

Hospital Autonomy Reforms in Pakistan and the politics of meanings

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Abstract

This research attempts to understand how various stakeholders developed unique meaning of the phenomenon of autonomy and later got engaged in a political contest such that their meaning prevailed over that of others. Results show that meaning of different stakeholder prevailed at different stages of the implementation process; however, every time the stakeholder who was relatively more powerful than others was able to ensure its meaning dominated meanings of other stakeholders. The study concludes that in societies where rule of law is not well established, power becomes the coinage; hence the powerful actors reign supreme. Furthermore, in the implementation of different reforms, a political approach would be more suitable which takes into account the relative power of stakeholders and plans how to use it for one's benefit or to neutralize it.

Key Words: meaning, politics, stakeholders, Pakistan, power, Hospital autonomy reforms

Introduction

Social phenomena are bound to be perceived differently by different people. It is quiet improbable for different individuals to take same meaning from a singular event. Edelman's opines that even the most unambiguous messages in politics can be subject to numerous interpretations (1977). In an article titled "Spectacular Politics, Dramatic Interpretations: Multiple Meanings in the Thomas/Hill Hearings" Sapiro and Soss (2010) gave various examples where people perceived various social phenomena differently and concluded that "different segments of the citizenry developed alternative conceptions of what constituted *the Thomas/Hill conflict*" (p. 308) as well.

Charles et al (1997) throws light on evolving meaning of the concept of medical necessity in the Canadian Health Policy since 1966. Despite its importance in the health policy it was never clearly defined, rather it took different meaning over time based on various policy objectives at various points in time. According to them, the concept of 'medical necessity' did not have unified, agreed-upon meaning of its own rather it was given meaning by different stakeholders based on their interpretation. Any attempt to gain consensus on its meaning was likely to fail because stakeholders had vested interests in defining the concepts in ways which suited their interests.

In another study which was aimed at exploring "aspects of *the meaning of home* as experienced by very old single-living people in Sweden", it was observed that "(t)he significance of the home (was) based on the fact that it mean(t) so many different things to the participants". The concept of home was housed in two broad conceptual categories i.e. *home meaning 'security'* and *home meaning 'freedom'*. These categories were further divided in three sub-categories. In *first category*, sub concepts were: living in a familiar neighborhood, everything functions, and having memories to live on; and second category included: a place for reflection, a social meeting-point, and leaving your own mark (Dahlin-Ivanoff, 2007, abstract). These different meanings represented different people who might be looking at 'home' from the perspective of the need which they wanted home would satisfy. All the above mentioned studies indicate the fact that social phenomena are prone to be interpreted differently by different stakeholders.

Freeman's defines stakeholder as "any group or individual who can affect or is affected by the achievement of the organization's objectives"(1984:46). Each stakeholder whether individual or group has its own unique interests and is related to the organization to pursue those interests. These interests are reflected in the meaning that they have towards some organization. So it is quite natural that different stakeholder, having their unique interests will perceive one phenomenon differently and will have its different meanings. In short, meaning is the reflection of one's interests.

More than one stakeholder is likely to be part of any implementation process. The implementation process might involve lots of resources as well which may interest different stakeholders; and the process might cause some harm or benefit to the interest of one or more stakeholders. So in both situations, the stakeholders will develop their meaning of the process and will likely influence it such that the process results are in line with their meaning. Yanow (1993) believes that these meanings "may differ from one another and may diverge from the intent of the

policy's legislators. This multiple interpretation may facilitate or impede the policy's implementation" (p. 42). And according to Sapiro and Soss (1999) "symbolic and dramaturgical theories suggest that in politics, as in a play, conflicts have meanings that extend beyond their manifest content"(p. 286). So making a good policy is just not good enough for the project/reform to be successful.

Charles et al (1997) argue that "the concept of medical necessity has taken on different meanings over time, depending on the perceived policy needs of the day" (p. 385). The meaning of the concept emerged after it was debated among different stakeholder. So the meaning was a reflection of their collective wisdom. And according to Hope (2010) "politics is about creating legitimacy for certain ideas to influence meaning construction" (p. 210). So different stakeholders use various political activities to ensure that their meaning prevails over that of others. As Pettigrew puts that "(t)he management of meaning refers to a process of symbol construction and value use designed both to create legitimacy for one's own demands and to 'delegitimize' the demands of opponents. (p. 85). So this shows that meaning construction is very much a political process where one tries to legitimize one's meaning of reality such that everyone takes it as natural and follows the rules set by that reality. Thus this political struggle between various stakeholders about prevailing of the meaning is natural. The more a society is considered political, the more stakeholders will be engaged in ensuring that their meaning prevails over others.

In a study conducted by Saeed (2012) which analyzed the implementation process of hospital autonomy reforms in Pakistan, he observed various stakeholder getting engaged in a tense tussle among each other. These stakeholders held different social positions, status and objectives. Thus, they naturally held their own meanings of the process and later adopted various political measures to ensure that their meaning prevailed over that of other's. Wicks et al. opine that stakeholders "interact with and give meaning and definition to the corporation" (1994: 483).

The Reforms:

Hospital Autonomy Reforms initiated in Pakistan in early 90s, were handed over to the Federal Ministry of Health, Government of Pakistan for its implementation first at federal level and later at provincial level. Hildebrand and Newbrander (1993) explain in detail the assumptions, objectives, and modus operandi of the reforms. These reforms were implemented first at Federal level in two hospitals as test cases and later were commissioned to be implemented in the Province of the Punjab. In the following pages, some details of the reforms and the meaning of different stakeholders which they held towards reforms are presented.

The process had a complete backing of the political government who led it from the front. The implementation process in Punjab started with the introduction of Punjab Medical and Health Institutions Ordinance 1998. Later, almost all the tertiary hospitals were granted autonomy in phases. In the erstwhile scenario, the running of the hospital was the sole responsibility of the government and hospitals were managed by provincial bureaucracy through the Department of Health (DOH). All the decisions about hospitals including financial, HR, administrative, purchasing, infrastructural development were taken by the bureaucracy. Though doctors headed the hospitals, yet they were totally powerless and subservient to the bureaucracy as was the case of other professional in their respective organizations.

These reforms continued for a couple of years before they were halted by the military government of Gen. Musharraf who had assumed power in a coup d'état against the democratic government. After some adjustments and alternations, a new version of the Ordinance was launched in 2002 which lasted for around a year. Later an enquiry commission was deputed to investigate the issues which led to the abandoning of the reforms. In the light of those suggestions, the process was again initiated in 2003 by launching yet another version of autonomy which still is in vogue.

However the experience of granting autonomy to teaching hospital has miserably failed to achieve the targets which were set initially. The four stakeholders who were identified during the data collection process are donors, politician, bureaucrats and doctors. All of them assumed a distinct position in the society and were able to influence the process at certain stages. In the next section a detailed description of all the four stakeholders along with their history, objectives and roles in the process is being detailed.

Donors:

Donors' intent is understood by the Hildebrand and Newbrander (1993) report which was developed by USAID for Federal Ministry of Health (FMOH). It is a policy document which delineates a comprehensive proposal for the reformation of the health service in Pakistan. Explaining the position of the hospitals under hospital autonomy

it says that they will be “at least partially self-governing, self-directing, and self-financing through the generation of revenues from user fees... giving them some autonomy is a way to empower the hospitals' management and to allow these institutions to become largely self-financing and self-governing (p. 8). The report though ensures that the hospital will continue to be retained by the government; however the financial responsibility of government towards hospitals will be shared by government and payment by patients. And within a matter of ten years, the share of government will be brought to zero level.

A large amount of literature identifies that such policies have been imposed on third world countries under the neo liberal policies, in social sector asking for cuts in social sector spending (e.g. see Hall and Taylor, 2003; Haque, 2002; Terris, 1999). According to Terris (1999), these neoliberal policies have been exported to the entire world through the International Monetary Fund and the World Bank, which have followed a consistent policy of demanding adherence to so-called "austerity measures". Hall and Taylor (2003) refer to the same approach of donors when they explain that under the influence of NPM and other related regimes “(e)mphasis was placed on reducing government involvement in all aspects of society”, and “(m)arket forces became the dominant model for service delivery” (p. 19). Explaining the role of World Bank and IMF with reference to current neo liberal policies, they point to their “emphasis on using the private sector to deliver healthcare services while reducing or removing government services. User pays, cost recovery, private health insurance, and public-private partnerships became the focus for delivery of healthcare services”(p. 19).

The report also suggested that “(a)s community participation on the board increases, control over the hospital would be gradually transferred to the community, which is in the best position to assess its needs, make trade-offs between service options, and determine the ability of clients to pay for services” (p. 12). This assumption might hold true in western societies where issues like rule of law, fundamental rights and relationship between governments and citizenry has been settled. However, assuming this for a country like Pakistan clearly points to the fact that ‘one size does not fit all’. This is a classic example of ethnocentrism. The contexts are very different and applying some knowledge developed in one country to the other is not likely to work. The context of Pakistan is very different as it is identified by Egger (1953) who himself was a US consultant to Government of Pakistan on redesigning its governance structure. He observed that “out of three constituent parts in Pakistan i.e. the people, the politicians, and the public servants, the people of Pakistan are the weakest element” (p. 2). The observation which he made around sixty years ago still holds it water till today. Public is nobody in a country like Pakistan. By no means, community could have benefitted from such autonomy where government structures are far too developed as compared to the public. So contrary to the assumptions of the report, bureaucracy in coming years grabbed back all the powers, which were likely to be handed over to the hospital and community.

Another statement made in the executive summary of the report is also very meaningful. It says that “growth in the government's resource burden for health would be reduced” (p.1). This is a clearly capitalist market oriented approach which sees government spending on health as ‘burden’. Whereas according to social contract theory, public allows governments to levy taxes on them on the condition that it will manage and develop collective systems of their lives. Moreover, the constitution of Pakistan holds Government responsible for the wellbeing and health of the public. So this suggestion is morally and legally very offensive and insulting.

To sum it all, the donor's meaning of granting autonomy was to slowly relieve government from its financial commitment towards hospitals which was termed as ‘burden’ thus improving government's capacity to pay back loans to the donors. And in the process develop strong control over the government. The Bretton Wood institutions such as the World Bank and the International Monetary Fund have used both covert influence and overt pressure on the economically vulnerable Third World nations to adopt such policy reforms in favor of globalization (Haque, 2002).

Politicians:

One of the respondents, who later became CEO of a public hospital, told the researcher that ‘the CM was my patient. We were both concerned about the deteriorating conditions of public hospitals and lack of proper health services for the poor. I was sent to Cuba and Iran to study their system by the CM. I myself had vast experience of working in UK system. So we were very clear about the idea’. This indicates that the CM was keen in uplifting the health services for patients through the intervention of autonomy. The same doctor further surmised that ‘CM may have been under obligation of donors to initiate the autonomy process but the implementation of the intervention was totally indigenous’. It is obvious that doctors being thorough professionals are normally more concerned with the technical side of the issues and few among them are aware of national or international context. Nevertheless,

official documents of DOH and World Bank indicate that autonomy project in the province of the Punjab was already on and this could not have been possible without the connivance of the Chief Ministers of the province.

One senior employee of the hospital narrated various local incidents including a black mailing campaign by sanitary workers which literally brought hospitals to a standstill; and the spoiling of very expensive hospital equipment and machinery, during a flood in Lahore, which was not taken care by anybody as doctors did not have the authority while bureaucracy thought it to be the duty of the hospitals, as reasons why CM went for the option of autonomy i.e. giving powers to the hospitals. Whatever the reason was, in fact the politicians were very much aware of the reform and its international linkage, yet publicly portrayed it as a local phenomenon, initiated to bring improvement in the healthcare service of the hospitals.

As mentioned in the previous section, autonomy as proposed by the donors was likely to take health services beyond the reach of the public as government funding was to be phased down to zero in a decade yet politicians presented it as a project for the public good. Interestingly, the grants to the health sector swelled instead of dipping in the era of next government, as was narrated by one informant. The reason was to be found in the political arena. The government in the province of the Punjab was established by Gen. Musharraf's military government who was fighting war on terror as an aide to USA, so US aid was pouring in as a reward. In order to gain legitimacy among the public and to avoid becoming too much unpopular in the face of the war, it had to bribe them, so good amount of money was funneled to the health sector.

Politician's meaning of the concept of autonomy can also be understood from another angle. Sour relationships between politicians and bureaucracy in Pakistan have its roots in the history. Bureaucracy was the de-facto ruler on behalf of their British masters and there was no mention of public or their representatives in the governance equation. As a result of the independence of the country, politicians as the representative of the public became the rulers and the bureaucracy now was subordinated to them. Bureaucracy never accepted the new reality as is evident through the history of Pakistan. According to Chaudray (2011),

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

So as in other areas of government, politicians wanted to place bureaucracy under the control of professionals in health sector, thereby reducing their status. In sum, the vision of politicians was in accord with that of donors but publicly they put a different face and in the process wanted to disempower bureaucracy. Whether politician were genuinely interested in reducing the grants to the hospitals is not fully clear. The reason for this doubt is that in the coming years, this aspect of autonomy could not be realized as visualized initially. Health sector was already receiving only 0.6% of its GDP, so its further squeezing was perhaps not possible. Instead they were more interested in achieving political mileage by doing some political actions which would reward them with votes in the next elections. So, further reduction in already meager health budget would have undermined their popularity.

Bureaucrats:

Due to its significance and load bearing capability, the bureaucracy was called the 'steel frame of the Raj' in the British colonial structure in the subcontinent. The current bureaucratic structure which exists now is a continuation of the colonial past. Egger (1953) commenting on the mindset of the bureaucracy remarks that it “is living in the past, and making all its comparisons and value judgments in terms of the civil service of undivided India” (p. 7). He believed that the remarks of Sir Percival Griffiths (1952), which he made about pre-partition ICS, are still valid for the civil service of Pakistan i.e. “despite their loyalty, dedication and efficiency, they are somewhat apart from the community which they serve” (p. 7).

Compared to the rest of the society, but excluding military bureaucracy which is her sister, bureaucracy is far more organized, structured and developed organization. These characteristics have given it a clear advantage over other institutions of the society. So it had enjoyed complete powers and control over the resources and decision making in all areas including health sector. The extent of their authority and the psychological awe that they enjoyed in

society can be gauged from an instance that was narrated by a senior doctor holding an administrative post of a public hospital.

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

In such a scenario where the autonomy reforms was strongly pursued by the donors and vigorously backed by politicians and doctors, bureaucracy had but to join the choruses as per the saying ‘if you can’t beat them join them’. It was a sure loser in case autonomy initiative was implemented successfully. But old habits die hard. Nobody likes to abandon authority and bureaucracy would have been the last to do it. So though they joined the initiative sensing the inevitability of the situation yet they employed different power tactics to derail the system.

The end result of all this was that after couple of attempts to develop a viable autonomous governance structures for the hospitals, the Secretaries of Health and Finance Departments made their way as members in the Boards of each teaching hospitals. So despite all the efforts and financial expenditure, the autonomy drive again reached the same position from where it commenced its journey – so now once again bureaucracy was back with a bang. It was so because no exclusive mechanism or institution was available and developed to take initiative home. Almost all of the doctors and even those in the FMOH were unanimous in their view that ‘autonomy was not granted in the true sense right from the outset’ and that ‘bureaucracy never wanted to give autonomy. So for bureaucracy autonomy meant a necessary evil which if could not be avoided should be managed in a way that their interests were not compromised and they don’t lose control of the system. This finding of the research endorses Haque’s (1998) thesis about bureaucracy when he says that:

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

Doctors:

As far as doctors are concerned, ever since the creation of Pakistan they have been struggling along with other specialists against the administrative domination of the generalist bureaucracy. The Bhore Report (1946) which was developed by a committee under the instruction of British Government also suggested that autonomy and decentralization should be the main guiding principle of the health services so that they are available to majority of the population in all parts of the empire. The coming turbulent years necessitated the prioritization for law and order orientation. So the report was forgotten at least for some time. Later, different seminars were conducted and various committees were commissioned which also suggested the decentralization of the health services but situation remained unaltered in the wake of ‘law and order’ orientation of the state, with the result that health sector never figured higher on the priority list of the governments.

Although health was assumed to be a provincial subject, most of the policy making and even major decision like purchasing equipment and machinery or initiating some health related programs were made at the federal level. In line with the colonial traditions of centralized control, provincial DOH were only expected to carry out the plans and projects that were designed and recommended by the federal government most of which were under the influence of donors with the result that provinces could not develop plans that could address the real health issues of the public.

According to one interviewee ‘at one point in time, under some external pressure, provinces were passed on some money to make purchases of the medicine on their own. However, provincial bureaucracies refused to take the responsibility on the grounds that they did not have the capacity for it’. In fact, institutions at provincial/local level were not meant to be autonomous and independent in their thinking and actions.

The same situation prevailed at the provincial level where health structures worked under the influence of DOH. All the decision making regarding governance, administration, HR, finance, purchasing was made at the provincial dept. of Health. Doctors though more qualified and represented *crème da la crème* of the society were made to

work under the control of bureaucrats. So doctors were very frustrated and angry on the situation. One of the doctors when interviewed explained the situation like this. 'Those who can't get admission in medical and engineering colleges complete master degrees, appear in the CSS (central Superior Services) exam and join civil service. Later they become the head of the technical institutions'.

Another senior doctor illustrated the point by giving his personal example in these words:

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

The doctors demanded independence and freedom from the control of the bureaucracy and aspired to hold top administrative positions in their professional institutions. This demand of doctors was rather legitimate as too much centralization greatly pegged down the ability of hospitals to make timely decisions and to provide better services to the public. However as its true for other sections of society, in most of the autonomous hospitals accountability structures could not be developed and doctors obviously, became tyrannical in certain cases. The comments of one employee of the hospital on the issue are as under:

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

So doctors' meaning by the concept of autonomy was that they wanted to be freed from the clutches of bureaucracy and to be allowed to make decisions in their area of expertise and also to be answerable to none.

Analysis and Discussion:

Frazmand (2007) states that a number of neoliberal reforms were introduced or imposed on most of the countries of the world during the past quarter of a century. In most of the developing countries these reforms were handed over as part of conditionalities of different aid programs. Since these reforms were external interventions, most of them were implemented adopting a top-down approach. Pressman and Wildavsky (1973) explain the concept of implementation in these words, "Policies imply theories... Policies become programs when, by authoritative action, the initial conditions are created... Implementation, then, is the ability to forge subsequent links in the causal chain so as to obtain the desired result" (p. xiii-xv). This shows that the top-down approach does not assign any importance to the implementation stage, nor attempts to understand the meanings of the stakeholders at implementation stage. It badly fails to visualize the inherent power that implementers might hold at the implementation stage. A coordinated political approach which involves all the stakeholders including the stakeholders at the implementation stage, and attempts to incorporate varying meanings of stakeholders will have much higher chances of success at the implementation stage.

The case of hospital autonomy in Pakistan also showed the process of meaning creation simultaneously participated by different stakeholders. However, the mechanism and intensity was different. Pakistan's is a hierarchical society as depicted by Power Distance Index of 55. In such a society power is accepted and expected. Leaders and powerful elements of society exert and express power whereas weak stratum of society and followers accept, respect and expect power. The current Pakistan has a strong stamp of colonial past on its culture. Weinbaum (1996) aptly presents this point in the following words:

Pakistan's political culture is naturally a strong product of its past, including its people's earlier history under the British Raj. What Pakistan's leaders knew best from this inheritance was the

so-called vice-regal system that made little or no provision for popular awareness or involvement. The system was designed to rule over a subjected population and intended to keep order and collect taxes (pp. 640-41).

In the case of the concept of autonomy, meanings of various stakeholders dominated the scene at different times depending upon who was more powerful at that time. The process was not characterized by debate and consensus-forming mechanism as was the case with 'medical necessity'; rather power - in rather raw and brute form - dictated which meaning prevailed at a particular point in time. Donors dominated at the phase of policy making. They were giving funds along with agenda and all others had to submit as is a norm in a high power-distance society. Their meaning of autonomy which was expressed in the report prevailed initially.

Later this policy was handed over to the politicians who following their orders started implementing it. In order to ensure its smooth implementation, they presented autonomy as one of the solutions to the problems of the health system. Moreover, they wanted to deprive bureaucracy of its unwarranted power which they enjoyed because of their historical dominance.

Doctors were working side by side with donors and politicians because the autonomy was to be transferred to them. They took it as an opportunity to get rid of bureaucracy' hold on their affairs and dreamt of being autonomous and powerful themselves. And Bureaucracy which historically held the power considered this reform to be a threat to the status quo. Initially when they saw the rest of the stakeholders having a consensus contrary to their interest, it bowed its head and started working along them. But no sooner did the political government get removed by Martial law regime, it slowly but surely regained the lost ground such that the earlier equilibrium was restored.

The whole process of implementation of these reforms was a continuous struggle among various stakeholders all searching for an opportunity for grabbing of power. "During change there is fertile ground for alternative perceptions of reality, but only one 'reality' will end up as the dominant and surviving 'reality'. Therefore, the political struggle will be about the power of meaning" (Hope, 2010, p.210).

In fact power is the coinage in this society. This was how they were treated by their rulers, so they learnt the 'might is right' lesson to survive in this society, thus everyone now tried to grab power for its interest. This demeanor is understandable in a society where rule of law is a rare commodity. Islam (2001) amply throws light on the rule of law status in Pakistan in the following words:

The rule of law remains an anathema to Pakistani culture. The inherent cultural propensity to take the law in one's own hands has been reinforced by feudalism, customs, sectarian creeds and religious traditions. Police brutality and lack of redress are also cited as reasons to circumvent the due process of law (p. 1347).

The end result of this ruthless political struggle was that autonomy reforms failed to achieve their objectives. All along the process, nowhere is found any mention of public's issues, people's rights or solutions to public problems; on the contrary all stakeholders are found making serious efforts to achieve their personal goals by making their meaning dominant. Yet, neither the objective to make governments reduce funding for health could materialize, nor could the bureaucracy be made subservient, nor hospitals gained meaningful autonomy. What actually happened was that the most powerful institution having permanent status and longest history was able to weather all the challenges and the idea of the reform was crashed to ground.

The interests of the stakeholders are generally affected by their values. Charles et al (1997) opined that understanding of the contrasting values of the stakeholders is likely "to illuminate more explicitly the different value commitments of the stakeholders, which can then be the subject of more thorough public debate" (p. 387).

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