Transformation of Healthcare System
A Case Study of Medical Teaching Institutions Reforms in Khyber Pakhtunkhwa

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CERTIFICATE

This is to certify that this thesis entitled: **"Transformation of Healthcare System: A Case Study of Medical Teaching Institutions Reforms in Khyber Pakhtunkhwa"** submitted by **Mr. Naeem Ullah Khan** accepted in its present form by the School of Public Policy, Pakistan Institute of Development Economics (PIDE), Islamabad as satisfying the requirements for partial fulfillment of the degree in Master of Philosophy in Public Policy.

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FORMAL DECLARATION

I, Naeem Ullah Khan, hereby solemnly declare that the work described in my thesis **"Transformation of Healthcare system: A case study of Medical Teaching Institutional Reforms in Khyber Pakhtunkhwa**" has been carried out by me under the supervision of Dr. Talat Anwar. I have not used any further means for the completion of this work except those I have explicitly mentioned in this thesis. All concepts adopted and copied from other written sources have been properly referred with the source.

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Naeem ullah Khan
6th June, 2020

DEDICATION

I dedicate this thesis to the memories of my Late Father Abdul Qayum Khan and my Late Mother Gohar Taj for their immense support throughout my life.

Naeem ullah Khan

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LIST OF TABLES

LIST OF FIGURES

Table of Contents

ABSTRACT OF RESEARCH

The intent of this research study is to pellucid the dynamics of Healthcare Reform system of Medical Teaching Institutions in Khyber Pakhtunkhwa and to analyzed the effects of reforms over the institutional performance and growth in provision of quality Health Care Services to the people of localities. The Medical Teaching Institutions healthcare reforms system has been scanned with the lenses of Policy design, autonomy dimensions, Governance & Accountability pattern with practices in order to diagnose and gauge the prevailed constraints increasing risks which affecting the performance , sustainability and growth of the system. In addition to this, the study also articulate the blurred concepts of autonomy exercised at the field level and its impact over performance in context of pre and post scenarios. The qualitative research strategy techniques have been applied with a tools of semi structure interviews, observation participant and focus group discussion to get primary data. In Khyber Pakhtunkhwa such type of study is unique in nature as no such type of study has been conducted at MTI Reforms in the specific context.

The findings of this research insights the trajectories of the Medical Teaching Institutions reforms system according to its values and differences prevailed at the implementation level which intercept and paced the success of these reforms as intended by the policy makers. The study extracted that although the system positively impacted the performance of hospitals to the extent of responsiveness however yet it will take time to achieve its objective of quality health care services provisions according to international standards. The governance of the system faces the lack of Coordination, Cooperation and Commitment among the stakeholders. Besides this, duality and complexity of the system expended due to weak policy designing. Similarly the efforts to balance control over autonomy hampered the autonomy values of the system. The recommendation of this

research torched those areas and will channelized the whole system according to its true values and the system will accelerate its velocity towards its objectives.

CHAPTER-I

1. Introduction

1.1 Study Background

It is evident from last few decades that hospitals remained as largest expenditure incurring units of the healthcare system in developing countries. According to World Bank health expenditure in Pakistan as a percentage of GDP remained 1% (World Bank, 2014). The experiences and research highlighted that lack of autonomy in decision making at local level in public hospitals, specifically in the area of finance, HRM and procurement are the cause of substandard health service delivery at hospitals (S.Preker, 2003).

In developing countries like Pakistan the disease ratio is high due to poor hygiene and lack of awareness on public health primitive measure thus the hospital becomes a critical place where the patient rushes to get tertiary healthcare services. In this context, the hospitals and provision of best healthcare services remained at the manifesto of almost every political regime. Around the world various countries made experiments by formulating healthcare reform polices enhance the hospitals efficiency and performance in provision of equity and quality healthcare services to the population. The focused of these reforms remained in structural change of Healthcare Institutions, autonomy and governance to standardize the clinical and non-clinical healthcare services.

The paradigm shift of decentralization in Western Europe during 1960 and 1970 which maneuvered structural reforms in the public sector was experimented in the developing countries during 1980s. The experiments of organizational reforms in European countries brought remarkable change in performance enhancement of public healthcare institutions. It diverted the incentive mechanism by articulating the role of managers within organizational structure and interlinked the external policy environment, governance, fund management and market competition.

Followed by the experiences of reforms and its success in other public sector services, policymakers in healthcare industry arrived at the decisions that the performance issues of public hospitals have interconnection with the rigid Anglo-Saxon model of hierarchical bureaucracies, weak operational command and control of executives, non-existence of appraisal and performance base numerations. Therefore, in order to address these barriers the New Public Management techniques have been emerged successfully through reforms in the health sector.

Pakistan has experienced Health Sector Reforms in 1990 at National level and later on at Sub National level in Punjab and KPK. In Khyber Pakhtunkhwa the Health Institutional reforms were firstly introduced in 1999 through Medical and Healthcare Institutions Reforms Act, 1999 whereby the Lady Reading Hospital Peshawar, Khyber Teaching Hospital and its allied Medical College, AYUB Medical Complex, its allied Medical College and Hayatabad Medical Complex were declared as semi-autonomous bodies (NWFP, 1999). In October 1999 after promulgation of emergency by the armed forces and the then Chief Executive of Pakistan Notified on 26th of June 2001 the Medical Teaching Institutions rules 2001 to regulate the Medical Teaching Institutions Reforms Act. No, XVII 1999.

In second phase, from semi to moderate autonomy initiatives were taken by the Provincial Government of Khyber Pakhtunkhwa and enforced North West Frontier Province Medical and health Institutions and Regulation of Health-Care Services Ordinance 2002 (Act XI, 2002), and repealed the Reforms Act No. XVII 1999. Similarly in 2006 through Act No. XI and Act No. VII of 2010 various amendments has been incorporated in the said ordinance. However, beside these amendments the authoritative role of bureaucracy over these institutions remained intact.

In third phase, the PTI regime in Khyber Pakhtunkhwa under Health Reforms initiatives granted autonomy to the eight Medical Teaching Institutions and its Allied Medical

Colleges consisting of Lady Reading Hospital Peshawar, Khyber Teaching Hospital, Hayatabad Medical Complex, Ayub Medical Complex Abbottabad, Mardan Medical Complex, Nowshera Medical Complex, Mufti Mehmood Medical Complex D.I.Khan and Bannu Medical College and its allied hospitals through enactment of Medical Teaching Institutions Reforms Act 2015 (Act: Reforms, 2015).

The Government of Khyber Pakhtunkhwa through enactment of Medical Teaching Institutions reforms Act 2015 awarded autonomy to the public Medical Teaching Institutions and their affiliated teaching hospitals to physically and technically regulate the services being rendered by these institutions. The intentions of these reforms are to enhance the performance, effectiveness and efficiency with responsiveness factors in the provision of quality healthcare services and other ancillary services being provided by the hospital to the patients.

In the said reforms, the performance and responsiveness with the inputs of autonomy has been focused to standardize the quality healthcare services provision by these hospital and quality medical education by the Medical colleges. The responsiveness became a new emerging approach in these reforms which enhances the aspects of health system. The responsiveness deals that how well the health system meets the legitimate expectations of the population for the non-healthcare services, consisting of dignity, confidentiality, autonomy, prompt attention, social support, basic facilities and choice of provider to enhance the performance of the hospitals to deliver their service effectively and efficiently.

In these reforms various changes have been made comparatively, which were not addressed in the previous statutes. The governance structure of Medical Teaching institutions has been reframed at different tiers consisting of Search and Nomination Council, Policy

Board, Board of arbitration, Board of Governors and a Management Committee to run the affairs of hospitals.

1.2 Problem Statement

The MTI Acts 2015 has so far been amended four times from the date of its promulgation. The amendments have been incorporated in the said policy due to non-addressing of some ground facts and realities at initial stage of policy design and formulation phase. The deficiencies in policy design affects the smooth implementation of reforms and the system development and therefore its initial outcomes were not according to the desired intentions of the policy makers. The stakeholders are also reluctant to accept the values attached to these reforms. The rules and regulations made thereon are also not being implemented in its true spirit, the autonomy concepts have been defined by each stakeholders in accordance of their own interests. The autonomy so granted to the institutions remained undefined in contents, which puts the institutions in compulsion to follow the inflexible colonial and bureaucratic rules.

The clinical and performance audit conducted by third party created a question mark upon the performance of these institutions under reforms. The Health and Finance Departments also did not provide Technical support to the Medical Teaching institutions to address the complexities arising during the implementation stages.

1.3 Research Problem

The intricate complexity of MTI Act and interrelationship between the stakeholders is a sustaining challenge which will be unfolded through this research study. Given the pretext to this problem, the researcher has taken the situation to identify the gaps in policy design, to articulate the complexities of the system and to diagnose the main constraints in success of the reforms. The said development, if endorsed by all the key stake holders in its true spirit will prove to be a long-term success in the path of these healthcare reforms.

The aforementioned research problem has been operationalized into following research questions and research objectives.

1.4 Research Questions

Q.1 How the MTI Reform Act 2015 is visualized and practiced?

Q.2. How autonomy affects the performance of Medical Teaching Institutions?

Q.3. What are the main constraints in the success of these reforms?

1.5 Objectives of the Research

Research objectives are the destination points that cover the scope and purpose of the overall research. They define aim of study which channelizes the entire process of research. The study draws attention to the overall reform process in the structural change of the Medical Teaching Institutions with inputs of autonomy and its ultimate impact on performance hospital clinical and non-clinical services. Furthermore, to investigate the gapes in policy process, governance, constraints and resistance confronted in the success of these reforms by addressing the following objectives:

1. To analyze the whole process of policy formulation and its subsequent operationalization.

2. To assess the autonomy granted through MTI Reforms Act 2015 and its impact upon the hospital performance in context of pre and post reform scenario.

3. To investigate the governance issues (internal and external) and constraints in the success of these reforms.

Chapter II
Literature Review

2.1 Drivers of Healthcare Reforms:

The masses in developing countries are mostly dependent upon public hospitals being an essential unit of healthcare systems, because they cannot afford the health expenses of private hospitals (Kutzin, 1993). The public hospitals expenditure ratio comparatively stood 50 to 80 percent government health sector expenditure (Chawla, 1996). In the past six decades, many developing countries established healthcare systems publically funded with services provision under the centralized bureaucratic setup. However, many weaknesses were noticed in the healthcare services systems which was being governed under bureaucratic system. The employees working in the public sector hospitals lack motivational behavior to do large volume of work due to non-incentive base human resource management rules and regulations. In addition, no effective and efficient resource utilization has been made, thus there was a need to improve the healthcare system based on the values of transparency and accountability in the utilization of resources (Paibul Suriyawongpaisal, 2006).

In context to the market failure and the experiences of Western systems such as the New Zealand and British National Health Services, these systems were restructured with the help of donors. The health sector policies focused on restructuring of human resources and other infrastructures like clinics, diagnostic facilities, laboratories in hospitals.

Similarly, comprehensive systems were developed in supply chain management and medical equipment as well as focus were made on the capacity building of staff.

In between sixties and eighties the number of hospital beds increased from five million to seventeen million by double of the per capita supply cross the world and simultaneously the figure of doctors from 1.2 million to 6.2 million also increased. (S.Preker A. H., 2000).

In developing countries, the Government is tasked to provide healthcare facilities with minimum resources to the large number of population. However it is difficult to ensure the provision of fundamental rights like basic health, education, enforcement of property rights, and road infrastructure. The development requires, the Government effectiveness must be in harmony to its capabilities to provides fundamentals rights. Therefore, to overcome the lack of confidence and to increase the credibility of the public hospital became the key drivers of reforms.

2.2. Policy cycle and Design:

The policy cycle generally refers to the process through which polices come into existence and are implemented as intended. Policy making is not a single stage process rather policies passed through different stages before to its final shape. These stages together are generally called a policy cycle. The first policy cycle was introduced by the Harold Lasswell in 1950s (Howlett, 2003). The policy making Activities are recurrent intentionally and the tools are used again and again to solve and address the problem (Freeman, 2013).

The policy cycle consist of five major stages and includes agenda setting, policy formulation, decision making, implementation and evaluation (Howlett, 2003). However some scholars and policy makers considered the identification of problem stage as a separate one (Dye, 2008).

In policy formulation all interlinked stakeholders are engaged in new policy formulation or to revise the existing policies relating to the specific institutions in context (Maetz, 2013). The bureaucracy plays a critical role in the implementation and formulation of policies. They are involved in drafting polices, making regulations and adhering to their discretion (Dye, 2008). A sound bureaucratic structure implements the Government policies and the success and failure depends upon the support and competency of bureaucracy (Mwije, 2013).

The identification of problem is the first stage which ignites the Government's will to intervene and formulate a policy to address the problem. The problem identification occurs when the interest group or individuals demand the government interventions (Dye, 2008).

Likewise, agenda setting takes place when the Government's attention is turned towards the problem (Howlett, 2003). The policy agenda and recognition of problem is done by the policy makers in political system (Mwije, 2013). The agendas are generally set on the demand of public opinion known as public agenda or formal agenda which is set by the Political persons and officials. The agenda setting may be directed from down to top or from top to down with either the masses or elites taking the lead as the case may be (Stone, 2013).

The implementation of policy is a very important stage and needs serious attention as this is a foundation from which the policy translates from table to practice and puts a plan for solution and its effects (Howlett, 2003). The resources and responsibilities are assigned at this stage, besides this some regulations and rules are also framed to carry out the operations of the policy as intended (Dye, 2008). The policies often fail due to inaccurate research, bureaucratic resistance or incompetency, design issue, in sufficient expertise or modification in the policy during implementation stages (Stone, 2013).

Evaluation of policy is carried out to assess the results of the policy implementation as intended by the decision makers. In evaluation, the outcomes are monitored both by the Government and concerned Actors (Howlett, 2003). The evaluation may lead to change or to terminate the policy according to the result of the evaluation.

2.3 Institutional Reforms and Autonomy:

Autonomy has many definitions in different contexts, but literally it is the state of being local governance and envisages the authority with power to be exercised at institutional level. Similarly, in reference to Health reforms a hospitals autonomy is the empowerment of hospitals to take decisions at their door step with the essence of freedom.

The hospital autonomy contributes in improvement of efficiency, recognition of physicians responsibilities, ensures accountability and standardizes the healthcare services. Correspondingly, the hospital autonomy focuses on quality care, reducing cost and increasing institutional surpluses (Méndez, 2010). The reforms for autonomous institutions empower the manager through devolution of power to manage and control the decision at local level (S.Preker A. H., 2000). These inputs in institutional reforms strategies have successfully improved the equity and access of public to the healthcare services. The performance of public hospitals is interlinked with incentive system and the hospital autonomy plays an important role in decision making.

S. Preker states that incentives are the outcome of pressures created from the external environment and the hospitals managerial tools. The external pressures consist of government oversight, health insurance schemes, market competition and style governance by the hospital owners. The managerial tools are rooted in the authority power with autonomy awarded to the manager at local level, the market environment originated by the provider payment mechanism and exposure to the market competition and the degrees for retaining surplus and sustain loss or debts by the hospitals, and the parameters of social functions of hospital explicit and funded.

The hospital autonomy is characterized to increase the decision-making power at local level comparatively more than the public sector executives being a funding agents (S.Preker A. H., 2000). This approach tried in many developing countries as tools to enhance performance, quality of health care, and to mobilize the resources (Mitchell, 2005).

The policy makers is therefore keen to know about the solution of paradigm shift that how to move from inflexible and poor delivery system to more efficient performing system to formulate a substantial and responsive independent service delivery units. (S.Preker A. H., 2000). Hospitals under public sector administration in developing countries confront

inefficient resource management, unprofessional patient care, complex hierarchical governance structure, non-productiveness, inefficient administration, lack of financial controls and lack of performance based awards (Akram & khan, 2007). However increase of serious issue in health, originated a quality health care delivery system (S.Preker A. H., 2000). Although equity remained as a motivation for public service delivery and resource distribution but rarely focused in those aspects (D. Gwatkin, 1997). The social service provision remained unresponsive and non-accountable to user of the public institutions and the patients are always treated in poorly manner in public health facilities. The quality remained a problem in healthcare organization both at clinical/patient care and poor management of bio medical equipment. Like other public services, health services is associated with technical inefficiency used of facilities at hospital level (M.A. Lewis, 1996).

Autonomy as a remarkable tool of health reforms have been practices in many countries for like Ghana, Kenya, India, Indonesia, Zimbabwe, Uganda, France, Italy, New Zealand, United Kingdom and Pakistan. It is proved that the concepts of award of autonomy to Government hospital in Pakistan is not a native idea rather inspiration from foreign experiences. Initially, the reform of choice was to give hospitals some degree of management autonomy. Limited success with this type of reform guided the policymakers move forwarded by restructured the public sector hospital as corporation bodies.

The transformational change of such type of reforms leads to the creation of health care trusts in the UK and Crown Health Enterprises in New Zealand attracted the world interest into the new system. Later on many developing countries like Hong Kong, Malaysia, Argentina Indonesia, Singapore and Tunisia adopted the same reforms with overall health policy framework with the environment of payment provider and market competition.

2.4. New Public Management:

The NPM is an approach to run public service organizations at Sub-National and National levels. The New Public Management approach emerged due to the lack of credibility of the public upon the limitation of traditional public service delivery system. The NPM reforms having a values of disintegration, service efforts, customer satisfaction, entrepreneurial spirit and innovations. The unique elements of the NPM system is delegation, performance and responsiveness, competition.

New Public Management in health care service was implemented in the early 1980s in New Zealand and Australia being an alternative of old public administration and considered as integrated and best public service model (Gregory, 2001).

The New Public Management reforms were firstly introduced under the command of Prime Minister Margaret Thatcher in United Kingdom. Thatcher performed dual functionary role as policy entrepreneur and premiership of United Kingdom. The main theme of the NPM entrepreneurs was downsizing of public sectors workforce and to restructure the public organization under the combine approaches of market and management theories.

The structural model of NPM focus upon the fragmentation and increase specialization both in vertical and horizontal directions (Boston, 1996). In vertical context, it was suggested that structural devolution will eliminate centralization issues and the managers will be able to work according to strategic plans argued that structural devolution was the answer to central capacity problems, because it would allow leaders to focus on more strategic plans and drive perfectly.

Later on many new models of structural reforms were developed like empowerment of agencies with leeway, isolation from political and executive, relaxation of rules being a

constraint and establishing regulatory authorities with higher degree of autonomy, establishing more regulatory agencies with strong autonomy base on professional values and prioritizing market values. The NPM system empower managers to have more authorities (Barzelay, 2001). In NPM the public manager can give verity of choices to the customer who can select or drop out the services completely (Kaboolian, 1998).

The NPM was considered superb standard for administrative reform in the 1990s (Farazmand:, 2006). The approach behind these reforms to use private-sector practices being efficient rather than rigid hierarchical bureaucracy. NPM change the approach from bureaucratic administration to professional business management. NPM was considered as ultimate solution in organizational context and policy making to enhance the performance of education and health care Institutions.

The NPM focused on decentralization of system where managers have more powers in their day to day operations without restrictions. However, it has been evident from Australia's experience that reformed strategy confronted two failures that the reforms technique was costly and increased the cost in short run and on other hand an attempt to save the cost indirectly affect the quality of services and innovation.

2.5 Delegation of Power and Empowerment:

Power is a key concept for an understanding the processes of empowerment. In the previous system the Medical Teaching Institutions were under the legitimate power and control of bureaucracy. However, some institutions like KTH, LRH, HMC and Ayub Medical Complex were awarded semi-autonomous status (Reforms Act, 1999; Care, 2002) but in the Management council the existence of bureaucracy representative still prevailed (Act, 2010) and their influence upon most of the decision through legitimate power was in practice.

The influence of bureaucracy consisted three-fold i.e. charismatic, traditional, and rationally legal. The German sociologist Max Weber described that bureaucracy is the most efficient and rational governing body which maximizes efficiency and eliminates favoritism. However, Weber narrated the dark side of unbridled bureaucracy as constraint to the individual freedom, with the potential to cage individual in rule base rational control (Swedberg & Agevall, 2005). In fact Weber saw the power of the bureaucracy in two directions control of human life while other is a threat to the freedom of human spirit. He also stated that this organizational style is a power tool and would suppress the democratic values of organizations (Morgan, 1986, 1997).

The social psychologists John R. P. French and Bertram Raven in their studies conducted in 1959 divided power into five different forms consisting as Power as coercive, reward, legitimate, referent and expert (Forsyth, 2006).

Later on Raven's in 1965 added a sixth separate and distinct base of power as an informational power (Raven B. H., 1965). Furthermore, French and Raven, defined social influence as a change in the belief, attitude, or behavior of a person being a target of influence and Action of another person an influencing agent as result, and called it as social power a base for influence with capabilities of the agent by using available resources about such changes (Raven B. H., 2004).

Similarly, empowerment is a measure taken by the Government to award autonomy and independence to the people and societies with a basic objective that they may take initiative in their own interests in a responsible manner and exercise their own authorities. It is the process of transformation of authority make one stronger and confident for decision making to control life and rights.

In empowerment the people are envisage with powers and professional support. it reduce the thinking of powerlessness and they are authorized to exercise their nfluences over the resources as their rights. The empowerment theory traced back with Marxist sociological theory. These sociological ideas have been developed and polished through Neo-Marxist Theory (Kagan, 1996).

The Karl Marx in a conflict theory detailed that society is in the state of everlasting conflict for limited resources. It holds that social stratum is enforced by power, rather than concurrence and conformance. It is further explained under conflict theory that elites with power and wealth suppress the powerless masses (Malia, 1998).

2.6 Bureaucratic Politics and control:

In reforms, a race for power and control among various politicians and bureaucracy begins and those who get more power become the winner while the looser becomes powerless (Bidhya Bowornwathana, 2010). In the context of reforms, the bureaucratic politics in the administrative and institutional reforms is a political game of bargaining, pulling and hulling for power and control between the politicians and bureaucrats. The bureaucrats have a major role in policy formulation process and always try their best to accommodate their role, power and control in the proposed policy directly or indirectly.

The bureaucratic politics is essential factor in defining and influencing the policy framework and process (Bidhya Bowornwathana, 2010). The political researchers have developed the concept of classical political model and modified it from time to time. In 1984 the Bendor and Moe proposed a neoclassical model like adaptive bureaucratic politics model having roots with a neoclassical approaches of Niskanen and peltzman proposed in 1971 and 1976 respectively where they have identified the three major groups who play a game in the policy arena and reforms are bureaucrats, politicians and interest groups.

2.7 Organizations Complexities & Reforms:

The modern organizations are more complex in public and private sector throughout the world. (Farazmand, 2002). The complexity and hybridity of these organization are originated due to conflicting proposals, values, increasing demands and incorporation of structural and cultural factors simultaneously. The complexity is notable characteristic of today public organizations because the modern democracies of the world formulating and implementing continuous reforms in public organizations. (Light, 1997).

The NPM reform were originated due to poor performance of old systems however on the other hand the post new public management reforms were also placed due to weakness of the NPM system and both as result mixed structural and cultural factors in organization and generated complexities (Olsen J. P., 2009). In this context the structure and culture factors to some extent remained constant while other factors institutionalized with strong parameters and some of them remained weak or discharged (Røvik, 1996).

Complexity in generally found in public organizations at structural and cultural complexes. The Organization theory categorized complexity as structural variable consist of horizontal and vertical complexity (Anderson, 1999). Furtherly the structural complexity in public sector organization may be classified as vertical specialization and horizontal specialization with intra and inter organization factors ((Egeberg, 2003). The vertical intra-specialization tells us the degree and delegation of formal authority among at different levels hierarchy. It will considered as strong vertical specialization where the control and coordination back by power is clustered among different leaders at different level. Similarly vertical inter-organization specialization having same characteristics among different interlink public organizations, so strong vertical specialization consist of ministries with many subordinate agencies, whereas weak specialization consist of more interlinked ministries.

Similarly intra horizontal organization means the division of organization into many department and units according to its functions, principles, objectives and clientage. Strong specialization indicates subdivision at many sub units. While inter-organizational specialization exist among public organizations on the same hierarchical level among ministries and its subordinate departments (Gulick, 1937).

These dimension of specialization fix the level of complexity of the public organizations. This vertical and horizontal strong specialization mean strong expansion and autonomy is the values of reforms made under the NPM models (Pollitt, 2004) .

The low specialization vertically and horizontally is the combination of political and old public administrative system and emerged in the reforms under post NPM models (Christensen, 2007).

Reforms being a tool for restructuring or designing organizations where political and administrative leaders may achieve their interests (Egeberg, 2003). The leader have greater control over the reform process and they mark high score with a rational calculation approach and social adjustment (Dahl, 1953).

In this context it is mind questioning that how and to what extent the leaders may develop complexity to balance control and autonomy. The answers to this effect is the rational solution to address the challenges faces by the organizations (March J. G., 1983), with a balance between complex structure, constraints and reforms (Lawrence, 1967). Leaders may advocate myths with some symbols keep balance between control and autonomy by spreading a news among the target population about the need of control and advantage of autonomy. So the organization and structure consist as mixture of control and autonomy (Brunsson N. , 1989) besides this diversity with in government, interests of institutions and a tug-of-war among stakeholders may provide platform to the origination of complexity (Allison, 1971).

The control could be a solution to conflicts at some time to deal with some players on the other side autonomy may be used in specific context without consistency to deal the other constituencies (Cyert, 1963) .

2.8 Cultural outlook:

In the context of cultural outlook the informal values and norms are developed within the organization with the passage of time and become distinct (Scott W. R., 2007). The cultural complexity means different informal cultural norms and values exist in the organization inter and intra. These cultural values and norms are attended and observed with its sub cultural norms developed though reforms. On the other hand weak cultural complexity is the characteristics of harmonized cultural values and organization Members with a unified purpose committedly observed these value in aggregative manner (Kaufman, 1960).

The national reforms of different counties have different roots associated with their cultural traditions and path dependent (March J. G., 1989). The reforms in the public organizations need to pass through cultural compatibility test. If there is more harmony and consistence between the value attached to the reforms and the cultural value of the existing system then the reforms will succeeds to achieve its desire results (Brunsson & Olsen, 1993).

2.9 Environmental outlook:

The environmental outlook of organization is categorized in to technical environment and institutional environment (Meyer & Rowan, 1977). The technical environment is shaped with exchange, outputs and efficiency. The technical environment is strongly dependent with external factors which determined the demands prevail at environment (Olsen & J.P, 1992).while the institutional environment has less technological character and more related to the structure of organization, its cultural values human resource polices and demographic elements. Public organization complexity is a dependent variable with external demands and its complexity in other sense if the demand is more complex the organization complexity will

be higher. However to make a balance control and autonomy there is a need to address all the Actors with in organization with a reconciliation approach.

2.10 Country wide Hospital Reforms:

In context of Pakistan the health sector organizational reforms have been implemented to enhance the performance of the health institutions. The health sector remained undeveloped and did not ranked at the top of the Government agenda like other social sector program. It can be easily ascertained from the budget figures around 2.90 % health expenditure of the GDP in 2017 while 17% of USA (world Bank, 2017). The lack of leadership, political instability non inconsistency in polices, bad governance and miss management are the key reasons that the health sector remained neglected in the past years. In health sector the poor delivery of health care services and miss use of resources push the Government for health reforms initiative (Islam, 2002). The award of autonomy to public sector hospitals in Pakistan remained under debate since 1990 but it became jargon among politicians and member of the society since early of 2000. (Abdullah, 2007).

The hospitals in Pakistan were awarded autonomy initially in 1992 and later on the same practices were implemented at provincial level (Saeed, 2012). These reforms were implemented in the two hospitals of Federal Government on pilot bases with a view that if these reforms succeeded would be later on extended at to the provincial level hospitals. The main intention of the Government behind these reforms were to address the principal agent problem and to reduce the government control over hospital with the inputs of autonomy and NPM models (Saeed, 2012). The initiatives of hospital reforms were firstly taken by the political party PML (N) in Pakistan but the idea were transferred by foreign donors like other developing countries.

The hospitals were awarded autonomy through PM&HI Act 1998 and subsequently with amendments in 2002 and 2003, with the intentions to improve the public sector hospital performance. The Federal Ministry of Health under autonomy provided grants through block

allocations and allowed Institutional user fee to be retained by the manager to economize the cost and to enhance the performance of institution that affordable and accessible quality health care services be provided to the patients (Makinen, 1993).

In context of Pakistan the literature reveled that autonomy was remained as spirit of the health care institutional reforms however it does not detailed that why these reforms polices did not delivered the desire results like western world. The Medical Teaching Institutional reforms in Khyber Pakhtunkhwa are facing the same situation and the research does not explore that after promulgation of MTI Act 2015 why the desire out comes were not achieved successfully and originate a gape in the literature upon the subject, need to explore and articulate the main reasons and constraints confronting in the success of these reforms in the area of policy design, governance, political and bureaucratic integrated support and capacity of institutions to accept the change.

2.11 Theoretical Underpinnings:

The neoclassical paradigm focus upon the factors of market failure. The logic for public proprietorship is an effective instrument to achieve social goal where market failures occurred. This concept is associated with a relationship between control and public proprietorship. In private sector, the organization generally focuses on profit maximization and to maximize the benefit of shareholders. In some instance these maximization of shareholder benefits do not maximize the benefit of the whole society. The market failure generally occurs where competition does not exist or there is lack of efficiency on account of externalities, lack of asymmetric information and the characteristics of public goods.

This argument in health sector advocate Government interventions to control the market failures with equity and efficiency as well as to ensure provision of quality healthcare services to the public. Based on these theories, the state ownership is used as a tool to intervene and to replace the personal interests of owners and to expand benefits to the all

society instead of concentration and profit maximization. As the neoclassical economics articulated the factors of market failure however this framework does not have effective solution to the institutional structure issues.

The techniques by which the Government intervention and ownership may lead to maximize social objectives has been articulated and the gaps have been bridged by analytical instruments development to understand the ownership and governance effective implications.

The old public administration has roots in political theory with negative social science impacts regarding persuasion or beliefs of a geo-political mass as social thoughts.

Political theory can also be considered in a way which focuses on the concepts of collective life, collective power and usage of resources collectively. On the other hand, the NPM is rooted through Economic Theory and positivist social science. The Economic theory upholds that increase in goods consumption is beneficial economically. The Economic Theories of John Maynard Keynes who argue that public monetary and fiscal policies intended to generate business Activity and generate employment opportunities where is the NPM have the bases of economic theories.

Institutional theory argue that social behaviors are regulated through structures, rules, norms and routines being authoritative practices (Scott, 2004). Scott indicates that organizations sustainability depend upon the rules and belief exists in the environment (Scott, 2004).

The agency theory or principal–agent problem occurs where a person is authorized with powers to take decision as an agent on the behalf of other another person as principal or entity (Eisenhardt, 1989). Complexity theory argues on interactions of different elements and the loops that transform system. It propose that system are not predictable where constraints are generated through rules and orders (Burnes, 2005).

Systems theory is the synthesizing study of systems. It is a viscidness of interlinked and dependent organs either naturally exit or developed by human. Each system is characterized by its own temporal boundaries and influenced by environmental factors, consist of its own structure and function. In more detail and effects it can be more than its structure and describes an emergent behavior. The dependable characteristics of systems depict that change in one organ may affect the other organ with forecasted patterns and behaviors (Beven, 2006).

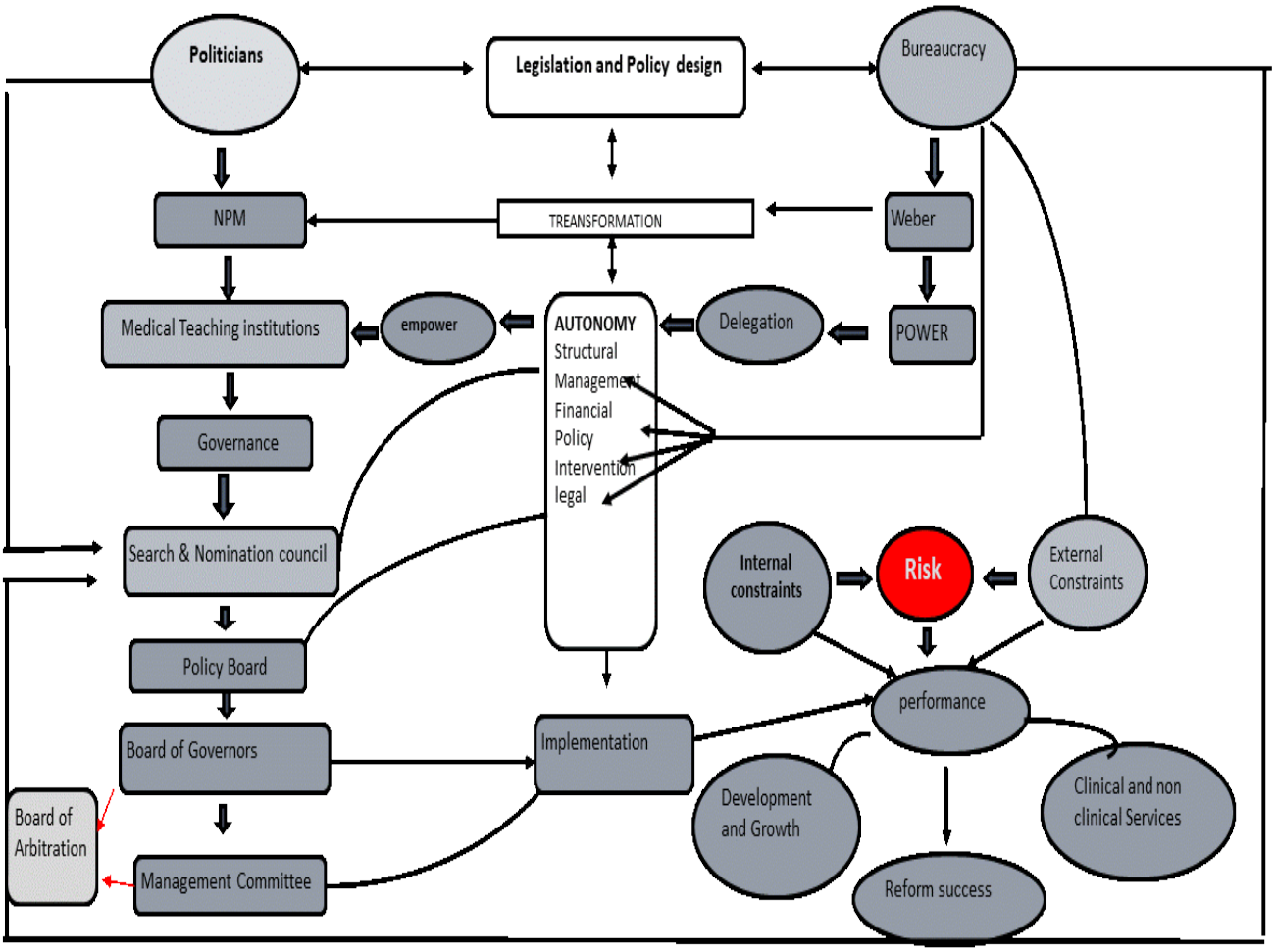
A hybrid organization theory focuses on organizations which have a mixture of system values and logic Actions like profit generation and social values of various sectors of society consisting public, voluntary and private sector. The hybrid institutions and governance is a more detailed the hybridity of organizations. (Johanson & Vakkuri, 2017).

2.12 Conceptual Framework:

Conceptual framework represents the researcher's approach to explain phenomenon with a interlink variables and their rationality in study of research. Thus the conceptual framework explain the connection of identified variable necessary for investigation of research. It is the researcher guide to pursue research investigations. The proposed conceptual framework of this research identified that the Institutional reforms policy was formulated with the collaborative efforts of politicians, bureaucracy and interest groups. The transformation has been made with the inputs of autonomy and delegation of powers from center to hospital level under the stewardship of NPM model through empowerment process. However, after establishment of Medical Teaching Institution and its governing Bodies a new system has been established which ultimately reduced the power of bureaucracy and politicians over these institutions. The arrows showed, that in the context of governance the politician and the executives inserted their role in the Search and Nomination Council of the medical Teaching Institutions to put control over the institutional governance.

Similarly, on other side the executives by intervention made access to the management, financial, policy and structural autonomy in contrast to the privilege of legislation sanctioned in favor of Medical Teaching Institutions which resulted in creating external constraints. Likewise, the intervention of Policy Board and design issues by default originate internal constraints. Both the internal and external constraints instigate risk which tends to affect performance and ultimately has an impact on improvement of healthcare services and success of reforms.

CONCEPTUAL FRAMEWORK



CHAPTER-III
Research Methodology

Methodology is the pathway which leads the researcher's efforts in manifolds aspect like application of researcher's in depth knowledge acquired about the topic, application and induction of data in accordance with framework applied in the research. In nutshell the methodology is the standardized process to conduct research and to answer the research questions. On the other hand methods are those techniques which are used for collection of data and its analysis. The researcher has outlined research methodology as follows:

3.1 Research Strategy:

Research strategy aids to execute the research plan which directs the researcher's thoughts and efforts systematically to achieve its targets. The researcher always deploys research strategy which is best suited to research orientation for collection of data and its analysis which can be either one type of strategy or either mix of strategies. The researcher has applied qualitative research strategy in the whole process of research for collection and analysis of data.

3.2 Research Design:

Research design logically integrates the components of research according to research strategy which correspond to the research problem effectively. Research design showcases the outline of data collection and analysis (Bryman, 2012) .

The research designs may be descriptive, explanatory or exploratory. In context of the research questions and research objectives, the researcher has used descriptive and explanatory research design as it facilitates to find and magnify the reality on ground and happenings.

The purpose and objective of this study is to analyze the transformation process in accordance of policy cycle consists of power and control from central to local level with

award of autonomy, its execution and impact on performance of Medical Teaching Institutions with the diagnosis of constraints confronted to these reforms.

3.3 Method of Data Collection:

Methods of data collection are techniques used for collection of data related to research questions. The following research tools have been used which were fruitful in finding out the specificities of the research topic:

1. Semi-structured interviews.
2. Observation as participant.
3. Focused Group Discussion (FGD).
4. Official Documents

3.3.1 Semi Structured interview:

The interview is a basic tool to capture primary data directly from the respondent; it is more reliable form of data and has high degree of authenticity. Interview is a linguistic method in which the researcher acquires data from respondent by asking research questions related to the research phenomena. This type of Activity can either be conducted one to one or with a group of respondents. Interview is a scientific tool for data collection in a set of questions to be carried in a systematic way in accordance of research questions and research objectives (Sarantakos, 1998)

The semi structure interview is the method of interview having a mixture of structured and unstructured interview thus it provides an open ended questions to the interviewee to express his views explicitly with incorporation of new thoughts, hems and idea fruitful for research phenomena. Similarly the structured part of the semi structure interview provides the interviewees reliable and qualitative data (Keller, 2020).

Thus the researcher used the said tool for collection of data from all UDCs. It facilitated the researcher to construct in-depth observations and insights of key stakeholders

about the transformation of healthcare system. The researcher considered it an appropriate tool for all UDCs of the subject research for the reason that the research is analytical in nature.

3.3.2. Observation as Participant:

Research methods like participant observation and semi-structured interviewing are used by researcher to look for new concepts and theories derived from data (Bryman, 2012). Observation as participant is a method of data collection generally used in the qualitative research studies. In this method of data collection the researcher remains in close relationship and familiarity with the target population of his research study.

The researcher himself served in the Medical Teaching Institution for approximately 2 years on an executive position of Director Finance hence the observation as participant for collection of data has been used as one of the prolific technique of data collection. Moreover, the researcher has taken due care about the limitation of such method of data collection by restraining the researcher's bias.

3.3.3. Focus Group discussion:

The focus group is an interview method for data collection to capture the different views of persons in a group discussion related to research topic. In focus group discussion the researcher is more interest in how people present their views reciprocally to each other during the interaction taking place within the group. This technique enabled the researcher to develop an understanding about perception and Actions of target population of the research topic (Bryman, 2012).

Due to the above stated reasons, the researcher applied focused group discussion to collect data from UDC 1 and UDC 2 which assisted researcher to double-check and authenticate data by connecting stakeholders at a particular forum. The researcher performed the role of moderator and recorded the discussion with key notes.

3.3.4. Official Documents:

Documents review related to the research study is one of the useful techniques to collect data related to research phenomena. The documents provide an in-depth knowledge about the subject of research and enable researcher to understand the concepts about the substance of research phenomena. The documents related to research study may be external or internal and it may be consisted of written or electronic record. These documents includes statutes, polices documents, regulations, minutes of the meetings, reports, performance rating, funding proposals etc. (US deptt of health, 2018). The use of documents and record in research study as data collection tool is efficient and easily accessible (Quentin Ainsworth Apr 02, 2020).

The researcher consider it most reliable tool for collection of data from the UDCs as well from other sources regarding research study. The Acts, regulations and other documents being an evidence are collected and review to address the research questions.

3.4 Data Analyses

Data analysis is a process for collecting data and transforming it into useful information for decision making. In research the data analysis are carries out by applying some technique through analysis process for answering the research question, test hypotheses or to nullify theories (Judd, 1989). In this research study the researcher has used the documentary and thematic data analysis technique to answer the research questions.

3.4.1 Document Analysis:

Document analysis is a systematic process for examination, reviewing and to evaluate documents related to the research. The documents may be in printed or in electronic forms. The documents analysis like other methods of analysis in qualitative research the data are reviewed and interpreted to explain meaning, understand concepts and developed empirical knowledge (Corbin, 2008). The documents provides a secondary source of data which can be proved as a valuable information and insight knowledge base. The documents analysis

provides a facts about the evolutionary change to the development process and the researcher can compare them to identify the changes. The timely and subsequent changes in a draft shows a development to the programs (Yin, 1994).

The researcher has reviewed and made documentary analysis of all the documents, Act, rules, regulations and subsidiary documents related to transformation of healthcare system in Khyber Pakhtunkhwa to address his research problem.

3.4.2 Thematic Analysis:

Thematic analysis is a process of data analysis where the themes are identified and developed within the data. These emerging themes becoming the categories for research analysis (Fereday, 2006). The process of thematic analysis is a careful Activity to focus on the content of the data for development of emerging themes.

The researcher took magnified the selected data and performed coding and categorization process to showcase the emerging themes based on the characteristics of data related to the research.

3.5 Sampling

3.5.1 Purposive Sampling:

Purposive or non-probability sampling is a non-probability sampling technique in which the researcher collects data by approaching individuals relevant to the field of study. The said technique has been used for interviewing the Members of the interlink stakeholders related to all most all UDCs

3.5.2 Stratified Random Sampling:

Stratified random sampling technique divides the population into strata/groups and then gathers data as per sample size. The said technique has been used to collect data from the two groups of employee i.e. Medical Teaching Institutions own employees and Civil Servant working in Medical Teaching Institutions.

3.5.3 Convenience Sampling:

Convenience sampling is a technique used to approach unit of data collection who are easily accessible on a by-chance basis. The said technique has also applied upon the employees working in different cadres of Medical Teaching Institutions.

The Members Board of Governors, Government Officials, executives and medical and non-medical staff Members of MTI mentioned in data collection unit. They have been taken in confidence about the privacy of information communicated and it will only be used for academic research only. The interview have been conducted with the permissions of interviewee by using interview guide.

The contents of interview have been repeated in the presence of interviewee to make the data credible. The transcription has been made to extract more information from the interview for data analysis.

3.6 Units of Data Collections

Units of data collection are the sources of investigation for research study. The following units of data collection have been used to collect data for this research,

3.6.1 Unit of Data Collection 1.

The unit of data collection 1 includes policy and decision making bodies who participated in the policy formulation process of Medical Teaching Institutions and those interlinked stakeholders who are responsible for the execution of the MTI policy and governance like Politicians, Board of Governors, Law, and Health & Finance Departments.

3.6.2 Unit of Data collection 2.

The Unit of Data collection 2 includes the Management Committee Members of Medical Teaching Institutions i.e. Medical Director, Nursing Director, Finance Director, Hospital Director and Dean of Medical College who are responsible for the operations of the Medical Teaching Institutions and are responsible for the implementation of these reforms successfully.

3.6.3. Unit of Data Collection 3

The unit of data collection 3 includes clinical and non-clinical staff directly involved in the provision of public healthcare services to the patients. This unit of data collection has been stratified in two groups i.e. Medical Teaching Institutions own employees and Civil Servants working in Medical Teaching Institutions

3.7 Locales

A. Peshawar:

In Peshawar the following Medical Teaching Institutions have been visited for data collection:

1. Medical Teaching Institutions Khyber Teaching Hospital and its allied Colleges.
2. Medical Teaching Institutions Hayatabad Medical Complex.
3. LRH Peshawar.

B. Mardan

In Mardan the following Medical Teaching Institution have been visited for data collection:

1. Mardan Medical complex and its allied Medical Teaching Institutions.

C. Bannu:

In Bannu the following Medical Teaching Institution have been visited for data collection:

1. Medical Teaching Institutions Bannu and its allied Colleges.

CHAPTER–IV
Finding and Analysis

4.1 Driving Approaches behind the MTIs Reforms:

The Government of Khyber Pakhtunkhwa made various efforts to standardize its healthcare system at primary and secondary level. The Government in order to standardize health sector made round about 23 enactments including Medical Teaching Institutions Reforms Act 2015 through. The KP government tried its best to strengthen the Healthcare system with a transitive approach to achieve economic growth in the province. The vision of best healthcare system and its impact upon the economic growth are interlinked with the other sectors of the economy and the same has been underpinned by the official of Health department as one of the respondent said;

"Health is one of the major sectors which come under the definition of tertiary sector among four sector of economy. Hence, strengthening and improving health sector may contribute to economic growth".

The objective behind these reforms is to strengthen the healthcare system with good governance, investment in healthcare with collaboration of public and private sector, utilization of resources up to the optimal level and adoption of best healthcare practices to ensure the access of the people to the affordable healthcare service. These reforms do not fall in the reactive policy domain rather it has proactive policy approach. These healthcare reforms are an effort to achieve the Sustainable Development Goals (SDGs). The Medical Teaching Institutions reform Act 2015 was enforced at tertiary healthcare hospitals and its allied education Institutes. The approach to bring reforms in the Medical Teaching Institutions is not innovative rather it has inspiration from the experiences of foreign and domestic private sector teaching Institutions who are delivering healthcare services according to international standards.

The core essence of the Medical Teaching Institution reforms is to enhance the performance of these institutions and to strengthen the non-healthcare services which have direct effect upon the quality healthcare services with equity. Although the reforms can be traced back in the Health Sector Strategy 2010[1] and Medical Teaching Institutions Reforms Act 1999 of KP Government but in spotlight the institutional and Healthcare reforms remained at the official manifesto for 2013 Elections of Pakistan Tehreek Insaf.[2]

Other respondents said, *"PTI government in KPK formulated MTI Act 2015 to bring health reforms through establishment of independent unit in public sector with grant of autonomy to enhance the performance of these institutions on the analogy of shoukat khanum, Agha khan and shifa international hospitals."*

Similarly another Respondent told that

"Many countries in world under 18 MDGs tried their best to achieve such goals by eradicating diseases and reducing mortality rates which is only possible if we have best healthcare service delivery institutions which are affordable and easy accessible to people."

Findings illustrate that the driving approach behind Medical Teaching Institutions reforms Act 2015 is coated with political commitment yet these reforms are not native but rather innovative in its nature as many developing counties experience such reforms. The driving approaches behind these reforms are:

(a) Political

(b) Inspiration from the experiences of foreign countries and institutions

(c) Declaratory like declarations of United National MDGs and later on SDGs

4.2 Reforms under Policy Cycle Lens*:*

Policy formulation is a process where the politicians, bureaucracy and experts collaboratively make an effort for formulation of policy. The policy cycle is not a single step

[1] Khyber Pakhtunkhwa Health care Strategy 2010
[2] Agenda for resurgence, the manifesto of Pakistan Tehrik Insaf 2013 election.

process but it involves a series of stages through which policy passes and comes to its final shape.

4.2.1 Problem Identification

Problem identification is the initial stage of policy cycle and originates when the interest group or individuals demand the government interventions (Dye, 2008). In context of Medical Teaching Institutions reforms Act 2015, the healthcare services delivery systems were in operation in those healthcare Institutions which are now the subject of MTI Reforms Act 2015. In the Province of Khyber Pakhtunkhwa some Institutions like KTH, HMC and Lady reading hospital were already declared semi-autonomous before the said Act while the rest were under the direct control of Health Department Government of Khyber Pakhtunkhwa. The semi-autonomous Institutions were being provided grants while the rest were dealt as budgetary units. However, the styles of Governance of all the Institutions were same. The national and international publications identify some loopholes in the previous system. One of the respondents remarked it as,

"In the previous system we did not have full autonomy and were dependent upon Health Department in many areas like finance, procurement, human resource, decision making, infrastructural development and policy making."

However, no proper performance evaluation of the previous system was carried out at Government level which may be attributed as problem identification platform for Government intervention to switchover from legacy to the new Reforms system.

The PTI government according to its party manifesto for 2013 elections intended to bring Institutional reforms in the health sector for provision of best healthcare services in accordance with international best healthcare practices. One of the respondents said,

"*The out of pocket health expenditure ratio is very high .The main objective of these reforms was that rich and poor both have an equal access to quality healthcare services."*

The finding illustrates that the previous system was working according to its attached values and there was no failure. However, it was not possible due to centralized control, governance issue, miss use of resources and non-existence of professional and technical persons to compete in the market. The quality healthcare services remained a key subject for the Khyber Pakhtunkhwa Government since long but the problem has been sensitized by the PTI Government to provide equal access for all to utilize quality healthcare services.

4.2.2 Agenda Setting for the Institutional Reforms:

Policy agenda is recognition of the problem by the policy makers in political system (Mwije, 2013). The agenda setting of Institutional reforms of Medical Teaching Institutions has its roots in the Party manifesto. The agenda setting was formal and had top to down approach. One the respondents told that,

"The Provincial Government on the direction of its central command and in accordance with its party manifesto desired to make the independent unit of Medical Teaching Institutions and its allied colleges with the grant of autonomy."

The findings illustrate that agenda setting of Medical Teaching Institutions reforms was not public opinion agenda but it was a formal agenda having political base and top to down approach.

4.2.3 Legislation Process:

The policy formulation is a very critical stage in the policy cycle and has overall impact on policy in the field. The politicians, bureaucrats and other actors play a very important role in the formulation of policy and its design. The pattern and design of the policy needs very close and sensitive attention, in case if there occurs a flaw or ambiguity in the policy design then it may become a cause of failure or difficulty in implementation of the policy in the field. It is mandatory to involve all the stakeholders at this stage who directly and indirectly affect the operations of the policy. This stage may consists of planning, analysis and design, besides this some regulations and rules are framed for the better

operations of the intended policy (Dye, 2008). The accurate research study before formulation and implementation of public policy is a very important fact and may affect the policy swings during implementation phase. The inaccurate or incomplete research may harm the success of policies (Stone, 2013).

The Provincial Government availed the expertise on voluntary basis of some national and international renowned Medical professionals who had worked in the development of state of the art hospitals like Shoukat Khannum Memorial Cancer Hospital Lahore. The task for development of policy draft of Medical Teaching Institutions Reforms Act 2015 was assigned to the Department of Health, Government of Khyber Pakhtunkhwa. So the Government designed the Medical Teaching Institutional Reforms Act 2015 with collaboration of those experts. The policy draft was finalized among the stakeholders and interest groups i.e. Politicians, Health Department, Establishment Department, Law Department and Finance Department of Government of Khyber Pakhtunkhwa and the Medical Professionals whose voluntary services were availed by the Government of KPK. One of the respondents told that,

"The reforms' bill was prepared and proposed by the Health department and more inputs were given by the medical professionals whose services were deployed by the Provincial Government on voluntary basis"

Other respondent told,

"During the discussion and debate among the those stakeholders, the Medical professionals who are the main architectures of the said reforms assured other stakeholders that through these reforms the hospitals will become self-generating income entities and it will reduce burden on Government financially and administratively as well the hospital performance and quality health care services will be enhanced through grant of autonomy to these institution"

The procedures for legislation are detailed in the rules and procedures 1988 of Khyber Pakhtunkhwa Provincial Assembly.[3] The legislations mainly come into existence through Government Bills introduced by the Ministers, Private Bills introduced by any member and Ordinances enforced by the Governors in cases where assemblies are not in session or recess.

One of the respondent said

"*The Legislation as per practice is passed through three in-house readings one is introduction, second is consideration (composed of committee scrutiny, report and clause by clause in house debate) and in third stage the Bill is passed from house and then forwarded to Governors for assent."*

The Bills are generally passed through three stages:

1. **Notice for discussion:** The Minister who holds the portfolio of the ministry may give notice for general discussion or notice for moving an amendment.

2. **Reading Stage:** In this stage the general principles of the Bills are debated at the floor of house where the rejection is possible in case of private bills. However, in case of government bills the possibility of rejection is often bleak and does not occur.

3. **Review and examination of the Standing Committee:** The Speaker of the house at the third stage of formulation of law sends the Bill to relevant standing committees who may debate it with experts, Minister and the Administrative Department. The standing committee after performing its legitimate duty may propose to rewrite the bill or make amendments as they detailed in the report. If the Standing Committee examined the Bill and does not propose any amendments then the Bill is passed on for third reading but in case if any amendment is proposed then the bill requires the assent of the house.

[3] Rules of Procedures 1988 of the Provincial Assembly Khyber Pakhtunkhwa.

4**. Enforcement of law**: When the bill with or without amendment is approved by the house then it is sent to the Governor for approval and when the Governor gives assent then the Bill is shaped into Act of law.

In context of Medical Teaching Institutions Reforms Act 2015 one of the respondents said,

"Although the MTI Act was prepared by Government however these reforms are totally guided by the professional experts of Medical Profession and their role was dominant than other stakeholders"

He further added that,

"The Medical Teaching Institutional Reforms Bill 2015 and all the amendments in the said act were not routed/referred for scrutiny to the Standing or Select Committee of the Provincial Assembly Khyber Pakhtunkhwa but only a few inputs were given during in house assessment by legislatures in the available time."

The finding concludes that the bill and its amendments have not been referred for scrutiny to the Standing and Select Committee of the Provincial Assembly of Khyber Pakhtunkhwa. The notion behind the said action is the raise of expert power as defined by the French and Raven (1959) where the people listen, trust, respect and value specialized ideas due to the level of knowledge and skill experts have in the subject area. The Provincial Government of Khyber Pakhtunkhwa considered it enough as already the experts have contributed with their expert inputs being an inspirational approach towards reforms. However, pre and post scrutiny by Standing committee has its own advantages as it consists of public participation, it is easier to alter the Bill when some amendments are proposed, parliamentarians are better informed about the law, which ensures better quality of law and smooth passage of Bill in the house[4]. In case of unawareness about the spirit of the law, many diversions from the intended policies

[4] Law Evaluation, Jessica Mulley Head of Scrutiny Unit, House of Commons, December 2013.

can be observed in implementation or misconceptions can be developed about the reforms, which may affect its success.

4.3. Structural anatomy of MTI Act 2015:

The Structure of the law generally describes the governance style and operational parameters of the entities which come under the subject of law of reforms. The Medical Teaching Institutions Reforms Act 2015 consists of Preamble, three chapters and 26 sections.

In preamble, the aim of the reforms has been showcased with a message that autonomy is awarded to the Medical Teaching Institutions and its affiliated colleges in KPK to improve the performance of these institutions with the essence of efficiency, effectiveness and responsiveness for the provision of quality healthcare services to the people of the province.

In the first Chapter, there is one section with four sub-sections related to the introduction of Act, extent and applicability upon the institutions and enforcement effects. The second Chapter of the Act comprises of definitions of various concepts used in the Act and consists of section 2 with 18 sub-sections denoted with alphabets. The Third Chapter consist of 3 to 26 sections with its sub sections related to governance, conduct of business, structure of the Institutions, Finance and revenue and ancillary matters.

4.3.1 Rules for the Operations of Law:

The Act is not a complete detailed procedure but there is a need of rules or regulations to be framed to give effect to the provisions of the Act. The Government of Khyber Pakhtunkhwa framed the rules to give effect to the provisions of MTI Reforms Act 2015 and it has also notified the said rule as an operational part of the Reforms with the Title of ’Medical Teaching Institutions Rules 2015’.

One of the respondents said that,

"The MTI rules 2015 are framed to give effect to the provisions of Medical Teaching Institutions Reforms Act 2015 considering the scope and context of structural change of the Institution however the former rules 2001 were more comprehensive than the later one in many areas like seniority matters, promotions and working relation of different authorities etc."

4.3.2 Comparative analysis of MTI rules 2015 with Medical Institutional Reforms Rules 2001

Points	***MTI Rules 2015***	***Institutional Rules 2001***
Mandate	These rules made under the mandate of section of MTI Act 2015	These Rules made under the mandate of Medical & Health Institutional reforms Act 1999
Amendment to rules	No Amendment to rules has been made although the Act has been amended four times.	An amendment was incorporated through Khyber Pakhtunkhwa Act No. IV of 2011 and by Notification No. SOH-1/3-15/04(K) dated 16-02-2006.
Comprehensiveness	The rules are limited and concise to the extent of Act and not in detail left many areas to be address by the Institutional Regulations	These rules were more in detail and comprehensive because there was limited space for regulations hence it covers all most all area with clear parameters.
Function and Responsibilities of Authorities.	No detail Function and responsibilities has been defined for other authorities except Search and Nomination Council, Board of Governors & Director Finance whereas in Act Function of MD,HD,DEAN and Nursing director has been addressed	The function of All Committees Chief Executive, Dean, and Director Finance were addressed in detail.
Human Resource	A very limited areas of Human Resource management has been address only to the effect of private practice and its numerations to consultants whereas the Act is more in detail but did not address the issue of social safety schemes.	The HR area was addressed in very detail like pension, seniority, recruitment and other social safety schemes.
Financial Governance	Audit, Budget and Accounts areas have been addressed and having similarities with the contents of 2001 rules.	The Audit, Budget, Accounts, finance and revenue have been addressed in more detail comparatively to MTI rules 2015
Complexity and Duality	No clear authoritative role has been defined to the extent of working relation between different authorities like Chief Executive, Dean, MD, HD , ND and DF as well Board and IMC	Clear Authoritative role has been defined for each authority to carries out the operations of the Organization.

Table I. comparative analysis of rules

Findings illustrate that Medical Teaching Institutions rules 2015 were not drafted in detail due to the reason that many areas were addressed in the legislation and the rest were left to be addressed in the institutional regulations to give effect to the policy implementation in accordance with the autonomy and needs of Institutions at local level. On the other side, Medical and Health Institutions Reforms rules 2001 was comprehensive to the effect that it did not leave much space for regulations to give effect to the provisions of Act. It concludes that the Medical and Health Institutions Reforms Act 1999 giving effect was based on rules while the MTI Act 2015 giving effect is based on regulations. The Medical Teaching Institutions Reforms policy implementation is much guided by the regulations instead of rules. The formulation of rules rests under the control of Bureaucracy while the regulations were drafted by the professionals according to their institutional needs.

4.4 Amendments in MTI Act 2015:

The policy design plays a major role and all the results based upon the design of a policy (DoHai, 2010). The Initial legislation of MTI Act 2015 was drafted with the collaboration of experts however from table to implementation some changes were desired and the Government deemed it necessary to make immediate amendments in the MTI Reforms Act 2015.

One of the respondents told that,

"There were some areas which the professionals desired to be changed to harmonize the enactment according to the intended scope of Reforms, because some technical issue were raised during the implementation phase of the policy which ignited these amendments."

4.4.1 First Amendment to MTI Amendment Act 2015:

The Government on 20th August passed the first amended Bill through Provincial assembly and assented by the Governor on 21st August 2015. Some amendments were made subsequently in the following sections of the MTI Reforms Act 2015 as explained below.

The Section 2 is mainly concerned with the definition of various authorities however the Government decided to define the status of various employees working in the Medical Teaching Institutions in detail. One of the respondent told that

"Due to these reforms many employees felt uncertainty regarding their service structure, status of employment, future prospects and pensioner benefits so there was a need to detail the status and categories of employee working in Medical Teaching Institutions."

In the MTIs five categories of employees have been defined in the Act: (a) MTI own hired employees, (b) Civil servants working in MTI, (c) Employees who are opted under section 16 of MTI Act 2015 and joined MTI, (d) Employees hired by the Management council under Medical and Health Reforms ordinance 2002, (e) those who are working in Medical Teaching Institutions on deputation basis. Similarly, as both designations of Principal and Dean appeared in the first draft of the Act, hence, to avoid duality the word principal has been deleted.

In section 5 the number of Board Members have been reduced from 10 to 7 and the representative of Finance, Health, Administration and Establishment Department have been excluded. One of the respondent told that

"*Those professional expert who provided voluntary services for these reforms later on held various positions in the governing bodies and desired to implement full autonomy in a sense that the Medical Teaching Institutions should be free from the influence of bureaucratic*

interventions and in this way the participation of Government's Members have been eliminated."

In the above context the demarcation of private and government Members concept has been recalled.

In section 6, one of changes made in sub section 5 i.e. the voting process for decision making, has been defined in such a way that every decision taken by the four Members being a quorum or two third of the total Members whichever is less will be considered as majority for decision making. In section 7, sub-section 'k' the Executive Committee that appeared in the first draft has been eliminated.

Section 9 has been amended to the extent of organogram of the Medical College as Dean, Chairperson and Medical faculties of various departments have been inserted.

One of the respondents said,

"*As there was no clarity about the organizational structure of the Medical Colleges and so there was no choice except merit cum seniority appointment of Dean and Chairperson of the Medical Departments of the college."*

The appointment of the Dean by the Board has been described through merit bases instead of merit cum seniority basis. Similarly, the Chairperson of various faculty appointments have been withdrawn from the Board of Governors and the appointment power has been given to the Dean of the College, while, the appointments among the faculty Members on merit cum seniority have been changed into merit base.

In section 10, the role of Hospital Director has been articulated that he will update the Board about the non-clinical Activities of the hospital and any other task assigned by the Board to the hospital Director.

Similarly, in section 12 the role of hospital Director has been showcased that he will be recruited by the Board on the recommendation of recruitment committee and will update the Board on all clinical activities and other matters assigned to him by the Board. In section 14, the role of Nursing Director has been defined that he will update the Board about nursing activities and any other matter assigned to him by the Board.

A respondent remarked,

"In the previous system the management power at hospital level were being exercised by Chief Executive and Medical Superintendent now these management functions have been separated in different divisions headed by Dean, Medical Director, Nursing Director Hospital Director and Director Finance but due to nonexistence of comprehensive rule of business and unfamiliarity with the new governing system the issue of duality and complexity of function arose."

In section 16, the amendment has been incorporated to articulate the ambiguity of services of different employees. In the said amendment, an opportunity of an option has been given to the civil servant working in MTI to join MTI. Pension benefits of such civil servants will be protected and while the MTI will contribute the pension share to the Government for their post retirement awards. Similarly, the pension contribution will be made by MTI in respect of those employees working in MTI on Deputation basis. The category of those civil servants who do not join MTI will be considered as 'civil servant' and the nature of job will be on detailed basis in nature and can be transferred in or out from MTI. However, all the

deduction on account of social safety schemes will be deposited into Government exchequer by the concerned MTI in favor of those civil servants.

In section 17, an amendment has been incorporated that those employees working in MTI if opt for private practice within the premises of MTI will be entitled for extra numerations as prescribed by the Board, while the rest will not be entitled for such financial benefits. Similarly, in section 22 the provision has been inserted that the Government can empower chairman if deem it necessary not inconsistent to any provision of the said act.

In section 24, the sub-section 2 has been deleted where the draft regulation of the MTI needed to be published for public opinion.

The nexus behind this amendment that government desired to implement these reforms without any resistance and due to technical aspects of the system, publically publishing the regulations for public opinion would be time taking task which could affect the implementation process.

4.4.2 Second Amendment to MTI Act 2015:

In 2016, the Governor of Khyber Pakhtunkhwa province issued an Ordinance No. IV 2016 [5] and made some amendments in the provisions of MTI Act 2015. The same ordinance was placed before the Provincial Assembly and was enacted as Medical Teaching Institutions Reforms Act (Amendment) 2016.

In section 7, sub-section a new addition has been made and the power of creation of post, re designation of post and abolition of post power has been given to the Board of Governors with an imposed condition that while creating a post the financial implications do not exceed its annual budget. One of the respondent said that,

[5] The Khyber Pakhtunkhwa Medical Teaching Institutions Reforms amendments Ordinance No.IV,2016

"The posts previously sanction by the Health and Finance Department were not adequate and the Institutions were in dire need of more staff to be hired for provision of quality healthcare services in accordance with the best practices however the budget constraint was imposed in the said amendment"

Before MTI the creation of post, resignation and abolition of post rested with the Secretary Health and Finance Department now these power delegated to the Board of Governors at local level with a condition that annual grants does not exceeds in case of more creations.

Similarly, in section 19 the grants provide by the Government will be in the form of single line budget. Previously, it was not defined that how the Government will provide grants to MTI, so mechanism for provision of grant as single line budget has been incorporated in the act through these amendments.

4.4.3 Third Amendment to MTI Act 2015:

The Provincial Government further amended the Act in 2017 and the Medical Teaching Institutions Reforms amended Act 2017 has been passed by the Provincial Assembly and thereafter incorporated in the following amendment in various sections of the MTI Act 2015 for effective implementations of reforms.

In section 5 sub-section 3 of the MTI Reforms Act 2015 the terms of office of the Members and right of vote has been mentioned; with the control on term of office for a period of three years, re- appointment after three years in normal conditions if otherwise direct by the Government.

One of the respondents told that,

"In previous draft there was no provision of control for curtailing the term of office of the Members".

In these amendments the Government now has the power to reduce the normal tenure of the Members in case when government deems it necessary.

Similarly, in section 7 a new sub-section 4 has been inserted through these amendments and the power has been given to chairman of the Board to appoint Dean, DF, DN, HD and MD on officiating basis when there is a state of exigency.

One of the respondents said,

"Previously no provision existed in the act detailing that in case of exigency when the MTI Managers are not available because of any reason then who will administrate the affairs of their Departments. So, the amendment has been incorporated that the chairman can appoint a person on officiating basis among the existing staff to run the affairs of the Hospital or college as the case may be and the chairman will place such appointment to the Board with in three month for approval but these appointment is limited to the post of HD, Dean, MD, DF &DN"

In section 22, the Government developed its control for intervention where necessary to ensure the provision of quality healthcare management.

4.4.4 Fourth Amendment to MTI Act 2015:

Pakistan Tehrik Insaf elected Government in the Province of Khyber Pakhtunkhwa completed its 5 years tenure and the assembly was dissolved. The care taker Government hold the cabinet office. The resistance against the professionals who were involved in the enforcement of these reforms increased and the Institutions were confronted with many constraints internally and externally.

The then Chief Justice of Pakistan took action upon various complaints lodged against the administration and Board of Governors of the Medical Teaching Institutions and established an Enquiry Committee under the supervision of Secretary health to submit its report to the Supreme Court of Pakistan regarding irregularities in these institutions and poor performance of Board of Governors. One of the respondent said *"The removal of Board Members was made upon the complaints lodged by Medical employee association, while the*

Chief Justice of Pakistan himself conducted some visits and noticed no improvement in the hospitals as claimed in the manifesto of the elected Government."

The then chief justice through his court Judgment ordered to dissolve all the Board of Governors and the care taker Government reconstituted Board of Governors for interim period except few which were left in abeyance.

One of the respondents told that,

"No opportunity of personal hearing had been provided to the Board Members by the administrative department as the dissolution was made cross the board and even those MTI BOGs were also dissolved against whom there was no complaint."

After dissolution of Board of Governors the reforms process was hampered and the decision making process became slow. New Board of Governors due to unfamiliarity with the system were unable to take decisions of important nature. Besides this the intervention from bureaucracy and caretaker Government also increased and uncertainty developed among employee with a fear that may be new elected Government other than PTI will reverse the system but the results were vice versa and the PTI regain its position established its Government with more strength in Khyber Pakhtunkhwa.

Those professional experts who were contributing in the reforms process were in position of governing bodies regained their position with more strength and the reforms agenda was yet again brought on its track.

The professional experts and the PTI Government learned from the bitter experiences and the outcomes of policy results. So, they decided to address all those weak areas which were proved as one of the major resistance factors in the implementation of these reforms. The Government of Khyber Pakhtunkhwa to accelerate the reforms process proposed the fourth amendment to the MTI reforms Act 2015.

The Medical Teaching Institutions Reforms amendment Act 2018 has been passed from the legislature and enforced. The following amendments in the various sections of the MTI have been incorporated.

In Section 2 of the said Act a few amendments have been incorporated where the Chairperson of Policy Board, Board of Governors and sub Committee have been mentioned. The status of MTI employees appointed under MTI Act and those appointed under Medical and Healthcare ordinance 2002 has been redefined. The Medical Teaching Institutions have been redefined in terms of control, source of funding and being public sector entity.

In section 4, a new section has been inserted as 4A where a new Governance structure of MTIs has been established as Policy Board through these amendments. Policy Board's main function is to provide insight guidance to the MTIs for standardization and uniformity in their internal structure as well as to assist the Government in Implementation of these reforms. This Board has two fold working function: one is to assist Government and second to provide capacity building and technical aid to Medical Teaching Institutions.

One of the respondents told that,

"Policy Board is an entity established in the Governance Structure of Medical Teaching Institutions with a basic function to propose rules, regulations, standards and policies to the Government for implementation upon the MTIs and on the other hand it will also perform a supervisory function on the MTIs."

In section 5, the Board of Governors powers and function have been re-aligned by giving administration and superintendence role to BOGs and its intervention and control in all matters of the institutions have been increased. The Chief Minister of the Province has been included being Governmental authority who can exercise its power upon MTI on behalf of the Government. One of the respondents told,

"The Government through these amendments re enforce control and authority of the Government over these institutions in the sense of accountability."

In section 6 of the said Act many amendments have been incorporated for the conduct of business of the Board of Governors as now if any decision is taken by less than three Members then it will not be invalid and needs to be presented for ratification of the Board. Similarly, all most in all sections some amendments have been incorporated. In section 16 a new section 16A has been inserted whereas another board for arbitration and dispute resolution has been established. The service tenure of Dean, Medical Director, Nursing Director and Hospital Director has been increased from 3 to 5 years. However, the extension on satisfactory performance has been incorporated. The pension issue has been addressed of the civil servants and those who opt to join the MTI services.

Finding illustrates that in-depth organizational structure analysis is required for implementation of any reforms. In the context of Institutional Theory, Scott W.R mentioned that it is an utmost necessary for survival of organizations that they must conform to the rules and belief systems prevailing in the environment. The lack of proper institutional governance study and compatibility test like cultural, environment and complexity has not been carried out at the initial stage before implementation of reforms policy, and weak policy design is also the main reason. The policy has been formulated among limited stakeholders and series of changes and amendments to the Act conclude that there was lack of coordination among the interest groups and policy makers. The bureaucratic politics is one of the important factors as the elimination of bureaucracy role at operational level became a cause of lack of interest from executive side. The professionals were active, having more knowledge and expertise about the Healthcare Institutions development in private sector but had less expertise in the public sector organization with a reason that the dynamic of public organization is different in many aspects from the private sector.

4.5 Governance Structure and Framework.

Healthcare reforms across the world are interlinked with the structural changes in the Healthcare Institutions and the policy makers targeted the structural change of Institutions by changing the Governance structure and award of autonomy to the Healthcare institutions for experiencing better performance outcome in shape of equity and quality care services to the population. The decentralization approach of healthcare services is associated with the delegation of powers to local level with the essence of autonomy however the policy makers and researchers agreed upon that autonomy and delegation of powers is not an ultimate solution without good governance. In this way, the reform whenever focused upon delegation of powers also has taken into account the Governance-based structural changes in the Institutions.

Governance framework refers to the structure of an organization and reflects the interrelated relationship of different factors which influence the organization's working operations. The Governance structure is a style of good governance better suited for the organization to meet public expectations[6].

The Governance structure of Medical Teaching institutions is associated with the Government centralized entities to the Governing bodies of the Medical Teaching Institutions. In the Governance setup of Medical Teaching Institutions many players like politicians, bureaucrats, technocrats, professionals and interest groups are working and interacting with each other to achieve certain common objectives and interests.

The Governance structure of the Medical Teaching Institutions consists of the following entities:

a. Government

b. Search and Nomination Council

c. Policy Board

[6] Writing good governance frameworks clayton utz. www.claytonutz.com

d. Board of Arbitration and dispute resolution

e. Board of Governors

f. Management Committee of the concerned Institutions.

The respondents told that:

"The Governance structure of Medical Teaching Institutions is complex in nature and there is also a lack of comprehensive governance framework because many missing links in working exists among different entities"

They further added that

"Although the Board of Governors have complete structural autonomy but Search & Nomination council is under the direct influence of politicians and Bureaucracy, Similarly no comprehensive regulations exists of Search and Nomination council and no working relation or Governance framework exist among these Institutions from top to down and down to top"

Finding illustrates that the working relation among these bodies are implicit and not explicit. The search and nomination council is under the direct influence of politicians and bureaucracy and due to lack of its regulations left space for indirect influence upon the Governance of MTI at local level. The policy board is just like an advisory Board having control over polices issue of the Medical Teaching Institution as previously the Board of Governors were performing these function which led to deviation from the standard polices. Similarly, the Board of Arbitration formation is proposed to reduce the burden on judiciary and to enforce the autonomy spirit however the same has not yet been operationalized as intended Hence the existence of many entities in governance structure and lack of governance framework do not lead to good governance concepts in Medical Teaching Institutions.

4.5.1 Board Governance Model:

Governance consists of polices and operational framework of the systems which are put in place by the Governing bodies to achieve its targeted goals. The model of Governance exercises and implements the mix of polices and systems. The Governance through Board in

the healthcare Institutions is traced back with the industrial revolution and new public management reforms due to growing complexity and isolation of ownership and control[7]. The board of healthcare institutions is responsible for ensuring the delivery of quality healthcare and performance of their organization. The same concept of governance through Board model is exhibited in the Medical Teaching Institutions reforms.

One of the respondents told,

"Board of Governors is the Governing Body with adequate powers and control over the Medical Teaching Institutions and is responsible for ensuring the quality healthcare service, policy making, performance and implementation of Government reform policy"

The Board of Governance models are classified according to organizational style i.e. profit and not profit organization. The nonprofit organization generally deals according to the needs of environment and welfare. The public Organization in healthcare industry is generally composes of nonprofit organization and the Board may select either one model or hybrid of governance model which are: Advisory Board, Policy Board, patron governance Board, cooperative Board and Management Team model. Similarly, in corporate Governance model the notable models are Traditional model, Carver Board model, cortex board model, consensus board model and competency Board model.

The organization's Board may either select one of governance model or they may adopt the hybrid model as combination of different models.

The following tabular analysis is made to articulate the board model of Medical Teaching Institutions:

[7] Naomi Chambers, (2012),"Healthcare board governance", Journal of Health Organization and Management, Vol. 26 Iss: 1 pp. 6 - 14

Governance Models of Boards in Medical Teaching Institutions.

Board	Governing Features	Governance Model approaches
Policy Board	a. Determine standards b. policies for Improvement of MTI c. Recommend Rules and amendments d. Recommend model regulations for MTI e. set minimum standard of qualifications f. provide guidance and advice g. Review annual reports h. assist and advice Government in health sector i. provide specialized training	1. Policy Board Model of John carver. 2. Advisory Board model where Members offer professional skills and talents at no cost 3. Cortex Board Model where board defines the standards, expectations, and performance
Board of Governors	a. effective management & strategic direction b. appointments procedures c. ensure performance d. approval of vision & mission e. approval of business plan & budget f. approval of bylaws & regulations g. constitute committees and superintendence compliance to Government standard and polices	1. Traditional model where Members have legal responsibility to the collective board and the board speaks as one voice on all matters. 2. Cortex board model. 3. Consensus board model It gives all board Members an equal vote, equal responsibility, and equal liability. 4. Cooperative Governance model The board makes consensual decisions as a group of peers, in a democratic mode.

Table -3: Board of Governance Model

Findings illustrate that no specific model of Board has been adopted rather the Government with the help of experts has designed the Governance board model for the Medical Teaching Institutions as hybrid a model that is the mix of various models according to the need and norms. The Board of Arbitration and dispute resolution is a part of Governance to settle disputes among the employees and the organizations. However, this Board does not have a major role in the operational governance of the Medical Teaching Institutions.

4.5.2 Governance Pattern and Practices:

In healthcare reforms where the Boards' models are adopted is one of the very critical decisions because the success and implementation of reforms depend upon the efficient and effective construction of Boards. The empirical evidences in the world depicts that many organizational reforms failed due to weak performance of the Boards. In 1991 the National Health Services construction of Board model which did not deliver in the best way is an ample example that the Board constructions have a vital impact upon the performance of institutions.

The formation of an ideal board or efficient board remained the topic of debate and many efforts were made to construct an ideal Board which can effectively steer the organization. The healthcare organizations have complex and challenging environment and there is a need of well trained and expert Board construction which can grip the local environment and confront challenges in a professional way to ensure quality healthcare delivery to the public.

The Board is primarily concerned with the corporate governance of the Institutions and functions mainly in three dimensions i.e. to determine strategic direction, control the performance vulnerability and to restructure the organizational values and norms.

Garratt described that board mainly focuses upon strategic plans, resource recognition and utilization and to ensure effective and efficient management. The Board is confronted with internal and external environmental challenges and always tries to balance the situation and to minimize the risk and threat to the system failure.

The Board functions as illustrated by the Garratte in conformance and performance parameters are as follows:

Focus	Short Term focus on Conformance	Long Term Focus on Performance
External Focus	Accountability	Policy Formulation
Internal Focus	Supervision	Strategic planning

Table.4 (Garratte Board Function model)

The Board functions are divided into external focus and internal focus. External focus is short run and it deals with external accountability requirement to be ensured regarding stakeholders, funders, regulators meeting audit, inspection and reporting. In the long run it focuses on performance like policy formulation with regards to setting and safeguarding the organization's mission and values, deciding long-term goals, ensuring appropriate policies and systems in practice.

On the other hand, internal focus is short run and it deal with hiring of executives, oversights management performance, monitoring key performance indicators, financial and budgetary controls and risks management. Similarly, in the long run performance, it plans strategically, long term plans review and takes decision about resource and investments.[8]

In the above context, the role function and responsibility of Board of Governors as mentioned under section 7 and relevant sections of MTI Act 2015 are comparatively same as described by various scholars. However, the practice in the construction of Board and its functions is a matter of great concern.

One of the respondents told,

"Search and Nomination Council is the main corporate body with the basic function to recommend the Board Members to the Government. However, the criteria for qualification of the Board member as mentioned in the Act is very limited and not clear to the extent that in

[8] Source: Adapted from Garratt (1997, pp. 45-7)

practice the recommendation is on the basis of pick and choose policy and not on merit base."

One of the respondents told that,

"The selection of board Members is political and network driven, any person who has some good reputation and good personal relation in political and bureaucratic environment is appointed on approach basis as member of the Board."

Other respondent told that,

"Those professional experts who rendered their services to the political Government of Khyber Pakhtunkhwa in the implementation of these reforms also made a space for themselves and held position in various Boards as a member or Chairman."

In Medical Teaching Institutions Reforms Act 2015 and the rules is also silent about the selection process of the Board Members and due to this vacuum the selection process of the Board Members remained under debate.

One of the respondents told,

"MTI reforms system is a new experience and it will take time to mature, because those institutions which consist of senior technocrats and professional experts work for the implementation of this system thus are performing well and also educating and training the Boards of other institutions. But in the field it is difficult to operate and manage the Board affairs of the Institutions without clear rules and guiding manuals. However, the Government constituted policy Board to streamline the working conditions of the Board and Institutions according to uniform standards and to eliminate the chaos but the position is still in inertia."

Another respondent told that,

"Previously few introductory and system related training sessions were conducted however due to complexity of the system it was difficult to address each issue in field, as there is lack of coordination vertically and horizontally among the Board and central level

governing bodies. And also there is no mechanism existing for resolution of conflicts among the board Members or to appeal against the misuse of authorities of Board Members or chairman."

The Board formation and construction plays a very important role, and selection process of Board Members and their performance evaluation is a key dimension for the successful operations and implementation of reforms. In the United States of America there are 7500 hospitals which are run under the Board system[9]. Similarly in United States the American College of healthcare executive is an institution that organizes healthcare management Board Members exam for the executive leaders and many individuals become the fellow Members of this college and perform leadership services in the healthcare Boards.

The college prescribed a Board of Governors exam to standardize the Boards practices in the healthcare management institutions. The outline of the exam consists of various dimensions and skills that are necessary to exist in the Board Members of the health institutions. The exam consists of 200 questions in different fields to evaluate the expertise of the Board Members. The outline of the Board of Governor exam of American College of healthcare executive is as follows:

[9] Naomi Chambers, (2012),"Healthcare board governance", Journal of Health Organization and Management, Vol. 26 Iss: 1 pp. 6 - 14

Area of Expertise	**Percentage**	**No of Questions**
Healthcare	14%	28
Management and Leadership	13%	26
Finance	12%	24
Human Resource	11%	22
Quality Performance Management	10%	20
Business	9%	18
Healthcare Technology and Information Management	9%	18
Law and Regulations	8%	16
Professionalism and Ethics	8%	16
Governance and Organizational Structure	6%	12
Total	100%	200

Table-5 American College of Health Care Board of Governors Exam outline

Findings illustrate that the hospital Governance through Board in practice in developed countries but in the context of Medical Teaching Institution reforms there is chaos in the selection process of these Members. There is no proper merit-based criterion to select the Board Members, may be later on the policy Board will work upon to address this issue but at presently the situation is still in inertia position. The selection of the Board Members is political base and not merit base. Search and Nomination Council only on the basis of past experience considers the recommendation of Board Members without assessment of the knowledge and expert skills through testing process.

Those Institutions where BOG Members are professional expert with experience in the healthcare management did progress and implemented the reforms as intended however they are also facing the issue of sustainability. On the other hand, where no healthcare governance and MTI reforms system specialists are present, they are confronted with many

challenges in the performance of these institutions. The findings also revealed that there is no coordination and response mechanism existent among the Government and Board of Governors, and not even among the Board Members for resolution of their disputes.

Similarly, in resource dependency model where the Members are selected on the basis of political and social capital connections have more influence in the Board and always control the agenda and pre-determine the outcome of meetings. This practice has also been observed in the Board of Governors proceedings of the Medical Teaching Institutions.

4.6 Reforms impact on performance:

The Institutional reforms are based on restructuring of Governance horizons with insight either to centralize the authoritative powers or to empower the Institutions. The decentralization and award of autonomy is always considered as a tool to strengthen the decision power at local level according to the need of the organization in discharge of their public service delivery. In context of health reforms and experiences it has been settled by the health policy makers through many experiences that provision of health services needs to be decentralized at local level for better management and effective service delivery. S. Preker highlighted the same concept that hospital with a decision making power at local level in the area of financing, human resources management, and procurement could prove as one of the good indicators for quality healthcare delivery.

The institutional Reforms models consist of Centralized entities, Autonomous bodies, corporations and privatization[10]. The first one generally relates to the centralize control of organization at Government level, in the second state of organization the public sector organizations are awarded autonomy and are empowered for decision making at local level. Similarly, Corporation is a business entity owned by its stakeholders who have the power to

[10] HNP Discussion Paper Understanding organizational Reforms The corporatization of public hospitals. April Harding and S.Preker.

select the Board of Directors while in Privatization the government transfers the ownership of an organization to the private sector.

4.6.1 Autonomy Dimensions

The main objective of Medical Teaching Institutions Reforms policy of Government of Khyber Pakhtunkhwa was to grant of autonomy to the Medical Teaching Institution for better performance, good governance and efficient healthcare delivery services to the communities. The autonomy so granted to the Medical Teaching Institutions has been analyzed with the help of Leuven research project at the six dimensions of autonomy. The area where the autonomy has been given to the Medical Teaching Institutions has been lenses at Management, policy, structure, legal, financial and interventional level.

The autonomy so granted to Medical Teaching Institutions is categorized in various sections of the Medical Teaching Institutions Reforms Act 2015.

One of the respondents said,

"The Government awarded in broad sense two types of autonomy: one is administrative autonomy to take day to day decision and second is financial autonomy to mobilize its resources according to the needs."

However, to measure the area and dimensions of autonomy granted to MTIs it can be analyzed with the help of Leuven research to articulate the pre and post autonomous status of the Medical Teaching Institutions under the Medical Teaching Institutions Reforms Act 2015.

Dimensions	Indicators	Budgetary units	Institutional setup under 2002 ordinance	MTIs, under MTI Reforms Act 2015
Management Autonomy	1. Whether the Organization can fix salary level without the intervention of Government	No	No	Yes
	2. Whether the Institutions appoint personal of various cadres	From 1 to 15 by Institution and 17 and above by DOH	Yes	Yes
	3.Whether the Institution set criteria for appointments and standards	No	No	Yes
	4. Whether the institutions give extra-legal advantage to the employee	No	No	Yes
	5. Whether the Institutions gives promotions to the employee and evaluate their performance	No	Yes	Yes
Policy Autonomy	Whether the Institutions can formulate polices	No	No	Yes
	Can formulate polices in contrast to Govt polices	N.A	N.A	No
	Can set its own vision mission, values and goals	No	No	Yes
	Can set its more detail objectives and norms	No	No	Yes
	Can Make judicious rules and laws	No	No	No
	Can make its regulations	No	Yes	Yes
	Can Make strategic and Business plans	NA	NA	Yes
Structural Autonomy	Organization have its own Board of Governors	No	No	Yes
	Can the organization appoint chairman of the Board	No	No	Yes
	Can appoint Executive Management of organization	No	No	Yes
	Can Evaluate the Executive Management	No.	No	Yes
	Is the Executive Management committee exist	No.	Yes	Yes
	Is the MC independent in major decisions	No	No	No
	Is the MC independent in	No	Yes	Yes

	Minor decisions			
	Is the Board independent Governing Body	NA	NA	Yes
	Is the Board Members from Private Sector	N.A	No	Yes
Financial Autonomy	Has the Grants received from Government	Yes	Yes	Yes
	Can fix rates for user fee	No	No	Yes
	Have its own fund	No	Yes	Yes
	Grants are conditional	No	No	No
	Can invest surplus money	No	Yes	Yes
	Can approve its own budget	no	Yes	Yes
	Can reallocate funds without Finance department	No	No	Yes
	Can retained surplus funds	No	Yes	Yes
	Can invest funds for revenue generations	No	No	Yes
	Can made resource mobilization	No	No	Yes
	Can awards contracts	No	Yes	Yes
	Has received Developmental funds	No	No	No
	Can shift budget in personal and running cost	No	No	Yes
	Is a self-Accounting entity	No	No	Yes
	Having own independent pre audit	No	No	yes
Legal Autonomy	Whether the institutions have independent legal personality	No	No	Yes
	Whether the institutions have its own tribunals	No	No	Yes
	Whether the Institutions can sign MOUs with other organization	No	No	yes
Interventional Autonomy	Sanctions and reward in case of good and bad performance	No	No	Yes
	Audit by oversight authority	Yes	Yes	Yes

Table.2 pre and post system autonomy analysis with the help of Leuven research project model.

4.6.1.1 Management Autonomy:

The management autonomy generally relates to the human resources management and operational management of an institution. In the Management autonomy the institutions are delegated the powers of hiring and firing and all other day to day operational matters related

to the human resource management, and other ancillary matters. It also empowers the manager in their day to day decision making process at the local institutional level. The section 16 of the Medical Teaching institution reforms Act provides a greater autonomy at the management level of the Institutions. One of the respondents told,

"The basic vision behind the award of autonomy to MTI is to eliminate bureaucratic and political influence and to empower the Management of the MTIs to take decisions of hiring firing and resource allocation and mobilization at local level for the better performance and quality healthcare service delivery."

Furthermore, a respondent told that,

"The Government provided autonomy to the Medical Teaching Institutions and so quite a number of clinical and non-clinical staff was recruited by the Institutions. However, due to financial impact the Finance Department did not agree to increase the sanction strength on the basis the grants are being provided later on through amendments in the Act to create post, re-designate posts or to abolish posts in MTI have been given with the condition that financial implications do not exceed its annual budget."

Finding illustrates that Medical Teaching institutions were initially awarded a greater Management autonomy and the literature reveals that the reforms always increase the cost. Although, the Government empowered the Board of Governors and MTIs for creation of different posts but a budgetary constraint was imposed which makes it difficult for the Institution to expand human resource according to the best practices standards.

4.6.1.2 Policy Autonomy:

The delegation of policy making power is one of the major component and dimension of the autonomy whereas the organizations is empowered to take decision for the better performance, to achieve its objectives and to deliver public services efficiently. The

Government delegated the power of decision making and policy formulation to the medical Teaching Institutions under Medical Teaching Institutions Reforms Act 2015. Christensen in his literary work "notion of legal autonomy" mentioned that those institutions who have the power to make regulations have a large extent of autonomy.

The Medical Teaching institutions Reforms Act section 24 empowers the Board of Governors to make regulations not inconsistent with the rules and provisions of the Act. However, under amendment in section 4A sub section 4 (d) the Policy Board function has been included and the independence in regulation making powers has been conditioned. Similarly, in section 7 sub section 1(b) of the MTI Act 2015 the Board of Governors has been empowered to make polices however in the said sub section (i) a condition was imposed upon the Board that in case of any deviation from the Government policies and standards the Board is required to get approval.

One of the respondents said,

"Although the Board Members are empowered to make regulations, policies and bylaws but we are not independent to target those areas through formulation of Institutional policies where already Government policies are in practice hence it indirectly affects the vision of better performance."

Other respondent said,

"The dynamics of Healthcare institutions are very complex in nature and need well-versed policy experts. A person who has never taken part in any policy formulation process in his entire life cannot be deemed as one of the best policy maker. /similarly the formulation of policy Board is one of the best solution to ensure uniformity in Medical Teaching Institutions across the board."

Finding concludes that Medical Teaching Institutions have the autonomy of policy making and the government delegated these powers to the Board of Governors of the Medical Teaching Institution. However, due to internal structure differences the Government with the help of professional experts amended the Act and the policy Board has been operationalized to bring uniformity, expert guidance and to track that the reforms lead to successful implementation. Although the approach of the Government is much rational but on the other hand contraction and complexity has occurred in the dimension of policy autonomy of the Medical Teaching institutions.

4.6.1.3 Structural Autonomy:

Structural autonomy generally relates to the appointments, evaluation, report and control of the governing bodies of an institution. Christensen and Verhoest Koen mentioned in their literary work that structural autonomy may be granted to the institutions which have some alternative structural supervision span of control or political supervision. The structural autonomy is determined on the degree of reporting level of the head of institution to the Minister of the Department. Moreover, it is also one of the determinants that the head of institutions or Board Members are appointed either by the Minister or the supervisory Board.

In the aforementioned context, Medical Teaching Institutions Board of Governors, Policy Board Members are appointed by the Search and Nomination Council headed by the Minister and the Board of Governors further nominates and appoints their chairman. Similarly, the Board of Governors also appoints the Institutional Management Heads like Dean, Hospital Director, Medical Director, Nursing Director and Director Finance. The structural autonomy is determined on the basis of extent of appointment of Board Members, head of Institution by the Government or other parties and representation of Government Members and other parties in the supervisory Board and its accountability matters.

One of the respondents said,

"Initially the representation of Government Members to the level of Additional Secretaries of Finance, Health and Establishment department were included in the Board of Governors however they had no right of vote but the inclusion of these Members was against the spirit of greater autonomy. Hence, through amendments the representation of Government Members was eliminated."

Finding illustrates that the supervisory Board or the Board of Governors are appointed by the Government where some representation is given to the other parties but they do not have a dominant role and there is no voting process mentioned in the Act regarding Search and Nomination Council . Moreover, at top level of hierarchy the appointment of Board Members are made by the Government and the structural autonomy seems weak as comparatively at local level whereas the chairman of the Board and the management heads of the institutions are appointed by the Board without the representation of Government Members which leads to greater structural autonomy.

4.6.1.4 Legal Autonomy:

Legal Autonomy generally determines the legal status and personality of the institutions on the basis of law. The degree of autonomy is determined on the basis of law which recognizes the existence of the entity. In Medical Teaching Institution reforms Act 2015 it has been mentioned in section 3 sub section 2 that MTIs are corporate entities having perpetual succession and a common seal with powers to acquire, hold and dispose of moveable and immovable property and may in the name sue or be sued. This provision of the Act recognizes the legal personality of the institutions.

Christensen described that under the legal autonomy the institutions are free from the minister or his advisor's influence in the decision taking according to law delegated to them. Similarly, in substantial legal autonomy the institutions take decision in individual cases as well as issue regulations to achieve the policy goals under the mandate of law.

One of the respondents told,

"Medical Teaching institutions are at liberty to issue such regulations which are not inconsistent with the provision of Act, without any intervention from the Government. However, through amendments the Board of Governors are bound to follow the policy Board recommended polices or model regulations as baseline. Nonetheless, the Board of Governors can amend these regulations above the baseline according to their need but not inconsistent with the Policy Board regulations or Government policies which need approval in case of deviations."

Finding illustrates that the Medical Teaching Institutions established under the corporate law- a sub branch of private law is the indicator of greater legal autonomy but some conditions have been imposed by the Government in case of deviation from the standards, as they needed to get approval from the Policy Board or Government as the case may.

4.6.1.5 Financial Autonomy:

Finance plays a vital role in the operations of an organization. It has an impact on the overall performance of the institutions and outcomes. Studies reveal that the success of reforms is always dependent upon the finances even if it is a very potential variable in policy implementation and its outcomes. The provision of quality healthcare service increases the cost however through better management and autonomy the resource utilization can be made efficiently. The concept of financial autonomy given by the Christensen is associated with the organization of self-generating revenue which is responsible for deficit and losses.

One of the respondents told,

"Government expenditure on the health and education sector is very high as compared to other sectors of the Budget. The notion behind award of financial autonomy to

the Medical Teaching Institutions was to reduce pressure upon the Government Budget and to enable these institutions to generate self-revenue."

In the Medical Teaching Institutions reforms Act 2015 the finance related matter are addressed in section 18, 19 and 20 of the said Act. Therefore, under the provision of Act the MTIs revenue is composed of grant received from Government as single line budget, user fee, donation and revenue received from other sources will form an institution fund. The MTI will prepare its institutional budget and will allocate these resources according to its needs and business plan. Similarly, MTIs under section 6 of the Act are authorized to invest the surplus funds for revenue generation as well as they are authorized to run private clinical practice in the premises of hospitals to generate revenue.

One of the respondents told,

"MTIs are fully dependent upon the Government grants as our own resources are not enough to subsidize the health expenditure of the public. MTI being public hospitals cannot raise user fee charges or even cannot generate such huge amount of revenue to deal with millions of masses."

He further added that,

"Some MTIs receive more grants than other MTIs from Government as there is no formula to increase the grant at the ratio of equality distribution according to the need of the hospitals."

Other respondent told that,

"On one side the Government and public expects best performance and provision of best healthcare services with state of the art facilities but on the other hand the grants so

provided are not adequate to maintain best services standard especially in a situation when every hospital has a high bed occupancy ratio."

In the last amendment made in the MTI Act 2015 it has been clearly defined that Medical Teaching Institutions and its allied colleges is a public sector organization and majority of its funds and expenses are born by the Government.

Finding illustrates that Medical Teaching Institutions do not have greater Financial Autonomy because in full financial autonomy the Institutions do not receive any grant from the Government. While in the case of MTIs it is evident that they have moderate financial autonomy as their revenue consists of Government grants and its own generated revenue.

4.6.1.6 Interventional Autonomy:

The interventional autonomy refers to that state of an organization where it has no obligation to report to the Government and there is no threat of sanction and punishment in case of deviation from the standards. If an organization is subject to statutory audit and is liable for disciplinary proceeding for bad performance or liable for reward in case of good performance then it will have a weak interventional autonomy. The Medical Teaching Institutions reforms Act section 7 (2) impose the condition of reward and sanction as well as the section 20 sub section (3) of the said Act described that the MTIs will be audited by the Auditor General of Pakistan.

One of the respondents told that,

"Due to many issues and complaints against the Board of Governors and Institutional Head, the Government took action and conducted enquiries and thereafter removed the Chairman of the Board."

Another respondents said that,

"Government as well as standing committee of KP provincial assembly on health many times on the basis of assembly question called the MTI management for presentation on the performance of Medical Teaching Institutions while also taking notice of recruitments made in Medical Teaching Institutions as *well the Public accounts committee also take actions upon the audit paras"*

Finding illustrates that Medical Teaching Institutions do not have an interventional autonomy and they are bound to report to the Government additionally they are subject to sanction and reward in case of bad and good performance. Similarly, their accounts are also subject to the statutory audit or special and performance audit by third party when directed by the Government.

Medical Teaching Institutions Autonomy Dimension passes through different phases of legislative amendments.

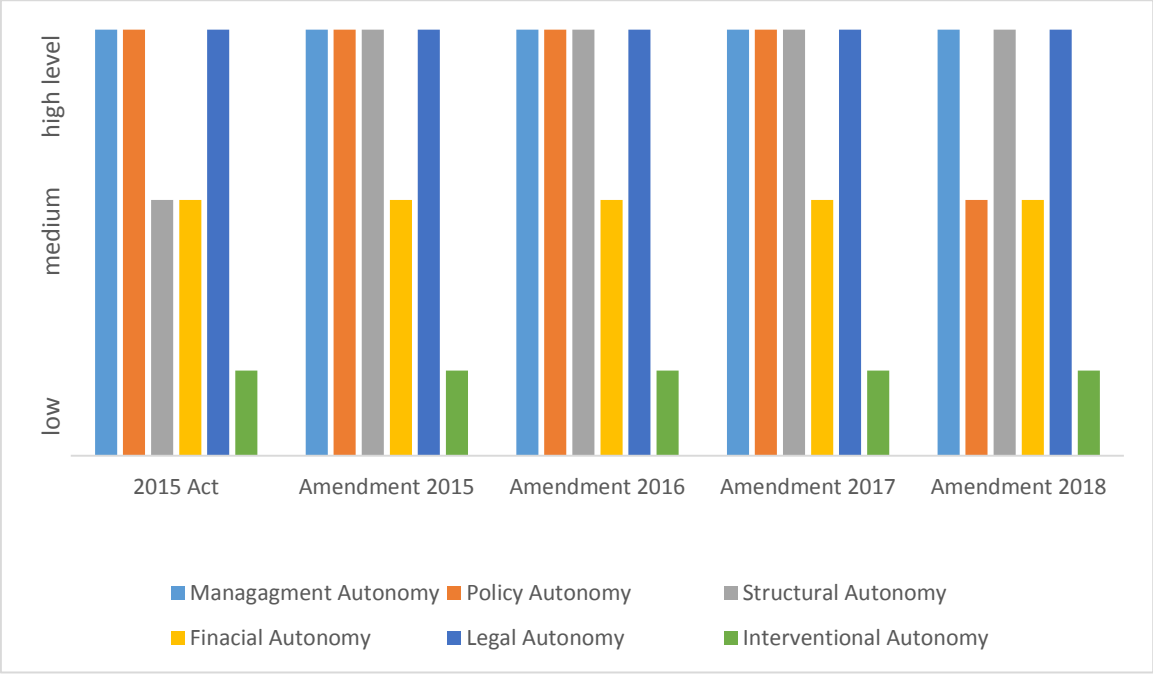


Figure-2

The above diagram shows level of autonomy for each dimension of autonomy. The Institutions have a high level of management autonomy where the agency may control and

decide all aspect of the management and its strategic plans. The strength of this dimension remained constant in all amendments. Similarly, Policy autonomy level remained high however after amendment in 2018 and constitution of policy Board the policy autonomy reduced up to medium level as the Institutions need to follow the model regulations framed by the Policy Board and other polices, and in case of any deviation they require the approval of policy Board or the Government as the case may be.

The Structural autonomy at the initial stage was medium due to representation of Government Members in the Board of Governors. However, in 2015 amendments the representation of Government Members has been excluded from the supervisory Board and the autonomy is extended to the high level.

Financial Autonomy remained constant at medium level as the institutions do not have high level of autonomy as the major portion of their budget is funded through governmental grants. Legal autonomy remained at high level as the institutions have separate legal personality constituted under corporate law- sub branch of private law. Similarly, the institutions have a low level of interventional autonomy as their performance is subject to sanction and rewards as well as their accounts are audited by the Auditor General of Pakistan.

4.7 Post performance evaluation:

Reforms in the healthcare industries in the developed and under developing countries showed remarkable positive impact upon the performance of the Healthcare organization. The literature reveals that experiments of organizational reforms in European countries brought remarkable change in performance enhancement of public healthcare institutions. Similarly, diversion of incentive mechanism, articulation of manager's role and interlink with policy environment developed a concept of best performance approach through market competition in the healthcare organization of Khyber Pakhtunkhwa.

The Medical Teaching Institutions reforms being politically driven remained under debate at various public and private forums. The charisma and critique from the desk of

various stakeholders due to threat to their existing values build more pressure upon the better outcomes and performance of the Institutions.

One of the respondents said,

"The isolation of system from Bureaucracy and Political interference at external level as well agitations and critique at internal level by the employee associations provides an opportunity to the politicians and bureaucracy to exercise interventional powers to assess the outcome of the system and to evaluate the performance of Institutions. Thus, Government ordered the performance audit under the mandate of Medical Teaching Institutions."

He further added that,

"It is the mandate of the Government under section 7 (2) of the MTI Act to assess the performance of MTI against set target in the area of efficiency, equity and effectiveness, and to intervene with sanction or reward."

The Health Department sensitized the prevailed situation at that time and approached the Chief Minister office to seek approval for Healthcare commission to produce a performance audit report of the three hospitals of Peshawar regions i.e. LRH, KTH and HMC. The government hired the serviced of Shifa Foundation for performance audit.

The Shifa Foundation in 2017 Conducted audit of these Institutions and assessed the performance on the international standard indicators. However, the Institutions did not score to the optimal level against each indicator and a general perception has developed among various stakeholders that the reforms are not delivering best results as intended.

One of the respondents told,

"Shifa foundation Islamabad audit team evaluated the Hospitals performance on the basis of Joint commission international standards accreditation indicators in the area of patient care safety and rights, anesthesia, surgical and clinical care, medication, quality improvement, safety, infection control, Finance and leadership. Whereas the MTI Act 2015

describes that Government will periodically evaluate the performance of Institutions against the set targets particularly related to efficiency, effectiveness and quality."

The Asian Development Bank in their report[11] on healthcare sector review of Khyber Pakhtunkhwa also highlighted that the report so generated by the audit team was on the basis of joint commission of international standards accreditation without taking into loop the limited period of two years after enforcement of Act. Only clinical and quality care aspects were addressed as well as no comparative analysis was made to the situations before the implementation of reforms.

One of the respondents further explained,

"MTI system is in transition period and not yet mature because there are many constraints. On the other hand neither the Government has yet developed any standards or given any targets to Medical Teaching Institutions to show performance against those indicators nor Government adopted international standards performance measurement framework for the public sectors hospitals. However, MTI tracked its progress towards the International best practices of quality health service both clinical and non-clinical which was not in practice before these reforms."

Finding illustrates that the performance audit was conducted at premature stage similarly the growth and performance was not measured comparatively to the previous system. The main reason that these reforms are politically driven is because greater autonomy concept in Pakistan was not experienced previously and the MTI in the government setup has been raised as independent power unit. The grip of politicians and bureaucracy becomes loose and the conflicts on various issues arise. The performance audit at the premature stage according to joint Commission international healthcare standard accreditation obviously did

[11] Khyber Pakhtunkhwa Health Sector Review Hospital Care October 2019 Asian Development Bank.

not mark best performance due to time factor and growth. On the other hand, as per requirement of the Act that the Government is required to set standards for performance evaluations was not put in place and thus a perception was developed among the stakeholders about the poor results of the system without taking into account the ground realities.

4.8 Measurement of Performance:

Reforms have direct impact over the performance of institutions and it has remained a focal point of the policy makers in healthcare industry to enhance the performance of healthcare services delivery units to the optimal level through reforms and structural change.

The experience of reforms witnessed that it is not mandatory that every reform will gives meticulous results as intended by the policy makers. However, the world through these reforms developed a standard concept of better healthcare delivery services and the performance has been associated with the explicit goals of the stakeholders. In developed regions of Europe like Germany, Denmark and United Kingdom they have their own framework for performance measurement and improvement of healthcare service delivery. However, developing counties like Pakistan have not yet developed their own performance measurement framework for healthcare Institutions. The Medical Teaching Institution Reforms Act 2015 distinctly focused upon the performance measurement on the bases of Government set standards. This provision refers to the performance evaluation framework but yet such framework is not in place.

One of the respondents stated,

"Performance evaluation of the Medical Teaching Institutions is not yet in track as the Government has neither put in place any set performance monitoring formats or any KPI particularly related to efficiency, effectiveness and equity nor did officials adopt any international standards performance measurement frameworks."

He further added that,

"MTIs at their own level tried their best to align the performance and delivery of healthcare system according to the standards and to compete the private sector hospitals and in short period of time remarkable achievements have been made in the areas of Human resource, clinical services and facilities and infrastructure development as compared to the previous system."

The hospital performance is generally measured with five key methods of performance measurement i.e. Inspections, survey of consumer experiences, third party assessment, statistical Indicators and internal assessments. The Inspections are generally related to the compliance of regulatory requirements and licensing like fire safety, radiations, medical equipment and medicine, infection control and incineration. In Pakistan these inspections are carried out by the PNRA, drug Control authorities, environmental Protection agency and PMDC etc. Similarly, consumer surveys are conducted to measure the performance of hospitals in services delivery to the patients like education, rights, comforts, complaints redresses and patient care etc. Third party assessment is conducted to measure performance on the basis of ISO, accreditation, and peer review and to combine internal assessment on the basis of national and International quality system. In the same way, Statistical Indicator method is used to measure performance against the set indicators for the use of end user and stakeholders.

One of the respondents told,

"All most in all the regulatory inspections the MTIs performance is well and they have full filled the regulatory requirement to the minimum level and improvements are also in process. However, the Government beside accreditation performance audit did not evaluate the performance of the Medical Teaching Institutions on basis of other methods because they did not developed a proper framework and mechanism for performance evaluation of MTIs."

He further added that,

"People are provided quality healthcare services in low cost comparatively to the private sector hospitals as the major portion of treatment cost is being subsidized from the public sources. Public has felt a change in healthcare services due to reforms however it is difficult to provide state of the art facilities to the huge population of patients."

Findings illustrate that although the performance according to the international standard framework is in growth process but in contrast to the previous system the concepts of best performance, quality healthcare service delivery, efficiency and effectiveness in the public hospitals emerged due to the healthcare reforms under Medical Teaching Institutions.

4.9 Development Initiatives under MTIs Reforms:

The exposure of healthcare organization to the external policy environment and market competitions under New Public Management leads to change in organizational structure and governance with an outcomes of development and growth. The expectation of the policy and decision makers always results in a change in the inertia. The Medical Teaching Institutions after award of autonomy tracked its development in many areas to enhance its performance and to achieve its explicit goals.

One of the respondents told,

"It is pertinent to be mention that MTI Reforms changed the values, patterns and dynamics of the Healthcare Institutions to wards quality healthcare delivery. The institutions tracked its strategic plans, expanded its human resource, materialized infrastructural development and tried to advance the healthcare services in accordance with best practices."

Medical Teaching Institutions have made various developments in the clinical and non-clinical services under Medical Teaching Institutions reforms due to award of autonomy in manifolds as discussed under.

4.9.1 Human Resource Development:

The human resource management concept has emerged in Healthcare organization according to the needs and diversity of cultural background of employees and patients. In

New public Management framework the Managers are exposed to compete the market environment and new emerging trends of human resource development which influences the organizational performance. In healthcare organizations, globalization and use of new technologies diverted the attentions of managers to the provision of high quality patient care services. In economic theories the Human resource is considered as one of the factor of production that contributes to efficiency and efficacy of the organization, productivity and performance. In healthcare organization the employees are clustered into two categories i.e. clinical and non-clinical. Similarly, in teaching hospitals and its allied medical colleges the clinical employees are sub divided into clinical faculty and Teaching faculty employees.

The clinical faculty's employees consist of professors, associate professors and assistant professors of different medical sciences who provide clinical services to the patients and also provide Teaching services to Medical students. On the other hand, teaching faculty is mainly concerned with teaching Activities at the college level, besides this consultants, physicians, medical Specialists, paramedics, nurses and pharmacists also exist in the Institutions to provide clinical services to the patients.

The non-clinical employees are mostly sub divided into two sub categories i.e. technical and non-technical which generally provide ancillary (non-clinical services) to the patients. The Medical Teaching Institutions after the award of greater autonomy experienced innovative trends of Human resource management which was not existent in the previous system.

One of the respondents told that,

"Before Medical Teaching Institutional reforms there was no concept of human resource development as the old practice was in fashion where there was no innovation. The Medical Superintendent and DMS were administrators of the hospital and the employees were dealt by them according to old bureaucratic models- as they had no expertise in human

resource management like effective staffing, employee compensation and benefits, training and development, performance evaluation of employees and defining and designing work according to the need of the day."

He further added that,

"The Administrators in the previous system were not professional human resource managers and had no expertise in human resource management. In Medical Teaching Institution reforms, a well-qualified and expert human resource manager has been appointed and a proper human resource department has been established according to the norms and values of the system to enhance the performance of the institutions."

The evidences reveal that after the establishment of human resource department many human resource policies have been formulated and put in place to deal with employee related issues.

One of the respondents told that,

"Under Medical Teaching Institutional reforms many polices have been framed like leave related matters, as previously the employees went on furlough for more than a year and there was no mechanism existent to appoint any person against the vacant seat due to their leave on that posts and so indirectly the patients care was suffering. Now all such issues have been addressed and the long furlough practices have been discontinued and the employees are now readily available 24/7 for provision of services to the patients. The practice of furlough has been discontinued and in case if any vacancy occurs then speedy appointment is made without disrupting services to the patients."

Another respondent told,

"Bio-metric and other employees' attendance ensuring monitoring technologies have been adopted in Medical Teaching Institutions which have eliminated the concept of ghost employees and maximum staffing has been ensured. Similarly, human resource management

information system has been developed and a well-structured hierarchy has also been developed. In all fields, a well-qualified and professional supervisory staff at each tire has been hired to strengthen the internal controls."

The award of Management Autonomy to Medical Teaching Institutions strengthens the management of internal work force as previously the Institution had no autonomy regarding creation, re-designation and abolition of post. Now the Institutions have the power to create, re-designate and abolish post. One of the respondents said that,

"Due to award of autonomy a number of vacancies have been created on clinical and non-clinical side through resource mobilization within the grant without extra financial implications and professional experts have been hired on attractive market based salaries which is not only having positive impact over the performance of Institutions rather is also having positive socio-economic impact by creation of employment opportunities."

Findings illustrate that after the Reforms remarkable development have been made in the area of human resource human resource according to the need of quality healthcare services. Medical Teaching Institutions created many vacancies on clinical and non-clinical side and enhanced the work force through optimal utilization of resources having positive impact on the performance of the Institutions.

4.9.2 Facilities Development:

Medical Teaching Institutions due to autonomy and to compete with the private sector developed state of the art hospitals, restructured the facility management and tried to make sure the availability of state of the art hospital facilities to patients. Besides clinical facilities the responsiveness has also been focused and many non-health facilities have been added to the patient care in accordance with best practices.

The top leader of PTI Government tweeted that:

"Better Management means better facilities to the patients."

Other respondent told that,

"After MTI Reforms many facilities have been added to facilitate patients. The 24/7 diagnostic services, Institutional base practice, online appointment system, queuing system, bed management, well qualified clinical and non-clinical staff recruited, modern equipment has been purchased, reachable ambulances for indoor services are provided to the patient, gender rights are protected, club foot clinic established, state of the art ward and ICU has been established, media cell and information dash board has been installed, wheelchairs and trolley bay along with 24/7 porter facility has been provided and many polices regarding patients' rights have been formulated."

Other responded remarked that,

"Although physical improvements and structural developments have been made in the Hospitals however it will take time to achieve the standard lines of quality healthcare services in MTI hospitals."

Findings illustrate that improvement has been made in the patient care management and facilities have been provided to patients after the implementation of reforms. Similarly, the Institutions tracked their performance to achieve the standard line of quality healthcare services in accordance with Joint Commission of international standards accreditation as these approaches and visions were not in place in the previous system.

4.9.3 Internal Policy development and Governance:

Medical Teaching Institutions after structural changes have their own Governing bodies and they have the autonomy to formulate internal polices for better performance and quality healthcare services to the patients. The Institutions have their own Board of Governors and they are empowered to take decision at their hospital level.

One of the respondents told that,

"Previously there was a centralized approach of governance and all the matters were dealt by the Chief executive and Medical Superintend of the Institutions. Now the management has been segregated among Dean of the College, Hospital Director, Medical

Director, Nursing Director and Finance Director who are experts of their fields and properly supervise their division. They work with close coordination horizontally through Institutional Management Committee and also vertically to supervise their division effectively and efficiently."

He further added,

"Managers are exposed to the markets trends and competition, they are highly paid employee of the Institutions and every manager tries its best to develop more policies and regulations to standardize the management Activities because their job security is interlinked with performance and their performance is ultimately tracked on progress and development of the organizational operations."

Findings illustrate that a technocratic approach at the level of corporate and operational Governance in Medical Teaching Institutions also impacts the performance of the Institutions. Those Institutions in which highly skilled Board of Governors Members had been selected by the Government brought positive change in the development of the Institutions as well as the high skilled and professional managers also diverted the progress of the institutions towards practicing the best quality hospital management and innovative trends. Many internal policies like infection control, medical and nursing protocols, strategic plans, financial regulations, human resource and patient care related polices have been formulated at institutional level which were not in place in the previous system.

4.9.4 Hospital Information Management System:

Hospital information Management system is one of the integrated software systems which has brought tremendous innovation to digitalize healthcare services in hospitals. The Health Management Information Systems (HMIS) comprises of six building blocks essential for health system strengthening i.e. health work force, health service delivery, health information system, and access to essential medicine, health system financing, leader ship

and Governance[12]**.** This HMIS helps management of the hospital in the area of planning, management decision making, transparency and accountability.

One of the respondents told,

"HMIS system of Shoukat Khanum Memorial cancer hospital and research Center has been customized and installed at majors Hospital of MTIs at the local level in Peshawar which is one of the best HMIS systems according to International standards. And, through this system patients, physicians and other management Members are being facilitated"

Other respondent told,

"Although the system is complex however training has been given to the employees working on it and it has channelized many operations of the hospital services to maintain reliable data which did not exist in the previous system."

Other respondent told that,

"Installation of HIMS system at MTIs not only developed Information technology department but has also created many jobs opportunities for the IT related professionals."

Findings illustrate that HMIS system is one of the essential building block as specified by the world health organization to strengthen healthcare system. The HMIS system installation at the MTIs Hospitals is one of the remarkable achievements having a positive impact over the performance of hospital services.

4.9.5 Infrastructural Development:

The major developmental projects are still under the control of centralized entities, and major developmental works under Annual Developmental program are controlled and initiated through Health Department and work and services Department of the Khyber Pakhunkhawa. The control over the developmental projects Funds is still with the Government and all the developmental schemes are being approved by the PDWP Planning

[12] Monitoring and Building blocks for Health System: A Hand Book of indicator and their measurement strategies World Health Organization 2010.

department or health department planning wing. However, MTIs management and professional experts being an end user department is now giving inputs for construction of new building for healthcare institutions according to the international standards.

One of the respondents told,

"Developmental schemes are under the control of Government and the MTIs have little control over these projects in terms of funding or supervisions. The emerging concept of sate of the art hospital after the reforms also impacts the structural design to be made according to the international hospital standard designs. And the MTI management experts now also contribute their expert ideas in the design and PC-I preparation phases."

MTIs reforms Act and the rules provide the provision to maintain a reserve fund out of hospital resources for the developmental Activities at the Institutional level. Due to autonomy in utilization of resources the Medical Teaching Institutions within the available resources renovated and re constructed many facilities at the hospitals level which gives a touch of the state of the art hospitals.

One of the respondents said that,

"We have initiated developmental Activities by renovating, and reconstructing many facilities within the grants without extra financial implications to enhance the performance and to bring positive impact over the patient care."

Other respondent told that,

"After reforms and autonomy we have establish our own nursing college and Paramedics College additionally a dental college is in progress at Mardan Medical Teaching Institutions, without even getting any extra grant from Government."

Other respondent told,

"We have renovated and constructed with the saving through resource mobilization all the wards, patient waiting area, triage, established state of the art ICU, standardized the

operation theaters, pharmacies, new wards, enhanced the bed capacities and purchased many latest state of the art equipment through direct imports which saved extra cost."

Findings illustrate that besides the Government developmental projects, the Medical Teaching Institutions within the grant made various developmental initiative which have direct positive impact over the performance of the Institutions and the institutional infrastructural growth has been materialized.

4.9.6 Resource Mobilization & Revenue Generation

Medical Teaching Institutions Reforms Act 2015 under section 18, 19 and 20 as well as MTI Rules 2015 empowered Medical Teaching institutions over the allocation and utilization of financial resources. The Institutions are now in a position to allocate or reallocate their resources according to their local needs.

One of the respondents told,

"Previously we had to approach administrative department for re-appropriations and additional grants as well as we were bound to observe the provincial Government financial discipline but now it has become very easy and we can re-allocate or mobilize our resources according to our needs at hospital level."

Another respondent told,

"Through Reforms the Medical Teaching Institutions are exposed to the market environment and competitions and the MTIs restructured their financial management values by focusing and looking for resource creating opportunities to cover the cost of quality healthcare initiatives."

He further added that,

"MTI Act 2015 empowered the Institutions to develop their business plans, invest their surplus money and to take other initiatives for the utilization of resources and financial Activities. In this context the opportunity of revenue generation has been tracked, the resources are being used and mobilized efficiently. "

Other respondent told,

"After reforms the Institutions initiated a private institutions based practice which deals with the Sehat Insaf Card holders and other patients, start-up own pharmacy shops, raised user fees at nominal rates, installation of HMIS and revenue reporting software, investment of surplus money and established Nursing and paramedical college which reflects a positive impact over the revenue generation of the Institutions as compared to previous system."

Four Years Revenue (In millions) analysis of MTIs Autonomous Bodies.[13]

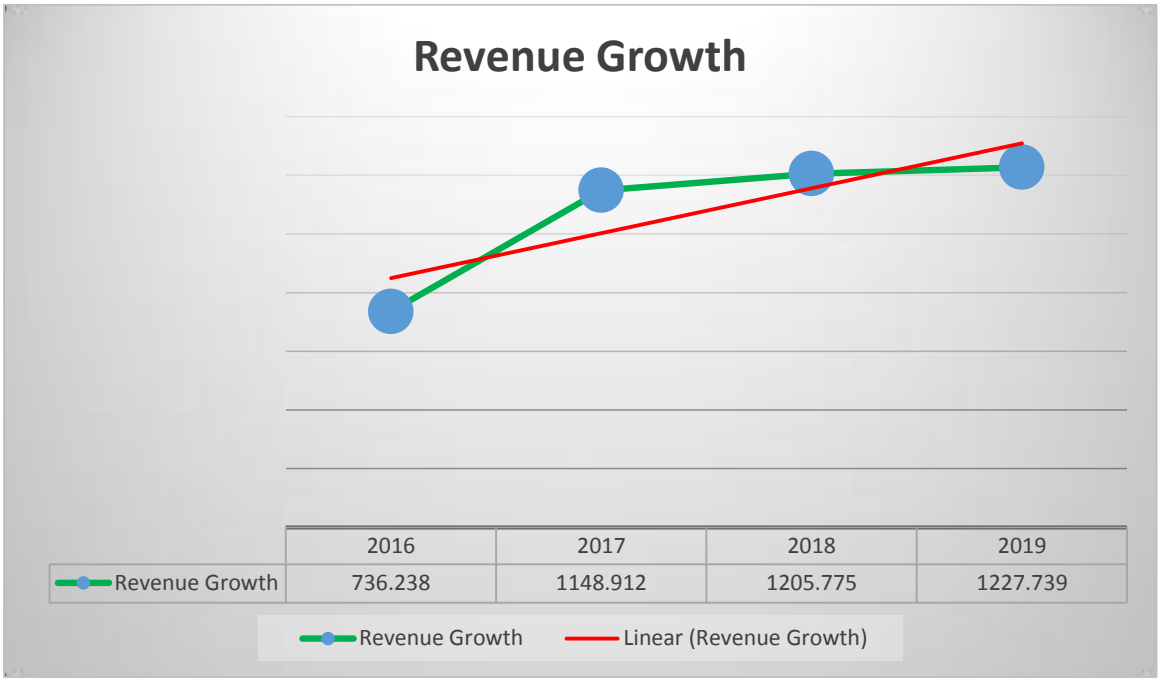


Figure: 3 Revenue analysis.

Finding illustrate that Reforms have positive impact over the revenue generation of the Medical Teaching Institutions. The diagram shows a 56 % increase from 2016 to 2017 which is due to inclusion of Mardan, Nowshera, Bannu and D.i.Khan Medical Teaching Institutions in the family of autonomous bodies. Similarly the Sehat Insaf Card reimbursements from insurance company and institutions base practice also contributed to the

[13] Source Annual budget statement Finance Department Govt of Khyber Pakhtunkhwa.

revenue generation. The growth lines show stand upward movement from 56%, 63% and 67 % in the rest of the years. The growth line intercept the liner trend line in 2019 which is due to non-operationalization of Institutional base practice at some MTIs. Similarly the Health Foundation KPK did not give approval to some MTIs for initiation of public private partnerships awards for diagnostic services, However there is positive impact ranging from 4% to 5% remained in trend over the four years in the revenue growth of the overall Medical Teaching Institutions.

4.10 Constraints and Circumscription:

The literature reveal that reforms polices at implementation stage are confronted with resistance forces applied from the desk of charisma because the playing actors in the existence system feel it is a threat to their values and therefore try to obstruct the reforms process by means of developing constraints or circumscription to modulate the value attached to the reforms in accordance with their own existing values.

This approach not only reshapes the reforms models but also enhances the degree of risk in the success of reforms. The reshaping, modulation and deviation from the standard experienced formula is a subject of policy design however it is very critical and sensitive process which could directly affect the success of reforms.

Although, Medical Teaching Institutions reforms have a full political support however due to power and control over the Institutions it leads to some changes in the autonomous status of the Institutions. Medical Teaching institution reforms was steered with greater autonomy concepts however at field level it faced some constraints and circumscription which are categorized into external and internal factors. The external constraints are thrust upon Medical Teaching Institutions and the Institutions have no control over these constraints. Similarly, these Institutions are also confronted with internal constraints which

are under their control however these constraints are malignant as they disrupt the internal system.

4.10.1 Political and Executive Authorities Control:

Medical Teaching Institutions' initial enactment envisaged authoritative role upon the Minister of the Health department by giving the power of Chairman in the Search and Nomination Council for recommendation of Board of Governors Members. Similarly, under the umbrella of bureaucratic politics the representation of Members from Establishment, Finance and Health Department were included in Governing body of MTIs. However, the same were excluded by immediate amendments in 2015.

One of the respondents told,

"Although Bureaucratic authoritative function had been eliminated at gross root level and the political authority had been enhanced to the extent of selection of Board Members. Later on the politicians and executives felt that Government's control has been reduced upon the Institutions hence further amendments were proposed to reinforce their control upon these Institution whereby Chief Minister have been given the power of appointment of Board members, policy Board have been established and minister of the Department has been delegated the power to oversight the performance of these institutions."

The control and autonomy has always remained debatable at various forums, the Government itself deviated from its policy to make an independent unit of healthcare service delivery and reinforced control over these institutions.

"Although t MTIs are autonomous bodies and this autonomy is just lays in paper. At field level those MTI Board of Governors who are professional experts and pioneers of the health system reforms in the KPK are free from political influence. However, the Management executives of those institutions may face some influences from bureaucracy and

local politicians and those institutions where Board Members are appointed on political approach are much affected from political interference."

4.10.2 Inexplicit Powers:

The political scientist Juan Linz in his influential work conducted in 1964 focused on that authoritative systems have the quality of inexplicit or ill-defined powers. In Medical Teaching Institutions reforms Act 2015 and its rules the function and responsibilities of various governing authorities are defined but the powers of each authority are blurred even in the Institutional regulations.

One of the responded told that,

"A good system always has a well-defined delegation of power, exercise of powers and parameters of powers but in Medical Teaching Institutions reforms system there is vagueness at all level of governance and each authority interprets and exercises their powers according to their own interests."

Finding illustrates that the Government reinforce its control over MTIs through amendments in MTI Act 2015, however these controls are remained in the cage of ill-defined powers. The politicians and executives although have little influence over those institutions where the third power of technocrats exists but institutions where they have incorporated their own representatives as board Members on the bases of political and administrative approach remain under their influence.

Similarly, no performance measurement framework exists to evaluate the performance of these institutions; the clinical and quality assurance audits are not properly operationalized. The regulations of these institutions are not comprehensive whereas the model regulations proposed by the Policy Board is the replication of Hayatabad Medical Complex regulations with some modifications which has not been even adopted by the other

Institutions except some MTIs. MTI system due to blurred powers of many authorities externally and internally leads to authorities and it provides opportunities for exploitation and misuse of authority which ultimately develops a risk to these reforms.

4.10.3 Financial Constraints:

Effective Financial management plays a critical role in the success of public policies. It was one of the drivers for reforms that public spending on health is very high but the results are very poor. The NPM reforms in the public hospitals generally focus upon the professional and market oriented approaches whereas the Financial Management is a core value of the new public management for service deliveries.

The effective Financial Management is the linchpin that integrates the resources, service delivery and objectives of an organization. In Medical Teaching Institutions reforms the financial autonomy has been awarded to medical teaching Institutions however they do not have maximum autonomy because their financial operations are wholly dependent upon the Government grants. In MTI Act 2015 the Medical Teaching Institutional Fund has been created and this fund consists of Government grants, own revenue generated by the Institutions through user fee etc. and any donation received to the Institutions. The Hospital Director is declared as Principle Accounting Officer of the concerned Medical Teaching Institution and the Director Finance role as a Chief financial officer has been defined in the rules of Medical Teaching Institutions 2015, however the Act 2015 is silent about the function and responsibilities of the director Finance.

One of the respondents told,

"In MTI Act 2015 the role of Dean, Hospital Director, MD and Nursing Director has been explained in detailed but Director Finance's role has not been much explained in detail comparatively. Similarly there is no departmental autonomy exist within the organization as all the division depend upon the Hospital Director being a principal accounting officer"

Pre-audit system has been given to Medical Teaching Institutions under the rules of MTI Act 2015 and the Board of Governors is authorized to establish their own pre audit system as they deem it fit. Some of the Medical Teaching Institutions established their own pre audit cells but in major hospitals like LRH, KTH, the local fund audit officials of Finance department are still working as pre audit authorities.

One of the respondents told that,

"We have financial autonomy only in papers as the local fund audit officials who are not an expert of the system are implementing Government rules and regulations upon the institutions and even on some instances they do not allow payment upon the Board of Governors approval that they are not in conformity with Government rules and regulations."

The pre-audit function has been delegated to the Board of Governors to make arrangements for pre audit and some MTI relieve the Finance department local fund staff as they have established their own pre audit cells like HMC and MTI Bannu.

The statutory audit of the MTI is vested with the Auditor General of Pakistan and this statutory audit is conducted on yearly basis by the Director General provincial audit. However, the Institutions are facing the same issue that audit department is also conducting their audit in the parameters of Government rules and regulation instead to take in consideration the MTI's own practices.

One of the respondents told that

"There is no comprehensive financial regulation existent in Medical Teaching Institutions that may cover all their financial operational activities. So, by default in the absence of any approved financial regulation of the MTIs the Audit department will scrutinize their financial transaction under the parameters of existing financial rules of

provincial Government and will report the audit objections to the public accounts committee of provincial assembly."

He further added that,

"MTIs are bound to submit their financial accounts to the Accountant General being a self-accounting entity in accordance with accounting procedures for incorporation in the state accounts. But presently, neither they are submitting their accounts to AG office nor have they prepared or exhibited any financial statement to the public."

The budget and financial statements are one of the essential policy documents for decision making however the financial reporting like Finance accounts, appropriation accounts, financial statements, Balance sheet of the Institutions are not yet prepared and exhibited by any institutions.

The Grants so provided by the Finance Department are as single line budget. The grants so provided to the Medical Teaching Institutions are not conditional grants however these grants are being provided to the Institutions on the quarterly basis as per demand of the Institutions.

The Finance department communicate tentative ceilings to the Health department of each MTI for preparation of their Budget. The Financial Management cell of the Health Department then forwards these ceilings to the concerned MTIs and then the concerned MTIs submit their demands. But, finance department does not provide grants according to their needs and approves the grants for MTI on the basis of their previous system sanction post. It is still keep intact by the Finance department and the non-salary component is fixed by the Finance department without any rational approach.

One of the respondents told that,

"Finance Department does not provide grants to MTIs according to their needs as some MTIs take more grants and other MTIs receive less grants as there is no formula for distribution of resources among MTIs with the Finance department."

4.10.4 Budgetary Process:

Medical Teaching Institutions reforms Act 2015 section 7 sub section (h) delegate the Board of Governors to approve financial plans and annual budget of the respective Institutions. Similarly, MTI rules 2015 section 8 & 9 detailed the budget and financial operations of the Institutions. Medical Teaching Institutions budgetary process is complex in nature as on one side they are required to observe the budget schedule of the Provincial Government for provision of grants and on the other side they are required to prepare their own budget.

4.10.5 Budget Preparation and approval of MTI Grants:

Grants provided by the Provincial Government are a sum of salary and non-component. Medical Teaching Institutions every year are intimated with tentative figures through Financial Management Cell of the Health Department to prepare Budget for Salary and Non salary component along with Midterm budgetary framework for the consecutive three years. The FMC then finalize the grants of each Institution on the basis of previously sanction strength of Salary component and non-salary component. The budget approach is incremental in nature.

FMC then forward the grants to the Finance department and Finance department then finalizes the demands of the Medical Teaching institutions by taking into accounts the revised receipt estimates of the Institutions own revenue and the remaining portion of budget quantum is balanced with Government funds. This matching technique is being used for fixing the grants of Medical Teaching Institutions. Once the grants are approved from

provincial legislation then these grants on quarterly basis are released and transferred to Medical Teaching Institutions reserve funds created at respective District Treasury offices.

One of the respondents said,

"Medical Teaching Institutions are autonomous bodies therefore as per rules they will retain their own revenue of institutional fund into designated Bank account. However, the Finance department is of the view that MTI's own revenue is part of their Budget so it should be deposited into the reserve fund created in Government treasury by the controller General of Accounts Islamabad and so it will be regulated under the Accountant General guidelines as per previous practice."

He further added that,

"Reserve fund concept in the rules of MTI is that it will be maintained by the Institutions and they will reserve some portion of their funds into reserve fund for utilization in developmental activities. While, the reserve fund created by the Finance Department for transfer of its grants is not in accordance with the rules of Medical Teaching Institutions."

The grants so provided by the Finance department and MTI's own revenue including remaining balances of grants are then again re allocated for different functions according to the need of the Institutions and approved from the Board of Governors. However, the funds so kept in the reserve funds maintained at District Treasuries are considered as public funds by the finance Department and cannot be removed from reserve funds for investment in any Bank account.

One of the respondents told that,

"As per Act the money not required for immediate disbursement can be invested by the Board. The surplus amount Balances if laying in the institutional funds which are not

required for immediate disbursement can be invested for profit earning with the approval of IMC & Board However, the District Accounts office refuses to honor the cheque with a plea that Finance department issued a letter that these funds are public accounts funds and cannot be invested."

One of the respondents further told,

"The budget process of MTI is complex in nature because the Act described that the budget of MTI will be approved by the Board of governors and will be prepared by hospital Director. While in the rules budget preparation responsibility is given to Director Finance and the demand will be submitted to the Provincial Government. Similarly, in the policy Board regulation budgetary framework the Division department will submit budget to CFO and the CFO will submit the budget to institutional finance committee and finance committee to the Dean, hospital Director and Medical Director as the case may be, and then to the Management committee and the Management Committee will submit the same to the Board of Governors and the Board of Governors if deem it necessary to the Board of Governors Sub Committee on Accounts and Finance ."

Findings illustrate that on one hand the finance department approves the grants as single line budget taking into account the receipt of Institutions and balance the budget with grants on matching basis technique. On the other hand, the MTIs are then to re-allocate these funds according to their needs and approve their own budget. The MTIs have limited control over the grants and they cannot invest the grants which are not required for immediate disbursement.

Grants are part of the Institutional Funds and so they are allowed under the Act to invest these funds for revenue generation but a constraint by default is imposed upon these institutions and finance department consider it as part of Public Fund. Secondly, there is no

mechanism existent with Government to fix their grants alike PFC and NFC and the old accounting guidelines have been enforced upon these institutions and old sanction strength are taken into account for salary component. The non-salary component budget is not being provided according to their needs. The Finance department is also not accommodating their SNEs with a plea that MTIs are autonomous bodies and creation of post is their own domain and MTIs can create posts with the condition that it does not exceeds the annual financial implication. In such position those MTIs whose sanction strength was more as per previous system are receiving more grants and those MTIs whose sanction strength is less receive less grants. Similarly, these institutions are also required to provide healthcare service on subsidized ratio and they cannot charge huge amount from general public to generate their revenue. Besides these constraints the MTIs through resource mobilization and savings within the grants created many posts to achieve their goals. However, their own revenue is not enough to achieve the desired out comes and it is affecting the motive of quality healthcare services.

4.10.6 Constraints in Procurement:

Hospital procurement is a part of supply chain management of hospitals and the efficient procurement may affect the cost of the hospital. The best and transparent procurement process is a key for efficient utilization of resources with maximum utility. The structural change, change in the pattern of diseases and change in the technology are all attributed with high cost and the hospitals are required to purchase durable and advance equipment. In the previous system there was no concept of state of the art hospitals or to provide quality healthcare services with a spirit of responsiveness. In Medical Teaching Institutions Act 2015 the reforms are interlinked with efficient utilization of resources, best performance of hospitals and provision of quality care services to the people of Khyber Pakhtunkhwa.

The hospital mainly deal with the procurement of bio medical equipment, drug and medicine, surgical equipment and other logistics necessary for health and non-healthcare services. Medical Teaching Institutions although are autonomous bodies however they are required to observe the Government policies being public entity. In the medical Teaching Institutions reforms Act 2015 there is a provision that MTI if deviate from any standard or Government policies are required to obtained prior approval from the Government or the policy Board as the case may be. In procurement the MTIs are required by default to make procurement according to the Khyber Pakhutnkhwa procurement authority rules 2014. Whereas they are required to initiate tender process if the procurement threshold limit is above one hundred thousand and other formalities thereon.

One of the respondents told that,

"Hospitals need to take immediate decision and accelerated procurement however due to KPPRA rules we are bound not to deviate from these rules. Comparatively in private sectors there are no such barriers and they can purchase quality commodities of brands according to their needs. In case we purchase anything of brand then it leads to audit para hence these rules do not provide an opportunity of choice to end user."

He further added that,

"Health department every years makes centralized procurement process and issues the list of firms post qualified for supply of medicine and equipment to the Government hospitals. The successful bidders often competed on price basis instead of quality base and the prices are also more than the prevailing market prices of those commodities. Secondly, the end user in the hospital also complains about the quality output of these procurements which impacts the quality healthcare services."

Medicine Coordination Cell (MCC) of health Department also conducts the procurement process to enlist the pharmaceutical firms for supply of medicine to the Government hospitals. The MCC properly evaluates the pharmacy companies and approves the lowest prices of those pharmaceutical companies who meet the set criteria. Some of the Medical Teaching Institutions initiated such process but the pharmaceutical companies do not quote such rates which are most economical for them and resultantly they are placing order for supply of medicine to the MMC approved pharmaceutical companies.

One of the respondents told that,

"Multinational products are costly and the hospitals due to lack of financial resources cannot afford quality and research products, and so in compulsion we place orders to the MMC approved firms"

One of the respondents told that,

"MCC list is not comprehensive and sometimes we need to purchase the same medicines from market which are costly and the hospital resources cannot afford it. Secondly, some firms of MCC do not make supply in time or do not provide medicines according to specification and then we have no control to initiate any proceedings against them because they are awarded contract by the health department and not by the MTIs."

Some of Medical Teaching Institutions like HMC and Mardan have their own Institutional Medicine Procurement Cell (IMCC) as well some MTIs make direct purchase of bio medical equipment from the foreign manufacturer through Letter of credit, which not only reduces the extra middle man cost but also ensures quality equipment according to their needs. However, they get NOC from different authorities to initiate such purchases which is obviously a time taking process.

Findings illustrate that no procurement rules or framework exists in Medical Teaching Institutions and they are dependent upon the Government policies which are complex in nature and time taking efforts. Secondly, the Government procurement process is price competition oriented rather than quality based procurement. The prices are high even doubled then market rates which are not in conformity to the values of Medical Teaching Institutions reforms and ultimately effects the provision of quality healthcare services to the patients.

4.10.7 Governance Challenges:

Medical Teaching institutions are confronted with Governance challenges and these challenges contribute to the risk. The Government from time to time amended MTI Reforms Act to grip these challenges and to streamline the system as to deliver it's desired out comes. The World Bank in its world development report "Governance and law"[14] focus upon commitment, coordination and cooperation being three institutional functions for effectiveness of policy implementation. Commitments generally focus upon the credibility of polices that the Actor may measure their behavior according to the values of the Polices. Similarly, the coordination among the Actors with the expectation that everyone will take the desired Action and cooperation leads to voluntary binding to the social contract.

Medical Teaching Institutions reforms' successful out comes are round about these three institutional functions. The commitment is required by all the playing Actors in the policy arena so that they may feel confidence upon the credibility and consistency of the policies.

One of the respondents told that,

"*Medical Teaching Institutions are politically driven reforms which can be reversed with the change of political regime. Similarly, the Government from time to time amended the*

[14] World Development report 2017 "Governance & law" The world Bank Group.

Act which leads to inconsistency of the policy and many modifications have been made which question the credibility of the policy."

He further added,

"The Government through establishing Board of arbitration has given an opportunity to the employees for dispute resolution but no mechanism exists for the conflict resolution among Board Members or those Members who are fired by the Government"

The changes in the policies and bargain are better for balancing the power asymmetries and to accredit the commitment. However, in case where the changes do not achieve their desired out comes then create risks regarding credibility of polices. Similarly, coordination is one of the most important functions of the institutions as the Actor feel confidence to follow others and to align the belief and preference of other Actors. In Medical Teaching Institutions reforms there is coordination at corporate level of governance and operational level.

One of the respondents told that,

"Government provided complete autonomy to these institutions and full administrative and financial power has been delegated to them now. So, they are expected to deliver the best quality care services and to enhance their performance."

MTIs are isolated from the bureaucratic influence however they are not free to steer the reforms at their own end because they are required to be supported by the Health Department with a track lighting to achieve the desired objectives. MTIs are confronted with day to day operational issues and due to vagueness of rules they depend upon the Administrative department. Similarly, the Board of Governors although have full delegated authority but in many aspects they depend upon the policy Board, Health and Finance Department.

One of the respondents told,

"MTIs Governance structure is not an integrated one and there is lack of coordination among all stakeholders. Government stresses upon the delivery of quality healthcare service while no forum or mechanism exists to redress the issues beyond the control of MTIs."

Similarly, in some MTIs there is also no coordination among the Board of Governors and Institutional Management committee. Even the Board of Governors is involved in the recruitment of employee at lower cadre which is done by IMC in LRH etc.

One of the respondents told that. "*IMC being an Executive committee of the MTI has powers but need to seek approval even on ordinary administrative or financial matters from the Board like even transfer of clerk or class-IV or to sanction leave to the employees has been noticed in some MTIs."*

Similarly, due to non-inexplicit power of different authorities of Medical Teaching Institutions the instances of duality and complexity occurred.

One of the respondents told,

"Dean is the chairman of IMC and chief executive of the institution but on other hand the Hospital Director is principal Accounting officer and has control over the College Funds. Similarly, Nursing Director is the head of nursing Division but many times hospital Director or Medical Director intervene in the Administrative affairs of the Nursing Directors. Also, many times hospital director and medical director intervene in the domain of each other as well"

No SOPs or rules of working relations exist which align the coordination horizontally and vertically among the Executives, Board of Governors, Policy Board and Health Department and Government.

Cooperation is also one of the most important functions of an institution as without cooperation no policy can achieve its desired objectives. It mainly deals with limiting the opportunistic behavior to prevent free riding. In public hospitals free riding is a fashion and everyone tries to avail the opportunity in their self-interests. The notion of cooperation and coordination is attached to the human behavior and volunteer in nature. The institution by taking cohesive measures can balance the system where all parties gain equally.

The employee working in MTI is of different statuses. One are civil servants working in MTI and others are MTI own appointees. The civil servant receive pay and allowances in accordance with Government pay scales and the MTI own employee are on fix or market base salaries. The Civil servant services are protected and their job status is pensionable while the MTI's own recruited employees are all most of fix pay and there is no job security. The NPM approach of market based high salaries is awarded to the consultants and executives. Similarly, in lower cadre the Civil servant salaries are more than MTI employees hence there are disparities in the salaries structure of the MTIs. Some MTIs are following the Government pay scales while some are following special pay scales.

One of the respondents told that,

"There is huge difference among the salary structure of employees. MTIs own employees' job are not pensionable, some MTI provides social safety schemes like CP fund or G.P.fund while in some MTIs there is no concept of social safety schemes for employees. Similarly, those civil servants who joined MTI their services pensioner benefit are protected

while those employees who are appointed by Management council of previous system are being deprived of such facilities."

He further added that,

"Most of managerial staff is junior and less experienced in healthcare organization therefore many senior doctors left jobs or got retirement because of non-protection of their basic rights."

Findings illustrate that there is lack of coordination, commitment and cooperation to some extent in Medical Teaching Institutions. Those Institutions where the Board of Governors Members are those persons who render their services voluntarily for the implementation of these reforms are performing but on the other hand some institution where there are no professional experts of the system in the Board or at managerial level are confronted with coordination, commitment and cooperation problems. Similarly, there is lack of coordination vertically among the Government, Policy Board and Board of Governors. The policy Board tries its best to harmonize the internal structure and to bring uniformity among all MTIs but due to non-expert professionals of Governance and administration many lacunas occurred at policy and regulation levels. Like, the Board Members are foreign nationals and they don't have adequate time to administer the affairs of the Institutions.

4.10.8 Accountability:

Literature reveals that although NPM reforms steered innovation and real development in public service delivery however the same was criticized due to lack of accountability. Medical Teaching Institution was granted with maximum delegation of administrative and financial powers however the Government from its initial experience enforced some controls over these Institutions.

One of the respondents said that,

"Accountability remains a major challenge for MTI reforms and at many forums like Provisional Assembly, August Courts and Accountability Bureau the transparency, accountability and performance of the MTI system remained under debate."

The accountability from the governance perspective has a broad concept as it focuses on that how much the institutions are answerable and blameworthy to the expected accounts.[15] The accountability is dependable upon the strong accounting practices.

One of the respondents told,

"Medical Teaching Institutions do not have strong integrated financial regulations and internal policies. The model regulation only sets out the budgetary frameworks and they do not exhibit their Financial statement publically in absence of strong internal control polices. Vagueness in segregation of responsibilities and accountabilities of different authorities question the transparency of the system at different forums."

The regulations of Medical Teaching Institutions are framed under the mandate of Medical Teaching Institutions reforms Act 2015; however these regulation are not accredited or ratified through third party.

One of the respondents said,

"The Law Reforms and control on subordinate legislation committee of provincial assembly basic function is to oversee the subordinate legislation (rules, regulations, statues notification) in conformity with the law. However, there are missing links to discuss the subordinate legislation in the house and the MTIs regulation has not been overseen by the said committee."

He further added,

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[15] Dykstra, Clarence A. (February 1938). "The Quest for Responsibility". *American Political Science Review*. **33** (1): 1–25. doi:10.2307/1949761. JSTOR 1949761.

"The selection process of Board Members, recruitment and performance remained under debate at the floor of the house many times. However, no mechanism exists to question the accountability and provision of healthcare service of the Medical Teaching Institutions."

Findings illustrate that the regulation of the Institutions deem to have an adequate mechanism to hold accountable the Governing Bodies and managerial authorities, or there may be an independent body to oversee the operation and performance of these institutions. MTI regulation of the Medical Teaching Institutions describes the role and function of different authorities however no mechanism exists to ensure the accountability of each tire of governance.

4.10.9 Accountability Structure:

The Accountability structure mainly deals with the role, responsibilities and function of different authorities with an outline of detailed regulations and policies.

One of the respondents told,

"In Medical Teaching Institutions the accountability structure exists as the statute empowered the Government to evaluate the performance of the Institutions with set parameters for sanction and reward. However, the Government has not yet developed any performance measurement framework or accountability mechanism of these Institutions."

The hierarchal structure of accountability of Medical Teaching Institutions exists within the statue of MTIs as indicated in the following diagram. However, the same has missing links at corporate and Management level as detailed in the figure-3 below.

Accountability Structure of Medical Teaching Institutions (Figure-3)

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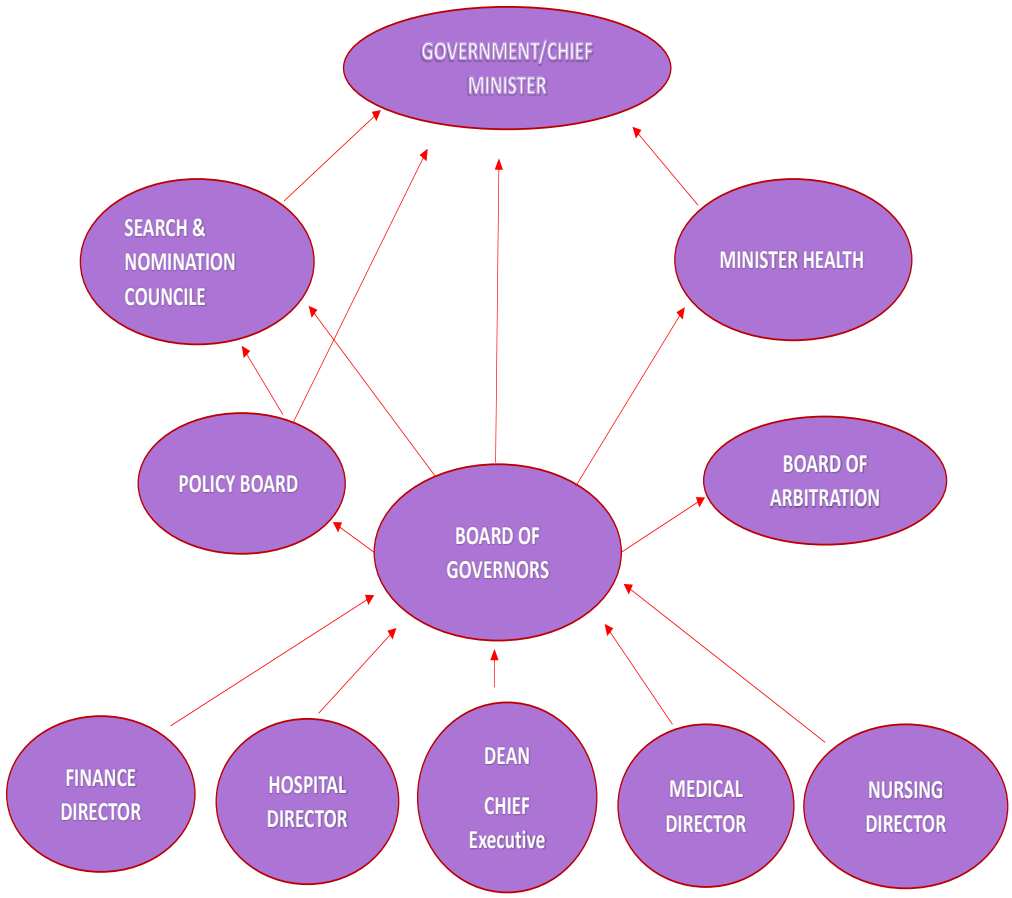

The accountability structure of Medical Teaching Institutions is complex in nature. At the Institutional level the Managerial authorities are accountable to the Board of Governors regarding their functions and discharge of responsibilities. However, the regulation does not detail the proper performance evaluation or any other criteria to fix the responsibilities and lapses upon individual. One of the respondents told that,

"MTI Act 2015 has described the sanction and award upon the performance of the organization and not on individual person. Whereas, no clear instruction or rule exists that can hold accountable or fix responsibility of any individual."

Accountability in a complex hierarchal organization like MTI is very difficult to be ensured. The minister in charge has been given the authority to intervene in case of poor performance however no mechanism exists that how the Minister will assess or evaluate the performance of the Institutions.

One of the respondents said,

"No check, internal control or criteria exists to evaluate the performance and hold accountable the Board of Governors, policy Board, Board of Arbitration and even the Search and Nomination Council"

Findings illustrate that the accountability structure of MTIs system is not effective due to the system complexity and nonexistence of proper internal controls or any standard operating procedure which can clearly hold accountable any governing or management body in its true spirit.

4.10.10 Social Constraints:

The colonial system under Weber's model in the Government hospitals is strongly routed in these institutions and has developed strong norms within the organizational practices. The change through Medical Teaching Institutional reforms abruptly hit the norms and values developed from the old system of rules and resultantly the resistance developed to the reforms.

One of the respondents told,

"*The normative behavior within the institutions can be changed with sanction and encouragement. However, the attached values of the reforms were more of sanction in nature rather than encouragement. Although the civil servant pension benefits have been protected while employee recruited under MTI Act 2015 have no opportunity of sustainable social safety schemes."*

He further added that,

"Previously there were seniority rules so all the civil servants and institutional employees were being promoted. But in MTIs reforms no seniority rules exist for the employees. On the other hand, the vacant posts are filled through direct recruitment on higher pay packages which create income disparities and cease promotional rights from the existing civil servants employees."

In MTI Act section 16, the pension benefit of civil servants is remained intact and the Institution will pay the pension contribution to the Government on their behalf. However, the promotion of civil servant working in MTI is badly suffered. Similarly, those civil servants who have joined MTI are allowed post-retirement benefits and the Government will provide a capital value share to MTIs for the period they served under the Government. However the MTIs do not have such regulation or to pay a huge commutation to these MTIs due to their limited resources and the same issues have not yet been addressed.

Other respondent told,

"The MTIs values are based on professionalism and gives opportunities to the skilled and professional specialists without going into the old bureaucratic rules of seniority. Those who are well qualified are being inducted in MTI to provide quality healthcare services."

At college level, a promotion regulation has been framed in the Model regulation of Medical Teaching Institutions however the seniority regulation has not been detailed in the said regulation. Some MTIs created extra posts which did not exist previously and awarded promotion even to the civil servants against these posts.

Medical Teaching institutions Act transformed the status of civil servants into deputations and the Board is empowered to repatriate them to the health department.

Other respondent told that,

"No comprehensive performance evaluation framework exists for hiring and firing. Similarly, the managerial persons appointed in the MTI system hardly understand the reforms system to its default values, and therefore on completion of their tenure or before maturity of contract they are removed without any performance evaluation."

The regulations of MTI are not in detail and lack of performance evaluation KPI to assess the performance has created uncertainty among the employees.

4.10.11 Resistance factors:

Resistance to reforms at organizational level is seen as a visible factor from the desk of employees and workers. Folger attributes the resistance as oppositional force to the organizational change[16]. Coestee interlinked the employee resistance in the shape of negative perception, lack of interest, strong opposing views, boycotts and strikes.

One of the respondents told,

"Employees initially boycotted and went on strike against the reforms however then the Government imposed essential service Act 1951 upon these institutions to suppress the voice of the employees. In response they knocked the door of court but however the court upheld the Government's action"."

He further added that,

"Government did not make any negotiation with them and the reforms were enforced by using Government's legitimate powers which led to lack of ownership of reforms implementation among the workers."

[16] Folger R. & Skarlicki D.P. (1999) Unfairness and resistance to change: hardship as mistreatment. Journal of Organizational Change Management

Employees as one of the stakeholders are a key factor in the implementation of these reforms. So, they are pushed for implementation of these reforms which leads to uncertainty in stewardship and eliminates ownership in the implementation of reforms. The Government skipped these employees during policy formulation and design phase and did not take in to loop the importance of such factor. Resultantly, it paved way for negative perception, fear, mistrust, loss of incentives, threat to job security and discouragement of existing employee skills.

One of the respondents told,

"MTI reforms have not been passed through compatibility test and did not take into account the existing cultural and environmental norms which directly hit the values of the existing employees. Also, the practices of MTIs are obsolete and the fundamental rights which leads to lack of confidence by the employees exist are all over the system."

Another respondent told,

"Learning from the experiences of KP Government's reforms, the Health employees in Punjab also went on strike against these reforms. Similarly, the Government of KP due to strong opposition also did not yet implement the DHA/RHA Act reforms in KP as well."

The resistance against DHA/RHA reforms was very effective as many health workers even in the MTI also went on strike and violence occurred at MTIs Hospitals as the Doctors, nurses and paramedics suspended OPD services.

One of the respondents told,

"*The Government did not take into confidence the employees at any stage of the policy formulation even though they were key stakeholders. Similarly the MTI system was neither customized nor modified according to the local environment."*

Findings illustrate that the MTI teaching Institutions reforms have been implemented by the Government without taking into loop the main stakeholder as well as no awareness about the benefits of the system were projected among the public and workers alike. There is lack of coordination and fear of job insecurity. The fundamental rights of the existing employees were not protected regarding promotion and disparities in salaries of MTIs and civil servants- all this generated frustration among the employees. Lack of ownership and stewardship has been experienced due to the concepts of self-interest; hence the weaknesses of the system developed risks towards the success of reforms.

Chapter-V

Discussion and Conclusion

The Institutional reforms under Medical Teaching Institutions Act 2015 are political commitments of the Pakistan Tehreek Insaf as embedded in the party manifesto. The drivers behind these reforms are rooted in foreign experience regarding public sector organizational reforms for better performance and quality healthcare delivery of services. Although not any specific study has been conducted towards problem identification but environmental, inspirational and declaratory factors gave an opportunity to the political Government of Khyber Pakhtunkhwa to take such initiative in order to fulfill their commitment of change with intensions to provides affordable, accessible and quality healthcare service to the people of Khyber Pakhtunkhwa.

The trajectories of the reforms according to the findings of the research reveal that these reforms were initiated with better intentions to increase the performance of hospitals, to harmonize the institutional practices with international standards and to provide affordable and quality healthcare services to the public. The Institutions have been exposed to market environmental competition and these institutions under the approach of New Public Management have given results in positive direction in some areas, while other areas remained in inertia position due to confrontation with constraints. The new concepts of International best healthcare standards and practices has been introduced and tracked within the organizational environment, the Governance structure has been changed according to the specification and value of the reforms.

In policy arena, the findings of research reveal that architecture of these reforms polices remained in the hands of Healthcare professionals who voluntarily rendered their services to Government while the bureaucratic influence has remained limited to the extent of

official procedures and legislation process of policy. The policy cycle like identification of problem, agenda setting, debate, consultation, implementation and evaluation was not properly addressed and even in the legislation the steps like scrutiny and consideration have also been skipped. The law reforms and subordinate legislation committee of provincial assembly also did not oversee the regulations and rules made by the Institutions. The policy was not properly designed and its externalities were observed at implementation level and to streamline the design many amendments were incorporated at later stage.

The expert power aroused in the shape of technocrats however the bureaucratic politics also showed its affects and some controls upon these Institutions have been reinforced. Politicians as well as the bureaucrats were not aware about the balance between control and autonomy regarding reframing the institutional structure on the bases of NPM model within the sphere of Public Sector domain. Thus the autonomy maximization got more weight than controls.

The findings reveal that in decentralization and delegation of power game, the politicians got more authoritative control over the Institutions than bureaucracy. Politicians and the professional experts who rendered their services on voluntary basis were not experts of public administrative practices and so the rules framed, the procedures adopted were left in the hands of technocrats who have more expertise in healthcare services but are not master of public administration practices. Thus, the system reframing has not been properly customized according to the Local environment.

5.1 Autonomy Dynamics:

The research finds that autonomy has been awarded as an input to enhance the performance of the Institutions- with an output of quality healthcare services. However, the autonomy so provided was not properly conceptualized according to its dimensions. The concept of autonomy remained in vague position and each stakeholder's perception about

autonomy was different. The professional experts due to their professional experience in market environment considered the Institutions having maximum autonomy while others were in confusion about status, visualization and practice of autonomy at field level.

This research analyzed the autonomy provision of the Act under Leuven framework at six dimensions i.e. Management Autonomy, Policy autonomy, Structural autonomy, financial autonomy, legal autonomy and interventional autonomy. The research findings reveal that the autonomy of the medical Teaching Institutions at management level of institutions is at maximum degree. The management autonomy brought positive impact over the institutional performance. Research further found that decision making, recruitment process and other day to day functions have been accelerated and now the hospitals and colleges of the Medical Teaching institutions have no difficulty in implementations of their decisions at local level. However, due to constraints like disparities in service structures of employees working in the organization, non-existence of proper service, seniority and promotion rules, nonexistence of grants fixing mechanism and limitation on additional demands of grants etc. have limited the scope of Managerial autonomy.

Similarly, within the organization the management autonomy has not been practiced at grass root level due to duality and complexity issue, and nonexistence of clarity upon coordination and working relations of the top managerial authorities.

The Board of Governors influences and intervention in managerial practices of the executives has also been observed. Due to this the executives being a professional functionary are not fully empowered in the decision making. The decision process although on consensus basis is more ownership oriented however the interventions leads to lack of accountability and fixing of responsibilities in case of failure.

MTI has a legal autonomy and research elucidates that it is declared as a separate legal entity under the statue of law. Legal autonomy from the initial policy design has remained at maximum level. The research findings illustrate that in 2018 amendments to the Act; the Government clarified the position of the Institutions as a public organization and thus are managed through public grants with an autonomous status.

Structural autonomy at initial policy design remained moderate as in the Governing bodies the representatives of Government department were included. However, the research result shows that the professionals experts of the system did not agree to the semi structural autonomy and in 2015 an amendment was incorporated in the Act stating that representatives from bureaucracy side have been excluded from the Board of Governors and the number of Board Members was also reduced from 10 to 7- all from private sectors as experts in their fields. Thus, the structural autonomy increased to the maximum level.

Research finding reveals that MTI Act 2015 initially empowered the Board of Governors and the institutions were independent in formulation of polices to address their management operations and practices subject to in case of deviation will obtained approval from Government.. The regulations having an important policy implementation tool have direct impact over the policy implementation and outcomes. Those Institutions where BOGs Members were professional experts of healthcare system farmed regulations having blend of state of the art and quality care hospital practices. While in other MTIs the regulations were not in accordance with the values attached to the reforms. Research findings revealed that those MTIs where regulations were comprehensive materialized good development and enhanced their performance and those where regulation were weak could not achieve its desired results.

The Government from its initial experience on the recommendation of professional experts proposed amendment in the MTI Act 2015 and constituted policy Board consisting of healthcare experts to advise the Government in implementation of reforms, frame base standards, polices and model regulation, and also to provide technical trainings for capacity building of the Institutions. However, the policy Board had the same persons who provided voluntary services to the Government and so they proposed the model regulation for MTIs as base standard with some modifications and replication of Hayatabad Medical Complex and LRH. Moreover, governance KPI and framework has also been developed to assess the operational practices of the MTIs however no further monitoring system developed to address the weak areas.

The research revealed that through amendments in the Act, the technocratic power of experts influenced policy design and they created space for their selection in policy Board with a clauses that one third of the Members will be from Board of MTIs. Although it is a good step to bring uniformity in the governance and management practices of all MTIs but the selection of Members having dual Membership of policy Board and MTIs Board increases the risk of concentration, centralization and dependency.

Those Institutions whose budget is fully covered from their own revenue and do not receive any grant from Government have maximum degree of Financial autonomy and so they can raise the user fee and generate revenue from other sources. The research findings also reveal that Medical Teaching Institutions have moderate or medium level of financial autonomy as the major portion of their budget receipt consist of public grants. The Financial autonomy dimension remained constant up to the latest amendment in the MTIs Act 2015 (amended 2018).

Medical Teaching Institutions Act as well as the rules constituted an Institutional fund consisting of grants, user fee, donations and other revenue which also gives complete control over the allocation and utilization of these grants like Federal grants to the sub national Government under NFC awards. The research finding reveals that the grants are unconditional but are defined under the Act as single line budget. The Finance department takes into account the Institution's own receipt and balance the tentative ceiling of grants with provincial Government funding. The research also revealed that the financial autonomy remained at par with the previous system however the investment of surplus funds and retention of user fee by the Institution have been allowed and so the institutions will allocate these funds and will approve their budget from Board of Governors under their regulatory framework. The research reveals that MTIs budget system has become complex in two ways: as on one side they follow the Provincial Government budgetary framework and schedule to prepare budget for grants under the tentative ceilings for salary (based on previous sanction post) and non-salary portion and then submit to the Finance department through Financial Management cell of Health Department while on the other hand they prepare their own Budget.

The grants to MTIs are then released on quarterly basis by the Finance department and the MTIs then wait for release of these grants which affect their own budget schedules and financial operations.

The research finding reveals that Interventional autonomy of the Institutions is at low degree as the Government has full control over these institutions in terms of interventions. Medical Teaching Institutions are subject to sanctions in case of poor performance and can be awarded in case of best performance. Similarly, their statutory audit remains with Auditor General of Pakistan and their financial operations are subject to oversight of public Accounts committee of Provincial Assembly.

5.2 Performance and Growth:

The Provincial Government once conducted the performance audit of these Institutions after the two years of its formation through Shifa Foundation however no Action had been taken regarding punishment and reward. The research revealed that Shifa Foundation carried out the quality of services audit under the KPI of joint Commission international health accreditation standards while the Government did not develop its own standard framework to assess the performance of these Institutions. Also, no targets up to date have been set by the Government for these Institutions.

Medical Teaching Institutional reforms bring various changes in operations of these Institutions. The research finding hold the view that the Government's objective was to provide quality healthcare services through these reforms and is linked with three stage process under the policy design. The first stage is related to empowerment of these institutions with maximum autonomy as an input; the second stage consists of processing stage to enhance the performance of these institutions it comprises of better governance, effectiveness, efficiency and responsiveness whereas the third and final stage is an outcome stage to achieve the objectives of quality healthcare services to the people.

Development and growth is not a one day process rather it takes time due to environmental effects. The Provincial Government of Khyber Pakhtunkhwa and the stakeholders after implementation of reforms in these institutions expect early results. The assessment of quality healthcare services has been conducted through Shifa foundation which assessed the quality of healthcare services under the joint Commission of international accredited standards and the performance of these Institutions against each KPI was not found up to the maximum level which leads to the uncertainty about the positive impact of reforms. The research revealed that although the institutions' performance for quality

healthcare services could not achieve the maximum standards however the Institutions have tracked their performance against these KPIs which did not exist in the previous system.

The Institutions tried to develop the path and took various steps in light of the necessary tools of development for enhancing the performance of Institutions. The research findings explain that besides confrontation with constraints, the development and growth has been observed in many aspects in these Institutions which did not exist previously.

The decision making process has become easy at local level, the human resource and employment has been created without increasing the financial implication, infrastructural development has been made, old buildings have been renovated, the interior designing of the buildings has been shaped to the extent of state of the art hospital, the resource mobilization has been done, revenue generation has increased, HMIS system has been implemented, management practices have changed, professional approaches have been blended and non-health services to the patients have been provided, new Institutions have been established like nursing colleges and paramedical colleges, institutional base practices have been started, emergency and trauma department has been upgraded and their protocols have been developed, bio medical equipment has been purchased, ICUs has been upgraded, internal hospital policies and regulations have been framed, availability of clinician has been ensured, ICT technologies have been introduced as well as medicine availability has been ensured for indoor patients and the bed capacities have also been increased.

Research findings revealed that the resources have been utilized effectively and efficiently under the reforms and a positive change has been showcased, however the quality healthcare services with the concepts of state of the art hospital is not yet fully ensured according to international standard. Nonetheless, growth and positive impact have been observed in MTIs some MTIs situated at capital territory of KPK. However the development

in MTI Bannu is not remarkable as compared to the other MTIs due its geographic location, political interference, and non-preference station for clinicians, lack of ownership and lack of Healthcare Professional experts in Management as well in Board.

5.3 Sustainability of Reforms and Risks:

The research findings explored the internal and external constraints. The external constraints work in a projectile manner and affect the growth and development of the system by disrupting the track of reforms from its attached values. Similarly, the internal constraints also hamper the performance and outcomes of the reforms. The internal and external constraints are interlinked through their receptive signals of interest and together they intercept the reforms success by increasing the degree of risk to the sustainability of reforms, slower the institutional growth by obstructing to pass on the benefit of these reforms to the public.

The research findings diagnosed many constraints and barriers to the reforms system. Some constraints are developed in the policy design to balance the control and autonomy of the organization and other constraints are generated as resistance barriers in the achievement of reforms objective. These constraints and barriers exist from top to bottom level of the system.

Research findings further reveal that in delegation of powers and policy formulation process the role of bureaucracy has been eliminated at organizational level however their influence still prevail in the Search and Nomination Council and up to some extent at financial level. The politicians' influence over the Institutions remained visible as the Chief Minister has been entrusted with power of appointment of Board Members and minister of the Department is given the authority to oversee the performance of these Institutions.

Research also reveals that those institutions where the professional experts are the architect of these reforms exists in Board are free from political and bureaucratic influence

while those institutions where the Board Members do not consist of those professional experts have still remained under political influence. Similarly, in the policy Board the professional experts incorporated their role and held dual positions. On one side, in policy board and on other side as member board of governors which has concentrated the powers in few hands and reduced the democratic and independence values of the system.

The research also reveals that no proper detailed studies of the institutions were conducted by the Government regarding the capacity of these institutions, cultural and environmental values were not properly assessed and no compatibility tests were conducted. In policy cycle stages the stakeholders' identification, consultation and debates were skipped, and also all the stakeholders were not taken in confidence to support the reforms and resultantly the resistance to change has been noticed at many stages.

Research shows that there is no comprehensive selection criterion for the appointment of Board of Governor and it is difficult to ensure meritocracy due to lack of proper regulation to regulate the practices of Search and Nomination Council. As in many cases they have selected Board Members who were not capable to run the affairs of the Board and later on removed them. The accountability mechanism and conflict resolution of Search and Nomination Council and Board of Governors is non-existent. It is a very critical point as it develops risk to the sustainability of reforms and its success. Besides a few Members most of the Members selected in the BOGs are of the old system and old school of thought and they do not have any expertise to govern the Institutions under NPM reforms. The research also revealed that the selection of BOG Members is political in nature and lack of merit base to properly assess their expertise in healthcare services like to conduct a Board exam by the American college of excellence and leadership.

The research findings elucidate that there is lack of coordination, commitment and cooperation at different layers of governance and management. The customization of NPM standards and fixing it in the public organization structure is a very sensitive task. The bureaucracy due to loss of power did not much contribute with the professional architect of the MTIs system and the professional architect although being an expert of the international healthcare quality did not have much experience of public administration and therefore could not modulate the values of NPM to fix them in Public sector organizational environment.

The research also revealed that resistance to change has been observed at many level during implementation of reforms. The Government did not project and develop awareness about the advantages of the system among the employees and other stakeholders and resultantly it paved way for negative perceptions, frustration, insecurity of jobs, fear of exposing the clinical practices through clinical audit, loss of their personal interest and loss of powers under status quo etc. The Government as well as the Board of Governors did not address these constraints under the Theory of constraints. The leadership style remained transactional and not transformative, the working relation among managers, Board, Policy Board and Government have not yet been defined in detail which leads to duality and complexity issue at top to bottom level of governance.

The research findings explained that although the Financial autonomy has been provided to MTIs and the grants are fixed on the basis of their old sanction post as one line budget but on the other hands the health and Finance department does not accept their additional demands for creation of posts in the organization and so a constraint by default has been created.

Further the research findings show that Government has no rational formula for fixing the grants of MTIs so some MTIs receive more grants while others receive less. The

population has increased but the burden of financial implication of expansion of human resource has been shouldered upon the MTIs which also affects the availability of adequate human resource to deal with the patients of the localities. The tentative ceiling of the grants is communicated by Finance department to the MTIs without taking into account their non-salary demands and the Government gradually reduced the grants under non salary component as compared to the previous budgetary system. Research discovered that the grants are not transferred to MTIs Designated Banks accounts and are under the Control of Government treasuries and therefore The MTIs have to incur their expenditure by presenting treasury cheques for disbursement. It has been also revealed that MTIs Act empowered the Board to invest their surplus money but the Finance department does not allow the MTIs to remove the surplus funds not required for immediate disbursement from Government treasury for investment elsewhere.

The research findings revealed that accounting guidelines of the previous system for withdrawal of funds from Government consolidated funds are implemented upon these institutions and they have less control over the investment of these funds. The Financial reporting system of these Institutions has not been developed and in the absence of strong integrated financial management system the accountability cannot be ensured

The research also revealed that there no performance evaluation framework exists to evaluate the performance of organization, Board of Governors, policy Board and the executive of the MTIs which ceased the concepts of accountability of the Institutions.

Research findings illustrate that most of the operational polices of MTIs are not yet developed and they depend upon the Government policies and financial practices. The hospital procurement is remained one of the major issue. MTIs do not have their own procurement rules and dependent upon the Khyber Pakhutnkhwa Government procurement

rules 2014. Although, KPPRA rules 2014 are more comprehensive but they could not meet the hospital requirement to ensure quality purchases on low prices, to ensure less utilization of resources and to get maximum utility. The institutions often issue medicine supply orders to firms enlisted centrally by the MCC of health department to supply medicine to Government Hospitals whereas the clinician often complain about the quality of these medicines as the MCC is more focused upon the price competition rather than to research and select quality product. Similarly, due to audit objections the MTIs followed the procurement cell of health department enlisted firms but some MTIs like HMC and LRH made direct purchases from original manufacturer and saved the middleman profit. However, due to many legal formalities it has not been practiced in other MTIs.

The clinicians focus upon the availability of adequate resources and quality medicine and other facilities for the patient care but due to lack of resources the manager comes under pressure to reduce the cost and to manage the patients care within the available resources. This position has direct impact upon the quality of healthcare services and the growth in the provision of quality healthcare services remained slower compared to the desired standards.

The discussions of the findings are wrapped up with the conclusion that MTIs system is more advance and complex in nature than the previous system. The Institutions have more autonomy then previous system however due to some constraints it has not been practiced according to the values attached to the system. The Impact of MTIs reforms upon the performance of these institutions has been observed in the research findings in positive direction in many areas however the targets of quality healthcare according to International best practices is not yet achieved but put on path the development of institutions. The system has external and internal constraints which intercepting the development process by creating risks in the success and sustainability of these reforms.

Recommendations:

The findings, discussion and analysis of this research study provide an opportunity to enunciate the following recommendations:

- The Governance system of the Medical Teaching Institutional reforms needs to be revisited. The Search and Nomination Council should need to be restructured and proper SOPs/regulations should be framed for its working. Its Members should be selected on merit base and not on political base. The chairman of the Search and Nomination Council should be an experts and not a politician. All Members of the council should be from private sector consisting of PhD scholars, Health organization Consultants and professional experts with a maximum experiences in Healthcare Industries. The same should be publically advertised and public opinion should be obtained about those Members who have applied for the Membership of Search and Nomination Council. Secondly, Search and Nomination Council should be given the power to conduct tests and interviews of the Board Members for their selection on merit base with proper qualification of maximum PHD or Master Level in the relevant field. The council should be given the power to assess the performance of the Board Members through policy Board on annual basis and strong check and balance system should be developed in this regard.
- The selection Policy Board need to be made on merit base though test and interview and a person holding PHD degrees in economics, health, finance, public policy, law and engineering. They should also be given an opportunity before selection to pass the Board exam to be taken by the Search and Nomination Council.

- The Board of Governors should be selected on the basis of qualification, experience in the healthcare organization and a Board exam should also be taken to assess their capabilities for running the affairs of the Board before selection.
- An independent election commission needs to be constituted for the chairmanship elections and those Members who secure more marks above the threshold limit should be eligible for submission of election paper for chairmanship. For this proper balloting process must be held and the person who secures more votes will be notified by the Election commissioner as chairman of the Board.
- The Board of arbitration needs to be abolished and comprehensive service and appellant authorities' unified rules should be made for the conflict resolutions at institutional level. A subsidiary independent committee needs to be established under the chairmanship of Search and Nomination Council for dispute resolutions.
- The hiring/firing rules and comprehensive polices and regulation for induction and promotion should be made to reduce job insecurity among the employees.
- The Policy Board needs to be given the power to monitor and to evaluate the performance of the Institutions under Government of Khyber Pakhtunkhwa's own healthcare standards framework.
- The policy Board needs to publish every year the performance report of these Institutions and Board of Governors in accordance with the set objectives.
- The Board of Governors and executive performance should be monitored on regular bases to ascertain sanctions and awards.
- Financial regulations, internal controls and reporting framework must be established to ensure proper accountability across the board.

- Comprehensive manual regarding responsibilities, functions, powers, accountability, working relations of different authorities within the organization and with board needs to be framed to avoid duality and complexity issues.
- Comprehensive conflict resolution mechanism among Board Members needs to be framed.
- The Grants provided to MTIs need to be rationalized on the basis of patient flow of the institutions instead of old sanction posts. The grants also need to be directly transferred to MTIs Fund instead of keeping them in treasury under the control of Finance department. The Developmental grants need to be transferred to MTIs for developmental purposes.
- MTIs own procurement rules, HR standards, Clinical Standards, non-clinical Standards, patient autonomy standards should be developed and must be implemented in all MTIs on uniformity basis.
- Proper awareness programs must be initiated among the stakeholders and confidence level of the all stakeholders needs to be obtained to support the reforms.
- Employees need to be empowered and their rights must be protected under the statutes of law and social safety scheme should be introduced for their family welfare.
- Comprehensive promotions rules need to be made with rewards and incentive system to rationalize and to eliminate income disparities among the same group of employees.
- Managers must be empowered in their day to day operations with systematic protocols and polices.

- The Institutions need to be empowered to award contracts and to outsource any clinical facilities under the public private partnership models to generate revenue and to reduce the burden upon the hospital budget.

Significance of the Study:

Health Reforms worldwide whenever implemented were criticized by the civil bureaucracy as all these reforms are politically driven but later on the western world recognized the phenomena of autonomization of public sector hospitals under New Public Management and New Public Service Model and so the health expenditure has been reduced with regards to public exchequers. MTI reforms Act no doubt is one of the great reform policy of KP Government in health industry however the bureaucratic constraints, capacity building issues, policy design debate and consultation phases were skipped by the Government which made stakeholders less interested to support theses reform as a successful experience.

Study has explored the ambiguities in implementation of Medical Teaching Institutions autonomy and therefore will be beneficial for all stakeholders i.e. Hospital Executives, Board of Governors, workers, public, bureaucracy and politicians to understand the concepts of hospital autonomy for successive policy implementations and improved governance and hopefully the tracks of this research study will lead to bridge the gaps.

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APPENDIX-I

Explanation of Key Terms/Concepts

Institutions:

Institutions are conceptualized in term of its definition is being a formal and informal rules and channelized social, political and economic relations (North, 1990) . Institutions build a systems having social rules with structure social interactions' (Hodgson, 2006). Institutions of Public sector are the policies, laws regulation, formal and informal norms and conduct rules that creates an opportunity for government decision-making, shape the behavior of public sector servants, resource allocation and exercise of power of authorities.

Structural change of Institutions:

The structural change of institutions means to modify, amalgamate or re constitute the design of organization due to external environmental pressure or influences. Structural change of organization occurs in the area of control of authorities, administrative standing operating procedures and policies, human resource, goals, objectives, mission and financial management system. However, the structural change depends upon structural inertia and in case if an in built mechanism exists then the change will definitely be confronted with resistance forces.

Medical Teaching Institutions:

Medical Teaching Institution consist of public sector Medical College, Dental College, Nursing College and Paramedical Colleges along with its Teaching Hospitals which provides healthcare service, medical education, training and medical research (MTI Act, 2015).

Hospital Autonomy:

Hospital autonomy is the delegation of powers and control to the public hospitals for decision taking, control over resource allocations and to retained hospital revenue and surplus. In the autonomy status the hospitals have the following characteristics.

• It has constituted under Act of legislation and operate under state supervision.

• Primarily responsible for curative and preventive care provision and promote quality of healthcare service financed by Government grants.

• Accountable to Government to meet basic standards technically and administratively.

• Financed through vertical block grants and locally generated revenue.

• Able to retain surplus resources and accountable for utilization of resources.

• The Institutions are being governed through Board and run by a Chief Executive Officer, Management Committees or Directors.

Institutional Reforms:

Institutional reform is the process of reshaping and restructuring public sector institutions to protect the human rights, prompt service delivery, maintain rule of law and ensure accountability (Magara, 2016).

Hospital Governance:

Hospital governance is a set of procedural practices related to decision making which gear the overall operational Activities of the institutions. The institutional Activities have major impact over organizational behavior, and bridge the complex relationships between multiple concern stakeholders (Scholten, 2018). The hospital governance held accountable the decision making bodies and Hospital Managers for continuously improvement of clinical and non-clinical operations. (Eisenstein, 2019).

Accountability:

Accountability means to be responsible and answerable for something within one's power or control. In Healthcare organizations the accountability is conceptualized in terms as the governing body and hospital authorities, clinical and non-clinical are held responsible for the goals and objectives given to them under a certain mandate.

Health care:

Healthcare is the combination of public health and personal healthcare services. The healthcare system consist of all Activities and structures with a primary function is to influence health in its broad scope. The world health organization defined it as *"all the Activities whose primary purpose is to promote, restore or maintain health"* (WHO, 2000).

Capacity for change:

Capacity means a technical consideration about the institutions, persons or groups' ability to provide services. The capacity for change in an organization is measured according to absorptive capacity of the Institutions, Cultural values, style of leadership, acceptance of change, and technologies (Spaulding, 2017).

Efficiency:

Efficiency is termed an Activities to avoid wasting of resources, energy, efforts, and time in the process to get maximum utility. The efficiency is an approach to generate outputs with avoid waste, less expenses and to reduce an extra efforts. Efficiency refers to very different inputs and outputs in different fields and industries (Sickles, 2019). The Organization for Economic Cooperation and Development (OECD) proposed health system performance framework (J, 2002) which includes macroeconomic efficiency to set accurate level of health expenses and microeconomic efficiency to maximize the value for money by increasing the ratio of health improvements and responsiveness to health expenditure.

Effectiveness:

Effectiveness is the quality and ability of an institutions which can delivered a desire output. When something is deemed effective, it means it has the potential of expected outcome, with deep and vivid impression (Dictionary.com, 2011).

Responsiveness:

Responsiveness are a system facilitates provided to the people to meet their legitimate non-health expectations (WHO, 2000), and consisting dignity, confidentiality, autonomy, prompt attention, social support, amenities, and choice of provider.