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What does it take to make a wrong decision? A qualitative study from Pakistan's health sector

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ABSTRACT

Background: Pakistan's health system over the past three decades has experienced social, economic, geopolitical instability, and notwithstanding man-made and natural catastrophes. Since 2001, the health system in Pakistan has undergone three phases of organizational and management reforms and does not have a unified national health policy since then. The aim of this research was to assess the factors behind the decision-making by policy planners in the health system of Pakistan.

Methods: An exploratory qualitative study based on grounded theory was designed where in-depth interviews conducted with 20 representatives of the political constituencies, civil bureaucracy, health planners and managers, research and educational institutions, NGOs providing technical support in the health sector, development partners and media.

Results: There leading reason cited was the dearth of leadership in health sector, which is compounded by a range of factors such as "institutional monopoly", "contextual deterrents", "power for turf"; "inadequate knowledge", and "design faults". Such factors were perceived to have a serious effect on the competencies, roles and responsibilities, use of knowledge for decision making. The behavioral aspects of decision makers include the "mindset," and "conflicting interests".

Conclusions: The multitude of factors and complexities within the health sector of Pakistan continue to widen the vacuum in the leadership echelons. Hence, there is a high probability of taking wrong decisions not based on evidence, and resulting in a grossly under-performing health system.

1. Background

Governance, meant to promote and protect the well-being of populations, is overseen by the politicians, planners and policy makers, who focus to exercise the powers in order to harmonize the interaction between the state and the population [1]. However, for governance to function to its optimum, requires public and private sector to practice with adequate capacity, so that they are able to design effective interventions and services for people [2]. Governance in health systems is beleaguered by weak institutions, lack of road maps, absence of genuine leadership, inadequate coordination, lack of performance frameworks and corruption [3]. The World Health Organization in its World Health Reports of 2000 and 2007 emphasize strongly for strengthened governance systems and structures [4,5]. In the domain of governance, health systems are viewed to outline policy intents, strategic directions, resource allocations, and coordination to play a regulatory role [6].

However, all the policy decisions ideally should be based on credible translational and implementation research, generating enough evidence. This would necessitate investing in health systems research for strengthening the health system and in turn making health services more client-centered and responsive [4,6].

Ever since the Millennium Declaration, the health sector became a priority in global agenda, which is manifested by a rising share for health in the Official Development Assistance. However, the countries with the highest levels of poverty and under-development, do not receive their due share of aid [7]. The global economic crisis around 2010 affected the heath financing, hence placing additional burden on the weaker health care systems [8]. Low priority has been given to health in the core planning processes in most of the low and middle income countries. Coordination with donor agencies have been limited to focus on the content of the coordination guidelines rather than its implementation. This has led to limiting

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capacity of many developing countries to foster the culture of health policy and systems research as well as use of evidence for policy making [9].

Pakistan's healthcare delivery system is comprised of both public and private sectors. According to the constitution, the responsibility for health primarily falls under the jurisdiction of provincial governments, with the exception of federally administered areas. In the past, the federal and provincial governments have jointly administered healthcare delivery, with district-level officials responsible for implementation. Healthcare services are typically provided through preventive, promotive, curative, and rehabilitative services, with the latter two being primarily offered at secondary and tertiary care facilities. Preventive and promotive services are generally provided through national programs and community health workers, who interface with communities through primary healthcare facilities and outreach initiatives. The state provides healthcare services through a three-tiered delivery system and a variety of public health interventions. Additionally, some government and semi-governmental organizations, such as the armed forces and a few parastatal departments, offer healthcare services to their employees and dependents through their own system, which collectively covers approximately 10% of the population. The private healthcare sector is a diverse group that includes doctors, nurses, pharmacists, traditional healers, drug vendors, and laboratory technicians, many of whom work in government hospitals during morning shifts. There are also numerous shopkeepers who sell medicines over the counter without prescriptions and unlicensed practitioners who provide medications without proper qualifications [10].

The mixed public and private sector configuration of Pakistan's health care system is important to understand. The public sector is largely designed on the colonial pattern with its inherent weaknesses and filling the gaps is the unregulated private sector. The most critical problem is institutional deterioration due to the status quo in the bureaucracy, staff malpractice and low government resources and priority for social sector reforms. This dampens the public system's capacity as well as performance and limits its ability for "out-of-the-box" responses for creatively dealing with the growing private sector and responding to intra-sectoral issues [11]. There has been a strange competition between public sector financing and service provision and private-sector service delivery. Same doctors serving the public system in the day time are practicing privately in the evening with much more empathy and care, hence promoting the use of private sector health care [12]. A wider interpretation of health is needed as a broad social policy vision and a universal right rather than the more commonly applied interpretation of health as a commodity.

Pakistan's health system, over the past three decades has experienced social, economic, and geopolitical instability and notwithstanding man-made and natural catastrophes. Health has never been high on the political agenda in Pakistan. This is evident from the fact that per capita expenditure for the fiscal year 2011-12 was even less than the per capita expenditure in 2006-07. Furthermore, the health expenditure as percentage of GDP, decreased from 0.72% in 2000-01 to 0.46% in 2016-17 [13]. Though the manifestos presented by political parties aspire to increase GDP expenditure on health to 5% by 2025, the health sector is marred by corruption, leading to pilferages. The progress on the health indicators is also slow against the goals set by the Sustainable Development Goals [14], and child and mother health indicators in Pakistan remain poor in South Asia [15]. In addition, Pakistan could not have a unified health policy since 2001, owing to administrative and political devolution of powers in 2011, leading to political differences within the health sector [16]. As a consequence of the 18th constitutional amendment, 'health' with other subjects on the federal legislative list were devolved to the provinces in 2011. Although a national health vision 2016-2023 was developed by the ministry of national health services, yet its role is limited to manage health services in the capital territory only, and to look after health sector regulatory affairs and to coordinate with the provinces on matters of international concerns such as global health security and the donors like GAVI and Global Fund.

With this preamble, the aim of this study envisaged was to assess the factors that contribute to decision-making by policy planners in the health system of Pakistan.

2. Methods

2.1. Study design and participants

The study intended to understand what are the actual factors behind the decision-making by policy planners in the health system of Pakistan, and what does it take to make a wrong decision, despite all good intentions. With this research premise, an exploratory qualitative study using grounded theory was conducted among representatives of the constituencies of politics, civil bureaucracy in health sector, health planners and managers, research and educational institutions, agencies providing technical support in the health sector, international NGOs working on health, development partners, donors and media. The participants were although purposively selected, yet a diverse selection was made in regard to their sectoral constituency, experience and gender. None of the participants who were approached for the interview, refused to participate.

Researchers opted for the grounded theory because it allows to begin with a general research question, and does not start with any preconceived ideas or theories. Data is analyzed in an iterative process in order to develop a theory that emerges from the data. One of the strengths of grounded theory is that it allows for the discovery of unexpected findings and new theories that may not have been apparent at the outset of the research. It also allows for a flexible approach that can be adapted to different research questions and contexts [17].

The study team ensured the validity of the findings by careful recording and note taking, as well as continual verification of the narratives that the researchers scribed during the interviews. To further overcome the researchers' bias, we conducted validity checks such as member checking or peer debriefing to ensure that the data collected accurately reflects the experiences of the participants. Also, we used a rigorous and transparent data analysis process to ensure that findings are supported by the data and not influenced by personal biases.

2.2. Data collection

We piloted an in-depth interview guide by interviewing two senior management personal working in the health sector. After this, the guide was revised. The interview guide focused on (a) devolution and its effects; (b) stakeholders in health sector; (c) decision making processes; and (d) factors and circumstances that influence their decision-making.

The study got the ethical approval from the Institutional Review Board of the agency commissioning the research. All interviews were recorded in English language, after obtaining written consent and explaining the objectives of the study. However, four out of twenty participants refused recording for the interviews. All the in-depth interviews were conducted by single group of researchers, led by the two authors. Hence, immediately after each interview, the notes were expanded into detailed transcripts. Each interview lasted for about 45 minutes. At the end of each day, the authors transcribed the interview and reflected on the day's proceedings with peers, and preliminary analysis of each interview was done. Data saturation was reached after twenty interviews as no new information emerged from the data. In order to increase the validity of the findings, a focus group discussion was held, comprising health experts. Thirty participants were purposively invited to represent the constituencies mentioned above. The proceedings of the panel were recorded and transcribed. The insiders' views (those from the health departments) were broadened by the outsiders' views (those representing the development partners, NGOs, media, academicians/researchers), which enriched the understanding of the data and contributed back to the analyses.

2.3. Data analysis

Qualitative content analysis approach was used for the analysis of the transcribed data through interpretation of meaning and intentions. This method enables the researcher to include large amounts of textual information. The transcripts were read several times to gain a sense of the

experiences and to understand the essence of the participant's views. Meaning units of the interviews responding to the objectives of the study were identified, condensed without losing meaning, and then coded. The software program Open Code was used for coding. The codes were grouped into categories. The underlying meaning of the data was abstracted into two subthemes and a main theme. To ensure trustworthiness, the authors undertook various procedures such as member check and peer review to capture the multiple narrations by the participants. The research team composition was diverse and brought in several perspectives, which ensured interpretation in its entirety. Discussions were done with other research team on the emerging codes, sub themes and theme until the consensus was reached.

3. Results

The main theme identified was "Dearth of leadership in health sector" draws upon two subthemes: "Institutional Monopoly" and "Contextual Deterrents" The main theme, subthemes, categories, which emerged from the analysis are presented in Table 1.

The two sub-themes will be unfolded further in this section of results:

3.1. Institutional monopoly

3.1.1. Power for turf

The aim of the analysis is to examine the various factors that contributed to a lack of trust in the development of a health vision. Based on the opinions of the majority of participants, it appears that a lack of visionary leadership and strategic guidance resulted in a fragmented health policy in Pakistan. The participants identified politicians, bureaucrats, and technocrats as leaders in this area. According to their views, politicians focused more on output rather than policy guidance, bureaucrats concentrated on inputs instead of translating policy into strategy, and technocrats were primarily involved in implementing guidelines instead of facilitating the implementation of health initiatives and programs. In addition, frequent changes in the political landscape were seen as a critical factor in the discontinuation of policies implemented by successive governments.

> *"Change in political systems also affects the health systems. Health is the last priority in the development sector. We do a lot of consultation, but the ownership is not there". [Technocrat – Ministry of Planning]*

A few participants expressed their thoughts that politicians' eagerness to demonstrate progress in infrastructure to their constituents had a significant impact on the planning process, with tangible hardware outputs being the main focus. The bureaucracy's desire to please politicians and secure support for budget inputs further exacerbated this situation, resulting in the technocrats and health service managers focusing on processes and reporting accordingly.

> *"The reason is that the government look as the targets, which are output based. To achieve these, one needs the inputs and for these inputs to take place, processes need to be placed in". [Bureaucrat – Ministry of Health]*

When questioned about the inability of successive governments to restructure the systems in order to achieve the goals set out in international agreements, all of the participants agreed that such a realignment requires authentic leadership and vision, which have been lacking in both past and current scenarios within the health sector.

Table 1
Analysis chronology.

Theme	Dearth of leadership in health sector	
Sub Theme	Institutional Monopoly	Contextual Deterrents
Categories	Power for Turf Lack of Coordination Undefined Roles and Responsibilities Limited use of knowledge Design Faults	Mindset Conflicting Interests

3.1.2. Lack of coordination

All participants perceived a lack of coordination within and with other departments as a significant hindrance to creating an enabling environment for better health service provision. According to the majority of participants, the desire to maintain full control over financial gains, hold onto positions, and a lack of clarity regarding roles and responsibilities led to an unfair distribution of resources. This, in turn, resulted in reactive measures to emerging issues, ultimately leading to a return to the status quo.

> *"Decision makers are tuned for day-to-day firefighting. The policy decisions that one has to make in timely fashion, are not being made. The leadership role is lost". [Health Specialist - Donor Agency]*

3.1.3. Undefined roles and responsibilities

The majority of participants believed that unclear roles and responsibilities have resulted in leadership positions functioning solely as managers. Participants perceived that those in leadership positions were ineffective, arrogant, and had limited autonomy to make strategic decisions.

> *"The leadership is coming from political aspects and also from the civil* bureaucracy. *If there are no people who have that strategic thinking, then no matter how good the power relationships are, nothing works. They are important but they are only important when there is clarity on what needs to be done". [Health Specialist - Donor Agency]*

3.1.4. Limited use of knowledge

All participants believed that a knowledge base, consisting of national surveys and independent research, was available to make informed choices and decisions. However, limited capacity and willingness to use available information hindered the understanding and use of evidence for decision making. Researchers and academics were of the opinion that research was driven by policy, but Pakistan lacked a health policy, resulting in incremental progress. Additionally, public sector research institutions were reluctant to provide accurate information to avoid antagonizing the government, which they depended on for future funding.

One participant highlighted the inadequate capacity of educational institutions to design educational packages that meet governance requirements. Additionally, a mindset was identified as responsible for making haphazard decisions about human resource planning, management, and development in the health sector. This mindset led to placing incompetent individuals in unsuitable positions.

> *"Mindset can only be made if they are taught to see what they are supposed to see. People sitting in the highest technocrat positions are not trained for the positions. Most of them are backed by a political patronage. These people are concerned with their seniority, their length of service but not with what they are delivering. Same is the case with the teachers on the other end". [Professional Development Specialist – Educational Institution]*

3.1.5. Design fault

One of the interviewed participants emphasized the government's role in financing, regulation, and availability of health services. The majority of participants believed that the new service delivery management model, managed by the bureaucracy through contracting-in, further increased their control over resources. Some participants criticized the fact that performance was not measured in terms of outcomes. They perceived that annual appraisals were not linked to an individual's performance,

contribution level, team leadership, or knowledge generation. Instead, they were focused on finding reasons for why an individual failed to produce desired results. This approach lacked a policy or strategic direction and was based on the desires of one person. Some participants believed that planners had ignored lessons learned over decades and had failed to redesign the system accordingly.

For most of the participants the culture of participatory planning was perceived to be non-inclusive and was based on incremental increase over years. The policies were perceived in a uniform manner and the rule of "one shoe fits all" was applied.

3.2. Contextual deterrents

This second sub-theme attempts to unfold the behavioral aspects of decision makers and draws upon two categories: "Mindset," and "Imbalanced Interests."

3.2.1. Mindset

It is concerning to hear that the leadership in the health sector may be more interested in maintaining the status quo for their own interests rather than pursuing reforms that could benefit the population. Lack of a results framework and a political mindset for reforms can hinder progress and accountability. It's important to have a system in place to measure outcomes and hold individuals and institutions accountable for their performance. It seems that there is a need for a shift in mindset towards prioritizing accountability and results over personal interests.

According to some of the participants, the frequent changes in the organizational structures and management systems in Pakistan over the last 13 years through political reforms had led to a state of confusion and chaos in the health system, which in turn had adversely affected the governance functions including health care financing models, strategic guidance and service delivery. It seems that the lack of stability and continuity in the policies and practices has contributed to the challenges faced by the health system in Pakistan.

Some participants mentioned that international donors may have contributed to the challenges faced by the health sector in Pakistan. They pointed out that some donors preferred to work outside of the government systems and focused on specific projects that aligned with their priorities. One participant suggested that the lack of government policies, coordinating bodies, and limited planning capacity created an environment where various stakeholders, including those with political influence, were welcomed to contribute to the health sector.

The majority of the participants from both the interviews and the round table discussion expressed their belief that the lack of trust was caused by inadequate coordination and self-interest. Additionally, they perceived that the trust deficit was influenced by power dynamics and an emphasis on tangible outputs.

> *"The value for money is related to inputs and not to outcomes. There is professional incompetence rather than corruption. Someone will pay you extra for you to write a good report". [Former Bureaucrat- Ministry of Health]*

3.2.2. Conflicting interest

According to the participants, conflicting interests were seen as a result of a particular mindset leading to design faults, which has caused polarization and fear of losing their position. Limited capacity of the decision makers to make decisions in the interest of citizens and the health system was cited as a reason for conflicting interests.

> *"Regarding conflicting interest, the conflict is in the interest" [Health Specialist - Donor Agency]*

According to the participants, the factors that contribute to making a wrong decision include personal interests, professional corruption, professional incompetence, power dynamics, unclear roles and responsibilities, and the knowledge that there will be no accountability.

> *"There is a complete strategic disconnect between finance, planning, and management, which is a perfect recipe for disaster". [Professional Development Specialist – Educational Institution]*

4. Discussion

In Pakistan, conflicting interests, design faults, mindsets focused on power and turf, and a lack of coordination have hindered the country's health system, resulting in an institutional monopoly and a lack of true leadership. Effective leadership and decision-making are critical in setting strategic priorities and motivating the workforce to provide efficient health services. Leaders must base their decisions on sufficient knowledge to evaluate and ensure the best choices are made, rather than personal interests, corruption, incompetence, or power games [18]. The absence of a national health policy has caused a disconnect between the national and provincial healthcare systems, leading to policy discontinuity and implementation issues [16]. Recently, health has been re-institutionalized at the federal level, presenting challenges for management and organizational change in overseeing policy planning, providing strategic guidelines, setting standards, monitoring and evaluating health programs, liaising with development partners, and reporting on international commitments.

The importance of pattern recognition and emotional tagging in decision making is widely recognized as it helps to reduce the risk of errors in judgment and promotes protective mechanisms within institutions [19]. Unfortunately, in Pakistan's health sector, there is a lack of such evaluation processes. The absence of an evaluation of the health policy and strategies implemented in the past has led to a lack of understanding of the progress made and the factors that contributed to success or failure. This highlights the need for a comprehensive evaluation framework that can be used to monitor and evaluate the performance of health policies and strategies, and identify areas that require improvement. By doing so, the health sector in Pakistan can move towards evidence-based decision making, leading to improved health outcomes for the population.

At the start of the millennium, WHO introduced the concepts of stewardship and governance [4]. Stewardship which encompasses the generation of intelligence, formulation of strategic policy direction, effective regulation, coalition building, creating an enabling environment and ensuring accountability, has never been institutionalized in the health sector of Pakistan [20]. Pakistan's health decision makers are considered to be output based, and hence loose the vision required to lead and evaluate performance. The leaders in health sector in Pakistan are bureaucrats who have a high turnover rate. Leaders are perceived to focus on acquisition of knowledge to realign themselves to their new roles and the effort to lead the team [21]. The inability of the health leaders in Pakistan to realign the system and responding to the emerging needs is manifested in the low priority to the health sector financing. The poor group dynamics and low level of coordination has affected the poor performance in achieving the health related MDGs and now the SDGs. Furthermore, the health sector has exercised various business models in the service delivery in Pakistan. Evidence has shown an enhanced service uptake but being politically driven has limited its expansion and coverage [22]. The evidence of health inequities in Pakistan is manifested by absence of performance frameworks and evaluations [13]. Assessments of service delivery models, performance, quality and accountability has shown positive results to ensure continuity in the policy and viability of interventions [23].

Healthcare financing, by the federal and provincial governments and the development partners, has a direct effect on the health outcomes

[24]. The core principle of healthcare financing is that it should reduce the out of pocket expenditure [25]. The health expenditure as percentage of GDP, decreased by three folds in one decade (2000-01 to 2011-12) [16]. Around 78% of the population of Pakistan pays out of pocket to manage its health. With 22% of the population living under poverty line, the catastrophic expenditure on health contributes to increase in poverty, malnutrition and social inequity [26].

Improving health governance ought to contribute to sustainable and country-owned mechanism, and adapt reforms to existing capacities and socio-political power dynamics [27]. Generation of knowledge by researchers and used by planners and advocates of health leads to recognition of triggers necessary for informed policy and strategic decisions [28]. This, however, requires political will, strategic vision and capacity in research and development institutions to translate the information into actionable knowledge. In Iran the stewardship functions have been reformed by policy makers and senior managers by creative effective communication channels and networking among stakeholders [29]. In Pakistan, the inertia and inability to reason with the policy planners accounts to conflicting interests or fear of raising a conflict with the institution.

Amidst poverty and widespread socio-economic inequalities, Bangladesh has demonstrated how health outcomes can be improved by following principles of good governance [15]. China, for instance, has consolidated key health financing responsibilities at the provincial level and strengthened the accountability of provincial governments, then defined targets for expenditure on primary health care, outputs and outcomes for each province and finally used independent sources to monitor and evaluate policy implementation and service delivery and to strengthen subnational government performance management [30]. Henceforth, learning from other health systems, Pakistan requires a radical change in its governance related mindset, and rolling out programs based on performance, quality and accountability [31].

5. Conclusion

The lack of effective governance and leadership in the health sector of Pakistan is a growing concern, leading to a higher likelihood of incorrect decision-making and a poorly performing health system. If this trend continues, the future of the health sector in Pakistan may be bleak, highlighting the need to address institutional inertia and re-align the system using outcome-based behavioral thinking processes. To avoid collapse, it is crucial to adopt a positive attitude and prioritize coordination under strong leadership that focuses on achieving goals rather than getting tangled up in power dynamics.

Ethics approval and consent to participate

The study got the ethical approval from the Institutional Review Board of LEAD Pakistan. Written informed consent was obtained from all the study participants before the interviews.

Consent for publication

Not applicable.

Declaration of Competing Interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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