CRITICAL BARRIERS IN THE FORMULATION OF EFFECTIVE PUBLIC HEALTH POLICY IN DEVELOPING COUNTRIES: CASE OF PAKISTAN.

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*Muhammad Fayyaz Nazir, **Ellen Wayenberg,

*PhD Scholar, Department of Public Governance and Management, Faculty of Economics and Business Administration, Ghent University Belgium.
** Professor, Department of Public Governance and Management, Faculty of Economics and Business Administration, Ghent University Belgium.

Note: This research paper is one component of my PhD research project: Critical Barriers in the Public Health Policy Practices in Punjab-Pakistan: An Analysis of Policy Makers' Frames and Framing. This paper is a first draft so please do not quote or spread without permission.

Key Words:
Policy Formulation, Public Health Policy, Critical Barriers.

ABSTRACT

The stability and prosperity of states are some of the vital factors that are dependent on the formulation of effective public policy. This is why there is a need for a solid theoretical foundation from which we can analyse this scenario. For this review study our primary focus is Pakistan (it's most populated province: The Punjab): a developing country with sixth highest population rate in the world and have worst health indicators. Pakistan commenced several national health policies: 1990, 1997, 2001 and 2007. After devolution[1] Punjab developed Health Sector Strategy 2012-17 and 2019-28 and emphasized on strengthening the healthcare system by optimising the hospital autonomy, to be in-line with the national health vision[2] 2016-2025 and sustainable developmental goals[3] of UNO, as of yet the results still seem unsatisfactory. The discrepancy raises the questions, why policy makers in this case are not developing effective policies? Are there some critical barriers involved? It is for that reason, we try to find, **Is Punjab-Pakistan facing the same critical barriers in the formulation of effective public health policy of autonomy to public health institutions, as other developing countries are facing?** For this existing literature is analysed through content analysis. The review described that the policy of hospital autonomy was failed to get required results in some developing countries because these countries did not give the actual decision rights to the autonomous entities. Pakistan also faced the same problem of failure of the policy and is facing the same type of barriers like other developing countries are facing.

[1] The Government of Pakistan passed the 18th amendment in its constitution on 8th April 2010 and gave more autonomy to its provinces.
[2] Pakistan developed its National Health Vision 2016-2025 for smooth implementation of SDG's.
[3] In September 2015, the Sustainable Developmental Goals (SDG's) were adopted by the United Nations General Assembly with the 2030 agends for sustainable development.

1. INTRODUCTION

Health is considered as a key aspect in the development of human capital of a nation. Improved health can enhance the efficiency and affectivity of the masses (Schultz, 1961). The nature, stability and development of any government organized country are the phenomena that are dependent on public policy (Osborne & Brown, 2011).

Till the first half of the twentieth century the policy makers gave specific importance to the provision of the primary health services and the hospitals had no specific room (Reerink & Sauerborn, 1996). In the second half of the twentieth century a wave of health sector reforms was triggered by developed countries including the United States, the United Kingdom, the Netherlands, France, Denmark, New Zealand, South Korea, as well as developing countries such as India, Indonesia, Malaysia, Uganda, Tanzania, Nigeria, etc. (Cassels, 1995)

In Pakistan, before the development of first National Health Policy in 1990, health was a component of every five year economic developmental plan[4]. Hildebrand and Newbrander prepared a report for United States Agency for International Development in 1993. Report became the basis of hospital autonomy initiatives in Pakistan. Autonomy is a mode of decentralization and has its roots in some reforming concepts (McPake, 1996), the scope of Public Private Partnership and New Public Management (Chawla & George, 1996) and the notion of organizational change (C. Collins & Green, 1993).

After introduction in literature review this paper includes the developmental phases of public policy studies, the public health policy in Pakistan along with its historical developments and policy of hospital autonomy, existing state of public health policy in Punjab-Pakistan and multilevel governance structure of health sector in Punjab, are discussed.

2. LITERATURE REVIEW

The health is one of the traits that indicate the level of development of a nation. The only thing which can help the governments in the provision of better health facilities to their masses is the domain of public health policy (Baslevent & Kirmanoglu, 2011).

2.1.Public Policy

Public Policy can be defined as "What governments choose to do or not to do' and more importantly, why they do, whatever they do" (Dye, 2013). Similarly "Public policy is sum of government activities contributing directly or

Figure No.01 (Source: Dye, 2012)

[4] Five year plans for the economic development were the series of nation wide centralised economic plans. First adopted in the year 1955.

indirectly to have an influence on life of citizens" (Peters, 2005). The policy experts identified the five steps of policy making, as mentioned in figure 01.

If we split the growth of the field of public policy we see three discrete ages of theory building and testing. The first was the classic period of studies of decision-making and rationality, the second was an age of fusion when theories of decision-making were mingled into interpretations of agenda setting and the third is contemporary approach, starting to take shape and is the age of political economy in which public policy is illustrated on models and methods that have been applied to international relations and comparative politics (John, 2013).

The explanation of public decision-making is the most problematic thing in public policy. Evaluation of public policies and to comprehend the procedures and organization of government are some other vital issues, but for policy scholars the key problem to resolve is policy choices. This query inclined the introductory studies in the field, such as work Herbert Simon on decision making choices (Simon, 1955) and incrementalist model of decision making (Braybrooke, 1987). These studies inclined some significant contributions like policy-making and democracy (Lowi, 1970) and empirical work in the field (Budgeting, 1975) influenced studies of decision-making in the field (Ripley & Franklin, 1984). Alison's (1971) classic contribution with its schematic approach discusses the limited rational model of decision making (Bendor & Hammond, 1992). The classic period of public policy literature ends in the decade of 1980 when the policy scholars separate the public policy and rational actors (Epstein & O'halloran, 1999).

The second age of policy literature emerges in the deacade of 1990 from the interaction of multiple factors particulalry the way policy agenda developed new ideas and resulted into changes and variations in field (Stone, 1989). Sabatier's framework explains the advocacy coalition: a grouping of bodies with the similar ideas and interests. Coalitions comprise more contributors than the customary trio of policy makers and they all play their part in the propagation of ideas. So some relevant policy advocacy coalitions with their own specific ideas, strive for supremacy in a sub system (Sabatier & Jenkins-Smith, 1993). Kingdon explains his policy streams approach in his book. He suggest that Policy formation is a outcome of the arrays of procedures: problems, policies and politics (Kingdon & Thurber, 1984). Similarly in some aspects, Baumgartner and Jones's presented punctuated equilibrium model to explain policy change, stability and variation that ideas are building blocks of agendas and the institutions set the agendas and the poliyc makers and the institutional framework frame the way the policy problems are defined (Baumgartner & Jones, 2010).

There have been comparatively limited innovations in the theory of public policy since 1998, as there were in the early 1990s'. Petridou's (2014) survey of latest work in public policy endorses this state of affairs (Petridou, 2014). Since the rise of behavioural public policy (John, 2015) there have been no new theories of policy change or variation. The core issue is that themes in public policy are discussing in contemporary discussions of political economy (John, 2013).

2.2.Public Health Policy in Pakistan

Since independence[5] Pakistan has formulated national health policies including The Health Policy 1990, 1997 and 2001 (Lashari, 2004), Medium Term Developmental Framework 2005-10, National Health Policy in 2016 to be in-line with National Health Vision 2025 (Pakistan, 2016). Pakistan already worked on the Millennium Developmental Goals (MDG's) of the UNO, 2000-2015. According to the report published by the Ministry of Planning and Development Reforms in 2013, about the achievement of targets, Pakistan achieved only two indicators, two were on track and remaining were out of track, from total sixteen indicators, targeting the three goals related to healthcare in MDG's. Pakistan has also agreed and became the signatory of the Sustainable Developmental Goals (SDG's) of the United Nations Organization 2015-30. These SDG's are the collection of total seventeen goals for the development of the world on different spheres including health (Organization, 2016).

Public Health Statistics of Pakistan

Population (Survey-2017)		**Resources per Population**	
Male	106,449,322	**Doctors**	
Female	101,314,780	Year - 2016-17	997
Transgender	10418	Year - 2017-18	957
Total	207,824,520	**Dentists**	
Health Budget (in Billion)		Year - 2016-17	10658
Year - 2013-14	173.42	Year - 2017-18	9730
Year - 2014-15	199.32	**Nurses**	
Year - 2015-16	225.87	Year - 2016-17	2093
Year - 2016-17	291.90	Year - 2017-18	2002
Year - 2017-18	384.57	**Population per Bed**	
Per Capita Health Expenditure		Year - 2016-17	1592
Year - 2013-14	39.5 USD	Year - 2017-18	1580
Year - 2014-15	42 USD	**Health Index**	
Year - 2015-16	45 USD	No.	150/189
Year - 2016-17	47 USD	HDI Value	0.562
Year - 2017-18	47 USD	Life Expentancy at Birth	66.6
Life Expentency		Expected years of schooling	8.6
Year - 2012	66	Mean Year of Schooling	5.2
Year - 2013	66	Gross National Income	5311
Year - 2014	65		
Year - 2015	66		
Year - 2016	66		

Table No. 1

Source: Pakistan Bureau of Statistics and http://hdr.undp.org/en/2018-update

[5] Pakistan got independence from the British Empire on 14th August 1947. The World War II, End of Colonialism regime, World Economic Order and Independence Movemenr in India were the key contributors.

2.3.Historical Analysis of Public Health Policy in Pakistan

Public health policy has its roots in the era of pre-partition: before the freedom, from the dominancy of British Empire in 1947. There were five major developments regarding the healthcare including the appointment of royal commission to inquire into the health of Indian army personnel's in 1859, introduction of an Act to delegate powers to vaccinate, formation of plague commission in 1896 and its report in 1904, introduction of reforms under Government of India Act 1919, reforms introduced by the Government of India Act 1935 and finally the formation of health survey and development committee in 1943 (Lashari, 2004).

Significant events in Public Health Policy in Pakistan	
All Pakistan Health Conference	1947
All Pakistan Health Conference	1951
All Pakistan Health Conference	1956
Medical Reform Commission	1959
Health Study Group	1969
Local health services in ruler areas	1969
Nutrition survey of west Pakistan	1966
Ruler health centers scheme	1971
Peoples health scheme	1972
Health made provincial subject	1973
Eradication of small pox program	1976
1st National Conference on Medical Education	1976
Conference of primary health care	1976
School health services program	1980
Decentralization of health services in Punjab	1990
1st National Health Policy	1990
Social Action Program	1993
National Health Policy	1997
National Health Policy	2001
National Action Plan	2004
Punjab Health Sector Strategie (2012-2017)	2012
National Health Vision	2016

Table No. 2 (Source – Planning Commission of Pakistan)

December 10, 2018 marked the 70th anniversary of the Universal Declaration of Human Rights (Assembly, 1948). The declaration delivers the basis for the international code of human rights. The code gave an internationally agreed set of some standards that also included the provision of health and strengthening of healthcare systems (Brownlie, 2009). Pakistan signed the Alma-Ata Declaration of the World Health Organization in 1978. It is the same declaration which laid down the targets and foundation for "Health for All" by the year 2000. The targets were launched in 1977 through the World Health Assembly resolution (Sabih et al., 2010).

In response to this, the government of Pakistan launched its first national health policy in 1990. The policy focused on school health services, family planning, nutrition programs, control of communicable diseases, malaria control program, sanitation and safe drinking water. After this the national health policy of 1997 was introduced in which health education and health promotion received a prominent place. Another national health policy was launched in 2001 and the fundamental goal of the policy was to construct the mass awareness in public health matters with the attention to the use of audiovisual aid to publicize important information (Ronis & Nishtar, 2007). In 2004 Government of Pakistan launched National Action Plan for

Prevention and Control of Non-Communicable Diseases and Health Promotion. This plan was initiated by the Ministry of Health, the World Health Organization and an NGO: Heart-file[6] (Ronis & Nishtar, 2007). The Government of Pakistan drafted another national health policy in 2009 mandated with the formulation of the strategies for different vital areas including the human resource management for health, but the government could not implement that policy (Hafeez, Khan, Bile, Jooma, & Sheikh, 2010).

The national assembly[7] of the Government of Pakistan passed the 18th amendment in its constitution of 1973, on 8th April 2010. After this (devolution of power) the provinces got more autonomy from the center and subject of health became the provincial responsibility and center slacked its rights and responsibilities over this the important portfolio of the state (Nishtar et al., 2013).

2.4.Current Status of Public Health Policy in Pakistan and specifically in Punjab

MULTI-LEVEL GOVERNANCE SETTING IN HEALTH SECTOR OF PUNJAB

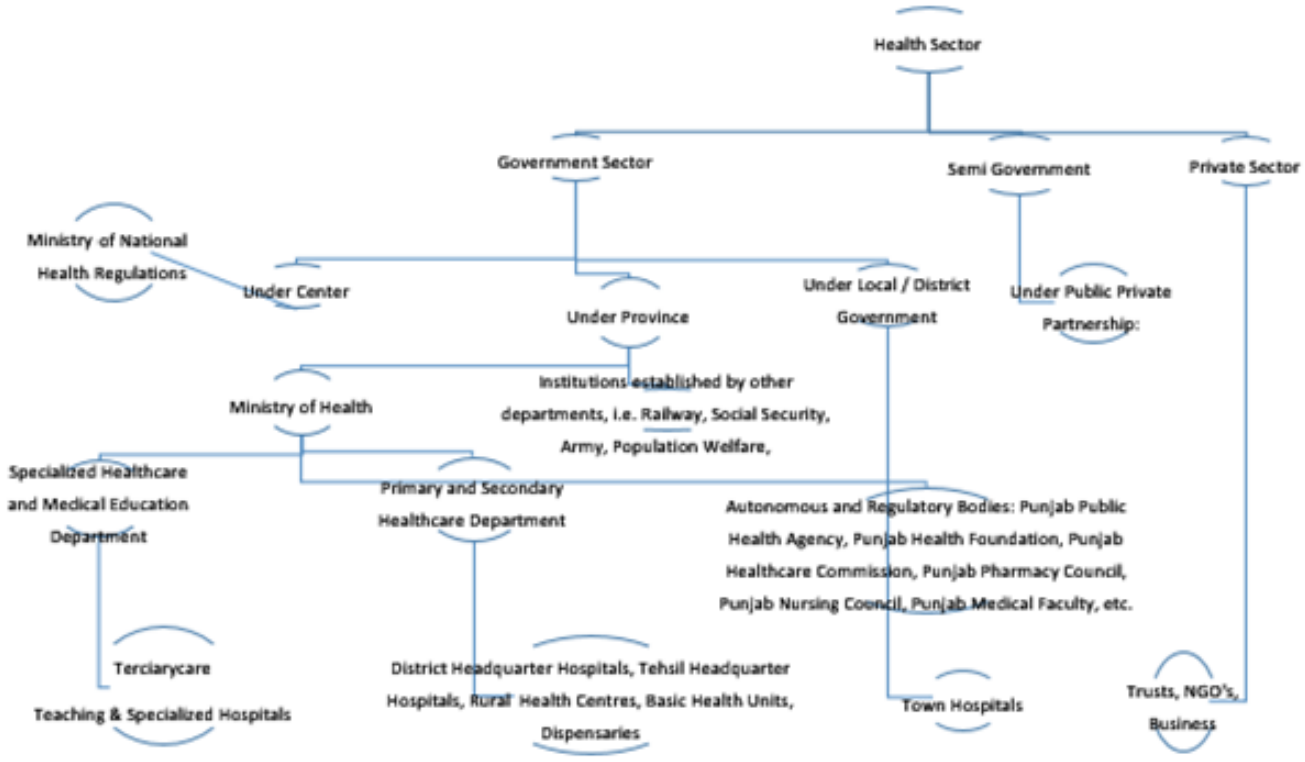

Figure No. 02. (Source: Federal, Provincial and District Government Documents)

[6] Heart file is a non-governmental organization working in Pakistan in different developmental sectors.
[7] National Assembly of Pakistan is lower house in Pakistan's political system, headed by the skeapker and is responsible for the formulation of rules and regulations for the state.

Additionally, Pakistan developed a National Health Vision 2016 incorporating international health priorities (the implementation of SDG's of UNO 2015-30) and provincial autonomy within the context of the constitution of Pakistan. The intention of the policy is to attain universal health coverage resulting in a fairer and efficient health financing (Karamat, Shurong, Ahmad, Waheed, & Khan, 2018).

After getting provincial autonomy the Punjab developed its Health Sector Strategy 2012-17[8]. The purpose of the strategy was to support the national health vision 2025 of the center and the international health priorities such as SDG's. The strategy document identified the issues, proposed a strategy and developed an expected outcome. The strategy was proposed to strengthen health system by optimizing decentralization and hospital autonomy, to resolve the issues of governance and accountability, for the sake to augment efficiency, effectiveness and responsiveness.

2.5.Public Health Policy of Autonomy to Public Health Institutions

Developing countries are adopting the policy of autonomy to public health institutions, to augment the efficiency in the health system and as a solution of the problem of health financing. The developing and under-developed countries can save money if they vest autonomy to the public health institutions and can invest the saved money on preventive and primary healthcare. The autonomy in this context means increased decision making power at hospital level, which includes financial and administrative decisions (Mitchell & Bossert, 2005).

The autonomous hospitals will have to generate at least a part of their funds to maintain their operations and Government will only grant them annual subsidies. Hospital management committee headed by the chief executive and members from the public and private sectors are made responsible for the overall administration of the hospitals. The autonomy made the hospital administrators able to curtail cost and raise quality of healthcare. Government affiliated autonomous hospitals would retain their social mission, they would not refuse to provide healthcare to those who are unable to pay (Makinen et al., 1993).

The reforms in autonomous hospitals in a comparison with the public sector hospitals, described by the Hearding and Preker, is given below in table No.03.

[8] After devolution the Punjab Health Sector Strategy was the first independent strategy in the province of Punjab.

PUBLIC HOPITALS AS BUDGETRAY ENTITIES VERSUS AUTONOMOUS UNITS

Financial Areas	Hospital as budgetary entity	Hospital as Autonomous entity
Legal Structure	Government Owned and Managed	Autonomy granted through presidential or ministerial decrees or by law approved by parliament. Govt remains the owner of the hospital.
Governance	National Standard Operating Procedures apply to govern government hospitals	Establishment of Board of Directors accountable to government.
Management Structure	Hospital director appointed by central level.	Chief Executive Officer appointed by and accountable to the board.
Financial Management	Government provide a line item budget and is responsible for deficits Accounts audited internally only.	Hospital receives a subsidy from government for uncompensated care. The hospital generates revenue from patient care, sales of supplies and pharmaceuticals.
Procurement	Government procures goods and services and is responsible for physical improvements.	Hospital purchases medical supplies of pharmaceuticals, investments in high tech equipment's and civil works are proposed by the board for approval by central government.
Human Resource Management	Number and type of staff defined nationally, central government decides hiring, terminating, promoting and transferring staff.	Staffing approved by board but subject to national guidelines. The CEO authorized to recruit permanent and contractual staff, promote and transfer staff
Information Management	Data collected for monthly and annual statistical reports by the department of statistics, Data are not use to improve hospital performance.	Hospitals define own needs to monitor and evaluate financial clinical performance. Actions are taken as a result of measuring results.

Table No.03 (Source: Harding and Preker, 2000)

Autonomy of health institutions or hospitals is influeced by the concept of New Public Management. It was commenced to overcome the part of government in administrative affairs of hospitals or public health institutions. For Pakistan the concept of hospital autonomy has roots from some foreign countries like indonesia, thailand and jordan etc. Autonomy was introduced in the health sector of Punjab through Punjab Medical and Health Institutions Ordinance 1998, promulgated on 23rd May 1998 and was supported by the World Bank in which certain teaching hospitals along with their medical colleges were given a semi autonomous status in two phases. In first phase five hospitals and in second phase six hospitals were granted the status of autonomy (Saeed, 2012).

Like Pakistan some other countries like Iran, Tunisia and leabnon also had attempted to grant autonomy to their public health institutions (De Geyndt, 2017). The government of Iran started the decentralization of public health institutions in the decade of 1990. The concerned ministry vested autonomy to 54 public university owned hospitals in 2006. The board of trustees for every autonomous unit, headed by the chancellor of the medical institution, was created (Doshmangir, Rashidian, Ravaghi, Takian, & Jafari, 2015). In Tunisia the ministry of health initiated the same process in 23 university hospitals in 1991 by creating

a legal entity “Etablissements Publics de Sante” administered by the President, Board of Directors and Members appointed by the Minister of Health (Ismail, 2015).

In Pakistan the grant of autonomy or decenteralization status to the public sector institutions as a section to public health policy was under discussion since 1990, but the policy got fueled in the government and policy benches in the early 2000. The policy was initiated under the Social Action program of 1993 (Abdullah & Shaw, 2007). The autonomy to the public sector institutions again adopted by the Naional Health Vision initiated in 2016 to be synchronized with vision 2025 and to support the sustainable developmental goals, regarding the provision of healthcare (Organization, 2018).

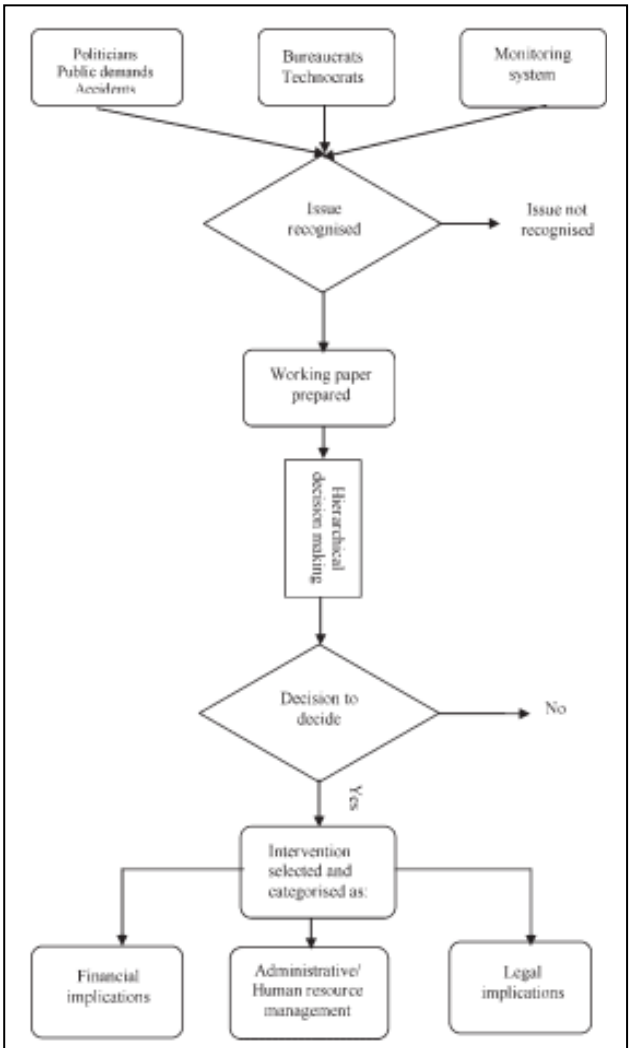

Figure No. 03 (Source: Policy Documents)

The health sector in Punjab was facing numerous obstacles which were tried to resolve by the Government of The Punjab through health sector reforms in the decade of 1990. Hence, seven major initiatives were taken including: Sheikhupura Pilot Project, District Health Authorities, District Health Governments, District Health Management Teams, Deligation of Financial Powers to Senior Medical Officers of Rural Health Centres, Contract appointment of Medical Officers and Leady Health Visitors and specifically autonomy to Medical Health Institutions. The policy process mentioned in figure No.03 was adopted for the health sector reforms (Tarin, Green, Omar, & Shaw, 2009).

3. RESEARCH GAP AND RESEARCH QUESTION

It is reported that governments of developing countries are spending their 50 to 80 percent of the total health budget on the secondary and tertiary healthcare hospitals. It became difficult for developing countries to operate the primary & preventive healthcare and other

developmental & non developmental expenditures of health sector (Chawla, Govindaraj, Berman, & Needleman, 1996). There is a need to advance the policy making process of decentralization of healthcare. One vital way is to assess the positive and negative aspects of the policy making process in health sector (C. D. Collins, Omar, & Tarin, 2002). In recent years developing countries are paying special attention to achieve the target No. 3.8 of Univeral Health Coverage[9] (UHC) of SDG's of UNO (Bongaarts, 2016). Nevertheless, it becomes important to evaluate any reforms in health sector in the context of achieving UHC (Fox & Reich, 2015). Every country applies the concept of autonomy in their respective hospitals differently (based on their socio-economic conditions) and every country gets different results (London, 2013). Autonomy reforms in Punjab-Pakistan were failed to achieve their objectives because in the overall process the pubic problems, issues and rights were not given due preference (Saeed, 2013).

As stated above, although the reforms were failed but no study was conducted to group the barriers contributed in the failure of the policy, in the context of policy makers and also to know either Pakistan is facing same type of barriers like other developing countries. Hence, this review study is conducted to inquire and document the barriers contributed in the failure of the reforms in the context of policy makers involved respectively, generally in developing countries and specifically in Punjab-Pakistan. The present paper aims at the detail documentation of public health policy of autonomy to public health institutions in Punjab Pakistan. Pakistan is a developing economy having 6th highest population rate in the world with total population of 207,824,520 (survey conducted in 2017 by Pakistan Bureau of Statistics), with complex health infrastructure and worst health indicators (enlisted in table No.1)

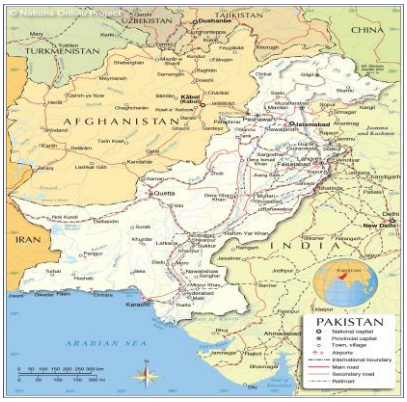

Figure No. 04

Pakistan has four provinces: Baluchistan, Khyber Pakhtunkhwa (KP), Punjab and Sindh, two autonomous regions: Gilgit Baltistan and Azad Jammu Kashmir and a capital territory: Islamabad.

For this paper we have focused on one of its province: The Punjab, because of below listed reasons:

[9] Achieving universla health Coverage including the financial risk protection and access to quality essential healthcare services.

1. In Pakistan the policy of autonomy to public hospitals was first initiated in the province Punjab, on experimental basis (Abdullah & Shaw, 2007).
2. After the 18th amendment in the constitution of Pakistan (in 2010), the health sector became the provincial subject whereas centre retained no right over the policy and financing.
3. The province of Punjab is densely populated with the approximate population of 110 million, which is approximately 57% of the total population of the country.

Public Expenditure on Health Sector (in billions)

		FY-15	FY-16	FY-17
Punjab	Current	45	61	70
	Development	21	33	32
Sindh	Current	40	54	62
	Development	8	14	15
KPK	Current	24	17	20
	Development	10	11	17
Balochistan	Current	14	15	n/a
	Development	4	4	n/a

Table No. 4 (Source: Provincial Budget Documents)

4. Punjab incurred more expenditure on healthcare as compared to other provinces of the country, as shown in the table No. 4.
5. Punjab developed Health Sector Strategy 2012-17 and emphasized on strengthening healthcare system by optimising decentralization and hospital autonomy to overcome the governance and accountability issues.

Despite of working on several public health policies, the obstacles in Punjab-Pakistan regarding the healthcare, are not being overcome (Akram, 2018).

In spite of the fact that many efforts were made to grant the autonomy to the public health institutions as of yet the results still seem unsatisfactory. The situation raises the questions – why the concerned officials, are not formulating public health policies effectively? Are there some critical barriers involved in this process, which made the relevant officials unable to take rational decisions towards effective public health policies? It is for that reason we are conducting a review study of the critical barriers to the Public Health Policy formulation in Punjab-Pakistan, by focusing on the policy of autonomy to the public health institutions.

4. PURPOSE AND SIGNIFICANCE OF THE STUDY

The purpose of the present paper is to identify and document the barriers in the domain of public health policy practices. The resolution of the barriers identified in present paper will help the decision makers towards smooth, result oriented and efficient practices of public health policy in developing countries and specifically in Punjab-Pakistan. Furthermore, the results of the paper will also enrich the decision makers with a road map i.e. how to identify the barriers in the way to formulate the public policy in other developing countries? In second phase of the

research I will propose a model for the formulation of public policy. The model may be equally applicable to all the sectors of economy and can be tested further in different domains of public policy, by the forthcoming researchers.

5. METHODOLOGY

Research Protocol, Criteria and Procedure

The paper is more focused on the practice of public health policy and aims to investigate the critical barriers in the formulation phase of the policy of autonomy to public health institutions. To execute the research smoothly, we entered into the actual research environment by dividing the paper into two phases.

In first phase we evaluated the barriers in public health policy practice. The relevant literature was reviewed under the Harding and Preker's difference of Public and autonomous healthcare entities through content analysis. Barriers to public health policy of autonomy to public health institutions in developing countries are enlisted. The relevant literature was reviewed by approaching some relevant and vital journals of English language and also using some databases like Web of Science, PubMed and Medline. Google Scholar was also explored for getting extra relevant information. The key words to search the relevant literature was: public health policy, health policy & public policy, hospital autonomy. The duplication was removed accordingly as mentioned in Figure No.05. Hence, this paper will be the systematic review of the potential barriers to the policy of autonomy in the context of health policy.

Selected Studies

Country	No. Of Studies	Author and Publication Year
Afhanistan	1	USAID, 2015
China	1	Allen et al, 2014
Dominia	1	Smith & Hason, 2012
Ethiopia	1	McNatt et al, 2014
India	1	Sharma & Hotchkiss, 2001
Indonesia	1	Maharani et al, 2015
Iran	1	Markazi-Moghaddam & Aryankhesal, 2014
Kenya	1	De Geyndt, 2017
Laos	1	Geng et al, 2016
Lebanon	1	Eid, 2001
Malawi	1	Tambulasi, 2015
Nicacargua	1	Jack, 2003
Pakistan	1	Saeed, 2013
Singapur	1	Ramesh, 2008
Thailand	1	Hawkins et al, 2009
Turkey	1	Sarp et al, 2002
Tunisia	1	De Geyndt, 2017
Uganda	1	Hanson et al, 2002
Vietnam	1	London, 2013
Zambia	1	Hanson et al, 2002

Table No.05

In a second phase we developed a model for the effective formulation of public policy. The gap for prospective researchers will be the opportunity to test the model on different domains of public policy.

Data was extracted and analysed through Harding and Preker difference of public and autonomous healthcare entities, mentioned in table No.03 and content analysis to meet the objectives of the study.

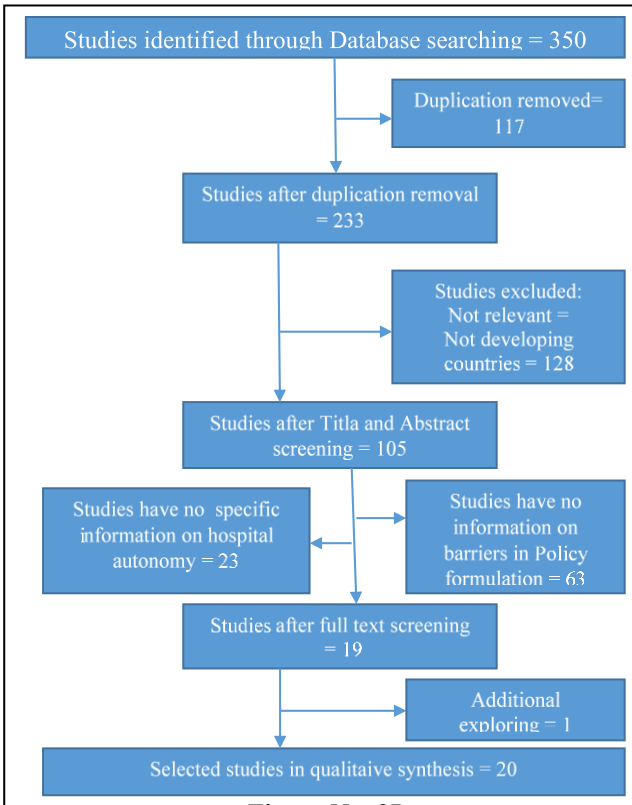

Figure No. 05

6. ANALYSIS, DISCUSSION & FINDINGS

Various researchers in their study nominate some barriers responsible for the failure of formulation of the policy of autonomy to the public health institutions or hospitals. The large scale organizational reforms in Iran to give autonomy to the public hospitals were unsuccessful because of the rigid centralized structure of health sector, missing of stakeholders' consent and rigid human resource policies (Markazi-Moghaddam & Aryankhesal, 2014). The hospital autonomy policy of 1991 in Tunisia did not get the required

List of Indentified Barriers

No.	Country	Author and Year	Identified Barriers
1	Iran	Markazi-Moghaddam & Aryankhesal, 2014	Missing stakeholders consent, rigid centralized structure of health sector, and rigid HR policies.
2	Tunisia	De Geyndt, 2017	Powerless Board of Directors, Undue involvement of Health Ministry into HR and Purchase matters
3	Dominican Republic	Smith & Hason, 2012	Involvement of Health Ministry into hospital internal affairs.
4	Kenya	De Geyndt, 2017	Lack of Standard Operating Procedures and Lack of decision making skills in Hospital Managers
5	India	Sharma & Hotchkiss, 2001	Non availability of guidelines, Divergence from the plan and Infrequent Meetings.
6	Pakistan	Saeed, 2013	Missing stake-holders involvement, Non availability of HR, Purchase, Finance and Administration rules for autonomous units, undue involvement of Health Ministry into hospital affair and powerless board.

Table No.06

results because of the powerless Board of Directors and undue involvement of health ministry in hospital human resource and purchase matters (De Geyndt, 2017). The objectives of autonomy to six public hospitals in Dominican Republic was not achieved, the involvement of ministry and centre in the hospital affairs specially in human resource matters was a chief barrier (Smith & Hanson, 2012). The results of grant of autonomy to Kenyata National hospital in Kenya under the State Corporations Act of 1986 was not fruitful because of delay in the appointment of Board of Governors with fair competition, lack of standard operating procedures and lack of decision making skills in the hospital managers and staff (De Geyndt, 2017). Medicare Relief Societies were introduced in sixty nine public hospitals under the umbrella of autonomy in the Rajasthan province of India in 1990. The results show that non-availability of guidelines, divergence from the implementation plan and infrequent meetings among society members are the chief barriers in the case (Sharma & Hotchkiss, 2001). In the province of Punjab-Pakistan the autonomy to public hospitals was granted in three phases. Proper rules of administration, human resource, purchases and finance required to manage the hospitals after giving autonomy were never drafted. With the passage of time the Secretary health and Secretary finance became the permanent members of the management committees of the autonomous hospitals and resumed all the major powers like appointments and purchases (Saeed).

The analysis of the developing countries under the difference of public and autonomous entities identified by Harding and Preker described in Table No. 07, shows that there is

ANALYSIS UNDER HARDING AND PREKER DIFFERENCE OF PUBLIC AND AUTONOMOUS ENTITIES

Financial Areas	Rights Delegated	Limited Rights	Rights Neglected
Legal Structure			
Governance		Iran, Uganda, Zambia	
Management Structure	Indonesia, China Thailand, Afghanistan		
Financial Management		Lebanon, Ethiopia, Kenya, Indonesia, Iran Pakistan and Zambia	
Procurement	Kenya, Indonesia, Thailand, China and Afghanistan		
Human Resource Management			Nicaragua, Lebanon, Indonesia, Thailand, Pakistan, Turkey, Zambia
Information Management	Singapore, Afghanistan, Indonesia		

Table No.07

divergence among all the developing countries in the delegation, limitation and neglecting the required rights to the autonomous units or hospitals.

All the cases have approximately same type of barriers in the formulation of the public health policy of autonomy to the public health institutions are regarding SOP's, powers of the board, role of the relevant ministry etc. as mentioned in Table No.06. Likewise the case of Punjab (Pakistan): is also facing the same nature of the barriers: missing stakeholders' involvement, non-availability of administration, HR, purchase, and finance rules for autonomous units, undue involvement of Health Ministry in hospital affair and powerless board. The categorization of the barriers suggest that the SOP's and segregation of roles and powers of ministry and hospital are missing in the overall process of the policy formulation and all these are the symbol of poor legislation.

Punjab – Pakistan has initiated this policy by inspiring the Turkish Model of hospital autonomy. So Punjab benchmark the Turkish model in its public health policy of autonomy to public health institutions. Benchmarking is actually a scientific concept, first used in engineering then management and now is common in social sciences especially in public policy. So the use of this scientific approach made the policy sciences more interesting and innovative. On the same way we can use other scientific approaches of engineering and management in policy sciences. Keeping in view the contemporary static condition of the policy sciences as per the description of Petridou's 2014 and John 2015, the element of "scientific addition" if further tested, with this view can satisfy the policy domain with the required innovation in policy sciences. But there will be a need to study the same processes in some other developing countries, and to identify other such useful scientific approaches from engineering and business management, in order to get strong arguments to include this denovo concept of "scientific addition" in policy sciences.

Here we recommend four stages process for policy formulation which includes: need identification, scientific addition, legal framework, and development of multilevel governance setting before implementation of the public policy to make it result oriented. This model not only will augment efficiency and effectivity in the domain of public policy formulation in developing countries but also satisfy the need of innovation in policy sciences.

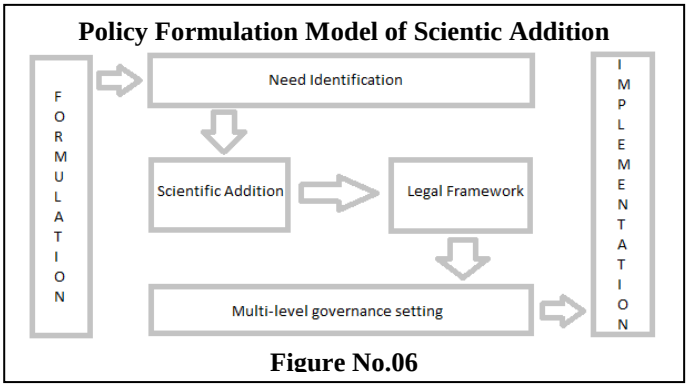

Figure No.06

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