UNIVERSITY OF SOUTHAMPTON

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HEALTHCARE REFORMS IN THE STATE TEACHING HOSPITALS OF PESHAWAR, PAKISTAN: A MULTI-STAKEHOLDER PERSPECTIVE

by

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BSc (Hons), MBA, MSc

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ABSTRACT

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HEALTHCARE REFORMS IN THE STATE TEACHING HOSPITALS OF PESHAWAR, PAKISTAN: A MULTI-STAKEHOLDER PERSPECTIVE

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This study examines the local government reforms embodied in the Medical Teaching Institution (MTI) Act of 2015 in Khyber Pakhtunkhwa province (KP), Pakistan. The aim of the Act was to improve employee performance in the province's public teaching hospitals, and this research explores the reforms from the perspectives of key stakeholders, especially with regard to the introduction of performance-related pay. This research fills gaps in the current body of knowledge on performance-related pay in developing countries and makes a significant addition to the few existing studies on this topic. It addresses the contradictory theoretical stance between the discourses of New Public Management and Public Service Motivation on performance-related pay in the public sector. The theoretical concepts are derived by integrating New Public Management, Institutional Theory, Public Service Motivation Theory and Cross-cultural Theory. The study uses a mico-meso-macro framework of analysis to investigate the actions and reactions of those affected by the reforms in three of the public teaching hospitals.

The underlying philosophy is one of critical realism. Following the case study approach, a multiple case study involving three public teaching hospitals was designed. The data were collected in three phases from participants at the Khyber Teaching Hospital (KTH), Lady Reading Hospital (LRH) and Hayatabad Medical Complex (HMC), Peshawar, KP, Pakistan. The respondents were doctors, ward managers, members of the boards of governance and the provincial health minister. The semi-structured interviews, as the main data collection tool, were

corroborated by participant observation, field notes, memo writing and MTI reforms documents.

The MTI reforms were a political initiative by the newly elected government in KP province to address problems of performance, poor service structure and the corrupt appraisal system. Changes included decentralisation, autonomy, a new system of accountability and the introduction of performance-related pay in the case hospitals. Poor communication, conflict of interest, lack of consultation with local actors, poor planning and dismissive behaviour by the higher leadership were the main reasons for doctors' resistance to the reforms. The research findings show that performance-related pay was acceptable to the study participants due to institutional and social realities in KP, Pakistan and that it did not undermine their public service motivation due to high professional standards and strong religious belief.

The research makes a number of contributions. First, it provides rich empirical material on employees' reactions to public-sector healthcare reform and offers valuable insight into how policy from a secular individualist culture can successfully integrate with a religious collectivist culture. Second, it addresses the contradictory stances of New Public Management and Public Service Motivation on performance-related pay in the public sector by taking an inter-disciplinary approach. Third, this research adds to the body of empirical research on public healthcare reform in a developing country, and fourth, it yields findings which, we hope, will inform and influence the academic community as well as public-sector policy-makers.

Dedication

This thesis is dedicated to my mother, who taught me the importance of education.

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DECLARATION OF AUTHORSHIP

I, Farooq Ahmad, declare that the thesis entitled *'Healthcare Reforms in the State Teaching Hospitals of Peshawar, Pakistan: A Multi-Stakeholder Perspective'* and the work presented in it are my own and has been generated by me as the result of my own original research. I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as:

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Signed: Farooq Ahmad

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Definitions and Abbreviations

AMC	Abbottabad Medical Complex
HMC	Hayatabad Medical Complex
HR	Human Resources
KP	Khyber Pakhtunkhwa
KTH	Khyber Teaching Hospital
LRH	Lady Reading Hospital
MTI	Medical Teaching Institution
NPM	New Public Management
OECD	Organisation for Economic Co-operation and Development
PPP	Pakistan People's Party
PRP	Performance-related Pay
PML (N)	Pakistan Muslim League (Nawaz)
PTI	Pakistan Tehreek-e-Insaf
PSM	Public Service Motivation
UK	United Kingdom
US	United States

Chapter 1: Overview of the Thesis

1.1 Introduction

This chapter gives an overview of the thesis, beginning with the main ideas which led to the formation of the research aim and objectives of the study. This is followed by introductions to the literature review and to the methodology, progressing to a summary of the research findings and discussion of the thesis. The final section outlines the contribution of this research to the current body of knowledge.

1.2 Development of the research ideas leading to the aim and objectives of the study

In 2013, a general election was held in Pakistan. In the Khyber Pakhtunkhwa (KP) province, the ruling Pakistan People's Party (PPP) was ousted by the newly-formed Pakistan Tehreek-e-Insaf (PTI), led by ex-cricketer Imran Khan. The PTI began to introduce a number of reforms in order to fulfil its campaign pledges, and these included a series of healthcare reforms embodied in the Medical Teaching Institution (MTI) Act of 2015. In the first phase of these structural reforms, the government targeted the teaching hospitals of Peshawar, the capital city of KP province, with the intention of rolling out the changes to other city and district hospitals of the province in the next phase. This first phase of the reform gave a measure of autonomy to the public teaching hospitals in Peshawar in an attempt to improve performance. Electronic, print and anecdotal sources indicate that the MTI Act was very much influenced by New Public Management style policies, and that the provincial government was particularly eager to introduce performance-related pay in public teaching hospitals.

A deeper engagement with the literature helped not only to refine the research question of the study, but also to ground the study on a firm theoretical base by clarifying the underpinning ideas of New Public Management, Institutional Theory, Public Service Motivation Theory and Cross-cultural Theory. The literature on performance-related pay in the public sector was therefore systematically reviewed, and studies by Perry and Wise (1990), Alonso and Lewis (2001), Perry, Engbers and Jun (2009), Perry, Hondeghem and Wise (2010), Frey,

Homberg and Osterloh (2013) and Christensen, Paarlberg and Perry (2017) were found to be especially important, since they question the suitability of the scheme in the public sector. It is assumed by many that performance-related pay runs counter to the spirit of public service and erodes employees' sense of vocation; however, recent developments in the management of performance-related pay have led to its increasing popularity in the public sector, and proponents maintain that it improves employee performance (Dunleavy and Hood, 1994; Hood and Peters, 2004; Andersen and Pallesen, 2008; Liu and Tang, 2011; Stazyk, 2013; Hasnain, Manning and Pierskalla, 2014). The strong division of academic opinion on performance-related pay in the public sector is pointed out by, for example, Ingraham (1993), Perry, Engbers and Jun (2009) and Hasnain, Manning and Pierskalla (2014), and there has been a recent tendency to adopt New Public Management style policies in public sectors internationally (Pollitt and Bouckaert, 2011; Laegreid and Christensen, 2013; Ashraf and Uddin, 2016; Hood and Dixon, 2016). Our study seeks to integrate these opposing stances on performance-related pay in the public sector, which is timely for two reasons. Firstly, authors such as Perry, Engbers and Jun (2009), Hasnain, Manning and Pierskalla (2014) and Abner, Kim and Perry (2017) have called for the resolution of theory-based arguments as to whether performance-related pay is suitable in public-sector employment, and secondly, despite the recent wave of performance-related pay schemes in the public sectors of developing countries (as a policy intervention or embedded in New Public Management reforms), there are no clear guidelines on which policy-makers can base implementation decisions. The current study investigates the dichotomy between the two strains of literature: New Public Management, economic and policy literature suggesting that it is appropriate and effective, and public administration and psychology literature maintaining that it works against the ethos of public service. We also examine the current tendency among policy makers to justify the validity of performance-related pay schemes by pointing to their success in other country contexts (Ashworth, Boyne and Delbridge, 2009; Beckert, 2010; Hasnain, Manning and Pierskalla, 2014; Greenwood *et al.*, 2017).

This study aims, therefore, to address the gap in our knowledge of performance-related pay in public healthcare, and to move the discussion forward by integrating four cross-disciplinary theoretical concepts of 'New Public Management', 'Institutional Theory', 'Public Service Motivation' and 'Theory of

Cross-Culture'. Further, for a multi-layered examination of the MTI reform in the public teaching hospitals, a micro-meso-macro frame of analysis is used. These three levels of analysis are: (a) the macro level, which deals with the triggers for MTI reform, the basis for the policies, and why the KP government brought reform to its healthcare system, (b) the meso level, showing how the MTI programme was shaped and implemented in the public healthcare system of KP and (c) the micro level, examining how it was implemented in the teaching hospitals of Peshawar, KP.

The overall aim of this research is to generate greater understanding of how modern western management practices are implemented in the public healthcare systems of developing countries. In order to achieve this we have chosen the example of MTI reform in the public healthcare system of KP province, Pakistan, and investigate its controversial implementation from the viewpoint of managers and employees as the key stakeholders. In particular, we look in detail at their reactions to the introduction of performance-related pay into the system. Thus, as a more specific research question, we can ask: ***what was the impetus for the MTI reforms and how were they received by the key stakeholders?*** In order to address this question, the research objectives and sub-questions are drafted as;

RO1 - To understand how doctors and ward managers perceive the organisational structure and human resource policies of KP public healthcare in three of the teaching hospitals before the reforms. Human resource policy includes recruitment, compensation, performance management and the reward system.

> ***RQ1.1****: What was the organisational structure of the KP healthcare before the reforms?*
>
> ***RQ1.2:*** *How did the doctors in the case hospitals perceive service structure and performance appraisal system before the reforms?*

RO2 - To clarify the rationale for the MTI reform and to identify how it was understood by the key stakeholders.

> ***RQ2.1:*** *Why was MTI reform introduced in the teaching hospitals in Peshawar, KP?*

RQ2.2: *How did the stakeholders perceive MTI reform in the case hospitals?*

RQ2.3: *Why did the doctors in the case hospitals oppose the Act?*

RO3 - To examine how MTI reform was implemented in the teaching hospitals.

RQ3.1: *What factors are preventing the successful implementation of MTI reform?*

RO4 - To explore the perspectives of the doctors and ward managers in the public teaching hospitals of the performance-related pay scheme introduced as part of the MTI reform.

RQ4.1: *How is performance-related pay viewed in the collectivistic society of modern Pakistan?*

RQ4.2: *What is the effect of performance-related pay on doctors' professional attitude in the case hospitals in KP, Pakistan?*

1.3 Disciplinary debate and synthesis of the literature

Chapter 2 sets out the context of the study, as well as the problem statement and rationale for the current research. It also discusses the political economy of Pakistan and the recent political events which triggered the healthcare reforms in KP province. **Chapter 3** reviews the literature of performance-related pay in the public sector, with the aim of understanding current developments in the field. Different perspectives and theories relating to the application of performance-related pay in the public sector are critically evaluated and discussed, and several new questions are raised which highlight gaps in the literature. **Chapter 4** deals with the theoretical influences and orientation of the study, addressing the research gaps identified in Chapter 3. In this regard, four theoretical constructs are introduced and discussed in relation to the study aims. The essential themes from the literature are drawn together to present the underlying arguments of the debate. The context which shaped the research question is revisited, and the analytical framework (micro-meso-macro) is described.

1.4 Introduction to research methodology

This study takes an open line of enquiry into the nature of public healthcare reform in Pakistan by exploring the perspectives of employees who are affected by it. The methodology of this research is critical realism (Bhaskar, 1975;1989; Sayer, 1992; Archer, 1995) and is largely influenced by Sayer's interpretation of a realist ontology. It acknowledges the limitations of the dominant paradigms of positivism and social constructivism in human perceptions and links the different layers of analysis within the study. The approach of critical realism makes it possible to study the complex structure of the public healthcare system of KP and to investigate different layers, which is key to the aim and research question of this study.

Taking influence from the nature of the research question, the type of study and the author's pragmatic assumptions of the world, the case study was chosen as the research approach. This reasoning is drawn mainly from Yin's (2014) approach to the case study, which states that it sits well with the critical realist paradigm (Easton, 2010). A multiple (three cases) case design was selected for this study (Yin, 2014). The research question and case design helped the sampling and bounding of cases.

Due to the nature of the study it was decided that data should be collected in three phases, an approach inspired by Patton's (2002) design for data collection in naturalistic inquiries. Primary data were collected through in-depth interviews with the study participants. Data from the interviews were supplemented by field notes, memos, and documentary evidence provided by the case organisations, such as MTI reports and Annual Confidential Report forms. A case study 'database' was established to store all data. It was recommended that the database should contain all interviews, field notes, memos and documentary evidence; these were then analysed from the transcripts using qualitative data analysis as suggested by Miles and Huberman (1994), Dey (1993) and Saldaña (2015).

Choices were made throughout the duration of the research process about which theoretical construct to include and which to eliminate from the final thesis. Based on the type of reform in the public teaching hospitals, the four theoretical

concepts[1] of new public management, institutional theory, public service motivation and cross-cultural theory were chosen, since these guided the sub-questions. In addition, the inductive approach to the research meant that the results of early data analysis were used to further shape the study. The initial coding list was influenced by the research questions and by the literature. However, although the original aim had been simply to explore employees' perceptions of performance-related pay, the data revealed strong opinions about other aspects of the reform, which added important new findings to the study and broadened its scope.

1.5 Research findings and discussion

Chapters 6, 7 and 8 of the thesis present the findings and discussion with reference to the research objectives and related sub-questions. **Chapter 6** presents deeper insights into the organisational structure and human resource policies of the KP healthcare system before the reforms. Numerous meetings were held with higher authorities such as hospital and human resource directors, followed by the interviews with doctors, ward managers, members of the boards of governance, and the provincial health minister. Several documents were collected which were corroborated by participant observations and interview responses. From the data, 'poor service structure' and 'lack of faith in the performance appraisal system*'* were the main concerns of the doctors in the case hospitals before the reforms were introduced. Taking this discussion forward, **Chapter 7** develops a greater understanding of the MTI reforms in the teaching hospitals using the macro-meso-micro framework of analysis. The MTI reform was a political initiative by the newly elected provincial government in order to satisfy the electorate and show commitment to campaign pledges. However, it would seem that the implications of the reform were misunderstood by the doctors and ward managers in the case hospitals. Factors such as 'poor communication', 'conflict of interest', 'poor planning', 'ignorance of local actors' and 'rigid attitude of the leadership' were the main reasons why the doctors and ward managers resisted the reforms. **Chapter 8** takes the discussion further by exploring the perceptions and reactions of doctors and ward managers to the

[1] During the course of PhD study, the author presented theoretical concepts and results at various conferences (e.g. Ahmad, Gatenby and Meyer, 2015; 2016; 2016; 2016; 2017).

introduction of a performance-related pay structure. In-depth interviews were the main source of data. Institutional and social realities such as 'lack of government contribution towards continuing professional development', 'lack of family and leisure time', 'the joint family system', and 'men as the sole earners' were the main reasons for the acceptance of performance-related pay in the case hospitals. It was found, moreover, that performance-related pay did not undermine the public service motivation of the doctors due to 'high professional standards' and 'strong religious commitment'. The research conclusions and contribution made by this thesis are presented in **Chapter 9**.

This study aims to contribute to what is at present an under-researched area. From an empirical standpoint, the research provides rich insights into public healthcare reform by analysing the perspectives of key stakeholders, and, from a theoretical standpoint, it resolves the dichotomous tension existing between New Public Management, economic and policy research on the one hand, and public administration and psychology research on the other, regarding the suitability of performance-related pay in the public sector. This is done by integrating the four above-mentioned theoretical concepts within the study. It is intended that this research should form part of the disciplinary debate, along with authors such as, Ingraham (1993); Perry, Engbers and Jun (2009), Hasnain, Manning and Pierskalla (2014) and Abner, Kim and Perry (2017).

1.6 Conclusion

This chapter has provided an overview of the thesis and has presented the main idea of the research along with its theoretical basis, showing how this led to the formulation of the overall aim and objectives of the study. The overview was followed by an introduction to the current academic debate and the concepts underpinning the study. After a short introduction to the research methodology, the chapter concluded by summarising the key findings and discussion of the study.

Chapter 2: Healthcare Reforms in the Public Teaching Hospitals of Khyber Pakhtunkhwa: Medical Teaching Institution ACT

2.1 Introduction

This chapter gives the problem statement and sets out the foundations of the research. The problem statement and background are presented along with an overview of the current political events in Pakistan and the background to the Medical Teaching Institution reforms taking place in the public teaching hospitals of Khyber Pakhtunkhwa province. The healthcare reform is known as the Medical Teaching Institutions Act (2015), which is described and briefly explained. The chapter concludes by summarising the problem and the main ideas of the study.

2.2 The public healthcare sector of Pakistan

Public institutions are crucial to democratic societies, especially those which are welfare states, and a high-functioning public healthcare system is non-negotiable as far as the electorate is concerned (LeGrand, 2003; Grand, 2010). In Pakistan, public healthcare has always faced management problems that have rendered it disappointing in terms of meeting citizens' expectations (Nishtar *et al.*, 2013). The Pakistani public healthcare system is not only experiencing a shortage of skilled and qualified healthcare staff, but also suffers from weak institutional frameworks and distortive traditional management (Suhail and Azhar, 2016), which yield poor performance and fail to deliver the expected results (Nishtar, 2006). There has been little reform since the independence of Pakistan, and the development of public healthcare has been held back by traditional management and employment structures which are out of step with today's global context (Khowaja, 2009; Mir *et al.*, 2015).

The current debate of modern management in public healthcare is based on the accountability, motivation and performance of medical professionals (West *et*

al., 2006; Borkowski, 2015). Think tanks and policymakers are developing new management styles and best practices to achieve the desired performance in public healthcare (Suliman and Al-Sabri, 2009). However, in Pakistan, lack of research and ignorance of current best practice in human resource management are the main causes of poor performance in public healthcare institutions (Aleem *et al*., 2012). The Pakistani public healthcare system is grounded in a traditional public management system, which was inherited from the British when Pakistan achieved its independence (Nishtar *et al*., 2013). There has always been an enormous pressure on governments by other stakeholders of society such as civil society, the media and non-governmental organisations (NGOs), to reframe public health sector policies in order to improve efficiency and performance (Nishtar, 2006). Although political parties in Khyber Pakhtunkhwa (KP) province have tended to pledge healthcare reform during their electoral campaigns, up until the 2013 elections the victors have routinely let their voters down by subsequently failing to deliver what they had promised.

2.2.1 The political system

Pakistan is a Muslim country which obtained independence from British rule in 1947. Pakistan has endured stormy political times since its independence. The country suffered many coups by the Army as elected governments were overthrown, such that in the 70 years of its history, politicians have served only for 30 years. Although the country is democratic, only the previous two civilian governments were able to complete their tenure and therefore the electorate expect that civilian governments should deliver. The country is a highly centralised state. The political system is adversarial, with a first-past-the-post electoral basis. There are three major political parties (Pakistani Muslim League Nawaz, Pakistan Tahereek-e-Insaf and the Pakistan People's Party) and a number of other minority parties. Having been a British colony, Pakistan inherited the Weberian attitude to managing public administration. The system was highly centralised with a concentration of power at federal government level. In 2010, the Pakistan People's Party (PPP) made changes to the constitution of Pakistan, known as the Eighteenth Amendment. One of the many purposes of the Eighteenth Amendment was to decentralise the federal management structure and give autonomy to the provinces. This meant that provinces could introduce reforms to their regional public institutions (Nishtar *et al*., 2013).

2.2.2 Political events

In 2013 a general election was held in Pakistan, resulting in different governments forming in each of Pakistan's provinces. At federal level, the Pakistan Muslim League (Nawaz) was elected as they won the majority of the National Assembly seats. In the KP province, a new party known as the Pakistan Tehreek-e-Insaf (PTI), swept to victory in the provincial elections. This was the PTI's first appearance on the political scene, with no previous experience of government. Many political pundits and analysts believe that people voted for the PTI because of the charismatic leadership of the party leader Imran Khan, who was a well-known professional cricket player.

2.2.3 Party political ideas

The new KP government represented a new breed of young politicians who saw the need for the modernisation and reform of public institutions. Like other political parties during the election campaign, the PTI pledged to bring reforms to health, education, policing and land revenue, with health and education reform emphasised as high priority. As the newly elected government, the party remained keen to bring about healthcare reforms, not only to keep the promises of their election campaign but also to increase the party's vote bank in other provinces by delivering effectively in KP province. As in many other developing countries, Pakistani public institutions faced problems of low efficiency and poor performance coupled with politicisation and entrenched attitudes. The PTI manifesto is based on institutionalisation and states that public institutions must be free from any political interference: '*You can see that the public healthcare institutions are not efficient and that they are relying on old policies in a modern era. I am not sure when the provincial government last had major reforms in public healthcare. On the other hand, we believe that modern management practice and reform in the public healthcare is the need of the times*' (Health Minister, PTI).

2.2.4 Elite decision-making

After being elected in KP province, the PTI's leader, Imran Khan, along with top think tanks of the party, took two bold steps. Firstly, a considerably higher budget was allocated to healthcare reform, and secondly, highly experienced

local and international management professionals were employed to collaborate on improving the efficiency and performance of KP public healthcare. As a result, the provincial government announced structural reforms to the KP healthcare sector which were embodied in the Medical Teaching Institution (MTI) Act, and a resolution was passed in the Provincial Assembly to endorse the Act in November 2014.

2.2.5 The contents of the reform package: policy analysis of healthcare reform

The first phase of the reform was implemented in January 2015 in three teaching hospitals of the capital city of KP province, Peshawar. Print (e.g. Down News, 2015; and Frontier Post 2016) and electronic media sources reported that the Act combined numerous New Public Management style policies for running public teaching hospitals, with policies borrowed from United States (US) healthcare and private sector counterparts. In order to understand the changes in policy it is important to summarise the previous structure and HR policies of the KP healthcare system. Pre-reform, the management model of the KP healthcare system was a typical Weberian public structure. Healthcare was financed by the provincial government through taxation and the provincial government played a central role in defining the healthcare policies, resource allocation and all important changes to the structure of the healthcare system. The management structure was highly centralised and hospitals derived their power from the bureaucratic department known as the Health Secretariat. Healthcare professionals were employed as civil servants according to predefined criteria and regulations. Since the system was tenure-based, promotions were based on the number of years spent in employment. The performance appraisal system was rather complicated and assessment was done through the Annual Confidential Report (ACR), a system in which doctors were assessed subjectively by ward managers based on annual performance, whereby performance was not defined by objective metrics. As civil servants, doctors were eligible either for a free flat in the doctors' hostel or a home living allowance of 5,000 Rs. Other privileges included a high degree of job security, free medical treatment for the family, subsidised utility bills and retirement pension. However, there was no reward system in the previous structure and

payments were based on 'fairness', with all employees receiving the same pay increases in line with the salary scales for public servants.

It was evident from the party manifesto and press statements that the party had clear intentions to bring reform to the structure and delivery of KP healthcare. Thus, the MTI reform sought to bring about changes including decentralisation of the management structure, computerisation of data and installation of a bio-matrix system to ensure accountability, a new appraisal system, diversification of the pay structure, pension cuts, and a new reward system. A synthesis of the MTI reform document, newspaper reports, and the Ministry of Health website show that the MTI Act featured seven basic changes to the employment and HR policies of the previous system. Firstly, the management structure was decentralised and power transferred from the Health Secretariat to a board of governance at the head of each hospital for day-to-day decision-making. Secondly, the hospitals were given financial autonomy to generate their own funds to run their affairs. Thirdly, in addition to structural changes, the MTI reform also imposed fundamental changes to HR policies and the employment relationship, i.e. under the Act recruitment is on a contractual basis with no permanent positions available. Contracts are now renewed based on employee performance. Recruitment and selection is highly competitive and the members of the board play an important role in hiring. Fourth, salaries are now more diversified, with some being increased by 100%. Fifth, the authorities introduced a new system of performance management. Under the MTI Act the performance appraisal system was radically changed and performance is divided into two categories – general and clinical auditing. Each ward has its own performance indicators, which are defined by the ward manager, and doctors' performance is assessed by these indicators. Sixth, since all new hiring is on a contractual basis, privileges such as retirement pensions are no longer available. Finally, performance-related pay was introduced to improve doctors' performance. Under the scheme doctors are evaluated on their performance according to indicators drafted by the ward managers. Clinical indicators (for example on the surgical ward) include the number of surgeries performed per day, methods used, and success rates, while general indicators include attitudes towards patients and colleagues, absenteeism and contributions to academic research. Every ward has their own performance indicator and performance is evaluated by the ward managers. These evaluations translate into lump sum payments

which are paid on top of the annual base pay, with 30% of the annual salary being the highest pay reward for exceptional performance. The table below summarises the changes to the employment structure and HR policies of the previous healthcare system of KP.

Table 2-1: Nature of HR policies pre- and post-reform

Nature of HR policies	**Previous Healthcare Structure**	**New Healthcare Structure (MTI reform)**
Recruitment	Through centralised healthcare bureaucracy	Through autonomous board of governance
Promotion	Tenure based	Criteria based
Performance Appraisal	A subjective assessment of the doctors via ACR	New appraisal system defined by the MTI reform as clinical and general auditing
Benefits and Privileges	Pension, home allowance, free treatment for the family, subsidised utilities	No benefits and privileges (cuts on all privileges), salaries could be raised by 100%
Reward Structure	No reward system	Good performance will be rewarded via performance-related pay
Other Employment Policy	Doctors are free to conduct their own private practice	The doctors hired under the MTI Act cannot conduct private practice independently (outside the institution)

2.2.6 The implementation process

'The MTI reform is an important healthcare reform, but it is controversial because the government does not know how to implement it. It is therefore

crucial for any major reform to be designed with full consideration of sectoral and regional specific circumstances'. (Sania Nishtar[2], Former Federal Minister)

Once the resolution was passed by the Provincial Assembly, the think-tank decided to implement the Act systematically in different phases in the KP healthcare system. It was decided that in the first phase the Act should be implemented in the three teaching hospitals (Lady Reading Hospital, Khyber Teaching Hospital and the Hayatabad Medical Complex) in Peshawar, the capital city of KP province. The provincial government believed that successful implementation of the MTI reform in Peshawar would be a test case for the overall healthcare reform which it wants to extend to village and district hospitals in the province and to other healthcare professionals such as nurses and other paramedic staff. The Act successfully attracted the attention of the media for two main reasons. Firstly, the PTI created much 'hype' during the election campaign about the proposed healthcare reform. Representatives spoke confidently about it in media interviews: *'If our party wins the election, we know what reform we will bring to healthcare. We will not forget about it like other political parties after election - we have worked on it and it is ready for implementation'* (Dawn News, 2013). Secondly, as soon as the Act was implemented, doctors in Lady Reading Hospital went on strike, and were soon followed by doctors and paramedical staff in all the primary and district hospitals in KP province, whether the MTI Act applied to them or not. Industrial action continued for 25 days, with doctors refusing to provide any healthcare services apart from emergency cover in public hospitals. Further protest focused on the dissolution of the Post Graduate Medical Institute (PGMI), and a small group of doctors joined with the ancillary staff of the hospitals to take yet another stand against the reform and eventually the provincial government halted the reform process for two months. These doctors, led by the president of the Union of Doctors, railed against the PTI government and their appointed health minister. For example, '*these policies are unfair and they are forced upon us. We will not let this happen*' (President of the KP Union of Doctors). Refusing to serve patients in the public hospitals captured the attention of both the national and

[2] Dr Sania Nishtar is a well-known policy maker and author of many books and research articles on healthcare in developing countries in general and Pakistani healthcare in particular. She also served as health minister in the caretaker government in 2013 at the federal level.

international media and the doctors were criticised by many as unprofessional. In terms of public awareness, however, very little was known about the actual terms of the MTI Act, why the government of KP is implementing it, and why the doctors were resisting it so vehemently. There were many perspectives on the MTI reform, with doctors reacting against what they saw as unjust policies which would drastically change their employment relationship, while the government authorities suggested that it was fair to both the doctors and the community, as beneficiaries of the public healthcare system. As these reforms are very recent and still in the implementation stage, very little has been written about them to date. The only data sources available are either TV promotions of the healthcare reform or media interviews with government representatives. Since little is known about the rationale of these reforms, and particularly the viewpoints of the affected employees, i.e. the doctors and ward managers, one of the more specific objectives of this study is to explore how these key stakeholders perceive and interpret the healthcare reforms. Figure 2-1 below shows the location of KP province and the case hospitals.

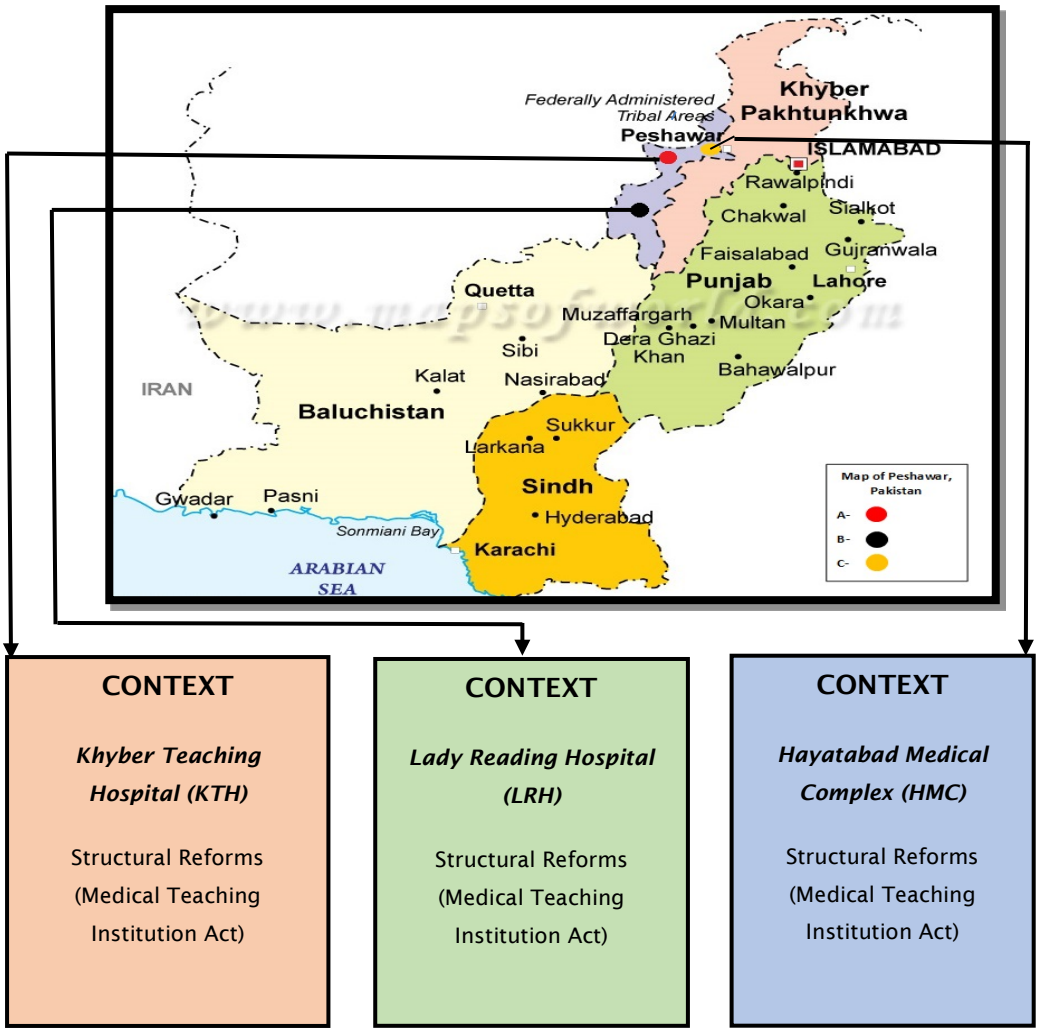

Figure 2-1: Location of the Teaching Hospitals of Peshawar, KP, Pakistan

2.3 Conclusion

This chapter has provided details of the MTI reform of 2015 in the public healthcare system of KP, Pakistan. The problem statement was presented first, followed by the relevant political history and the rationale for the healthcare reforms in the teaching hospitals of Peshawar, KP. The chapter concluded with a discussion of the reform implementation problem.

Chapter 3: Performance-Related Pay in the Public Sector: Debates and Synthesis of the Literature

3.1 Introduction

The MTI Reform Act proposed four changes to the structure of the KP healthcare system, one of which was the introduction of a performance-related pay scheme. This chapter reviews and synthesises the literature on performance-related pay in the public sector, since, while perspectives on the other reforms are an important part of the research, the role of performance-related pay forms the main focus of the study. The first section describes how the review is structured and sets out the criteria used to select the publications. This is followed by a brief historical background of performance-related pay and different definitions of such schemes. Relevant theories from different disciplines are then discussed before presenting a review of recent research on performance-related pay in the public sector. The existing disciplinary debates on performance-related pay are then assessed, based on a synthesis of 78 studies, with particular focus on studies published from 1993-2017. The purpose of the review is to substantiate our knowledge and understanding of performance-related pay in the public sector and to identify research gaps in the existing knowledge.

In order to be relevant to the aims of the study, certain criteria were used to select the publications for review. Attention was given primarily to the methods and outcomes of these studies, which have been categorised and evaluated to reveal different perspectives in the on-going debate. In order to find a wide range of views on performance-related pay in the public sector, publications were drawn from two sectors: the public sector in general and public healthcare specifically. Choices made to review the publications in the two sectors are influenced by the aim of the current study. The synthesis and critique of the studies in these sectors helps to construct an overview of performance-related pay in the public sector. The studies were categorised by their research methods, location of data collection, and sector. In general, it was found that performance-related pay literature is highly diverse in terms of focus and purpose, which made it difficult to extract common themes and directions in the on-going

debate. This was true particularly of studies dealing with the public sector in general. However, synthesis of the literature helped to identify gaps in the current knowledge base about performance-related pay in public healthcare institutions, and posed a number of pertinent questions, which have guided this research.

3.2 Structuring the literature review

In order to ensure an objective and logical review of the existing literature, a number of factors are considered which make it easier to draw conclusions from the synthesis. The studies cover a 25-year period, with particularly emphasis on research published since Kellough and Lu's review of performance-related pay in the public sector in 1993. Since then many other such studies have been published, including Perry, Engbers and Jun's systematic review (2009), which concentrated on developed countries. Here we expand our focus to research published in the context of developing countries in order to paint a wider picture. The literature was coded systematically, drawing on Hedges' (2009) method. Hedges advocates a five-stage process: 1) identify the problem, 2) search the literature, 3) code the literature, 4) analyse and interpret the findings, and 5) present the findings. References were traced backward from the most recent papers by the process of footnote-chasing, which led to those studies which have influenced recent research, and helped to identify the theories underlying performance-related pay.

3.2.1 Criteria for selecting empirical work

While not all of the studies reviewed were of equal relevance to the research, they all conformed to some degree to the basic criteria for inclusion:

- The purpose and objective of the studies must be relevant to the main theme of the current research, i.e. performance-related pay in the public sector and healthcare
- Studies published from 1993 to 2017

3.2.2 Multiple sources reviewed

The key sources reviewed included journal articles, reviews, reviews of reviews, and books. Findings from other sources such as conference papers, unpublished material, and current papers in the process of production by peers and academics were not included. Reports and papers, which did not meet the criteria were excluded from the synthesis. A total of 78 papers were found to be of appropriate quality for use in this research.

3.2.3 Journals used:

Following is the list of journals referenced;

- Academy of Management
- Human Resource Management (USA)
- Human Resource Management Journal (UK)
- International Labour Review
- The International Journal of Human Resource Management
- Public Administration
- Public Administration Review
- Journal of Public Administration
- International Journal of Manpower
- Public Management Review
- Journal of Management in Medicine
- Journal of Public Affairs
- Organisation and Society
- Asia Pacific Journal of Human Resource
- Human Resource for Health
- Health Services Research
- Social Science & Medicine
- Journal of Public Administration Research and Theory

Reviews include:

- Public Administration Review
- Public Management Review
- The Cochrane Collaboration
- The World Bank Research Observer

- BMC Health Services Research
- Health Policy

3.2.4 Database and key search word used

Several research databases were used, such as DelphiS, Web of Sciences, EBSCO, Wiley, Elsevier Google Scholar, and Google (least reliance on Google and Google Scholar). Databases were searched using different combination of words with different orders and sequences such as 'pay-for-performance', 'PFP', 'performance-related pay', 'PRP', 'performance-based pay', 'merit pay', 'incentive pay', 'public sector', 'New Public Management', 'NPM', 'healthcare', 'change', 'reforms', 'accountability', 'hospital', 'developing countries', and 'low-middle income countries'.

It became apparent while reviewing multiple studies in the field that different terms are used for performance-related pay. These vary according to sector and country. For example, in the context of the EU and other developed countries, such pay systems are referred to as performance-related pay, and its abbreviation 'PRP' is widely used. In the US, 'merit pay', and 'pay for performance' are the terms most commonly used, while a few studies refer to it as 'performance financing' in federal organisations (public sector). Also, the term varies from sector to sector. For example, in the healthcare sector the terms most commonly used are 'performance-based pay', 'P4P' and 'performance-based financing' – in developing countries. Similarly, in the public sector (in US context) it is known as 'merit pay'. Whilst the term is used differently in different sectors and countries, the spirit and meaning are understood to be the same. For this study, to be consistent with the adopted terminology, the term 'performance-related pay' is used for the remainder of the discussion.

3.2.5 Frequency of search

To capture recent perspectives on the topic a regular search (at least once a month) was carried out during the PhD candidature, using the different combinations of key words listed in Section 3.2.4. This regular scanning for new information also helped to identify any emerging trends in the research community.

3.2.6 Filtering

In searching for studies which focused on performance-related pay schemes, a total of 161 studies was found in the databases. Filtering these using another criterion of focus on the public sector reduced the number of studies to 132. However, in order for the review to be even more specific and systematic, the literature selected for this study was narrowed down still further to those studies with a bearing on our particular research problem i.e. performance-related pay in the public sector (two categories – general public sector and healthcare). This reduced the number of relevant publications to 78.

3.3 Overview of performance-related pay: a brief history

The philosophy of linking pay with performance is not new; in Europe, it can be traced back to the Protestant Reformation of the 16th and 17th centuries. Protestantism promoted the concept that Christian salvation was attainable through the performance of good works, and that hard work was a virtue in itself. This belief that those who worked hard were spiritually great in the eyes of God gradually widened in scope until it gave moral sanction to business success and the acquisition of financial riches. The mind-set that work is virtuous and should be rewarded proportionately (Weber's 'Protestant work ethic') is thus thought to have influenced the concept of performance-related pay (Price, 2007). Other historians trace performance-related pay back to third century China, where Emperor Wei rewarded his government employees based on performance evaluations (Coens and Jenkins, 2002). While, commenting on the history of performance-related pay, Heneman and Werner (2005) suggest that the first actual performance-related pay scheme appeared around the early 1900s, and note that the Larkin Company applied the scheme to its supervisors in 1912. Such schemes accompanied the rapid growth after World War II, until by the 1980s, almost 80% of the US public organisation were using a scheme in one form or another (Podgursky and Springer, 2007). Recently, performance-related pay has acted as a standard in the management toolkit, helping organisations to achieve higher performance and competitive edge (Belfield and Marsden, 2003). The proponents of performance-related pay suggest that since traditional time-based reward does not link the individual to performance, it therefore has a detrimental effect on the organisation (Storey and Sisson, 2005). Lawler (2000)

and more recently Gupta and Shaw (2014) have suggested that traditional pay structures make the organisation less competitive and reduce accountability.

Generally, the term performance-related pay covers a variety of similar pay structures which differ in the details. Two of these, for example, are 'merit pay' and 'variable pay'. Performance-related pay refers to any incentive plans that link salary to some measure of performance (Kessler and Purcell, 1992). Therefore, performance-related pay can include merit plans that reward employees according to subjective measures of performance and also systems that rely on quantifiable measures of performance (see Section 3.5 for a detailed synthesis of the literature on performance-related pay). Variable pay may include performance-related incentives, but is not pay that is permanently added to the employee's base salary. Loosely defined, performance-related pay is a form of incentive whereby pay increases are granted according to previous performance, in the hope of motivating improvements in future performance (Heneman and Werner, 2005)

3.3.1 Defining Performance-related Pay

Despite appearing to be a self-explanatory term, performance-related pay can be extremely difficult to define, and a number of definitions are presented in the literature. Milkovich and Wigdor are considered prominent scholars in the field of performance-related pay and their research has contributed greatly to the implementation of performance-related pay schemes in US Federal organisations. They define it as,

> *'Compensation contingent on performance that is awarded to individuals and/or groups either as permanent increments to base salary or as bonuses' (Milkovich and Wigdor, 1991, p12).*

Swabe (1989) incorporates the concept of performance appraisal in his definition:

> *'An individual's increase in pay is determined solely or mainly through his/her appraisal or merit rating' (p 4).*

Kessler and Purcell, two British authors who have elucidated the complexities of performance-related pay across different sectors, define performance-related pay as,

> *'A means of translating and transmitting market based organisational goals into personalised performance criteria whilst at the same time preserving the integrity of a coherent grading structure' (Kessler and Purcell, 1992, p 2).*

The author found Kessler and Purcell's (1992) definition of performance-related pay more interesting and comprehensive, as it links an individual's pay increase to performance appraisal using pre-determined criteria based on objectives, behaviours, and competencies. This definition is more in-depth than others, and Kessler and Purcell's work explores performance-related pay in terms of three broad categories: 1) the nature of the performance criteria, 2) how performance is assessed against the criteria and 3) how assessments are linked to pay. Going further, it clarifies the processes involved in a 'successful' performance-related pay scheme and highlight the connection between motivation, effort, and reward,

> *'A key aim of performance-related pay is to improve employee performance or productivity… based on an underlying view of motivation which suggests that employee performance is improved through the establishment of a clear link between effort, as formalized and measured through specified, individual criteria or targets, and rewards' (p 20).*

It can be seen from the literature that performance-related pay is defined with different emphases. Some definitions focus on the idea of a permanent increase in basic salary, while others focus on the concept of continuing performance appraisal. However, the general consensus in the literature is that performance-related pay offers employees judicious pay increases as a motivating force to improve performance.

3.3.2 Aim of Performance-related Pay

There is general consensus among the research community that in addition to the basic purpose of performance-related pay as a motivator, there is a wider purpose, which is to 'attract' and 'retain employees' (Gerhart, Rynes and Fulmer, 2009). Noe *et al.* (2006) postulate that organisations introduce performance-related pay in an attempt to overcome problems of performance and to reduce turnover, as well as to stimulate motivation and promote a competitive

organisational culture. Highlighting the role of performance-related pay in attracting skilled employees, Belfield and Marsden (2003) believe that skilled and able workers apply for and stay in jobs which value and reward high performance. For some organisations, the priority may be to retain knowledgeable and skilled staff; while others may want to improve the individual performance of employees for the benefit of the whole organisation. Reasons for the introduction of performance-related pay schemes can vary according to the needs of the organisations, for example, for some organisations performance is the issue, while for others it is the attraction and retention of employees. Co-operation and Development (2005) reports additional objectives of performance-related pay that include:

- Weakening the power of unions by making individual rather than collective contracts,
- Making managers responsible for taking decisions,
- Giving better value for money,
- Advertising the organisation's core values, and
- Changing the culture of the organisation.

3.3.3 Why do governments introduce performance-related pay schemes?

Traditional pay is based on the principle of 'fairness', whereby all employees receive the same pay increase. The premise of performance-related pay is that able and successful employees should be rewarded more generously than their lower-performing colleagues. Performance-related pay acts as a motivator both by providing incentives in the form of monetary reward and by recognising achievements (Baruch, Wheeler and Zhao, 2004). Performance-related pay is built on the premise that reward can foster a desired behaviour and that money is a potentially powerful incentive with which to influence the quality and quantity of employee effort (Kessler and Purcell, 1992). Policy makers have been drawn to introducing this scheme into their public-sector workplaces for different reasons. Empirical research by Co-operation and Development (2005) suggests that European Union (EU) countries implement performance-related pay in the public sector according to the particular requirements of each organisation. Commenting on the adoption of performance-related pay in this same context, scholars such as Chamberlin *et al.*, (2002) suggest that it is

influenced by the success of similar schemes in US federal organisations. Highlighting the role of performance-related pay as a tool in attracting and retaining employees in the public sector, Marsden and Richardson (1994) point out that the scheme was introduced by the British Inland Revenue to attract able workers and retain skilled employees. Co-operation and Development (2005) conclude that the reasons for introducing and extending performance-related pay vary within the public sectors of Organisation for Economic Co-operation and Development (OECD) countries, and that individual countries are influenced by their own particular circumstances. For example, Spain and Italy introduced public-sector performance-related pay in order to improve the accountability of public servants, while the government of Malta introduced the scheme to weaken the power of the unions. Likewise, Greece introduced the scheme to encourage competition in the public sector. According to Brown and Armstrong (1999), the basic purposes of such schemes are:

- To improve motivation
- To improve organisational performance
- To facilitate organisational change
- To ensure accountability
- To strengthen the relationship between individual and organisational goals
- To attract and retain talented employees.

Although performance-related pay schemes may be introduced for a variety of sound reasons such as those outlined above, the path to successful implementation may not always be straightforward. It can be seen from the literature that there are many factors, both internal and external to the organisation, which can affect the overall effectiveness of such a scheme. In the section which follows we discuss some of the macro and micro level factors which are thought to influence the implementation of performance-related pay schemes.

3.3.4 Key success factors for implementation of performance-related pay in the private sector

Brown and Armstrong (1999) remind us that the main reasons for the failure of performance-related pay in 1980 lie not in the fundamental concept, but in that

it may not have been appropriately implemented and managed. The implementation and success of such schemes is conditional upon certain factors, such as environmental level, organisational level, and the structural design and administration of the scheme. The environmental level consists of factors outside of the boundaries of the organisation that should be considered in making decisions regarding implementation. These include the present and anticipated stability of the economy, law and regulations, and the presence or absence of labour organisations (Brown and Armstrong, 1999). At the organisational level, these factors are institutional arrangements such as type of sector (public vs. private), organisational structure (centralised vs. decentralised), organisational culture, labour unions, job characteristics and HRM practices. Organisational factors couple with environmental factors to facilitate or hinder decision making with regard to the implementation of the scheme (Heneman and Werner, 2005). Likewise, for its successful implementation and effectiveness, it is equally important to design and administrate the scheme adequately, i.e. the creation of policies, appropriate performance indicators and performance measurement, and the establishment of pay increases, as well as design and evaluation of the scheme (Storey and Sisson, 2005).

An effective performance-related pay scheme needs to have clear performance indicators, which should be acceptable to employees and communicated clearly to them. The more objective and tangible the performance indicators, the more likely it is that such a scheme is effective (Belfield and Marsden, 2003). Performance must be adequately measured. The sophistication of performance appraisal is the heart of the scheme. Performance may be measured in terms of traits, behaviours, results, ranking, or paired comparison (Bratton and Gold, 2012). Factors such as non-transparency of the scheme, unfairness of application, or flaws in performance assessment are potential reasons why employees are less likely to respond positively to performance-related pay (Kauhanen and Piekkola, 2006). Finally, the reward must be of adequate value to the employees, i.e. high enough to attract and motivate them. If the reward is too little, the scheme is less likely to attract and motivate employees (Baruch, Wheeler and Zhao, 2004). In the same vein, Brown and Armstrong (1999) highlighted factors that influence the successful implementation of schemes. The authors suggested that communication between employees and

management on achieving targets and feedback on performance, employee's participation in designing the scheme, transparency of the scheme, a high trust environment, fairness and equality, creation of a positive psychological contract, good organisational infrastructure, and good communication are key factors in the successful implementation of performance-related pay schemes.

Armstrong and Taylor (2014) also summarise factors for success as follows:

- The existence of an entrepreneurial culture, which emphasises growth, competition and achievement of financial objectives within the organisation.
- The management's belief that the scheme will lead to a change in organisational culture, which will improve performance.
- A highly sophisticated performance management system, with clear objectives that are integrated with the overall objectives of the organisation, with feedback and review of performance which provides a sound basis for making fair and consistent pay decisions.
- The scheme should be transparent and the employees should understand how it works.
- The organisation should have adequate budget to make meaningful performance-related pay increases.

3.3.5 Components of performance-related pay schemes

Performance-related pay is perhaps the most honest of payment systems in that it is the effort of the individual rather than the fact of holding a particular position which affects earning potential (Belfield and Marsden, 2003). Employees are able to increase their pay as they improve their performance, as far as can be assessed by measurable indicators. Managers, however, wield ultimate power in this scenario, although their control is regulated via certain mechanisms which are pivotal for the scheme to be effective (Storey and Sisson, 2005). Recall the definition of Kessler and Purcell (1992), which identifies three key components of performance-related pay. First, setting the objectives; second, measuring performance against pre-defined objectives; and third, establishing the link between performance and pay.

In a typical reward system, objectives are not always clearly stated and employees may have little knowledge of what they are trying to achieve.

However, in performance-related pay the objectives are defined and clear to the employees (Baruch, Wheeler and Zhao, 2004). Forest (2008) reminds us that for performance-related pay to be successful, objectives must be fair, reasonable and acceptable to employees. Performance indicators can be objective and quantifiable or may be subjective, depending upon the nature of the organisation and sector. However, quantifiable and more concerted performance indicators are always preferable as they minimise the bias in performance evaluations (Gerhart and Fang, 2014). Differentiating the nature of performance indicators in private and public sector organisations, Burgess and Ratto (2003) suggest that in private organisations, performance indicators are clear and performance is assessed in terms of profit or number of units produced. On the other hand, the multifaceted nature of the public sector can mean that it is more challenging to develop measurable indicators. For performance-related pay to be effective, it is important to have well-defined performance indicators and to communicate these clearly to employees.

Once it has been decided which aspect of performance needs to be measured, the next stage is how to measure it, since identifying a good performance indicator is pointless if it cannot be properly measured (Daley, 1992). Bratton and Gold (2012) remind us that sophisticated performance appraisal is at the heart of a good performance-related pay scheme. The literature (e.g. Co-operation and Development, 2005; Gerhart and Fang; 2014) suggests that the more simple and straightforward the performance indicators are, the greater the chance of performance-related pay success.

Finally, the reward must be valuable enough to motivate employees (Lawler and Suttle, 1973; Beer *et al.*, 2004). It is also important that the increments of the reward should be adequate enough to inspire greater work effort (Kessler and Purcell, 1992; Baruch, Wheeler and Zhao, 2004). If the amount is very low, there is less chance of performance-related pay succeeding. Heneman and Werner (2005) point out that performance-related pay can be given in different ways; for example, through a percentage increase, a lump sum, or incremental progression on a pay scale (Storey and Sisson, 2005). Factors such as non-transparency of the scheme, unfairness of application or flaws in performance assessment are potential reasons why employees may be less likely to respond positively to performance-related pay (Kauhanen and Piekkola, 2006).

3.3.6 Types of Performance-related pay plans (form of reward individual or group received)

It is important to understand how an organisation can reward its employees via performance-related pay. Milkovicha and Widgor (1991) designed a 2x2 matrix to explain the options. The matrix is reproduced below (Figure 3-1) below to illustrate the subsequent discussion.

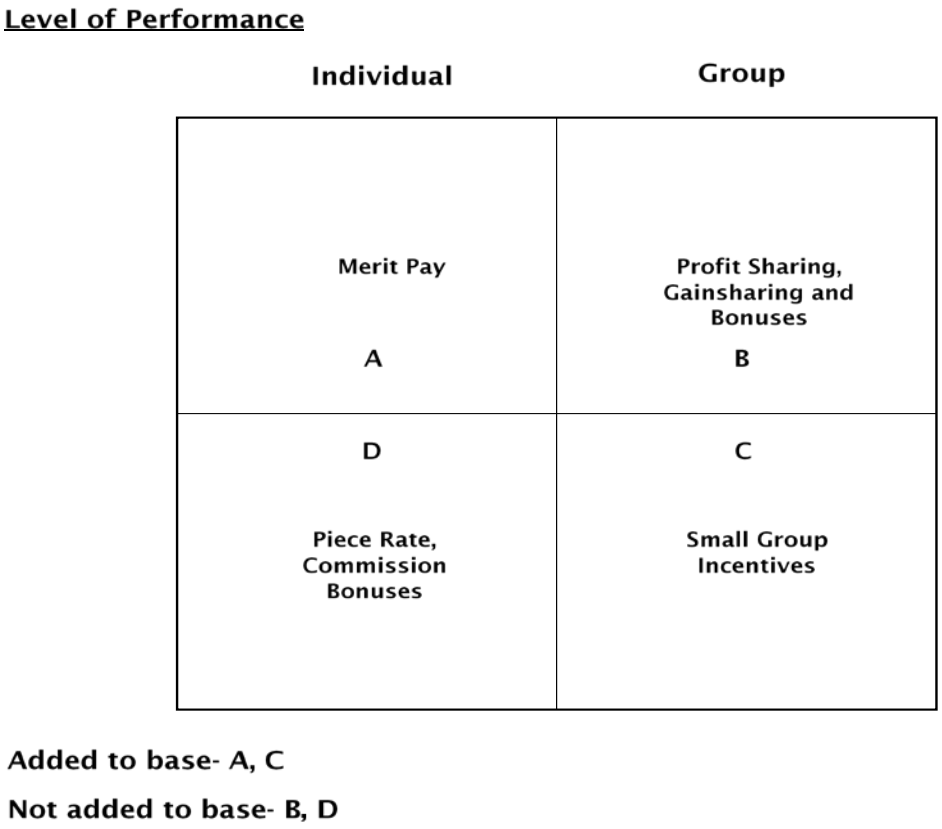

Figure 3-1: Contribution to base salary (adapted and interpreted from Peters and Pierre, 2003)

A: Merit plans

Heneman and Werner (2005) point out that merit plans tie an individual's base salary to pay. Employees are rewarded by percentage increases to their base salaries. Merit plans are the most common type of public sector performance-related pay scheme (ibid). Milkovicha and Widgor (1991) remind us that the beginning of the merit pay movement in the public sector can be traced back to the Civil Service Reform Act of 1978 (US civil jobs). The purpose of the scheme

in the US public sector was to hold civil servants accountable and promote a performance-based culture in public organisations.

B: Piece rates, commissions and bonuses

Pierre (2003) argues that in piece rate systems, compensations are determined based upon the amount of output produced by the employees. Piece rates were first discussed by Frederick Taylor (1911) and the scientific management movement. Taylor revealed interesting facts about the employment and payment structures of the time, and found that workers who were paid according to a piece rate scheme were more productive than their counterparts. However, flaws in the scheme tended to cause conflict between workers and management, and the piece-rate system declined in popularity after the end of the Second World War (Heneman and Werner, 2005).

C: Profit sharing, gain sharing and bonuses

Elaborating on profit- and gain-sharing bonuses, Heneman and Werner (2005) suggest that profit-sharing and gain-sharing plans are similar in many ways. For example, in both plans the performance is tied to group-level performance. Also, profit- and gain-sharing plans work by redistributing the earnings. In profit-sharing, a base level of earnings is set, and any profits above this amount are distributed among employees belonging to the scheme. Gain-sharing is similar, except that the profits distributed are linked to employee performance (Pierre, 2003). This system is slightly more complicated due to the need to accurately correlate performance with profit, and gain-sharing plans have been found to work better in small to medium-sized groups in the private sector (Lawler, 2000).

D: Small group incentives

There are several examples of gain-sharing and profit-sharing plans for individuals or groups of employees in the private sector, but small group incentive schemes that add reward to base salary are rare (Pierre, 2003). Organisations that utilise group-based performance evaluation are perhaps more likely to favour compensation that does not become a permanent part of the employee's pay (ibid). This can lead to horizontal pay discrepancies and mistrust between management and employees within the organisation due to the non-permanent increase of profit-sharing in the base salary.

To summarise, the literature synthesis has suggested that different plans of performance-related pay are used in different sectors to reward good performers. Pay which links individuals (rather than groups) to work-related goals is viewed by employees as being easier to accomplish when goals and appraisals are considered to be fair. Different organisations use different performance-related pay schemes depending on the type of sector; for instance, Kessler and Purcell (1992) suggest that piece rate commission may simply be better fitted to the private setting rather than the public sector. The nature of the public sector thus affects the success of performance-related pay.

3.4 Theoretical debate related to Performance-related pay

In order to understand employees' perspectives on performance-related pay, it is necessary to examine, broadly, current theories of human motivation. What drives us to give of our best at work? Are we motivated by money or by job satisfaction? What can employers in the different sectors expect when performance-related pay is introduced? Below we look at a selection of theories with relevance to this study and evaluate them in terms of how they might influence performance-related pay.

3.4.1 Expectancy theory

Expectancy theory can be traced back to 1957, when Georgopoulos, Mahoney and Jones (1957) investigated factors that relate to employee productivity. It was formally developed by Vroom in 1965. Expectancy theory emphasises the importance of the link between behaviour and reward. Later, many authors such as Heneman and Schwab (1972), Lawler and Suttle (1973) refined and contributed greatly to the theory (Heneman and Werner, 2005). According to expectancy theory, when an individual decides to apply effort, this is driven by conscious decisions which rest on a set of three perceptions: 'expectancy', 'instrumentality' and 'valence' (Chiang and Jang, 2008).

In this theory, expectancy is the logical idea that a certain amount of effort is required to achieve a certain level of performance. Instrumentality refers to the idea that a certain level of performance will lead to a specific outcome (Wigfield and Eccles, 2000). According to Lawler and Suttle (1973), valence is the

attractiveness of these outcomes to the individual, and the authors suggest that individuals will change their behaviour if they believe that doing so will lead to a reward; i.e. the change in behaviour must have a value in order for the individual to enact it. Thus, in practical terms, employees will respond to the promise of reward only if they ascribe sufficient value to it, and only if they believe that the extra effort they put into their performance will be sufficient to trigger this reward (Heneman and Werner, 2005).

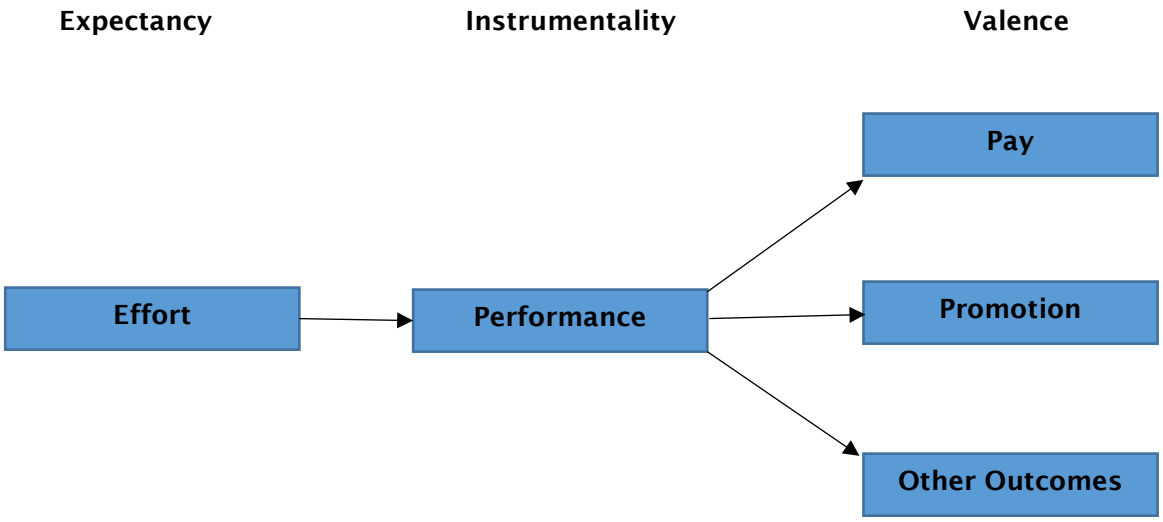

Figure 3-2: Expectancy Theory (Adopted from Heneman and Werner, 2005)

Expectancy theory has significant importance in the performance-related pay process and has a significant impact on employees' motivation if they meet the following conditions (Forest, 2008). Firstly, the performance of employees must be accurately measured otherwise they will not make the connection between effort, performance and performance reward. Secondly, increased reward (as a result of increased efficiency and performance) must be acknowledged and valued. If a reward is less attractive to an employee, the employee will be less motivated to perform. Thirdly, the link between performance and reward must be clearly defined. Other factors contributing to the success of the scheme include adequate facilities, equipment, leadership and supervisory support to perform the task. In the absence of these conditions, performance-related pay is unlikely to be effective (Co-operation and Development, 2005).

3.4.2 Reinforcement theory

Reinforcement theory, originally proposed by Skinner and colleagues, suggests that behaviour can be changed using the concepts of 'reinforcement', 'punishment' and 'extinction'. Pinder (2014) explain that in the context of the theory, rewards are used to reinforce or change behaviour, the concept of punishment is used to prohibit unwanted behaviour, and extinction is used to stop a learned behaviour. Commenting on positive and negative reinforcement, Kuvaas (2006) suggests that positive reinforcement occurs when the reward increases the desired behaviour, such as giving a financial bonus to an employee for good performance. On the other hand, negative reinforcement occurs when the reward is withheld due to undesired behaviour and such action is likely to increase the probability of achieving the desired behaviour. Punishment is used as a negative consequence to reduce the undesired behaviour and extinction is used to stop the learned behaviour by withholding the positive reinforcement (Stipek, 1993). Along with expectancy theory, reinforcement theory is central to performance-related pay schemes as theoretical bases and argument of the scheme are rooted in the expectancy and reinforcement theories (Perry, Engbers and Jun, 2009)

3.4.3 Cognitive evaluation theory

In the field of Human Resource Management, motivation and work incentives can be divided into two general categories of intrinsic and extrinsic motivation (Ledford, Gerhart and Fang, 2013). It is worth defining and explaining 'intrinsic' and 'extrinsic' motivation in order to construct and understand the discussion. Intrinsic motivation can be defined as the motivation to perform a task or activity when there is no objective, tangible reward, while extrinsic motivation is defined as the motivation to perform strictly for perceived external reward (Reiss, 2012). Intrinsic motivation refers to performing a task which is inherently interesting and enjoyable, while extrinsic motivation refers to doing something because it leads to a separate outcome, such as monetary reward (Dysvik and Kuvaas, 2013).

Cognitive evaluation theory is an important theory in psychology which was originally proposed by Edward L. Deci in 1971 during his experimental work with pupils. In terms of the effect of external rewards on intrinsic motivation,

cognition evaluation theory identifies the factors in a social context that produce variability in motivation (Shettleworth, 2010). For example, under certain conditions monetary rewards can undermine one's intrinsic motivation. In practice, this means that if an individual is motivated to do a task because it is enjoyable, then offering a financial incentive will make it less likely that the task is performed for enjoyment. In the field of psychology, there is substantial evidence from laboratory-based experiments which suggests that external rewards can conflict, with intrinsic motivation (Bandura, 2001). A classic laboratory experiment which supports this argument was conducted by Deci (1975), who found that giving contingent reward for performing a puzzle task led to significantly less intrinsic motivation towards the task in those who received no reward. Similarly, based on a meta-analysis of 128 studies, Deci, Koestner and Ryan (1999) assessed the effect of extrinsic reward on intrinsic motivation. Unexpected rewards, which were introduced after completion of tasks, did not affect intrinsic motivation, but if rewards were expected prior to the task, this condition actually reduced the intrinsic motivation (Ledford, Gerhart and Fang, 2013).

Cognitive evaluation theory is controversial in management science for three reasons. First, most of the studies that tested cognitive evaluation theory propositions were laboratory experiments rather than organisational studies (Rynes, Gerhart and Minette, 2004). Second, it was difficult to incorporate cognitive evaluation theory propositions into behavioural-prevention and expectancy-valence approaches (Gagné and Deci, 2005). Third, most people work to earn money to feed themselves and their family, so using money as a central motivational strategy seems appealing and practical (Ledford, Gerhart and Fang, 2013). Recent developments in the theory have led many researchers (e.g. Rynes Gerhart and Kathleen, 2004; Ledford, Gerhart and Fang, 2013) to conclude that incentives such as monetary rewards do not always undermine intrinsic motivation.

3.4.4 Self-determination theory

The limitations of cognitive evaluation theory are addressed by Ryan and Deci (2000) self-determination theory. Self-determination theory is a broader theory of motivation at work and distinguishes between autonomous and controlled motivation (Gagné and Deci, 2005). In order to engage in the debate around self-

determination theory it is important to explain what is meant by 'autonomous' and 'controlled' motivation. Autonomous motivation refers to doing a job out of choice. When people engage in an activity that they find interesting, they perform that activity wholly volitionally. In contrast, controlled motivation involves acting with a sense of pressure, a sense of having to engage in the actions (Deci and Ryan, 2010). Deci's (1971) earlier experiment found that extrinsic reward could lead to controlled motivation. Self-determination theory suggests that autonomous and controlled motivation differ in terms of both their underlying regulatory processes and their accompanying experiences, and that behaviour can be characterised in terms of the degree to which they are autonomous or controlled.

Ledford, Gerhart and Fang (2013) observe that self-determination theory acknowledges the limitations of cognitive evaluation theory. They further argue that it distinguishes various types of motivational states, considers different organisational conditions where extrinsic rewards are more effective than intrinsic rewards (such as organisational climate and boring versus routine work), examines individual differences in orientation towards intrinsic versus extrinsic motivation and discusses managerial behaviour that can enhance intrinsic motivation. Self–determination theory maintains the predictions of cognitive evaluation theory while expanding upon it to indicate organisational conditions under which the predictions do not apply or are less relevant in real-world settings.

3.4.5 Motivation crowding theory

Motivation crowding theory integrates theories of monetary incentives from the fields of economics and psychology. It was proposed and developed by Frey and Oberholzer-Gee (1997) and Frey and Jegen (2001). In the economics literature, most of the theories emphasise extrinsic incentives as causes of behaviour and do not consider intrinsic motivation. Motivation crowding theory proposes that extrinsic reward has two aspects, 'supportive' and 'controlling'. When extrinsic reward is perceived as controlling, it 'crowds out' intrinsic motivation; likewise, if extrinsic reward is perceived as supportive, it 'crowds in' intrinsic motivation (Ledford, Gerhart and Fang, 2013). Crowding out can have a negative effect on performance if the economic theories do not predict it. For example, Ariely, Bracha and Meier (2007) argue that monetary rewards do not work in charitable

organisations because people are not thinking of money as a priority in charitable work. The introduction of paid positions in charities may signal that the personal relationship has been transformed into an economic arrangement and this could be counterproductive. However, this observation is not relevant in the public and private sectors, where earnings are an inherent part of the employment structure (James, 2005). Table 3-1 below summarises motivational theory in relation to performance-related pay.

Table 3-1: Motivational theories and performance-related pay

Motivational Theory	Key Reference	Major Claims Concerning Effects of Extrinsic Rewards
Expectancy Theory	Vroom	If an individual values extrinsic reward, it will improve the performance of that individual.
Reinforcement Theory	Skinner and Colleagues	Behaviour can be changed by the concepts of reinforcement, punishment and extinction
Cognitive Evaluation Theory	Deci and Ryan	Under certain conditions, extrinsic reward undermines intrinsic motivation.
Self Determination Theory	Ryan and Deci	Under certain conditions, extrinsic rewards can enhance intrinsic motivation.
Motivation Crowding Theory	Frey and Jegen	Intrinsic motivation can be crowded out by extrinsic motivation created by incentives.

3.5 Systematic review of performance-related pay in the public sector: Looking at the empirical literature

In this section we review existing empirical studies of performance-related pay and discuss how they might inform the subject of the current study, i.e. the introduction of performance-related pay into the employment structure of public-sector teaching hospitals in KP, Pakistan. In order to organise the material, studies were divided into two main categories of the public sector in general and the healthcare sector in particular. This cross-sectoral synthesis of performance-related pay studies is then summarised and important questions

are identified. The focus here is on outcomes, country context, sectoral context and the research methods of those studies.

3.5.1 Evidence from the public sector in general

Studies of performance-related pay in the public sector began in the 1980s, after US schemes were implemented in 1978 in federal organisations to improve the performance of civil servants (Perry, Engbers and Jun, 2009). Since then performance-related pay has been adopted by many other countries for a variety of reasons. In terms of the success and general acceptability of such schemes in the public sector, the literature suggests diverse views. For example, Kahn, Silva and Ziliak (2001) report a successful example of performance-related pay in the public taxation sector in Brazil. According to the scheme, employees are rewarded for reporting citizens who violate the taxation system. Eligible employees are rewarded based on their salary and at individual and group levels. The group reward was calculated on the basis of relative performance of local agencies, with performance measured according to predefined goals of total tax collection, number of inspections, and collections overdue. Individual rewards were based on monthly evaluations, objective performance criteria and managerial discretion, and employees were rated on a scale of 0 to 70. The scheme proved very successful and the revenue from taxes and fines increased significantly. In another public-sector study, Dowling and Richardson (1997) evaluated the effectiveness of a performance-related pay scheme in Britain's National Health Service (NHS), focussing on administrative jobs. Using a self-reported survey, the authors found that performance-related pay had a positive effect on managers' motivation and performance. Likewise, Andersen and Pallesen (2008) studied 162 Danish research institutions, using a mixed methods approach to examine whether a financial incentive scheme would encourage academics to publish more papers. They found that output generally increased as a result. In a similar vein, Stazyk (2013) examined the effectiveness of the scheme in US local government. Drawing on cross-sectional data from a sample of managers, assistant managers and heads, the author concluded that the scheme had a positive effect on job satisfaction. Weibel, Rost and Osterloh (2010), in their review and meta-analysis of performance-related pay research, also found that the scheme had a positive effect on performance, as did Jenkins Jr *et al.* (1998) in a previous meta-analytical review. Other studies which show

the positive effect of performance-related pay include Heckman, Heinrich and Smith (1997), Condly, Clark and Stolovitch (2003), and Blasi *et al.* (2008), who found that it reduced absenteeism and turnover, and improved performance. All of these public-sector studies took a positivistic research approach.

On the other hand, critics such as Grimshaw (1998), Cardona (2006) and Fryer Jr (2011) suggest that performance-related pay has either no effect on performance or leads to negative consequences such as low job satisfaction and mistrust between employees and management. Others, e.g. Ingraham (1993) and Perry, Engbers and Jun (2009) suggest that performance-related pay is at odds with public-sector organisational culture, which has always been vocational in nature. Also, some studies suggest that schemes are effective when applied to simple jobs with easily measurable performance indicators, but is unsuited to more complex jobs with harder to measure performance indicators. For example, Weibel, Rost and Osterloh (2010) conducted a meta-analysis of performance-related pay in the public sector in Switzerland, and found that it improved performance in simple tasks such as administration and day-to-day work but not in complex jobs involving innovation and creativity. The authors concluded that government and practitioner communities need to be careful when adopting performance-related pay in the public sector, as it depends on whether the job is simple and easy to assess or complex and multifaceted. Likewise, Prentice, Burgess and Propper (2007) highlighting the negative consequences of the scheme, studied the application of performance-related pay in the UK public sector with mixed results. Although performance-related pay was found to have a positive effect on employees' performance, it had some negative consequences such as the development of a gaming situation where employees manipulated the results in order to qualify for increased pay. Furthermore, the authors point to a lack of studies on performance-related pay in the public sector, emphasising that further research is needed in order to enhance our understanding.

In another UK study, Marsden and Richardson (1994) concluded that employees working for the Inland Revenue found performance-related pay to be de-motivating. Commenting on this study, Dowling and Richardson (1997) argue that Marsden and Richardson's findings were in some measure due to the fact that performance-related pay had only very recently been introduced into the organisation. A later study by Belfield and Marsden (2003) on the British public

sector confirmed that performance-related pay can have a positive effect on employees, but is subject to the size of the financial reward, the quality of goal setting and the nature of the performance appraisal. Other studies which are critical of the application of performance-related pay in the public sector included Kellough and Nigro (2002) and Courty and Marschke (2004), both of which took a positivistic approach.

Interestingly, most of the reviews on performance-related pay in the public sector have been carried out in the US. A possible explanation for this could be that this type of scheme was first introduced in the US, in 1978 (Perry, Engbers and Jun, 2009). The first review was conducted by Perry (1986), who assessed performance-related pay for public managers. The study was confined to research on individual performance-related pay systems that added performance increments to base pay. Perry's review of performance-related pay was based on studies conducted prior to 1985 and no positive effect was identified. Although the empirical base of the study was narrow, Perry concluded that performance-related pay in the public sector was invalid due to employee contract and information asymmetries, as supervisors lacked accurate information about employees' performance.

A well-known study by Ingraham in 1993 assessed performance-related pay in federal programmes in the US and Europe. From surveys and interviews with stakeholders from both continents, she identified a number of factors affecting the success of performance-related pay in the public sector. These include local and institutional conditions such as civil laws and the prevailing economic situation. She also suggested that the agenda for future research should include ascertaining how far performance-related pay is compatible with public sector culture, pointing out that diffusion of these schemes has occurred without consultation with local stakeholders. If local contexts are not taken into account nor employees consulted, there is a risk that performance-related pay schemes will become haphazardly diffused across countries, which can lead to problems of extra-organisational fit. In other words, pay schemes not only have to accord with organisational culture, but also with national culture. Thus, several authors (Ingraham, 1993; Co-operation and Development, 2005) discuss the relationship between the type of state and possibility of civil service reforms, lack of funds, and degree of centrality of the pay determinant process. According to these authors, performance-related pay is likely to succeed in a decentralised system.

Ingraham (1993) suggests that whether the context is an OECD country or a developing country, the nature and needs of the organisation should be identified before the performance-related pay implementation process begins. Ingraham (1993) phrased this as, 'ask what public organisations need, not what private organisations do' (p.5). When managers consider the local circumstances which would affect performance-related pay plans, they are more likely to design one that fits into the given organisational context.

In the same year, Kellough and Lu (1993) carried out a systematic review on the same topic, reviewing 14 empirical studies of performance-related pay. The study covered federal, state and local managers; public school administration; and non-supervisory and local government employees. The authors concluded that performance-related pay generally had little positive impact on employee motivation and organisational performance. In referring to a US Navy case of positive effect on performance, they pointed out that the effects of the performance-related pay scheme were confounded by other changes implemented simultaneously, as well as difficulties relating to the performance evaluation system and a lack of resources to fund the system at the appropriate level.

Another review by Perry, Engbers and Jun (2009) concludes that performance-related pay is not an appropriate reward strategy for the public sector. The authors examine the psychology behind adopting the scheme in the public sector and suggest that the scheme is copied by public sector managers in order to attain organisational legitimacy. The authors advise that the successful implementation of performance-related pay should take into account contextual factors such as employee and management perspectives, funds to run the scheme, and to what extent a scheme is aligned with the professional and institutional culture of the organisation. Advising practitioners and managers Perry, Engbers and Jun (2009) assert, 'Don't adopt conventional performance-related pay systems simply because everyone else is doing it. Consider the contextual contingencies and adopt accordingly' (p.46).

New public management and areas of literature in economics both take a positive stance towards the application of performance-related pay in the public sector, finding in general that performance is improved via increased motivation. However some studies highlight the difficulties of implementing performance-

related pay due to nature of the public sector, while others emphasise the acceptance of the scheme by those carrying out evaluations. For example, Burgess, Propper and Wilson (2002) suggest that due to the multifaceted nature of the public sector employees face multiple principals with different expectations, such as public and immediate management, as well as politicians. The presence of multiple principals means that employees are assessed from several different vantage points, making cohesive performance appraisal problematic (Atkinson, Fulton and Kim, 2014). In addition, some of the more complex jobs are more difficult to evaluate. A further point made by Dahlström, Lapuente and Teorell (2010) is that performance-related pay is more likely to be effective in those jobs where there is relative separation between the beneficiaries of the incentive scheme and those who manage it; if the interests of both overlap, then the scheme will be less credible.

Importantly, another criticism comes from the psychology and public administration discourse, where performance-related pay is perceived negatively. The theoretical basis of this argument lies in self-determination theory and public service motivation theory. The critiques suggest that performance-related pay is against the ethos of the public sector as it undermines the public service motivation of public-sector employees. Intrinsic motivation[3] and prosocial behaviour is critical to the public sector, where the focus of the employees is to serve members of the public. Likewise, Frey and Oberholzer-Gee (1997) and Frey and Jegen (2001) take the view that performance-related pay under certain circumstances crowds out intrinsic motivation (also known as Motivation Crowding Theory). Explaining further, the authors state that performance-related pay has two aspects, 'controlling' and 'supporting'. When performance-related pay controls intrinsic motivation it proves ineffective and undermines the intrinsic motivation (under certain circumstances), but when it supports intrinsic motivation, it 'crowds in' intrinsic motivation. Likewise, the public administration literature suggests that extrinsic reward undermines public service motivation and public-sector ethos, which is pivotal to public sector institutions (Gneezy and Rustichini, 2000; Perry and Hondeghem, 2008; Perry, Engbers and Jun, 2009)

[3] The difference between 'intrinsic motivation' and 'prosocial behaviour' is explained in detail in Chapter 4 (Section 4.4, p120).

The above discussion illustrates the diverse opinions of performance-related pay in the public sector. Some studies suggest that it improves performance in the public sector by increasing motivation, while others suggest that it has no significant impact. Likewise, another dominant view is that the scheme works against the spirit of the public sector as it erodes the prosocial motivation, which is deemed central in public institutions. We can see divided opinions on performance-related pay in the general public sector, and it will be interesting to next explore research in the healthcare context, in which the current study is empirically rooted.

3.5.2 Evidence from the healthcare sector

As in the general public sector, the spread of performance-related pay to healthcare in other countries is influenced by the success of the scheme in the US, which pioneered performance-related pay in its healthcare sector (Lindenauer *et al.*, 2007). In the context of healthcare, performance-related pay has multiple purposes. For example, some organisations focus on the performance of professionals (Liu and Mills, 2005; Mannion and Davies, 2008), while others emphasise their accountability (Rowe, 2006). Few use the scheme as a tool to improve the quality of healthcare service (Petersen *et al.*, 2006; Lindenauer *et al.*, 2007; Gillam, Siriwardena and Steel, 2012). Policy scholars such Doran, Fullwood and Gravelle (2006) and Campbell *et al.* (2007), who are active in the healthcare management field, suggest that performance-related pay has the potential to improve the quality and efficiency of healthcare delivery.

There is a growing trend towards the study of performance-related pay in healthcare, as the topic has begun to attract interest in the field in recent years. The literature in the healthcare sector suggests that there is a diversity of empirical approaches which focus strongly on OECD countries. Particular attention has been paid to the US and UK healthcare settings (Van Herck *et al.*, 2010). Britain began to implement performance-related pay in its NHS 1999, although some researchers maintain that official implementation did not start until 2004. As in other countries, the introduction of performance-related pay in the NHS was strongly influenced by the success of such schemes in US healthcare, and was intended to improve the performance and efficiency of healthcare professionals. Since its implementation, several studies have attempted to assess its effects. For example, Doran *et al.* (2006a) conducted a

survey across 8,000 family practices in the UK to gauge the effectiveness of the scheme since its implementation. The outcomes found a marked improvement in patients' experience of primary care. Similarly, Chalkley *et al.* (2010) report findings from NHS dental care and found that dentists' performance improved by 26% under the new pay system. Likewise, Campbell *et al.* (2007) analyse the effectiveness of the scheme in a stratified sample of British general practice focusing on care for coronary heart diseases, asthma and type 2 diabetes, and significant improvements were found in tackling the diseases. In a similar vein, Vaghela *et al.* (2009) conducted a study to evaluate diabetes outcomes under the national performance-related pay programme. The authors used data from 2004 to 2008, the results suggesting that the scheme contributes to increased achievement of targets and reduced problems of low performance. Other studies which show a positive effect of the scheme in Britain's healthcare include Millett *et al.* (2009) who show a positive result of the scheme on coronary heart disease across ethnic groups, Gillam, Siriwardena and Steel (2012) who found marked improvement in the quality of healthcare, and Van Herck *et al.* (2010), who found it controlled absenteeism in healthcare professionals. These authors all used a positivistic research paradigm to investigate the relationship of the scheme on performance in healthcare. Other qualitative research includes Campbell *et al.* (2009) who found improved quality targets, and McDonald, Harrison and Checkland (2008), who showed that the quality of service delivery was improved by the introduction of performance-related pay.

There are, however, other studies, which suggest that the pay scheme has either no effect on performance or leads to unintended consequences such as 'gaming'. For example, Gavagan *et al.* (2010) compared data from six hospitals before and after the introduction of performance-related pay and concluded it had no significant effect on performance. These findings were in line with the research of Chung *et al.* (2010), who studied the effect of a scheme on doctors in California. Similarly, highlighting the negative consequences of the scheme, Rosenthal and Frank (2006) found that in British healthcare, professionals focused more on tasks which were covered by performance-related pay and neglected those not included in the appraisal; a form of manipulation known as 'gaming'. Shen (2003) showed that after the introduction of performance-related pay, doctors chose cases which were more likely to respond to treatment in order to qualify for financial rewards. It also appeared that employers were guilty of

manipulating the results of performance appraisals. Other studies which have documented negative effects include Hillman *et al.* (1999), who found that performance-related pay failed to improve child immunisation statistics, Pearson *et al.* (2008), who found that the scheme did not improve the quality of healthcare, and Mullen, Frank and Rosenthal (2010), who also found no marked improvement in performance.

Most of the above studies appear to evaluate performance-related pay for targeted and easily measurable tasks in highly sophisticated and institutionalised environments. Therefore, such studies cannot be generalised to low-middle income countries where the healthcare institutions are in transition. In addition, to the best of the author's knowledge, the theoretical (Honda, 2013) and empirical bases of studies dealing with performance-related pay in the public healthcare sector are limited in the context of low-middle income countries (Eichler, 2006; Oxman and Fretheim, 2009; Witter *et al.*, 2013). Despite the paucity of studies on performance-related pay in developing countries, healthcare reforms have received some attention in recent years (Meessen, Soucat and Sekabaraga, 2011; Honda, 2013). Authors such as Witter *et al.* (2013) and Meessen, Kashala and Musango (2007) who have researched healthcare organisations in developing countries, suggest that the adoption of performance-related pay seems influenced by its success in the US and UK.

3.5.2.1 Studies published in the context of low-middle income countries (LMICs)

In recent years, reformers and policy makers have been considering performance-related pay as an innovative policy to improve the performance, quality and efficiency of public healthcare organisations in low-middle income countries (LMICs) (Hasnain, Manning and Pierskalla, 2014). In addition to this, Honda (2013) argues that performance-related pay is a means of progressing towards the achievement of health-related millennium development goals (MDGs). In the policy literature, the term performance-related pay is used interchangeably with terms such as performance incentives, result-based financing and performance-based financing (Eichler, 2006). In these areas of the literature, incentives have been targeted at healthcare recipients, individual healthcare providers, healthcare facilities, private sector organisations and government or public sector organisations (Oxman and Fretheim, 2009).

The definition of performance-related pay specifically within healthcare differs somewhat from Kessler and Purcell's (1992) general definition (as discussed in Section 3.3 of this Chapter) in the management literature. Further, performance-related pay in the healthcare organisations of developed countries is different to that in LMICs. Eichler (2006) argues that the difference between the two definitions is that in the context of developed country healthcare systems, the emphasis is on performance (defined as quality, accountability and reduced mortality), while in LMICs, the emphasis is on the achievement of targets (e.g. goals set by the regulatory bodies, such as polio or HIV vaccination of certain populations). According to Eichler (2006), 'pay for performance is defined as the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target' (p 5). Kessler and Purcell (1992) stress the productivity which is relevant to the industrial sector, while (Eichler, 2006) emphasises quality and the achievement of targets in the healthcare sector in developing countries. Terms for performance-related pay commonly used in policy literature are: result-based financing, performance-based incentives, pay for performance, performance-based contracting, conditional cash transfer and cash on delivery (which may be confusing for readers) (Witter *et al.*, 2013).

In the context of OECD healthcare, performance-related pay is generally described as a tool for improving performance, quality and efficiency (Cromwell *et al.*, 2011) However, in the LMIC context it has wider objectives that include 1) increasing the allocative efficiency of health services, 2) increasing their technical efficiency by better use of existing resources such as healthcare staff, and 3) increasing equal distribution of outcomes by encouraging expansion of healthcare services to remote areas (Witter *et al.*, 2013). Research with a focus on performance-related pay in the LMIC context is discussed below.

Eichler and Levine (2009) view performance-related pay as a way of changing the behaviour of healthcare employees. They explain how performance-related pay addresses issues of low efficiency in the LMIC context, and discuss the importance of having a well-designed scheme that is sensitively implemented. They use evidence from schemes in Haiti, Nicaragua, Rwanda and Afghanistan to support their recommendations.

In the context of LMICs, Basinga *et al.* (2010) conducted a randomised controlled trial to assess the effectiveness of performance-related pay among healthcare providers, based on the use and quality of child and maternal healthcare services in Rwanda. The study was conducted in 166 primary healthcare facilities. The results suggest that performance-related pay had a positive effect on the quality of several maternal and child healthcare services but had no effect on parental care and on timely completion of child immunisation schedules. The authors concluded that the scheme had the greatest effect on services with the highest payment (healthcare professional more focused on highest payment). Likewise, in the same country context, Meessen, Soucat and Sekabaraga (2011) reported that performance-related pay provided an opportunity for comprehensive reform and that the scheme could address structural problems in public healthcare services in LMICs. The authors argue that conferring more autonomy in exchange for greater accountability for performance-related pay provides health facilities with an opportunity to tailor services to the populations they serve. Policy makers can improve efficiency by strengthening management, and health performance-related pay can deliver a cross-sectorial model for result-based public finance management.

On the other hand, Ireland, Paul and Dujardin (2011) caution against recent optimism in performance-related pay approaches to healthcare reform in LMICs. They argue that empirical research needs to focus on why and how these interventions work in various settings and emphasise that there is still very little research into the side-effects of such schemes, their costs and benefits, and the views of the employees. The authors acknowledge that performance-related pay could play a significant role in improving performance, although they take the view that such results-based interventions on their own may not bring about an adequate response from employees, and that further robust research is needed.

Likewise, Witter *et al.* (2013), in their review of performance-related pay in LMICs, point out that the whole notion of performance-related pay is based on the powerful assumption that individuals and organisations are motivated to perform better when offered financial incentives. Witter, along with other authors, shows that the scheme is being increasingly applied in a variety of ways and contexts, and with varying objectives, but with the overall expectation that it will improve the performance of healthcare systems. Witter *et al.* (2012) and Honda (2013) point to the growing body of research on performance-related pay

in the LMIC context and cite recent studies which have found evidence to support its effectiveness.

On the other hand, Ireland, Paul and Dujardin (2011) find that there is very limited research on the factors necessary for successful implementation of performance-related pay schemes in public healthcare in LMICs. Cochrane's review of Witter *et al.* (2013) on performance-related pay in LMCs concluded that 'almost all dimensions of potential impact remain under-studied, including how external and internal factors influence the success of these scheme, intended and unintended impact on health outcomes' (p 6). This is an important gap, since performance-related pay is increasingly viewed as a potential intervention to target systemic change and improve healthcare systems in LMICs.

Interestingly, research by Witter *et al.* (2011) into performance-related pay arrangements in international NGO-led health projects (Save the Children, US) in the Battagram district of Pakistan found improved general provision but unclear effects of the performance-related pay elements. The authors used mixed methods to give quantitative analyses of the health management information system, financial records and project documents from 2007 to 2010, as well as qualitative analysis of interviews with stakeholders at all levels. The authors concluded that the Save the Children US project had contributed to the rebuilding of the district health services and achieved substantial growth in outputs. The staff, managers and clients were appreciative of the gains in availability and quality of services. In the short term, with the help of an international NGO, the performance-related pay component proved a useful tool to achieve targets.

Lagarde and Blaauw (2009) reviewed literature that was published in the contexts of both developed and less developed countries. The focus of the study was the whole of healthcare, not just the public sector. The authors contended that performance-related pay has not been very effective in the healthcare sector, although they acknowledge that their review was based on secondary data and lacked an evidence-based perspective. The authors concluded that performance-related pay is more likely to depend on design features such as performance measures, payment conditions, and acceptance from employees and, more importantly, whether the payment is made to the healthcare organisation or to the individual.

Eldridge and Palmer (2009) conducted a systematic review of literature on performance-related pay in LMICs and found that the concept of the scheme varies greatly in terms of who is making payments and what is meant by performance-based. These authors describe the agenda for future research and include an assessment of optimal conditions for the implementation of performance-related pay in LMIC contexts. Furthermore, they emphasise the need for further in-depth research that records the experiences of employees and management, and how they deal with the implementation of performance-related pay. In addition, such research should highlight the related contextual factors and local conditions such as political will, institutional setting, role of governing bodies and public-sector bureaucracy that influence the successful implementation of performance-related pay and how performance is defined and measured in a local context.

Witter *et al.* (2012), in another systematic review on the effects of performance-related pay on healthcare outcomes in LMICs, compared the findings of nine studies from eight different countries. The studies consisted of mainly positivist research featuring experiments and surveys, and Witter notes that performance-related pay is not a uniform intervention but rather an umbrella term for a range of approaches. The success and effect of performance-related pay depends on the interaction between several variables, including the intervention design, availability of funds, ancillary components such as technical support, and contextual factors, including the organisational context in which the performance-related pay scheme is implemented. The author highlights weaknesses in current research and suggests that it is lacking in quality as well as quantity. Questioning the quality of recent studies, she points out that some of the findings may be misleading and that areas of potential impact remain under-studied, such as the acceptance of performance-related pay by public healthcare professionals.

To the best of the author's knowledge there are only four systematic reviews published which examine current literature on performance-related pay in LMIC healthcare sectors. All these reviews suggest that there are large variations in how performance-related pay schemes operate. According to the reviews, almost all dimensions of potential impact remain under-studied, particularly the perception of the different stakeholders of the healthcare system and how they see the performance-related pay in their institutions. There are methodological

issues in the current evidence base and, in particular, there is a lack of conclusion about the net effect of the schemes, most of which are part of larger reforms (Honda, 2013; Witter *et al.*, 2013). In addition, all of the studies conducted in the LMIC context discuss the effect of performance-related pay on performance, target achievement, and other performance indicators. However, they ignore discussion of public healthcare institutions i.e. to what extent performance-related pay is relevant in public healthcare and how public healthcare professionals perceive the scheme in the context of LMICs.

The KP government in Pakistan has recently implemented performance-related pay in three Peshawar teaching hospitals as part of the MTI reforms, which is the first phase of implementation. The reforms provide us with an ideal situation in which to explore the perspectives of public healthcare professionals on performance-related pay, how local institutions see it working in their healthcare system, and how different stakeholders perceive it in terms of motivation, performance and relevancy. In Pakistan, many researchers and policy makers have recently called for pay reforms in public healthcare to improve the performance of healthcare staff. It will thus be particularly interesting to see how these key stakeholders view the introduction of performance-related pay. This provides an opportunity to fill a gap in the field and answer questions raised by many prominent authors in the field, such as Eldridge and Palmer (2009), Ireland, Paul and Dujardin (2011), Witter *et al.* (2013).

3.5.3 Outcomes of the review synthesis

A key aim of the literature review is to assess studies on performance-related pay in the public sector in order to deepen our understanding from multiple perspectives. A synthesis of the research on performance-related pay points to some interesting ideas; these include research trends, methods and approaches used in the reviewed publications, the positive and negative effects of performance-related pay schemes in developed and developing countries, and, importantly, the success of the scheme in healthcare as compared to the general public sector. The section below provides a summary of the literature reviewed and highlights the research gaps. A list of the studies reviewed is given in Appendix (A).

Research on performance-related pay in the public sector: An emerging trend

An examination of the literature shows that the number of studies of performance-related pay in the public sector has increased considerably over the last 25 years. From 1993 to 1999 only 7 such studies were published. However, between 2000 and 2007 the number increased to 24, and between 2008 to date (2017) 41 articles were published. The sharpest rise in publications occurred between 2005 and 2011, possibly because of the introduction of performance-related pay into Britain's NHS in 2004. Since then, many researchers have attempted to assess the effectiveness of the scheme. Figure 3-3 below illustrates the increase in public-sector performance-related pay research.

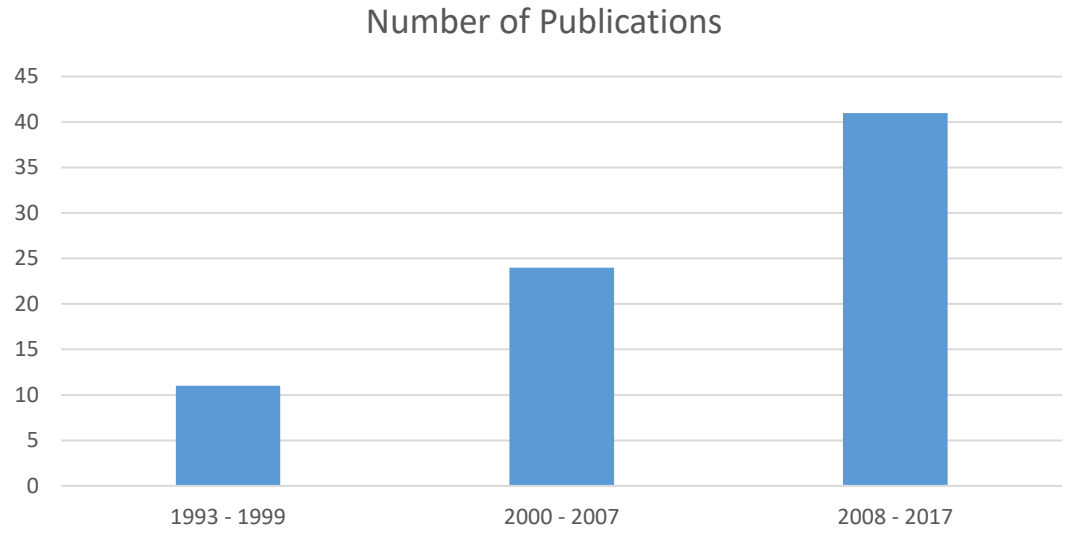

Figure 3-3: Emerging research trends: Publications on performance-related pay from 1993 to 2017 (author's own findings).

Most of the studies were carried out in the context of developed countries, that is, the US and Europe. Eight of the papers reviewed the outcome of performance-related pay in healthcare sectors in African countries. Surprisingly, only five of the studies focused on the South Asian context, despite the fact that GDPs of South Asian countries are higher than those of African countries. This points to a gap in the discourse, and a low focus on performance-related pay in the public sector in the Asian context. Therefore, attention needs to be paid to conducting research on performance-related pay in the public sector of Asian countries such as India, Pakistan or Sri Lanka, which have stable economies. Table 3-2 below

provides information about the type of sectors and country focus in the literature.

Table 3-2: Sectors and countries included in the empirical review

Sectors Studied	Country Context
Services, Transportation, Healthcare Administration, Teaching, Police, Public Sector, School, Primary Healthcare, Administration, Hospitals, Municipal Service (Garbage Collection), NGO's, University, Sports, Tree planting, Taxation.	United States, United Kingdom, Italy, Mexico, France, Pakistan, Brazil, Canada, China, Zambia, India, Rwanda, Burundi, Congo, Tanzania, Haiti, Switzerland, Brazil

Just over half (56%) of the public-sector performance-related pay literature consisted of quantitative research influenced by the positivist paradigm, while 12% used mixed methods and, surprisingly, only 4% relied on qualitative methods influenced by the phenomenology paradigm. The remaining 28% of publications were systematic reviews, eight dealing with public sector studies and twelve with healthcare. Interestingly, none of the studies used the critical realist paradigm. This breakdown of the research methods is illustrated in Figure 3-4 below.

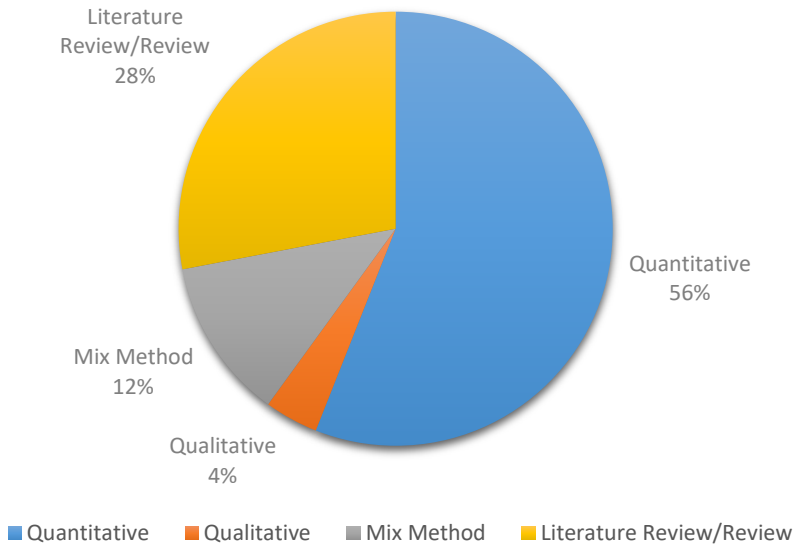

Figure 3-4: Research methods used in the studies under review (authors own findings).

An interesting point to emerge from the literature is that studies on performance-related pay in the context of developing countries show more positive results than those in developed countries. At the time of writing only 19 studies exist on performance-related pay in the developing world and this number is too low to allow robust generalisations to be made with any degree of confidence. So, we can see the potential of performance-related pay in a very different set up, but to the best of the author's knowledge, no research has been conducted to discover why performance-related pay has been accepted in some contexts rather than others, and existing theories even suggest that material based incentives such as performance-related pay is less likely to be applicable in a developing country context. Thus, further research in this area is highly recommended. Study contexts are illustrated in Figure 3-5 below.

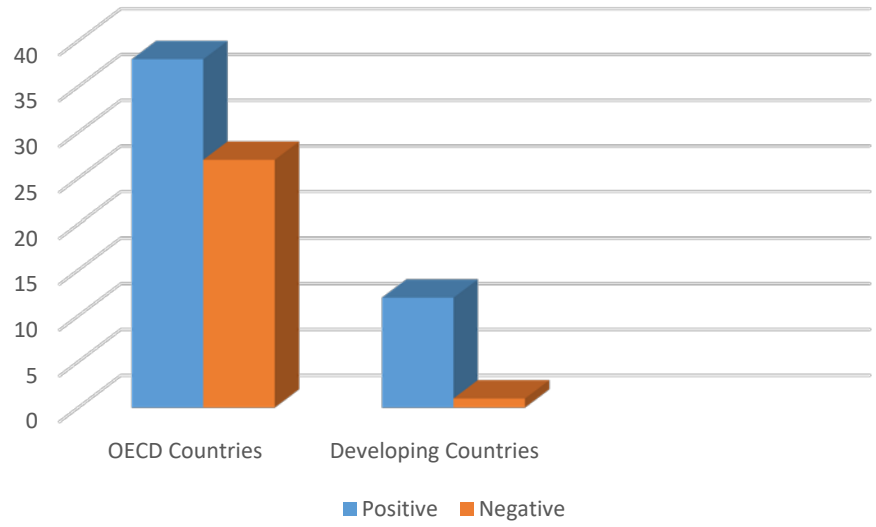

Figure 3-5: Number of studies by sector and country context (author's own findings).

The studies were conducted in different sectors such as healthcare and general public sector that included administration, taxation, bureaucracy, police and municipal. Performance-related pay was found to be successful in terms of increased performance and other side-effects (such as attraction and retention of skilled and qualified staff) in healthcare compared to general public sector, as shown in Table 3-3 below.

Table 3-3: Findings of studies by sector and country context – source: author's own findings

Country Context	General Public Sector	Healthcare
OECD	38	27
Positive	17	21
Negative	21	6
Developing Countries	1	12
Positive	1	11
Negative	0	1

3.5.4 Summary and research gaps

Our empirical review of the relevant literature from 1993 to 2017 shows a marked inconsistency in research findings on the application of performance-related pay in the public sector. The lack of consensus among the research community on the application of the scheme in the public sector means there is no clear basis on which readers and practitioners can form their decisions. A study of the costs and benefits of the performance-related pay in the public sector has been called for by the research community in several publications (e.g. Ingraham; 1993; Anderson and Pallesen, 2008; Hasnain, Manning and Pierskalla 2014). Perry, Engbers and Jun (2009) asserted that, 'Research needs to be conducted in a range of outcomes to help sort out the trade-offs associated with performance-related pay' (p 48).

Another feature of the literature is the general atmosphere of confusion surrounding performance-related pay and its effects, particularly seen in studies published on the general public sector. For instance, in the public administration and psychology literature, the scheme has been depicted negatively, with claims that it undermines the prosocial behaviour of public employees and that it works against the spirit and ethos of vocations such as the healthcare and education professions. On the other hand, the literature of New Public Management, economics and policy suggests that performance-related pay is important in changing employee behaviour. Thus, we can see a dichotomy in how these disciplines view public-sector performance-related pay schemes. A robust research endeavour to incorporate these contrasting perspectives and take a multi-theoretical approach in a single study could address this issue and provide clearer guidance to the academic and practitioner communities as to the extent performance-related pay is relevant to the public sector (Ingraham, 1993; Perry, Engbers and Jun, 2009; Frey, Homberg and Osterloh, 2013). Such research is

timely as there is a current tendency among policy makers to mimic those policies that have shown some success in other countries in order to attain legitimacy (Ashworth, Boyne and Delbridge, 2009; Beckert, 2010; Laegreid and Christensen, 2013; Hasnain, Manning and Pierskalla, 2014; Greenwood *et al.*, 2017).

Existing research into performance-related pay focuses exclusively on the mechanical aspects of its reform; that is, how to measure performance, how much an incentive should be, the size of the incentive, and other factors – the 'closed system' concept. In addition, the current review shows that most of the empirical work has been carried out in the EU, US, and the Far East. Only very few studies (in Rwanda, the Congo, Vietnam and India) have investigated performance-related pay schemes in developing countries. To the best of the author's knowledge, no study has explicitly considered the contextual and social factors such as local politics, political economy, and cultural and local institutions. A study that encompasses all of these factors and takes a line of open enquiry is highly recommended by academics such as Ingraham (1993), Perry, Engbers and Jun (2009), Witter et al. (2013), Hasnain, Manning and Pierskalla (2014).

Another gap identified in the literature review is the lack of research on performance-related pay in developing countries. Reviews of performance-related pay schemes in the context of low-middle income countries suggest that the quality of current literature is very weak, particularly in evidence-based work, with a limited number of studies to date (Hasnain, Manning and Pierskalla, 2014). In addition, a high risk of bias has been found in the methodology of most of these studies. This point is raised in several publications, and particularly in reviews (e.g. Ireland, Paul and Dujardin, 2011; Witter, Toonen and Meessen, 2013). Research into performance-related pay in developing countries would both yield useful data and widen our understanding of how well it may integrate into different public sector employment structures. The research community needs to address this issue and a healthy debate on the effectiveness of performance-related pay in the context of public sectors in developing countries should be on the agenda of future researchers (Perry, Engbers and Jun, 2009; Meessen, Soucat and Sekabaraga, 2011; Witter *et al.*, 2013; Hasnain, Manning and Pierskalla, 2014).

3.6 Conclusion

This chapter has provided a review of the performance-related pay literature, with a focus on general public sector and healthcare. The general overview of performance-related pay schemes in the public sector was followed by a discussion of theories relating to performance-related pay from different disciplines. A detailed review of the performance-related pay literature published between 1993 and 2017 was presented, and an analysis of different perspectives on performance-related pay revealed a number of unanswered questions. This chapter provides the foundation for Chapter 4, which identifies the theoretical orientation needed to address the research gaps identified thus far.

Chapter 4: Theoretical Orientation

4.1 Introduction

The purpose of this chapter is to present the theoretical positioning of the study. Taking influence from the type of reform in the case hospitals and the research gaps identified in Chapter 3, four theoretical concepts are introduced and a case is constructed for each concept and its related theory. After outlining the theoretical debate, the theoretical constructs are then summarised in the light of the study context, which also shapes the research question. The chapter concludes with a description of the micro-meso-macro framework of analysis used to investigate the MTI reforms in the case hospitals.

4.2 Positioning the research idea

In order to orient the work, four theoretical concepts are brought into the study. Several factors influenced the choice of concepts, including the research gaps identified in Chapter 3 and the nature of the public healthcare sector in Pakistan. As outlined in Chapter 2, the provincial government introduced an amalgamation of New Public Management style reforms into the three public teaching hospitals in Peshawar, KP, Pakistan. In planning the reforms, the government worked with a number of external professionals to review policy and formulate what would become the MTI Act of 2015. The Act stipulated four basic changes to the structure of the KP public healthcare system, which were decentralisation, financial autonomy, a new performance appraisal system and the introduction of performance-related pay in the public teaching hospitals. The four theories that were found to be relevant to the overall aim and context of this study are briefly described below.

4.2.1 New Public Management

Two major waves of radical reform in public administration have taken place within the last two hundred years. The first, known as progressive era public administration, represented an attempt to professionalise the public sector by ensuring that promotion and selection were granted on merit rather than

patronage, and by creating fair rules for all, free from any political influence (Hood and Peters, 2004; Dunleavy *et al*., 2006; Manolopoulos, 2008). The second wave emerged in the 1980s with a new form of managerialism known as 'New Public Management' (Laegreid and Christensen, 2013). The concept of New Public Management was introduced by Hood (1989) in response to the reforms announced by the conservative government in the UK under Mrs Thatcher. The sole purpose of New Public Management was to make the public sector more efficient and accountable by introducing modern human resource practices, often incorporating a culture of competition and disaggregation, and by rewarding best performers with financial bonuses (Dunleavy and Hood, 1994; Hood and Peters, 2004; Bovens, Goodin and Schillemans, 2014; Hood and Dixon, 2016). Highlighting these new interventions in the public sector, Hood (2000) and Pollitt and Bouckaert (2011) argue that public sector organisations are under constant pressure to improve efficiency, which leads to the introduction of many market-driven management practices in the public sector. Elaborating on the diffusion of market-based approaches in the public sector, Manolopoulos (2008) suggests that in this rapidly changing world, policy makers need to change their approach towards public management and should develop a performance-oriented culture. Such diffusion is witnessed in many public-sector areas such as university education, teaching, Inland Revenue and healthcare.

The impetus for New Public Management institutional reform is heavily based on the assumption of a public choice approach, principal agent theory, and transaction cost economics and rationale of administrative practice (Brinkerhoff and Brinkerhoff, 2015). The underlying philosophy of New Public Management reform is the belief that the private sector is more efficient than its public sector counterpart (Alonso, Clifton and Díaz-Fuentes, 2015). In this style of reform, political roles such as voters, bureaucrats, regional politicians, elected representatives and other interest groups, including international bodies such as the International Monetary Fund and World Health Organisation, are all viewed as important stakeholders in the process (Kaboolian, 1998; Dahlström, Lapuente and Teorell, 2009).

New Public Management reforms have varied widely in scope, depth and success, depending on the country; however, one of the main goals of reform in most countries is to improve the performance of public institutions by eliminating the

barriers of slow bureaucracy (Drechsler, 2014). Policy initiatives are driven by the need to maximise productivity and efficiency, goals which have hitherto been hampered by the kind of 'bureau-pathology' which includes lengthy and obstructive bureaucratic procedures that render public institutions unresponsive to the needs of those they were intended to serve, as well as tolerance of self-interested and power-hungry politicians (Kaboolian, 1998; Pollitt and Bouckaert, 2011). Laegreid and Christensen (2013) and Osborne (2010) both highlight the common assumption that politicians are congenitally venal and use their office to enrich themselves, friends and relations. However, the true extent to which bureaucrats and power elites obstruct institutional efficiency is difficult to determine, and methods to eradicate corrupt bureaucracy in developing countries are the subject of much controversy.

However, concerns have been raised by the scholarly community on New Public Management based reforms in the public sector. Criticisms include the inherent contradictions between New Public Management (Denhardt and Denhardt, 2000; Brinkerhoff and Brinkerhoff, 2015), adaptations of a market-based model of decentralisation and enhanced coordination between public sector organisations (Kaboolian, 1998; Bryson, Crosby and Bloomberg, 2014), and the movement towards privatisation and public sector entrepreneurship, which may undermine democratic and constitutional value such as fairness, equality and participation (Terry, 1998; Wiesel and Modell, 2014). Others, such as Perry, Engbers and Jun (2009), question how international the New Public Management reforms have been and how many successful examples there are. The proponents of New Public Management counter this by stating that there is no 'yes' or 'no' answer to this, and that although policy makers seem to have entrenched pro- or anti-New Public Management views, other stakeholders may have different opinions on both the justification and meanings of this brand of reform and its outcomes.

New Public Management theory has widely influenced many local and national government policy innovations. Depending on the political economy of the country, this type of reform has been implemented in the public sector with varying degrees of success, leading to research and debate in the academic community (Kaboolian, 1998; Laegreid and Christensen, 2013). Highlighting reforms in the public sector, Hood and Peters (2004) argue that most of the developed nations have gone through the reform process in order to improve

public employee performance and to meet civilian expectations. These countries were particularly influenced by the concept of New Public Management and introduced market-based approaches to manage their public sectors; each country introduced these approaches for its own reasons. For example, Pollitt and Bouckaert (2011), reporting evidence from the UK, suggest that New Public Management was introduced to counter the effects of the recession and tackle the inefficiency of the public sectors. Likewise, Manolopoulos (2008), reporting from the Greek public sector, argues that the authorities introduced New Public Management practices in Greece to counter the role of bureaucracy and change the culture of public office. Similarly, the Co-operation and Development (2005) source book states that Norway introduced the practice of decentralisation of hierarchal structures in order to afford the public sector greater autonomy. The diffusion of this approach can be clearly seen in many public-sector areas such as university education, teaching, internal revenue agency and healthcare. One recent debate in the field concerns the spread of New Public Management from OECD countries to countries such as Japan, Bangladesh and Singapore (Laegreid and Christensen, 2013; Brinkerhoff and Brinkerhoff, 2015; Ashraf and Uddin, 2016). The reformers advocate the homogeneity of all organisations and adopt policies from other countries in tackling public sector problems, claiming legitimacy from the success of the reform in the home country. Institutional theory can provide us with further guidance in this regard.

4.2.2 Theory of institutional isomorphism

Institutional isomorphism is the process by which changes across organisations result in the homogeneity of those organisations. The concept is explored by DiMaggio and Powell (1983), who suggest that once organisations become institutionalised, they grow more and more like each other via three different mechanisms. The three types of organisational isomorphism are coercive, which relates to power; normative, which is the instinct to conform for success; and mimetic, in which organisations copy an institutional model (Beckert, 2010). However, the distinctions between these three types are often blurred in reality (DiMaggio and Powell, 1991). The first mechanism identified by DiMaggio and Powell (1983) is ‘coercive’ change, which occurs when organisations are pressured to conform by other organisations on which they depend, or by

cultural and social expectations. The coercive drive is the strongest mechanism, since when institutions become discredited, hegemonic power[4] influences them to initiate the reforms. These mechanisms begin with powerful external actors, political pressure, or external regulatory bodies which exert pressure on the institutions (Scott, 2013). Beckert (2010) asserted that 'isomorphic changes occur if existing institutions have been thoroughly discredited and at the same time, if there is a powerful external actor who is able to enforce a new institutional design' (p 153). When institutions become discredited, hegemonic power tends to exert its influence to initiate institutional change. Cross-societal institutional adaptation based on external power over societies is well documented by post-war authors such as Beckert[5] (2010). Beckert argues that the victorious power jeopardises the existing institutions by imposing its own guidelines to rebuild new political institutions and corporate structures. For example, after colonialism the Weberian structure of public administration was adopted by Indo-Pakistani institutions. Likewise, public institutions can experience coercive pressure by governmental, regulatory or other political agencies, such as the International Monterey Fund and World Bank, to adopt structures which favour them (Thornton, Ocasio and Lounsbury, 2015). In the public sector, these pressures are political, often associated with health and safety regulations and contractual obligations with other actors. For example, neoliberal reforms in the public healthcare institutions dictated by the International Monetary Fund and World Bank (Homedes and Ugalde, 2005). Ashworth, Boyne and Delbridge (2009) further remind us that the role of coercive forces in institutional theory are more political than technical on organisational change.

The second source of isomorphic organisational change is normative pressure, which stems from professionalisation (DiMaggio and Powell, 1991). Beckert (2010) suggested that if coercive pressure is a push to initiate changes in institutions, institutional change can also be a pull factor to attract institutional

[4] Hegemonic power refers to states, governments, political parties and international political bodies like the International Monetary Fund and the World Bank.
[5] Beckert (2010) took a world society approach to explain institutional isomorphism and to explore the mechanism by which isomorphic change can also support the process of divergent change.

actors. Isomorphic changes occur when actors seek to imitate models that are interpreted as an attractive solution to the problems being faced. Such changes are voluntary, and the actors are motivated by the promise of great results after adopting such institutional models. When a successful model is available, actors can adopt it as a design template in their own context (Thornton, Ocasio and Lounsbury, 2015). A classic example of normative isomorphism is mentioned by Beckert (2010) in his article on institutional reforms in core public institutions in Japan during the Meiji period. Japan was pressured to adopt institutional templates from European states in core public service organisations such as the army, police and civil law, in order to gain acceptance as a sovereign nation. These particular models are adopted in order to save time in decision-making as they are already available. Likewise, Suddaby, Seidl and Lê (2013) argue that normative forces describe the effect of professional standards and the influence of professionals on organisational characteristics. Institutions adopt those systems and techniques to which they are expected to conform in order to attain legitimacy by relevant professions. Greenwood *et al.* (2017) remind us that institutional change will only happen if it is attractive, i.e. is perceived to be a 'good fit' by providing real solutions to issues of regulation. Models of institutional change can be similar to those of organisational training and networking in which normative and cognitive ways of thinking are standardised and diffused nationally and internationally within the organisation. However, if the model is not attractive enough, no change will result.

The third mechanism of isomorphic change is 'mimesis' (DiMaggio and Powell 1991; p 69). If an organisation is experiencing efficiency or certainty problems and cannot find the solution, an institutional template can be mimicked. In other words, when authorities come across organisational problems, they often copy a model which has been shown to be successful in another organisation. Conveniently, this strategy can also act as a protective shield, since if the adopted model or policies fail to achieve their objectives, the blame can be passed back to the original policy maker. Beckert (2010) states that 'since rational assessment for the best institutional designs are unavailable, the success of institutions operating elsewhere provides legitimation for using them as templates' (p 158). In researching new institutional theory, a number of authors (e.g. Meyer and Rowen, 1977; DiMaggio and Powell, 1983; Greenwood,

Oliver, Lawrence and Meyer, 2017, Ashworth, Boyne and Delbridge, 2009 and Thornton, Ocasio and Lounsbury, 2015) have explored the concept of mimetic isomorphism as a response to uncertainty. Their studies suggested that the ultimate reason for mimetic isomorphism is to legitimise and regulate a particular institution or field. Likewise, public sector reformers follow the same logic, as when public institutions are facing problems of uncertainty, reformers often become aware of innovative models that have proven successful elsewhere and transfer them directly to their own organisation (Park, 2014). The recent wave of public institution reforms in Asia, however, sometimes demonstrate attempts to gain legitimacy in which the culture and economics of the model's country of origin have not been checked beforehand (Ashraf and Uddin, 2016).

Scholars such as DiMaggio and Powell (1991) and Beckert (2010) suggest that institutional homogeneity is propagated via culture theory. Cultural models provide templates for institutional change, although there is no guarantee of success. Such imitation will be successful if the institutions perceive that the model is consistent with their cultural identity as well as political and economic interests. In discussing societal heterogeneity, Beckert (2010) cites the example of Western practices which are taken for granted, such as formal schooling for girls, standing in opposition to the policies of Islamic states which forbid them. Institutions may then reject templates which are not based on the same religious and cultural norms. However, the legitimisation of specific institutional models can be the driving force behind institutional homogenisation, despite the unknown (positive or negative) consequences. The mechanism can itself cause homogenisation or divergent institutional change, and the direction of change is dependent upon the conditions of legitimisation. In the current study the primary stimulus for using institutional theory as one of the constructs is to understand the reform process in terms of the New Public Management style practices which were introduced at the various levels of the public healthcare system in KP province, looking especially at how these practices are perceived by the actors in the local institutions.

4.2.3 Public service motivation

As mentioned earlier in the discussion of New Public Management, there are criticisms surrounding whether these reforms achieve what they promise.

Another criticism of New Public Management concerns the vocational nature of public-sector employment. Frey, Homberg and Osterloh (2013) remind us that New Public Management is characterised by a strong emphasis on the output performance measurement system, using performance-related pay according to output indicators. These theoretical concepts are built on self-interest and may not be entirely relevant to certain sectors. Further, Ingraham (1993), Horton and Hondeghem (2006) and Perry, Engbers and Jun (2009) remind us that New Public Management does not incorporate public institutional rules and norms and that its failure to do so highlights more powerful motivations such as public-sector ethics, civic duty, and professionalism, which may be more powerful motivators for many people to pursue public service. There are certain social service sectors and professions where 'prosocial behaviour[6]' is important, such as in education and healthcare. Ingraham (1993) and Perry, Engbers and Jun (2009) believe that institutional norms are important and that to offer financial reward in exchange for good performance is against the spirit of such institutions and undermines the ethos of prosocial behaviour.

Before taking the debate further, it is worth shedding light on the construct and meaning of public service motivation, since it varies across disciplines. In the fields of public administration, public management and political science, public service motivation refers to the driving force that underlies the actions of those who work in the industry. Perry and Wise (1990) provided the first conceptual definition of public service motivation as 'an individual's predisposition to respond to motives grounded primarily or uniquely in public institutions and organisations' (p368). Later, Rainey and Steinbauer (1999) defined it as 'general, altruistic motivation to serve the interests of a community of people, a state, a nation or humankind' (p 20). Most recently, Vandenabeele (2007) defined public service motivations as 'the belief, values and attitudes that go beyond self-interest and organisational interest, that concern the interest of a larger political entity and that motivate individuals to act accordingly whenever appropriate' (p 547). From the definitions above we can see that public service motivation is a

[6] Prosocial motivation takes a 'eudaimonic' perspective by emphasising meaning and purpose as drivers of effort, whereas intrinsic motivation takes a 'hedonic' perspective by emphasising pleasure and enjoyment as a driver of effort.

drive to help others which goes beyond self-interest. Sociologists and social psychologists tend to refer to this trait as 'altruism', which, according to Piliavin and Charng (1990) is defined in terms of cost and motive and should be central to the definition. To them, altruism is 'behaviour costly to the actor involving other-regarding sentiments; if an act is or appears to be motivated mainly out of a consideration of another's needs rather than one's own, we call it altruism' (p 30). Perry and Hondeghem (2008) remind us that scholars did not originally connect altruism with public service motivation, however, economists did connect the term and thus, public service motivation is thought of as 'code' for altruism, meaning 'the willingness of an individual to engage in sacrificial behaviour for good of others without reciprocal benefits for themselves (p 5).'

It is worth noting that in the field of organisational behaviour, the term 'prosocial behaviour' is used to cover a broad range of similar altruistic behaviours to those described above (Perry and Hondeghem, 2008). Prosocial behaviour in organisational settings was comprehensively defined by Brief and Motowidlo (1986) as, 'behaviour which is (a) performed by an organisation, (b) directed toward an individual, group, or organisation with whom he or she interacts while carrying out his or her organisational role, and (c) performed with the intention or promoting the welfare of the individual, group, or organisation toward which it is directed' (p 711). These authors preferred a broader definition, while others have proposed narrower ones which focus more specifically on the actor's motives. For example, Walster and Piliavin (1972) simply state that the act is voluntary and without expectation of reward. However, whether we use the term prosocial behaviour or public service motivation, we can see that the common ground between the different definitions is more important than the disciplinary difference (Perry, Hondeghem and Wise, 2010). The common theme is that of actions in the public domain that are intended to do good to others and shape the well-being of society. For the remainder of this study the terms public service motivation[7], prosocial behaviour and professional attitude are used

[7] It is pertinent to remember that in the literature, public service motivation is used to refer to work ethics, intrinsic motivation, public sector ethos, civic duty and professionalism interchangeably; but the philosophy and meaning refer to prosocial behaviour in the public sector.

interchangeably to mean the drive of an individual to help others in an altruistic and selfless way without expectation of reward.

The concept of public service motivation is highly relevant in any study involving public healthcare employees, since it could well be affected negatively by fundamental policy changes to employment structure. In the current study we aim to discover whether the doctors' reactions to performance-related pay affected their prosocial attitudes towards their patients. With reference to the context of the study and to the literature, there are two strands to the discussion. Firstly, Wright (2001) and Lyons, Duxbury and Higgins (2006) argue that public sector employees have a stronger desire to serve the public. They are strongly driven by a sense of vocation that is reinforced by their strong self-regulation based on their own ethical codes of practice (Brewer *et al.*, 2000; Horton and Hondeghem, 2006; Perry and Hondeghem, 2008). It is assumed that, generally, public sector employees have higher public service motivation than their private sector counterparts (Rainey and Steinbauer, 1999). Alonso and Lewis (2001) suggest that employees in organisations that rely on public service motivation are less likely to respond to utilitarian incentives, such as performance-related pay. They further believe that such incentives actually undermine motivation and result in lower motivation among the public-sector employees high in public service motivation.

However, many scholars (Rainey, 1982; Perry and Rainey, 1988; Crewson, 1997; Andersen and Pallesen, 2008; Liu and Tang, 2011) suggest that monetary reward is also valued by many public employees and serves to improve work performance, and that this also applies to health professionals (Taylor-Gooby *et al.*, 2000; Gosden *et al.*, 2001; Andersen, 2009). Crewson (1997) empirical research concluded that there is no significant difference between private and public-sector employees in terms of desire for money, and that public-sector employees value monetary reward just as much as those in the private sector. Crewson suggests that wages are a very important motivator and his study showed that eight out of ten employees responded positively to monetary rewards. Gabris and Simo (1995) also criticise the notion of public sector motivation and find that wages and monetary rewards are an important and equally strong motivator for both private and public-sector employees.

Contrary to the notion of public service motivation and the response of public sector employees to performance-related pay, studies by Andersen and Pallesen (2008) and Weibel, Rost and Osterloh (2010) also show that financial incentives motivate public-sector employees to redouble their work effort, and that higher paid workers produce better organisational outcomes. This finding is common to other studies, particularly in the healthcare setting (e.g. Taylor-Gooby, Sylvester, Calnan and Manley, 2000, Gosden, Forland, Kristiansen, Sutton, Leese Giuffrida, Sergison and Pedersen, 2001). Andersen and Pallesen (2008) suggest that employees exert more effort and are more productive when they are paid fees for their services rather than on a fixed salary basis. The exception is when strong professional standards for behaviour are in place; in such cases fees for service versus salary seems less important in determining individual behaviour (Andersen, 2009).

In a second strand of the discussion, performance-related pay has been criticised in the public administration and psychology literature as undermining public service motivation (e.g. Ingraham, 1993; Perry, Engbers and Jun, 2009; Belle, 2015). However, recent additions to the literature (e.g. Liu and Tang, 2011; Fang and Gerhart, 2012; Ledford, Gerhart and Fang, 2013; Stazyk, 2013) suggest that monetary rewards do not always undermine intrinsic motivation but that sometimes they crowd it in. The theoretical argument is explained by Frey and Oberholzer-Gee (1997) and Frey and Jegen (2001) as part of motivation crowding theory (discussed in Chapter 3; Section 3.4.5). Frey and Jegen's (1997) findings are in line with Andersen's (2008) study of a performance-related pay scheme in Danish Education Institutions. Andersen and Pallesen (2008) carried out empirical research in 162 Danish research institutions, and concluded that when perceptions of financial incentive were taken into account, the researchers were motivated to increase publications. However, this is contradictory to Andersen's study (2009) on Danish healthcare in which she found that doctors did not attach importance to financial incentives, and that they gave less importance to performance-related pay due to their high professional standards. Andersen's study is interesting because it was conducted within the healthcare sector and used doctors as research participants. She suggests that the field would benefit from 'more research on how professional norms, economic incentives and public service motivation jointly affect performance' and that 'future research will

hopefully compare professionals from different countries' (p 95), which provides a justifiable avenue to the research presented in this thesis.

It is clear that to date, research into the effect of performance-related pay on public service motivation has yielded contradictory results, although the more recent studies suggest that monetary rewards increase intrinsic motivation (e.g. Liu and Tang, 2011; Fang and Gerhart, 2012; Ledford, Gerhart and Fang, 2013; Stazyk, 2013). However, most of these studies have been conducted in wealthy industrialised countries, where the medical profession commands a high income. Further studies investigating the performance-related pay phenomenon in poorer counties with underpaid healthcare sectors should yield interesting outcomes.

Highlighting the non-static nature of public service motivation, Perry and Wise (1990) argue that public service motivation should be understood as a dynamic attribute that changes over time and, therefore, may change an individual's willingness to join and to stay with a public organisation. This infers that motivation is not permanent and can change over time. People may join public service because they want to serve the community, but this rationale may change over time for numerous reasons; for example, employees may need more money to look after their family or they may feel dejected if working conditions are poor. Also, Perry and Hondeghem (2008) identified that the values associated with public service motivation are quite different around the world. It is possible that the meaning of public service motivation differs from country to country and that the concept is more institutionalised in some than in others. This makes it difficult to assess public service motivation across cultures and countries. Therefore, researchers need to be cautious and take account of linguistic, contextual and cultural considerations.

Public service motivation continues to evolve, and although its meaning outside of the US has been unclear, in the last decade growing research into public service motivation in the European context has allowed the concept to be revised (Kim, 2009). The author believes that the meaning of public service motivation differs between societies, especially where public institutions are in transition in developing countries. The question arises as to whether or not public-sector employees in Pakistan are familiar with the concept. If not, how do healthcare

professionals tackle their jobs in the underpaid healthcare sector? Perry reminds us on several occasions (Perry and Wise, 1990; Perry, 2000; Perry and Hondeghem, 2008; Perry, Hondeghem and Wise, 2010) that the meaning of public service motivation varies across sectors (private and public) and nations. However, public service motivation scholars tend to ignore the concepts of culture, local institutions, and religion (which are a very important aspect of day-to-day life in certain cultures) in the overall concept of public service motivation, and the author believes that this is an important point which should be addressed in the overall concept of public service motivation. In addition, beyond the theoretical limitations of the public service motivation theory, it can be seen that most intrinsic motivation and public service motivation studies are laboratory based. We can resort to laboratory experiments, but their external validity is low, and, as Frey and Jegen (2001) argue, it is difficult to induce the perception of incentives experimentally. A gap is therefore noted in the overall concept of public service motivation and the research addresses this by investigating the sectoral and contextual environment that public service motivation exists in, and the perspectives of doctors in real world institutions.

4.2.4 National culture

Another theoretical concept that is important to this study is that of the specific culture in which new policies are implemented. The concept of culture is relevant here, because the MTI Act, which was highly influenced by New Public Management and comprises quasi-market-based practices (particularly performance-related pay), was designed to promote a performance-based culture in a very different institutional and cultural setting. In the literature of anthropology and social sciences, culture has been discussed from various perspectives. We shall now investigate national culture from a policy innovation perspective; that is, New Public Management practice and particularly performance-related pay acceptability in the collectivistic society of Peshawar, Pakistan.

In the literature of management science, it is argued that theories and policies around the world are culture-sensitive (Hofstede, 1993; Budhwar, 2003; Budhwar and Debrah, 2013). Theories and norms that are successful in Western culture may not necessarily apply to the rest of the world (Howe-Walsh and Schyns,

2010). Newman and Nollen (1996) define national culture as the values, beliefs, and assumptions learned in early childhood that differentiate one group of people from another, which has been shown to be a relatively stable component of countries. Hofstede (1993) painted an impressive picture of national culture, suggesting that it is the software of the mind, is deeply embedded in everyday life, and is fairly resistant to change.

In cultural and cross-cultural studies, the work of the anthropologist Hofstede (1980, 1983, 1993 and 2007) is particularly significant. Several scholars such as Brewster (1995) and Fernandez *et al.* (1997) have praised Hofstede's work on culture. Hofstede developed a multidimensional cultural model from his analysis of survey questionnaires administered to employees of the IBM Corporation in 72 countries. The bipolar dimensions he identified serve as a guide to understanding a culture; the dimensions of national culture, power distance, uncertainty avoidance, individualism, and masculinity, long-term orientation and indulgence.

Highlighting differences between Western and Eastern societies, in 1980, Hofstede introduced the terms 'collectivism' to (referring to Eastern societies) and 'individualistic' (referring to Western). Hofstede (1999, 2007) suggests that every culture contains elements of both individualism and its opposite, collectivism. Individualism implies a loosely knit social framework in which people are supposed to take care of themselves and of their immediate family only, while collectivism is characterised by a tight social framework in which people distinguish between in-groups and out-groups (family, clan, organisations) to look after them, and in exchange, they feel they owe absolute loyalty to the group. Hofstede (1999, 2007) pointed out that management theories and other human resource practices may be popular in the individualistic society but may not work in the collectivistic society, and the same applies to programmes and policies. He also advised that when employing theories and policies, policy makers and practitioners should not undermine the cultural context of the country. This is not only a matter of different employee values; there are also, of course, differences in government policies and legislation which usually clearly reflect the country's different cultural and sectoral positions, and there are differences between labour market situations and labour union power positions. Typically, universal policies that may work

out quite differently in different countries are those dealing with financial incentives, promotion paths and grievance channels. Hofstede (1980) characterised highly individualistic societies as likely to make widespread use of individual-based contingent rewards, and reward that emphasises individual recognition. Elaborating further, he argues that there is a tendency for performance-related pay to be acceptable in individualistic societies rather than in collectivistic ones (Schuler and Rogovsky, 1998). With respect to the aim of this research, which is to investigate New Public Management and performance-related pay in the public healthcare system of Pakistani culture, a collectivist society, Hofstede's dimension of individualism and collectivism relevant to this study.

There is, however, some criticism of Hofstede's doctrine; interestingly, we note that such criticism comes from recent publications in the field. Hofstede's main critic is a British anthropologist, McSweeney, who points out that most of Hofstede's work is based on IBM data from 72 countries (mainly the US, Europe countries, and few others). McSweeney (2002) suggests that based on such a limited sample we cannot generalise the outcome to another country's culture, especially an Eastern one. Jones (2007) and Baskerville (2003) raise other methodological flaws in Hofstede's analysis of the IBM database, suggesting that data obtained from a single multinational company do not have the power to unlock the secrets of entire national cultures. Jones (2007) further criticises Hofstede for selecting just two countries (Australia and Indonesia) in his analysis of individualism and collectivism, and suggests that one cannot generalise findings based on only two countries. We know that Hofstede developed his dimensions of culture 35 years ago, but since then the world has changed dramatically in terms of management and society. Culture and societies are increasingly fluid and dynamic over time and space (Griswold, 2012). Different cultures are merging, technology is changing and the way we communicate is evolving, particularly recently, and globalisation is changing the way we trade and interact.

However, the concept of individualistic and collectivistic societies is important for this discussion for two reasons. First, there are some studies (Baruch, Wheeler and Zhao, 2004; Bozionelos and Wang, 2007) which show that performance-related pay has been implemented successfully and accepted by

individualistic societies. Elaborating on this point, Adler and Jelinek (1986) suggest that the application of performance-related pay can apply to the context of both individualistic and collectivistic societies. The authors suggest that performance-related pay is common in individualistic societies, and that the egalitarian system is a common pay structure in collectivistic societies. Expanding on the application of contingent schemes in China, the empirical studies of Baruch, Wheeler and Zhao (2004) and Bozionelos and Wang (2007) suggest that a collectivistic society also favours performance-related pay in such a context. Unfortunately, there is very little research with which to robustly support this point and so the research community needs to include this in its agenda and undertake empirical research in the collectivistic culture context. Secondly, the world is changing and societies are non-static; hence in such a changing, technology-driven world, performance-oriented reward systems are becoming acceptable to collectivistic societies where life is different. For these reasons, researchers such as Jones (2007) and Baskerville (2003) consider that Hofstede's study is too old to be of any modern value, particularly with today's rapidly changing environments, internationalisation and convergence.

4.3 Summary of the theoretical concepts in the light of the context of the study

The government introduced New Public Management-based reform in three public teaching hospitals in Peshawar, KP with the aim of improving performance in the healthcare system. Recent changes in public sectors across the globe have led practitioners and policy makers to develop new management strategies to improve the performance of public institutions. As in other countries, the introduction of New Public Management-style ideas into KP healthcare was done with the mind-set of mimicking a successful Western model in order to attain legitimacy as well as improve performance. External experts were consulted to effect a restructure, which would bring it up to date and improve performance with particular focus on performance-related pay. In this way the newly-elected government kept its promises, but chose to implement pay reform in the public sector, where pro-social or altruistic behaviour is seen as an essential attribute of employees. The question is, what effect does performance-related pay (as advocated by New Public Management) really have on the performance of

service-motivated healthcare employees? The literature of New Public Management and economics holds that offering monetary reward is a successful way to stimulate extrinsic motivation in order to improve performance (as discussed in Chapter 3 and in Section 4.2.1 of this chapter). On the other hand, the literature of public administration and psychology suggest that performance-related pay can actually undermine prosocial motivation, which is central to social service institutions. Scholars such as Andersen (2009) and Le Grand (2003; 2010) remind us that the objective of public healthcare is to serve all patients equally regardless of wealth or status, and so prosocial behaviour and professional attitudes are imperative in public healthcare service. The dichotomy represented by these two strands of academic literature exemplifies how modern global business strategy poses a challenge to the integrity and ethics of public-sector service. In the case hospitals, the provincial government introduced performance-related pay as part of the MTI reforms in three public healthcare hospitals in Peshawar, KP which offers an opportunity to explore how doctors in the case hospitals perceive performance-related pay in their sectoral context, especially when the academic community has two extreme stances towards the application of performance-related in the public sector. Another underpinning construct of this study is Hofstede's cultural dimension of collectivism and individualism. The MTI reform was influenced by the doctrine of New Public Management, which advocates material based (non-egalitarian) practices, particularly performance-related pay, and Hofstede's cultural dimension of collectivism and individualism is relevant here, in that material based (non-egalitarian) based practices such as performance-related pay may be less likely to be applicable in a collectivist society like Pakistan. Studying MTI reforms in the KP public healthcare system gives us fertile ground in which to assess to what extent New Public Management and performance-related pay are relevant in a collectivist society.

The implementation of the MTI Act in 2015 led to a strike by doctors in Lady Reading Hospital, which was followed by industrial action in all of the primary and teaching hospitals in KP province, whether the MTI Act applied to them or not. The strike continued for 25 days, with doctors refusing to provide any healthcare services apart from emergency cover in public hospitals, this led to the government suspending the implementation of MTI reform for two months.

This captured the attention of both the national and international media, and the doctors were criticised by many as unprofessional. Beyond political statements and press reports, however, in terms of public awareness, very little was known about the actual terms of the MTI Act since it had only recently been passed. Accurate analysis, however, requires a thorough understanding of the context, and the identification of key questions. What were the MTI reforms and why did the government want to change the KP healthcare system? What were the government's motives, expectations and vision? What was wrong with the previous management structure? Further, how did the doctors and ward managers of the teaching hospitals perceive the MTI reforms? And finally, how did they perceive the new reward system i.e. the performance-related pay scheme embodied in the reform? From these questions, sub-questions were formulated as described below.

4.4 Research aim, objectives and questions

This section presents the overall aim, objective and questions in a logical and structured format. They are influenced by the research gaps identified in literature Chapter 3 and theoretical constructs (as discussed above in Section 4.2).

4.4.1 Linking research gaps with objectives and sub-questions

The overall aim of the research is to generate greater understanding of how modern western management practices are implemented in the public healthcare systems of developing countries. In particular, we look in detail at employees' reactions to the introduction of performance-related pay into the healthcare system. In order to address this, we have focused on specific recent healthcare reforms in three public teaching hospitals in Peshawar, KP province, Pakistan. Given the overall aim, the more specific objectives of the research are:

RO1 - To understand how doctors and ward managers perceive the organisational structure and human resource policies of KP public healthcare in three of the teaching hospitals before the reforms. Human resource policy includes recruitment, compensation, performance management and the reward system.

***RQ1.1**: What was the organisational structure of the KP healthcare before the reforms?*

***RQ1.2:** How did the doctors in the case hospitals perceive service structure and performance appraisal system before the reforms?*

RO2 - To clarify the rationale for the MTI reform and to identify how it was understood by the key stakeholders.

***RQ2.1:** Why was MTI reform introduced in the teaching hospitals in Peshawar, KP?*

***RQ2.2:** How did the stakeholders perceive MTI reform in the case hospitals?*

***RQ2.3:** Why did the doctors in the case hospitals oppose the Act?*

RO3 - To examine how MTI reform was implemented in the teaching hospitals.

***RQ3.1:** What factors are preventing the successful implementation of MTI reform?*

RO4 - To explore the perspectives of the doctors and ward managers in the public teaching hospitals of the performance-related pay scheme introduced as part of the MTI reform.

***RQ4.1:** How is performance-related pay viewed in the collectivistic society of modern Pakistan?*

***RQ4.2:** What is the effect of performance-related pay on doctors' professional attitude in the case hospitals in KP, Pakistan?*

The table below shows the translation of the research aims to the objectives and sub-questions, along with the specific issues and gaps which are the rationale for the sub-questions.

Research Objectives	Sub-Questions	Research Gaps Identified in Chapters 2, 3 and 4 (to be addressed)
RO1 To understand how doctors and ward managers perceive the organisational structure and human resource policies of KP public healthcare in three of the teaching hospitals before the reforms. Human resource policy includes recruitment, compensation, performance management and the reward system.	**RQ 1.1** What was the organisational structure of KP healthcare before the reforms? **RQ 1.2** How did the doctors in the case hospitals perceive the service structure and performance appraisal system before the reforms?	➢ No study found that presents the management of the Pakistani healthcare system in terms of HR practices such as recruitment and selection, goal setting, and performance appraisal. ➢ Lack of empirical studies investigating management in the public sector of developing countries (especially Pakistan). ➢ Lack of studies on the public healthcare system of Pakistan
RO2 & RO3 To clarify the rationale for the MTI reform, how it was understood by the key stakeholders and to examine how MTI reform was implemented in the case hospitals	**RQ 2.1** Why was MTI reform introduced in the teaching hospitals in Peshawar, KP? **RQ 2.2**- How did the stakeholders perceive MTI reform in the case hospitals? **RQ 2.3** Why did the doctors in the case hospitals oppose the Act? **RQ 3.1** What factors are preventing the successful implementation of MTI reform?	➢ No research on New Public Management in the public healthcare sector of Pakistan ➢ No study found in the literature that focuses on the application of NPM in the political economy of developing countries such as Pakistan. ➢ No study found that addresses the issues associated with the application of NPM in a politicised public healthcare system. ➢ No study found that presents a critical realist perspective on the application of NPM in the public sector. ➢ No study on MTI reform which takes the perspective of the policy makers and those who are affected by the reform
RO4 To explore the perspectives of the doctors and ward managers in the public teaching hospitals of the performance-related pay scheme introduced as part of the MTI reform.	**RQ 4.1** How is performance-related pay viewed in the collectivistic society of modern Pakistan? **RQ 4.2** What is the effect of performance-related pay on doctors' professional attitude in the case hospitals in KP, Pakistan?	➢ No research on performance-related pay in the Pakistan public healthcare sector ➢ No other study explicitly integrates the dichotomous views of public administration, psychology and economics and New Public Management literature in a single study in order to answer the question of whether performance-related pay is suited to the public healthcare sector ➢ No insight from the literature review on the application of performance-related pay scheme in the public sector, and no exploration of the micro-meso-macro level to overview the whole political-economic system of a country in general and Pakistan in particular. ➢ Very few studies on performance-related pay in the public sector of a collectivistic society such as Pakistan.

4.5 The analytical structure of MTI reforms: applying the micro-meso-macro framework

In order to better understand how the MTI reform was introduced and shaped in the teaching hospitals of Peshawar, KP, Pakistan, the author has used Erving Goffman's[8] micro-meso-macro framework of analysis (1974, 1986). Since this framework was first introduced, authors such as Ritzer (1985), Dopfer, Foster and Potts (2004) and Vliegenthart and Van Zoonen (2011) have added other factors, e.g. resource utilisation, politics, and experiences of individual reforms. By adopting this framework in the current study a greater understanding of the distributional impacts of the MTI Act can be achieved, which will influence a more informed and locally embedded process of policy review and design of healthcare reform. Further, the micro-meso-macro framework helps in data collection and analysis by helping to categorise the actors at different levels.

To identify how this framework applies to this study, we need to answer the following questions.

1) What do the terms 'micro', 'meso and 'macro' mean from the perspective of the MTI reform process?
2) How can these terms be conceptualised for this study?

The micro-meso-macro framework is used to examine how the MTI reforms developed from policy idea to programme implementation, as well as to analyse how the participants at each level understand the reforms. Using a variant of Goffman's (1986) framework, we first investigate the MTI reform initiative as a policy context (the macro level); then how the reform programme was shaped and implemented in the existing structure of the KP healthcare system (the meso level); and finally, how it was implemented in the case teaching hospitals (the micro level). The author is interested in the perspectives of the key stakeholders at each layer in order to fully understand the MTI reform in KP province. The

[8] Erving Goffman is one of the most widely-read sociologists in the history of the discipline, whose work is frequently cited in social and humanistic sciences. Goffman devised the micro-meso-macro framework to study how people understand situations and activities.

reason for adopting and translating the micro-meso-macro framework of analysis is to understand the MTI reforms by examining their adoption (acceptance/rejection) and interpretation, and the changes they made to the public healthcare system of KP province. This is done by exploring the interconnections between the meaning of the MTI Act, its purpose, and its effect on public healthcare across different hospitals levels.

Thus, the micro-meso-macro framework will help to generate an in-depth understanding of the MTI reforms in the public healthcare structure of Pakistan, by investigating the reform process at different levels, as a political initiative and in its policy context, and as a structural change affecting key employees and other stakeholders. The micro-meso-macro levels of data collection and analysis help to define and categorise the actors and show how the MTI reforms, on a national and local level, were developed and implemented in the KP healthcare sector. The actors working at the macro level are the visionaries behind the MTI Act, which specifically addresses the basis of the public healthcare system of KP province. They are defined as politicians and members of the board of governance in this study. The meso level is where the MTI Act begins to take shape as a specific programme in the KP healthcare system. Here, the author asks how actors (members of board of governance, doctors and ward managers) working at this level translate their understanding of the aims and objectives of the MTI reform as a policy into the working structure of the case hospitals. The micro level consists of the employees and the three case hospitals they work in. Here we look at individual experiences and examine perceptions of the MTI reforms, especially the introduction of performance-related pay. In practical terms, this level deals with how the Act is perceived, understood and interpreted by the doctors and ward managers in the case hospitals. Table 4-1 below highlights the micro-meso-macro level of analysis and how it translates to this research.

Table 4-1: The micro-meso-macro framework as applied to the study

Analytical level	Translation to this research
Micro- level	*Informants:* doctors at junior and senior level, ward managers local teaching hospitals Activity: implementation in case hospitals
Meso-level	*Informants*: members of the boards of governance, senior doctors and ward managers Activity: policy shape at KP healthcare level, understanding of the MTI reform in the KP healthcare system
Macro-level	*Informants*: members of the boards of governance, health minister Activity: trigger of reforms, at policy level, political level, national level

4.6 Conclusion

This chapter has established the theoretical positioning of the research and explained the four theoretical constructs on which the analysis is based. We have seen how the choice of constructs is guided by the research aims as well as gaps in the existing literature, and have explained how the research objectives and sub-questions were shaped and revised according to the context of the study. The chapter ended with an explanation of the macro-meso-micro framework used to analyse the data and present the findings of the research.

Chapter 5: Research Methodology

5.1 Introduction

This chapter describes the research method used in the study. The first section discusses the different philosophical stances available to researchers and constructs a case for using critical realism. Next, the research design and case study approach are explained, followed by descriptions of the data collection and data analysis procedures. Research ethics are discussed next, and the chapter concludes with the steps taken to address issues of research quality.

5.2 Research paradigms: ontological and epistemological considerations

Two questions are fundamental to academic research. The first asks how we know what reality is and the second asks how we can acquire and know that we possess valid knowledge. To answer these two questions, we must engage in an ontological and epistemological debate.

The first question is ontological, addressing the form and nature of reality and what can be known about these. Duberley, Johnson and Cassell (2012) explain that 'ontological assumptions deal with the essence of phenomena and the value of their existence' (p7).

From an ontological perspective the two main viewpoints are the objective and the subjective (Burrell and Morgan, 1979). Objectivism refers to a view of reality in which objects exist independently of social actors, while subjectivism deals with social phenomena and suggests that the interaction of social actors forms reality (Johnson and Duberley, 2000). Ontology therefore relates to meaningful questions of how things really are and how things really work. Denzin and Lincoln (1998) explain the ontological positions of the two dominant stances of positivism (also known as empiricism, post positivism or logical positivism) and social constructivism (also known as postmodernism, interpretivism, or the phenomenological stance) in a simple way. They argue that ontology relates to the question of whether reality is single, objective and concrete or whether it is subjective, multiple and created by people. For the positivist purist, reality is

single, objective and tangible, while for the social constructivist, it is multiple, subjective and intangible, being constructed socially by human interaction.

The epistemological question asks how knowledge is acquired, and how we know what we know. Denzin and Lincoln (1998) suggest two main stances of positivism and constructivism. The positivist position sees the world as a single reality and believes that knowledge can only be acquired objectively, directly and through tangible form. A typical positivist statement, for example, asserts that social research should adopt a scientific method that consists of the rigorous testing of hypothesis by means of data that take the form of quantitative measurements (Atkinson and Hammersley, 1994).

In contrast, social constructivists believe that reality exists in multiple forms, and that knowledge is acquired subjectively and is socially constructed by the way we interact with each other in daily life (Maxwell, 2012). Advocates of social constructivism suggest that observations of reality are never purely objective, and that they will always be biased according to the values and interests of those who are observing. However, where other people are the object of study, it is important to reach as full an understanding of them as possible to mitigate the influence of the observer's character and agenda. 'observation cannot be pure, altogether excluding the interest and values of individuals, investigations must employ emphatic understanding of those being studied, paradigm supports qualitative methods' (Tashakkori and Teddlie, 2010).

A research paradigm is the set of philosophical beliefs held by the researcher (Burrell and Morgan, 1979). Willis and Jost (2007) defines the paradigm as a 'comprehensive belief system, world view, or framework that guides research and practice in a field' (p.8). Guba and Lincoln (1994) state that paradigms are basic belief systems based on ontological, epistemological and methodological assumptions.

Creswell (2013) reminds us that there are three broad categories of paradigm in social science research - the positivist, the social constructivist and the critical realist - which express contrasting views and approaches. Elaborating on the difference between the first two (positivist and social constructivist) dominant paradigms, Gill and Johnson (2010) suggest that for quantitative purists, the laws of social phenomena should be studied as for physical phenomena. Social

science research should be generalised without restrictions of context and time. The social constructivist approach is different, in that qualitative research uses the concept of relativism to accommodate views of the individual and to acknowledge subjectivity and the existence of multiple realities (Denzin and Lincoln, 2011). Highlighting further the debate of epistemological stances, Duberley, Johnson and Cassell (2012) suggest that positivism can be applied to several disciplines, ranging from economics to accounting and is particularly useful in decision making. However, it does not take into account the views of individuals, due to determinism and reductionism.

Highlighting the limitations of positivism, Lincoln and Guba (1985) point out that the positivistic paradigm is unable to deal adequately with two crucial and interacting aspects of the theory-fact relationship; 'theory induction' and 'theory ladenness of the facts'. Elaborating on this point, positivism cannot determine theory and nor is it capable of theory induction (open), but rather it believes in the deduction (closed) of theories. The theory-ladenness of facts is the apparent impossibility of dealing with facts that are not themselves theory-determined.

The argument in favour of qualitative research is the value it puts on constructivism, realism and humanism (Johnson and Duberley, 2000). However, the problem associated with social constructivism is the fact that the data collection process is highly labour-intensive and time-consuming (Patton, 2002). Another argument against social constructivism is the interpretative nature of data, which can lead to weak findings, thus challenging traditional notions of generalisability (Guba and Lincoln, 1994). Positivism and social constructivism would therefore appear to have generated purist but opposing viewpoints.

5.2.1 Critical realism: The paradigm of choice

The paradigm debate has led scholars towards a third approach which combines these two stances, positivism and social constructivism, into another ontological position known as 'realism'. It suggests that what our senses tell us is the true reality, but also that objects exist regardless of whether we observe them or not. In other words, reality exists regardless of the human mind, and researchers need to adopt a scientific approach in order to create knowledge (Fleetwood and Ackroyd, 2004).

Critical realists assume that the world exists independently of our knowledge of it, and that this knowledge is by nature fallible and theory-laden. Bhaskar (1975) divides the social world into three interrelated yet distinctive layers, the domains of the empirical, the real and the actual. The empirical is the domain of observation; the real is the domain of mechanism and the actual is the domain of events (Bhaskar, 1989; Sayer, 1992). In other words, the 'empirical domain' is where observations are made as experienced by the observer. However, events occur in the 'actual domain' which may not be observed accurately by the observer. Events occur as a result of mechanisms, which operate in the 'real domain'.

In praising this unique approach to reality, Johnson and Duberley (2000) argue that the critical realist questions the simplistic ontologies of positivism and social constructivism. Positivism can limit scientific measurement, while social constructivists believe in a reality as experienced and interpreted by the social actors only. In response to this, critical realists suggest that reality is deeper, more complex, and comprises the three layers the empirical, which correspond to experiences; the actual, corresponding to events and behaviour; and the real, corresponding to structures and mechanism (Sayer, 2000;2004). Hence, critical realism identifies the underlying causal mechanisms which generate the tendencies for observable phenomena (Bhaskar, 1989; Sayer, 1992).

Critical realism has been chosen as the research philosophy in this study. The study aims to generate a deeper understanding of the MTI reform in the teaching hospitals of Peshawar, and this is achieved by exploring the perspectives and opinions of key stakeholders in these hospitals. It is important to reiterate that a micro-meso-macro frame of analysis has been used in order to gather a wider range of informed opinion on the reform. Thus, central to the research questions are opinions and perspectives of actors at different levels of the healthcare system – employees, management, and policy makers.

The nature of the research questions is such that neither positivism, nor social constructivism, offers an adequate framework for a response. For example positivism lacks a deeper understanding of human viewpoints and emotions due to its philosophical position. Revisiting the research questions of this study shows that human perspectives, emotions and experiences are central to their nature. Social constructivism also has limitations, such as not allowing objective

views and, importantly, often has an inability to acknowledge causal links and connections at micro, meso and macro levels, the three layers of analysis, which form an integral part of the study.

On the other hand the ontological stance of critical realism provides a firm foundation for investigating social reality in depth. Critical realism provides us with a stratified ontology with which to investigate reality further and explore the underlying causal mechanisms (Sayer, 1992). This study aims to gain a deeper understanding of MTI reform in the teaching hospitals of Peshawar by exploring the perspectives of key stakeholders on the structure of KP healthcare system. The nature of public healthcare in KP is complex (stratified ontology), with the government attempting to introduce a stratified system (MTI reform) into the existing structure, necessitating careful examination of the political economy, local politics, local institutions and culture of KP province. Further, the structure of KP healthcare is multi-layered, containing many actors/agents at different levels of hierarchy (politicians, boards of governance, ward managers and doctors) who all have the ability to influence each other. Critical realism thus provides a way of exploring and understanding this complexity. As Pawson and Tilley (1996) remind us, we can use the framework of critical realism to demonstrate the multi-layered nature of reality, and to explore the mechanisms by which social events are interwoven and experienced across these different layers.

5.3 Research design

There are several ways of carrying out qualitative research in social science investigation, such as biography, ethnography, action research, grounded theory and case study. For quantitative research, the approaches include experimental, survey, cross-sectional and longitudinal studies (Creswell, 2013). Punch (2013) suggests that strategies of inquiry are types of qualitative, quantitative or mixed methods designs or models that provide specific direction for procedures in a research design. In the literature, inquiry is also referred to as approaches or research methodologies. To be consistent with the terminology the author uses the term ‘approaches’ for the remaining discussion. Each approach has its advantages and disadvantages. The researcher’s decision to use a particular research approach is based on the research question/s, study phenomena,

research philosophy, available resources, experience and personal interest. The following section constructs the argument for case study research.

5.3.1 Case for case study research

The author applies the case study as research approach. Case study research is one of the main research methods in organisational and management studies (Baxter and Jack, 2008). It has been employed successfully in a variety of situations and disciplines, particularly in business research (Boyer and Swink, 2008). Yin (2003) describes a case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, particularly when the boundaries between phenomenon and context are not clearly evident. Yin (2014) Eisenhardt (1989), Patton (2002) and Easton (2010) remind us of the benefits of case study research, which are summarised below.

5.3.1.1 Extent of control over behavioural events

Experimental research is more suited to contexts in which the researcher can manipulate behavioural events, whereas histories are the preferred method when the researcher has no access to, or control over events (Yin, 2014). On the other hand, case study can be suitable for situations where behaviour cannot be manipulated by the researcher (Creswell, 2013). This study focuses on healthcare reforms in the public teaching hospitals in the Peshawar where the perceptions of key stakeholders on reforms were explored without controlling their behaviours or thoughts.

5.3.1.2 Type of research question/s

Patton (2002) suggests that case study research can be used in many situations regardless of the number of research units involved and it enables researchers to gather thoughtful, in-depth data with the objective of studying 'why things are the way they are'. In case study research, the research questions are usually defined in terms of 'why' and 'how'; i.e. they are exploratory in nature (Yin, 2014). Taking guidance from the research question of this study, the author intends to arrive at an in-depth understanding of the MTI reform in the teaching hospitals of KP province, by asking 'how' and 'why' questions, such as why the

provincial government introduced MTI reforms into the KP healthcare system and how doctors and ward managers perceived the reforms in the case hospitals.

5.3.1.3 Focus on contemporary phenomena

In contrast to histories, case study research is based on contemporary events (Yin, 2014). This research focuses on the recent healthcare reforms in the public healthcare sector at the present time rather than in the past. Further case study research is appropriate in the exploration of problems on which the literature is silent, in the application or evaluation of new programmes/interventions, or where the theory is in an infant stage (Eisenhardt, 1989; Patton, 2002). The MTI Act is a very recent phenomenon in the public healthcare sector of Pakistan. There is not much written on MTI reforms and we have limited information on the topic; hence this study meets criteria of being concerned with a contemporary and under-researched phenomenon.

Several authors (e.g. Yin, 2014; Stake, 1995; and Eisenhardt, 1989) endorse the use of the case-study method in researching contemporary events and issues, and using case studies can be especially appropriate in the following research situations:

1) Describing real life phenomena which the researcher wants to investigate;
2) Explaining causal links between real-life interventions which are difficult to replicate in experimental or survey-based research;
3) Dealing with human judgement and perceptions of interventions or programmes in real-life situations; and
4) Covering contextual conditions which are relevant to the phenomenon under study.

In order to explore the perceptions of key stakeholders on the MTI reforms and performance-related pay in the public healthcare sector of KP, Pakistan, the study was conducted within the real-life context of the hospitals affected. The respondents were studied in real-life situations and their views about the new interventions were explored.

5.3.1.4 Flexibility in methods of data collection

Case research allows flexibility of data collection by using multiple sources of evidence through qualitative (e.g. interviews, observation, focus group discussion) and quantitative (e.g. survey, experiment) methods. It permits different ways of dealing with the research problem, enabling the researcher to understand the phenomena in depth (Patton, 2002). Due to the nature of the research question and type of inquiry, collecting data from multiple sources was critical to the research process. In the current study data was collected from various sources in order to generate greater understanding of the research problem in question. Primary data was collected from the in-depth interviews, participant observations, field notes and memos, while the secondary data was collected from reform documents such as the MTI Act, historical records, Annual Confidential Reports and governments reports on the healthcare reforms. Both sources were corroborated in the overall analysis of this study. Table 5-1 below summarises the different research approaches.

Table 5-1: Relevant Situations for Different Research Approaches

Strategy	Form of Research Question	Requires Control of Behavioural Events?	Focus on Contemporary Events?
Experiment	How, why?	Yes	Yes
Survey	Who, what, where, how many, how much?	No	Yes
Archival analysis	Who, what, where, how many, how much?	No	Yes/No
History	How, why	No	No
Case study	How, why?	No	Yes

Source: COSMOS Corporation, Cited in Yin (2009, p.7)

5.3.2 Case study design

All empirical research must have a research design. Merriam (1998) describes research design as a planned process of data collection, analysis and interpretation. Yin (2014) suggested that two key components of case design (1) research questions containing 'how' and 'why' questions and (2) the unit of analysis and with its definition of the case. Research questions of this study is disused in Chapter 4. Section below describe the unit of analysis along with the definition of the case.

5.3.2.1 Unit of analysis and defining a case

Yin (2014) argues that case can be conceptualised as an individual, a group of individuals, an organisation, a process, change, an intervention, an industry or a sector. Baxter and Jack (2008) suggested that a unit of analysis is the entity being analysed in a study and should not be confused with the unit of observation. Yin (2013) reminds us that the unit of analysis is determined by the formulation of the research question. After revisiting the research objectives and questions, it is evident that the purpose is to generate deeper understanding of MTI reform in the public teaching hospitals of Peshawar, KP. Thus, the unit of analysis can be defined as the 'perspectives and opinions of key stakeholders of the KP public healthcare system'.

5.3.2.2 Binding the case

Baxter and Jack (2008) mention that one of the pitfalls associated with case study research is the tendency of researchers to attempt too many objectives in one study. Yin (2014) suggests that placing boundaries on a case can prevent this and maintain the reasonable scope of the study. The boundaries indicate what will and will not be studied, and what is inside and outside the scope of the study. As evident in the research questions and the aim of this study in mind, we can define the boundaries of the case as being the public teaching hospitals in Peshawar, KP province, where the provincial government introduced the MTI reform – i.e. the Khyber Teaching Hospital (KTH), Lady Reading Hospital (LRH), and Hayatabad Medical Complex (HMC).

5.3.2.3 Number of cases and design choice

Although using a single case can be particularly appropriate for a completely new and exploratory piece of research (Eisenhardt, 1989). Yin (2014) argues that 'Single-case designs are vulnerable if only because you will have put all your eggs in one basket' (p 53). Unless there are any obvious restrictions such as limited resources, multiple cases are always preferred (Patton, 2002), with the ideal number of cases being a matter of debate. In approving the use of multiple cases, Eisenhardt and Graebner (2007) argue that this strategy has a distinct advantage over single case design in that it enables a broader exploration of the research question and theory. The findings and evidence from multiple case designs are often considered more complete and thus, overall, these studies are regarded as being more robust (Yin, 2014). Therefore, given the research questions and objectives, three in-depth case studies were conducted, one for each of the public teaching hospitals.

Yin[9] (2014) introduced a two-by-two matrix of case study design consisting of single case design (types 1 and 2) and multiple case design (types 3 and 4). Multiple case design allows replication logic and cases are treated as a series of experiments which confirm patterns drawn from others. In other words, putting it in the context of the study, each hospital includes multiple units of analysis (doctors, ward managers and members of board of governance) which were investigated, which represents (in Yin's 2x2 matrix) multiple case design with embedded units of analysis (type 4). Figure 5-1 below illustrates this.

[9] Yin's (2014) matrix consists of four case designs, i.e. single case with single unit of analysis (type 1), single case with multiple units of analysis (type 2), multiple cases with single unit of analysis (type 3), and multiple cases with multiple units of analysis (type 4).

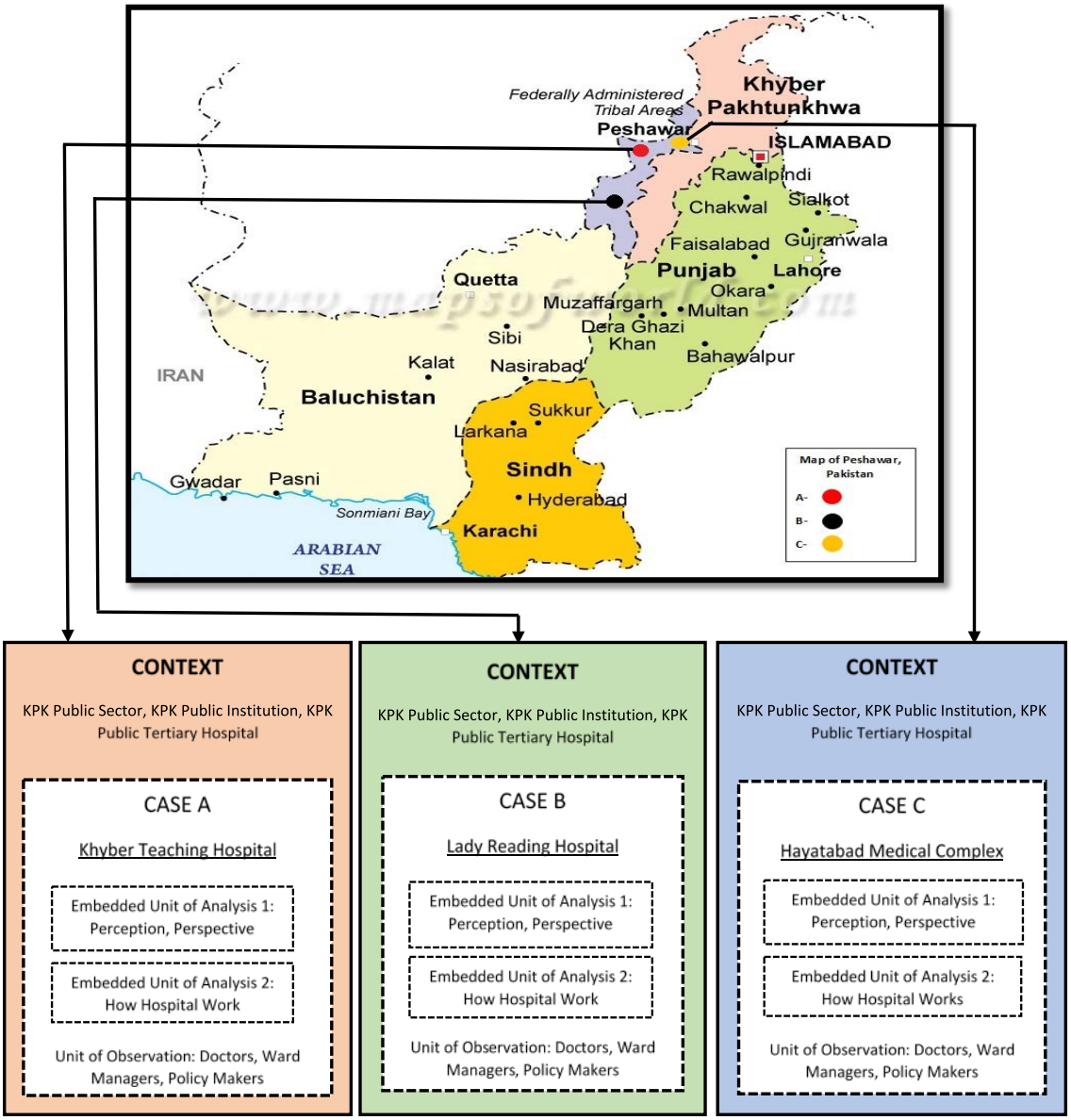

Figure 5-1: Multiple (Three) Case Design (Embedded: Type 4)

5.3.3 Case account

As mentioned earlier in Chapter 2, Section 2.2.6, in the first phase of the reform, the provincial government implemented the changes in three major teaching hospitals in Peshawar. These hospitals play an important role in serving not only Peshawar, but also patients from other parts of the province that need specialised and tertiary level healthcare services. Below is a brief description of each case hospital.

1) Khyber Teaching Hospital (KTH, CASE A)

Khyber Teaching Hospital, formerly Hayat Shaheed Teaching Hospital, is a university hospital located opposite the University of Peshawar. Khyber Teaching Hospital was established in 1976 and provides tertiary healthcare services to the local areas including Danish Abad, Tahakal and University-adjacent areas. It also receives complicated cases from Afghanistan. The hospital occupies over 962,000 square feet and is situated on the busy Jamrud Road. It is affiliated with the local medical colleges known as Khyber Medical College and Khyber Dentistry College. Students from these colleges visit the Khyber Teaching Hospital for their training. The medical colleges and the Khyber Teaching Hospital are within walking distance of each other and are connected by an over-head bridge on the Jamrud Road. Before the establishment of Khyber Teaching Hospital the medical students used to attend the Lady Reading Hospital for training. The hospital was commissioned as a scientific and research base in the province and as a teaching hospital for the Khyber Medical College. With a capacity of 1,202 beds, this hospital caters for 0.5 million patients a year. With massive increases in the urban population during the Afghan war (1978-98), the hospital's ability to serve the local population has been severely affected. Since the PTI government came into power there have been recent major developments, such as new blocks for institutional based practice, making it more effective, viable and productive for the stakeholders, i.e. patients, students, consultants, physicians and trainees in human resource development in the health sector.

2) Lady Reading Hospital (LRH, CASE B)

Lady Reading Hospital is located in the heart of Peshawar city. Named after the wife of the Viceroy of India, Lord Reading, Lady Reading Hospital is the biggest hospital of KP and one of the most important postgraduate medical institutes in the country, providing tertiary care facilities. Established in 1927, this hospital became affiliated with Khyber Medical College in 1956 with the medical, ENT, surgical, eye and TB wards. It is situated 200 meters away from the Grand Trunk Road, behind the famous historical Qila Balahisar, The famous Masjid Muhabat Khan, Ander Sher, Qissa Khwani Bazaar are across the road to Lady Reading Hospital. The hospital suffers from overcrowding, since it is in central Peshawar and also treats patients from adjacent areas such as Shahi Bagh, Sikanderpura,

Nasirpur, Saddar and the Defence areas. Since it was founded before independence, Lady Reading Hospital is highly regarded as a historical hospital serving Peshawar for more than 90 years. According to one estimate, the A & E department of the hospital caters for between 1,500 and 1,800 casualty cases per day while the OPD clinics are attended by more than 2,500 patients daily. Currently the hospital has the capacity of 2,000 beds, and is in the process of expansion in order to cater for the increasing patient load. The PTI government has allocated Rs 100 million for this extension, which also includes a new building for Institutional Based Practices for those patients who want to be served privately in the evening.

3) Hayatabad Medical Complex (HMC, CASE C)

Compared to Khyber Teaching Hospital and Lady Reading Hospital, Hayatabad Medical Complex is a slightly smaller hospital, located in the wealthy Hayatabad area of Peshawar. Hayatabad Medical Complex is a modern tertiary healthcare institute that provides acute healthcare services to the people of KP, FATA and adjoining areas of Afghanistan. It was established in 2004 and is situated on the Jamrud Road. Like Khyber and Lady Reading Hospitals, Hayatabad Medical Complex also provides tertiary healthcare services such as medical and surgical specialities in the fields of cardiology, paediatrics, plastic surgery, medicine, dentistry and orthopaedics. Medical students from Khyber Medical College and Khyber Dentistry College also attend for basic medical training. It has 800 beds. A total of 700 healthcare staff work different shifts in the hospital. Due to the porous nature of the adjoining border with Afghanistan, patients from Afghanistan are also served here. The hospital is comparatively newly established, however, due to recent construction and development in the Hayatabad and the adjacent areas, the hospital has become more crowded over the years. The government has estimated that in the next 10 years the hospital will struggle to meet local demand, and so has allocated Rs 50 million for the construction of three new blocks to cover the shortfall.

5.4 Data collection procedure

This section details the construction of the interview schedule, sampling procedure and data collection plan of the study. Several factors influenced the

choice of the semi-structured interview as the main data collection tool; these include research question, type of study, underpinning philosophy of this research and research design. The empirical data for the study was collected between September and October 2015. It is important to remember that at this stage of data collection, some of the reform measures had already been implemented in the case hospitals. For example, staff were now recruited on a contractual basis, salaries had been increased, performance-related pay was a reality, Institutional Based Practice (IBP) was enforced, and, as from November 2015, staff who opted for an MTI contract would not be able to run private practice. Thus, at the time the data was collected, implementation of the MTI reform was well under way.

5.4.1 Choice of data collection tool, construction of the interview schedule, and accompanying sampling procedures

In order to answer 'how' and 'why' questions, the semi-structured interview is employed as primary data collection tool in this research. Burgess (2002) reminds us of the benefits of using interviews in qualitative research; he argues that the interview provides an opportunity for the researcher to probe deeply and to uncover new dimensions of a problem under investigation as a result of the respondent sharing his/her experiences. Edwards, O'Mahoney and Vincent (2014) suggest that interviews provide a route for gaining access to the attitudes and emotions of the informants. In this study, the fundamental reason for using semi-structured interview was to obtain rich textured accounts of the MTI reforms from the multiple perspectives of the stakeholders of the KP healthcare system. The semi-structured interview enabled the author to encourage participants to share their experiences and stories of the MTI reform in the case hospitals.

The interview questions were inspired by the research gaps identified in the literature review and by the theoretical constructs of the study, as discussed in Chapters 3 and 4. Since this research aims to investigate MTI reform in the teaching hospitals in Peshawar the questions were designed to elicit the respondents' perspectives on the new interventions. At the beginning of each set of interview questions, general enquiries about background and cadre of the employee are made. The questions then move to respondent's reactions on the

previous management structure and human resource policies of the previous structure, then specific aspects of the healthcare reforms and finish with performance-related pay in the case hospitals.

The first three questions were guided by the first research objective and were designed to elicit information about the participant's role as well as HR policy before the reforms. Questions 4, 5, 6, 7 and 8 relate to the reforms and their rationale, and were inspired by the research aims and the two theoretical constructs of New Public Management and institutional theory of isomorphism. Likewise, Questions 9, 10, 11, 12 and 13 relate to the application of performance-related pay, drawing on public service motivation theory and cross-culture theory (see table in Appendix B). All of the questions were formulated to allow the respondents to talk openly on the topic, and further probing questions were asked depending on what emerged from the discussion. The interview questions were discussed with the supervisory team and amended accordingly (see Appendix C for interview questions).

A significant part of 2015 was spent in planning the collection of primary data. The author was in continuous contact with hospital authorities, formally and informally, during a 12-month period. In February 2015 the case hospitals were sent formal letters outlining the purpose of the study and requesting data. In May 2015, the necessary research ethics application forms were submitted; these included the interview guide, participant consent form and participant information covering all ethical issues (discussed in greater detail in Section 5.6). At the end of May 2015, the author obtained the department's ethical approval and data collection in the form of face-to-face interviews took place between September and October 2015.

5.4.2 Sampling procedure

Maxwell (2012) explains that selection of participants for a research study is known as 'sampling' which is more appropriate for quantitative studies than qualitative studies. He further argues that the aim of qualitative research is not to generalise the results to a larger population; rather the purpose is to understand the process, meaning and local contextual influences involved in the phenomenon of interest for the specific settings or individuals under question. Elaborating on the selection of 'cases' and 'participants' in qualitative research,

Patton (2002) argues that the guiding principal in selecting settings and participants for qualitative research is not representation, but to identify the phenomenon of interest and group of people that best fit the study. This is known as 'purposive sampling', which should provide 'rich information' about a phenomenon in question.

In the current study 'cases' and 'participants' were selected based on the author's own judgment of what and who would yield the richest insights. Referring to the research objectives and questions of the study, it is evident that its purpose was to generate deeper understanding of the MTI reform in the public teaching hospitals of Peshawar by exploring the perspectives and opinions of key stakeholders. As mentioned earlier in Chapter 2 (Section 2.2.5), the provincial government are implementing the MTI reform in phases. In the first phase the Act is applicable to doctors in the three teaching hospitals (Khyber Teaching Hospital, Lady Reading hospital and Hayatabad Medical Complex) of Peshawar. It means that other healthcare professionals (such as nurses and paramedic staff) in the case hospitals are exempt in the first phase of MTI. Thus, at employee level, the research participants are public sector doctors in the three case hospitals where the government are implementing the MTI reform. Likewise, at management level, the ward managers and HR director were selected from the case hospitals. These respondents are important stakeholders. The HR director is closely involved in the implementation process and attends many important meetings with the board of governance, so his perspective is vital to understanding the current level of implementation. Ward managers are responsible for their wards and write performance appraisals for their employees in the ward. Under the Act they now have a wider role as they will assess performance and make recommendations for performance-related pay. Likewise, the health minister and members of the board of governance were selected to give their views at the macro level, i.e. the rationale and political aspects of the MTI reform. Thus, the public teaching hospitals in Peshawar provide the context for exploring perspectives of the reform at all levels of the employment hierarchy. It is important to remind ourselves that since the Act is applicable to the doctors, performance-related pay is applicable to them as well.

It is interesting to note that after collecting data in the initial phases, some of the research participants nominated other suitable respondents, who were also

interviewed. A total of 45 interviews took place. The interview participants included three members of the boards of governance, one from each case hospital, five ward managers (four male and one female), the health minister and the HR director of the Khyber Teaching Hospital (male). The remainder comprised 33 male doctors and three female at junior [10]and senior level from the three hospitals. This information is summarised in Table 5-2 below.

Table 5-2: Sample of research participants

Name of Case Hospital	Level of Access						
	Doctors		Ward Manager	Member of BOG	HR Director	Total number of interviews in each case	Health Minister
	Junior	Senior					
Khyber Teaching Hospital (KTH) **CASE A**	6	10	3	1	1	21	1
Lady Reading Hospital (LRH) **CASE B**	3	5	1	1	0	10	
Hayatabad Medical Complex (HMC) **CASE C**	5	6	1	1	0	13	
Total number of interviews across three cases : 45							

5.4.3 Data collection plan

Data were collected via a three phase approach influenced by Patton's (2002) argument that acquiring an understanding of the field involves three stages; the entry stage, routinisation and analysis, and the closing stage. Each phase serves a different aim in the data collection process.

[10] In the context of the study, junior doctor refers to one holding an MBBS degree with no post-graduate training (Part 1 or Part 2), while senior refers to one with post-graduate training (done with Part 1 and Part 2); a few of the senior doctors were taught in medical colleges. These categorisations follow the criteria of the Health Secretariat.

a) Preliminary phase: Pilot study, established contacts, collected secondary data, informal discussion, preliminary interviews (semi-structured) and preliminary analysis
b) Build-up stage phase: Semi-structured interviews, secondary data, further analysis and report the research findings
c) Closing phase: discussion of research findings with participants

5.4.3.1 Preliminary phase

The case hospitals were visited for primary data collection between September and October 2015. A polite reminder was sent out to the management by email one month prior to arrival. All formal and ethical procedures were implemented before visiting the case hospitals. Once the author was granted an appointment, the hospital director personally introduced the author to other staff members and explained the study. The introduction helped in understanding the environment of the hospital in terms of management, operations and culture. Also, it helped to identify the key research participants who were to be interviewed in the preliminary and build-up phases. Once access was granted the author requested documents that included archival records, financial reports, performance appraisal form, government reports, and commentaries on the specific reforms under study. The author also requested permission to visit the case hospital in the following months. The purpose was to build a rapport with the potential respondents and understand the hospital system and the environment.

The interview questions were formulated in such a way as to encourage participants to share their experiences without hindrance. However, it was decided to pilot-test the questions in order to highlight any problems or design limitations. Sampson (2004) and Kim (2011) remind us that piloting a qualitative study enables the researcher to reflect on the efficiency of the data-gathering process and to identify flaws and weaknesses in question design. Three pilot interviews were conducted with two senior doctors and one junior doctor from Khyber Teaching Hospital. These Pashtun participants were fluent in English, and the 30-45 minute interviews were conducted in a mix of Pashto and English (which is how the respondents converse naturally). The fundamental purpose of the pilot interviews was to check that the participants had no problem in understanding the language used to ask the questions, which helped in

constructing validity by ensuring that all of the concepts were incorporated. After the pilot interviews some of the questions were rephrased to make them easier to understand and broad enough to allow participants to expand on their experiences and some of the technical terms were changed. For example, in the question regarding the importance of monetary reward, the term 'extrinsic reward' was replaced by 'money' and 'monetary rewards'. Likewise, the term 'public service motivation' was replaced with 'helping patients'. Patton (2002) reminds us that interview questions should reflect participants' normal conversational style in order to elicit honest and genuine responses. No major changes were made to the interview schedule.

After refining the interview schedule, the preliminary phase interviews were conducted at two of the case hospitals, the Khyber Teaching Hospital and Lady Reading Hospital. Interviews were conducted with the HR director, five senior doctors (four male and one female) and two junior doctors (male), two ward managers and one member of the board of governance (Khyber Teaching Hospital). In addition to collecting data, the preliminary phase was designed to develop the author's deeper understanding of the case hospitals in terms of background, management structure, pay and promotion systems, appraisal system and management system. In this regard, the hospitals were visited several times. During visits, important documents were collected for analysis; these included reform documents (MTI Act), performance appraisal form (the Annual Confidential Report), historical records and government reports on the reforms. The first batch of data comprised eleven interviews.

5.4.3.2 Build-up phase

As well as constructing an understanding of the context, the preliminary phase gathered information about the previous system and explored doctors' perceptions of the MTI reforms. Interesting information emerged during the discussions, such as the government's ban on private practice due to conflicts of interest, and this additional information was recorded by the author in the form of memos. The focus of the build-up stage was to explore doctors' perspectives of the MTI reform, why they accept or reject the new interventions, and their opinions on the implementation process. Particular attention was paid to their views on the new performance-related pay scheme. Likewise, the ward managers' views on the changes were immensely important. Ward managers are

not only responsible for ward management but also write Annual Confidential Reports (ACRs) for doctors. Similarly, at the macro level, the views of the health minister and members of the boards of governance are considered to be as important as those of the other employees in building up a bigger picture of reactions to the healthcare reform. In the build-up phase a total of 34 interviews were conducted across all three of the case hospitals, and included an interview with the health minister.

5.4.3.3 Closing stage

The fundamental purpose of the closing stage was to discuss research findings with respondents in order to increase confidence in the results and clarify any ambiguity identified during early analysis. The author took a summary of the research outcomes back to the field in September- October 2016 and discussed it with six senior doctors, four from Khyber Teaching Hospital (Case A) and two from Hayatabad Teaching Hospital (Case C). These respondents had also been part of the early data collection phase. The research findings were discussed with and validated by the respondents, hence there were no additions or corrections made to the original findings. Table 5-3 summarises the data collection process of this study.

Table 5-3: Data Collection Plan

PRELIMINARY PHASE: Develop Initial Contacts, Pilot Study, In-depth Interviews, Participant Observation, Secondary Data (September- October 2015)			
Type of Respondent	**Procedural Issues Prior to Data Collection, Pilot Interview Questions, Establishing Contacts**	**Length of Interview**	**Procedural Reminders During Data Collection Process**
HR Director (Case A)	It is vitally important to have approval from the hospital director in order to secure access to case hospitals. Informal discussion with the director helped to identify key stakeholders and to secure important secondary data such as government documents and historical documents.	60 min	The initial contact was made for informal discussion and to understand the culture of the hospital. Interview protocols and professionalism were maintained at all times.
Hospital employees (two senior and one junior doctor) Case A	A pilot study was conducted to refine the interview guide.	30-45 min	Recording was not undertaken during the pilot study; however, field notes were used.
Hospital employees (junior & senior level doctors – seven respondents from Case A and Case B) Case A and Case B and at management level two ward managers (one from each case hospital) and a member of the board of governance (Case A)	Interviews were conducted among doctors, ward managers and at board of governance level. During the discussion the respondents suggested other participants, who were then incorporated in the next phase of data collection.	60-80 min	Interviews were conducted in a highly professional manner and the interviewer (researcher) was dressed formally. Although professionalism was maintained, the discussion was kept informal and semi-structured allowing the respondents to discuss their answers openly.

Data Analysis Step 1: Create a File in NVIVO, Translate and Transcribe Interviews, Participant Observation, Secondary Data, Memo Writing			
BUILD-UP PHASE: In-depth Interviews, Participant Observation (October-November 2015)			
Type of Respondent	**Procedural Issues Prior to Data Collection**	**Length of Interview**	**Procedural Reminders During Data Collection Process**
Ward managers (two from Case A and one from Case C)	After several cancellations of the scheduled meeting an interview was conducted with the ward managers.	60 min	In-depth interview was conducted to incorporate the management perspective. The interview guide was used and questions were sequenced according to the respondent's answers.
Hospital employee (junior and senior doctor) Case A, Case B and Case C (28 respondents – junior and senior level)	More interviews were conducted within different case hospitals to incorporate perspectives from all case hospitals.	60-80 min	Initial analysis of the data collected during the preliminary phase helps to understand the overall situation of the case study and views on the changes. In addition to interview questions memos were also used to asked more questions.
Member of Board of Governance (each from Case B and C)	A member of the board of governance scheduled an appointment at short notice to report his view (in case C).	60 min	Views of the members of the BOG were vital as members are appointed by the regional government of KP to initiate the reforms.
Health Minister	After several cancellation of the scheduled meeting an interview was conducted with the health minister	30 min	In-depth interview was conducted with KP's health minister. His view of the healthcare reforms was immensely important.

DATA ANALYSIS BUILD-UP PHASE: Update the Database, Data Analysis, Write-up of Analysis and Summarise the Research Findings			
CLOSURE PHASE: Discus research findings with research participants (September-October 2016)			
Type of Respondent	**Procedural Issues Prior to Data Collection**	**Length of Interview**	**Procedural Reminders During Data Collection Process**
Research participants (Case A and Case C)	The research outcomes were discussed with six research participants and their feedback was recorded.	60-80 min	The research outcomes were summarised and discussed with research participants. Formal and informal discussion was carried out among doctors (at senior and junior level) and the author's interpretations of the data were discussed in greater detail.

To summarise the data collection procedure, the semi-structured interview was used as the primary data collection tool. A total of 45 interviews were carried out, 44 of which featured participants from the three case hospitals and the remaining interview was with the provincial health minister. Data were collected during September and October 2015 and the research findings were checked with the participants in September 2016. Other sources of data included the MTI Act (all three versions), employees' payslips, the Annual Confidential Report (ACR) form, and historical records from the case hospitals and the Health Secretariat. Table 5-4 summarises the sources of information for the study.

Table 5-4: Data sources in each case hospital

Case Category	Case	Interviews	Documentation
Public Teaching Hospitals In Peshawar, KP	Case A	Member of board of governance, HR director, ward managers, senior doctors, junior doctors	Government policy documents and MTI Act, payslips, historical record of the hospital, performance appraisal form (ACR)
	Case B	Member of board of governance, ward manager, senior doctors, junior doctors	payslips, historical record of the hospital
	Case C	Member of board of governance, ward manager, senior doctors	payslips, historical record of the hospital
Health Secretariat	N/A	Informal discussion with clerks on MTI reforms and a general discussion with the employment structure of previous system	Historical record of case hospitals and recent events on MTI reforms and other activities related to MTI reforms
Ministry of Health	N/A	Health Minister	N/A

5.5 Data analysis procedure

This section details the data analysis procedures employed in this study. The process of data transcription to verbatim text is explained. A case is constructed for the accompanying data analysis technique in the light of its suitability to the research objectives and related sub-questions, the underpinning philosophy, and the research methods. A database was established to manage all interview

transcriptions and secondary data. Numerous analysis techniques were employed to analyse the data that include Miles and Huberman's (1994) start list, field notes, memo writing and Dey's (1993) splitting and splicing technique for coding. Braun and Clarke's (2005) guidance was used to maintain quality in the analysis process of this study.

5.5.1 Transcribing data:

Data were collected in the native languages of the respondents - Pashto and Urdu. Before the start of any interview the author asked the respondents to speak in their native language which allowed them to express themselves more openly without any hindering language barriers. Most of the respondents understand and speak Pashto; however, two interviews were also conducted in Urdu. Since the author is from Peshawar and is fluent in both languages, no linguistic problems were encountered while conducting the interviews. All field notes, memos, transcription and analysis were written in English. The author did not use a professional transcription service for two reasons. Firstly, the author wrote field notes for each respondent, which were consulted during transcription, and memos were also written. Secondly, although the data transcription was the most time-consuming part of the research process, the author opted to respond to this challenge for the benefit of the research. A total of 45 recorded interviews were transcribed word-for-word so as to avoid the loss of meaning, and two 'rules' were followed. The first was the '24 hour rule' to complete all transcriptions and notes within 24 hours of the interview. The second was to include all data regardless of its apparent lack of importance at the time of the interview.

The qualitative software package NVivo version 11 was used to manage this study. A database was established in NVivo comprising the interview transcripts, audio recordings, memos, secondary data and analysed data. The NVivo program was only utilised to assist the author to manage the data efficiently; it did not have any role in the analysis process. The software program does not have any capability to make judgments about the data (Dey, 1993; Silverman, 2013). Scholars such as Patton (2002), Miles and Huberman (1994) and Saldaña (2015) highlight the benefits of using a software program in qualitative research.

5.5.2 Data analysis technique

In qualitative research there is a diverse range of data analysis techniques such as a grounded approach, narrative analysis, discourse analysis, content analysis and thematic analysis. Miles and Huberman (1994) suggest that a researcher should choose an appropriate technique for data analysis according to the type of study, research question and tools used in the data collection process. This research is influenced by the gaps identified in the literature review and prior theories in the field that shaped the research question of this study. The grounded theory option was discarded in this case. Choosing thematic analysis over content analysis was due to its pragmatic suitability with the realist/social constructivist paradigm of this study.

Thematic analysis can be conducted within both realist/essentialist and constructivist paradigms (Braun and Clarke, 2006) although both approaches are based on a 'factist' perspective. The author was interested in exploring the key stakeholder perceptions of the MTI reforms in the public teaching hospitals in Peshawar, KP province of Pakistan. To the best of the author's knowledge no study of these reforms has been published previously. The in-depth discussion with stakeholders and their narrative about the change programme was central to the aims of this research. Thus, thematic analysis is beneficial in such a case. The themes that emerged from the data were then compared with the literature in order to address the sub-questions of this study. It was suitable for answering questions such as why the provincial government introduced MTI reform in the teaching hospitals, how doctors and ward managers perceived this reform and how doctors and ward managers perceived performance-related in the KP healthcare system. All these questions were investigated in the KP teaching hospital in a naturalistic setting.

5.5.3 Steps in data analysis

The analysis presented in this study was based on data collected in the preliminary and build-up phases during September and October 2015. In order to validate the research findings, they were discussed with the research respondents during the closure phase of the thesis in September and October 2016.

Scholars such as Eisenhardt (1989) emphasise the active role of a researcher. Moreover, she advises us to employ different techniques in the same case research that add coherence to the analysis process. To address Eisenhardt's point, guidance was taken from Yin's (2014) source book, and various analytical techniques were employed, such as Miles and Huberman's (1994) start list, field notes, memo and tabular display and Dey's (1993) splitting and splicing technique of coding, which were particularly helpful in re-conceptualising the data and connecting the different themes that emerged as a result of coding.

Data analysis - Coding

Codes are labels or tags that are assigned to a chunk of descriptive data collected during a study (Miles and Huberman, 1994). A 'start list' of codes[11] was created to manage the initial set of data, and this helped with the preliminary understanding of the data. The initial list of codes was influenced by the sub-questions of this study; however, more codes were incorporated in the list as more data were collected. The interview was semi-structured so the respondents were allowed to speak openly. As the data was gathered, so the list of codes was revised and more codes were added. Initially transcripts were coded manually and were then transferred into NVivo 11 in the latter part of the analysis (See Appendix D for full codes). Initially, most of the codes generated were descriptive in nature; some of the codes were interpretative. The table below (5-5) presents a list of codes employed in the early steps of data analysis.

[11] It is important to remember that Miles and Huberman (1994) advise us to create a list of codes which should be influenced from the research questions and conceptual framework. The data collection should be closely aligned to the research question and conceptual framework that is more or less deductive approach. Since the nature of this study is exploratory, therefore, a start list was created by the author to guide the data collection process. The start list was revised with more codes as more data was collected.

Table 5-5: Initial Set of Codes

Short Description	Code	Sub-Question
PRE-REFORM ORGANISATIONAL STRUCTURE	***PRE-Ref - OS***	**RQ1.1- 1.2**
Human Resource Practices	*PRE-Ref – OS-HRP*	
Recruitment and Selection	*PRE-Ref – OS- HRP-Rec*	
Nature of the Job	*PRE-Ref – OS- HRP-NJ*	
Promotion System	*PRE-Ref – OS- HRP-PS*	
Performance Appraisal	*PRE-Ref – OS- HRP-Per Apr*	
Positive Aspect of Previous System	*PRE-Ref – OS- HRP-PA*	
Negative Aspect of previous System	*PRE-Ref – OS- HRP-NA*	
General Perceptions	*PRE-Ref – OS- HRP-GP*	
MTI REFORMS IN THE CASE HOSPITALS	***MTI-Ref-CH***	**RQ2.1-2.3& RQ3.1**
Rationale of MTI Reforms	*MTI-Ref-CH-Rat*	
Idea of MTI Reforms	*MTI-Ref-CH-Ide*	
Changes to the Previous Structure	*MTI-Ref-CH-CPS*	
Reasons For Resistance	*MTI-Ref-CH-RR*	
Implementation Process	*MTI-Ref-CH-IP*	
Main Obstacles in Implementation	*MTI-Ref-CH-Obs*	
Positive Aspect of MTI Reforms	*MTI-Ref-CH-PA*	
Negative Aspect of MT Reforms	*MTI-Ref- CH-NA*	
Future of MTI Reforms	*MTI-Ref- CH-Fut*	
General Perceptions	*MTI-Ref-CH-GP*	
PERFORMANCE-RELATED PAY IN THE CASE HOSPITALS	***PRP-CH***	**RQ4.1-4.2**
Rationale of the Scheme	*PRP-CH-Rat*	
Idea of the Scheme	*PRP-CH-Ide*	
Importance of the Scheme	*PRP-CH-Imp*	
Perspectives on the Scheme	*PRP-CH-Per*	
Organisational Culture	*PRP-CH-OC*	
Professional Context	*PRP-CH-PC*	
Cultural Context	*PRP-CH-CC*	
Positive Aspect of the Scheme	*PRP-CH-PA*	
Negative Aspect of the Scheme	*PRP-CH-NA*	
Future of the Scheme	*PRP-CH-Fut*	
General Perceptions	*PRP-CH-GP*	

Data analysis - Splitting and Splicing

An initial part of the data analysis involved the splitting and splicing of code (Dey, 1993). The purpose of splitting enabled the author to dig deeper into nuances of data and discover new information and ideas. The smaller chunks of data were assigned codes and the process of 'recontextualisation' (Tesch, 1990) was carried out whereby the data was reorganised in line with codes formulated during the data splitting process. The splitting process continued as new ideas and themes emerged from the memos and field notes. In some cases, data was spliced rather than split, which means that it was joined or integrated where this seemed logical, in order to add coherence to the analysis. The most straightforward example of splicing categories is simply to reverse-split them. Like splitting, splicing is an increasingly focused activity that enabled the author to select which data was the most appropriate for study. Splicing also helped to concentrate on central categories emerging from the early analysis, which were in line with the research questions.

Data analysis - Field notes and memos

Field notes were made while conducting interviews with the respondents. Patton (2002) reinforces the benefits of making field notes during interviews; these enable the researcher to observe important reactions to questions. In this study, therefore, any noticeable reactions of the respondents were noted, which enabled the author to revisit important points later. Apart from unusual responses and gestures, these notes contained ideas that emerged during the field study. The codes assigned to the field notes were marked in coloured pen and referred to a certain concept, theory, event, action or process. These field notes were particularly useful during memo writing, transcription, assigning codes and analysing data. Figure 5-2 below shows some of the author's field notes.

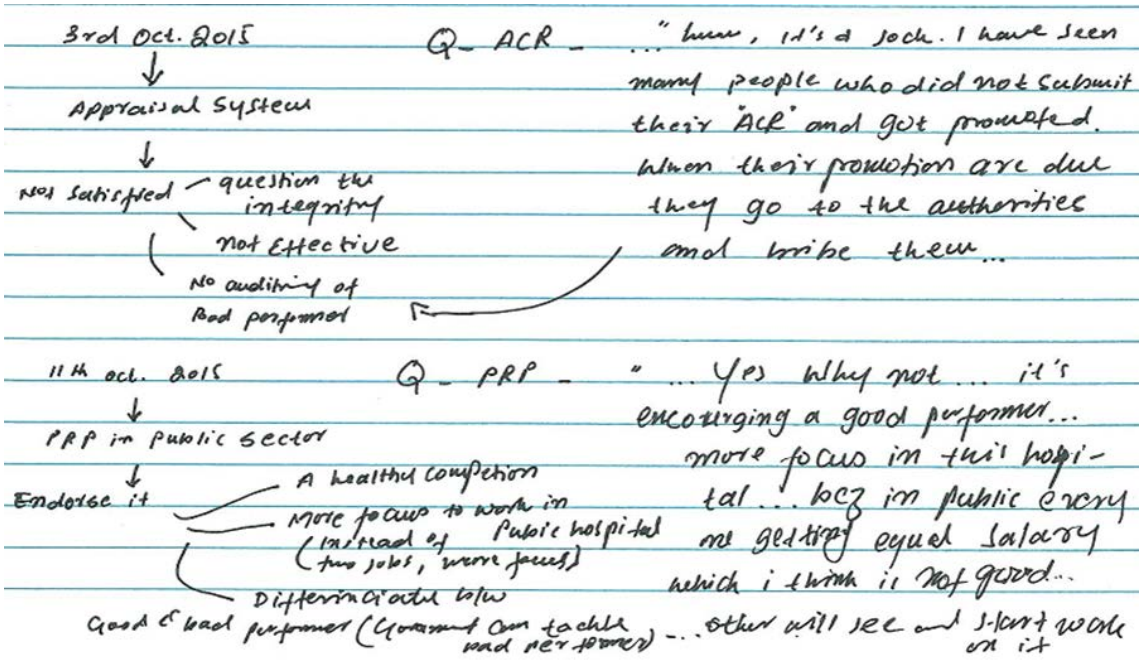

Figure 5-2: An example of the author's field notes

The transcripts were read several times to acquire an initial understanding of the data. The systematic examination of the text data proved to be a lengthy process. Miles and Huberman (1994) stress the need for the thorough examination of the text data and suggest that the researcher should read the documents several times. During reading and re-reading a marginal remark was made on the right side of the text document, while codes were marked with red pen on a transcript document. The process of coding and making marginal comments helped the process of thinking critically, and memos were written referring to certain themes, ideas or theories. Figure 5-3 below shows an example of the transcript with comments in the margin.

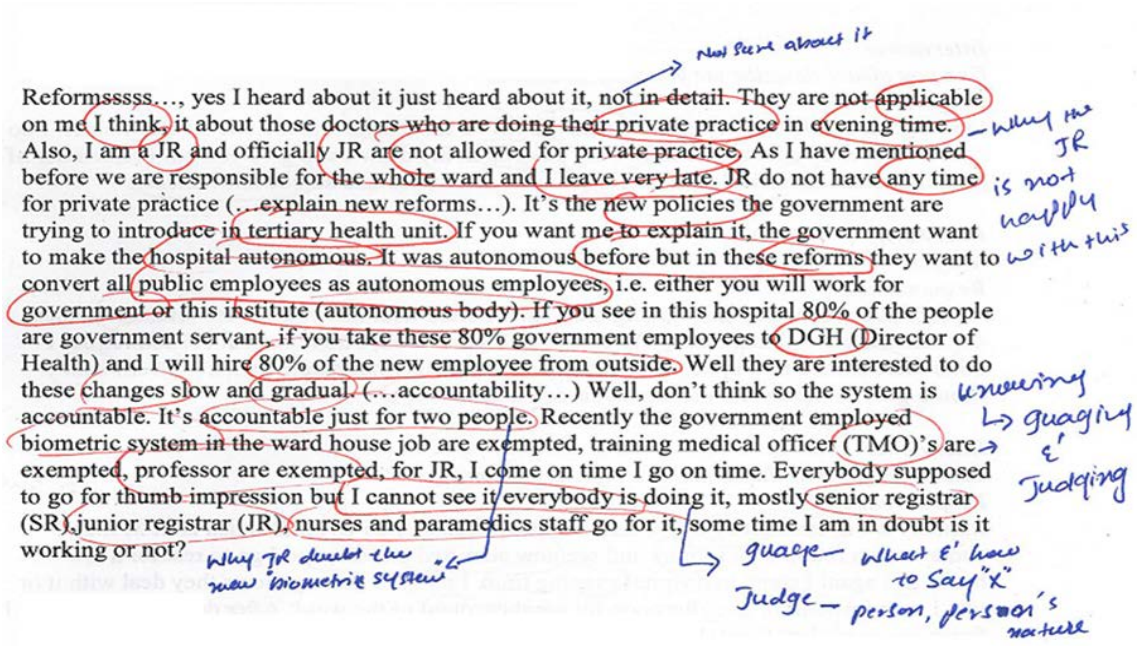

Figure 5-3: An example of a typical transcript with labelled data and marginal remarks

Data analysis- Case study documents and other secondary data

Case study research is one of the more distinctive and tolerant research approaches of all of the qualitative methods (Patton, 2003; Easton; 2010). It enables researchers to use multiple sources of evidence about the case in question (Stake, 1995; Patton, 2002; Yin, 2014). During the course of this study, many documents were collected; these comprised the MTI Act, employees' pay slips, Annual Confidential Report (ACR) documents and website information, among others. These documents were also corroborated in the overall analysis; in particular, the MTI document was very important.

Preliminary outcome:

As mentioned earlier, data from the initial eleven interviews revealed some interesting facts about the MTI reforms, which were then noted for further exploration; for example, why the government is banning private practice and how private practice leads to conflicts of interest. Thus the author wrote memos in order to elicit further information. Dey (1993) and Saldaña (2015) believe that analytical memo writing is a creative activity which can lead to the development of new ideas. Memo writing involves 'retroductive' interference and it enabled the author to apply counterfactual thinking, which helped in understanding the condition(s) under which certain things happened – i.e. cause and effect. Memo

writing was particularly beneficial during the analysis process. It helped new ideas to emerge and added coherence to the analysis. Memos were used in all three cases to make deeper and more conceptually logical sense of what is happening in the case hospitals. Figure 5-4 shows an example of a memo written during discussions at the Khyber Teaching Hospital (Case A).

Memo 05

Date: 02/10/2015

Site: Khyber Teaching Hospital

Theme: Private Practice and Conflict of Interest

There is a general perception that private practice is the main problem of the inefficient healthcare system. Why did respondents informally raise this issue? This needs further exploration. The MTI Act also implicitly states that 'private practice will be abandoned'; respondents 2, 5, 6 and 7 were explicit about this inference, while respondents 1, 3 and 4 indirectly inferred that the private practice is the culprit of inefficient healthcare system. What is the meaning behind why no one can admit a patient without the approval of the unit-in-charge? Why has private practice been described as a parallel healthcare system? The public and private sectors are working in parallel and admissions are made directly from the private sector to the public sector which is not right; one has no right to do this. By the private 'sector' I mean private 'practice' and its (almost) private hospitals, which operate in multi-storeyed buildings with every facility for admissions and investigations, including CT scanning equipment and operating theatres. The machines which are not fully functional in the hospital will be properly functioning in private sectors. All the junior hospital staff - after working in hospital - move to the private sector; they are employed in different roles including as technicians and nurses, and they are more loyal to the private sector. As I explained earlier, if you are making one month's worth of your salary in one day, then your interest would obviously lie there.

Figure 5-4: An example of a memo

Build-up Phase

In the build-up phase of data collection more interviews were conducted. It is important to remember that no additional questions were added to the interview guide and that a similar set of questions were asked as in the preliminary phase, however, memos were written to record more information about the MTI reforms. The same techniques were used to analyse the build-up phase interviews as for the preliminary phase, and the overall data was corroborated with other sources such as field notes, memos and other secondary data such as MTI Act, government documents on healthcare reforms.

5.5.4 Summary of key steps in data analysis

The data analysis process followed a number of iterative steps, as described in Figure 5-5 below.

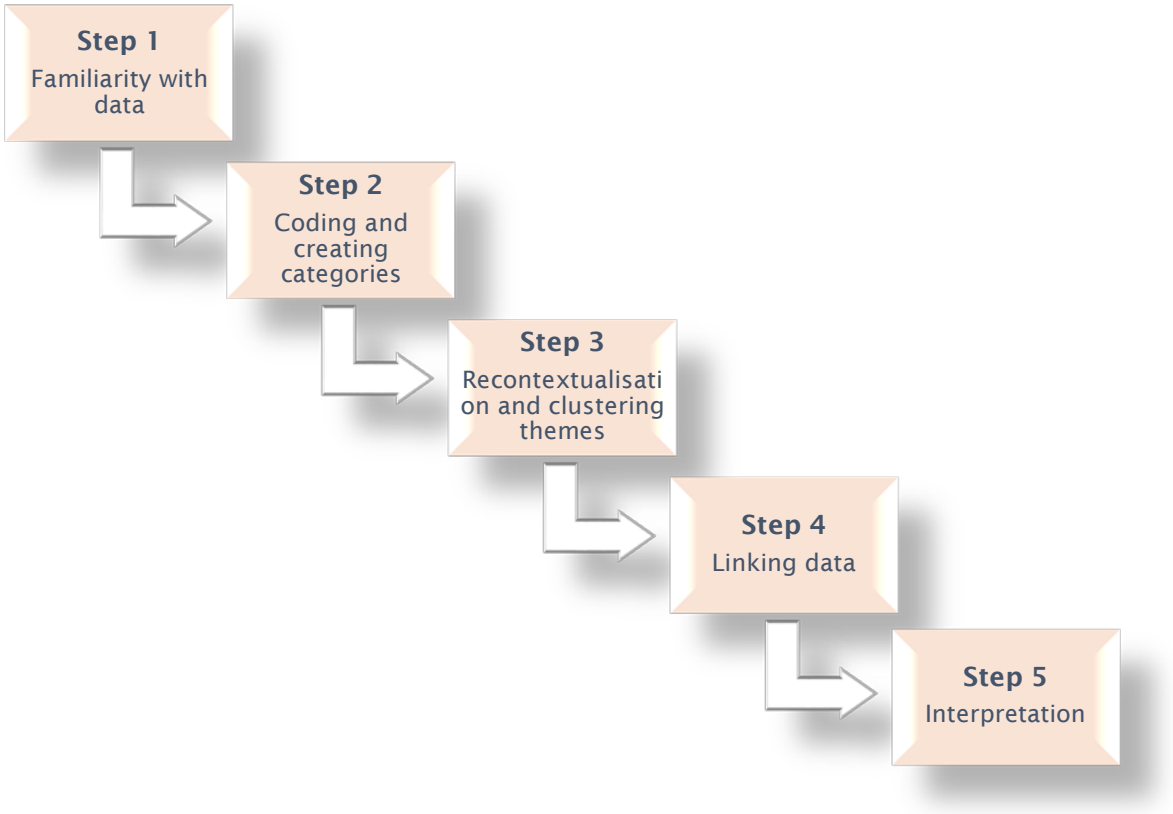

Figure 5-5: Key steps in data analysis

Initially the author analysed the data manually and then created a database in NVivo 11 software, where the data was transferred to be systematically arranged.

Step1 Familiarity with data: The author carefully transcribed each interview as a Word file. As mentioned earlier, data was collected in the native languages (Pashto and Urdu), but was transcribed and analysed in English only. In the first step of analysis the author read the transcripts several times, which helped to understand the data in the light of the overall aim of this research.

Step 2 Coding and creating categories: Reading the transcripts several times enabled the author to understand which parts were important to the research questions. The sections (bits) of the transcripts that contain rich information relevant to the research questions of the study were highlighted. The coding phase involved splitting (disaggregating) the data and assigning labels to

different sections of the interview transcripts to categorise the data in a way which made sense of them. Once all transcripts were coded, they were compared to ensure that the rules of coding were consistent and that the same rules were applied to each. The coded data that share similar characteristics were clustered together to form a category, e.g. 'jumping like headless chickens' and 'no clear directions' were placed under the category of 'confusion'. It is important to remember that along with interview transcripts, other sources such as field notes, memos and secondary data also contributed to the development of categories.

Step 3 Recontextualisation and clustering themes: The coding step led to the core categories. The different categories, which were assigned codes, were compare with each other to consolidate meaning and develop explanation and relationship. These categories were recontexualised to form different themes. This process helps in transferring the raw data to a form that aids its interpretation and presentation (Saldaña, 2015).

Step 4 Linking data: This stage provided a more holistic view of the data. It involved identifying and recognising the pattern and relationships that emerged between codes, categories and key themes in the data. A total of 10 themes were found. These themes are discussed in Chapters 6, 7, and 8. A detailed description of each theme is provided at the beginning of each chapter.

Step 5 Interpretation: In this stage the author gives meaning to the data, helping to build theory through transcending the data and probing into what they indicate (Patton, 2002). This has been done through abductive reasoning coupled with the author's personal experience as part of the whole process of data collection (Miles and Huberman, 1994). As a result of this phase the author produced the explanatory framework (discussion), which is presented in Chapters 6, 7, and 8.

It is important to reiterate that the analysis process was not linear and the original documents and field notes were consulted multiple times. In a few cases the author returned to the field and checked with respondents as new information emerged. This process has been called 'the abstraction ladder' by Miles and Huberman (1994; 224).

5.5.5 Steps to maintain quality in the data analysis process

Maintaining quality[12] in qualitative data analysis is crucial for the social scientist (Dey, 1993). Critics of qualitative research question the lack of rigour in the analysis process. However, Braun and Clarke (2006) oppose this view and suggest that qualitative approaches provide rigorous analysis. Patton (2002) sets guidance on how to maintain quality in the data analysis process, while Silverman (2013) sets his own criteria to tackle quality issues in the qualitative data analysis. In order to address quality issues in the analysis process, guidance was taken from several authors, such as Miles and Huberman (1994), Dey (1993), and Braun and Clarke (2006).

In this study the data were transcribed by the author at an appropriate level of detail. The audio recordings made during data collection were checked for accuracy against the text data. All data were stored and managed in the NVivo program along with respective audio recording and memos. In the coding process each case was given equal attention. The themes were adequately supported by the transcript data. Ambiguous themes with insufficient support from the text data were discarded. All themes were checked against each other and against the original data. The analysed data were presented in a coherent structure relevant to the topic, case study, data collection and analysis, and interpreted in the context it was collected. The data were displayed coherently in tables and matrices which also explained the author's choice of analysis technique: Miles and Huberman (1994) provide detailed guidance in this regard. The language and concepts were used while reporting the outcomes to ensure they were consistent with the epistemological position of the analysis. The table 5-6 below describes the steps taken to address this issue.

[12] It is import to distinguish between 'maintaining quality of analysis' and 'Judging quality of the research'. The former refers to the steps taken to ensure rigorous analysis. The latter refers to the criteria for judging the overall quality of this research.

Table 5-6: Recommended checklist of criteria for analysis

Process	Recommended Criteria
Transcription	• The data were transcribed in detail by the author; transcripts checked against tapes for accuracy • Database was established in the Nvivo software and all transcripts stored with relevant memos and tapes in an organised manner.
Coding	• Cases were created and each case was treated equally for coding. Each transcript was read several times and manual coded. • Apart from manual coding, software (NVivo) was also used to collate all codes. • Themes with weak codes were discarded, along with those codes with no support from the text data. • Once themes emerged from the codes they were checked against each other and referred back to the original data for rigorous checking. • Various approaches were adopted for coding.
Analysis	• Analysed data were interpreted in the context they were collected and sense made out of them in the context of Chapter 5. • Analysed data were matched with each other and organised to reflect the findings about the problem and research question.
Overall	• Ample time and attention ensured. • Analysed data were discussed with respondents for their view and to tackle any ambiguity in the closing phase • Overall analyses were supplemented from various sources of information.
Written Report	• An argument was constructed for accompanying analysis in the light of the research problem, research question and philosophical assumption of this study. • Language and concepts were explained in the context of this study and data. • Active role of this author in data collection and analytical process.

5.6 Addressing ethical issues

Silverman (2016) reminds us that ethical considerations are key to good qualitative research and Patton (2002) states that it should be addressed throughout the research. It is especially relevant when the research participants are human beings. Due to the sensitive nature of this study the author felt a keen sense of responsibility to adhere to a code of ethics. Since the healthcare reforms are considered controversial by the media, adherence to a code of ethics was vital from the beginnings of the study. In this regard, the ethical procedures of the University of Southampton were followed and the supervisory team were aware of the nature of the study. In July 2015 ethical approval was applied for via ERGO (Ethics and Research Governance Online) and approved. Before going into the field a reminder notification was sent to the hospital directors along

with the interview guide, consent form (See Appendix E.1) and participant information sheet (See Appendix E.2). On arrival in the field, the author formally explained and informally discussed the purpose of the study, its associated risks, the participants' rights to withdraw from the study, and the policy of anonymity and confidentiality. The author also explained how the study would be of benefit to practitioners and policy makers. The author assured the participants that voice recording the interviews could be stopped at any time, and that 'a situational approach' would be taken (Mauthner *et al*., 2012), i.e. what is best in each situation for the individual research participants. In addition, the author assured the respondents that they would not be pressured to give their views if they were reluctant or had no knowledge of a particular topic. All possible effort was made to conduct the interviews in a relaxed environment, and the participants were free to choose the location. During the analysis process the author ensured the confidentiality and security of all transcripts, which were stored in pass worded files on a laptop computer owned by the University of Southampton. Bringing the data back to the participants in the closing phase equally supported an ethical approach, by ensuring that the interpretations did not misconstrue the views of participants.

5.7 Criteria for judging the quality of research

Lincoln and Guba (1985) offer guidance on how to 'establish trustworthiness' in naturalistic inquiry. Patton (2002) provides us with an alternative to how quality issues in qualitative research can be addressed. Likewise, Yin (2014) sets 'criteria for judging quality of qualitative research'. He suggests that research should be judged against construct validity, internal validity, external validity, and reliability. The demands for quantitative research include internal validity, external validity, reliability and objectivity (Lincoln and Guba, 1985). However, the same criteria cannot be applied to qualitative research due to the human element, which demands different criteria of judgement (Lincoln and Guba, 1985; Patton, 2002; Creswell, 2013). Highlighting further the importance of maintaining quality in qualitative research, Lincoln and Guba (1985) cite criteria of credibility, transferability, dependability, and conformability, and Yin (2014) lists construct validity, internal validity, external validity and reliability, in judging the quality of qualitative research. This research followed the tenets of naturalistic inquiry, with no control behaviours of the setting and respondents,

and the following steps were taken to establish the trustworthiness of the research.

Credibility

The credibility of the findings is increased through rigorous methods of conducting and validating fieldwork (Lincoln and Guba, 1985, p. 296). The issue of credibility is immensely important and is a major concern in qualitative research (Eisenhardt, 1989). Yin (2014) identifies three tactics to increase credibility: utilisation of multiple sources of evidence to enhance convergence of line of inquiry relevant to the data; establishment of a chain of evidence; and having a draft case-study report reviewed by key informants. Likewise, Lincoln and Guba (1985) recommend prolonged engagement with the participants, persistent observation, peer checks and use of multiple sources of evidence as the steps to establish trustworthiness in qualitative research. During the course of this study, several visits to the case hospitals were made during the data collection process. This enabled the author to understand the culture and the overall system in the hospitals and helped to develop rapport with the participants. A pilot study was conducted first, to ensure that the respondents understood the aim of the study and concepts under investigation. Data relating the specific questions were collected from multiple sources rather than one source alone. The author's interpretations of the analysed data were taken back to the research participants for in-depth discussion and verification in the closing phase of data collection. The supervisory team engaged with the research findings and incorporated their suggestions, and the findings were presented at various conferences and discussed with members of the academic community. Further steps taken to increase the credibility of this research include the use of multiple sources of evidence which were corroborated in the overall analysis.

Transferability

Transferability suggests the possibility or otherwise of the application of research findings to other contexts. Stake (1995) and Yin (2014) suggest that external validity cannot be applied to qualitative case study research in the same way as to quantitative. Eisenhardt (1989) argues that case study research is not a sampling exercise whereby one case is studied in order to understand others. This research does not aim to generalise the results to a greater population, as

would be the case in a quantitative study; instead its main aim is to generate deeper understanding of MTI reform in the teaching hospitals in KP. The inquiry was carried out in three case hospitals in greater detail, and this research can be said to adhere to the principle of analytical rather than statistical generalisation (Yin, 2014). Highlighting transferability, Lincoln and Guba (1985) argue that external validity is not an issue for a naturalistic inquirer; however, the researcher can provide a thick description of the case and someone from a similar setting can apply the outcomes in their context. In this research the context of the study was discussed in a separate chapter (Chapter 2). Furthermore, the multiple case-study approach was used to observe the similarity and dissimilarity, which also increased robustness and added strength to the analytical generalisation of this research.

Confirmability and dependability

The concepts of confirmability and dependability involve demonstrating confidence in the research process and outcomes for internal coherence and external trust (Lincoln and Guba, 1985). In this research, a database was developed in NVivo to manage all data structurally. Multiple cases were used in this research; data were collected from multiple sources systematically in different phases. Different audit inquiries were carried out to explain the themes and different relationships. The process of themes emerging from data has been elaborated in textual form as well as in tabular form. Along with responses from the participants, analysis was supplemented with field notes and memo writing to ensure a rigorous analysis. Data interpretation was discussed with participants. The outcomes were discussed with the supervisory team and presented at various conferences. Table 5-7 below gives details of the way in which quality was ensured in this study.

Table 5-7: Establishing the trustworthiness of the research in the tradition of naturalistic inquiry embedded in critical realism

Design Quality Criteria	Recommended Criteria	Actions Taken	Research Phase
Credibility	A. Prolonged Engagement	A. Understanding the culture and system setting through prolonged engagement with participants during several visits which also helps to gain their trust.	Chapter 5
	B. Triangulation	B. Data were collected from multiple sources and were corroborated in overall analysis.	Chapter 5
	C. Member Checks	C. All interview transcripts were shared with the participants and findings were discussed in the closing phase.	Chapter 5
	D. Peer De-briefing	D. Research was discussed with supervisory team and presented in several conferences during the research candidature.	Chapter 5
Transferability	Thick Description and Generalisability	. Contextual information is provided which explains information about the context of the study and background of the reforms. This is followed by describing the case hospitals.	Chapter 2
		. To justify research process, methods and analysis process.	Chapter 5
		. Data was collected and analysed systematically, the research findings were discussed with supervisory team and research community at various conferences	Chapter 5
Confirmability	Audit Trail	. To justify research process, research paradigm, and methodology	Chapter 5
		. Any remaining ambiguities were incorporated and addressed in the closure phase of the data collection; cases were not closed prematurely.	Chapter 5
Dependability	A. Inquiry and External Audit	A. Systematic data collection and various procedures followed field notes, memo writing, data reduction, data reconstruction, research findings were discussed with supervisory team and participants in the closure phase of the research.	Chapter 5
	B. Triangulation	B. Data were collected from multiple sources and were corroborated in the overall analysis.	Chapter 5

5.8 Conclusion

This chapter explained the underlying philosophy and methodology of the study, followed by the research approach. Presented next were details of the methodological tools and sampling procedures used in the research. Data collection procedures and the three-phase approach were described, followed by explanations of data analysis procedures, including coding, field notes and memo writing. Then details of ethics, security, and confidentiality Issues is provided. The chapter was concluded by providing details on addressing the quality of this research. This chapter, along with Chapters 3 and 4, serve as the basis for the detailed findings, which follow.

Chapter 6: Organisational Structure and Human Resource Management in the Khyber Pakhtunkhwa (KP) Healthcare System

6.1 Introduction

This chapter presents the analysis and discussions addressing the first research objective (RO1) and related sub-questions (RQ1.1-1.2). The main aim of the chapter is to establish an understanding of the previous structure of the KP healthcare system, i.e. how HR policies were carried out and how doctors and ward managers perceived those practices before the healthcare reforms. It should be mentioned here that since the structure and nature of all three cases are similar, they are presented and discussed together rather than separately. The main themes are elaborated and explained in the light of research objective RO1 in order to answer the sub-questions RQ 1.1-1.2. A constant effort has been made to compare and contrast the outcomes with the literature, and the data is displayed in chart and tabular form wherever possible. The chapter concludes with a summary of the debate, which sets out the basis of the second research objective RO2 in order to address sub-questions 2.1-2.3. The table below provides a summary of the sub-questions and related objectives of the study.

Table 6-1: The first research objective and the related sub-questions

Sub-Questions	Research Objective
RQ1.1: What was the organisational structure of the KP healthcare before the reforms? **RQ1.2:** How did the doctors in the case hospitals perceive service structure and performance appraisal system before the reforms?	**RO1:** To understand the organisational and human resource structure of public healthcare before the reforms in KP healthcare.

In this chapter we attempt to understand the management structure of the case hospitals before the MTI reforms, and how doctors and ward managers perceived HR management policies in KP healthcare. As a result of the interviews and

discussions new information emerged which helped to address research objective RO1 and to answer the related sub-questions RQ1.1-1.2. In the first section we review the original management structure and HR practices of KP public healthcare in order to understand the context which preceded the reforms. This is then followed by a discussion of the themes which were identified during the interviews.

The interviews revealed that poor service structure and lack of faith in the performance appraisal system were the main complaints about the previous system. The rich data obtained in the interviews and discussions enabled conclusions to be drawn about how doctors and ward managers perceived the previous management, pay structure, promotion system and performance appraisal. Table 6-2 below summarises the themes that emerged.

Table 6-2: List of themes

Themes	Major Categories	Minor Categories
Poor Service Structure	Complex Promotion System	dissatisfaction, old system, no reforms, too complicated to understand, migration, waiting for many years, frustration, comparison between other public sector, no regard for good performance
	Low Salary	respectable life, second job, private clinics, three bedroomed house, private car, good salary in other public institutions, inflation, private schools, emigration to other countries
Lack of Faith in the Performance Appraisal System	Lack of Trust in ACR	tenure system, relaxed attitude, no timely filled ACR reports, complicated promotion criteria, lost interest
	Politicised and Corrupt ACR	nepotism, family member, relative, friends, personal contacts, good relationship with ward manager, bribing
	No Communication in ACR	no feedback, poorly structured ACR, no real accountability, no regard for good performance, outdated system

6.2 Employment relationship in Khyber Pakhtunkhwa (KP) public healthcare

As a former British colony, Pakistan adopted the Westminster model of government with its constitutional monarchy and a parliamentary system. The structure of core civil service institutions, including public healthcare, was always highly centralised, which, according to Ferlie (1996), is the typical public sector model. Prior to the 2015 reform act, the healthcare employment structure offered a guaranteed job for life, with pay coupled to grade, and promotion based on seniority and a satisfactory performance appraisal known as the Annual Confidential Report (ACR). Industrial relations are still collectivist, and unions play a critical role in protecting the rights of the employees. Before the reforms, administrative affairs and other systems functioned according to certain predefined rules and regulations. Healthcare professionals hold civil servant status and enjoy maximum job security along with other benefits such as home allowance, free healthcare for immediate family and retirement pension. The healthcare bureaucracy is known as the Health Secretariat and functions under the Ministry of Health. All employment decisions in KP public healthcare, such as recruitment, transfers and dismissals, are made by the Health Secretariat. All policy makers, civil bureaucrats and clerks work in the Health Secretariat and liaise with the rest of the KP healthcare administration.

6.2.1 Recruitment and selection

As healthcare is a typical public sector industry, employees are employed as civil servants according to predefined criteria and regulations. A vacant post is announced in the local newspaper and applicants are invited from across KP province. All candidates then take part in written examinations, which take place at Khyber Medical College (KMC) in Peshawar. The examinations assess the academic and practical capabilities of the doctors, and successful candidates are then called for interview and selected by panel decision. The whole recruitment process from job announcement to appointment takes several months, which is typical of a Weberian model of public bureaucracy. Posts can remain unfilled for several months due to the slowness of the recruitment process, especially in rural areas. This affects patients adversely and many of them travel great distances to Peshawar to have even minor complaints treated. Once the

candidates have been appointed they are required to serve in a local primary care unit known as the Basic Healthcare Unit (BHU), or in a secondary healthcare District Hospital (DH), the doctor must serve in at least three hospitals in order to be eligible to apply for a position in the teaching hospitals in Peshawar.

6.2.2 Nature of the job

In a typical public sector model, the employee has a clear idea of what their job title is and what the role entails (Farnham and Horton, 1996). However this was not always the case in KP healthcare, and obtaining a clear job description could be problematic. Successful job candidates are informed by letter of their appointment, as is usually the case in any organisation. However, during the course of discussion it emerged that, while they receive confirmation of their civil servant status, doctors receive no formal job description. The author was curious as to how they came to know what their duties were in the wards and further discussion was encouraged. The respondents stated that in the initial days they work under the supervision of senior doctors. In addition, during the third year of medical school, they begin working in a hospital to develop their skills on the ward and by the end of the fifth year they do a year's internship in the hospital, known as a 'house job'. The government pays them a stipend during the house job, and this is where they learn their fundamental duties as junior doctors. Nevertheless, officially they are not given a specific written job description, and the respondents were not happy with this situation. One of the more recently appointed junior doctors expressed it as follows,

> *'They don't provide us with an official job description… it would be much better if the authorities provided us with a formal job description so we know exactly what our duties are' (Junior doctor, 23, Case C)*

The data shows that under the previous system, doctors were not given a formal job description. Although they come to know their duties by a combination of student internship work and learning on the job, they would prefer to be issued with written job descriptions.

6.2.3 The service structure

In a typical Weberian public sector model, employment is based on the notion of a career with security of tenure and lifelong employment, which is framed through the operation of an internal labour market (Boyne, 2003). In the management and public sector literature, a 'remuneration package' is defined as public tenure, working hours, privileges and retirement pension (Lane, 1997). In KP healthcare the career and promotion system is known as the 'service structure' and define one's promotion system and salary. According to the official documents and discussion with a senior level respondents, a doctor is first appointed as a civil servant at grade 17, designated officially as Medical Officer (MO) and starts his career in the KP health service. The promotion criteria is based on seniority and on having a satisfactory performance appraisal known as the Annual Confidential Report (ACR), (this is discussed in greater detail in Section 6.4). However, certain specialised posts, such as senior registrar, assistant professor, associate professor and professor need additional requirements such as specialisation in a relevant field, publications and research activities, and appropriate further training. Although the rules and regulations state that promotion is again based on seniority and satisfactory ACR, in practice other factors such as research activity, training, education and teaching also influence promotion. One of the respondents at senior level complained about the lack of clarity:

> *'To be honest the promotion criteria is confusing and hard to understand.' (Senior doctor, Case A)*

If someone is promoted from one grade to another, this is reflected in an increase in salary. All respondents criticised the promotion criteria as being complex and inconsistent. A typical doctor's career begins as a grade 17 medical officer and ends in retirement at grade 20 (subject to other requirements). Tenure within the KP system may involve being transferred to other hospitals in other areas of the province. Figure 6-1 illustrates the career stages of a typical doctor as a civil employee in the KP healthcare system.

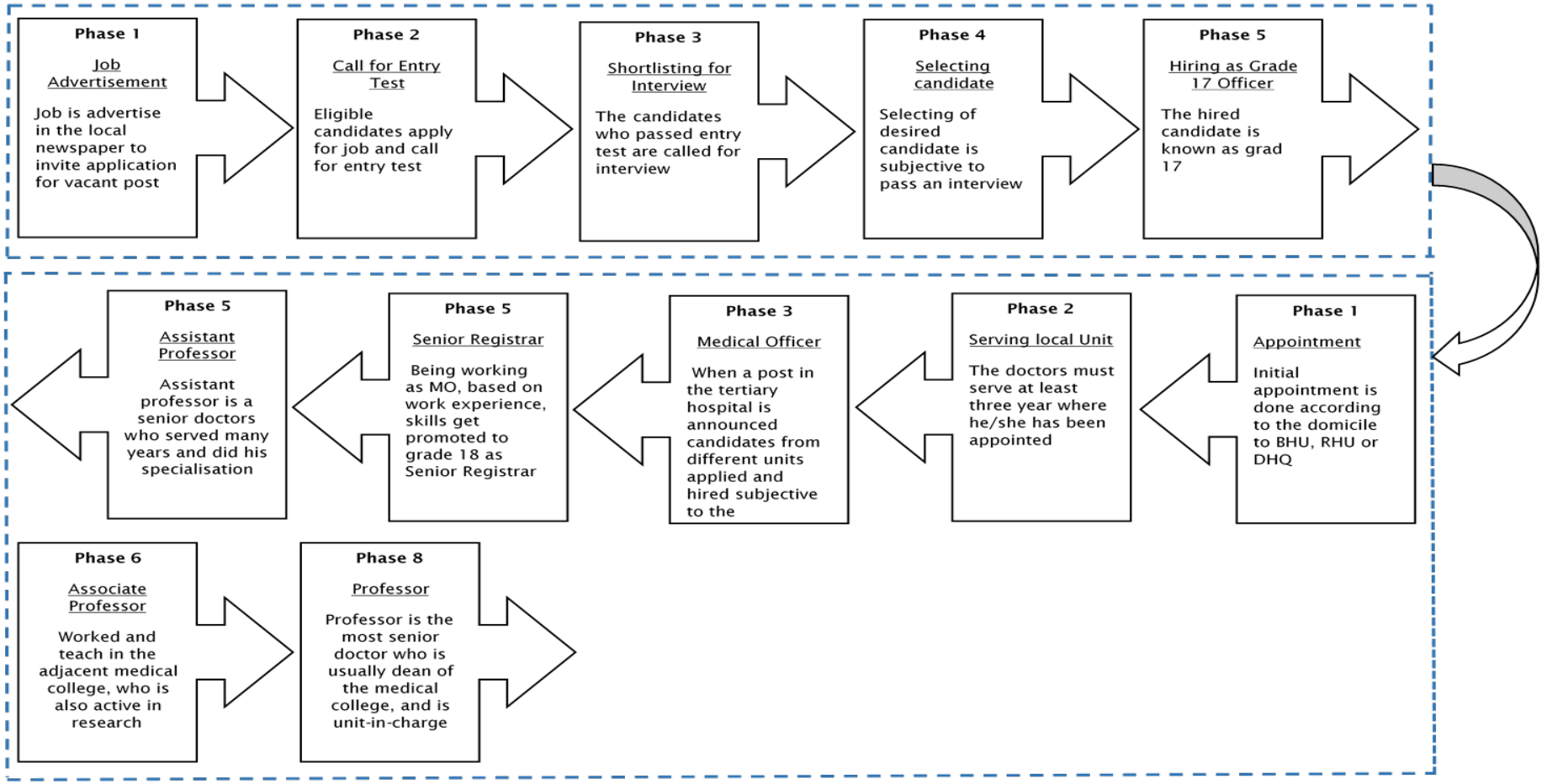

Figure 6-1: Career stages of a typical civil employee (doctor) in the KP healthcare system

6.3 Poor service structure

In the KP healthcare system the term 'service structure' is widely used by the Health Secretariat to refer to 'promotion criteria' and 'salaries'. The existing service package defines the basic salary, benefits and privileges, and as stated above, promotion in the pre-reform system was based on seniority and having a satisfactory ACR, while the career path was stable, offering lifelong employment with high job security. During the course of discussion the respondents point out two aspects of the service structure of the previous healthcare system – complex promotion system and low salary.

6.3.1 Complex promotion system

The interview data indicate that all doctors from the sample experience issues with the service structure of the KP healthcare system. They expressed their dissatisfaction with the promotion criteria, which they complained was too complicated to understand. Further, they complained that they were often forced to wait many years for promotion. Although KP healthcare regulations stipulate that promotion is based on seniority and subject to satisfactory ACR, in practice it was not so simple. One of the senior doctors, who was about to retire, spoke of his disappointment with the promotion system,

> *'Well to be honest, the service structure is the main culprit of the rotten system...structuring is a big issue here…I don't know how people get promoted here…my pay scale is Grade 19 after serving 31 years in the KP public sector…I am on the verge of retirement and I am not sure I will ever be promoted to Grade 20'. (Senior doctor, Case C)*

Most of the respondents (33 out of 36) felt that the previous promotion system was ill-defined, outdated and corrupt. Over half of the doctors compared promotion in KP healthcare with other elite institutions of Pakistan such as the civil service and the army. Careers in these institutions are highly desirable in Pakistan, especially so since employment structures have been reformed and provide good salaries based on merit. However, in contrast, the KP healthcare system has relied on a traditional management system that has not kept pace with the changing world. One of the respondents constantly compared his

situation to that of a friend of his, a former doctor who passed the civil service examinations (known as Central Superior Services or 'CSS') and now has a senior role in the government:

> *'I've served in healthcare for 21 years but have only just been promoted to Grade 18 last year. One of my friends passed his CSS exam and left his job in the middle of his medical career. Look at him now — he serves the government as Secretary for Health. He is Grade 21 already, while I have only just been promoted to Grade 18 after 21 years of service.' (Senior doctor, Case C)*

Similarly, more than half of the respondents expressed fears of being stuck at the same grade year after year. Around 15 out of 36 of the doctors said they were planning to emigrate to countries such as Canada and Australia. Showing their deep concern about the promotion criteria of the KP healthcare system, the respondents further suggested that this situation would never be allowed to occur anywhere else in the world. One of the respondents had been working for fifteen years at the same grade and was hoping to be promoted eventually. He expressed a great deal of frustration about the situation:

> *'For the last 15 years I have been working as a Grade 17 officer. You won't see this in any other system in any part of the world, where you work for 15 years at the same pay scale. I should have been a Grade 18 or 19 by this time.' (Senior doctor, Case A)*

In the same way, one of the younger doctors criticised the system for having no regard for good performance and was thinking of going abroad for work:

> *'The promotion criteria here are very frustrating… I achieved a first in my college finals, but under the current system I will never get ahead because performance isn't taken into account. To be honest I no longer care, because I have submitted my documents for immigration to Canada under the Skilled Migration Scheme.' (Young doctor, Case B)*

There was consensus among all respondents that complex promotion criteria are a major cause of concern for employees who work in the public healthcare

sector of KP. Respondents felt that poor grading structure is one of the main problems and that this should be reformed so that promotion reflects performance.

The discussion revealed widespread uncertainty about performance acknowledgement, as well as dissatisfaction with the lack of a defined and regulated promotion policy. Criticising previous governments in KP province, they complained that reforms or other initiatives have never been on the healthcare agenda. The doctors in the case hospitals showed frustration with the service structure of the previous healthcare system. The author was curious as to why the study participants drew comparisons with the civil service and army, and how they knew these had better service structures than healthcare. They revealed that friends and relatives were employed in these institutions and that they often discussed these issues. Junior doctors were particularly critical of the service structure, since under the existing system, they had to wait for several years for promotion even if their performance was better than that of senior doctors. These younger doctors were enthusiastic about their work and keen to rise through the ranks sooner rather than later. They suggested that working for many years at a low grade did not reflect their education, experience and skills. From the discussion, the author concludes that this situation is detrimental to public healthcare in Pakistan. These doctors are the future of the healthcare system; they are young and keen to do well, but are angry about injustices in the system. They believe that the poor service structure has an adverse effect, especially on them, and many had begun to consider alternatives such as emigration. The option of emigration was brought up several times, particularly by the younger professionals, who were disappointed by the poor employment structure.

6.3.2 Low salary

During the discussion, it emerged that low salaries in public healthcare are another cause for concern among the doctors in the case hospitals. Most of the respondents (34 out of 36) suggested that pay in public healthcare is too low and not reflective of the current inflation in Pakistan. Almost all of the respondents felt that their pay did not allow them to have what they considered a ‘respectable’ standard of living; a concept which cropped up on many occasions during the discussion. It was important therefore to ask them to define

what they meant by this, and a variety of ideas were offered. To one of the doctors, it meant having a house in the Hayatabad[13] area and giving his children private schooling. Another specified similar conditions and felt that a new car would be appropriate to his status. The general consensus among respondents were that their current salaries did not allow the right sort of lifestyle. One senior doctor replied,

> *'I am always concerned about good education for my kids, but on this pay you cannot send your kids to good schools… by good schools I mean private schools…you know that the situation of government schools is not good…On this pay you cannot have a respectable life.' (Senior doctor, Case B)*

The story of another respondent is worth mentioning here. This doctor had worked in Irish healthcare for three years while he was doing postgraduate studies. He found that the money he earned in Ireland was more than adequate to support a respectable lifestyle, even though technically he was still training. In contrast, back in Peshawar he was a grade 18 senior registrar and struggling to maintain the same standard of living. He maintained that he was still using savings from his job in Ireland to compensate for this:

> *'I did my FCPS in Ireland and I had an opportunity to work in Irish healthcare sector during my studies…During my training, I was getting 500,000 Pakistani rupees, while as a Senior Registrar I am getting only 60,000 here…I am using my savings here in Pakistan. I don't know what I will do once they run out.' (Senior doctor, Case A)*

During the discussion over half of the respondents complained frequently about their salaries and made comparisons with friends, relatives and colleagues who were working either in elite professions in Pakistan or in healthcare abroad. On further questioning, they explained that their fellow students and colleagues had gone on to work in the US, UK, Canada and the Gulf countries. One respondent shared a story about a friend of his who had gone to live and work in the UK after graduation. He was bitter about the difference in their respective salaries:

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[13] Hayatabad and the Defence area are considered as elite areas of Peshawar.

> *'If you compare our pay with international rates, it's like peanuts. One of my very close friends went to the same school and medical college, and soon after his house job, he went to the UK for specialisation and got a job there. I got my job in a HMC hospital and started my specialisation here. If I compare my salary with his I am so ashamed of mine.' (Senior doctor, Case C)*

It is a general misconception that doctors, who are considered as elite medical professionals, are paid well. It seems that this is particularly not the case in Pakistani public healthcare and that professionals here are vastly underpaid compared to those working in other countries.

To summarise, the discussion showed that the main complaints of doctors working in KP public healthcare are the complex promotion system and low salaries. Dissatisfaction often seemed to translate into the impulse to emigrate in search of pay that would reflect their education, skills and experience. Seven senior doctors optimistically pointed out that the regulations allow two years of unpaid leave, which would enable them to work abroad and earn enough to save for the future. Most (10 out 11) of the junior doctors, however, were keen to leave Pakistan altogether as they were not happy with the low pay and service structure of the KP healthcare system. Further, they suggested that under the existing seniority-based system, there was little opportunity for fast promotion.

In the literature, the term 'brain drain' is used to refer to the migration of educated professionals from one country to another. Aluwihare (2005) reminds us that the phenomenon of 'brain drainage' is not new, but started in 1963, when scientific personnel emigrated from the UK to the US, where the market offered better working conditions and pay. According to Naicker *et al.* (2009) Western countries did not produce enough qualified healthcare professionals, and so, to meet the demand, they employed immigrant doctors from across the globe. Ahmad (2005) shows that for over a half century, there was a large-scale migration of doctors from developing countries such as India, Pakistan and the Philippines, to developed, mainly English-speaking countries such as the US, UK, Canada, Australia and Gulf countries such as Saudi Arabia, Bahrain, Kuwait and United Arab Emirates.

In a study of medical migration, Hallock, Mckinley and Boulet (2007) are of the opinion that this topic is under-discussed, and there is no consensus as to why many thousands of medical professionals migrate each year to other countries. Few studies have identified different reasons for medical migration; for example, Astor *et al.* (2005) report that it is due to the lack of specialist training in the parent country and the financial lure of the host country. Likewise, Chikanda 1 (2007) found that the attractions of improved prospects, better standards of living, and residency status in the host country were the main reasons for medical migration from low middle income countries to Western countries.

The current study shows that the doctors in the case hospitals have a positive attitude to medical migration, and that perceived low pay and poor employment structure are the reasons for this. This presents an alarming situation for the Pakistani healthcare system, as the country is already lacking in qualified doctors. The Pakistani population currently stands at 200 million and there are not enough medical colleges to produce more qualified staff (Dawn, 2017). All medical education is free in state colleges, and so training costs are high for the government. However, as we have seen, the subsequent low pay and outdated promotion system of public sector employment is pushing doctors to consider emigration in search of a better standard of living. The respondents showed a tendency to favour migration to Middle Eastern countries, such as Saudi Arabia and United Arab Emirates, mainly because of the recent introduction of stricter immigration regulations in English-speaking countries. The previous research on medical migration highlights the improved prospects for doctors, which include opportunities for post-graduation education, higher standards of living and residency status. Our findings suggested that standard of living, better employment structure, better future prospects and higher salary were the primary motivating factors for medical migration.

6.4 Lack of faith in the performance appraisal system

Performance appraisal is one of the main human resource tools used in the management of performance in public sector organisations (Mayer and Davis, 1999). It is fair to say that although this concept existed in KP public healthcare, concretised in the Annual Confidential Report or 'ACR', it was routinely both neglected and manipulated according to the whims of management. Previous to the MTI reform, two factors were considered in promotion: the number of years

one served in KP healthcare and having a satisfactory ACR (as discussed earlier in Section 6.2). Therefore, it was important to find out more about the ACR and how the respondents perceive it. An open-ended discussion among respondents generated three main concerns on ACR: lack of trust, politicisation and corruption, and lack of feedback.

6.4.1 Lack of trust in the ACR

The doctors who took part in the study unanimously proclaimed their complete lack of faith in the performance appraisal system. Aside from taking into account the number of years served, promotion relies on the mandatory completion of an ACR for each year of employment. However, the respondents stated that this rule is not complied with, and that a report is completed hurriedly only when promotion is due. In addition, the rules of promotion are complex and doctors often have to wait for many years to advance. In the meantime, ward managers and hospital administrators take a relaxed attitude towards completing the ACRs. One of the respondents, who had waited fifteen years for promotion had this to say:

> *'The ACR is supposed to give you promotion, but I have spent 15 years in one grade, and so naturally lost interest in the ACR…the ward manager is supposed to complete the ACR every year to assess my performance but he doesn't bother…to be honest, I haven't filled in my part of the ACR in the last ten years either.' (Senior doctor, Case C)*

Similarly, almost all of the respondents at junior level openly criticised the ward managers for not completing the ACR on time, and the hospital administration for not asking the ward managers to submit them. The respondents had, in general, lost faith in the ACR as a method of appraisal, since the senior doctors and management appeared to attach little or no importance to the process. One doctor expressed his opinions:

> *'To be honest I do not trust the ACR system, as even the ward managers and hospital administration themselves don't give it importance …we need the ACR when our promotion is due, and I don't know when that will be (laughs)' (Young doctor, Case C)*

The relaxed attitude of the ward managers and hospital administration towards submitting the ACR on time was coupled with total lack of attention to performance. In fact, no importance was attached to the ACR until the possibility of promotion arose, which, due to the poor service structure, often took many years, and so eventually doctors lost trust in the ACR system.

6.4.2 The politicisation and corruption

During the discussion, most of the respondents (35 out of 36 of the doctors) stated that they had no faith in the credibility of the ACR as a valid and impartial assessment tool, and that in reality, nepotism and corruption were rife. Almost all of the participants expressed cynicism towards the system and the following quotes are typical of their views:

> *'The ACR system in our setup is rotten. Over the years I have seen many evaluations, both of those who work hard and those who do not, and I have been astonished at the reports. Personally, I don't attach any importance to the ACR as I have seen fraudulent people getting good reports and being promoted. I have also seen good, hardworking doctors getting bad ACRs due to the personal grudges of the management ruining their chances of promotion.' (Senior doctor, Case B)*

In addition to this, just under half of the respondents mentioned corruption in the Health Secretariat. They described how, after counter-checking by the hospital Managing Director, all ACRs are sent to the Health Secretariat, where promotion is decided. If someone has received a bad report, they may bribe someone in the Secretariat or use other contacts to manipulate a more favourable outcome. In the words of one of the senior doctors,

> *'ACR here?... (laughs) It's just a joke; there are several things to say about this. I've also seen those with unsatisfactory ACRs and bribe people in the Health Secretariat when promotion is due. I personally know doctors who have bribed them…and that's why personally I pay no attention to the ACR system here' (Senior doctor, Case A)*

Data from the interviews shows that the participants overwhelmingly believe the appraisal and promotion system in the public hospitals to be politicised and corrupt, mainly due to the common practices of nepotism and bribery in relation to the ACR.

6.4.3 Lack of feedback in the ACR system

Another aspect highlighted in discussions of the ACR is the lack of communication in the appraisal system. All of the respondents felt that the system was ill-structured and that it suffered from inadequate communication between doctors and ward managers. The author personally examined an ACR document and found it to consist of five pages of statements with Likert scale points. The ward manager has a duty to write an ACR for each doctor at the end of the year, and these are then sent to the hospital director to be counter-checked (which the author perceived from discussion is very rare). All respondents suggested that the appraisal system should contain a mechanism by which they can access feedback on their performance. The ACR contains a section for the ward managers to comment on performance, but there are no arrangements for any follow-up communication or feedback to enable doctors to improve their performance. One of the respondents, who worked in the NHS while doing postgraduate studies in the UK, shared his experience of the feedback system there:

> *'Having a feedback system is very important; wherever there is a monitoring system there is accountability. When I worked in the UK, if I applied for a job in a hospital, I would contact my managers and ask for a reference. Not only from my boss, but also from colleagues and subordinates – it was a collective assessment. Feedback is very important — even the smallest workshops want to know your opinion.' (Senior doctor, Case C)*

It emerged during the interviews that there was a distinct lack of feedback to the doctors during the performance appraisal process. The author's close examination of an ACR document also confirmed that there was no communication or feedback mechanism to enable performance improvement. Both ward managers and doctors were convinced that the ACR system is old and outdated, and they further suggested that it is very important to have

communication between ward managers and doctors and that the report should include formal feedback sessions. Given the importance of the working relationships between ward managers and doctors, effective appraisal communication is critical.

Selden and Sowa (2011) suggested that the objective of performance management in the public sector is to align individual performance with organisational performance. Guest (2002) reminds us that the effectiveness of performance appraisal depends on the employee's perception of fairness, and that managers should regularly give feedback on employee performance. The data from the case hospitals shows that the hospital administration, ward managers and doctors do not bother to fill in the ACR. The report becomes an issue when promotion is applied for, but other than that, no-one attaches any importance to it and hence it has largely lost all meaning. There is no true link between the report and performance; it has become an empty formality.

Another concern of the doctors in the case hospitals is the corruption surrounding the ACR. Daley (1992) argues that good performance appraisal should incorporate a high level of fairness and trust, which offers a means to improving the manager/employee relationship. Further highlighting an unbiased appraisal system, Rajput (2015) suggests that managers should assess the performance of employees fairly, since if an employee discovers that this has not been done, the message that the organisation is operating unfairly will propagate to the rest of the employees, who will eventually have no faith in the appraisal system. In the case hospitals, there was a perception that the ACR process suffers from corrupt practices of bribery and nepotism. Doctors on the wards believe that they more likely to have their performance judged according to their relationship to the ward manager as by their actual competence.

Another concern of the respondents was lack of communication between doctors and ward managers in terms of appraisal feedback. Highlighting the benefits of performance appraisal, Roberts (2003) suggests that performance management provides a useful communication tool between managers and employees which helps in goal setting and performance planning. Further, it facilitates discussions about employee growth and personal development. Likewise, Van Thiel and Leeuw (2002) stress the importance of communication in performance appraisals in the public sector. The authors conclude that communication plays

an important role in performance appraisal and that managers should feed directly back to employees about their performance and training needs. The current study's respondents suggested that there is no provision for feedback in the ACR performance appraisal system in the KP healthcare sector. Once the ACR is completed and sent to the management, doctors are not informed of the outcome. Some of the doctors who had worked abroad suggested that there needs to be a regulated performance appraisal system into which peer perspective should also be incorporated. The responses identified the need for drastic reform of the ACR process, to include not only a feedback mechanism but also an accountability component in the overall appraisal system.

6.5 Conclusion

This chapter has addressed the first research objective, RO1, and sub-questions RQ1.1-1.2, relating to the employment structure before the MTI reform and how it was perceived by the doctors and ward managers. The highly centralised Weberian structure of the previous public healthcare system was a relic of British colonialism and had not been reformed to keep pace with modern HR practices. Although the promotion system was theoretically based on number of years and performance appraisal via the ACR, it was perceived in practice to be flawed and corrupt. The overall promotion process involved a confusing mixture of additional criteria, including extra training, qualifications, research activity and teaching, which led to general uncertainty of what exactly was required in order to secure promotion, and a general lack of faith in the system. In addition to complex promotion system the pay in the public hospital were too low to have a respectable life and respondents show a great concern. The combination of poor structure, lack of impartial appraisal, lack of performance feedback, and frequency of nepotism and bribery seems to have generated an overwhelming view of the older performance appraisal system as dysfunctional and badly in need of regulation and modernisation.

Chapter 7: Medical Teaching Institution (MTI) Reform in the Teaching Hospitals of Peshawar (KP)

7.1 Introduction

This chapter presents the analysis and discussion of the second and third research objectives (RO2 and RO3) and related sub-questions RQ2.1-2.3 and RQ3.1. The focus is our understanding of the Medical Teaching Institution (MTI) reform in the public teaching hospitals in Peshawar, Khyber Pakhtunkhwa (KP). More specifically, we are investigating why the KP government introduced these reforms, how the key stakeholders perceived them, and the factors affecting their successful implementation. Due to the similar nature and structure of the three case study hospitals, the case insights and results are discussed together rather than separately. The findings are compared with those in the literature and the data is displayed in chart and tabular form wherever possible. A summary of the debate then sets down the basis for the fourth research objective (RO4), which addresses sub-questions 4.1-4.2. The table below provides a summary of sub-questions 2.1-2.3 and 3.1, and RO2 and RO3 of the study.

Table 7-1: Sub-Questions (2.1-2.3 and 3.1) and related Research Objective (RO2 and RO3)

Sub-Questions	Research Objective
RQ2.1: Why was MTI reform introduced in the teaching hospitals in Peshawar, KP? **RQ2.2:** How do the stakeholders perceive the MTI reform in the case hospitals? **RQ2.3:** Why do doctors in the case hospitals oppose the Act?	**RO2:** To clarify the rationale for the MTI reform and to identify how it was understood by the key stakeholders.
RQ3.1: What are the factors which prevent successful implementation of MTI reform?	**RO3:** To examine how MTI reform was implemented in the teaching hospitals.

In order to address these research objectives and related sub-questions, interviews were held with the different stakeholders, who were doctors, ward managers,

members of the boards of governance and the health minister. Four themes emerged from the interview data and supporting documents:

- Change in the public healthcare institutions
- Poor communication
- Conflict of interest
- Implementation issues

Table 7-2 below summarises the themes that emerged from analysis.

Table 7-2: List of themes

Themes	Major Categories	Minor Categories
Change in the public healthcare institutions	Political agenda	change, change slogan, election campaign, let down by previous governments, best management practice, experienced professionals, experts in the hospitals management,
	Faith in the newly elected government	charismatic personality, first time in power, change, dynamic leadership, honest leadership, young generation, youth, change in the system, charismatic leadership
Poor communication	Uncertainty	Job security, dismissal, previous system, rare dismissal, trouble in securing employment, lack of information about pension schemes, careers in the KP public healthcare, safe retirement life
	Confusion	pensions, GP fund, no idea, total chaos, no clear direction, MTI Act is not clear, ambiguous policy, rumours, headless chicken, chaos in the wards
Conflict of Interest	Private practice	abandoning private practice, cause of low efficiency, lack of trust, influence of senior doctors and ward manager, root cause of problem, direct admission, no protocol, bypass operation list, bed manager are influenced
	Loyalty to private jobs	good money, no accountability, influencing other healthcare, professionals, low pay in public sector, respectable life, lack of accountability, personal development, CV development, high earnings
Implementation Issues	Poor planning	modern healthcare, expensive affair, lack of planning, many projects, ran out funds, paying according to the old system, not full implementation
	Local actors	lack of communication, ignoring in MTI drafting, wealth of experience, experience of senior doctors, US healthcare policies, and private sector, local problems, poverty, local people, Professor Burki
	Bad attitude of leadership	rude behaviour, attitude problem, ignoring, threatening language, Pathan, dictatorial fashion, no respect for senior doctors aggressive attitude,

The micro-meso-macro framework used to analyse the data (see Chapter 4, Section 4.5) allows us to view the reform from multiple perspectives ranging from policy idea to implementation in the case hospitals. The analysis at each of the three levels is discussed individually.

7.2 Provincial government healthcare reform agenda

This section explores the overarching policy ideas, which represent the macro level of analysis. The focus here is the rationale for the healthcare reforms in KP province and the policy analysis. In order to develop a rich understanding of the MTI reforms, semi-structured interviews were conducted with the health minister of KP province and members of the boards of governance of the three case hospitals. The theme of change in public healthcare institutions emerged, and we also outline here the main features of the MTI reforms and changes to the previous structure of KP (in Section 7.3) which are relevant to the overall aim of this research. The section below describes the key points.

7.2.1 Change in the public healthcare institutions

The structural reforms implemented in the case hospitals were the consequence of political change in Pakistan. A new political agenda and public faith in the newly-elected government were major causes of institutional change in the KP healthcare system.

7.2.1.1 Political agenda

During the course of discussion, it was revealed that the PTI electoral slogan was ‘change’, and the momentum generated by the campaign led to concrete proposals for public sector reform. During the interview discussion the health minister stated that the PTI believed in the strength of public institutions and that Pakistan could not move forward without public institutional reform. He criticised previous governments for ignoring the public healthcare sector and reiterated that his party believed in the performance of public institutions and that public institutional reform was mandatory for future success. To this end, the PTI have also initiated reform programmes in other public sector areas, such as education, Inland Revenue and the police force. Elaborating further on healthcare reforms, the minister explained that in the first phase, the MTI reform was introduced in the three teaching hospitals of Peshawar as

a test case before rolling it out in other hospitals in the province. The minister claimed that the PTI had studied the best models of healthcare worldwide in order to select the most appropriate policies for the MTI reform. The party believe that the best hospital management practices in the world are reflected in the MTI reforms and the minister asserted that many Western countries have also adopted similar models. In his words,

> *'The PTI believe in systems and institutions. Pakistan cannot move forward unless we strengthen institutions…Like other public institutions, public healthcare has been ignored by the previous government… the PTI are introducing healthcare reforms in the KP healthcare system.' (Health Minister of KP)*

The government developed the MTI reform after studying many different healthcare models and in consultation with a number of experts. Research discussions with the health minister, board members and senior doctors revealed that an American professor, Nausherwan Burki, was instrumental in planning the reforms. Probing further, the author learned that Professor Burki is a founding member of the Shaukat Khanum Memorial Cancer Hospital and Research Centre (SKMCH & RC), which is a charitable specialised cancer hospital established in 1994 by Imran Khan, who is not only the leader of the PTI party, but is also related to Professor Burki. Looking into the success of the SKMCH & RC, Mr Khan requested Professor Burki to assist the KP government in managing its healthcare reforms. The health minister commented that,

> *'The reforms were initiated as a result of the party's promises to the voters when we ran the election campaign back in 2013… We don't believe in making promises and not keeping them, and we wanted to fulfil the voters' expectations.' (Health Minister of KP)*

It is evident from the discussion with the Health Minster that the PTI initiated public healthcare reform in order to fulfil pledges to the electorate and to demonstrate commitment to public sector institutions. In consultation with experts in the field, the MTI Act was passed and reforms were implemented. These reforms can thus be seen to be politically driven, and were to some degree enacted to satisfy voters and increase the party's popularity.

7.2.1.2 Faith in the newly elected government

During the course of the discussion, the doctors and ward managers expressed trust in the newly elected government, and suggested that unlike other political parties, the PTI were trustworthy as they had never previously been in power. Previous governments had not taken the initiative in healthcare reforms and their promises were limited to their election campaigns. On the other hand, the PTI was assuming power for the first time and possessed an edge that had not been tested before in the political arena. Further discussion revealed that trust in the PTI was to a large extent inspired by the leadership of Imran Khan. During the discussion the respondents frequently referred to the leader rather than to the party, and praised his dynamic and honest leadership. One of the participants believed strongly in Khan's integrity and in his ability to bring about changes important to the younger generation.

> *'From the very beginning the PTI were chanting 'change' in their election campaign…I think they can be trusted…This current government has an edge, compared to the previous one, due to its dynamic leader Imran Khan. He is young like Bhutto, he has worked a lot for his people. Employees have a fear in their minds that if they do wrong and move away from the government, the people will hold them accountable. The public and especially young people should be motivated to help the government implement change in the system.' (Senior doctor, Case C)*

During the discussions, the author noted that many respondents (30 out of 36) made frequent positive references to the new government and appreciated their reform effort in the healthcare sector. Apart from the healthcare sector, they gave examples of successful reform in the police force and in the education sector. During the discussions, the respondents were constantly comparing the current provincial government with their predecessors, and made many references to the perceived negligence of previous governments in bringing about healthcare reform. Generally, more than half of the respondents supported the reforms, as they had been regulated by out-dated policies that were introduced as far back as 1947, when Pakistan came into being.

7.3 The healthcare reforms - Medical Teaching Institution (MTI) Act

The aim of the MTI Act is to improve the performance of teaching hospitals in KP province by introducing structural, management and technical changes in the system. During the discussions with the health minister and members of the boards of governance, four main points emerged: decentralisation, institutional autonomy, performance auditing of doctors and introduction of performance-related pay in the case hospitals.

7.3.1 Decentralisation

The government set the reforms in motion by first of all decentralising the structure of the KP healthcare system. The previous structure had been highly centralised, as explained in Chapter 6. The MTI Act, however, shifted power away from the Health Secretariat and granted a measure of bureaucratic autonomy to the case hospitals themselves. Each hospital has a decision-making board of governance, which is an impartial and diverse group of 17 to 20 professionals, including accountants, lawyers, doctors, bureaucrats, deans of private and public medical colleges, technocrats and retired army officers.

> *'The board of governance is comprised of people from diverse specialised fields; their job is to provide technical advice and guidance on the implementation of the MTI Act.' (Member of Board of Governance, Case C)*

The purpose of heterogeneity in the boards is to encourage diversity of input on policy decisions, from legal, financial, administrative and healthcare management perspectives. The different specialists offer advice on many aspects of policy, and so the board is better informed when implementing initiatives. One of the interview respondents, the dean of a local business institution, explained his own role:

> *'The KP government appointed me to serve on one of the boards and my job is to assist in financial matters.' (Member of Board of Governance, Case A)*

With a background in accountancy, he is able to share his area of expertise with the board of the Khyber Teaching Hospital.

In general, the government provides policy frameworks to the boards for review and implementation in the hospitals. The boards are intended to be impartial and independent, and they are free to impose measures without interference from the Health Secretariat. They are answerable only to the Ministry of Health.

7.3.2 Financial autonomy

As well as bureaucratic autonomy, the MTI Act gave financial autonomy to the teaching hospitals. This has enabled the hospitals to function more independently, but they are now responsible for their own day-to-day running costs, and, interestingly, private practice now forms a major source of income for them. Initially, the MTI Act had prohibited public healthcare employees from working in private practice; however, in the interests of bolstering hospital income, the Ministry of Health and the boards of governance collectively decided to encourage private practice on condition that it takes place within the teaching hospitals and that half of the income goes to the institution. One of the respondents stated:

> *'Under the MTI Act I had to stop my private practice outside of the hospital as it is illegal now…but the government gave us an option to start within the institution…we can use hospital consultation rooms and equipment; however, we have to share our fee with the institutions'. (Senior doctor, Case C)*

This form of private practice within the hospitals is known as Institutional Based Practice (IBP) and is a major source of fund generation in all three of the case hospitals. Doctors wishing to conduct IBP in the evenings are allowed to use hospital facilities and patients can integrate their private and public healthcare treatment at the same hospital. In return for the use of hospital infrastructure, doctors pay 50% of their IBP income to the hospital, and payments for private X-ray and laboratory services also increase hospital revenues.

7.3.3 Accountability and performance auditing

A primary purpose of the MTI Act was to reform the accountability system of healthcare professionals. In the context of this study, accountability refers to attendance, time-keeping, and clinical auditing. In the previous system, only the ACR was officially used as an accountability mechanism, but this was judged to be inadequate for purposes of accountability and performance auditing, as discussed in

greater detail in Chapter 6. Interviews with participants and synthesis of MTI documents suggested that one of the main aims of the MTI reform was to revise the performance management system of the teaching hospitals. Under the new performance management system, the accountability of the doctors is divided into two categories i.e. general auditing and clinical auditing. According to MTI documents, general auditing refers to a doctor's 'attendance', 'sign in and sign out timings', and 'peer and patient relationship'. Therefore, to monitor attendance and time-keeping, the management have installed biometric equipment and CCTV cameras in each ward. Clinical auditing is set up to evaluate technical abilities of the doctors, e.g. the number of surgeries performed per day, success rates, and methods used. Each ward uses its own auditing measures as specified by the ward manager. Discussion with board members showed that they approved of the new system and were not prepared to compromise on matters of accountability. For example:

> *'With the MTI reforms we are introducing the concept of accountability in a true sense. This is genuine accountability…everything (performance) will be defined, clear as crystal…If the institution is not happy with an employee's performance, or if accountability is lacking, they will either be dismissed or we won't renew their contract' (Member of Board of Governance, Case B)*

7.3.4 Performance-related pay for doctors

One of the most important changes to the structure of the previous system is the introduction of performance-related pay. In discussions with board of governance members, it emerged that the authorities were particularly eager to introduce performance-related pay in the case hospitals. In the previous tenure-based system there was no link between pay and performance, but the MTI Act has introduced a new system of performance-related pay within public healthcare. The respondents suggested that the primary stimulus for the scheme was to motivate doctors and to develop a performance-based culture on the wards. As one of the board members pointed out:

> *'Under the MTI Act we have introduced performance-related pay in the hospitals, which is a step towards improving the performance of the doctors' (Member of Board of Governance, Case A)*

Respondents from the higher management levels suggest that Western healthcare employment models inspired the scheme. They were of the opinion that performance-related pay has succeeded in the West and that Pakistan would benefit from this next step in the modernisation of public healthcare. One of the respondents expressed his enthusiasm for the scheme:

> *'Importantly in the MTI we have introduced performance-related pay, which is new in the context of public healthcare in Pakistan. You can see that the modern healthcare model includes performance-related pay, and so we hope it will also give us the results we're aiming for.' (Member of Board of Governance, Case C)*

From discussions with respondents working in management roles it became apparent that the scheme is an example of isomorphic change, as they explicitly stated that it was directly influenced by Western healthcare.

We can summarise the context leading to the MTI Act as follows. Reform of the public healthcare system was a political initiative by the newly elected PTI government in KP province. During the election campaign the party had pledged to introduce reform, and since this was their first term in power they were keen to deliver in order to maintain and increase their vote bank for the next election. To ensure success, several healthcare management experts were employed to advise on policy. The American professor Nausherwan Burki, who successfully runs the Shoukat Khanum Memorial Hospital, was one of the main experts consulted, and the Act is largely an amalgamation of New Public Management style practices and a US healthcare model. The Act sought to improve doctors' performance in the teaching hospitals by instituting four major changes to the previous structure of management in the public healthcare system. First, a policy of decentralisation, which shifted bureaucratic power to an independent board of governance in each hospital. Second, the introduction of financial autonomy, which has led to Institutional Based Practice becoming a major source of revenue for the three teaching hospitals. Third, new accountability measures replace a dysfunctional appraisal system, and fourth, the introduction of performance-related pay to motivate better performance and promote competitive culture in the wards. In addition, the Act has introduced performance-based promotion, pension cuts, and the abolition of the 'job-for-life' tenure system.

With reference to the underpinning construct of this study (Chapter 4, Section 4.2.1), we can see that New Public Management-based reforms wield power at the macro

level due to the assumption it will improve accountability and job performance in public institutions and satisfy other stakeholders such as voters and local politicians (Hood and Peters, 2004). Our study supports the notion that New Public Management-based reforms are important at the macro level as a trigger of political and policy change which may diffuse to other countries. Further, Pollitt and Bouckaert (2011) suggest that diverse countries have their own reasons for adopting New Public Management reforms in their public organisations, such as decentralisation and autonomy (Norway), reducing the role of bureaucracy (Greek), countering recession and reducing expenditure by enhancing accountability (UK) and countering the role of unions.

With reference to the construct of the study, the argument of the thesis is twofold. Firstly, it supports the general notion that New Public Management reform takes place at the macro level of political and policy change, and that every country has their own reasons for adopting such policies in the public sector. Laegreid and Christensen (2013) remind us that New Public Management theory has widely influenced many national and local government policy innovations. New Public Management policies support a variety of objectives, such as countering recession, eliminating long-winded bureaucratic processes and restructuring traditional public sector culture. In such reforms, voters, bureaucrats, regional politicians and elected representatives are all viewed as critical to the process (Kaboolian, 1998). With reference to our study, healthcare reforms in the teaching hospitals of Peshawar were implemented in order to fulfil the PTI's campaign pledges. The Act is a mixture of New Public Management style policies with focus on decentralisation, financial and managerial autonomy, a new performance auditing system and performance-related pay for the healthcare professionals. The purpose of decentralisation was to speed up day-to-day decisions and to allow public hospitals to generate their own running costs. The previous structure, which had been in place since the Independence of Pakistan in 1947, was highly centralised and prone to corrupt practices which undermined overall performance. The new healthcare reforms aimed to bring the system up to date in order to improve the performance of public healthcare.

The second argument of the thesis centres on institutional theory, whereby the reforms appear to be driven by two of the three forces of organisational change, the coercive and mimetic types of isomorphism (DiMaggio and Powell, 1983) (as explained in Chapter 4, Section 4.2.2). Beckert (2010) reminds us that when institutions become discredited, hegemonic power influences them to initiate the

reform process. The 'change agent' is either the government, a regulatory body or political pressure. In the process, institutions mimic a successful institutional model in response to institutional uncertainty in order to attain legitimacy. In the context of our study, the reform initiative by the PTI government forced KP public healthcare institutions to improve their performance, which is a clear example of the coercive mechanism at work. Since KP healthcare was somewhat discredited when the PTI assumed power, the new government looked for outside help to tackle the problem of low efficiency. Professor Burki (a powerful external actor) was instrumental in designing the reform and used New Public Management style policy as a template for the KP healthcare system, a tactic of mimetic isomorphism. The role of the PTI in healthcare reform was more political than technical, since the government wanted to impose their party agenda in order to improve their vote base in KP and other provinces of Pakistan. Osborne (2010) and Laegreid and Christensen (2013) reminds us that New Public Management, political entities such as the electorate, bureaucracy, regional political groups and elected representatives are all viewed as important to the process.

The data indicate that the MTI reforms were introduced partly as a strategic move by the newly elected PTI to demonstrate integrity to the electorate. In order to gain popularity both at the provincial and national level, a number of New Public Management style reforms were introduced to diverse institutions in the public sector. These reforms mimicked policies originally drawn up the US, and were expected to work equally well in the context of Pakistani culture.

7.4 Reasons for resistance to the MTI reforms (contextual problems)

Implementation of the MTI reforms was strongly resisted by doctors and ward managers in the teaching hospitals. As discussed earlier in the context of the study, doctors went on strike for 25 days and refused to provide services in the public hospitals. During our discussion, the respondents pointed out three key reasons for this reaction: poor communication, conflict of interest, and implementation issues. This section discusses the meso and micro layers, i.e. how the MTI reform began to take shape as a specific programme in KP healthcare and how the Act was perceived, understood and interpreted by the doctors and ward managers in the case hospitals.

7.4.1 Poor Communication

The current provincial government carried out the MTI reforms in 2015; however, from the beginning, the Act was poorly understood by the doctors and ward managers. The doctors interviewed felt that the leadership had failed to communicate the objectives and principles of the MTI reform and that they had not been adequately informed about what the government was trying to achieve with the Act, nor how their employment would be affected in terms of permanent posts and pension schemes. There were many rumours in the public teaching hospitals that the new Act would enforce the privatisation of public healthcare and that this would have an immediate effect on doctors' employment and pension arrangements. The prevalence of these beliefs suggests that the MTI reform was widely misunderstood. The actual terms of the reform stipulated that the teaching hospitals would still ultimately be accountable to the Ministry of Health. The doctors and ward managers interviewed (36 out of 41) said that they had believed the government was trying to privatise the teaching hospitals and that, as existing staff; they would no longer be government employees. They believed that such changes would drastically affect the employment relationship and result in loss of pensions and public service career. In many cases, the respondents had remained unaware of the terms and consequences of the MTI reform, since the hospital senior management apparently had limited their communication of this information to one notice pinned to the noticeboard near the main entrance of the hospital. In most cases, the employees had gained their information about the reforms from colleagues, which led to many rumours and false interpretation of the Act. Explaining poor communication one of the respondent stated,

> *'To be honest, nobody is aware of the Act. The hospital management and administration are not completely aware of it, and neither am I. All I know is that the government is trying to privatise all teaching hospitals and there will be no more pensions and other funds, but to be honest I don't know anything more than that…I saw a copy of the Act hanging on the noticeboard, I was in a rush so I thought I would read it later, but next morning it was gone' (Young doctor, Case A)*

On the other hand, the Health Ministry and board members knew very well that the government was not trying to privatise the case hospitals, but rather making structural reforms to improve the performance of the teaching hospitals, (see Section

7.3). Thus, existing staff who were employed as civil servants would still enjoy the career privileges and status of a government employee, i.e. those doctors already employed by the public service commission before the Act retain the same permanent contract and pension arrangements. The changed terms of employment embodied in the Act were applicable only to those employed after enactment of the legislation, and who were appointed by the Ministry of Health on a contractual basis. In addition, the hospitals remain accountable to the Ministry of Health and continuously provide them with performance data. Hence, we can see that the MTI reforms were misunderstood by the key stakeholders doctors and ward manager. The Act clearly states that its intention is,

> *'To provide autonomy to the government-owned Medical Teaching Institutions and their affiliated teaching hospitals in the province of the Khyber Pakhtunkhwa to improve performance, enhance effectiveness, efficiency and responsiveness for the provision of quality healthcare services to the people of the Khyber Pakhtunkhwa.' (MTI Act, 2015)*

Almost all of the doctors and ward managers felt that poor communication by the authorities had led to general misunderstandings about the Act. It was evident from interviews that they had not understood the purpose of the reform, what kind of structural and management changes would occur after its implementation, or what the effect would be on their employment arrangements. The senior management had given almost no explanation and direction to existing healthcare staff and the result was confusion and strong resistance. Ultimately, the MTI reform was a political move by the KP authorities to deal with low efficiency and accountability by giving autonomy to the teaching hospitals, although each hospital would still be answerable to the Ministry of Health for its performance. The interview data shows that poor communication provided fertile ground for rumour and misinformation, leading to 'uncertainty' and 'confusion' which affected the implementation of the Act.

7.4.1.1 Uncertainty

The previous system was based on the Civil Servant Act, under which employees enjoyed life tenure of employment. Jobs were protected under the Act (as discussed in greater detail in Chapter 6) and so dismissal for under-performance was rare. If any employee was suspended or transferred to another hospital for any reason, the employee had the right to appeal for a court order against the decision. After the MTI

Act, these employee rights were withdrawn. Unsurprisingly, the interview data shows that the respondents were concerned about their job security, since implementation of the Act implied that they were no longer government employees and that powers of dismissal would lie with the board of governors instead. Thus, poor performance could result in dismissal. Doctors were understandably concerned that if they were dismissed they would have trouble securing employment in the private sector, since they had served in the public sector for so long. One of the respondents who had served in KP healthcare for fifteen years expressed his concern about the new Act and job insecurity. He complained about the changes, saying that under the previous system he had had a secure career with no threats of dismissal:

> *'Their policies are not clear about what they want to do, or what the future of our jobs will be and what will happen to job security. Before, we had permanent government jobs and nobody could just fire us; in the new system, the hospital can hire and fire any employee they want…I've served for fifteen years in the government sector and if suddenly I'm fired, where will I go then?' (Senior doctor, Case A)*

The stories of the respondents indicated that the government did not provide clear information about pension schemes for existing employees, and there were rumours that the Act would abolish the current pension schemes. The previous system was based on the civil system, under which doctors working in the teaching hospitals were eligible for workplace pensions and certain other privileges such as free accommodation. In this particular case, the pension scheme is known as the General Provident (GP) fund. More than half of the doctors were concerned about what would happen to their pensions and GP funds after the implementation of the MTI Act, which, as public servants, they had enjoyed for many years. The respondents were also concerned about privileges such as home allowance or a free flat in the doctors' hostel. They worried that the government would be able to take away a doctor's right to live in a flat as a government employee. Some of the senior doctors had served for more than 30 years in the public hospitals and were about to retire from their jobs. In the past, they had had many chances to settle for good pay and better career prospects abroad, in exactly the same way as their colleagues; however, they preferred to remain in public-sector hospitals and pursue their careers with the mind-set that by retirement age, they would receive pensions and their retirement life would be safe. However, since the MTI Act, they were unsure of what would happen to their pensions. One respondent stated,

'I have served this institution for thirty years and am very concerned about my pension. I had many chances in past to settle abroad, however, I refused and followed a career in the public sector, and now my hope is that my pension will enable me to live a good life after retirement.' (Senior doctor, Case B)

The leadership did not explain how the new system would apply to existing employees, many of whom had served for many years, in terms of whether their jobs would remain permanent or whether they would work on a contractual basis. This issue was not discussed in the MTI Act, and the ward managers were uninformed about it. This situation created a lot of uncertainty among the doctors, particularly those who had worked in teaching hospitals for many years as civil servants.

7.4.1.2 Confusion

Apart from pensions and other privileges, lack of communication about the MTI reform meant that respondents were not aware of changes to the promotion procedures under the new system. Previously, promotion had been based on seniority, and although the Act abolished this system, there were no other directives regarding what the process should be. Nearly all of the doctors believed that promotion is now based on performance, but there appeared to be no clear-cut rules in relation to this, i.e. who would assess performance and how it would be assessed. One of the respondents, who had served for 32 years in KP healthcare, suggested that employees were in state of confusion about the promotion criteria as there had been no clarification on performance assessment and indicators. No-one seemed to know whether the ACR (the previous performance appraisal system) would still be used, which itself is a biased system, and there was no direction whatsoever. Explaining this situation, one of the respondents stated,

'Now we are like headless chickens jumping here and there with confused states of mind. What will be the new statutory hours for the doctors' work? And the OPD? How will promotion will happen? And after serving 32 years what will happen to my pension? Everything seems a big mess.' (Senior doctor, Case B)

During our discussion, it seemed that another cause for confusion was the number of shift hours. It was thought that this would increase from six to nine hours. As there was no clear direction about this from senior management, rumour again played a

role in confusing the healthcare employees. In the previous system, each shift lasted six hours, and this was set to rise to eight or nine hours after the implementation of the MTI reform. However, respondents were confused about whether there would be a corresponding increase in salary or not. In the words of one of the respondents,

> *'I heard now we will be working nine hours, I don't know if it's the truth or just a rumour… if that's the case, will they increase the basic salary or not?...as I mentioned earlier, there is confusion about the polices, and even members of the board of governance are confused' (Senior doctor, Case A)*

Lack of awareness of the scheme and poor communication were frequently discussed in the interviews. Even the ward managers were not aware of how the reforms would affect their employment and promotion. Thus, we can see that most of the respondents were highly critical of the way the authorities were communicating information about the reforms, and this was thought to have led to the spread of false rumours. They were worried about the hospitals gaining new powers of dismissal and also concerned about changes to their pension schemes after MTI implementation. Derived from our discussion, Table 7-3 presents a role-ordered matrix (Miles and Huberman, 1994; p 123-126) showing how key stakeholders perceived the MTI Act.

Table 7-3: Role-ordered matrix: the perspective of key stakeholders on MTI reform

Individual	Types of Respondent	Poor communication	Example Quotations
Doctor	Junior doctor	Misunderstanding of reform: The MTI Act was misunderstood by the doctors and ward managers which created fertile ground for other consequences like uncertainty and confusion	*I am not aware of it (MTI reform). I have heard from here and there that the government will privatise the teaching hospital and there will be no pension system anymore.*
	Senior doctor		*I am not sure how they will assess my performance nor how they will regulate promotion. In the previous system, we had a 'job security' and now under the new system we don't have this any longer.*
Ward managers			*To be honest, nobody is aware of the Act. All I know is that the government is trying to privatise all teaching hospitals.* *Their policies are not clear about what they want to do, what will be the future of our jobs and what will happen to job security. Before, we had permanent government jobs and nobody could just fire you; in the new system, the hospital can hire and fire any employee they want.*
Health Minister Board of Governance			*The purpose of MTI reform is to decentralise the healthcare structure and give autonomy to the teaching hospitals. We want to focus on performance auditing of the doctors…the institutions will be run under the provincial government and they must provide us with their performance reports.* *The purpose of the MTI is decentralisation of the healthcare system… it's not privatisation…till the hospitals stand on their own feet, the government of KP will pay employee salaries.*

Junior Doctor = Medical Officer (Grade 17) and newly recruited doctors according MTI regulations**, Senior Doctor=** Assistant Professor (Grade 18 and 19), Associate Professor (Grade 20)

To summarise, generally, the respondents appreciated the effort and intention of the provincial government in introducing the MTI Act (at least during our discussion) and the younger doctors in particular were very enthusiastic about the reforms. However, they complained about the way the government communicated during implementation. During our discussion, poor communication was the focus most of the time and doctors complained about the leadership. The board of governance and other authorities failed to adequately communicate the MTI reform. The participants indicated that poor communication was the root cause of their misunderstanding of the reform act, and that this had generated much uncertainty and confusion. The findings of our study raised important questions about the role of the leadership and its failure to communicate the details of the Act clearly to the doctors in the case hospitals. In reality, the MTI Act was intended to give a degree of autonomy to public hospitals while they were to remain principally accountable to the provincial government. However, this detail was misunderstood by the majority of our interview respondents, whose information seemed to be limited to rumours of privatisation and pension cuts. Kotter (1995) suggests that in public reforms, the vision of the leadership needs to be organised into a plan which should be communicated clearly and unambiguously, so as not to create confusion among employees.

Referring to our data, senior management in the case hospitals did not formalise the planned changes or persuade other departments, such as human resources, to liaise with and communicate this information to the ward managers and doctors. With reference to our theoretical construct (as discussed in Section 4.2.2 in chapter 4), Beckert (2010) reminds us that the actual diffusion of an institutional model depends on the social structure, informational conditions and the will of implementation. The leadership has to have the capacity to manifest the envisioned model, and needs support from local actors in order to put the institutional blueprint into practice. In the case hospitals, the MTI Act entailed major changes to the structure of public hospitals and directly affected the employment conditions of the doctors. Because of this, regular meetings with key stakeholders should have been an important part of the process of conveying the details of planned changes and who would be affected. However, it seems that doctors in the teaching hospitals were informed only via a noticeboard, which proved to be ineffective. The leadership did not provide a clear vision and failed to convey the exact message of the reform, leading to misunderstanding of the Act and the creation of uncertainty and confusion. Van de Ven (1993) and Cloutier *et al.* (2015) reminds us that individuals are highly adaptable

to gradually emerging conditions, and a stimulus of significant magnitude is required for them to accept change as inevitable. In the case hospitals, the doctors, particularly the senior doctors, were in a state of shock because after working in the public sector for so many years and the leadership did nothing to reassure them. Cummings and Worley (2014) and Fernandez and Rainey (2006) emphasise the need for the leadership to take an active role and state that effective communication is vital in order for employees to understand reform and how it will affect them. From our data, we can see how policy makers performed poorly in this regard and did not communicate adequately how the MTI reforms would affect employees. The inevitable effect of this was rumour and wrong interpretation of the reform, which created uncertainty and stress among doctors and ward managers alike.

7.4.2 Conflict of interest

In the discussions with members of the boards of governance and doctors, it was suggested that one of the reasons for initiating the MTI reform was that certain practices were leading to a conflict of interests. Interviews with the health minister and members of the boards of governance revealed that they were fully aware of what is going on in the hospitals, i.e. that most of the doctors serving in public sector hospitals also ran their own private practices, particularly at the senior level. During the discussions, 'private practice' and 'loyalty of doctors to private practice' emerged as two factors that led to conflict of interest.

7.4.2.1 Private practice

In the context of this study, private practice refers to private clinics often run by senior doctors during the late afternoon/evening. Public healthcare employees at all levels commonly staffed these clinics as a way of supplementing their civil service income. The remainder of this discussion deals with how private practice impacted doctors' commitment to their public-sector work, as perceived by senior officials. In this regard, several questions were asked at junior and senior levels. The MTI Act also provides a little information on this, but the main data was generated by doctors and members of the boards of governance, who clearly explained why it has been one of the most important factors behind the low performance of public hospitals, and why MTI documents advocate its prohibition.

In the context of our study, private practice refers to private clinics in which doctors see patients who either do not want to go to public hospitals or who want to avoid

the waiting list in the public hospitals. These clinics have unfortunately been a major cause of low efficiency and compromised service in public hospitals. One of the objectives of the MTI Act was to ban this practice, since it represents a serious conflict of interest with a significant negative impact on public healthcare services. Some of the senior managers who were interviewed for this study suggested that the situation of public healthcare doctors running private practices is one of the main reasons why people no longer trust public hospitals. Since the implementation of the MTI Act, doctors who work in the teaching hospitals are prohibited from conducting private practice, although this blow has been mitigated by making provision for Institutional Based Practice. There was a general feeling among the majority of the respondents that conflict of interest lay at the root of the problem, although senior management revealed in the interviews that they felt unable to talk about it explicitly as a matter of tact. Government officials, however, were clear that working in the public sector while practising privately constitutes a conflict of interest. This issue was highly relevant to the senior doctors and ward managers. In the course of the interviews the author heard that ward managers are able to use their power to enhance and enrich their private practices, since all management issues lie in their hands. As ward managers, they control which patients are admitted to the ward and are free to recruit patients to their private practice. Patients who live at a distance believe that if they see a doctor privately, they have more chance of being admitted to the hospital. This point was raised by many doctors and they indicated that doctors who are also ward managers are very busy in their own private practices. In the words of one of the respondents,

> *'The ward manager is only interested in his private practice; he wants to see his own patients and wants them to be served well in a public hospital. When the bed manager finds out from a patient's notes that they see the consultant privately, he can't refuse the admission. There might be no vacant beds available, but as the consultant has seen him/her, the patient will be admitted at any cost.' (Junior doctor, Case C)*

According to the respondents, a senior doctor can forward a kind of 'pass' (written by the ward manager on a prescription slip) to the bed manager, with the implicit request to admit a particular patient to the ward. Patients have the mind-set that if they have been treated well by a doctor privately, they will be treated well in a public hospital, should they need to be admitted. Patients know that having paid for private

care, they will be admitted to a ward without any problem, and this peace of mind is considered worth the fees. In some cases, bed managers cannot admit patients without the permission of ward managers, who automatically give priority to patients from their private clinics. It was important to investigate this matter in greater detail, where it was further revealed that certain protocols are followed for admission to public hospitals, such as that patients are admitted to hospital only on a particular admission day (the week is divided into operation days and admission days); this is known as the 'route of admission'.

There are two ways a patient can be admitted to hospital, via the Out-patient Department (OPD) and Emergency Department. Direct admission means that patients who are seen in private practices do not go through Emergency or OPD. Instead, their doctor writes a message to the doctor who is responsible for admission, asking for the patient to be admitted directly to a particular ward. One of the younger doctors said that, broadly speaking, there are two kinds of people who attend private practice. The first are those who are rich; any operations are done relatively quickly in the clinic and they return home the next day. Others are poorer and cannot afford an operation in the clinic; in this case, they are admitted to a public hospital for their operation. During the discussion with the interview participants, it was clear that not only do these doctors use their powers to nourish their private practice, but they also use their authority to influence operating theatre protocols. Thus, patients who see consultants in their private practices are prioritised in operation waiting lists. Again, the doctor writes a note to the operating theatre supervisor to request that the private patient be given priority. The supervisor feels unable to refuse, and so others, who may have waited months for their operations or procedures, have to wait even longer. As one of the respondents explained,

> *'Not only do these patients get priority in admission to the ward but they also show up at the top of the waiting list on operation day…I feel sorry that those who have been waiting for months are bypassed in this way… this is the reality and is one of the pitfalls of private practice which affects patients of this hospital.' (Junior doctor, Case A)*

From the author's discussion with the respondents, it is evident that doctors are very committed to their private practices and use their public offices to promote these. The existence of private practice alongside public sector employment produces a

conflict of interest in the public healthcare system. This was not only suggested by the doctors and ward managers but also pointed out by members of the boards of governance and the health minister. In order to improve the performance of the public teaching hospitals, the MTI Act states that doctors who are working in the public teaching hospitals are forbidden to run private practices outside the institutions. There are two reasons for this action; the first (as discussed in Section 7.3) is that hospitals can generate their own funds by allowing doctors to conduct private practice within the institution on condition that they give a percentage of the fee to the hospital. The second reason for abolishing private practice is the problem of conflict of interest, as the government believe that it damages the trust of patients and lowers efficiency in public sector hospitals. There is a general perception among higher management and doctors that doctors use their public healthcare contacts and offices for the benefits of private practice. In the Pakistani Medical Association (PMA), which is the governing body for doctors in Pakistan, there is no ban on conducting private practice. The MTI reforms have abolished private practice among public sector doctors, who now rely on their salary alone; however, this has increased by 100%. The concept of conflict of interest was very evident in the discussion, and particularly among young doctors and those who were not conducting private practices. Many respondents suggested that the parallel system of private practice is the root cause of lower efficiency in public hospitals. The MTI Act seemed to state that, after its implementation, employees would not be able to carry out private practice outside of the institution.

7.4.2.2 Loyalty to private practice

The interview respondents explained that the doctors, nurses and technicians who work in private practices run them alongside public healthcare and work from late afternoon into the evening. The junior doctors assist their seniors while technicians maintain the machines and other equipment. Likewise, nurses work alongside doctors in their private clinics. Pakistani culture is very conservative and women are not allowed to be seen by a male doctor, and so the male senior doctors who own the practices appoint female doctors and nurses to assist them. One respondent raised the issue of loyalties, and said that in his experience, technicians were more likely to spend time repairing the equipment of private practices than maintaining machinery in the public hospitals, since private work is more lucrative. He also pointed out that,

'All of the junior staff go to work in private clinics after working at the hospital. These doctors, nurses and technicians are more loyal to the private sector. As you know, here (public hospital) there is no accountability so they can come late and leave early, however, they cannot do that in the private hospital… they are very punctual there and sign in and out on time.' (Senior doctor, Case B)

During the discussion, the respondents suggested that salaries are too low in KP public healthcare and that working privately provides them with the opportunity to earn more money. During the discussion, the author was interested in how these healthcare professionals manage two jobs, as the nature of the work is intensive and tiring. The respondents suggested that the lack of monitoring in the public healthcare setting meant that employees used to take advantage of the failings of the system by arriving late and leaving early, which allowed them to retain enough energy to work privately in the evenings. During discussion with senior doctors, the author observed that they were very reluctant to discuss this matter in detail. One of the junior doctors told how he worked for a senior doctor in his private practice for two years, until he found a job in the public sector. He stated that a senior doctor with an established private practice can earn more in one day than he would in a month in the public sector.

'To be honest salaries in the public healthcare sector are too low, a doctor working in hospital can earn almost the whole of his monthly salary in one evening of private practice, and so his interest is obviously going to be there. His priority is the private sector not the public. Obviously, you will give more time to work which carries more benefits, especially when there is no accountability.' (Young doctor, Case A)

According to the interview respondents, the clinics where the doctors conduct their private practices are private buildings furnished with high-quality equipment and facilities. In order to run their private practices, ward managers need supporting staff such as junior doctors, nurses and technicians, and they often recruit from those they work with in the public healthcare setting. During our discussion, the respondents suggested that we cannot hold the doctors solely responsible for this since the other healthcare professionals are also involved in this activity. One of the senior doctors agreed with this and revealed that in the private setup technicians are not forced to

work there, but that they are very conscientious in this setting, since the pay is better than their public-sector salaries. If a machine is out of order in the public hospital, there are no consequences if it is not reported immediately, but in private practice it would mean dismissal.

> *'The place where doctors conduct their private practice is known as 'Dubgari Garden' – it is almost like a private hospital… it is in multi-storey buildings with every facility for admissions and investigations, including CT scanners and operating theatres. The machines which are not in functioning condition in public hospitals will be properly functioning in private practice.' (Senior doctor, Case C)*

During the discussions, it was also revealed that despite earning much more money in the private sector than they do in the public sector, these doctors (senior doctors and ward managers) do not actually want to leave the public sector. They suggested that apart from a permanent career, public hospitals provide the base for networking with people and recruiting patients for their private practice. Further, by the time they retire, they will be eligible for a permanent pension for the rest of their lives. Highlighting the advantages of working in public healthcare, one senior doctor suggested that it is very important for their professional career and CV development, to work and teach in the medical college of public hospitals. In the public hospitals, they come across many different types of cases, which provide the opportunity to improve their knowledge and skill base. In addition, doctors earn respect in society by working in public hospitals, and this is another reason why they stay. Explaining the situation, one respondent stated,

> *'Well to be honest I like working here for many reasons…for example, it's good for my career development and my self-development, and there's the fact that public hospitals provide us with a platform for discussing and learning from the different cases we encounter in the teaching hospitals' (Senior doctor, Case A)*

These doctors are more loyal to their private practices but use their public work as a security net and client base, as well as benefitting from other perks, especially the retirement pension. The public-sector jobs are used for career development and for technical and medical support. Several respondents revealed that the public healthcare work functions as a kind of back-up service, in that if a doctor makes a

mistake and the patient became seriously ill, they can be sent over to the public hospital to be attended by a team of doctors.

To summarise, the data showed that the freedom to run public and private sector careers simultaneously was another important reason for resistance to the MTI reform. However, the new government takes the view that using public office to enrich private practice constitutes a misuse of power and that this conflict of interests is detrimental to public healthcare. The MTI Act thus prohibited doctors from running independent practices outside of their public hospital work, which naturally caused great anxiety among those who were supplementing their income in this way, and junior doctors resisted the new regulations by taking industrial action. Public hospital pay is considered by doctors to be insufficient to maintain social respectability and an appropriate standard of living; however, they remain in public service for three main reasons. First, their public position is a permanent and secure post, which brings perks and pensions. Secondly, the public hospital is where they recruit patients for their private practice, and thirdly, working for public institutions is good for their career development.

With reference to the theoretical construct of this study (in chapter 4, Section 4.2.1), the intentions behind New Public Management in public institutions is to depoliticise them and to reduce bureaucratic and elite interference. With reference to our findings, there are two strands to discuss in relation to the literature. Firstly, Kaboolian (1998) and Dunleavy *et al.* (2006) remind us that progressive public administration and democratic accountability depend on the elimination of corruption and incompetence. Powerful government figures routinely used high office to enrich themselves, their friends and relations, traditional public management was almost devoid of any meaningful accountability (Hood, 2000; Osborne, 2010; Laegreid and Christensen, 2013). Hood (1995); Hood and Peters (2004); Hood and Dixon (2016) suggests on several occasions that the accountability paradigm of progressive public management relies heavily on two basic mechanisms. One is upholding the distinction between private and public sectors in terms of ethos, business organisational design, career structure and reward system. The other is the maintenance of a buffer against political and powerful managerial discretion by elaborating the design and structure of the new management procedural system to prevent favouritism and corruption, while keeping a safe distance from the power elite and traditional custodians of the particular public services. With reference to our study, two aspects of New Public Management reform are important for our

discussion. Firstly, the decentralisation and shift in power to the boards of governance helps to reduce corruption in the Health Ministry and enables the board of governance to make decisions according to merit rather than political influence. Secondly, doctors and other staff who engaged in private practice were compromising the integrity and performance of the public healthcare services. After the MTI Act, private practice was forbidden and a new system of accountability introduced. The data indicate that the changes were designed to reduce the power of the senior doctors and to improve overall performance.

Secondly, in the context of institutional theory, DiMaggio and Powell (1991) and Beckert (2010) point out that acceptance of a specific institutional model or policies depends on whether the actors perceive it to be in line with their cultural identity, as well as their political and economic interests. Further, the authors suggest that if the actors do not find the policies to be in their interest, they are more likely to resists the change. Our study reveals that doctors in the case hospitals run their own private practices alongside their employment in the public sector. Private medical practice is a reality in developing countries and cannot be ignored (Ferrinho *et al.*, 1998). In the context of Pakistan, it is a legal practice; however, doctors in teaching hospitals are using their public office, position and authority to enrich their practices, which constitutes a conflict of interest. There is a general misconception that medical professionals are well paid worldwide and that they enjoy a higher standard of living than other professionals (Andersen, 2009). However, in the case of Pakistani public healthcare, doctors are underpaid compared to their counterparts in developed countries, and this is one of the main reasons for the phenomenon of medical migration. As doctors, these professionals are seeking a 'respectable' standard of living, which they cannot afford on their public-sector salaries. To maintain certain lifestyle standards, these professionals carry out private work in private settings, using their public hospital jobs to cultivate new clients, and they also encourage other support staff such as nurses and technicians to work with them during the evenings. Doctors' private earnings are much higher than their government salaries, and thus focus and loyalty swing from public hospital to the private clinic. As well as earning much more from private practice than from their public-sector jobs, they recruit private patients from those public-sector patients who would prefer to avoid waiting lists. The MTI reforms worked against the strategic and economic interests of the doctors, i.e. the Act restricted and regulated private practice and the new auditing system imposed performance accountability. Such action created divergent instead

of homogenous institutional change, because new reforms were not aligned with the strategic, political and economic interest of the doctors, who took steps to resist them.

7.4.3 Implementation issues

This section focuses on the meso layer of analysis in order to identify the factors that affected the successful implementation of the MTI reforms. Influence is drawn from the micro-meso-macro analytical framework as well as the original research questions as discussed in Chapter 4. During the discussions, the respondents identified three main factors that were affecting the implementation of the MTI Act in the case hospitals: 'poor planning', 'ignorance of local actors' and the 'rigid attitude of leadership' emerged as main factors.

7.4.3.1 Poor planning

There was a general perception among the ward managers and doctors that lack of proper planning of the MTI reform had led to delays in the implementation programme. Insufficient budget for the reform programme resulted in its temporary suspension at one point, and even now the government is struggling to implement the changes on time. In the words of an experienced ward manager:

> *'No planning was done for the MTI reform…the government employed too many specialised people on high salaries. They started on the refurbishment of the teaching hospitals and purchased expensive new equipment for them. The implementation of the MTI Act was halted for six months because the government ran out of money.' (Ward manager, Case C)*

It appears that the high salaries of the policy consultants involved in the reforms absorbed a large chunk of the budget, and that the financial burden was made heavier still by the government's decision to begin major hospital refurbishments at the same time. Modern medical practice is largely about investigation, and updating to state-of-the-art equipment is a highly expensive business. Thus, it was felt by the participants that a combination of poor planning and inadequate budgeting had served to hamper the reform process.

The discussions revealed that new doctors are, in theory at least, employed according to the new MTI rules and regulations. These include extended working hours,

employment on a contractual basis, and ineligibility for the older pension scheme. However, in practice, it seems that new doctors are being paid according to the old system. One of the younger doctors who was recruited recently as a medical officer (MO) claimed that,

> *'You won't believe it but it's a fact that they are paying us according to the old system, It's ridiculous…I am getting paid according to the old system.' (Junior doctor, Case B)*

His contract stated that he would receive 120,000 PK rupees (per month), but in practice he was getting 65,000 PK rupees, which was an MO's salary under the old system. On probing the matter with senior management, he was told that it was because the MTI Act has not yet been fully implemented and that the situation would be rectified in due course.

When the author raised this issue with the health minister, the minister denied that this could be the case and suggested that it was a false allegation. The matter was further discussed with ward managers and other junior doctors who were recently recruited under the MTI Act, who confirmed that they are being paid according to the old system. Respondents at senior level and those who are closely following the reform process suggested that the government has again run out of budget and is now using these tactics to save money.

7.4.3.2 Failure to consult local actors

The respondents were adamant that doctors from the teaching hospitals were not consulted at any stage of the drafting and implementation of the MTI reforms. Among them, senior doctors are the most important stakeholders in the healthcare system, since they have spent most of their lives working in the healthcare sector of KP and have accumulated a wealth of experience. They are thus very aware of the problems and are in a good position to advice on policy. The story of one ward manager was particular interesting, as he had worked in public hospitals in different cities and villages, and latterly in teaching hospitals, for twenty-five years. He had the opportunity to serve in all of the teaching hospitals in Peshawar. In putting forward his views on MTI reform in teaching hospitals, he criticised the authorities and policy makers and pointed out that no-one in the hospitals had been consulted during the whole process from draft to implementation of the MTI Act. The senior doctors are the most knowledgeable of all as they have worked in different contexts and

locations: villages (primary care), district hospitals (secondary) and city hospitals (tertiary and teaching). They are aware of the immediate and long-term problems and are in good position to give their input on improving the performance of the teaching hospitals and KP healthcare system. He further asserted that Professor Burki, who had a large influence on the terms of the Act, had no idea of how the KP healthcare system functioned or what the issues were, both in terms of institutional problems and local realities. He stated,

> *'Nobody consulted the doctors' community, and they are important stakeholders of the healthcare system…the senior doctors have a wealth of experience and they know the problems from the grass roots…But the authorities completely ignore us. I am not questioning the capabilities of Professor Burki but he does not know how the KP healthcare system works, the institutional problems, and what kind of patients visit here' (Ward manager, Case 3)*

The respondents maintained that despite their status as important stakeholders with many years' experience of service delivery and management, they were not consulted in any way over the reforms. Having worked with patients from all walks of life in a variety of hospital departments, these doctors could have contributed immensely to the reform drafting process. Professor Burki, who has experience of running a US healthcare hospital and the Pakistani SKMCH & RC, was instrumental in planning much of the reform, and his preferred healthcare model is clearly reflected in the MTI Act. For example, the formation of a board of governors and plans for financial autonomy of the teaching hospitals indicate that he was trying to implement a US based model in the Pakistani healthcare system. However, Pakistani public hospitals are very different to US hospitals and the SKMCH & RC. Under the MTI Act hospitals are now allowed to be self-financing, but much of this money has to come from prescription charges. In Pakistan, public healthcare treatment is free and the patient only has to pay a nominal prescription charge at the pharmacy counter, usually Rs20 (equal to $0.20). The patients who visit public hospitals are often very poor; in some cases they cannot even afford to pay the prescription charges, which are very low. Under the new Act, public hospitals are forced to generate money from these patients, which is unrealistic. One of the ward managers who had served 35 years in the KP healthcare system in different villages and cities was horrified at this development:

> '*Generating money out of these patients? I think it's madness, and the authorities are living in cloud-cuckoo land.' (Ward manager, Case A).*

Criticising the government's lack of consultation of local senior doctors in the MTI reforms, another participant pointed out that,

> *'No homework was done before drafting the reform. They were supposed to sit with those people who run the system, who are the real stakeholders. We have been working in the system for many years and they should have consulted us before bringing in the new regulations.' (Senior doctor, Case B)*

With regard to the problem of low efficiency in the hospitals, more than half of the junior and senior doctors in the sample suggested that the main problem is that the teaching hospitals are overcrowded and lack a referral system; members of the public from the whole of KP province attend teaching hospitals for every kind of health issue. Patients may be better off attending the basic health unit (BHU), which can deal with a range of conditions, but instead they travel from outlying villages, spending a lot of money, to have even the most minor complaints dealt with at the hospital. The lack of a referral system heavily overloads the teaching hospitals and they cannot give proper time to serious cases which need more attention. The government's failure to consult local actors was mentioned frequently during the discussion, particularly by the senior doctors.

7.4.3.3 Rigid attitude of the leadership

Stories of the rude and dismissive behaviour of the higher authority emerged during our discussion. We discussed in Section 7.4.1 of this chapter how the higher leadership failed to communicate information about the MTI reforms, thus creating uncertainty and confusion among doctors and ward managers. To sort out the confusion and uncertainty the doctors did their utmost to meet with board members, but without success, and they were directed towards the Managing Director and the Human Resources Director of the hospitals, who were unfortunately just as poorly informed. From the interview data, the author gathered that the underlying message of the authorities was that they were not interested in consulting on the MTI Act and that it would be implemented their way at any cost. The story of one of the doctors illustrates the rigid attitude of the leadership towards the implementation of reform

in the local hospitals. He recounted how the government authorities treated the strikers in a dictatorial fashion, refusing to enter into talks to resolve their issues. Instead of consulting doctors and taking them on board, they imposed the reforms on them by threatening to dismiss those who would not sign up to the Act. He suggested that this attitude is unacceptable here in Peshawar and that in his opinion it was not according to 'Pathan'[14]; reform and change should be discussed and agreed upon rather than unilaterally imposed by the government.

> *'During the meeting, the authorities suggested that MTI reform would be implemented at any cost, but they said it in a way that no-one would accept in a normal situation. This is KP - trust me, no one will accept it. Here you have to convince people politely and you cannot implement such reforms through force.' (Senior doctor, Case C)*

During the discussion, the attitude of the senior management was frequently brought up by the senior doctors and ward managers. They are on the verge of retirement, and feel that the way they are treated is inappropriate to their rank and years of experience. The author observed from the discussion field notes that the attitude of the health minister and senior management was aggressive, and that they were unwilling to compromise on the implementation of the MTI Act. The thematic conceptual matrix (Miles and Huberman, 1994; p 131-133) below in table 7-4 illustrates the problems encountered during the implementation of MTI reforms and which were addressed in the third version of the MTI Act.

[14] Also known as 'Pashtuns' are an ethnic group who mainly live in the Pashtun region of Southern and central Asia, in Afghanistan and North-Western Pakistan.

Table 7-4: Thematic Conceptual Matrix: Problems and Coping Strategies

Problem	Technical	Political
Contextual Problems 1. Lack of coordination 2. Uneven implementation	The focus was LRH and followed by other two hospitals which also create ambiguity among doctors. The MTI reforms have been implemented across the three teaching hospitals.	The PTI government new minister was appointed one year after the implementation.
3. Rigid Behaviour of Leadership	Empower different unions who can meet the Board of Governance and can address doctors' issues.	
Problem stemming from Programme/ Reasons for Resistance 1. Abolition of private practice for public healthcare employees	The doctors can run private practices in teaching hospitals, subject to certain conditions. The practice is knowns as Institutional Based Practice (IBP).	The MTI Act was revised and the senior doctors can conduct their private practices.
2. Poor communication 3. Inability to address local factors 4. Planning inadequacy 5. Paying new doctors according to the MTI Act	NOT ADDRESSED	The MTI Act was revised and the senior doctor are eligible for pensions.
6. Pension issue	The senior doctors are eligible for pensions	
7. Insufficient funds 8. Slow Implementation of MTI Reform	Budget for implementation was insufficient	More funds were allocated to the MTI reforms

During our discussion with respondents on the implementation of MTI reform four main points emerged. First, the government did not plan the reform appropriately and there was insufficient budget to successfully implement it in a timely fashion. Fernandez and Rainey (2006) firm that reform in the public sector is not cheap and involves a large financial outlay to include developing a plan for implementing reform, hiring and training new staff, and carrying out the re-organisation. Failure to provide an adequate budget may lead to weakening of the implementation effort and the creation of a higher level of personal stress among public employees. Likewise, highlighting the importance of budgeting and financial resources, Laegreid and Christensen (2013) suggest that proper planning for resources is critical for new reforms to be effective. Referring to the current study data, it is clear that the government did not plan the MTI reforms adequately and allocated too little budget

to the programme. Overspending on expert consultation, hospital refurbishment and new equipment very soon took its toll, and the implementation of the reform programme was abandoned for several months until new funding was approved. This also affected doctors' pay structure, and new doctors contracted after the MTI Act were paid according to the previous lower rates, causing a loss of faith in the senior management, the Ministry of Health, and most importantly in the MTI reforms themselves.

Secondly, the senior management did not consult local stakeholders while drafting and implementing the MTI reforms. By failing to consult the doctors during the process of drafting the Act, leaders not only missed a valuable opportunity to gather useful insight into the real problems faced by public healthcare, but they also angered their most experienced hospital employees, who felt that their wealth of insider knowledge was roundly dismissed and ignored. If politicians and bureaucrats refuse to take notice of such hard-won information, they are unlikely to make the best decisions for their community. The disrespectful way in which the doctors were treated during the reform process led them to strongly resist the changes that were implemented. If they had been genuinely consulted on the reform process, they would have felt that their knowledge and experience counted and that they were included in planning for change. By valuing employee feedback, the leadership could have reduced the barriers to change by creating psychological ownership of the MTI reform during both planning and implementation. However, by ignoring doctors' opinions and adopting an authoritarian attitude, the leadership only managed to add fuel to the fires of discontent.

Thirdly, with reference to the theoretical construct of this study (as discussed in Chapter 4, Section 4.2.2) and institutional theory, when institutions are discredited, reformers and politicians tend to adopt models or policies which have been successful in other sectors or countries in order to regain legitimacy. Explaining this same point, Beckert (2010) notes that politicians and reformers present the proposed reforms not as their own creations, but as being based on successful and high-functioning models from other countries. Likewise, in our study, government officials were mainly interested in copying New Public Management based policies and the US healthcare model, and, wanting to replicate the success of the SKMH & RC, they simply transferred a collection of New Public Management-style policies to the KP teaching hospitals. Thus, the main leadership error was rooted in the decision to use a healthcare management model from a developed country with very different cultural,

institutional and social conditions. Instead of considering the local context and institutional logics and conditions while drafting the MTI Act, the higher authority opted to directly copy New Public Management-based policies along with policies of US healthcare, which were designed to tackle performance and efficiency in the private institutions of that particular country. Beckert (2010), however, also acknowledges that reformers sometimes cannot avoid being influenced by the institutional arrangements of their region or country. This means that the original model cannot be implemented without modifications, which are of necessity shaped by the specific cultural, social and political context, and which result in the creation of a hybrid model of reform. In our study, the authorities adopted policies from the system used at the private SKMCH & RC, without taking into account the differences in health insurance and economic status of patients, as well as the purpose of public healthcare in developing countries and the fragile healthcare structure in which employers pay on the employees' behalf. In the case of Pakistan, many poorer patients attend public hospitals as they are unable to pay private healthcare fees. Looking back at our data, the stories told by some of the doctors indicated that some patients are unable to pay even prescription charges, which are very nominal, and therefore it is unrealistic for the government to expect them to pay for healthcare services. Taking guidance from institutional theory, it means the society and institutions of Pakistani healthcare are not necessarily compatible with New Public Management theory and policies adopted from the US healthcare. Local institutions and social problems in developing countries are usually considerably different to those in developed countries, and it is vital that this is taken into account by policy makers.

A fourth factor that emerged during our discussion was the attitude of the leadership in the change process. Elaborating on the role of leadership in the reform process, Fernandez and Rainey (2006), and Cummings and Worley (2014) suggested that the leadership has to build internal support for change in order to reduce resistance through taking on board the stakeholders in the change process. The author's further show that successful leaders acknowledge that change involves a political process of development and support from major stakeholders and organisational members. In our findings, the doctors in the case hospitals suggested that the MTI reform was unjustified as it would drastically effect their employment relationship and the way they worked in the public teaching hospitals. Van de Ven (1993) points out that although individuals are highly adaptable to gradually emerging conditions, a

stimulus of significant magnitude is required for them to accept changes as inevitable. In the case hospitals, the senior doctors in particular were highly anxious about any changes to their pension arrangements after so many years of public healthcare service, and they felt they lacked clear guidelines on how the Act would affect their employment. The attitude of the authorities was very disappointing and rigid and failed to address the concerns of doctors. The events chart below 7-1 (Miles and Huberman, 1994; p 115-117) summarises the timeline, different events related to MTI reform and implementation (rationale, formulation, implementation, strikes, revision and re-implementation) since the government announced MTI reforms and its implementation in the public healthcare system of KP province.

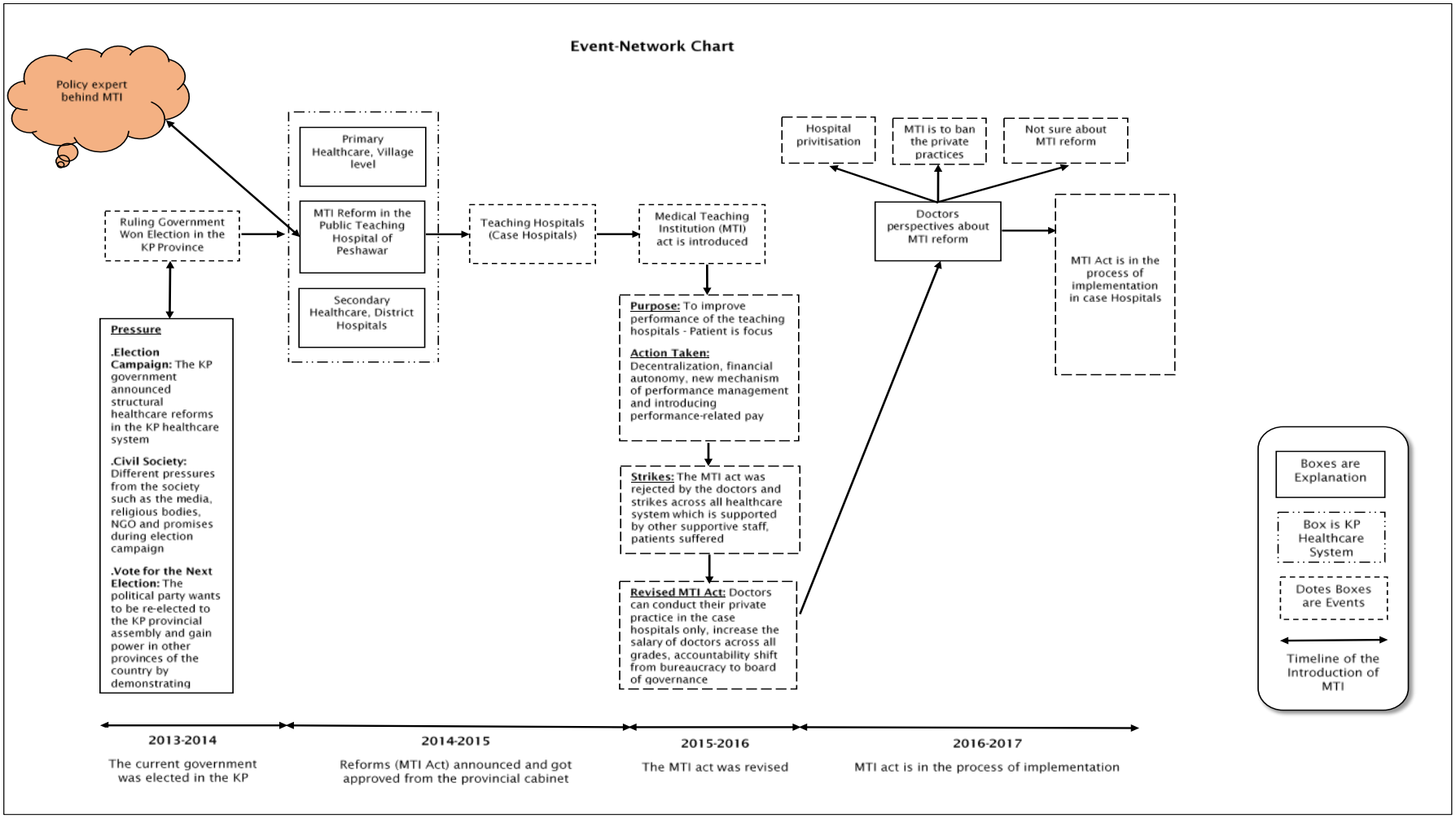

Figure 7-1: Timeline of events in the case hospitals

7.5 Conclusion

This chapter has presented the findings relevant to research objectives RO2 and RO3 and sub-questions RQ2.1-2.3 and 3.1, which concern the MTI reform and how it was perceived by the key stakeholders. Four themes were identified: change in the public healthcare institutions, poor communication, conflict of interest and implementation issues of the Act. The findings indicate that healthcare reform was a political initiative by the new government (PTI) to follow through pledges made in the general election campaign of 2013. In consultation with management experts, new policies were built along the lines of New Public Management and US healthcare models, and the main changes to previous structure were decentralisation, financial autonomy, a new performance appraisal system and, most significantly, performance-related pay. However, soon after their implementation the doctors resisted the reforms. One reason for this was that the terms of the Act had been poorly communicated to them, which led to rumours and misunderstandings. The other reason was that the Act prohibited doctors from running private practices alongside their public sector roles. Implementation of the Act was also hampered by three top-down issues: firstly, the Act was not adequately planned and the government failed to realistically estimate the costs involved. Second, during the whole drafting, planning and implementation process, the government and senior management neglected to consult those most affected by the changes. And thirdly, the dictatorial attitude of these higher authorities in the negotiation and implementation process alienated the employees. Thus, we can conclude that poor communication and conflict of interest, coupled with implementation issues of poor planning, failure to consult local actors and rigid management attitudes, led doctors and ward managers to take industrial action against the MTI reforms.

Chapter 8: Application of Performance-Related Pay in the Case Hospitals

8.1 Introduction

This chapter presents the analysis and discussion of the fourth research objective (RO4) and its related sub-questions (RQ4.1-4.2). The purpose is to explore the perspectives of key stakeholders on performance-related pay, which is one of the main MTI reform measures. The chapter examines to what extent performance-related pay is suitable for the public healthcare system in KP province, with reference to the analytical framework and sub-questions described in Chapter 4, and represents the micro level of analysis. Interview questions were drafted in such a way as to encourage the respondents to talk openly about performance-related pay in the teaching hospitals. Due to the similar structure of the case hospitals, the insights and results from all three are presented and discussed together rather than singly. Table 8-1 below summarises the fourth research objective and related questions.

Table 8-1: Sub-Question (4.1-4.2) and related Research Objective (RO4)

Sub-Questions	Research Objective
RQ4.1: How is performance-related pay viewed in the collectivistic society of modern Pakistan? **RQ4.2**: What is the effect of performance-related pay on doctors' professional attitude in the case hospitals in KP, Pakistan?	**RO4:** To explore how performance-related pay is perceived by the key stakeholders (doctors and ward managers) in the teaching hospitals in Peshawar, KP.

Data from the MTI reform documents and interviews with members of the boards of governance show that performance-related pay was introduced to motivate, improve job performance, and to develop a competitive culture. The rationale for the questions was explained in Chapters 3 and 4, and is echoed several times throughout the study. Data gathering took the form of semi-structured interviews with doctors and ward managers in all three case hospitals. Four themes emerged from the interview data:

- The nature of public healthcare institutions
- Social realities of Pakistan
- Standards in the medical profession
- Religion

As summarised in table 8-2 below.

Table 8-2: List of themes

Themes	Major Categories	Minor Categories
The nature of public healthcare institutions	Lack of support for continuing professional development	demands of the profession, discoveries in the field, no support from the government, mandatory for promotion, low pay, personal development, up to date with their knowledge
	Sacrifice family and leisure time	respectable life, low pay, prospect of earning, high social status, family expectations, financially necessary, high standard of living, inflation, low pay in the public sector
Social realities of Pakistan	Joint family system	financial burden, culture, welfare state, no support from the government, widowed sister, social system, tradition, culture
	Men as the sole earners	culture, norms, social structure, Pashtun culture, more burden, disgrace, against the Pashtun culture, food and shelter, values
Standards in the medical profession	Code of conduct	code of conduct in healthcare profession, commitment, care of patient, Hippocratic oath, ethical conduct, intrinsic motivation, individual's own code of conduct
	Medical training	medical education, guidelines in healthcare profession, teaching professionalism, ethics and conduct, taught, moral philosophy and ethics, syllabus, free medicine, commitment to professional standards, low pay, social respectability, not to reject patients
Religion	Inspiration from the teaching of Islam	guidance to help poor, Islamic teaching, Quran and Ahadith, Khuday da para, free medicine, poor patients, sake of God, fear of Allah, humble back ground, cannot afford nominal charges
	Sadaqha	inspiration from Islam, teaching of Islam, Quran and Ahadith, a gate for Jannah, fire of hell, Day of Judgment, fear of Allah, do not refuse poor patients, strongly motivated to help poor, to please God, Jannah

8.2 Performance-related pay in the teaching hospitals

The literature review in Chapter 3 points out that little has been written on performance-related pay in low-middle income countries in general and in Pakistan in particular. Therefore, during the interview, open-ended questions were asked about how the respondents view the performance-related pay scheme in the case hospitals, and more specifically about the extent to which the scheme is appropriate to public institutions in KP, Pakistan. During the course of discussion, 'the nature of the KP healthcare system' and 'social realities of Pakistan' emerged as a main themes, however, the ward managers' perspectives of the administration of the scheme (see Section 8.3.3) were also identified as being relevant to the overall aim of this research. The sections below discuss these key themes.

8.2.1 The nature of the KP healthcare system

The public healthcare institutions of KP differ in many ways from those of other healthcare institutions. The interview respondents highlighted two aspects that characterise the KP healthcare system. These are lack of government funding for continuing professional development, and the low pay, both of which mean that doctors often sacrifice family and leisure time in order to work at a second job.

8.2.1.1 Lack of support for continuing professional development

The respondents understand that medicine is a dynamic field that demands engagement with supplementary training during the course of professional life in order to keep their knowledge fresh and up-to-date. In the medical field, breakthroughs in healthcare are discovered and introduced into mainstream care on a regular basis and new treatments and techniques constantly being discovered and developed. Doctors are therefore expected to engage in continuing professional development (CPD) by attending a wide range of training courses. During the interviews almost all of the respondents acknowledged the need for CPD, since it ensures high standards of medical practice through the development of knowledge, skills, attitudes and behaviour. They explained that their CPD courses were a mixture of structured and unstructured, formal and informal activities that gave them new technical skills and updated their knowledge so that they were better able to serve the community. As well as

conventional training courses, CPD could also take the form of attendance at conferences and workshops both in Pakistan or abroad. The doctors acknowledged that CPD is a mandatory part of their job and defined it as attending regular training in their respective specialisms in order to build on and acquire skill and expertise. One of the respondents explained the necessity for CPD by pointing out,

> *'Every day we come across new and different cases in the out-patient department (OPD) which means we have get back to the literature and discuss amongst ourselves which is the best approach. Often, the cases we come across are not even described in the literature, and we need to know about new procedures and surgical techniques. Professionally, we are in any case required to keep ourselves up to date with progress in the field and enhance our knowledge and skills.' (Senior doctor, case C)*

Likewise, another respondent highlighted the importance of continuous professional development, saying,

> *'The medical field has evolved and changed a lot in several ways…now there are different methods and techniques being developed. In order to keep ourselves up-to-date with medical technology we have to engage in different trainings…Likewise we have to engage in research activity, which is not only important for the patients but also for our professional career too…Right through our professional career we engage with continuous professional development'. (Senior doctor, Case C)*

In addition to this, medical training and specialisms play an essential role in doctors' promotion in the KP healthcare system, as discussed earlier in Section 6.2. For example, if a medical officer (grade 17) is due to be promoted, according to the rules of the KP healthcare system their assessment is based on the number of years spent in the KP public healthcare, as well as the amount of specialised postgraduate training they have received, their research activities and teaching experience. Likewise, promotion from senior registrar (grade 18) to assistant professor (grade 19) needs further compulsory specialist training. To be

promoted to the rank of associate professor, publications and teaching experience in medical college are required. One of the respondents, who has passed the Part 1 theory and plans to take the Part 2 oral and practical exams next month, stated,

> *'You see I have to do my postgraduate training (which is surgery), because it's not only critical for my professional career but it's a basic requirement for promotion. Like other doctors, I want to get promoted to grade 18…Fifteen years ago we had to go abroad for specialisation, and now it is outsourced to major cities of Pakistan…Next month I am taking a post-graduate exam in Karachi' (Junior doctor, Case A)*

We can see from the data that doctors in the case hospitals also engage with CPD for their own benefit, e.g. as personal development, or in order to meet the requirements for promotion. However, government funding is not available for this, and so doctors are forced to study at their own expense. The respondents pointed out that CPD courses and exams can be very expensive as well as requiring travel, since many of them are held in the UK or the US. Most of the responds were very critical of the lack of government support for developmental training. One of the respondents recounted the story of how he had recently spent half a million Pakistani rupees on a particular surgery training in France, and was unhappy that the government had not helped him financially. He further stated that money was a big motivator for him in his work, since he needed it not only to look after his family but also to pay for his CPD:

> *'Yes, money is a motivator for me. The thing is, even if I leave my needs and my family's needs aside, I need money for other reasons too - in this world everything is money; if I want to enhance my knowledge or skills, I have to spend money on my own training. The government doesn't fund my professional development. Last year I went to a laparoscopic surgery course in France and paid half a million rupees for it out of my own pocket.' (Senior doctor, Case B)*

Likewise, a junior doctor also shared his experience of struggling to pay for his exams, which are part of his continuous professional development:

'You see, nowadays, with simple graduation there is no scope, I have to do post-graduate training if I want to excel in the medical field… These exams are very difficult to pass on the first attempt, and if I fail I have to do them again in six months' time, which means I have to pay again…the government don't fund my education and professional development, I have to pay for it out of my own pocket if I can afford it…on average one attempt costs 100 thousand rupees and my pay is sixty thousand a month, that means I have to pay forty thousand rupees of my own money to sit the exams.' (Young doctor, Case A)

It emerged that many of the respondents (27 out of 36) were critical of the government's failure to fund continuing professional development for public service employees. The nature of the medical profession demands that doctors keep up-to-date with their professional skills, and indeed extra training is often a condition of promotion in the different specialisms, as was pointed out earlier. The government, however, is not involved in this type of training and doctors have to fund themselves. Thus, the doctors in the case hospitals not only need money to live on, but also to fulfil the requirements for continuing professional development.

8.2.2 Sacrifice of family and leisure time

The respondents stated that all doctors in the case hospitals have a second job, and that the senior doctors mostly run their own private clinics. The senior doctors work in the public hospitals in the morning (the morning shift is defined as 8.00am to 2.00pm) and work in their second job (private clinics) in the afternoon/evening (usually from 3pm until late at night). Almost all of the senior doctors in the teaching hospitals conduct private clinics in Dubgari Garden, which is a private building in Peshawar where rooms can be rented. There is a consensus among all senior doctors that the second job is financially necessary, although it leads them to devote their evening and family time to work. The doctors, tired from their day's work in the hospital, rush straight to their clinics, sacrificing family and leisure time for the sake of more money. Complaining about the low pay in the case hospitals, they stated that it does not allow them to live a 'respectable life'. In Pakistani society, there is the general perception that doctors have high social status, and thus they expect to be able to maintain

a relatively high standard of living. The prospect of higher earnings compels them to take on additional jobs and to devote their family time to private clinic work. Highlighting the importance of money and complaining about the low pay in the public hospitals, one doctor suggested that private practice was a way they could provide adequately for their families. He admitted to missing out on quality time with his family:

> *'These doctors (who conduct private practices) miss out on their family life - for what? For the money, of course. As I said earlier, pay in the public hospitals is too low and as you can't live a respectable life on this pay, then you will be motivated to resort to private practice and in our society the doctor have status to have a good life…I miss my family time, I want to play with my kids but I can't because I have to rush to my private clinic in the evening.' (Senior doctor, Case A)*

Likewise, junior doctors either have a second job in a private hospital or assist in private clinics. These junior doctors carried out their second jobs in the evening time after finishing their jobs in the public hospitals. Stories from junior doctors suggest that public hospital pay is very low and that by the end of the month they are struggling financially if they rely only on this work. They confirmed that money is a major motivator for them, just as in other professions. During the course of discussion, one of the respondents compared this situation with the teaching profession, saying,

> *'If I said I don't give importance to money, I would be lying to you. Money is very important to me…In our profession, we do our jobs in the public hospitals during the day, and then work in private practice all through the evening until midnight. Likewise, in education, there are many coaching schools which have opened everywhere. Many teachers work in these schools during the evenings.' (Junior doctor, Case B)*

Generally, the respondents endorse the scheme in the case hospitals. More than half of the respondents felt that performance-related pay would give them an opportunity to earn more money in the public hospitals. They further suggested that if they could earn enough money to have a good standard of living, they

would not need to take on a second job, and they would then be able to spend more time with their families. However, during the course of discussion, a few respondents (6 of 36 respondents) posed the question of the adequacy of the reward; would performance-related pay be enough to meet their expenses, and would they enjoy a better standard of living? One of the respondents said,

> *'You see I think it's a good idea, this provides us an opportunity to earn more money…If I am able to earn enough money here to have a decent standard of living, I won't continue to put all that effort into a second job; I prefer to spend time with my family…the question is how much we can earn from performance-related pay? Is this enough to have a respectable standard of living?' (Junior doctor, Case C)*

The interview data shows that senior and junior doctors in the case hospitals agree that money is an important motivator for them.

8.3 Social realities of Pakistan

Pakistani society differs from others in many respects. The sociocultural realities are deeply rooted in the culture, rituals, values, traditions and religion of Pakistan. During the interviews the respondents pointed out two key sociocultural aspects which characterise Pakistani society, which are discussed below.

8.3.1 Joint family system

Reference was made to the joint family system on several occasions during the discussion, and this was investigated as a factor affecting the doctors' work-life balance. Almost half of the respondents were part of a joint family system, in which responsibilities are shared between family members. Probing further, it was revealed that a joint family in the context of Pakistani society comprises immediate and extended family members, including the families of siblings, as well as parents and grandparents. A few respondents also counted uncles, aunts and cousins as part of the joint family system. It is an interesting fact of Pakistani culture that people prefer to live in this joint system, looking after their extended family and sharing responsibilities. In such a system, the oldest family member leads the family and decisions are carried out collectively with the consensus of

the family. One respondent explained how problems were shared and dealt with by the whole family, saying,

> *'I live with my parents and siblings (three brothers and a sister), we have a joint family system…before that my grandparents also lived with us but they passed away five years ago…I think I prefer to stay in the joint family system, since, if anyone has a problem it is shared between the family members and we sort it out together.' (Senior doctor, Case A)*

The respondents believe that the system exists because the Pakistani government does not provide financial support to those in need, as is the case in Western welfare states. During the discussion, they referred frequently to welfare state countries which provide quality healthcare and unemployment benefits. However, in Pakistani society, when one family member is financially weak or having other problems, it becomes the responsibility of the other family members to help out. In other words, the financial burden is shared by all of the family members, and if anyone has a highly-paid job, they are expected to contribute more. Consequently, as doctors, the respondents accepted more financial responsibility for their families. One of the respondents explained how he worked to support his widowed sister and her son, as well as looking after their parents. He complained about the social structure of Pakistani society in which the government provides no support to the needy. He stated,

> *'My parents are still alive. They are living with me along with my other brothers and sisters; yes, it is a joint family. I have four kids but I am also sponsoring my nephew and niece; they rely on me. One of my sisters is a widow so now she is my responsibility. My other sister's husband does not have a good job, so her child is also my responsibility…In Pakistan, you have to look after yourself, even if you are out of work, as there is no support from the government.' (Senior doctor, Case A)*

Pakistani society is a collectivist one in which the concept of the joint family system is dominant and people prefer to live according to this tradition. The *Express Tribune* (2015) suggests that two-thirds of Pakistanis prefer the joint family system. If a member of the family falls on hard times, responsibility shifts

to those family members who have good jobs or are financially sound, for example, doctors or lawyers. In the context of our study, approximately half of the participants lived in the joint family system, where they shared the financial responsibilities. It seems that the participants all have more responsibilities due to the nature of the society they live in, and therefore, understandably, they place a lot of importance on money and earnings.

8.3.2 Men as the sole earners

It emerged during the discussion that the respondents adhere to certain cultural and traditional norms. The respondents explained that they do not allow female family members to do jobs outside. Pakistani is a patriarchal society where men take on many roles and are responsible for providing for their families, while women are obliged to stay at home. This is even more relevant in Pashtun culture, which is generally considered more conservative than the rest of Pakistani society. During the course of discussion, the respondents pointed out that they are the sole earners and are relied on by their entire family. The concept of the man as the sole earner arose on several occasions and was mentioned by more than half of the respondents, and so it was discussed in further detail. The respondents explained that in the Pashtun culture the man takes responsibility for providing shelter, food, clothing and all other necessities of life to the family. The wife looks after the children and takes care of the house. It is considered in Pashtun society that the standards of morality and respect for women are high in forbidding them to work outside of the home. Thus, it is the man's responsibility to provide all the family's necessities. One of the respondents told us how his wife is highly educated and holds a Master's degree, however, being from Pashtun family he does not allow her to work. He said,

> *'I have three kids and myself and my brother are the only earners in the family…my parents live in the village and every month I send some money to them because they rely on me and my other bother…My wife did an M.A. in political science but she is not working…No she is not working as it's against our (Pashtun) culture.' (Senior doctor, Case C)*

The author noted that a number of respondents mentioned that their wives were well-educated but were not allowed to work. Some of the wives were very highly

qualified and one doctor's wife had lived and worked in the US before her marriage. Further discussion revealed that Pashtun society forbids women to work due to cultural values and fears of disrupting family traditions. One Pashtun respondent admitted that he could not allow his wife to work out of fear that his father and other family members would consider it a disgrace:

> *'I bear all of the burden…You see my situation is different since I come from a village and we are a bit conservative about this… my wife did her Masters in Economics but I cannot allow her to work; she is now my responsibility…no I cannot allow her to do a job as it is against my culture… if my parents realise that she (wife) is working they will not be happy at all' (Young doctor, Case A)*

It is important to remember that Pakistan is a collectivistic society and that culture in KP province is more patriarchal and deeply rooted in customs and traditions than other parts of Pakistan. The interview data showed that half of the doctors in the case hospitals preferred to follow tradition and forbid female members of the family to work outside the home, mainly because it is against cultural norms. It must be remembered that almost all of the respondents in the sample were Pashtun, and they explained that the women in their families were not allowed to work outside the home, despite being well-educated, and that they, as sole earners, were expected to take responsibility for providing for the whole family. Following from this, they went on to explain that as they were culturally required to shoulder the family's financial burden, thus needing to maximise their earnings as much as possible. They felt that on the whole performance-related pay provided them with the opportunity to increase their salary in a fair and regulated way, and so they tended to approve of the scheme.

8.3.3 Culture of competitiveness in the wards

During the course of discussion, the participants gave their views on the introduction of performance-related pay in the teaching hospitals. Generally, they favoured the scheme and suggested that it would not only improve job performance but also develop a healthy competition in the wards. Under the old system there was little appreciation of good performance, while the new system seeks to distinguish between good performance, which will be rewarded with

higher pay, and bad performance, which will be treated accordingly. One of the respondents thought this was a good idea and that it would motivate employees to work harder and become more competitive. He felt that this would improve public healthcare services:

> *'Yes, why not? It's a good idea. If you encourage good performance, someone who is not performing well may become motivated. He will think, 'if he is getting more money, why not me?' People will start…a healthy competition will start…the ward performance will be improved and eventually patient care will be improved. Often, I think that good performers can see that we are all getting the same money, and wonder why they should work so hard if others aren't putting in the effort.' (Junior doctor, Case C)*

During the course of discussion with ward managers on performance-related pay in the teaching hospitals, they generally appreciated the scheme's potential to enhance motivation and establish a culture of competition among doctors. However, it appeared that the ward managers were also concerned about the increase in administrative load related to the scheme, including monthly performance evaluation, responsibility for budgeting and other paper work. Some of the respondents were very positive about the changes. One of them had taken a creative approach and developed her own performance management system known as 'Doctor of the Month'. This ward manager has 19 doctors on her ward and their performance is rated against a number of indicators that include punctuality, peer relationship, dress, research activity and behaviour towards patients and colleagues. She particularly emphasises doctors' attitudes towards patients and nurses, as she feels this has become a major issue in the teaching hospitals. Every month, after she has announced the winner, she hosts a tea party on the ward. She further commented that although this may appear to be a light-hearted competition, it is nevertheless very effective in improving performance. She endorsed the scheme in the teaching hospitals by explaining,

> *'You see I have my own management style. I appreciate a good performer on my ward and so I started an 'employee of the month' system in which we asked nurses and other staff who*

work with these doctors, about the doctors' performance…it's a minor thing but really effective.' (Ward manager, Case A)

This ward manager also believes that performance-related pay will not only improve the performance of the doctors but will also lead to healthy competition, and she favours the scheme based on her own experience of her employee of the month contest. She further suggested that young doctors who are beginning their careers would be very motivated by the scheme. It is worth noting that she sets her own performance indicators, which not only include quality of care but also positive attitudes towards colleagues as well as patients.

Based on the findings of the study, four key points emerged during the discussion related to the institutional and social realities of KP healthcare. There was consensus among the key stakeholders (doctors and ward managers) that money is a major motivator, and that the scheme should be endorsed for a number of different reasons related to social and institutional realities in Pakistan. One reason is that the government do not provide funding for mandatory continuous professional development, which can drain family finances, especially for those without a second income. Secondly, due to low pay in the public hospitals almost all doctors (senior and junior) found themselves working in a second job, drastically reducing family and leisure time. Thirdly, half of the respondents live within the joint family system and thus bear more financial responsibility towards members of their extended families, especially since Pashtun culture forbids women to work and share the financial burden. Under such circumstances the respondents in the case hospitals value money due to the institutional and social realties where they work and belong. Therefore, we can assert that the performance-related pay scheme has been generally accepted in the case hospitals and that the scheme has a positive effect on work motivation.

In comparing our findings with the theoretical constructs of this study (as discussed in Chapter 4, Section 4.2.3), we can observe similarities and differences in attitudes to financial reward. According to the theoretical constructs, in the public sector in general and healthcare specifically, employees do not value money and monetary rewards are not an effective strategy to motivate public sector employees. With reference to our findings in the light of

the theoretical construct of this study, there are four points to add to the discussion.

Firstly, our findings stand in contradiction to those of Andersen (2009) study of doctors working in Denmark. Andersen found that doctors valued their professional standards above their salary, while our study suggests that Pakistani healthcare professionals value money as well as high professional standards. To put Andersen's study in context, it must be pointed out that Denmark is a wealthy, industrialised country with a highly developed and regulated healthcare system; the country is a welfare state in the true sense. Danish healthcare professionals command high incomes and are therefore expected to perform to exacting standards. The violation of professional norms or malpractice in countries like Denmark lead to formal exclusion from the medical profession as well as other sanctions. Le Grand (2003; 2010) reminds us on several occasions that in welfare states, the government plays a major role in both finance and the delivery of social services such as education, healthcare, housing and social care. In a developed welfare state such as Denmark, benefits such as unemployment allowance and disability allowance are available, and the state is responsible for social care. However, public healthcare in Pakistan is socially, economically, institutionally, and culturally very different. In the context of our study, doctors in KP healthcare are underpaid compared to other professions in Pakistan and to their peers in other countries. This was revealed on several occasions in our discussions, in which doctors constantly compared their salaries with those of friends and colleagues working in healthcare abroad. The salaries they receive from the public sector are not enough to maintain norms of social respectability nor to fulfil their responsibilities to their extended families. Another factor in the nature of Pakistani healthcare institutions is the lack of government funding for continuing professional development. The respondents indicated that CPD training is very expensive and that they are forced to bear the expenses themselves. Another reason why Pakistani healthcare is different from others lies in the collectivistic social and cultural norms, i.e. almost half of the doctors live in a joint family system where they share financial burdens with other male family members. Therefore, institutional conditions coupled with the social realities of Pakistan make it different from others in several ways. Andersen's study, therefore, cannot be generalised to Pakistan, due to socio-economic, institutional and cultural differences. However,

our study findings are in line with Gosden *et al.* (2001) and Taylor-Gooby *et al.* (2000), who suggested that healthcare professionals value money as well as professionalism, and that performance can be changed by monetary reward.

Secondly, in public sector discourse, it is generally taken for granted that public institution employees do not value monetary incentives and that performance-related pay is not an effective strategy to improve performance. Perry and Wise (1990), Marsden and Richardson (1994) and Horton and Hondeghem (2006) suggest that public-sector employees are different to their private sector counterparts in term of response to monetary incentives. These authors take the view that employees engage in public service with a mission to serve the community and that monetary reward is not an effective strategy. Contrary to their conclusions, our findings suggest that doctors and ward managers value money just as much as any other professionals. Further, our outcomes suggest that the attitudes of doctors working in the public sector are similar to those of private sector healthcare professionals. The reason why public-sector employees accept performance-related pay is rooted in the institutional and social realities of Pakistan. In developing countries, such as Pakistan, public-sector salaries are so low that they are not even compatible with inflation. The doctors in the case hospitals are struggling to afford a respectable life and there is no financial support from the government towards continuing professional development. In addition, as part of the joint family system, doctors have more social responsibilities that included supporting weak members of the family and being the main breadwinner of the family in a country, which is not a welfare state. Performance-related pay therefore provides them with another avenue to increase earnings and contribute toward their social responsibilities. For these reasons, performance-related pay is more successful in developing than developed countries. Our research findings echo those of other studies in the public sector, such those of Rainey (1982), Crewson (1997), Andersen and Pallesen (2008), Liu and Tang (2011) and the recent study by Stazyk (2013) which suggest that there is not much difference between private sector and public sector employees in terms of the importance placed on money and the potential of monetary incentives to change performance behaviour.

Third, Pakistani culture is different in many respects. For example, Pakistani society in general, and KP society in particular, are very collectivistic and male-

dominated societies. In such a society families traditionally prefer to live together and share their joys and sorrows. When they come across problems they come together and take decisions collectively. If a family member is struggling financially it is the responsibility of the others to share the financial burden, and those with a good job or high earnings contribute more. For example, in the context of the study one of the respondents (a senior doctor) was sponsoring his sister and her son because she was a widow and had no income to support herself. In this situation the responsibility shifted to him since he is a financially stable member of the family. Although he is not legally bound to take responsibility, he is acting according to common practice in Pakistani culture. Secondly, KP society is a very masculine one that is also very sensitive to norms, rituals, culture and traditions, and these factors play a fundamental role in day-to-day living and decisions. In KP culture it has been the tradition for thousands of years that women stay at home to look after the children while the men take on the role of breadwinner for the family. For example, in the context of the study, it emerged that many respondents do not allow female family members to work outside of the home. Therefore, in the context of the study the respondents shouldered all of the responsibility for the extended family as the sole breadwinner. For this reason, respondents in the case hospitals accept performance-related pay since it offers more control over earnings. Thus, it can be concluded from the discussion that in collectivistic non-welfare states performance-related pay can be an effective and successful reward strategy to motivate employees. This contradicts, to some extent, Hofstede's (1983; 1991; 1993; 2007) theory of cross-culture regarding relevance of material based reward to individualistic societies only. Hofstede (1980; 1991; 1993; 2007) insists on several occasions that performance-related pay is more likely to be associated with cultures having higher levels of individualism and that collectivistic societies do not respond to the scheme. A common finding is that collectivism is more consistent with equal distribution of rewards, while individualism is more consistent with the distribution of rewards based on performance (Schuler and Rogovsky, 1998; Baruch, Wheeler and Zhao, 2004). Hofstede has identified Pakistan as generally being a collectivistic culture according to his theory; performance-related pay would not generally be appropriate for Pakistani organisations. However, contrary to this, our findings show that doctors in the KP public healthcare system generally accept performance-related pay because it gives them the opportunity to increase their

earnings. Despite working in the public sector, doctors in KP province place great value on their pay, firstly in the Pakistani masculine society they are the main breadwinners in the traditional marital relationship; secondly, being a collectivistic society they often take on a wider financial responsibility within the extended family; and thirdly, because they are required to pay for their own CPD training. Beyond cultural and societal explanations, the reason why our research findings are different to Hofstede's doctrine (individual vs collectivist dimension) may lie in the fluid nature of society. We know that culture and societies change over time, and that globalisation is influencing Pakistani culture and society. Hofstede's dimensions of culture were developed 35 years ago, but since then the world has changed dramatically in terms of business, management and society, with culture and societies becoming increasingly fluid and dynamic (Griswold, 2012). Different cultures are merging, technology is changing and the way we communicate is evolving, particularly recently, and globalisation is changing the way we trade and interact (McSweeney, 2002).

Finally, as discussed earlier in Chapter 3 (Section 3.3.3), the underlying idea of performance-related pay is: the greater the performance, the higher the pay (Baruch, Wheeler and Zhao, 2004; Armstrong and Taylor, 2014). Performance-related pay schemes work on the assumption that the promise of a reward will result in more work effort by employees, and that the establishment of a carefully-graded system of pay rises is the most powerful way to achieve this (Kessler and Purcell, 1992; Belfield and Marsden, 2003). It is also assumed that offering performance-related pay is a way to attract and retain employees as well as to develop and reinforce a competitive organisational culture (Brown and Armstrong, 1999; Co-operation and Development, 2005; Armstrong and Taylor, 2014). In terms of this study, the main aim of performance-related pay in the teaching hospitals was (a) to motivate doctors to improve performance and (b) to develop a competitive culture in the wards. The research findings suggest that the scheme has been accepted by the doctors and endorsed by the ward managers. The doctors are happy to compete for pay increases for many reasons, such as their need to self-fund CPD courses and support extended families, as well as their desire to maintain a 'respectable' standard of living. Any new opportunity to increase earnings is thus highly appreciated by them. Likewise, ward managers see the scheme as a way of developing healthy competition in the wards and improving job performance. Returning to the

literature on performance-related pay, authors such as Brown and Armstrong (1999), Co-operation and Development (2005), Heneman and Werner (2005), Armstrong (2010) and Armstrong and Taylor (2014) suggest that that the basic assumptions of performance-related pay are that it will motivate, attract and retain employees, as well as develop a competitive organisational culture. Our study findings show that performance-related pay achieves these goals in the teaching hospitals, partly due to the social and economic circumstances of the doctors as outlined above.

8.4 Performance-related pay and its effect on the professional attitude of doctors

As discussed in Chapter 2 (Section 2.4), the KP government introduced performance-related pay into Peshawar public teaching hospitals (Khyber Teaching Hospital, Lady Reading Hospital and Hayatabad Medical Complex) as one of the policies of the MTI reform of 2015. The mission of the public healthcare sector is to serve the community without expecting anything in return (Le Grand, 2003; 2010). Due to the nature of the public healthcare and type of profession, the author asked open-ended questions on the introduction of performance-related pay in the case hospitals. From the discussion with respondents 'standards in the medical profession' and 'religion' emerged as two factors, which prevented the public service motivation of the respondents from being undermined.

8.4.1 Standards in the medical profession

During the interviews it emerged that certain characteristics distinguish medicine from other professions; for example, the spirit of commitment that is pivotal to the vocation of healthcare. Our discussion revealed that two aspects, 'code of conduct' and 'medical training' are rich sources of motivation for doctors to serve patients to the best of their ability.

8.4.1.1 Code of conduct

The respondents pointed out that the healthcare profession holds to specific ethics and norms which are central to practice. During the interview, the term 'code of conduct' occurred frequently and so further discussion was encouraged.

The respondents confirmed that a code of conduct sets the standards expected of healthcare professionals, and that this professionalism is the basis of doctors' implicit contract with society. It demands that the interests of patients are placed above those of the doctor that standards of competence and integrity are established and met, and that expert advice is given to the best of the practitioner's knowledge. Elaborating on code of conduct, the respondents suggested that standards of healthcare conduct are deeply rooted in commitment, conditionality and relationships. They are committed to performance improvement, care of patients and self-accountability in all practices, with patients being the focal point at all times. They further explained that, contrary to popular belief, doctors no longer swear to uphold the Hippocratic Oath, although they do agree to abide by a very strict code of ethical conduct and to treat patients to the best of their knowledge and ability, regardless of race, gender and financial circumstances. Elaborating on the code of conduct associated with the healthcare profession, one of the participants expressed the unique nature of medical ethics and standards as follows:

> *'This field is all about motivation. We agree to strict ethical standards before entering the medical profession and we work under a certain code of conduct. We treat patients regardless of race and economic status…You see, this profession works under certain ethics that distinguish it from other professions. We have a specific and strict code of conduct to which everyone agrees to adhere.' (Senior doctor, Case C)'*

Likewise, highlighting the code of conduct associated with the medical profession, another respondent asserted,

> *'You see our profession is very different from others, there are rules and regulations under which we operate…the code of conduct is the spirit of this field and it helps us to make the best decisions on behalf of patients for their best interests...you cannot isolate the healthcare profession from the code of conduct as it is based upon it.' (Junior doctor, Case B)*

The respondents suggested that the medical field is itself intrinsically motivating and that people join this field not solely for money but to serve humanity. They

believe that the medical profession is beyond self-interest and involves self-sacrifice for the patients. During the course of discussion the respondents mentioned awareness of one's own code of conduct. Probing further the matter of a personal code of conduct, the respondents suggested that this may not be in total agreement with the code agreed by the majority of the profession but is individually arrived at. For example, one of the respondents had the following story to tell:

> *'To be honest, our profession is patient-centred…As far as professionalism is concerned, every person has their own level. We have a professor who only sees twenty patients per day in his clinic, since he feels that to see more than twenty would be unfair to his patients.' (Senior doctor, Case A)*

So even if this professor theoretically could see forty patients and earn double the money, he is acting ethically and according to his professional code of conduct. The respondent who told this story is also highlighting that doctors may impose their own personal ethics in addition to the standard codes of practice.

Similarly, another respondent elaborated on personal code of conduct in this way:

> *'Code of conduct is very important to our profession, but in addition to our professional code of conduct every doctors has their own code of conduct as well…for example some doctors suggest there should not be any private practices while other suggest it's a legal practice. Likewise, some doctors don't see many patients in the private clinic, while others don't care and see as many as they can; you see it's a matter of the individual's own code of conduct.' (Young doctor, Case C)*

It was evident from the respondents that the medical profession works under a specific code of conduct which makes it different to other professions, and that these codes of conduct are deeply rooted in professionalism. This code of conduct provides guidance on how to carry out professional tasks. Respondents further suggested that monetary rewards do not undermine professional attitudes as they continue to take guidance from their codes of ethical conduct and altruism. They gave examples of colleagues who demonstrate high

standards of professionalism and for whom the code of conduct is more important than high earnings.

8.4.1.2 Medical training

It was pointed out in the discussion that from the very start of medical training, doctors are given guidelines on professionalism in practice, and that ethics and professionalism are emphasised throughout the course. Medicine is one of a small number professions in which professional ethics are taught as part of the syllabus. On discussing the matter further, the respondents explained that they are specifically instructed on moral and legal issues which are relevant to medical practice. As well as ethics and conduct, there is an emphasis on altruism and one's obligations to society. More than half of the respondents point out that during training, students have to demonstrate certain attitudes, including an awareness of the moral and ethical responsibilities involved in individual patient care and in the provision of care to special populations. In addition, during practical training on the wards, medical students learn how the code of conduct works by observing the senior doctors. One of the important points they are taught is to treat all patients equally, whether rich or poor. In addition to this, during their continuing professional development and postgraduate training they are taught modules other than medical education, including moral philosophy and medical ethics. Such training helps them to understand that professionalism is not inherent but rather an acquired quality. A number of the respondents who ran private practices indicated that they would waive the fee for those patients who really could not afford it, and in some cases, doctors also provided free medicines. The respondents suggested that it was their commitment to professional standards which prompted this kind of action. One of the respondents told us how he dealt with this kind of situation:

> *'We are taught in medical college and trained in the ward about our professional attitude, how should we carry out our work professionally. This profession is very noble and I entered it by choice…I conduct my private practice in Dubgari Garden, and sometimes I come across poor patients who cannot afford my fee. In such cases I ask them how much they can pay, then I charge accordingly. In some cases, I see them for free. I have*

been taught in my professional training not to reject patients simply because they are poor.' (Senior doctor, Case B)

Many respondents described the satisfaction they get from meeting patients whom they have treated when they are well again. They felt that this kind of job satisfaction is only experienced by those in the healthcare profession. Entering the medical profession was by choice, not force, and the main motivation was to serve others. Many participants felt strongly that higher earnings would not kill their altruism and job satisfaction in being a doctor. The main problem for doctors in the case hospitals was that low pay meant they struggled to provide their children with a good education and found it hard to maintain social respectability in material terms. One respondent was adamant that monetary reward did not undermine his professional attitude, but on the other hand, he said that low pay and inability to send his children to good schools meant that he was unhappy with his job:

'You see doctors adhere this profession by choice…I get a lot of satisfaction when I treat people; I don't think I get that much satisfaction in any other area of my life. But I don't think that performance-related pay will kill our intrinsic motivation. My requirements are that I need adequate financial reward as well as job satisfaction. If I cannot provide a good education for my children, how can I be happy with my job?' (Senior doctor, Case C)

We can see from the data that doctors are well trained in professional practice and are comfortable with treating patients whatever their social or financial circumstances. In some cases, respondents who work in private practice do not charge patients for treatment or medicines if they are unable to pay. Thus, it is clear that for the majority of the study participants, performance-related pay does not undermine the professional standards and attitudes they were taught at medical school.

The discussion data show that healthcare professionals work under certain rules and regulations which distinguish them from other professions. Among them, code of conduct is an important concept, being an unwritten yet very important aspect of belonging to the healthcare profession. It represents doctors'

obligation to society and to the best interests of the patient, and implies the sacrifice of self-interest for the benefit of the community.

To summarise, medicine is among the few professions in which ethics and moral philosophy form part of the syllabus. Most of the respondents were altruistically motivated to a level where financial reward (performance-related pay in this case) did not affect their professional attitude. Their profession is a permanent source of motivation for them, and they believe that the codes of conduct they agreed to when entering the profession represent a commitment to serve their community. They are motivated by money in order to compensate for their lower public-sector salary and maintain what they feel is an appropriate lifestyle. However, the respondents believe that neither performance-related pay nor any other financial reward scheme would undermine their strong sense of altruism due to the nature of their profession, where compliance with the code of conduct is imperative to the their profession.

8.4.2 Religion

As mentioned earlier in Section 9.2, Pakistani society is deeply rooted in its values, customs and, most importantly, religion, which make it different from other societies. The vast majority (97%) of the population of Pakistan is Muslim, and religion plays an important role in daily life. The respondents pointed out two aspects which stem from their religion and shape their thinking in terms of helping individuals and the wider community.

8.4.2.1 Inspiration from the teaching of Islam

During the discussion, it emerged that the participants were motivated to help less affluent patients by the ethics of their religion. During our discussion they described how Islam gave them inspiration and motivation to help patients in need and stated that they try to help the poorer ones for the sake of God - (the term locally used as 'khuday da para'). They gave a number of examples from the Quran[15] and other Islamic teachings, in which God and the Prophet Muhammad (peace be upon him) exhort us help our fellow human beings and

[15] The Quran contains the main holy scriptures of the Muslim religion and represents the fountainhead of divine guidance for Muslim life.

explained that God promises reward selfless behaviour. Thus, aside from professional duty, religion is a major source of inspiration to help others, particularly the poor, as well as the wider community. One of the respondents told us that he allows patients to have free medicine if it is clear that they are unable to afford the prescription fees. Explaining the religious motivation for this kind of altruistic action, he stated that,

> *'Apart from our professional duty I try to help these people (especially poor patients), because our religion encourages us to help the poor…If somebody comes from my village I always try to get them free medicines for the sake of God, and for that, God will reward me…to be honest I am not the only one; there are many more doctors who try their best to help patients along with their professional obligations' (Senior doctor, Case B)*

It emerged during the discussion that the doctors and other staff members in the ward try to help those patients who cannot afford nominal charges in the hospital. Like any other public hospital in KP, there are nominal charges for prescriptions and tests and it is obligatory for every patient to pay them. However, one of the respondents pointed out that many patients cannot afford even these charges. In such cases, doctors often set up a collection among the staff to pay the fees for these less well-off patients, who offer many prayers in return. Doctors felt that this spontaneous response to the needs of others reaches beyond the boundaries of professional duty and is stimulated by their firmly-rooted religious convictions. One of the respondents explained it as follows:

> *'To be honest there are many patients coming to the hospital who even cannot pay for their prescriptions and essential tests. In these situations we and other staff members collect money for them and help them out as much as we can…I know it's our professional duty to help patients but we go the extra mile and collect money for them. Of course our religion teaches us to help others who are in need.' (Senior doctor, Case A)*

The same spirit was also observed among other doctors working in private practice who did not charge patients with little means to pay the fees. They affirmed that aside from professional demands, their religion forbids them to

refuse treatment to patients who struggle to pay. They pointed out that Islam teaches the importance of looking after the poor, and quoted verses from the Quran and Ahadith[16] which promise that this behaviour will be rewarded by God. Another respondent from a humble background told us that he never charges patients in his private clinics who cannot afford to pay, firstly out of respect for God, and secondly because he has himself experienced the same situation. He also said that he provides free medicines to the patients who cannot afford them. In his words,

> *'Sometimes I see patients who can't afford the fees, and I take them on for the sake of Allah. I'm from a very humble background and struggled a lot to become a doctor. I know what it feels like to be poor. We get a lot of representatives from pharmaceutical companies coming to the ward to promote new drugs. They leave us a lot of free samples which I distribute to poorer patients.' (Senior doctor, Case C)*

It can be seen that respondents are motivated to help less affluent patients through the teachings of Islam. Islamic scripture clearly promises that those who help humanity are specially rewarded, and the doctors interviewed were all committed to following the requirements of their religion. There was a consensus among the respondents that they should not refuse treatment to patients who are unable to pay. Aside from professional commitment, religion is a major source of motivation for doctors to give freely of their services to those in need.

8.4.2.2 Sadaqah (Charity)

During the course of discussion, the respondents revealed that they regularly give Sadaqah in one form or another to help poor patients. Sadaqah means to give charitably and voluntarily, out of the goodness of one's heart, and the concept of charity is given a great deal of importance in Islam as well as in other religions. The ultimate goal is to help people in need, and to give Sadaqah is highly preached and encouraged in Islam: 'Give Sadaqah without delay, for it

[16] Ahadith (plural of hadith) is one of various reports describing the words, actions, or habit of the Prophet Muhammad (P.B.U.H).

stands in the way of calamity' (Tirmidhi: 1887). Many verses in the Quran and Ahadith are devoted to the importance of giving Sadaqah, which could be in the form a charitable act, charitable giving or donating money with an intention to please Allah. The respondents explained that Islam is very clear on Sadaqah and that it is a distinctive feature of the Islamic teachings. During the course of discussion more than half of the respondents highlighted the role of charity and reward in Islam and gave examples from Islamic scriptures. Some of the participants suggested that Sadaqah is the gateway to Jannah (paradise), while others believe that if one gives Sadaqah to others, Allah will respond with rewards both in this world and on the Day of Judgment. A few of the respondents suggested that Sadaqah guards against hell fire, and backed this up with references from the Quran and Ahadith. One respondent asserted,

> *'You see there are a lot of different verses in the Quran about Sadaqah, which suggest how much God loves those who regularly give it. For example, Sadaqah will guard you against the Fire (of Hell), even if it be only with half a date-fruit (given in charity); and if you cannot afford even that, you should at least say a good word.' (Al-Bukhari and Muslim via a senior doctor, Case C)*

It emerged during the course of discussion that the participants give Sadaqah to the patients who visit them in the private clinics. Sometimes poor patients come to the clinics but cannot afford the fee, so doctors do not refuse them and they are treated for the sake of Allah. A few of the doctors explained that they dedicate a full day in their private clinics to seeing poorer patients because they consider it as Sadaqah. One of the respondents told us how he sees impoverished patients every Friday in his private clinic, and he explained that his religious principles led him to attend the poor free of charge one day a week. He believes strongly that as God gave him the skills, it is incumbent on him to treat the poor for free for the sake of Allah. He stated,

> *'I spare one day (Friday) in my clinic to see poor patients for free…This is my practice of Sadaqah and I do it for the sake of God. Islamic teachings tell me that God loves those who help the poor, and the Quran says 'And whoever volunteers good – then*

indeed, Allah is appreciative and knowing'. (Ward manager, Case B)'

The interview data shows that most of the respondents are altruistically motivated to help poor patients, and that they derive such inspiration from the concept of Sadaqah, which is an important teaching in Islam. Islamic scripture plays an important role in shaping their thinking, and the respondents often gave examples from the Quran and Ahadith. Almost all of the respondents help poor patients in different forms; senior doctors help them in their private clinics by giving discount or in many case not charging, while junior doctors play their role in the public hospitals by providing free medicines or finding other means to help them pay charges. Helping these patients is done solely for the sake of pleasing God and the scriptures suggest that those who help others will be rewarded for their actions.

It is clear that religion plays an important role in shaping doctors' attitudes towards their patients in the hospitals and private clinics, particularly poorer patients. It is clearly written in the Islamic scriptures that we have an obligation to help those less fortunate than ourselves. There was consensus among all doctors that their religion encourages them to offer Sadaqah to please God. It is clear from the discussion that religion is an important influence on their day-to-day decision making.

To summarise, we can see from the data that the introduction of performance-related pay did not undermine doctors' professionalism for two main reasons. Firstly, the medical profession demands adherence to a code of ethical conduct which is the core of the healthcare professions. Secondly, their Muslim religion represent a strong source of inspiration to help patients in both public hospitals and private clinics. Many doctors in the case hospitals who run private practices do not refuse poor patients, while others help patients in public hospitals by providing free medicine or organising a collection to pay the fees for those who cannot afford them. They further indicated that performance-related pay did not undermine their professional attitude and that their religion inspired them to help the poor patients. Therefore, performance-related pay can be said not to undermine the professional attitude of the doctors.

Returning to the theoretical constructs relating to performance-related pay in the public sector, we saw in Chapter 4, Section 4.2.3 how scholars such as Frey, Homberg and Osterloh (2013), Wright (2007) and Durant *et al.* (2006) argue that performance-related pay in the public sector in general, and in public healthcare in particular (Grand, 2010), is not an appropriate strategy and that it undermines prosocial behaviour. Prosocial behaviour is seen as an essential attribute of employees in public service industries (Perry, Engbers and Jun, 2009), and the argument for this is rooted in Self-determination and Public Service Motivation theories (see Chapter 4, Section 4.2.3). With reference to our theoretical constructs, our research calls into question the claims that performance-related pay undermines public service motivation (Bellé, 2015) and that public healthcare professionals do not place the same importance on earnings as their private sector counterparts (Andersen, 2009). With reference to the theoretical arguments, the evidence of our findings allows us to comment on two main strands, as follows.

Firstly, looking at the idea that monetary reward erodes the spirit of public sector work and undermines prosocial behaviour, most of the studies in public service motivation discourse are experimental and use the positivistic paradigm to reveal a linear relationship between monetary reward and public service motivation in a closed system, where the situation and other factors remain constant, and the relationships between variables or concepts is studied (Wright, 2007; Perry and Hondeghem, 2008; Perry, Engbers and Jun, 2009; Bellé, 2015). The validity of this research, however, is questionable in the real world context, since, as Frey and Jegen (2001) remind us, it is difficult to induce the experience of incentives experimentally. Our data, on the other hand is derived from employees who work in real public institutions with an open system, where other factors such as culture, politics, profession, value, social problems and religion are variables which influence thinking and behaviour. Our outcomes suggest that performance-related pay does not undermine professional attitude, and the two main reasons for this are strong professional standards coupled with deep religious conviction. The healthcare profession is different from others in many respects because of the nature of the services it provides and the particular code of conduct that practitioners are obliged to observe. Aside from practical training, doctors are also taught to consider the ethics and moral aspects of their profession. In addition, they engage in continuing professional development

during their entire medical career. The doctors' strong prosocial behaviour is also rooted in their deeply-held religious conviction. The research participants all derive their inspiration and motivation from Islam, which teaches followers to help others less fortunate than themselves, especially the poor, and for this they will be rewarded. In the context of the study, then, religion plays an important role which shapes day-to-day actions and decisions. Islam also includes the concept of Sadaqha, which can be translated as voluntary charitable aid to all in need. In the context of the study several participants were engaging in different forms of Sadaqha either by not charging poor patients or by contributing to the payment of their fees. This study has found that when professional standards and norms are coupled with religious conviction, performance-related pay does not undermine public service motivation.

The second strand of the discussion hinges on the concept of public service motivation. Public discourse literature defines public service motivation as the protection of public and community interests over that of self-interest. For example, Perry and Wise (1990) show that this kind of motivation is grounded primarily or uniquely in public institutions and organisations, and Rainey and Steinbauer (1999) describe it as motivation to serve the interests of a community of people, state, or nation, while Brewer (2008) sees it as public, community, and social service. More recently, Vandenabeele (2007) has defined public service motivation as the beliefs, values and attitudes that go beyond self-interest, organisational interest or the needs of large political entities, and which induce, through public interaction, the motivation for targeted action. If we synthesise the debate on public service motivation, it is centred on (1) uniqueness of the institution (2) the state (3) the nation (4) social services (5) setting aside self-interest (6) setting aside organisational interest and (7) firm social values. Our findings suggest that healthcare employees in KP province, Pakistan, find strong motivation in maintaining their professional standards and religious commitment. We believe that the concept of professionalism is critical to healthcare where the motive is to help patients without self-interest. Similarly, the religious aspect is an important concept that helps employees to serve the community, people or nation without self-interest, and is particularly pertinent to Muslims, since they look to Islam for inspiration and take guidance from how to live life and that influence day to action in their daily life. This can also be particular to certain countries, for example in the Middle East and Asia, in which

religion strongly shapes thinking and actions. In the overall definition of public service motivation, factors of professionalism and religion both need to be included in order to generalise the concept of public service motivation beyond Western cultures. The findings of this research suggest that within the medical profession in an Islamic culture, religion has a supporting effect, such that performance-related pay does not undermine the public service motivation of the doctors. Prominent authors such as Perry and Hondeghem (2008), Wright and Grant (2010) and Maynard-Moody and Musheno (2012) highly recommend research into public service motivation in different contexts and believe that qualitative study of the narratives and stories that emerge from such research will give a strong foundation for understanding the motives of those who serve the public sector. As Perry and Vandenabeele (2015) point out, the rapid rise in quantitative studies on public service motivation has done much to formalise our knowledge of the subject. However, they also propose that future researchers should use qualitative approaches in order to obtain a more in-depth understanding of prosocial behaviours.

8.5 Conclusion

This chapter has addressed RO4 and its sub-questions (RQ4.1-4.2), exploring the perspectives of doctors and ward managers on performance-related pay in the case hospitals in Peshawar, KP, Pakistan. Due to the nature of public healthcare, their perspectives on public service motivation were also explored. The four themes identified and discussed are the nature of public healthcare in KP province, the social realities of Pakistan, standards in the medical profession and religion. Money is a prime motivator in employment, and performance-related pay is intended to encourage doctors to improve their performance. The scheme has apparently been accepted in the case hospitals by both doctors and ward managers, who are in agreement that they are motivated to work harder if they are rewarded with higher pay. The reasons for their compliance are rooted in the particular institutional and cultural realties of Pakistani society, which is not a welfare state, and where the government does not fund professional development. Doctors in Pakistan are continually seeking extra finances both to support poorer members of their extended families and to pay for their own continuing professional development courses. This situation is part of traditional adherence to culture and rituals. The usual solution to this situation has been to

work in a second job in some form of private practice, but the introduction of performance-related pay has given doctors another route to increasing their basic public hospital earnings. We can conclude, then, that performance-related pay is accepted by doctors and ward managers in the case hospitals and that the primary reasons for acceptance are rooted in institutional and social realities. However, accepting the scheme and earning more money does not mean that doctors' professionalism is compromised, as performance-related pay does not undermine their public service motivation. These doctors derive motivation and inspiration from three sources: first, their professional code of ethics; second, the nature of their training to serve the public without prejudice; and third, their commitment to the Islamic religion. Thus we can see that monetary reward is a supportive factor when combined with high professional standards and committed religious belief. This chapter, along with Chapters 6 and 7, provides the basis of the conclusions of the study, and aims to highlight its contribution to both theory and practice.

Chapter 9: Conclusions and Recommendations

9.1 Introduction

This chapter has concluded the thesis by summarising the findings and identifying the main contributions of this research to the field. The first section revisited the research aim, objectives and related sub-questions. The second discussed the contributions of the thesis to the academic debate and to practice. Next, the author reflected on the learning experience of the PhD journey, and finally the limitations of the study were outlined and recommendations made for further research.

9.2 Revisiting the research aim, objectives and questions

The overall aim of the research is to generate greater understanding of how modern western management practices are implemented in the public healthcare systems of developing countries. In particular, we look in detail at stakeholders' reactions to the introduction of performance-related pay into the healthcare system. In order to address this, we have focused on specific recent healthcare reforms in three public teaching hospitals in Peshawar, KP province, Pakistan.

The aim, objectives and questions were continually refined during the research process, and the four main objectives and sub-questions were eventually formulated as follows.

First research objective:

To understand how doctors and ward managers perceive the organisational structure and human resource policies of KP public healthcare in three of the teaching hospitals before the reforms. Human resource policy includes recruitment, compensation, performance management and the reward system.

The associated sub-questions were:

- What was the organisational structure of KP healthcare before the reforms?
- How did the doctors in the case hospitals perceive service structure and performance appraisal system before the reforms?

These questions were addressed by in-depth study of the previous management system of the KP healthcare system. The outcome of the first research objective found that the previous public sector hospital employment structure was based on the Weberian model, with a tenure system, which proved to be a major barrier to high performance, and a traditional recruitment process that took several months to complete. The system was highly centralised. Newly recruited doctors were appointed as civil servants and were guaranteed lifetime employment, but over time they became increasingly dissatisfied with poor service structure, and a badly managed performance appraisal system. Doctors were unhappy that the promotion criteria were based around seniority and having a satisfactory ACR, the latter of which proved in practice to be obfuscatory and time-consuming. They felt that low pay prevented them from enjoying what they considered to be an appropriately high standard of living, and they had no faith in the existing appraisal system of the ACR. This ACR system was ineffective largely because of nepotism in the workplace and because managers regularly failed to write them up in the first place. There was a lack of communication between doctors and ward managers, and no feedback on performance.

Second and third research objectives:

To clarify the rationale for the MTI reform, to identify how it was understood by the key stakeholders and to examine how it was implemented in the teaching hospitals.

Associated sub-questioned were drafted as:

- Why was MTI reform introduced in the teaching hospitals in Peshawar, KP?
- How did the stakeholders perceive MTI reform in the case hospitals?
- Why did the doctors in the case hospitals oppose the Act?
- What factors are preventing the successful implementation of MTI reform?

These questions were addressed by looking at the MTI reform from three different perspectives of policy (macro), implementation in KP healthcare (meso) and impact on doctors and ward managers in the case hospitals (micro). The outcomes for the second and third research objectives show that the MTI reform in KP public healthcare was a strategic initiative by the newly elected PTI government to fulfil promises to voters. The reforms were an amalgamation of innovative polices which were mainly influenced by New Public Management as practised in the US healthcare system. As mentioned above, the old healthcare system was highly centralised and rooted in the traditional public sector. The new government made four major changes to this by (1) decentralising the healthcare system and minimising the role of central healthcare bureaucracy, (2) giving autonomy to the teaching hospitals, enabling them to make decisions and generate funds, (3) introducing a new system of accountability, and (4) introducing performance-related pay scheme in order to raise performance and promote a competitive culture on the wards. The circumstances which led the doctors and ward managers to resist the MTI reforms were (1) the failure of the senior leadership to convey the exact details of the reforms and how they would affect employment, (2) doctors' misplaced belief that the government was privatising the teaching hospitals, which would adversely affect pensions and job security, (3) the proposed abolition of private practice by public sector doctors, and (4) issues relating to the implementation process i.e. lack of planning and budgeting, the failure of the government to consult with local senior doctors in the planning stages of the reform, coupled with the dismissive attitude of the authorities when questioned by those most affected by the changes.

Fourth research objective:

To explore the perspectives of doctors and ward managers on the performance-related pay scheme introduced as part of the MTI reform.

The associated sub-questions were:

- How is performance-related pay viewed in the collectivistic society of modern Pakistan?
- What is the effect of performance-related pay on doctors' professional attitudes in the case hospitals in KP, Pakistan?

Findings relating to the fourth research objective show that money is important to the doctors in the teaching hospitals and that performance-related pay is an effective performance motivator. This is because they are strongly affected by factors relating to the existing economic and social conditions in Pakistan, including lack of government funding for continuous professional development, low public sector pay, increased responsibility towards members of the extended family and exclusion of women from the jobs market. Generally, the idea of performance-related pay was accepted by the doctors and ward managers, and it was found not to undermine their professional attitude for two reasons. First, the strong sense of high professional standards, commitment to serving patients, and compliance with codes of conduct, and secondly their commitment to the Islamic religion. Thus, we can see that in the KP teaching hospitals performance-related pay does not undermine public service motivation because employees are committed to high professional standards and hold strong religious beliefs.

9.3 Contribution to the ongoing scholarly debate

This section outlines the contribution of this research to the academic debate as well as to practice. The review presented in Chapter 3 and the extended part of the literature review in Chapter 4 identified a number of gaps in the existing knowledge in the field. Below we discuss how this study has helped to address these gaps.

9.3.1 Taking a multi-theoretical approach

The literature presents contradictory views on the application of performance-related pay in public-sector organisations. For instance, public administration and psychology research take a negative stance towards the scheme, asserting that financial reward undermines public service motivation, which is seen as integral to public service work (Durant *et al.*, 2006; Wright, 2007; Perry, Engbers and Jun, 2009; Frey, Homberg and Osterloh, 2013). On the other hand, New Public Management, economic and policy literature suggest that performance-related pay is an important motivator for behavioural change and improves the performance of public-sector employees (Hood and Peters, 2004; Dunleavy *et al.*, 2006; Liu and Tang, 2011; Hasnain, Manning and Pierskalla, 2014). Thus,

previously there were no conclusive findings and the research community was divided by two extreme stances.

This study addresses the contradiction between these two theoretical arguments, and offers a more realistic understanding of the issues by taking account of political forces and political economy, as well as institutional and cultural boundaries. Further, the research takes a multi-theoretical approach by integrating New Public Management theory, Institutional theory and Public Service Motivation theory and Hofstede's theory of cross-culture. Such integration has been called for by several scholars (e.g. Ingraham, 1993; Perry, Engbers and Jun, 2009; Hasnain, Manning and Pierskalla, 2014) and is presented here for the first time. A realist philosophical stance has been used, which has not only enabled integration of the different theories but has also facilitated a micro-meso-macro analysis, embedded in a qualitative approach. There is an increasing recognition of qualitative approaches in general (Denzin and Lincoln, 1998; Patton, 2002; Flick, 2009; Perry, Engbers and Jun, 2009; Wright and Grant, 2010; Maynard-Moody and Musheno, 2012; Silverman, 2013; Hasnain, Manning and Pierskalla, 2014; Perry and Vandenabeele, 2015) and a growing appreciation of using a realist ontology in public-sector research in particular (Maxwell, 2012; Edwards, O'Mahoney and Vincent, 2014; Paulsen, 2014). By using a realist ontology embedded in qualitative research, the complex structure of KP healthcare has been revealed, and the healthcare reforms in the case teaching hospitals have been investigated in finer detail.

As mentioned earlier in Chapter 3, Section 3.8, the studies on performance-related pay published in the context of the public sector suggest fragmented and inconsistent research findings. Therefore, it is hard for the academic and practitioner community to derive a clear picture of how performance-related pay is working in the public sector in general (e.g. Ingraham, 1993; Perry, Engbers and Jun, 2009) and in the context of developing countries in particular (e.g. Witter, 2013; Hasnain, Manning and Pierskalla, 2014). These authors suggest that future research should explore to what extent performance-related pay is relevant to the culture of public organisations. Further, they believe that future researchers should take a multi-theoretical stance to investigate this question. This study contributes to the disciplines of sociology and public-sector studies by clarifying that in collectivistic, masculine societies where men are the main

breadwinners, public healthcare professionals approve of performance-related pay, as it gives them more control over earnings and also improves job performance. Performance-related pay does not necessarily undermine public service motivation due to the existence of high professional standards and the influence of strongly-held religious beliefs.

9.3.2 Theoretical contribution

On a theoretical level, this study has made specific contributions to the theory of public service motivation and Hofstede's theory of cross-culture. Firstly, Hofstede (1983, 1993, 2007) suggested that material-based incentives such as performance-related pay are more likely to be associated with cultures having higher levels of individualism and that performance-related pay may not be appropriate in collectivistic cultures such as Pakistan (Schuler and Rogovsky, 1998; Baruch, Wheeler and Zhao, 2004). However, our research findings contradict this notion and suggest instead that performance-related pay is accepted by doctors in Pakistani public teaching hospitals. The reason for its acceptance is rooted in the institutional and social realties of Pakistan, which is a collectivistic, conservative and masculine society in which public-service pay has traditionally not been enough to meet daily needs. Performance-related pay now provides doctors with the opportunity to earn more money and fulfil their social responsibilities, and in this way we have contradicted Hofstede's theories regarding behaviours of collectivism and individualism.

The second theoretical contribution of this research is to the theory of public service motivation. According to public service motivation theory, monetary reward such as performance-related pay undermines the public service motivation of public-sector employees, thus it considered as counterproductive in the public sector (Perry, Engbers and Jun, 2009). However, our study findings seemingly contradict this theoretical statement. Taking an open inquiry our research findings suggest that when employees have high professional standards and strong religious beliefs, monetary rewards, such performance-related pay, do not undermine public service motivation. Thus, our study questions the notion that performance-related pay necessarily undermines public service motivation. It is important to remember that most of the previous research into public service motivation was conducted within the positivistic paradigm and this has been noted in reviews by, for example, Perry and

Vandenabeele (2015), Bozeman and Su (2015) and Pandey *et al.* (2017) and these authors advocate going beyond traditional qualitative methodology in the study of public service motivation. This research contributes to the recent move towards studying public service motivation using qualitative research methods.

The principle learning outcome of this study is that performance-related pay can be successful in a developing, collectivistic society, at all levels of the employment hierarchy. We have found that offering monetary reward does not undermine the public service motivation of doctors working in public healthcare, and thus performance-related pay is an acceptable strategy both for the employees, who gain more control over their earnings, and managers and policy-makers, who see continual improvements in job performance.

9.3.3 At the methodological level

To date, most performance-related pay studies have used quantitative methods; 56% have been influenced by the positivist paradigm, while only 4% of studies have relied on qualitative methods influenced by the phenomenological paradigm. Only 12% of studies used mixed methods and there were five reviews of public sector literature and four of healthcare, making up 28% of the studies, as discussed in greater detail in Chapter 3. The present research takes a rare but much-needed realist perspective embedded in qualitative research to explore employees' perspectives of performance-related pay in real public institutions. Consequently our study gives a firm response to 'ivory-tower' controversy by revealing the actual mechanisms of public-sector policy integration within a real-world culture. The need for insightful research into public organisations in general is acknowledged by Ingraham (1993) and Perry, Engbers and Jun (2009) and in the context of developing countries by Witter *et al.* (2013) and Hasnain, Manning and Pierskalla (2014). These authors invite researchers to engage in a dialogue that integrates different theoretical and disciplinary perspectives. In this study, we investigate the introduction of performance-related pay in the KP healthcare system as a consequence of the MTI reforms of 2015. The study has used qualitative research to explore the perspectives of the key stakeholders relevant to the healthcare system. The outcome of the study shows that doctors in the public teaching hospitals of Peshawar accept and even welcome the introduction of performance-related pay, and that this response is driven by their

existing institutional and social culture and environment. In terms of public-sector culture, performance-related pay does not undermine the doctors' prosocial behaviour due to their high professional standards and strong religious beliefs.

9.3.4 At the empirical level

Most of the empirical work on performance-related pay has been carried out in the contexts of the EU, the US and Far Eastern states, as discussed in detail in Chapter 3. Only a very few studies have investigated performance-related pay schemes in developing countries (Rwanda, the Congo, Vietnam and India). To the best of the author's knowledge, no study has explicitly considered contextual and social factors such as the political, economic, cultural and institutional circumstances, to the extent that performance-related pay is a rational scheme beyond the US and OECD countries. Several scholars in public sector (e.g. Ingraham, 1993; Anderson; 2009; Perry, Engbers and Jun, 2009) and sociology (e.g. Witter *et al*., 2013) have recognised the need for such research. On the other hand, Hasnain, Manning and Pierskalla (2014) point out that the perspectives of developing countries are important because their institutional and cultural dynamics are different to those of developed countries. For instance, our study highlighted institutional realities such as lack of government financial support for continuing professional development for doctors in public hospitals and low pay in public healthcare institutions, as well as social realities such as the extra financial burden due to obligations to the extended family and men's role as sole earners. This study encompasses social factors, including local politics, political economy, culture and local institutions. The findings suggest that performance-related pay is accepted by the key stakeholders and that it functions as a motivating tool in public healthcare. Furthermore, performance-related pay does not undermine the prosocial behaviour of healthcare professionals, due to their high professional standards and sense of religious duty.

9.3.5 Relating to practitioners

The first recommendation is at a macro level, i.e. for governments, policy makers and regulatory bodies, which initiate healthcare reform such as the International Monetary Fund and World Health Organisation. These actors should consider

local contextual and institutional conditions while drafting and implementing policies copied from other sectoral and country contexts. The problem with politicians and reformers is that in wishing to replicate the success of other healthcare policies, they are failing to take into account the realities of their local institutions. This is particularly relevant to developing countries where institutions are fragile, lack regulation and have different goals. For example, in our particular research context, the government is trying to make money from patients who visit public hospitals. However, expecting large revenues from these patients is unrealistic, as almost all who attend public hospitals are struggling financially; some cannot afford even the nominal prescription charges. Although the author believes that the steps towards reforming KP healthcare are generally well-intentioned, practitioners should treat external policies as guidelines only, and tailor them to their local institutional settings. Based on the findings of this study, reformers need to be more open-minded about their domestic policies and local management structures rather than imposing policies directly from other contexts. Socialists remind us that when institutional policies ignore the logic of domestic institutional arrangements, such action creates divergent instead of homogenous institutional change. This suggests the need for increased pluralism in respect of healthcare reforms and that standardisation based on a single management model is unrealistic, particularly in our context. The author suggests here that when public healthcare reform in developing countries is based on policies that are successful in developed nations, the results can be somewhat unpredictable, and very much depend on the existing social and administrative conditions.

This study shows that for doctors working in KP public healthcare, the mere fact of working in public service does not erase the need for a good salary, and that fair and adequate remuneration does not decrease prosocial attitudes and behaviour. Our research demonstrates, in fact, that low wages do more to increase the tendency towards corruption and unethical behaviour, e.g. in the case hospitals of the study, senior doctors regularly persuaded patients to see them in their private practice, which is unethical behaviour that is unacceptable to the profession. However, the need for 'decent' earnings is forever an issue in traditional Pashtun society, where doctors find themselves sole earners weighed down by financial responsibility towards their extended family, as well as the added burden of paying for their own CPD training. The research suggests,

therefore, that adequate performance-related pay could be an effective booster of doctors' job satisfaction, which does not detracts from their commitment to public service and indeed reduces unethical behaviour. It shows that in the context of developing countries, the scheme has the potential to be part of the reward policy to improve the job performance of public-sector employees. Although performance-related pay has been embraced by the doctors and ward managers, we should also remember that it is not a remedy for all issues related to performance, nor should one ignore the importance of other motivating factors such public ethics.

At the meso level, the question for the management community is how to lead effectively in organisations undergoing major transformation from public-sector to autonomous body. In change management the role of leadership is highly important, and the traditional tools of goals, plans, and communication should be reviewed. It was found in this study that the leadership did not provide adequate guidance and communication on the reform process. The senior management singularly failed to inform doctors of what the government was trying to achieve and what the implications were for their employment and pensions. Ingraham (1993) and Fernandez and Rainey (2006) emphasise the need for the leadership to take an active role and state that effective communication is vital in order for employees to understand reform and how it will affect them. From our data, we can see how policy makers performed poorly in this regard and did not communicate adequately how the MTI reforms would affect employees. The inevitable effect of this was rumour and wrong interpretation of the reform, which created uncertainty and stress among doctors and ward managers alike. Instead of using the hospital noticeboard as the sole means of communication, senior management could have used other ways of communicating, such as arranging meetings with ward managers, emailing summaries of the legislation to the doctors and circulating regular updates around the wards. Therefore, the take-away message for practitioners is that the senior management must clearly communicate the details of reforms to the local actors as they begin to put an institutional blueprint into practice. Senior management should decide the best way to communicate the reforms, and be prepared to go beyond the conventional ways of communication in order to fully disseminate the exact message of the new reforms. In this regard the author suggests that dialogue should be initiated between management and

senior employees, or at least between management and union members who are able to speak on behalf of employees.

We have stated that the purpose of this research is not to generalise the findings; however, they can provide guidance for practitioners in developing countries who are in the process of planning public healthcare reforms. Lincoln and Guba (1985) and Yin (2014) have suggested that the transferability of a given research can be enriched by providing a detailed description of the study so the reader can transfer the findings to their own settings. In this respect, the author has provided a rich description of the context of the study in Chapter 2, which provides a narrative of the pressure, which triggered the change. In order to achieve this interpretation, the findings of the research are presented in a clear and comprehensive manner. The main findings of the study support the use of performance-related pay for healthcare professionals within a collectivistic society, since where healthcare professionals have high professional standards and strong religious beliefs, performance-related pay does not undermine their public service motivation. The findings can be used by the research community, regulatory and political bodies such as the International Monetary Fund and the World Bank, and by practitioners in developing countries who share similar features of culture, religion, institutions and society, such as poverty, lack of government support and corruption.

9.4 Author's learning experience

The author's learning experience during the PhD journey can be seen on three levels: academic development through engagement with the literature, personal development from intense training, and gaining confidence in the research ideas by discussion with peers and the general academic community.

This study began with the author's personal interest in the topic of employment relationships and public administration, and this was shaped and reshaped over time as the literature was engaged with. In order to develop the author's initial ideas about the context of the study, a firm theoretical positioning was required. In the early stages of planning the research, various techniques were used such as mind-mapping, arranging sticky notes on a large board and conceptualising ideas and relationships. These methods not only helped to refine the overall idea but also facilitated the categorisation of the literature to be reviewed. As a PhD

researcher the author had the opportunity to review a stock of literature from different disciplines, including public administration, sociology, organisational studies, and philosophy, enabling a multi-theoretical approach to be taken which will contribute to current understanding.

The University of Southampton Management School offer a variety of additional courses and training programmes on and off campus. The purpose of these is to develop and enhance the skills to use methodological and analytical techniques. The author enrolled in compulsory and optional methodology courses in order to learn about methodological approaches and data analysis techniques. The author also learned to use referencing and data analysis software, including EndNote, NVivo and SPSS, which were invaluable aids in the research process. In addition to this, the author took courses and training sessions to develop teaching, research, and conference organising skills.

The author was lucky enough to have an experienced and committed supervisory team who always encouraged engagement with research activities during the years in which the study was carried out. The research was thus presented at a number of conferences and seminars nationally and internationally, giving the author unique opportunities to discuss the work with notable authors from the fields of public sector policy, organisational studies, and philosophy, such as Prof Mike Reed, Prof Joe O' Mahoney, Prof Andrew Sayer, Prof Margret Archer and Prof Tony Lawson. Their valuable suggestions led the author to re-evaluate some aspects while gaining confidence in the worth of the research as a whole.

To conclude, the path of PhD study has been one of challenge, learning and discovery, both in terms of academic skills and knowledge, and of personal development. The journey, with its many high and low points, has been at times exciting and exhilarating, and at others intense and arduous, but it has always been tremendously interesting and was undertaken with determination and commitment to the greater good of society.

9.5 Limitations and suggestions for future research

Although every effort was made to ensure the robustness and rigour of the methodology, these could have been further improved in the following ways. For example, with regard to research methods, in addition to the interview and participant observation, focus group discussions could have been held which

would have given greater insight into the reforms. It would also have been interesting to carry out a cross-case analysis by inviting participants from all three hospitals to group discussions in order to gain a deeper understanding of their experiences. However, the practicalities of organising this within the time constraints would have been too difficult.

Other potential participants were identified by the respondents as possible sources of interesting information, and these extra perspectives could have added more richness to the study. However, travelling to interview these other respondents was deemed to be both impractical and risk-laden at the time. In the context of Pakistan, access to civil bureaucracy is also not easy to manage, and although a half-hour appointment with a minister was eventually secured, more time would have been an advantage. An interview with Professor Burki would also have added valuable insight to the reform process; however, since he is based in America, this was not possible.

The MTI reforms were introduced in 2015, but since then there has been very little description or analysis available. At the time of data collection, the reforms were already in the process of implementation. The data was collected in September and October 2015 and provides a snapshot of perspectives on the reform as it was happening. However, one of the limitations of this approach is that once the reform is fully implemented, a similar study may result in different findings. Another limitation is that the relevant data was available only from the doctors, since the reforms were scheduled to apply to doctors first and other healthcare staff at a later date. Clearly, staff such as nurses and paramedics are also important stakeholders in the healthcare system and they may have been found to have different views and perspectives. Analysing these other perspectives once the reform process is completed would be highly interesting. Thus, it is suggested that future research might take the form of a longitudinal study. Ideas for future research are summarised below:

- Future longitudinal research could track participants over time until the MTI reform has been fully implemented.

- Future research could include other medical healthcare professionals such as nurses and paramedical staff, since they are also important stakeholders in the healthcare system and are affected by the reforms.

Each group of professionals could be studied separately to identify their reactions to the MTI reform and especially their opinions on performance-related pay.

- Empirically this research was rooted in public healthcare. The study reveals that performance-related pay did not undermine the public service motivation of the doctors due to the nature of the profession, which has an inherent code of ethics and high standards of conduct. Future research could examine the effect of performance-related pay on public service motivation in other public service industries such as taxation, banking, and councils. Quantitative studies would reveal whether performance-related pay schemes undermine public service motivation of public employees in these sectors in the context of Pakistan.

9.6 Conclusion

This chapter has given an overall summary of the study findings and their contribution to theory and practice. A summary of the research objectives and their associated sub-questions was followed by a description of the contribution of this study to the current body of published research and practice. Next, a short account of the author's learning experience was presented, and the final section discussed the limitations of the study and gave suggestions for future research.

Appendix A **Synthesised empirical studies**

Author (s)	Year	Methods/Approaches	General Public Sector	Effect	Country context
Anderson	2009	Mix Method	Public Sector	Negative	OECD
Anderson and Pallesen	2008	Quantitative	Public Sector	Positive	OECD
Atkinson *et al.*	2014	Qualitative	Public Sector	Negative	OECD
Belle	2015	Quantitative	Public Sector	Negative	OECD
Belfield and Marsden	2003	Mix Method	Public Sector	Positive	OECD
Brudney and Condrey	1993	Quantitative	Public Sector	Negative	OECD
Bertelli	2006	Quantitative	Public Sector	Positive	OECD
Blasi *et al.*	2008	Quantitative	Public Sector	Positive	OECD
Burgess and Ratto	2003	Quantitative	Public Sector	Positive	OECD
Cardona	2006	Review	Public Sector	Negative	OECD
Pollitt and Bouckaert	2011	Review	Public Sector	Positive	OECD
Condly *et al.*	2003	Quantitative	Public Sector	Positive	OECD
Courty and Marschke	2004	Quantitative	Public Sector	Positive	OECD
Dahlström *et al.*	2009	Quantitative	Public Sector	Positive	OECD
Dowling and Richardson	1997	Mix Method	Public Sector	Positive	OECD
Egger-Peitler *et al.*	2007	Quantitative	Public Sector	Negative	OECD
Forest	2008	Review	Public Sector	Negative	OECD
Frey and Oberholzer-Gee	1997	Quantitative	Public Sector	Negative	OECD
Frey and Jegen	2001	Quantitative	Public Sector	Negative	OECD
Fryer	2011	Quantitative	Public Sector	Negative	OECD
Gneezy and Rustichini	2000	Quantitative	Public Sector	Negative	OECD
Grimshaw	1998	Quantitative	Public sector	Negative	OECD
Hasnain *et al.*	2014	Review	Public Sector	Positive	OECD
Heckman *et al.*	1997	Review	Public Sector	Negative	OECD
Ingraham	1993	Review	Public Sector	Negative	OECD
Jenkins *et al.*	1998	Quantitative	Public Sector	Positive	OECD
Kahn *et al.*	2001	Quantitative	Public Sector	Positive	Developing Countries

Kellough and Lu	1993	Review	Public Sector	Negative	OECD
Kellough and Nigro	2002	Quantitative	Public Sector	Negative	OECD
Kellough and Selden	1997	Quantitative	Public Sector	Positive	OECD
Marsden and Richardson	1994	Quantitative	Public Sector	Negative	OECD
OECD	2005	Review	Public Sector	Positive	OECD
Perry and Hondeghen	2008	Review	Public Sector	Negative	OECD
Perry	1986	Review	Public Sector	Negative	OECD
Peitler *et al.*	2007	Quantitative	Public sector	Negative	OECD
Perry e*t al.*	2009	Review	Public Sector	Negative	OECD
Prentice *et al.*	2007	Mix Method	Public Sector	Negative	OECD
Stazyk	2013	Quantitative	Public Sector	Positive	OECD
Weibel *et al.*	2010	Quantitative	Public sector	Positive	OECD

Evidence from healthcare

Author (s)	Year	Methods/Approaches	Healthcare Sector	Effect	Country context
Basinga *et al.*	2011	Quantitative	Healthcare	Positive	OECD
Campbell *et al.*	2008	Qualitative	Healthcare	Positive	OECD
Campbell *et al.*	2007	Quantitative	Healthcare	Positive	OECD
Campbell *et al.*	2009	Quantitative	Healthcare	Positive	OECD
Campbell *et al.*	2005	Quantitative	Healthcare	Positive	OECD
Chalkely *et al.*	2010	Quantitative	Healthcare	Positive	OECD
Chen *et al.*	2011	Quantitative	Healthcare	Negative	OECD
Chung *et al.*	2010	Quantitative	Healthcare	Negative	OECD
Cromwell *et al.*	2011	Review	Healthcare	Positive	OECD
Doran *et al.*	2006	Quantitative	Healthcare	Positive	OECD
Doran *et al.*	2006	Review	Healthcare	Positive	OECD
Doran *et al.*	2008	Quantitative	Healthcare	Positive	OECD
Eichler	2006	Quantitative	Healthcare	Positive	Developing Countries
Eichler and Levine	2009	Mix Method	Healthcare	Positive	Developing Countries
Eldridge and Palmer	2009	Review	Healthcare	Positive	Developing Countries
Gavaghan *et al.*	2010	Quantitative	Healthcare	Negative	OECD
Gillam *et al.*	2012	Quantitative	Healthcare	Positive	OECD
Herck *et al.*	2010	Mix Method	Healthcare	Positive	OECD
Hillman *et al.*	1999	Quantitative	Healthcare	Negative	OECD
Honda	2013	Review	Healthcare	Positive	Developing Countries
Ireland *et al.*	2011	Mix Method	Healthcare	Positive	Developing Countries
Lagarde and Blaaue	2009	Review	Healthcare	Negative	Developing countries
Liu and Mills	2005	Quantitative	Healthcare	Positive	Developing Countries
Lindenauer *et al.*	2007	Quantitative	Healthcare	Positive	OECD
Magrath and Nichter	2012	Qualitative	Healthcare	Positive	OECD
Mannion and Davies	2008	Review	Healthcare	Positive	OECD
McDonald *et al.*	2008	Quantitative	Healthcare	Positive	OECD

Meessen *et al.*	2011	Mix Method	Healthcare	Positive	Developing Countries
Millett *et al.*	2009	Quantitative	Healthcare	Positive	OECD
Mullen *et al.*	2010	Quantitative	Healthcare	Negative	OECD
Oxman and Fretheim	2009	Review	Healthcare	Positive	Developing Countries
Petersen *et al.*	2006	Review	Healthcare	Positive	OECD
Rowe	2006	Review	Healthcare	Positive	OECD
Rosenthal and Frank	2006	Quantitative	Healthcare	Positive	OECD
Sheen	2003	Quantitative	Healthcare	Negative	OECD
Vaghela *et al*	2009	Quantitative	Healthcare	Positive	OECD
Witter *et al.*	2011	Mix Method	Healthcare	Positive	Developing Countries
Witter *et al.*	2012	Review	Healthcare	Positive	Developing Countries
Witter *et al.*	2013	Review	Healthcare	Positive	Developing Countries

Appendix B **Interview questions**

Interview Questions	Source
1. Please describe your career in the public teaching hospital healthcare system of KP (Khyber Pakhtunkhwa). 2. Could you explain the previous employment system in Khyber Pakhtunkhwa public healthcare, e.g. recruitment process and promotion criteria? 3. How do you perceive the performance appraisal system of the previous system?	These three questions are asked at the start of the interview in order to understand human resource practices in the case hospitals. They related to RO1 and sub-questions RQ1.1-1.2.
4. Could you explain the new Medical Teaching Institution healthcare reforms in the public teaching hospitals of Khyber Pakhtunkhwa province? 5. Could you describe the principal objectives of the Medical Teaching Institution reforms from an employee's point of view? 6. As a doctor working in the teaching hospital, would you like to share your experience of the Medical Teaching Institution reform? 7. What would you say were the main obstacles to implementing the new Medical Teaching Institution reforms? Would you describe these as technical or philosophical? 8. Could you comment in general on the applicability of the	Fundamentally Q 4 was designed to develop a deeper understand of the MTI reforms in general i.e. how actors see the new healthcare reforms and to what extent they know how these have changed the previous structure. Q 5 stems from the institutional theory of isomorphism and the author was aiming to explore the rationale for MTI reforms in the teaching hospital i.e. what was the trigger for change. The health minister and members of the BoG were asked additional questions on New Public Management and the idea of MTI (as discussed in Chapter 4) Questions 6,7 and 8 are concerned with the experiences of key stakeholders on the MTI reforms in the teaching hospitals i.e. how they see the changes, and their ideas and stories on the way it was implemented (the stimulus for these questions is in Chapter 4).

Medical Teaching Institution reforms in the public teaching hospitals?	
9. Do you see money as a motivating factor in your work? 10. What do you think of performance-related pay as a remuneration strategy in the teaching hospitals?	Questions 9 and10 are derived from economics and public administration literature (the 'Love of Money' scale in Tang *et al.*, 2006 and Liu and Tang, 2011), and the author was trying to understand the importance of money and to record the ideas and opinions of doctors and ward managers on performance-related pay. More probing questions were used depending on the discussion with the respondents.
11. Could you describe to what extent performance-related pay fits into the public healthcare system of Khyber Pakhtunkhwa?	The source and motivation of Q 11 is rooted in public service motivation. The author was interested in exploring the perspectives of doctors and ward managers on how the performance-related pay scheme affected prosocial activities (public service motivation). Questions were adapted from Perry's (1996) Public Service Motivation scales.
12. As an employee, could you describe to what extent performance-related pay fits into the public healthcare system of Khyber Pakhtunkhwa? 13. How do you see the future of performance-related pay in the KP healthcare system?	The motive for Questions 12 and 13 is to explore the perspectives of doctors and ward managers on the relevancy of the scheme i.e. sharing their thoughts, bearing in mind in the institution they are working in and the society they live in.

Appendix C Interview guide

C.1 Semi-structured Interview Guide

The following questions identify the main areas to be explored in the personal interviews. The questions are intended to guide the participants and to capture their thoughtful responses. Depending on the responses, the interviewer will ask further questions to encourage the participants to elaborate on each point. The participants are allowed and indeed actively encouraged to tell the stories they think are most important.

Questions for Discussion with the Doctors:

1. Please describe your career in the public teaching hospital healthcare system of KP (Khyber Pakhtunkhwa).
2. Could you explain the previous employment system in Khyber Pakhtunkhwa public healthcare, e.g. recruitment process and promotion criteria?
3. How do you perceive the performance appraisal system of the previous system?
4. Could you explain the new Medical Teaching Institution healthcare reforms in the public teaching hospitals of Khyber Pakhtunkhwa province?
5. Could you describe the principal objectives of the Medical Teaching Institution reforms from an employee's point of view?
6. As a doctor working in the teaching hospital, would you like to share your experience of the Medical Teaching Institution reform?
7. What would you say were the main obstacles to implementing the new Medical Teaching Institution reforms? Would you describe these as technical or philosophical?
8. Could you comment in general on the applicability of the Medical Teaching Institution reforms in the public teaching hospitals?
9. Do you see money as a motivating factor in your work?
10. What do you think of performance-related pay as a remuneration strategy in the teaching hospitals?
11. As an employee, could you describe to what extent performance-related pay fits into the public healthcare system of Khyber Pakhtunkhwa?
12. Do you think that the introduction of performance-related pay has had any effect on your motivation to help your patients?
13. How do you see the future of performance-related pay in the KP healthcare system?

C.2 Questions for Discussion with the Ward Managers:

1. Please describe your career and position in the Khyber Pakhtunkhwa healthcare system.
2. Could you explain the previous employment system in Khyber Pakhtunkhwa healthcare, i.e. recruitment process, promotion criteria and performance appraisal system?
3. Could you explain the new Medical Teaching Institution healthcare reforms in the public teaching hospitals of Khyber Pakhtunkhwa province?
4. Please describe the principal objectives of the Medical Teaching Institution reforms from a ward manager's point of view.
5. As a ward manager in the teaching hospital, what is your experience of the Medical Teaching Institution reforms?
6. What would you say were the main obstacles to implementing the new reforms? Would you describe these as technical or philosophical?
7. How did doctors here greet the reforms? Would you like to share your experiences?
8. Comment in general on the applicability of Medical Teaching Institution reform in the public teaching hospitals?
9. Being a ward manager, how do you see performance-related pay as a remuneration strategy in the public teaching hospitals?
10. How did doctors greet the introduction of performance-related pay in the hospital?
11. Would you say that the introduction of performance-related pay has had an effect on your attitude towards the patients in your care?
12. As a ward manager, could you describe to what extent performance-related pay fits into the public healthcare system of Khyber Pakhtunkhwa?
13. How you see the future of performance-related pay in the Khyber Pakhtunkhwa healthcare system?

C.4 Questions for Discussion with Board of Governance Members and the Health Minister:

1. Could you give an outline and describe the origins of the Medical Teaching Institution reform in the public teaching hospitals in the province of Khyber Pakhtunkhwa?
2. Could you describe principal objectives of the reforms from a government point of view? What was the impetus behind the reform?
3. Could you explain the main features of the Medical Teaching Institution Act and what sort of changes it has made to the healthcare system?
4. How have the doctors and ward managers responded to the reform?
5. In implementing the reforms, what were the main obstacles that you had to confront? Would you describe these as technical, philosophical, or political?
6. What was the principal objective of introducing performance-related pay?
7. What do you think the government was trying to achieve with this measure?
8. Could you explain why the government has emphasised the importance of performance-related pay within the MTI reform?
9. Could you elaborate on why you think the Medical Teaching Institution Act will work in the KP healthcare system?

Appendix D **List of codes**

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
MTI Reforms (RQ2.1-2.3 and RQ3.1)	0	0	04/11/2016 11:51	FAROOQ	10/09/2017 10:42	FAROOQ
Change in the Public Healthcare Institutions	1	1	04/11/2016 12:35	FAROOQ	10/09/2017 10:44	FAROOQ
Faith in the newly elected government	6	6	10/09/2017 10:46	FAROOQ	17/11/2017 11:46	FAROOQ
Political agenda	2	4	04/11/2016 12:37	FAROOQ	17/11/2017 11:31	FAROOQ
Political events and healthcare reforms	3	4	04/11/2016 12:38	FAROOQ	17/11/2017 11:31	FAROOQ
Reasons for resistance to the MTI reforms	1	1	05/11/2016 11:56	FAROOQ	10/09/2017 11:02	FAROOQ
Conflict of interest	1	1	10/09/2017 10:53	FAROOQ	10/09/2017 10:53	FAROOQ
Loyalty to private practice	9	17	10/09/2017 10:55	FAROOQ	17/11/2017 11:32	FAROOQ
Private practice	10	32	10/09/2017 10:54	FAROOQ	17/11/2017 11:41	FAROOQ
Implementation issues	1	1	10/09/2017 10:58	FAROOQ	10/09/2017 10:58	FAROOQ
Ignorance of local actors	14	64	10/09/2017 11:00	FAROOQ	17/11/2017 11:32	FAROOQ
Poor planning	10	56	10/09/2017 10:59	FAROOQ	17/11/2017 11:41	FAROOQ
Rigid attitude of the leadership	6	22	10/09/2017 11:00	FAROOQ	17/11/2017 11:41	FAROOQ
Poor communication	2	2	05/11/2016 11:57	FAROOQ	10/09/2017 11:40	FAROOQ
Confusion	15	51	10/09/2017 10:51	FAROOQ	17/11/2017 11:47	FAROOQ
Uncertainty	11	35	10/09/2017 10:49	FAROOQ	17/11/2017 11:47	FAROOQ
Pre- Reform Organisational Structure (RQ1.1-1.2)	0	0	04/11/2016 11:50	FAROOQ	10/09/2017 11:55	FAROOQ
Human Resource Practices	1	3	10/09/2017 10:09	FAROOQ	11/09/2017 12:05	FAROOQ
Lack of Faith in the ACR	1	1	10/09/2017 10:13	FAROOQ	11/09/2017 11:52	FAROOQ
Lack of Feedback in the ACR System	11	16	10/09/2017 10:17	FAROOQ	13/10/2017 11:08	FAROOQ
Lack of Trust	15	39	10/09/2017 10:15	FAROOQ	28/10/2017 15:58	FAROOQ
The Politicised and Corrupt ACR	10	15	10/09/2017 10:16	FAROOQ	22/09/2017 13:03	FAROOQ
Nature of Job	12	22	11/09/2017 12:16	FAROOQ	14/11/2017 10:34	FAROOQ
Poor Service Structure	3	4	10/09/2017 10:11	FAROOQ	22/09/2017 12:51	FAROOQ
Complex Promotion System	11	28	10/09/2017 10:18	FAROOQ	22/09/2017 13:01	FAROOQ
Low Salary	15	37	10/09/2017 10:19	FAROOQ	17/11/2017 11:47	FAROOQ
Recruitment and Selection	3	5	11/09/2017 12:17	FAROOQ	17/09/2017 10:59	FAROOQ

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
PRP in the Case Hospitals (RQ4.1-4.2)	0	0	04/11/2016 11:52	FAROOQ	10/09/2017 11:05	FAROOQ
PRP and its effect on the professional attitude of doct	0	0	06/11/2016 11:24	FAROOQ	10/09/2017 11:13	FAROOQ
Religion	2	2	10/09/2017 11:17	FAROOQ	14/11/2017 10:40	FAROOQ
Inspiration from the teaching of Islam	5	14	10/09/2017 11:18	FAROOQ	17/11/2017 11:49	FAROOQ
Sadaqah (Charity)	3	4	10/09/2017 11:18	FAROOQ	14/11/2017 10:44	FAROOQ
Standards in the medical profession	6	7	10/09/2017 11:15	FAROOQ	14/11/2017 10:40	FAROOQ
Code of conduct	7	11	10/09/2017 11:16	FAROOQ	14/11/2017 10:47	FAROOQ
Medical training	4	4	10/09/2017 11:17	FAROOQ	14/11/2017 10:42	FAROOQ
Social realities of Pakistan	2	3	10/09/2017 11:11	FAROOQ	10/09/2017 11:11	FAROOQ
Culture of competitiveness in the wards	6	8	10/09/2017 11:15	FAROOQ	13/10/2017 11:10	FAROOQ
Joint family system	17	28	10/09/2017 11:14	FAROOQ	17/11/2017 11:49	FAROOQ
Men as the sole earners	14	25	10/09/2017 11:14	FAROOQ	14/11/2017 10:49	FAROOQ
The nature of the KP healthcare system	2	3	04/11/2016 12:42	FAROOQ	10/09/2017 11:06	FAROOQ
Lack of support for continuing professional develo	10	18	10/09/2017 11:09	FAROOQ	13/10/2017 11:10	FAROOQ
Sacrifice family and leisure time	12	16	10/09/2017 11:10	FAROOQ	13/10/2017 11:10	FAROOQ

Appendix E **Consent form**

E.1 CONSENT FORM (01)

Study Title: Healthcare Reforms in the Public Teaching Hospitals in Peshawar, KP, Pakistan

Researcher name: Farooq Ahmad
Ethics reference: 9698

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet and have had the opportunity to ask questions about the study.	☐
I agree to take part in this research project and agree for my data to be used for the purpose of this study	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐
I am happy for the interview to be tape recorded.	☐
I am happy to be contacted regarding other unspecified research projects. I therefore consent to the University retaining my personal details on a database, kept separately from the research data detailed above. The 'validity' of my consent is conditional upon the University complying with the Data Protection Act and I	☐

Data Protection
I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name)……

Signature of participant……

Date……

E.2 Participant Information Sheet

Study Title: Healthcare Reforms in the Public Teaching Hospitals in Peshawar, KP, Pakistan

Researcher: Farooq Ahmad **Ethics number**: 9698

What is the research about?
I am a PhD student at the University of Southampton and am conducting research on healthcare reform in the public teaching hospitals of Peshawar, KP, Pakistan.

Recently the KP government introduced healthcare reforms in the public teaching hospitals in Peshawar, KP, Pakistan to improve the performance of the teaching hospitals. In this study I will explore how key stakeholders view these new reforms. For this, I would like interview you about your opinion of the healthcare reforms in order to answer my research questions. The questions will ask for your experiences and thoughts on these reforms, what you think the reasons are for the reforms, and what you think about how the government is implementing them in the teaching hospitals. The information you give will remain strictly confidential.

Why I have been chosen?
You have been chosen because you are a valuable source of information. The nature of my research is qualitative and I need rich information about your own experience of the situation. Your job title and experience are relevant to the research and this is the fundamental reason for asking you to be part of my research sample.

What will happen if I take part?
Once you have agreed to take part we will arrange the interview at a time and place convenient for you. The interview may last from 60 min to 90 min. I will tape-record the interview (with your consent), and this will be used in the data analysis. I will interview you only once, but I would like to be able to contact you at a later date if I need more information.

Are there any benefits to taking part in the study?
Your contribution to this study is very valuable as the research concerns the effect of the changes on your life, and the results may inform future reform policy. You will have the freedom to express your point of view anonymously about issues relating to your employment structure and the MTI reforms, and your opinions may be taken account of by regulatory or political bodies in deciding future initiatives.

Are there any risk involved?
There is no risk in participating in this study.

Will my participation be confidential?
In compliance with the Data Protection Act and Data Protection Policy of the University of Southampton, the data will be confidential and your identity will be anonymous. All data will be secured on a password-protected laptop computer owned by the University.

What happen if I change my mind?
If you change your mind you are free to withdraw from participation in the study at any time. There is no legal obligation which will affect you.

What happen if something goes wrong?
In the unlikely event of anything going wrong, or if you want to register a complaint, you may contact the Research Support Officer or the Head of Research Governance:

Ying Ying Cheung (risethic@soton.ac.uk) or
Head of Research Governance (02380 595058, rgoinfo@soton.ac.uk)

How I can get more information?
If you have any questions or concerns, please feel free to contact me by phone or email.

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List of References

Abner, G.B., Kim, S.Y. and Perry, J.L. (2017) 'Building evidence for public human resource management: Using middle range theory to link theory and data', *Review of Public Personnel Administration*, 37(2), pp. 139-159.

Adler, N.J. and Jelinek, M. (1986) 'Is "organization culture" culture bound?', *Human Resource Management*, 25(1), pp. 73-90.

Ahmad, O.B. (2005) 'Managing medical migration from poor countries', *BMJ: British Medical Journal*, 331(7507), p. 43.

Aleem, M. *et al.* (2012) 'An empirical investigation of human resource practices: A study of autonomous medical institution employees in Punjab, Pakistan', *African Journal of Business Management*, 6(21), p. 6390.

Alonso, J.M., Clifton, J. and Díaz-Fuentes, D. (2015) 'Did new public management matter? An empirical analysis of the outsourcing and decentralization effects on public sector size', *Public Management Review*, 17(5), pp. 643-660.

Alonso, P. and Lewis, G.B. (2001) 'Public service motivation and job performance evidence from the federal sector', *The American Review of Public Administration*, 31(4), pp. 363-380.

Aluwihare, A.P. (2005) 'Physician migration: donor country impact', *Journal of Continuing Education in the Health Professions*, 25(1), pp. 15-21.

Andersen, L.B. (2009) 'What determines the behaviour and performance of health professionals? Public service motivation, professional norms and/or economic incentives', *International Review of Administrative Sciences*, 75(1), pp. 79-97.

Andersen, L.B. and Pallesen, T. (2008) '"Not Just for the Money?" How Financial Incentives Affect the Number of Publications at Danish Research Institutions', *International Public Management Journal*, 11(1), pp. 28-47.

Archer, M.S. (1995) *Realist social theory: The morphogenetic approach*. Cambridge university press.

Ariely, D., Bracha, A. and Meier, S. (2007) 'Doing good or doing well? Image motivation and monetary incentives in behaving prosocially'.

Armstrong, M. (2002) *Employee reward*. CIPD Publishing.

Armstrong, M. (2010) Armstrong's handbook of reward management practice: Improving performance through reward. Kogan Page Publishers.

Armstrong, M. and Taylor, S. (2014) *Armstrong's handbook of human resource management practice*. Kogan Page Publishers.

Ashraf, J. and Uddin, S. (2016) 'New public management, cost savings and regressive effects: A case from a less developed country', *Critical Perspectives on Accounting*, 41, pp. 18-33.

Ashworth, R., Boyne, G. and Delbridge, R. (2009) 'Escape from the iron cage? Organizational change and isomorphic pressures in the public sector', *Journal of Public Administration Research and Theory*, 19(1), pp. 165-187.

Astor, A. *et al.* (2005) 'Physician migration: views from professionals in Colombia, Nigeria, India, Pakistan and the Philippines', *Social science & medicine*, 61(12), pp. 2492-2500.

Atkinson, M.M., Fulton, M. and Kim, B. (2014) 'Why do governments use pay for performance? Contrasting theories and interview evidence', *Canadian Public Administration*, 57(3), pp. 436-458.

Atkinson, P. and Hammersley, M. (1994) 'Ethnography and participant observation'.

Bandura, A. (2001) 'Social cognitive theory: An agentic perspective', *Annual review of psychology*, 52(1), pp. 1-26.

Baruch, Y., Wheeler, K. and Zhao, X. (2004) 'Performance-related pay in Chinese professional sports', *The International Journal of Human Resource Management*, 15(1), pp. 245-259.

Basinga, P. *et al.* (2010) 'Paying primary health care centers for performance in Rwanda'.

Baskerville, R.F. (2003) 'Hofstede never studied culture', *Accounting, organizations and society*, 28(1), pp. 1-14.

Baxter, P. and Jack, S. (2008) 'Qualitative case study methodology: Study design and implementation for novice researchers', *The qualitative report*, 13(4), pp. 544-559.

Beckert, J. (2010) 'Institutional isomorphism revisited: Convergence and divergence in institutional change', *Sociological Theory*, 28(2), pp. 150-166.

Beer, M. *et al.* (2004) 'Promise and peril in implementing pay-for-performance', *Human Resource Management*, 43(1), pp. 3-48.

Belfield, R. and Marsden, D. (2003) 'Performance pay, monitoring environments, and establishment performance', *International Journal of Manpower*, 24(4), pp. 452-471.

Bellé, N. (2015) 'Performance-related pay and the crowding out of motivation in the public sector: a randomized field experiment', *Public Administration Review*, 75(2), pp. 230-241.

Bhaskar, R. (1975) *A Realist Theory of Science*. Leeds: Leeds Books.

Bhaskar, R. (1989) *The Possibility of Naturalism*. Hemel Hempstead: Hemel Hampstead.

Blasi, J.R. et al. (2008) Creating a bigger pie? The effects of employee ownership, profit sharing, and stock options on workplace performance.

Borkowski, N. (2015) *Organizational behavior in health care*. Jones & Bartlett Publishers.

Bovens, M., Goodin, R.E. and Schillemans, T. (2014) *The Oxford handbook of public accountability*. OUP Oxford.

Boyer, K.K. and Swink, M.L. (2008) 'Empirical elephants—why multiple methods are essential to quality research in operations and supply chain management', *Journal of Operations Management*, 26(3), pp. 338-344.

Boyne, G.A. (2003) 'Sources of public service improvement: A critical review and research agenda', *Journal of public administration research and theory*, 13(3), pp. 367-394.

Bozeman, B. and Su, X. (2015) 'Public service motivation concepts and theory: A critique', *Public Administration Review*, 75(5), pp. 700-710.

Bozionelos, N. and Wang, L. (2007) 'An investigation on the attitudes of Chinese workers towards individually based performance-related reward systems', *The International Journal of Human Resource Management*, 18(2), pp. 284-302.

Bratton, J. and Gold, J. (2012) *Human resource management: theory and practice*. Palgrave Macmillan.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative research in psychology*, 3(2), pp. 77-101.

Bretz, R.D., Milkovich, G.T. and Read, W. (1992) 'The current state of performance appraisal research and practice: Concerns, directions, and implications', *Journal of management*, 18(2), pp. 321-352.

Brewer, G.A. (2008) 'Employee and organizational performance', *Motivation in public management: The call of public service*, pp. 136-156.

Brewer, G.A. *et al.* (2000) 'Individual conceptions of public service motivation', *Public Administration Review*, 60(3), pp. 254-264.

Brewster, C. (1995) 'Towards a 'European'model of human resource management', *Journal of International Business Studies*, 26(1), pp. 1-21.

Brief, A.P. and Motowidlo, S.J. (1986) 'Prosocial organizational behaviors', *Academy of management Review*, 11(4), pp. 710-725.

Brinkerhoff, D.W. and Brinkerhoff, J.M. (2015) 'Public sector management reform in developing countries: Perspectives beyond NPM orthodoxy', *Public Administration and Development*, 35(4), pp. 222-237.

Brown, D. and Armstrong, M. (1999) Paying for contribution: Real performance-related pay strategies. Kogan Page Publishers.

Bryson, J.M., Crosby, B.C. and Bloomberg, L. (2014) 'Public value governance: Moving beyond traditional public administration and the new public management', *Public Administration Review*, 74(4), pp. 445-456.

Budhwar, P.S. (2003) 'Employment relations in India', *Employee Relations*, 25(2), pp. 132-148.

Budhwar, P.S. and Debrah, Y.A. (2013) *Human resource management in developing countries*. Routledge.

Burgess, R.G. (2002) In the field: An introduction to field research. Routledge.

Burgess, S., Propper, C. and Wilson, D. (2002) *Does Performance Monitoring Work?: A Review of the Evidence from the UK Public Sector, Excluding Health Care*. University of Bristol, Centre for Market and Public Organisation.

Burgess, S. and Ratto, M. (2003) 'The role of incentives in the public sector: Issues and evidence', *Oxford review of economic policy*, 19(2), pp. 285-300.

Burrell, G. and Morgan, G. (1979) *Sociological paradigms and organisational analysis*. London: Heinemann.

Campbell, S. *et al.* (2007) 'Quality of primary care in England with the introduction of pay for performance', *New England Journal of Medicine*, 357(2), pp. 181-190.

Campbell, S.M. *et al.* (2009) 'Effects of pay for performance on the quality of primary care in England', *New England Journal of Medicine*, 361(4), pp. 368-378.

Cardona, F. (2006) 'Performance Related Pay in the Public Service in OECD and EU Member States', *Programme SIGMA de l'OCDE. Paris*.

Chalkley, M. *et al.* (2010) 'Incentives for dentists in public service: evidence from a natural experiment', *Journal of Public Administration Research and Theory*, 20(suppl 2), pp. i207-i223.

Chamberlin, R. *et al.* (2002) 'Performance-related pay and the teaching profession: a review of the literature', *Research Papers in Education*, 17(1), pp. 31-49.

Chiang, C.-F. and Jang, S. (2008) 'An expectancy theory model for hotel employee motivation', *International Journal of Hospitality Management*, 27(2), pp. 313-322.

Chikanda 1, A. (2007) 'Medical migration from Zimbabwe: magnitude, causes and impact on the poor', *Development Southern Africa*, 24(1), pp. 47-60.

Christensen, R.K., Paarlberg, L. and Perry, J.L. (2017) 'Public Service Motivation Research: Lessons for Practice', *Public Administration Review*, 77(4), pp. 529-542.

Chung, S. *et al.* (2010) 'Does the Frequency of Pay-for-Performance Payment Matter?—Experience from a Randomized Trial', *Health services research*, 45(2), pp. 553-564.

Cloutier, C. *et al.* (2015) 'Agency at the managerial interface: Public sector reform as institutional work', *Journal of Public Administration Research and Theory*, 26(2), pp. 259-276.

Co-operation, O.f.E. and Development (2005) Performance-related pay policies for government employees. OECD.

Coens, T. and Jenkins, M. (2002) Abolishing performance appraisals: Why they backfire and what to do instead. Berrett-Koehler Publishers.

Condly, S.J., Clark, R.E. and Stolovitch, H.D. (2003) 'The Effects of Incentives on Workplace Performance: A Meta-analytic Review of Research Studies 1', *Performance Improvement Quarterly*, 16(3), pp. 46-63.

Courty, P. and Marschke, G. (2004) 'An empirical investigation of gaming responses to explicit performance incentives', *Journal of Labor Economics*, 22(1), pp. 23-56.

Creswell, J.W. (2013) Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications.

Crewson, P.E. (1997) 'Public-service motivation: Building empirical evidence of incidence and effect', *Journal of Public Administration Research and Theory*, 7(4), pp. 499-518.

Cromwell, J. *et al.* (2011) 'Pay for performance in health care: methods and approaches'.

Cummings, T.G. and Worley, C.G. (2014) *Organization development and change*. Cengage learning.

Dahlström, C., Lapuente, V. and Teorell, J. (2009) 'Bureaucracy, politics and corruption', *QoG Working Paper Series*, 2009(21), p. 21.

Dahlström, C., Lapuente, V. and Teorell, J. (2010) 'Dimensions of bureaucracy. A cross-national dataset on the structure and behavior of public administration', *QoG Working Paper Series*, 13.

Daley, D.M. (1992) 'Pay for performance, performance appraisal, and total quality management', *Public Productivity & Management Review*, pp. 39-51.

Deci, E.L., Koestner, R. and Ryan, R.M. (1999) 'The undermining effect is a reality after all—Extrinsic rewards, task interest, and self-determination: Reply to Eisenberger, Pierce, and Cameron (1999) and Lepper, Henderlong, and Gingras (1999)'.

Deci, E.L. and Ryan, R.M. (2010) *Self-determination*. Wiley Online Library.

Denhardt, R.B. and Denhardt, J.V. (2000) 'The new public service: Serving rather than steering', *Public administration review*, 60(6), pp. 549-559.

Denzin, N.K. and Lincoln, Y.S. (1998) 'The landscape of qualitative research: Theories and issue'. Thousand Oaks, CA: Sage Publications.

Denzin, N.K. and Lincoln, Y.S. (2011) *The SAGE handbook of qualitative research*. Sage.

Dey, I. (1993) Qualitative Data Analysis: a user-friendly guide for social scientists. London: Routledge.

Dieleman, M., Gerretsen, B. and van der Wilt, G.J. (2009) 'Human resource management interventions to improve health workers' performance in low and middle income countries: a realist review', *Health Research Policy and Systems*, 7(1), p. 7.

DiMaggio, P. and Powell, W.W. (1983) 'The iron cage revisited: Collective rationality and institutional isomorphism in organizational fields', *American Sociological Review*, 48(2), pp. 147-160.

DiMaggio, P.J. and Powell, W.W. (1991) 'The new institutionalism in organisational analysis', *The new institutionalism in Organisational analysis*.

Dopfer, K., Foster, J. and Potts, J. (2004) 'Micro-meso-macro', *Journal of Evolutionary Economics*, 14(3), pp. 263-279.

Doran, T. *et al.* (2006a) 'Family practice performance in the first year of the UK's new'pay for performance'scheme: good clinical practice or gaming?', *New England Journal of Medicine*, pp. 375-384.

Doran, T. *et al.* (2006b) 'Pay-for-performance programs in family practices in the United Kingdom', *New England Journal of Medicine*, 355(4), pp. 375-384.

Dowling, B. and Richardson, R. (1997) 'Evaluating performance-related pay for managers in the National Health Service', *International Journal of Human Resource Management*, 8(3), pp. 348-366.

Drechsler, W. (2014) 'The rise and demise of the New Public Management: Lessons and opportunities for South East Europe', *International Public Administration Review*, 7(3).

Duberley, J., Johnson, P. and Cassell, C. (2012) 'Philosophies underpinning qualitative research', *Qualitative organizational research: Core methods and current challenges*, 15.

Dunleavy, P. and Hood, C. (1994) 'From old public administration to new public management', *Public money & management*, 14(3), pp. 9-16.

Dunleavy, P. *et al.* (2006) 'New public management is dead—long live digital-era governance', *Journal of Public Administration Research and Theory*, 16(3), pp. 467-494.

Durant, R.F. *et al.* (2006) 'Motivating employees in a new governance era: The performance paradigm revisited', *Public Administration Review*, 66(4), pp. 505-514.

Dysvik, A. and Kuvaas, B. (2013) 'Intrinsic and extrinsic motivation as predictors of work effort: The moderating role of achievement goals', *British Journal of Social Psychology*, 52(3), pp. 412-430.

Easton, G. (2010) 'Critical realism in case study research', *Industrial Marketing Management*, 39(1), pp. 118-128.

Edwards, P.K., O'Mahoney, J. and Vincent, S. (2014) *Studying Organizations Using Critical Realism: A Practical Guide*. Oxford university press.

Eichler, R. (2006) 'Can "pay for performance" increase utilization by the poor and improve the quality of health services', *Background papers for the Working Group on Performance Based Incentives. Centre for Global Development*.

Eichler, R. and Levine, R. (2009) Performance incentives for global health: potential and pitfalls. CGD Books.

Eisenhardt, K.M. (1989) 'Building theories from case study research', *Academy of management review*, 14(4), pp. 532-550.

Eisenhardt, K.M. and Graebner, M.E. (2007) 'Theory building from cases: opportunities and challenges', *Academy of management journal*, 50(1), pp. 25-32.

Eldridge, C. and Palmer, N. (2009) 'Performance-based payment: some reflections on the discourse, evidence and unanswered questions', *Health policy and planning*, 24(3), pp. 160-166.

Farnham, D. and Horton, S. (1996) 'The political economy of public sector change', in *Managing the new public services*. Springer, pp. 3-24.

Ferlie, E. (1996) *The new public management in action*. Oxford university press.

Ferlie, E.B. and Shortell, S.M. (2001) 'Improving the quality of health care in the United Kingdom and the United States: a framework for change', *The Milbank Quarterly*, 79(2), p. 281.

Fernandez, D.R. *et al.* (1997) 'Hofstede's country classification 25 years later', *The Journal of social psychology*, 137(1), pp. 43-54.

Fernandez, S. and Rainey, H.G. (2006) 'Managing successful organizational change in the public sector', *Public administration review*, 66(2), pp. 168-176.

Ferrinho, P. *et al.* (1998) 'How and why public sector doctors engage in private practice in Portuguese-speaking African countries', *Health Policy and Planning*, 13(3), pp. 332-338.

Fleetwood, S. and Ackroyd, S. (2004) Critical realist applications in organisation and management studies. Psychology Press.

Flick, U. (2009) An introduction to qualitative research. Sage.

Forest, V. (2008) 'Performance-related pay and work motivation: theoretical and empirical perspectives for the French civil service', *International review of administrative sciences*, 74(2), pp. 325-339.

Forrester, G. (2001) 'Performance-related pay for teachers: an examination of the underlying objectives and its application in practice', *Public Management Review*, 3(4), pp. 617-625.

Frey, B.S., Homberg, F. and Osterloh, M. (2013) 'Organizational control systems and pay-for-performance in the public service', *Organization Studies*, p. 0170840613483655.

Frey, B.S. and Jegen, R. (2001) 'Motivation crowding theory', *Journal of Economic Surveys*, 15(5), pp. 589-611.

Frey, B.S. and Oberholzer-Gee, F. (1997) 'The cost of price incentives: An empirical analysis of motivation crowding-out', *The American economic review*, pp. 746-755.

Fryer Jr, R.G. (2011) 'Financial incentives and student achievement: Evidence from randomized trials', *The Quarterly Journal of Economics*, 126(4), pp. 1755-1798.

Gabris, G.T. and Simo, G. (1995) 'Public sector motivation as an independent variable affecting career decisions', *Public personnel management*, 24(1), pp. 33-51.

Gagné, M. and Deci, E.L. (2005) 'Self-determination theory and work motivation', *Journal of Organizational behavior*, 26(4), pp. 331-362.

Gavagan, T.F. *et al.* (2010) 'Effect of financial incentives on improvement in medical quality indicators for primary care', *The Journal of the American Board of Family Medicine*, 23(5), pp. 622-631.

Georgopoulos, B.S., Mahoney, G.M. and Jones Jr, N.W. (1957) 'A path-goal approach to productivity', *Journal of Applied Psychology*, 41(6), p. 345.

Gerhart, B. and Fang, M. (2014) 'Pay for (individual) performance: Issues, claims, evidence and the role of sorting effects', *Human Resource Management Review*, 24(1), pp. 41-52.

Gerhart, B., Rynes, S.L. and Fulmer, I.S. (2009) '6 pay and performance: individuals, groups, and executives', *The Academy of Management Annals*, 3(1), pp. 251-315.

Gerhart, B.A., Milkovich, G.T. and Murray, B. (1992) 'Pay, performance, and participation'.

Gill, J. and Johnson, P. (2010) *Research methods for managers*. Sage.

Gillam, S.J., Siriwardena, A.N. and Steel, N. (2012) 'Pay-for-performance in the United Kingdom: impact of the quality and outcomes framework—a systematic review', *The Annals of Family Medicine*, 10(5), pp. 461-468.

Gneezy, U. and Rustichini, A. (2000) 'Pay enough or don't pay at all', *Quarterly Journal of Economics*, 115(3), pp. 791-810.

Goffman, E. (1974a) '1986 Frame Analysis'. Boston: Northeastern University Press.

Goffman, E. (1974b) Frame analysis: An essay on the organization of experience. Harvard University Press.

Gosden, T. *et al.* (2001) 'Impact of payment method on behaviour of primary care physicians: a systematic review', *Journal of health services research & policy*, 6(1), pp. 44-55.

Grand, J.L. (2010) 'Knights and knaves return: public service motivation and the delivery of public services', *International public management journal*, 13(1), pp. 56-71.

Greenwood, R. et al. (2017) The SAGE handbook of organizational institutionalism. SAGE.

Grimshaw, D. (1998) The ESRC Labour Studies Seminar. London.

Griswold, W. (2012) Cultures and societies in a changing world. Sage.

Guba, E.G. and Lincoln, Y.S. (1994) 'Competing paradigms in qualitative research', *Handbook of qualitative research*, 2(163-194), p. 105.

Guest, D. (2002) 'Human resource management, corporate performance and employee wellbeing: Building the worker into HRM', *The journal of industrial relations*, 44(3), pp. 335-358.

Gupta, N. and Shaw, J.D. (2014) 'Employee compensation: The neglected area of HRM research', *Human Resource Management Review*, 24(1), pp. 1-4.

Hallock, J.A., Mckinley, D.W. and Boulet, J.R. (2007) 'Migration of doctors for undergraduate medical education', *Medical Teacher*, 29(2-3), pp. 98-105.

Hasnain, Z., Manning, N. and Pierskalla, J.H. (2014) 'The Promise of Performance Pay? Reasons for Caution in Policy Prescriptions in the Core Civil Service', *The World Bank Research Observer*, p. lku001.

Heckman, J., Heinrich, C. and Smith, J. (1997) 'Assessing the performance of performance standards in public bureaucracies', *The American Economic Review*, 87(2), pp. 389-395.

HEDGES, H.C.L.V. (2009) 'Research synthesis as a scientific process', *The handbook of research synthesis and meta-analysis*, p. 1.

Heneman, H.G. and Schwab, D.P. (1972) 'Evaluation of research on expectancy theory predictions of employee performance', *Psychological Bulletin*, 78(1), p. 1.

Heneman, R.L. and Werner, J.M. (2005) Merit pay: Linking pay to performance in a changing world. IAP.

Hillman, A.L. *et al.* (1999) 'The use of physician financial incentives and feedback to improve pediatric preventive care in Medicaid managed care', *Pediatrics*, 104(4), pp. 931-935.

Hofstede, G. (1980) 'Motivation, leadership, and organization: do American theories apply abroad?', *Organizational dynamics*, 9(1), pp. 42-63.

Hofstede, G. (1983) 'The cultural relativity of organizational practices and theories', *Journal of International Business Studies*, pp. 75-89.

Hofstede, G. (1993) 'Cultural constraints in management theories', *The academy of management executive*, 7(1), pp. 81-94.

Hofstede, G. (1999) 'Problems remain, but theories will change: The universal and the specific in 21st-century global management', *Organizational dynamics*, 28(1), pp. 34-44.

Homedes, N. and Ugalde, A. (2005) 'Why neoliberal health reforms have failed in Latin America', *Health policy*, 71(1), pp. 83-96.

Honda, A. (2013) '10 best resources on… pay for performance in low-and middle-income countries', *Health policy and planning*, 28(5), pp. 454-457.

Hood, C. (1995) 'The "New Public Management" in the 1980s: variations on a theme', *Accounting, organizations and society*, 20(2), pp. 93-109.

Hood, C. (2000) 'Paradoxes of public-sector managerialism, old public management and public service bargains', *International Public Management Journal*, 3(1), pp. 1-22.

Hood, C. and Dixon, R. (2015) '1. Title: What We Have To Show for 30 Years of New Public Management: Higher Costs, More Complaints', *Governance*, 28(3).

Hood, C. and Dixon, R. (2016) 'Not What It Said on the Tin? Reflections on Three Decades of UK Public Management Reform', *Financial Accountability & Management*, 32(4), pp. 409-428.

Hood, C. and Peters, G. (2004) 'The middle aging of new public management: into the age of paradox?', *Journal of Public Administration Research and Theory: J-PART*, pp. 267-282.

Horton, S. and Hondeghem, A. (2006) 'Public service motivation and commitment', *Public Policy and Administration*, 21(1), pp. 1-12.

Howe-Walsh, L. and Schyns, B. (2010) 'Self-initiated expatriation: Implications for HRM', *The International Journal of Human Resource Management*, 21(2), pp. 260-273.

Ingraham, P.W. (1993) 'Of pigs in pokes and policy diffusion: Another look at pay-for-performance', *Public Administration Review*, pp. 348-356.

Ireland, M., Paul, E. and Dujardin, B. (2011) 'Can performance-based financing be used to reform health systems in developing countries?', *Bulletin of the World Health Organization*, 89(9), pp. 695-698.

James, H.S. (2005) 'Why did you do that? An economic examination of the effect of extrinsic compensation on intrinsic motivation and performance', *Journal of economic psychology*, 26(4), pp. 549-566.

Jenkins Jr, G.D. *et al.* (1998) 'Are financial incentives related to performance? A meta-analytic review of empirical research'. American Psychological Association.

Johnson, P. and Duberley, J. (2000) Understanding management research: An introduction to epistemology. Sage.

Jones, M.L. (2007) 'Hofstede-culturally questionable?'.

Kaboolian, L. (1998) 'The new public management: Challenging the boundaries of the management vs. administration debate', *Public Administration Review*, 58(3), pp. 189-193.

Kahn, C.M., Silva, E.C. and Ziliak, J.P. (2001) 'Performance-based Wages in Tax Collection: The Brazilian Tax Collection Reform and its Effects', *The Economic Journal*, 111(468), pp. 188-205.

Kauhanen, A. and Piekkola, H. (2006) 'What makes performance-related pay schemes work? Finnish evidence', *Journal of Management & Governance*, 10(2), pp. 149-177.

Kellough, J.E. and Lu, H. (1993) 'The Paradox of Merit Pay in the Public Sector Persistence of a Problematic Procedure', *Review of Public Personnel Administration*, 13(2), pp. 45-64.

Kellough, J.E. and Nigro, L.G. (2002) 'Pay for Performance in Georgia State Government Employee Perspectives on GeorgiaGain After 5 Years', *Review of Public Personnel Administration*, 22(2), pp. 146-166.

Kessler, I. and Purcell, J. (1992) 'Performance related pay: objectives and application', *Human Resource Management Journal*, 2(3), pp. 16-33.

Khowaja, K. (2009) 'Healthcare systems and care delivery in Pakistan', *Journal of Nursing Administration*, 39(6), pp. 263-265.

Kim, S. (2009) 'Revising Perry's measurement scale of public service motivation', *The American Review of Public Administration*, 39(2), pp. 149-163.

Kim, Y. (2011) 'The pilot study in qualitative inquiry: Identifying issues and learning lessons for culturally competent research', *Qualitative Social Work*, 10(2), pp. 190-206.

Kotter, J.P. (1995) 'Leading change: Why transformation efforts fail'.

Kuvaas, B. (2006) 'Performance appraisal satisfaction and employee outcomes: mediating and moderating roles of work motivation', *The International Journal of Human Resource Management*, 17(3), pp. 504-522.

Laegreid, P. and Christensen, T. (2013) Transcending new public management: the transformation of public sector reforms. Ashgate Publishing, Ltd.

Lagarde, M. and Blaauw, D. (2009) 'A review of the application and contribution of discrete choice experiments to inform human resources policy interventions', *Human resources for health*, 7(1), pp. 1-10.

Lagomarsino, G. *et al.* (2012) 'Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia', *The Lancet*, 380(9845), pp. 933-943.

Lane, J.-E. (1997) Public sector reform: rationale, trends and problems. Sage.

Lawler, E.E. (2000) 'Research directions', *Human Resource Management Review*, 10(3), pp. 307-311.

Lawler, E.E. and Suttle, J.L. (1973) 'Expectancy theory and job behavior', *Organizational Behavior and Human Performance*, 9(3), pp. 482-503.

Lawler III, E.E. (1990) Strategic pay: Aligning organizational strategies and pay systems. Jossey-Bass.

Ledford, G.E., Gerhart, B. and Fang, M. (2013) 'Negative Effects of Extrinsic Rewards on Intrinsic Motivation: More Smoke Than Fire', *World at Bank*, (second quarter), pp. 17-29.

LeGrand, J. (2003) 'From Knight to Knave, From Pawn to Queen'. Oxford: Oxford University Press.

Lincoln, Y.S. and Guba, E.G. (1985) *Naturalistic inquiry*. Sage.

Lindenauer, P.K. *et al.* (2007) 'Public reporting and pay for performance in hospital quality improvement', *New England Journal of Medicine*, 356(5), pp. 486-496.

Liu, B.C. and Tang, T.L.P. (2011) 'Does the love of money moderate the relationship between public service motivation and job satisfaction? The case of Chinese professionals in the public sector', *Public Administration Review*, 71(5), pp. 718-727.

Liu, X. and Mills, A. (2005) 'The effect of performance-related pay of hospital doctors on hospital behaviour: a case study from Shandong, China', *Human resources for health*, 3(11), pp. 1-12.

Lyons, S.T., Duxbury, L.E. and Higgins, C.A. (2006) 'A comparison of the values and commitment of private sector, public sector, and parapublic sector employees', *Public administration review*, 66(4), pp. 605-618.

Mannion, R. and Davies, H.T. (2008) 'Payment for performance in health care', *BMJ: British Medical Journal*, 336(7639), p. 306.

Manolopoulos, D. (2008) 'Work motivation in the Hellenic extended public sector: an empirical investigation', *The International Journal of Human Resource Management*, 19(9), pp. 1738-1762.

Marsden, D. and Richardson, R. (1994) 'Performing for pay? The effects of 'merit pay'on motivation in a public service', *British Journal of Industrial Relations*, 32(2), pp. 243-261.

Mauthner, M. et al. (2012) 'Conclusion: navigating ethical dilemmas and new digital horizons', Teoksessa Miller, T., Birch, M., Mauthner, M. & Jessop, J.(toim.) Ethics in Qualitative Research, London: SAGE Publications Ltd, pp. 176-187.

Maxwell, J.A. (2012) A realist approach for qualitative research. Sage.

Mayer, R.C. and Davis, J.H. (1999) 'The effect of the performance appraisal system on trust for management: A field quasi-experiment', *Journal of applied psychology*, 84(1), p. 123.

Maynard-Moody, S. and Musheno, M. (2012) 'Social equities and inequities in practice: Street-Level workers as agents and pragmatists', *Public Administration Review*, 72(s1).

McDonald, R., Harrison, S. and Checkland, K. (2008) 'Incentives and control in primary health care: findings from English pay-for-performance case studies', *Journal of health organization and management*, 22(1), pp. 48-62.

McSweeney, B. (2002) 'Hofstede's model of national cultural differences and their consequences: A triumph of faith-a failure of analysis', *Human relations*, 55(1), pp. 89-118.

Meessen, B., Kashala, J.-P.I. and Musango, L. (2007) 'Output-based payment to boost staff productivity in public health centres: contracting in Kabutare district, Rwanda', *Bulletin of the World Health Organization*, 85(2), pp. 108-115.

Meessen, B., Soucat, A. and Sekabaraga, C. (2011) 'Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform?', *Bulletin of the World Health Organization*, 89(2), pp. 153-156.

Meyer, J.W. and Rowan, B. (1977) 'Institutionalized organizations: Formal structure as myth and ceremony', *American journal of sociology*, pp. 340-363.

Miles, M.B. and Huberman, A.M. (1994) Qualitative data analysis: An expanded sourcebook. Sage.

Millett, C. *et al.* (2009) 'Ethnic disparities in coronary heart disease management and pay for performance in the UK', *Journal of general internal medicine*, 24(1), p. 8.

Mir, A.M. *et al.* (2015) 'To serve or to leave: a question faced by public sector healthcare providers in Pakistan', *Health research policy and systems*, 13(1), p. S58.

Mullen, K.J., Frank, R.G. and Rosenthal, M.B. (2010) 'Can you get what you pay for? Pay-for-performance and the quality of healthcare providers', *The Rand journal of economics*, 41(1), pp. 64-91.

Naicker, S. *et al.* (2009) 'Shortage of healthcare workers in developing countries--Africa', *Ethnicity & disease*, 19(1), p. 60.

Newman, K.L. and Nollen, S.D. (1996) 'Culture and congruence: The fit between management practices and national culture', *Journal of international business studies*, 27(4), pp. 753-779.

Nishtar, S. (2006). Pakistan's Health Policy Forum.

Nishtar, S. *et al.* (2013) 'Health reform in Pakistan: a call to action', *The Lancet*, 381(9885), pp. 2291-2297.

Noe, R.A. *et al.* (2006) 'Human resource management: Gaining a competitive advantage'.

Osborne, S.P. (2010) The new public governance: Emerging perspectives on the theory and practice of public governance. Routledge.

Oxman, A.D. and Fretheim, A. (2009) 'Can paying for results help to achieve the Millennium Development Goals? Overview of the effectiveness of results-based financing', *Journal of Evidence-Based Medicine*, 2(2), pp. 70-83.

Pandey, S.K. *et al.* (2017) 'Public service motivation research program: Key challenges and future prospects'.

Patton, M.Q. (2002) 'Qualitative research and evaluation methods. Sage', *Thousand Oaks, CA*, p. 688.

Paulsen, M.B. (2014) Higher education: Handbook of theory and research. Springer.

Pawson, R. and Tilley, N. (1996) 'What's crucial in evaluation research: a reply to Bennett', *British journal of Criminology*, 36(4), pp. 574-578.

Pearson, S.D. *et al.* (2008) 'The impact of pay-for-performance on health care quality in Massachusetts, 2001–2003', *Health Affairs*, 27(4), pp. 1167-1176.

Perry, J.L. (1986) 'Merit pay in the public sector: The case for a failure of theory', *Review of Public Personnel Administration*, 7(1), pp. 57-69.

Perry, J.L. (1996) 'Measuring public service motivation: An assessment of construct reliability and validity', *Journal of Public Administration Research and Theory*, 6(1), pp. 5-22.

Perry, J.L. (2000) 'Bringing society in: Toward a theory of public-service motivation', *Journal of public administration research and theory*, 10(2), pp. 471-488.

Perry, J.L., Engbers, T.A. and Jun, S.Y. (2009) 'Back to the Future? Performance-Related Pay, Empirical Research, and the Perils of Persistence', *Public Administration Review*, 69(1), pp. 39-51.

Perry, J.L. and Hondeghem, A. (2008) 'Building theory and empirical evidence about public service motivation', *International public management journal*, 11(1), pp. 3-12.

Perry, J.L., Hondeghem, A. and Wise, L.R. (2010) 'Revisiting the motivational bases of public service: Twenty years of research and an agenda for the future', *Public administration review*, 70(5), pp. 681-690.

Perry, J.L., Mesch, D. and Paarlberg, L. (2006) 'Motivating employees in a new governance era: The performance paradigm revisited', *Public Administration Review*, pp. 505-514.

Perry, J.L. and Rainey, H.G. (1988) 'The public-private distinction in organization theory: A critique and research strategy', *Academy of management review*, 13(2), pp. 182-201.

Perry, J.L. and Vandenabeele, W. (2015) 'Public service motivation research: Achievements, challenges, and future directions', *Public Administration Review*, 75(5), pp. 692-699.

Perry, J.L. and Wise, L.R. (1990) 'The motivational bases of public service', *Public Administration Review*, pp. 367-373.

Petersen, L.A. *et al.* (2006) 'Does pay-for-performance improve the quality of health care?', *Annals of internal medicine*, 145(4), pp. 265-272.

Pierre, B.G.P.J. (2003) Handbook of public administration. Sage.

Piliavin, J.A. and Charng, H.-W. (1990) 'Altruism: A review of recent theory and research', *Annual review of sociology*, 16(1), pp. 27-65.

Pinder, C.C. (2014) Work motivation in organizational behavior. Psychology Press.

Podgursky, M.J. and Springer, M.G. (2007) 'Teacher performance pay: A review', *Journal of Policy Analysis and Management*, 26(4), pp. 909-949.

Pollitt, C. and Bouckaert, G. (2011) Public Management Reform: A comparative analysis-new public management, governance, and the Neo-Weberian state. Oxford University Press.

Powell, W.W. and DiMaggio, P.J. (2012) *The new institutionalism in organizational analysis*. University of Chicago Press.

Prentice, G., Burgess, S. and Propper, C. (2007) 'Performance pay in the public sector: A review of the issues and evidence', *Office of Manpower Economics*.

Price, A. (2007) Human resource management in a business context. Cengage Learning EMEA.

Punch, K.F. (2013) Introduction to social research: Quantitative and qualitative approaches. Sage.

Rainey, H.G. (1982) 'Reward preferences among public and private managers: In search of the service ethic', *The American Review of Public Administration*, 16(4), pp. 288-302.

Rainey, H.G. and Steinbauer, P. (1999) 'Galloping elephants: Developing elements of a theory of effective government organizations', *Journal of public administration research and theory*, 9(1), pp. 1-32.

Rajput, V. (2015) 'Performance Appraisal System', *Asian Journal of Nursing Education and Research*, 5(2), p. 287.

Reiss, S. (2012) 'Intrinsic and extrinsic motivation', *Teaching of Psychology*, 39(2), pp. 152-156.

Ritzer, G. (1985) 'The rise of micro-sociological theory', *Sociological Theory*, 3(1), pp. 88-98.

Roberts, G.E. (2003) 'Employee performance appraisal system participation: A technique that works', *Public personnel management*, 32(1), pp. 89-98.

Rosenthal, M.B. and Frank, R.G. (2006) 'What is the empirical basis for paying for quality in health care?', *Medical Care Research and Review*, 63(2), pp. 135-157.

Rowe, J.W. (2006) 'Pay-for-performance and accountability: related themes in improving health care', *Annals of internal medicine*, 145(9), pp. 695-699.

Ryan, R.M. and Deci, E.L. (2000) 'Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being', *American psychologist*, 55(1), p. 68.

Rynes, S.L., Gerhart, B. and Minette, K.A. (2004) 'The importance of pay in employee motivation: Discrepancies between what people say and what they do', *Human Resource Management*, 43(4), pp. 381-394.

Saldaña, J. (2015) The coding manual for qualitative researchers. Sage.

Sampson, H. (2004) 'Navigating the waves: the usefulness of a pilot in qualitative research', *Qualitative Research*, 4(3), pp. 383-402.

Sayer, A. (2000) Realism and social science. Sage.

Sayer, A. (2004) *Why critical realism?* : Routledge, London.

Sayer, R.A. (1992) Method in social science: A realist approach. Psychology Press.

Schuler, R.S. and Rogovsky, N. (1998) 'Understanding compensation practice variations across firms: The impact of national culture', *Journal of International Business Studies*, 29(1), pp. 159-177.

Scott, W.R. (2013) Institutions and organizations: Ideas, interests, and identities. Sage Publications.

Segall, M. (2003) 'District health systems in a neoliberal world: a review of five key policy areas', *The International journal of health planning and management*, 18(S1), pp. S5-S26.

Selden, S. and Sowa, J.E. (2011) 'Performance management and appraisal in human service organizations: Management and staff perspectives', *Public Personnel Management*, 40(3), pp. 251-264.

Shen, Y. (2003) 'Selection Incentives in a Performance-Based Contracting System', *Health services research*, 38(2), pp. 535-552.

Shettleworth, S.J. (2010) *Cognition, evolution, and behavior*. Oxford University Press.

Silverman, D. (2013) *Doing qualitative research: A practical handbook*. SAGE Publications Limited.

Silverman, D. (2016) *Qualitative research*. Sage.

Stake, R.E. (1995) The art of case study research. Sage.

Stazyk, E.C. (2013) 'Crowding out public service motivation? Comparing theoretical expectations with empirical findings on the influence of performance-related pay', *Review of Public Personnel Administration*, 33(3), pp. 252-274.

Stipek, D.J. (1993) 'Motivation to learn: From theory to practice'.

Storey, J. and Sisson, K. (2005) 'Performance-related pay', *Strategic Human Resource Management: Theory and Practice*, pp. 177-184.

Suddaby, R., Seidl, D. and Lê, J.K. (2013) 'Strategy-as-practice meets neo-institutional theory'. Sage Publications Sage UK: London, England.

Suhail, A. and Azhar, A. (2016) 'Managing Human Resources in Public Health Care System in South Asia: Case Study of Pakistan', *South Asian Journal of Human Resources Management*, 3(1), pp. 75-83.

Suliman, A.M. and Al-Sabri, N. (2009) 'Surviving through the global downturn: employee motivation and Performance in healthcare industry', *The Open Business Journal*, 2(1), pp. 86-94.

Swabe, A. (1989) 'Performance-related pay: A case study', *Employee Relations*, 11(2), pp. 17-23.

Tashakkori, A. and Teddlie, C. (2010) Sage handbook of mixed methods in social & behavioral research. Sage.

Taylor-Gooby, P. *et al.* (2000) 'Knights, knaves and gnashers: professional values and private dentistry', *Journal of Social Policy*, 29(03), pp. 375-395.

Terry, L.D. (1998) 'Administrative leadership, neo-managerialism, and the public management movement', *Public Administration Review*, pp. 194-200.

Tesch, R. (1990) Qualitative analysis: Analysis types and software tools. Falmer Press, London.

Thornton, P.H., Ocasio, W. and Lounsbury, M. (2015) *The institutional logics perspective*. Wiley Online Library.

Vaghela, P. *et al.* (2009) 'Population intermediate outcomes of diabetes under pay-for-performance incentives in England from 2004 to 2008', *Diabetes care*, 32(3), pp. 427-429.

Van de Ven, A.H. (1993) 'Managing the process of organizational innovation', *Organizational change and redesign: Ideas and insights for improving performance*, pp. 269-294.

Van Herck, P. *et al.* (2010) 'Systematic review: effects, design choices, and context of pay-for-performance in health care', *BMC health services research*, 10(1), p. 247.

Van Thiel, S. and Leeuw, F.L. (2002) 'The performance paradox in the public sector', *Public Performance & Management Review*, 25(3), pp. 267-281.

Vandenabeele, W. (2007) 'Toward a public administration theory of public service motivation: An institutional approach', *Public management review*, 9(4), pp. 545-556.

Vliegenthart, R. and Van Zoonen, L. (2011) 'Power to the frame: Bringing sociology back to frame analysis', *European Journal of Communication*, 26(2), pp. 101-115.

Walster, E. and Piliavin, J.A. (1972) 'Equity and the innocent bystander', *Journal of Social Issues*, 28(3), pp. 165-189.

Weibel, A., Rost, K. and Osterloh, M. (2010) 'Pay for performance in the public sector—Benefits and (hidden) costs', *Journal of Public Administration Research and Theory*, 20(2), pp. 387-412.

West, M.A. *et al.* (2006) 'Reducing patient mortality in hospitals: the role of human resource management', *Journal of Organizational Behavior*, 27(7), pp. 983-1002.

Wiesel, F. and Modell, S. (2014) 'From new public management to new public governance? Hybridization and implications for public sector consumerism', *Financial Accountability & Management*, 30(2), pp. 175-205.

Wigfield, A. and Eccles, J.S. (2000) 'Expectancy–value theory of achievement motivation', *Contemporary educational psychology*, 25(1), pp. 68-81.

Willis-Shattuck, M. *et al.* (2008) 'Motivation and retention of health workers in developing countries: a systematic review', *BMC health services research*, 8(1), p. 247.

Willis, J.W. and Jost, M. (2007) Foundations of qualitative research: Interpretive and critical approaches. Sage.

Witter, S. *et al.* (2012) 'Paying for performance to improve the delivery of health interventions in low-and middle-income countries', *Cochrane Database Syst Rev*, 2.

Witter, S. *et al.* (2013) 'Performance-based financing as a health system reform: mapping the key dimensions for monitoring and evaluation', *BMC health services research*, 13(1), p. 367.

Witter, S. *et al.* (2011) 'Paying health workers for performance in Battagram district, Pakistan', *Human resources for health*, 9(1), pp. 1-12.

Wright, B.E. (2001) 'Public-sector work motivation: A review of the current literature and a revised conceptual model', *Journal of Public Administration Research and Theory: J-PART*, pp. 559-586.

Wright, B.E. (2007) 'Public service and motivation: does mission matter?', *Public Administration Review*, 67(1), pp. 54-64.

Wright, B.E. and Grant, A.M. (2010) 'Unanswered questions about public service motivation: Designing research to address key issues of emergence and effects', *Public administration review*, 70(5), pp. 691-700.

Yin, R. (2003) 'K.(2003). Case study research: Design and methods', *Sage Publications, Inc*, 5, p. 11.

Yin, R.K. (2014) Case study research: Design and methods. Sage publications.

Young, G.J. *et al.* (2007) 'Effects of paying physicians based on their relative performance for quality', *Journal of General Internal Medicine*, 22(6), pp. 872-876.