and implementation stage)?
- Are there any international organizations that are involved in any stage of the reform process?
- What kind of political -executive relationship exists at center and in the province? What role does the Health Minister play? What role does the Secretary Health play?What role does the Chief Minister play?

CONTENT - REFORM INTERVENTIONS
- What has been the focus of current health sector reforms?
- Can you identify some documents/policy briefs/reports/proceedings that can throw light on the current reforms?

- Have there been any financial reforms pertaining to budgeting and accounting procedures?
- Have there been any personnel/HR related reforms related to recruitments, postings, remunerations, tenures, security of employment, T&D etc.?
- Have there been any reforms that have resulted in restructuring?
- What have been the effects of decentralization previously and in lieu of the recent decentralization efforts? Have some functions been centralized/decentralized?
- Have there been any contractual/quasi-contractual arrangements for health service delivery?
- Has there been any involvement from the third sector (NGOs and Non-profit organizations)?
- Has there been any downsizing/mergers or breaking up of any institutes/organizations?
- How is coordination achieved?
- Have there been any reforms That have focused on performance measurement? Is there a link between performance and resource allocation?
- Have there been any performance audits? If yes, what have been the purpose of these performance audits?

IMPLEMENTATION
- Who is responsible for the structural and managerial implementation of reforms?
- How is the Health Department carrying out the implementation of these reforms?
- Are there special agencies departments who are responsible for implementation of the health sector reforms?
- Are there any training programs that have been designed and conducted for those who are going to involved in the implementation of reform?
- Has there been any legislation that has been passed in the assembly to aid the implementation of reforms?
- Have the reforms been uniformly implemented in all the districts?
- Have there been any districts where the reforms have not been taken well? If yes, what do you think are the possible reasons for poor implementation?
- Do you see any policy -implementation gap? If yes, what are the reasons? Have there been any policy failures?