

Measuring Extent of Autonomy in Teaching Hospitals of Punjab: A Case of Services Hospital, Lahore

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ABSTRACT

This study examined 'to what extent' hospital autonomy has affected the internal management of Services Hospital Lahore (SHL). It is a case study and semi-structured interview guide was used for in-depth interviews. Doctors, administrative staff and Para medical staff were included in the sample. Findings of this study showed that Hospital Autonomy Reforms could not achieve its claimed objectives. Most of the powers still lie with the bureaucracy and there is no significant impact on the hospital management due to autonomy as all decisions are still finalized at secretariat through health and finance department.

Key words: autonomy, hospital, reforms, health sector

Introduction:

Public sector hospitals in developing countries are generally exemplified by inefficient resource management, low productivity, unfriendly and unprofessional patient care, rigid hierarchical structure, ineffective administrative and financial controls and at the last but not the least, an absence of performance based incentives (Akram & Khan, 2007). Autonomy as a significant health reform has been introduced in many developed and developing countries. Some of them are Ghana, Kenya, India, Indonesia, Zimbabwe, Uganda, France, Italy, New Zealand, United Kingdom and Pakistan.

Autonomy has different meanings in different contexts. In dictionary meanings, it is the quality or state of being self-governing especially the right or power of self-government. In context of health sector autonomy:

Hospital autonomy involves public hospitals that pass from being part of the public health sector to being institutions that rely on greater freedom in their governance and management. Autonomy seeks to improve efficiency, the acknowledgment of physician responsibilities, accountability and recipient decision making in the provisioning of services. Likewise, it seeks to improve the quality of care, to reduce costs and to increase institutional surpluses (Méndez & Torres, 2010).

Hospital autonomy is influenced by New Public Management (NPM). It was initiated in order to diminish the role of government. Public sector hospitals were over-burdened and were suffering from the problem of Principal-Agent relations. These problems were supposed to be overcome by this reform called Autonomy (Saeed, 2012). PML (N), a political party in power at that time, took the credit of launching of this reform in Pakistan, but the real idea came from some foreign donors. "Pakistan was not the only country where this reform was prescribed by the donors. Some

of other countries included Indonesia, India, Jordan, and Thailand. There was some funding by foreign authority to test hospital autonomy at Federal level hospitals...phenomenon of hospital autonomy was first launched at Federal then at Provincial level in Pakistan (Saeed, 2012).

Concept of autonomy is not native to Pakistan rather has some foreign roots. Autonomy was implemented in health sector of Pakistan via three acts i.e. PM&HI Act 1998, 2002, & 2003, with some proclaimed objectives of improving the worsening situation of public sector hospitals. The basic purpose of FMOH (Federal Ministry of Health) of giving autonomous status to the public sector hospitals is that, the public hospitals will receive indexed block annual subsidies from the government and will generate additional revenues from the user payments. Autonomy would enable the hospital managers to contain costs and to raise quality of care. Because government hospitals would retain their social mission, they would not refuse to provide care to those unable to pay (Makinen et al., 1993).

In the Punjab, the reform of autonomy was supported by the World Bank. Under 'The Punjab Medical and Health Institutions Ordinance' promulgated on 23 May 1998 and subsequently enacted by the legislature, certain teaching hospitals with their attached medical colleges were given a semi-autonomous status (Government of the Punjab, 1998a). In the first phase five institutions, Jinnah Hospital Lahore, Punjab Institute of Cardiology Lahore, ShaikhZayid Hospital Rahim Yar Khan, Holy Family Hospital Rawalpindi and Bahawal Victoria Hospital Bahawalpur, were made autonomous. In the second phase six teaching hospitals with their attached medical colleges, Nishtar Hospital Multan, Services Hospital Lahore, Allied Hospital Faisalabad, DHQ Hospital Faisalabad, Rawalpindi General Hospital Rawalpindi and DHQ Hospital Rawalpindi—were granted autonomy (Collins, Omar, & Tarin, 2002).

Hospital autonomy has been defined in two dimensions, (1) the extent of centralization of decision-making ("extent of autonomy"); (2) and the range of policy and management decisions that are relevant to hospitals including both policy formulation and implementation (Chawla & Group, 1996). The focus of this study is on the extent of autonomy and emphasis is on finding out the extent to which decision making in the hospitals got decentralized in the Services Hospital Lahore (SHL).

Objectives of the study:

The study aims to find out that 'to what extent' hospital autonomy has affected the internal management of Services Hospital Lahore (SHL)."

Internal management includes:

- A. Strategic management; it includes;
Mission definition, Strategic planning, Operational guidelines, Asset management
- B. Administration; it includes
All other day-to-day management activities required in implementing hospital mission and running hospital, such as: time schedules, space allocation, information management, consumer relations, etc.
- C. Financial management; it includes;
Resource mobilization, Resource planning and allocation, Accounting of income and expenditures
- D. Human resource management; it includes;
Hiring and firing of personnel, Creation of posts, Determination of employee rules, Contracts and salaries.
- E. Procurement; it includes;
Purchase of drugs and medical supplies, Purchase of non-medical supplies, Purchase of equipment (Chawla & Group, 1996)

Literature Review:

Public hospitals are important and most considerable part of health systems, especially in developing countries. People don't have enough resources to bear the expenses of private hospitals. Barnum and Kutzin (1993) reported that, public hospitals are usually responsible for 50 to 80 percent of regular government health sector expenditure (Chawla & Group, 1996). Autonomy was considered a solution of all these problems. Hospital autonomization is generally characterized by increased decision-making power at the hospital level in comparison with higher public sector authorities/funding agent. It has been tried in several developing countries as a means to enhance system efficiency, quality of care, and resource mobilization (Mitchell & Bossert, 2005).

In Pakistan, autonomy reform was introduced to improve the situation of health sector. Situation of health sector was worsening day by day as it was among the most neglected of the areas in social sector. The extent of this neglect can

be estimated from the fact that its budget was around 0.6% of the GDP (Saeed, 2012). There are many reasons behind such a criminal negligence including poor leadership, bad governance and awful management of assets of country. All sectors of Pakistani society i.e. from foreign affairs, to finance to education, health care and social services, are badly affected by the political instability. Demographic, epidemiological, economic, and systemic, all these factors stress the need for HS reform (Islam, 2002). To grant autonomy to public hospitals in Pakistan has been under discussion since the mid-1990s. But it became heavily debated in the political and journalistic circles only since the early 2000s (Abdullah & Shaw, 2007).

Hospital autonomy was first launched at Federal and later at provincial level in Pakistan. The plan was launched at two federal hospitals on experimental basis on the condition that if found successful, this plan will be introduced in provinces (Saeed, 2012).

(Abdullah & Shaw, 2007) narrated that:

Series of health service reforms was undertaken in the Punjab during the 1990s, all involving attempts at decentralization. The initial trigger was the World Bank funded Second Family Health Project that was established as part of the Social Action Programme. The two initiatives, which are relevant to autonomy, are the Sheikhpura Pilot Project and the granting of institutional autonomy to a number of public hospitals.

Several studies have been conducted to know the reality of autonomy in the context of Pakistan. Most of them have studied this concept in a broader sense, as, (Abdullah & Shaw, 2007) conducted a study, in order to review the experience of autonomy in Pakistan. They narrated that, “The notion of autonomy from the Department of Health kept oscillating between ‘little’ and ‘more’.” They further said that:

The processes leading to autonomy over the years that have discussed, may be viewed as a transitional phase that should subsequently lead into its ‘second generation,’ whereby the autonomy reforms are not only publicized and recognized for their obvious merit but also owned by all the stakeholders and implemented in letter and true spirit (Abdullah & Shaw, 2007).

Recent study regarding policy implementation process in Pakistan has been conducted by Saeed (2012) in which the whole process of implementation of hospital autonomy in Pakistan has been discussed. He, while, explaining the overall implementation process, found that, “certain factors including legacy of executive rule, political instability, ethnic politics, poor distance, sycophancy, lack of accountability and elite culture have strongly affected the process of implementation of hospital autonomy” (Saeed, 2012). He further said that, “without the knowledge of the good colonial heritage in power relations, ways of thinking and without a good analysis of implementation processes; the project has a little chance of success” (Saeed, 2012).

It has been discussed earlier that the concept of autonomy has been studied in a broader mode in Pakistan. But none of the studies have tried to study the effect of HA reforms at micro level. Thus, this paper aims to find out that, to what extent the grant of autonomy has affected the internal management of Services Hospital, Lahore.

Research Methodology:

The purpose and objective of this study is to explain the impact of hospital autonomy on the internal management of the Services Hospital Lahore. In order to achieve this objective explanatory approach is adopted. Qualitative research methodology is used in this study as the explanatory needs of a study are found to be best served using qualitative method of research (McNabb, 2008). To find the answers of the research questions, embedded case study design is followed as it helps in reliable and valid explanation of the variables under investigation (Yin, 2003).

The reason of choosing case study as research methodology is that, “they are preferably used when researcher has little control over events, and when the focus is on contemporary phenomenon within some real-life context” (Yin, 2003). This study is being called a case study as it tries to know, to which extent or how much autonomy has affected the internal management of SHL. Chamm (1971) recounted Yin (2003) that “The essence of a case study, the central tendency among all types of case study is that it tries to illuminate a decision or set of decisions: why they were taken, how they were implemented, and with what result” (Yin, 2003).

“Case studies often involve putting yourself in the environment that is being studied. Entry sometimes can be difficult, and the acceptance in almost is always a problem” (Willis, 2007, p.241). “Contrary to quantitative analysis, where number counts; the qualitative research stresses upon the quality of the information. It prefers significant few to insignificant many” (Saeed, 2012).

Population and Unit of analysis:

It is quite difficult to get detailed information about the internal management of all hospitals of Punjab; because of time and accessibility issue. So for this reason, researchers have selected Services Hospital, Lahore as a sample. The population of this study consists of all the administrative medical and non-medical staff of Services Hospital, Lahore and hospital is the unit of analysis. In depth interviews of 13 employees, including Doctors, administrative and paramedical staff, who were present there at the time of launching this reform, has been conducted in order to get detailed information.

Instrument for data collection:

Semi-structured interview guide is used as a tool for collecting the data from respondents. For further guidance and assistance “The Punjab Medical and Health Institutions (PM&HI) Act 2003” and interview guide given by Govindraj & Chawla(1996).

Data collection:

The top level administrative medical and non-medical staff members of Services Hospital, Lahore were included in the sample. They were assured privacy of information provided by them and that the data will be used for academic purpose only. With prior appointment the respondents were interviewed using interview guide. Information provided by the respondent was repeated in the presence of interviewee in order to enhance the reliability of the data. Each interview was transcribed to ensure that maximum information provided by the respondents is available for data analysis.

Data Analysis:

The analysis of data will help us in understanding the underlying factors and overall impact of hospital autonomy on the internal management of Services Hospital Lahore. Data collected by the researchers after interviews demonstrated that autonomy is unable to produce any significant results. Some senior doctors opined that:

“Basic idea of autonomy is good. Before launching this idea to the SHL its critical analysis was also first-class. Its enactment shows government political will, which was also good. Rules and regulations that are going to be followed are up to the mark. Hence one can say paper work was excellent. But the real fact is NO RULE; NO ACT is implemented in its true sense. Rules are abolished not practiced. Rules are totally relaxed and are not followed. Only meetings get held with no results. In fact such meetings are mere cause of increase in liabilities. Number of patients gets increased. But it’s a natural growth as population is increasing day by day. Autonomy is not the cause of it. Moreover number of beds is also not significantly increased. There is a huge shortage of funds, as there are no donations made by the donors yet.”

During the data collection stage, the researchers also observed that state of staff attitude and commitment with their job was very low as the employees were in a state of confusion due to this reform of autonomy. Besides this, Annual reports were also not deposited to health department. It is a requirement of autonomous hospital to submit their annual reports to the government within three months of the conclusion of the calendar year as per the PM&HI Act (2003). One more thing that is worth mentioning is that annual reports only include number of patients and some other similar facts and figures but the main theme regarding the performance of the hospital was not discussed in detail.

Most of the powers have taken back from the Board of Management in PM&HI Act (2003). Thus the real essence of autonomy has lost and autonomy is of no use. Real powers still lie with government and bureaucrats. Thus, there is no positive outcome & effect of autonomy on the internal management of the SHL.

Strategic Management:

Strategic management refers to the function of defining the overall mission of the hospital, setting broad strategic goals, managing the hospital’s assets and bearing ultimate responsibility for the hospital’s operational policies.”(Chawla & Group, 1996).

In case of the SHL, researchers observed that most of the respondents have no idea about the mission statement and objectives of the hospital in which they are working. They had no idea about the real essence of mission statement by considering it just as a statement. Similar observations were also made during the interviews conducted with the top level staff of the SHL. A senior doctor while talking about the mission statement said:

‘What kind of question you are asking about, every institute and organization has mission statement. So, yes! There is a mission statement of the hospital available at its website’

It means that the top level staff members of SHL have no interest in knowing about the purpose and significance of the mission statement. Similarly, the researchers also noted that the target population of the hospital is also not clearly defined by the hospital management. This fact can be gauged from the following statements made by a senior staff member of the SHL.

“Population cannot be clearly defined by the hospitals in a country like Pakistan especially in prime cities how it can be targeted, as Lahore is considered as a metro city of Pakistan. Patients across all over the country came here for treatment.”

During the data collecting stage, it was also observed that Board was not functioning properly and it had low level of influence in decision-making at hospital level. Although some decisions were taken at the Board level but nature of those decisions was not strategic which might have any significant importance for running the hospital independently. The situation is evident from the following excerpts:

‘The only matter of discussion during the board meetings is the development of infrastructure. Situation is not very hopeful due to the poor role of the board at SHL. Extent of autonomy is low as independent decisions are not taken by the hospital’

Administration:

Administration refers to all the other responsibilities (i.e., other than financial, personnel and procurement management) involved in the day-to-day running of the hospital and the discharge of the functions defined by the mission statement (Chawla & Group, 1996). The management and administration of a health institution shall, subject to the directions of government, vest in such body or person as may be notified. According to PM&HI Act (2003) board should perform following functions.

The board shall;

- a) Approve overall plans, policies and programs of the Institution in accordance with the approved policy of the Government;
- b) Approve the annual development and non-development budget of the Institution;
- c) Examine and approve the annual report and evaluation report of the Institute for submission to the Government;
- d) Ensure that the Government servants are provided treatment according to their entitlement;
- e) Determine user charges and fees for admission, clinical and procedural services and facilities with the prior approval of the Government;
- f) Ensure that poor patients and vulnerable sections of society receive adequate health care; and
- g) Determine modalities for treatment of private patients.

The Board may request the Government to sanction additional grant-in-Aid on case to case basis. The Board shall be responsible for generating the sources for the institution through grants, donations, contributions and other such means.

Although the act shows that there is some autonomy in public hospitals. But government involvement is still there. Hospitals are not fully autonomous as independent decisions are not taking by Board. While conducting the interviews with some senior faculty of SHL, it was noted that BOM of SHL is not performing its functions in an appropriate manner. Similar types of observations were also noted during the data gathering stage. It is also highlighted in the following statement made by a senior doctor during the data gathering process.

“Board members are not as efficient as they should be. They haven't taken such decisions yet which seems to be fruitful for the hospital, staff and patients. Meetings are mere cause of increase in liabilities; Board members consider meetings as a get together; they enjoy good lunch in meetings and that's It.

Another doctor, while talking about the board said.

“It is just a White Elephant. It is just a show piece. Real powers still lie with government. There are no donations received by the donors yet. No quality control is there. Hospital has not been developed as a business institution and there is no role played by the social workers.”

Responses of interviewees regarding administration of SHL have shown that BOM is not as functional as it should be. It has no role in major decisions. Moreover Board meetings are not taken into consideration seriously. Board itself has not taken such decisions which are useful for the hospital. There is no management operating body under board's direction, with significant independent decision making capacity. Government involvement to a larger extent is still there. So, autonomy is not fully enjoyed by this area too.

Financial Management:

Financial management refers to the generation of resources for the running of the hospital, and the proper planning, accounting, and allocation of these resources. In addition, there may be increasing opportunities for the hospital to raise their own resources, through user charges, institutional finance, donations, etc., reporting and auditing requirements may also be challenging tasks in an autonomous hospital (Chawla 1996).

PM&HI Act, 2003 stated that, there shall be fund, to be known by the name of institution, which shall vest in the institution and to which shall be credited all sums received by the institution. The fund shall be kept in such custody and shall be utilized and regulated in such a manner as may be prescribed. The budget of a medical institution shall be approved and its accounts shall be maintained and audited. The government may order financial, medical and managerial monitoring and audit on quarterly basis, through a third party nominated by government and paid for by the medical institution and the board shall comply with the directions, which may be issued thereon (PM&HI Act 2003).

The Principal / Head of Institution shall be assisted by the Director Finance, who shall be appointed by the Government. The Director Finance shall, with the approval of the Board, arrange for the financial management of the Institution. The financial set-up of the Institution shall include the Accounts officer, Audit Officer and Budget & Finance Officer (*PM&HI Act 2003, clause-18*).

Rules laid down in Act are not strictly followed by SHL. One of the respondents said that,

'Hospital raises its revenue from two things i.e. laboratory tests & X-rays. Both didn't get improved after autonomy.' User charges are equity based. It is different for different classes of society. there is a paradox due to social injustice and protocol system. Socially high risk people usually paid user fee in actual. Before autonomy, budget was given to the hospital head wise but after autonomy one line budget is given to the hospital. Institute has to distribute it by itself. There is no clear idea about the total income and expenses of the hospital. They are not properly managed. Annual reports of the hospital only reported about the number of patients and number of beds.

Another respondent mentioned that:

Hospital is not audited by third party on quarterly basis. He further said that, increase in number of patients and beds are not because of autonomy. The major reason behind this is that, population of Pakistan is increasing day by day. Procedure that was followed before autonomy is now following in SHL from last 3 years. So there is no autonomy in financial area.'

From the responses of employees of SHL, it is evidently noticed that there is low state autonomy in the area of finance, because still it is funded by the government. Funds are not generated by board in prescribed manner. Hospital is not audited by the third party. No donations have been made by the donors yet. So hospital is not autonomous in terms of finance. Autonomy is useless and is unable to give any good results if it is not given in financial area. "Autonomy will be meaningless until the hospital which is given autonomy is financially independent or it has assured financial inflow which can be expended as per the discretion of the hospital authorities." (Saeed, 2012).

Human Resource Management

Human resource management refers to the training and management of the various categories of hospital personnel (Chawla & Group, 1996).

The Government or, as the case may be, the Board appoint such persons in the service of Institution, as may be necessary, on the recommendations of the Special Selection Board. The Board may temporarily fill up an existing vacancy on ad hoc basis for a period of six months or till the arrival of the new incumbent recommended by the Special Selection Board, whichever is earlier. The existing employees shall continue to be governed by the Punjab Civil Servants Act, 1974 and the rules made there under (PM&HI Act 2003).

The Special Section Board shall consist of such number of members as may be determined by the Government. The terms and conditions of service of the members shall be such as may be prescribed. Act does not give full autonomy in this area of HR, as board cannot appoint employees on permanent basis. Hospital could not make independent decisions regarding the employee recruitment (Ahmad & Saeed, 2013a). Situation is same as it was before autonomy. Respondents while talking about autonomy in HR sector said that:

“Shortage of staff at every department of SHL is at its peak. No definite cadre is made by the board of management and they have failed in the development of staff. There is dichotomy of control especially among officers. Employees get hired through PPSC; there is no role of board in hiring of staff.”

Saeed (2012) narrated that;

In nutshell, by virtue of being the appointing and controlling authority for Boards, hospital administration and doctors and officer in Grade 17 and above, bureaucracy has complete control on the running of the hospitals and situation is more favorable to bureaucracy right now than what it was in pre autonomy scenario i.e. pre-1998 era (Saeed 2012).

Similar types of findings were also noted by Ahmad & Saeed (2013) while evaluating the nature and extent of autonomy in the case of Jinnah Hospital Lahore.

The teaching hospital could not get autonomy in the area of employees recruitment as decisions regarding hiring and firing are done at the health and finance department level. The non-gazetted employees were hired by the hospital administrator even before granting autonomy to the hospital and similar practice of making recruitment for the lower staff can currently be observed in non-autonomous hospitals. So no major change had occurred after the so-called autonomy process

“PM&HI Rules 2002 talked about transferring the services of the government employees to the institution but in 2003 Rules, no such intention is shown and employees have to remain under the control of the government.” (Saeed, 2012)

‘Director Finance also told the same story that, recruitment is through PPSC, board can only appoint on ad-hoc basis. Salary structure is of Grading (BPS); Staff is not employed by the board. Permanent employees are appointed by the government’

So level of autonomy in HR sector is very low, as per frame work given by (Chawla & Group, 1996). After granting autonomy to the public sector teaching hospitals, it was assumed that they could run their affairs through their boards but this could not happen (Ahmad & Saeed, 2013b).

Procurement:

Procurement management refers to the purchase of medical and non-medical supplies for the hospital, as well as the purchase of hospital equipment (Chawla & Group, 1996).

While talking about the procurement policies of SHL, one interviewee said that,

“Quality is getting lower day by day because of the rule of lowest bid, which is against quality concept. For which quality is compromised.

All material / supplies received shall be inspected by the respective inspection Committee constituted by the Principal / Head of Institution, which shall be other than the Purchase Committee. All purchases shall be made in accordance with the specifications of equipment, instruments, medicines and such other items as approved by the Departmental Standardization Committee (DSC) / Inter Departmental Standardization Committee (IDSC) constituted by the Government. But this rule is not followed by SHL (PM&HI Act 2003).

Another respondent said that;

Capacity building is same as before autonomy. Clinical audit reports are not published as per rule. There is no third party audit in SHL. And there is no survey for client satisfaction. Only forced documents are available. Scientific additions are also not remarkable. So SHL is far behind the real essence of autonomy concept. There is no concept of competition. Building gets deteriorated day by day.

Another interviewee said that,

“Pharmacist defines what amount of drugs is to be required by the hospital. Board only overlooks it. Biotechnical wing is responsible for maintenance. For major issues companies get consulted but final approval is made by the government. No donations are yet given by social welfare actors.”

Most of the decisions of the board regarding purchasing medicine are influenced by the bureaucracy, because District Coordination Officer (DCO) is the head of the purchase committee. On practical terms, the Board is not autonomous in taking any decision regarding procurement, the real power lies with the health and finance department (Ahmad & Saeed, 2013b).

Conclusion

Autonomy in public sector hospitals has not yet yielded hoped-for benefits. Process of autonomy in health sector is influenced by many factors. Major reason of its poor effect is that autonomy enjoyed relatively short period of time, real powers are still in the hand of government and bureaucrats. Analysis of data collected from the respondents of SHL shows that hospital is not autonomous in deciding its affairs. Board is not even fully functional. It is just a show piece and the primary source of power is health department. Moreover hospital has failed in generating its own income. It is run by the budget given by the government. Hospital is not autonomous as far as hiring or firing of staff is concerned. In true sense, hospital is not autonomous in running its affairs. The top level posts including post of medical superintendent, principal, director finance and doctors are filled with the approval and orders of health and finance department (Ahmad & Saeed, 2013a). Overall autonomy that prevails in SHL came into the category of “some autonomy” as per the frame work given by Chawla & Govindraj (1996). The idea of autonomy itself is good, as said by many respondents, but poor implementation has led to limited success. Amount of autonomy enjoyed by the hospital is negligible. If health sector wants to see the good results regarding implementation and its impact on hospital’s performance, then good governance and effective leadership is required. Government should give space to the hospital to perform its functions in an independent way, by allowing them to increase their management decision-making capacities both at the administrative and financial levels.

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