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The physicians power to affect the outcome of a Public healthcare program:

a study on the implementation of a pharmaceutical Cancer treatment program in Punjab, India

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Abstract

The somewhat neglected area of policy analysis, and more specifically cross sectional studies of implementation, might not be seen as the most interesting areas of research. Especially if examined though a power perspective viewed through the eyes of a professional front-line bureaucrat.

If instead presented as a case study exploring physician's perceived roles in the implementation of a health care policy reaching nearly all victims of cancer in a state with 30 million people. More explicitly, in a subsidizing pharmaceutical cancer scheme for the uninsured population in Punjab, India. While describing the daunting effects that the physicians might have on the equity and outcome of the scheme not raise more interest?

This study might be defined as in the latter or/and the first. By using concepts from theories of profession, front-line bureaucracy and power, and by conducting interviews with physicians at 6 hospitals the study thoroughly aims to explore and explain the physician's ability to change or alter the outcome of this health care policy through a power perspective.

The study finds that the examined physicians exert positive power on the cancer treatment program while feeling relatively disempowered due to lack of guidelines and resources. No evidence for exerted negative power was found in the study.

Key Concepts: Positive Power, Negative Power, Autonomy, Discretion, Professionalism, Subsidized cancer treatment, Public Health in India, Disempowered physicians

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1. INTRODUCTION

This section highlights the subject, presents the problem and declares the purpose & contribution. The research questions and earlier research will also be presented here.

1.1 Background

The state of Punjab in India started a state cancer program in 2010. The program include four major parts; health education, controlling and decreasing environmental toxins and pesticides, diagnosis of cancer and free cancer treatment for the uninsured. The part of the program which gives free cancer treatment was started in 2013 and is called Mukh Mantri Punjab Cancer Rahat Kosh Scheme (MMPCRKS) (Department of health and family welfare, Government of Punjab, Cancer control program).

The government states on the official website that; "Under this scheme rupees 50.00 crores has been made available by Govt. of Punjab, for treatment of all cancer patients except Govt. employees and those having health insurance cover. An amount of upto rupees 1.50 lakhs is made available for treatment of every cancer patient. Till date, sanctions worth about rupees 53.55 crores have been accorded to hospitals for treatment of 4987 Cancer patients." (Department of health and family welfare, Government of Punjab, Cancer control program).

This means MMPCRKS will pay for the cancer treatment, curative and non-curative, for the individual patient up to the amount of 1,5 lakh INR, or 150 000 indian rupees (as per may 2014 is corresponding to roughly 16820 SEK (valuta.se)). The cost for initial diagnosis will not be paid through this scheme, but there are other schemes in Punjab which heavily subsidizes the cost for the initial diagnosis of cancer. As of 2014 there are 118 cancer treatment medicines under a special rate contract. Only these medicines will be subsidized through Mukh Mantri Punjab Cancer Rahaat Kosh Scheme (Department of health and family welfare, Government of Punjab, 118 cancer treatment).

Only residents of Punjab have the right to take part of the MMPCRKS. The treatment under MMPCRKS can only be given by physicians on one of the 16 empanelled hospital. These are:

- AIIMS in New Delhi
- PGI, Government Medical College, Grecian Superspeciality Hospital, Indus Superpeciality Hospital and Max Healthcare in Chandigarh and Ajitgarh
- Oswal Hospital, CMC and Dayanand Medical College in Ludhiana
- Acharya Tulsi Dass Hospital in Bikaner
- Max Hospital in Bathinda
- Patel Hospital Jalandhar
- Gurur Gobind Singh Medical College in Faridkot
- Government Medical College and Sri Guru Ram Das Institute of Medical Science and Research in Amritsar

- Government Medical College in Patiala
- (Department of health and family welfare, Government of Punjab, Cancer control program).

To recieve the financial aid under MMPCRKS the patient needs to fill out a certain form and go through a kind of needs assessment. Both the local civil surgeon and the treating physician need to attest the form in order for the patient to get the funds, which is given from a board within the Department of Health and family welfare in Punjab (Department of health and family welfare, Government of Punjab, Cancer control program). These procedures can be seen in figure 1.

1.2 Overview of the situation in India

Public health expenditures in India vary greatly across different states, but there is a clear trend. The overall costs of public health in India has decreased over the last ten years, at the same time has the public expenditures on medicine increased its share of the total public health costs. This has to do with medicine getting increasingly expensive. In India there is also a geographic difference in the percentage of the expenditure on medicines as a part of total public health expenditures. States in the southern part of the country spend 10-15 % of the public health budget on drugs whereas states in the northern part of the country, such as Punjab, spend 2-5 % of the public health budget on medicines (Kountey, 2011).

The current situation in India is severe; around 30% of the population in rural parts of India does not seek medical help because of financial reasons and for those who seek medical help, around 20 % don't take any pharmacologic treatment for their diseases due to financial reasons (TNN. National Pharmaceutical Pricing Authority told to fix prices of 33 anti-cancer drugs, 2013). Furthermore, the cost of medicine in India has risen much in later years and out-of-pocket payments for vital medicines is one of the major reasons for household debts as well a leading contributing factor for causing poverty in the country (Chan, WHO, 2013)

In 2013, the state of Punjab launched a wide cancer aid program which is based upon the tradition and guidelines of the national cancer control program founded in 1984 by the Indian government. One of the initiatives within Punjab's cancer program was the subsidized pharmaceutical program for cancer patients in Punjab is the Mukh Mantri Punjab Cancer Rahat Kosh Scheme (MMPCRKS). The normative basis which lies as the foundation for MMPCRKS falls in line with UN-resolution 17/14 which was recently signed by the republic of India, where the country has agreed to facilitate aid to all its citizens by the;

> *"Right of everyone to the enjoyment of the highest attainable standard of physical and mental health in the context of development and access to medicines"*
>
> (United Nations, 2013)

The new interest for the founded national cancer program, which aims to both control the spread of cancer and help the affected, comes concurrent to alarming reports on the growing number of cancer patients being discovered each year. A report states that due to development in social welfare in India and other factors including, urbanization, increased mean-age in the population and changing living habits the number of cancer patients is thought to continue rising over the next decade; preliminary reports show that the number is going to be reaching over 1 million new cases by the year 2020 (Department of health and family welfare, Government of Punjab, Cancer control program).

At the same time, the medical costs for cancer medicine has increased, 2004-05 it was calculated that around 19 million people where forced in to poverty in India, due to out-of-pocket expenses related to medical care (Department of health and family welfare, Government of Punjab, Cancer control program).

The inequalities of the Indian healthcare are persistent. As an example, hospital care and distribution of essential medication is often determined by in which state the individual lives and even within a state there is asymmetrical distribution of health care between the countryside and cities. Moreover the asymmetrical welfare is not only a product of geographical and economical differences between the different states, but is also a consequence of other inequalities like; caste, class (Baru et al 2010) and gender (Dasgupta 1987) which persist within India.

1.3 Physicians as professionals with power to affect the implementation

Physician represented in the public healthcare system act as professional front-line bureaucrats and usually represents the implemented political activities in the area (Lipsky 1980). In so far as the medical profession provides for autonomy and discretion from its superiors, there’s also room to change the outcome of the policy. It is with the unique knowledge and position within the healthcare system that physicians might truly become important players in the outcome of medical policy decisions. They are both experts in relation to their political superiors and decisions makers for their patients. There are rules that govern physicians in their choice of treatments and medications, among other things because the tangible assets are limited. The physicians can however, control their diagnoses so that they fall outside or inside the financial frames. It is difficult for someone who does not have postgraduate medical degree to question the judgments made in individual cases, so there is a space for physicians to interpret the ruling regulations and also to some degree control resources, costs and expenditures. By this causal link the physicians can be seen to have a position of power within the Indian healthcare system. But the questions then arise, to what extent do the physician perceive their power and are they able to use it effectively enough to change the outcome of the concerned policy.

1.4 Problem

How the physicians perceive their ability to use their professional power to influence the outcome of the state policy dealing with cancer treatment among the population is a problem for investigation. On a state level, the physician's main goal is to implement the healthcare which is set by political goals and therefore the physicians work is ought to be strongly affected by standardizations and regulations (Currie, 2012). The power to effectively alter the outcome of the political goals seems to derive from certain mechanisms which are to be found within the organizational level. In the organization; the physician, both as a professional and as a front-line bureaucrat has a central position of power. Towards both managers and the population (Lipsky, 1980) (see also Lehmann & Gilson, 2013, pp. 356-359).

On an individual level, the physicians' day-to-day contact with the population reflects in their professional role as well as their role as front-line bureaucrats, within the public healthcare system. This can in certain instances, for example where corruption, selectivism and noncooperativism are prominent, reflect badly on both the state and the profession, explicitly hurting the equity in the healthcare system (Sheikh & Porter, 2011, p 84).

But to what extent do the physicians truly exert their power over the implementation within the healthcare system and do they have the ability to divert or alter the policies which regulate their work?

Sheikh & Porter claim in their article "Disempowered doctors? A relational view of public health policy implementation in urban India" that physicians in India's public healthcare system mainly can hinder policies from being implemented while they have a weak position in regard to their ability to alter, change or initiate new policies. In the case of the MMPCRKS, the physicians might show resistance to the implementation, by the use of negative power, or actively, by the use positive power changes or improves the implementation accordingly.

1.5 Purpose

The study primarily aims to describe and explain physicians' ability to change the outcome of a state public health policy through a power perspective.

1.5.1 Contribution

Our contribution with this study will thus be an increased knowledge in the availability for the physicians, in the mantle of professional street-level bureaucrats to affect the outcome of policies within the MMPCRKS. Theories and conclusions made should also be applicable on other similar programs within India as theories are taken from both universal, international and national levels. The thesis also highlights the important power, of both positive and negative kind, which this profession possesses in the organization and by

exerting power these actors influences the equality in the healthcare and the policies goal attainment.

1.5.2 Significance of the study

Even as the study doesn't implicitly aim to investigate the misusage of power within the system, earlier research suggests that misuse and corruption is prominent within the public administration in India's public health sector (Sheikh & Porter, 2011). It's therefore of importance to examine the role of the physician, as a prominent and powerful actor of the implementation.

1.6 Research questions

* *What do the physicians think about the new state policy dealing with the cancer program for the uninsured population in Punjab?*

* *How do the physicians, as frontline bureaucrats, use their professional power when implementing the cancer program to influence the outcome of set policies?*

* *Are the physicians exercising positive or negative power to change the outcome of policy today or do they stand disempowered?*

1.7 Previous research

Municio (1982) describes in *Implementationsforskning. En litteraturöversikt,* the field of implementation research and points to the implementation of policy as the most important to the outcome of policies. Within the implementation research there are further subdivisions, mainly between the so-called *field implementation* and the *guideline writing*. Wherein as guideline writing is about making the regulations and sub-goals on lower levels of the organization, field implementation is about transforming the policy into practical work. Ex ante and ex post are two ways to examine the latter, where ex ante is an implementation analysis that decision makers do when they faced with the choice of different policy. Ex post studies however examines the already made decisions and how they are implemented.

In the article *Organizational Models of Social Program Implementation*, Elmore (1978) has elaborated four models used for ex post studies. One of the models - the bureaucratic process model, focuses on *discretion* and *routines* and their role within the organization from a bottom-up perspective. Implementation is here seen as a process where these mechanisms are being controlled. The organizations behavior is, according to the theory, dependent on the delegations within the organization and routines created to enhance ones position within the organization. The power is thus divided into small units that greatly influence their own responsibilities. The model also brings to light, the inherent inertia within the organization that reflects in the slippage between the policymakers thought reforms and the factual response and implications of the workers and their routines. Changing the daily routines is the hardest to accomplish according to the model and

Elmore implicitly recommend the usage of the street-level bureaucracy when examining implementation.

Winter (2000) raises the question on whether the street-level bureaucrat is the master or servant, a reflection in the context of power and thought to reflect discretion used by the bureaucrats and the ability to change policies that comes with it. Winter also concludes that the political control over front-line bureaucrats is limited and often focused on easily accessed numbers, such as, the total number of inspection conducted under a certain period of time. Organizational control is also difficult since, the more specialized the work are, the harder it is to exercise control over and the more discretion is needed. Maynard-Moody and Musheno (2003: 8) for example states that: “Street-level work is, ironically, rule saturated but not rule bound”. Winter (2001) also concludes that the extent of discretion offered the bureaucrats is restricted to the amount of resources available. When confronted with limited resources or time, the bureaucrats tend to cope by rationing services, rationalizing program goals and discriminate by selecting cooperative clients (see also Lipsky 1980).

The article *Reforming the health sector in developing countries: the central role of policy analysis* by Gill Walt and Lucy Gillson (1994) argue for a new model of looking at policy, they analyze their model against research done within the field. The argument of their paper is that health policy often neglects the actors involved in “the policy reform, the processes contingent on developing and implementing change and the context within which policy is developed” (Walt & Gilson, 1994, p.1), thus only focusing on the content of reform and policy itself. This according to the authors is key to understanding why desired outcomes of policy sometimes fail. The paper suggests a more extensive model, taking into account both context, content, process and actors (both as individuals and as members of groups) to further grasp the essence of the health- policy process.

Prottas (1978) highlights the difficulties in controlling every day behavior of low level bureaucrats and in the article *The Power of Street-level Bureaucrats in Public Service Bureaucracies,* Prottas aims to provide a theoretical explanation. The study builds on the concept of “boundary actor” and thus place the source of the street-level bureaucrats’ power in their unique role as policy implementer in a street-level environment. He then examines the bureaucrats’ role and ability to seek autonomy from management and how their power actualizes. The study finds that a lot of the reported autonomy comes from the bureaucrats’ control of important functions, vital to the bureaucracy. Also that the actualization of power is dependent on the expectations of the bureaucrats work and to the extent it can be governed, Prottas shows that this is problematic; as the policies are often loose and the work highly specialized. The management can thus have problems in defining exactly what and how the bureaucrats should work, which is increasingly difficult if the bureaucrats work is built on standards as of a profession.

Irene Ajuya Agyepong and Sam Adjei's paper (2008) on *Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme* highlights, among other things, the importance of further study into the field of implementation. They argue that politicians need to further develop their appreciation for "technical analysis to support decision making rather than an indiscriminate use of political approaches". The argument is taken, in the context of political leaders desires, to use political approaches that may not reach the desired objectives of the policy. The study sheds a light on the situation in Ghana regarding the initiative to implement a national health insurance scheme and is based on a qualitative method which observes and explores the challenges brought up from the adherent policy reforms. The papers view on the issue is mainly taken from a political perspective and thus little regard is given to the bureaucrats, other than the stated observations, that policies are not always understood or in line with the organizational traditions or the individuals own interests and thus not implemented as originally intended.

Cadwallader et.al. (2009) presents in their paper *Frontline employee motivation to participate in service innovation implementation* points to the situational level of motivation among the frontline employees. According to the paper, the relevance of participants understanding of the initiative and their autonomy in the work process are both of key importance in creating motivational participation in service innovation implementation. The paper also claims to have found an empirical relationship between task autonomy and motivation. It confirms a significant positive relationship between "employee role clarity and employee recommending behavior, which was partially mediated by situational motivation to participate in implementation". Methodologically the paper makes use of quantitative research and earlier tried scales, such as Breaugh (1985) and others. The conclusion of the paper could point to the relative task autonomy of the physicians as a motivation to derive from certain policies, or rather implement positive power, exempli gratia, to go beyond the policies directives during in the implementation of policies. Ipso facto, altering the outcome of the policies. Wang and Clegg (2002) also points out that there is a greater chance that the physicians will be more willing to take responsibilities for their decisions if they can influence the outcome of their work.

Another paper that tells of the significance of deeper research into the "much-neglected aspect of policy analysis" and contributes through a qualitative examination to the use of power in implementation, is Uta Lehmann and Lucy Gilson's paper *Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes takes into account the difficulties of policy implementation in the context of power practice.* The article explores micro-practices and their culminate impact on the diversion and or reshaping of set policy goals. It also finds that, almost all the policy actors seems to be using some form of power as a means to "make the intervention 'fit their understandings of local reality" (Lehmann & Gilson 2013 p. 358). In its conclusion, the paper states that the understanding of the local situations complexities

and the practices of power could possibly allow for better management strategies to be constructed in the future. It also concludes that “implementing actors with informal authority can exercise power in ways that assist implementation towards policy goals, whilst those with formal authority sometimes use their power to undermine the achievement of policy goals” (Lehmann & Gilson 2013 p. 359).

Subsidies are one form of financial incentive which is made to encourage a certain type of behavior by offering financial means. Consumer-oriented subsidies are common in developing countries and the intention is to influence the population to certain positive behaviors. The intentions behind the subsidies are often based upon normative ideas about equality, for example that people should have basic rights like access to food, clean water and fundamental health care (Bril-Mascarenhas & Post, 2012

1.8 Demarcations

We want to make certain demarcations in this thesis in order to achieve the purpose and be able to make the indentations required to answer the research questions. The study will not take into account the relation between different professions in the Indian healthcare, nor delve into the theory behind the layout of healthcare policies. The main basis for most of the boundaries is made based on the fact that we examine the professionals in the central organization for implementation. This means that theories relating to the users of public healthcare programs or the policy makers and their ability to influence the implementation part of a healthcare policy will not be lifted up thoroughly. This is also motivated by the theory’s relevance to the research question, which is limited to the aspect concerning the physician’s power, as a frontline bureaucrat, and his ability to use it.

Physicians have other responsibilities towards their patient than just implementing programs, but we won’t study these responsibilities, neither will we study the physicians power after the patient being treated under the program. This is because we want to examine their perceived ability to self exercise power within their organization and how this affects the outcome of policy, not what happens after the implementation phase.

2. METHODOLOGY

This part concludes the study design, data-collection, ethical commitments, validity and operationalization of the concepts.

2.1 Study Design

This is a qualitative cross-sectional case study; Physicians own thoughts about their power to implement the MMPCRKS will be measured only at this time.

2.2 Study Population and Centrally Placed Sources

The interviewees will be chosen by the permits off centrally placed sources and limited to physicians functioning within the program (Esaiason et Al. 2012, p 253). With the help of contact persons from the University of Panjab and the Department of health and family welfare in Punjab we were able to find and locate these centrally placed sources within the healthcare system. These centrally placed sources are to be found in both the private and the governmental hospitals which implement Mukh Mantri Punjab Cancer Rahaat Kosh Scheme. Namely the PGI (3) and GMC (1) in Chandigarh, Indus superspeciality Hospital (1) and Max Healthcare (1) in Ajitgarh and Oswal Hospital (1) and Dayanand Medical Hospital (1) in Ludhiana. The centrally placed sources consisted of 6 administrative physicians and 3 clinicians.

2.3 Data collection

2.3.1 Conversational Interviews

To be able to examine physicians within the MMPCRK-scheme, it's not enough to have relevant theories and concepts described in the theoretical framework. There has to be some consensus as to, how the empirical data will be collected and subordinated to its corresponding theory. Since the ambition is to understand the physicians own perception on the issue, interviews will be used as a mean of data collection (Esaiason et Al. 2012, p 253). As such, conversational interviews will be conducted on hospitals empanelled in the scheme.

2.3.2 Attaining good quality

The respondents own views on the situation create the starting point for our result and conclusion, as their thoughts are crucial to understanding the issue. They are crucially important since they are the focus and subjects of the study and hence holds key information to asserting their own role within the implementation of the program. It is through precision and a deeper insight into the investigated physicians' perception of the cancer program that this study derives its good quality.

In a qualitative study like this, the method can not be designed after the same requirements as for a quantitative study, as these are different kinds of research methods that responds to different types of questions. Yet it is undeniable, that the descriptions made in a qualitative study should hold equally as high a precision as the required accuracy of the quantitative study. If the qualitative study have this standard then it also has a very high quality (Kvale, 1997).

2.5 Constructing the questions

The character of the interviews issues for questions that directs responses to the topic but leaves the questions itself relatively open. The questions are based on the concept determined by the theoretical framework and is meant to answer the study's research questions. Supplementary questions can hence vary from different interview subject. Based

on the interviewees' answers, the connection between these answers and the theoretical concepts develop and become available for analysis. This approach ensures the prerequisite to an in-depth examination of the physicians' perception on their ability to influence the outcome of policy as well as examining how they can do so.

The theories found in the theoretical framework of the thesis are based on specific ontologies, but the theories are all proven to be scientific through the usage of empirical epistemology. Based on the physicians' own social construction we try to analyze their responses by taking so little regard to our subjective ontology as possible. This is carried out with such an open approach as possible, since the interviewee's own description will be compared with the theories presented in the theoretical framework.

2.6 Operationalizing the theories

All the interview questions are connected to how the physicians perceive their own organizational environment. Question 5, 6 and 10 connects with the coercive dimension of the institutional power (Currie, 2012) which is exerted by the policy makers in order to control the physicians whereas question 5 and 10 also can provide answers which we can connect to the normative dimension of institutional power.

Question 12 and 14 will provide answers connected with the medical profession. Furthermore will question 5, 9, 10, 13 and 22 give us answers which we can connect to the *deprofessionalization* of the medical profession. It is important to understand the organization and the direct environment of the physicians in order to determine their given latitude in regards to the implementation and question 15, 16, 17 and 20 will provide answers which connect to *autonomy* and *discretion*. It's also important to see the physicians in their dualistic role and understand their latitude in accordance to their individual perception, since this gives additional understanding to how the physicians coop with their situation and possibly changes set policies, the questions which directly connects with this is; 18,19, 22 and 23. Question 16 helps to mediate the physicians understanding of the state policies themselves.

2.6.1 The interview questions

1. What do you know about the MMPCRK-Scheme?
2. What do you think about the program?
3. In what way are you a part of the program?
4. Is there, in your opinion, something that can be improved with the program?
5. Who decides ultimately who has the right to the medicine?
6. Have you received any incentives to be part of the program?
7. *Do you think knowledge and information reaches all those affected by the program's scope?*
8. Is there available information about the program on the hospital? How are the patients informed about the program?
9. Who would you estimate has the most power to change the program outcomes?

10. Who controls the work process?
11. What do you think affects most if a patient gets medicine or not?
12. What expectations do you think the government has on you?
13. In which way does the program influence your work situation, can you give some examples, please?
14. Have your work practices changed because of the program?
15. How do the administration of cancer medicine within the program work in practice?
16. What directives have you received from the authority about the implementation of the program?
17. *To whom are you reporting?*
18. How do you feel about the design of the program?
19. How do you feel about the scope of the program?
20. How are the program and the patient physician meetings surveilled?
21. Is there a change of program implementation today?
22. Is the program doable in regards to design and scope?
23. Do you feel any personal controversities between what your job tells you to do and what you want to do in regards to the program?

2.7 Ethics

Ethical consideration is taken through all steps of the conducted research, it is to be given to the interviewees as well as to earlier research on the area. The interviewees are guaranteed anonymity, that interviews will only continue as long as they want that any patient names logged during the interviews will be censored. They are also given the opportunity to receive a short manuscript with their logged answers so that they know what data which has been collected, and thereby given a chance to give an opinion. After collecting our samples, the different interviews, we randomize the inherent order of the interviews so that the physicians and the hospitals in Chandigarh and Ludhiana are presented randomly in the attached transcription. This is being done so there is no clue about whom have given which answer.

2.8 Processing the data

2.8.1 Making transcription

The transcriptions of the interviews will be verbatim, although minor hesitations, moans and other small sound will be overlooked due to their irrelevance. No special formatting is needed but we make use of different in font style so the material will be more easily legible. To analyze the material the study pinpoints quotes which are of importance due to the context which they are taken from. The quotes is then mapped together with concepts which is to be found in the theoretical framework of the thesis.

2.8.2 Coding in the analysis section

Our analysis is created on the basis of quotes made by the physicians which supports various concepts connected with the theories presented in our theoretical framework. In order to get a better overview over where to find these chosen quotes in the attached interview transcription we have created a coding. The first three symbols represent: Interview (I), interview object number (1-8) and main theory (A = Power, B = Frontline bureaucracy, C = Professionalism, Z = Opinion about MMPCRKS).

As an example it might be written like this: I2A. This explains that the quote comes from interview object number 2 and that the quote is connected with the analysis of power.

Another example is I7B. This mean that the quote is taken from interview object 7 and is connected with the analysis of frontline bureaucracy.

Furthermore each quote is given the symbol of X and is then given a number chronologically, in accordance of appearance in each interview, and not in accordance to all interviews, therefore X1 (quote 1) is found amongst all interview objects.

This is two examples of how a total quote-code may look: I2A X3 and I1B X4.

2.9 Validity

Internal validity is secured through an interview scheme that dictates a clear connection between our questions and the theories and concepts which lies as the foundation in reaching answers to our research questions.

There are many different ways to measure power and it's hard to produce results with perfect validity (Esaiasson et Al, 2012). How is *construct validity* reached when linked to the theories and concept brought up in our theoretical framework? By asking as open questions as possible and then connect the individual responses to the theories we have presented, we reach *face validity*. This occurs through a process where we in the analysis make use of reasoning and common sense to connect operationalization to theory (Ibid). What we want to measure, is as mentioned before, not the degree of power, but how and what kind of power the physicians' perceive themselves to have and how they operationalize this perceived power to impact the outcome of Mukh Mantri Punjab Cancer Rahaat Kosh Scheme. Having face validity we decrease the risk for this study being non consequential.

3. THEORETICAL FRAMEWORK

This section includes the theoretical framework concerning front-line bureaucracy, power, professionalization and adherent concepts.

3.1 Power

3.1.1 What is power?

Power can be seen as the ability to impact other people and Bertrand Russel (1938) identifies three different kinds of impact; *physical impact*, *impact through incentives such as punishments and rewards* as well as the *impact over opinion*. Power has always existed in human associations because there is, and always has been, a need for someone to control, make decisions and initiate actions in a society. Anyone who does this thus has organizational power. Power as seen through a sociological and organizational perspective often takes the form of two counter poles. Hegel's dialectical approach to power with his work "Master and servants" describes the relation between the powerful and the powerless and their dependency on each other for their positions of power. The analysis of Hegel by Rus (1980) generates the idea that power cannot be completely autodetermined (determined by its own) since the servant is born for the master and the master is born for himself. The master can only be born for himself if the servant is born as a servant for the master and this creates the understanding that the power between people is never completely determined by one actor in a relationship but is instead generated by the structure of a relationship, this means that power always is partly heterodetermined, e.g. determined by someone else. Hegel's dialectical approach of power and how one actor's power is inherent from another actor's powerlessness might seem extreme in modern times and fails to completely explain how the power relation between individuals with similar amount of power might be dependent on each other for their structure of power. Nevertheless it is possible to make use of Hegels theory because it explains the basics of interhuman power structure, namely the fact that power cannot exist by itself in one individual and thus the power is dependent upon another actor's state of power.

In summary, it can therefore be said that the power in social relations and organizations is the ability to impact others to perform an activity by punishing or rewarding their behavior. Those who have power are in a position of dependence on those who do not have power, and vice versa, and only through collaboration the power structure is upheld.

3.1.2 Juxtaposing positive and negative power.

There is a grand difference between positive and negative power which is needed to be comprehended in order to understand the basis of the power which the physicians may or may not possess or exert in their implementation of the cancer program in accordance to MMPCRKS. Rus (1980) describes positive power as *induction*, the ability to initiate activities. On the contrary he describes negative power as *resistance*, the ability to stop

activities. While it in a philosophical way might seem like resistance and inhibition are antitheses the article highlights that the two concepts of power, in theory, are part of a sustainable dialectical process where induction and resistance are "two poles of an otherwise uniform, contradictory process" (Rus, 1980, p. 6) and that these powers affect the processes of each others. This explains the fact that the two kinds of power are not complete opposites. According to this dialectical approach to positive and negative power, a strong negative power can be turned into positive power.

Physicians in India hence can be seen to possess either or both of these two types of these organizational powers. If they possess negative power, they are able to hinder the implementation of a certain policy, in the case of possessing or exerting positive power, the physicians might influence the outcome of policy by actively altering the policy or changing their implementation.

3.1.3 The implementation perspective on Power as seen in the public healthcare

With regard to the aim of this study we focus on the physician's power within the public health care system. Power in the public health care is difficult to measure since power is an abstract term, however in the article "How to start thinking about investigating power in the organizational settings of policy implementation" (2008) by Erasmus and Gilson some concrete examples of how power can be exercised is highlighted; physicians can for example exercise power over colleagues by giving them "derogatory labels or identities" (ibid,p. 3), they can exercise power over patients by withholding information to the patient directly or to other health instances. The physicians may also exert power over the policy implementation by simply not doing what they are told to do or by altering their performance procedures. There is also other less concrete ways to exemplify how power is exerted which is connected with the social interactions between people, for example using titles or academic language. Power might also be sprung out of the personality of a physician, for example the physician's charisma and personal network

Everywhere, but maybe more profound in middle income countries such as India it is not uncommon that the power to influence the implementation in a organization comes from local organizational customs. Physicians often do as they always have been doing and therefore they possibly exert negative power over the implementation of a new policy that maybe challenge the professional latitude or impose a threat to the power that they already possess (Erasmus & Gilson, 2008). This is connected with the *normative dimension* of institutional power, which governs the professionals in a workplace and maintains institutional norms and belief systems by praising or demonizing players so that they follow the institutional standards. It also creates myths about the institution and enhances the daily routines and the organizational practices in the workplace. Regional hospitals which are offering specialized care often have a more academic profile than local hospitals and usually have a higher status. The same is true for the doctors' status who works in

these hospitals. Professionals with higher status often enjoy a higher degree of professionalism, which in turn leads to more power within the organization in which the professional works (Currie et Al. 2012).

The highly professional physicians who are working in the hospitals that are authorized to give medical cancer treatment under MMPCRKS should therefore enjoy more autonomy and a great power to influence the implementation of the current cancer program due to their special competence, academic language and social status. Furthermore are the empanelled hospitals according to the theory presented ought to be affected by a strong professionalism which means that much of the organizational power lies behind the hospitals doors.

3.1.4 Disempowered doctors

Sheikh and Porter (2011) describe the power paradox which occurs in the Indian healthcare system in “Disempowered doctors? A relational view of public health policy implementation in urban India”. The article highlights the fact that physicians have a complicated relationship with those who create public healthcare policy. It is not uncommon for physicians to manipulate policy makers to create policies that suits the physicians own interests. Through a multilevel perspective, physicians in India are seen as a dominant factor in public healthcare system. The physicians exercise power over other actors, for example they may affect institutions such as health authorities by their expertise and may also directly affect the policy making through lobby making. The intricate power paradox however leads the physicians to have a negative power over policy makers in that they can hinder implementation of policies at the same time it seems like the physicians lack the positive power to change current policies because they lack real influence over policymakers. One sign of this power imbalance is the fact that it is commonplace to try to control physicians from state level “by coercion or inducements” (Sheikh & Porter, 2011, p. 89) to deviate them from taking too much control over their own procedures. This is connected with the *coercive dimension* of institutional power is mainly used by those who govern an institution to promote compliance with rules, it is done by facilitating and supporting the department, through surveillance, such as supervision and control and through deterrence (Currie, 2012).

There is also a lack of independent medical advice boards, which fails to perform their professional regulatory functions. This is partly because these medical advice boards overlook misconduct, punitive duties and corruption. The article claims that it is important to understand this problem of seeming freedom that gives doctors the ability to flout the rules (Sheikh & Porter, 2011, p 84).

The connection between the equality problems in the Indian public healthcare system and how the professionals implement public health should therefore take into account the power paradox to be fully comprehended.

3.2 Frontline bureaucrats

3.2.1 Lipskys street-level bureaucrats

The description of the concept "front-line bureaucracy" derives from the work that the public agency does, namely dealing with the public on a face to face level; interacting with citizens and using discretion over distribution of the public resources. Lipsky's book (1980) *street-level bureaucrat, dilemmas of the individual in public services,* gives a direct insight into the public workers dualistic role in policy implementation and their political power as front-line bureaucrats. In the foresight of the theory are the bureaucrats and their direct relation to the population in contrast to their obligations within the public sector. The presented theory is taken from a bottom-up perspective and points to the bureaucrat as an important and final player in the outcome of policies. It's depending on the relative discretion and autonomy of the work itself that the bureaucrat's room for maneuverability is dependent. Thus the power to change policies also varies.

To make use of the theory, the theoretical framework needs to formulate some consensus as to the tools used for practical examination. The core concept to be used in the theory is discretion and autonomy; as such the tools of examination should be advised on the basis of these concepts.

3.2.2 Discretion

Within Lipsky's theory, discretion is seen as the amount of freedom a professional have to assert a certain situation and act according to his or hers professional judgment. Jointly, these judgments will later make up the agency's behavior on certain matters. Discretion is deemed necessary since it's impossible to severely reduce within certain areas. Lipsky mention two such areas, namely; complicated situations and situations that demand human dimension responses (Lipsky 1980 p. 13-16).

From the theory, it's understood that the more specialized a professions, the more discretion it usually holds. In turn, this give professional bureaucrat's considerable power in determining who for example gets help, how they in turn get help and to what extent they get help from the agencies. Lipsky takes an example from one such profession, "Policemen decide whom to arrest and whose behavior to overlook" (IBID., p. 13). As such, there is room for the bureaucrat to assert his own judgment, ruling set policies. (IBID., p. 13-16)

However, this does not mean that the professions have unlimited resources and power nor that they are not controlled in any way. There are still laws, rules and standards for the profession to uphold. (IBID).

In the context of discretion, the inevitability of the bureaucrats ruling decisions also creates difficulties for the management to control the work, especially in a direct manner. This

creates to the extent of the bureaucrat's area of expertise, a room to define their own work and themselves. Musheno and Maynard-Moody (2003) points to the relationships shaped within such an area to be more influential for the work process, than actual rules. This is also true in the relation to the individual citizen (Lipsky, 1980). As such, the street-level bureaucrats are in a political role due to the element of their work, namely earmarking goods and services for the public (IBID). They are, "… not only policy-making actors in a policy process, but to a certain extent, they are policy formers rather than implementers." (Hupe & Hill 2007 p. 283).

3.2.3 Relative autonomy from Organizational Authority

The street-level bureaucrat strives to greater the amount of autonomy within their position. The amount of autonomy is decided by the amount of regulations, standards as well as the organizational structure set by the management. Autonomy as such, is here described as the organizational latitude for bureaucrats to control their work themselves (Lipsky 1980 p. 16-18).

The theory also highlights that the level of institutionalization among the professionals may influence the claim to certain values and ethical codes within the group. Assumed the influence this has on autonomy, it may in turn affect the degree to which the professionals use self-binding mechanism. I.e. the front-line bureaucrat's talent for self-imposed regulation. In this case Lipsky points to the bureaucrats as policy-makers in the context of *defense against discretion,* and *coping strategies* (Hupe & Hill 2007 pp. 282-283), (see also Lipsky 1980 p. 149, 151).

Within an organization there is normally a slippage between set policies and the output of policies. This usually has to do with poor communication between managers and workers. It can also derive from possible disagreements between the bureaucrats and the current policy or organizational goals set by policy-makers. Such disagreements are however to be expected and are normally small enough to be neglected and still on track for goal attainment. Additionally, pressure or limited resources may force the bureaucrat to make certain alterations in policy, simply to cope with the situation at hand (IBID., p. 16-18).

Noncooperation however is seen in some cases were workers does not agree with set policies, goals or decisions. In such cases the productivity and performance is crippled, thus hurting the organization. Such actions could be both individual, cooperative and can for example include, not working, strikes, negative attitudes, forming trade-unions, stealing, deliberately wasting resources and working against set policies. Workers can also alter the policies, given their level of autonomy and discretion as declared by their governance (IBID., p. 16-18).

In relevance to the study, the focus will be taken on the premise and possibility of action resulting in diversion of policies and not the factual actions taken. Lipsky declares that

(IBID., p. 17), it's the managers' core problem to make "workers' needs for personal, material or psychological gratifications mesh with the organization's needs". Hence the concept regarding autonomy will be seen from the perspective of the relationship between managers and workers in regard to the possibility to strive from directives and change policy output (IBID., p. 16-23). Similarly the concept of discretion will be seen as the amount of freedom offered to the physician in his routines and dealings with the concerned patients.

From the theory of front-line bureaucracy, the concepts of relative autonomy and discretion are made available for the examination of physicians. Through these we are able to create an understanding of the relative amount of freedom offered to the physicians, in their contact with patients. This in turn enables further understanding into how much room to maneuver the physicians possess; thus affecting their ability to influence or effectively alter the programs policies. The theory also captures the dimension of the physicians as a public agent, auxiliary framing a base to which the individual interviewee can be made able to be generalized as a broader group of professionals. Thus the concepts facilitates examination and takes into contrast the physicians possibilities, as front-line bureaucrats to change the outcome of policies.

3.3 The Profession

The concept of the profession where first covered by Sir Alexander Morris Carr-Saunders and Pail Alexander Wilson in their book The profession (1933). Since the book was published, the concept has developed and become of increasingly significance in the field of public administration. Today research mainly points towards professions from a relation, society and conflict-perspective wherein as Saunders and Wilson focused on the professional as a positive force on community development. (Brante 1990:75 och Einarsdottir 1997:8-10)

3.3.1 Defining profession

What defines a profession has been classified in diffrent ways, the definition used in this study is taken from Alan Bullock and Stephen Trobley (1999) and is defined as "the development of formal qualifications based upon education, apprenticeship, and examinations, the emergence of regulatory bodies with powers to admit and discipline members, and some degree of monopoly rights" (Alan Bullock & Stephen Trombley, The New Fontana Dictionary of Modern Thought,London: Harper-Collins, 1999, p.689.).

3.3.2 The medical profession

There is a special contract between the medical profession and the government. The government gives the professionals a monopoly market for their profession and puts high value on their knowledge. The medical professionals can by own means control their expertise and are protected by the government to maintain control of their special status by

special legal protection and certification. The government in turn expects the physicians to treat patients based on specific scientifically based expertise.
Since the late 1970s the physicians' are gradually in a process of losing their special professional status, and there is three main reasons for this; *proletarianization* (physicians becomes wage laborers instead of self employees), *deprofessionalization* (physicians lose their professional attributes, such as autonomous decision-making), and *corporatization* (physicians makes their organization a profit-maximizing corporation) (Timmermans & Oh, 2010, pp 95-96).

India has in comparison with other countries such like China been trying to change the public health policy implementation and goals by changing the attitudes within the bureaucracy, but has failed to make important changes in the attitudes of professionals, exempli gratia; the physicians ability to gain equality and effectively in the sector. Furthermore are Indian physicians far more autonomous than their counterparts in China, and therefore have sustained their specific rights and importance within the public healthcare as opposite to the Chinese example where other professional groups such as nurses and technicians have taken over some of the physicians work (Maru, 1977).

Out of the three concepts brought up by Timmerman and Oh (2010), the thesis will put focus on *deprofessionalization.* The effect of deprofessionalization on the medical profession is of high importance to comprehend the physicians *power* to influence their outcome of our chosen policy.

4. RESULT

Here the analysis, conclusion, and discussion will be presented.

4.1 Analysis of Power

4.1.1 Disempowered physicians

When the physician lacks sufficient knowledge about the program and how it works, they are also disempowered to implement it. They cannot give advice to the patient of how to apply for the free cancer treatment. One physician expresses:

I1A X1: "The patient from Punjab we can recommend medicines for and say that the cancer program exist and that if they want, they can apply for it. Now the patient ask us, where can we apply for this? This also we don't know. They will have to find it on their own."

In addition, the same physician says:

I1A X6: "I learned it from the newspapers…"

Another physician seems to have knowledge about the program but lack information about where the forms for the program are to be found:

I8A X6: “No, I Just fill the forms. Somebody else has them.”

The physicians are also disempowered when the bureaucracy or the system which they are dependent upon fails to be efficient or fast enough so that their ability to implement is halted or slowed down. This is commonly expressed by the interviewed physicians:

I1A X5: "And then it is up to you and the government how quickly they give the money. So, this is the problem, we don’t know when it comes, how quickly it comes, how much comes. …There is not much time to wait, most cases are discovered late."
I1A X7: "… patients needs to get the medicine by this date. There seems to be late, they need to deliver better welfare and speed up the process…"
I6A X13: “You know - when you’re dealing with the government it always take some time...”
I7A X2: “But getting the money is the problem, because knowing when the money is coming is something like a mental service…”

Being disempowered by the government’s financial delays, one physician describes the how the situation looks when comparing getting the funds from MMPCRKS and private insurance companies:

I7A X4: “In India, when the government does the set up… Sorry to say, but they are a bit lethargic so getting money from them can take some time. You have to understand the financial implications of this scheme, if we don’t get the money we won’t be able to treat the patient. By comparison, if we deal with a insurance company, they will do the medical auditing and put money on our account and the patient does not need to run anywhere to get the treatment, that’s the mayor difference.”

Even if the physicians are the ultimate implementers of the cancer program, they can stand disempowered and not be able to enforce the policy since MMPCRKS’s design causes malfunction on another level. One physician discloses that:

I1A X8: "But remember, we have signed this form many times, but I can’t remember anyone coming back to me, saying: “look sir, the money has come”. They usually come back and we give them whatever they can afford. But I never seen someone come back saying they got the money."

Two of the empanelled hospitals seem to lack resources to fully be able to implement the policy in some cases. This also makes the implementing physicians disempowered. One physician tells:

I7A X8: “But for the patients who come here, most of the are terminal who come here , and the problem is that we don’t have a hospital for terminal ill patients. Like a hospice

thing with palliative care. So they occupy resting beds, they occupy essential services where we actually could treat a patient who can survive."
I7A X17: "Since we are a charitable institution so we participate for this reason. We only get 5-6 % cut on the medicine prices, and there is a lot of job storing and administrating the medicines."

Another physicians say:

I2A X4: "This is good for society. But we need manpower and have asked for this, but this is lacking. We need manpower to maintain the people that are coming to us."

One physician feels that MMPCRKS doesn't give a fair funding in relation to what treatment the patient in reality might need and therefore expresses that he is disempowered:

I8A X8: "Companies will produce new things so and all the time we are thinking that it maybe is not a thing that is leading to a cure, I would not be very happy to write out these kinds of medicines in a palliative setting but if it is curative I would, and I think there is room for improvement here. We should have more access to money for the curable patients."

4.2 Positive Power

Positive Power, or induction of activities, which leads to alteration or improvement of MMPCRKS is shown by many of the physicians. The room for the physicians to exert induction seems too often have been given by the hospital in which the physician works. Furthermore the impression is that the incentive for the positive power seems to derive from the will to reach both official and personal goal attainment. This is demonstrated by some physicians as:

I1A X14: "No, some extra administrative job. But we don't mind, it's for the good of the patients."
I4A X4: "They don't need to do anything, all is the hospitals headache. We take care of everything. This is how it works because they don't have to pay anything they don't have to wait."
I4A X9: "But then like this one is only for cancer patients. So I for one, is hired simply for this purpose. So I'm taking care of everyone who is coming and I'm guiding them and filling their form."
I7A X11: "When he comes to us, he doesn't need to go home because our civil surgeon takes care of it, he do all the job, he gets the file sanctioned, he send it and we get the approval from the government."
I8A X2: "First we have to confirm the diagnosis and then it has to be confirmed here again, as a part of standard care… Rather than to wait for confirmation from an outside hospital, to make it more uniform. I cant say that we are the bosses, but to make it more uniform it is being done fast so that the cancer is definite and it is not just radiological…"

One physician has made innovations, as a great example of positive power, in order to better utilize the program and make it more efficient:

I4A X11: "Earlier it was just a copy, but now to be sure we are keeping the original and giving the copy back to the patient. Because they need it for record but we can claim it and they have to pay us the money. This is what I initiated. This is done, and then we start the procedure."
I4A X14: "Then I keep these reports if he dies, that he was certainly dying in the reports also, this is also my initiative."

One interviewee mentions that he other physicians are disempowered due to coercive regulations, still the physician states that they give advice to the regulators of the MMPCRKS. The advice is another example of exerted positive power:

I7A X12: "… the problem with this scheme is that we after 50 % of the 150 000 rupees which is the sanctioned amount from the government is used we send the bill there. But we think it is quite unjust. There is actually 50 % of the patients which are at the follow up state, and we have advised the government to narrow down this 50 % to 30 %, so when these 30 % are exhausted we can send the bill."

4.3 Negative Power

No physician expressed that they resist or want to resist the cancer program. The exertion of negative power is therefore not found amongst the interviewees answers.

4.4 Presence of a Normative Dimension

There is evidence for the existence of normative dimension of institutional power; that things are being done as they always has been in the organization. This is not the same thing as resistance, but instead it means that the physician is more or less unwilling to change the work practice that might lead to exertion of negative power, however in this case the normative dimension seems to only affect the attitude to not exert positive power. The physician declares:

I1A X13: "…here no one can tell us how things is run here. Our job at the department is to treat the patient in a specific field; if the money comes we treat them."

4.5 Presence of a coercive dimension

The coercive dimension of institutional power; that the physicians are controlled in the process of implementation of the MMPCRKS might inhibit induction of activities that alter or improve the program. One physician say:

I7A X9: "Basically they discuss all the SOP's, standard operation procedures, which have to be followed. Then the implementation comes and any patient can come for screening here and we will do our responsibility, we will cure them and we cooperate with other hospitals which are also part of the program and provide awareness and treatment."

Governmental coercive measures empower physicians to defend their own discretion as well as it might lead to a smaller latitude for them to exert positive power. The general impression of the interviewee's answers is that they would like to have more guidelines and regulations so they know how to implement the program more equally and effectively to all who can take benefit from it. Two examples of this:

I4A X8: "I feel it is ok, but I feel that right now, there should be certain guidelines and such."
I7A X10: "Yes, it has been improved since the guidelines came from 2014."

4.6 Frontline bureaucracy

4.6.1 Discretion

The perceived discretion amongst the treating physicians shows the individual departments as largely self-regulating. This argument is strengthened by several administrative physicians whom seem to conclude that, business concerning patient treatment is left to the departments and treating physicians. A clinician explains:

I1B X1: ”The departments will be independent, here no one can tell us how things are run here”,

An administrative physician expresses:

I2B X6: "Whatever the treating doctor say, we use, we have good deals with companies and medicines are comparative here, so it's cheap”

The physicians, on all levels, also seems to be lacking guidelines from the scheme in regarding the implementation. Therefore the individual department and thus the treating physician are left with the unabridged responsibility of informing and guiding the individual patient. This in turn creates a situation where the physicians' discretion is elevated. One physician concludes:

I4B X8: "No, how should I work, there are no guidelines. Their policy is only this (points the earlier mentioned criteria's of the scheme). Now however if I see a patient with cancer who does not have any insurance, of course I will feel for them, I will sympathies. You know. I put myself in their shoes, it all I'm doing, my work”

I4B X4: ”I feel its ok but I feel that right now, there should be certain guidelines and such”

The room for decision-making within the alleged discretion seems to fluctuate dependent on the amount of resources, information and time available to the physician. Where such resources are threatened the room to maneuver also diminishes. This becomes apparent

when questions about how the patients are informed about the scheme and thereafter guided through the bureaucratic steps of filling forms are answered, and so on. This ipso facto, also reflects that availability of such resources differ in-between hospitals. The hospitals with greater resources available seem to have the ability to deliver better information and administrative help to the patients whom are applying for the scheme. Physicians on these hospitals therefore have greater discretion ability.

I4B X11: “Earlier the girl whom you met was taking care of all this, but then she was all alone and it was too much for her. Then they hired me you know, I have been here 2 months only - but pretty much everything, I change it. So I cleaned up the administrative part and told everyone this is how it should be done in this system”

I1B X9 “The patient from Punjab we can recommend medicines for and say that the cancer program exist and that if they want, they can apply for it. Now the patient ask us, where can we apply for this? This also we don’t know. They will have to find it on their own”

Potential dangers with limited resources and a high amount of discretion could be in the context of defense against discretion as well as coping strategies. This is asserted by one physicians as;

I4B X3: ”However there are times that you do not see, you know, me being an employee and taking the initiative of guiding them”

4.6.2 Autonomy

The amount of autonomy given to the individual departments from the management may vary between the hospitals, but the general impression is that it’s largely tied to financial boundaries. Thus focus on control is in the numbers and not in the procedures. This also shows in the administrative knowledge in administrative and economical questions, coinciding to the practicing physician’s general lack of managerial guidelines.

I1B X3: ”I learned it from the newspapers… No one has given us information!”

So you came up with your own solutions to the administrative problems?
I4B X12 - "Yes, yes"

4.6.3 Professionalism

From the interviews conducted three where with physicians working as clinicians and six where with physicians working administratively. From analyzing the answers there is a clear connection to that administrative physicians, in general, are much better versed in their knowledge about the scheme than the clinicians. On the other hand, clinicians seem to be more aware about the problems of implementation. An administrative physician discloses that:

I4C X5: "The patient generally don't know what to do. So we fill everything, the form. We give the estimate from the physician, we tell them to get this document, we make their file, right. I make their file and then once its completed. I tell them that, "now you must go to your home town, then meet this physician there". "then hand it over to them and do not leave unless you get the acknowledgement slip". Otherwise he go there and the physician there he is not interested in this extra work and he leave the file on the table only. So the file is lying there, he sitting at home and I sit here waiting for the patient. Therefore I tell them not to leave before they get the acknowledgment slip..."

Whereas clinicians express:

I1C X2 - "The patient from Punjab we can recommend medicines for and say that the cancer program exist and that if they want, they can apply for it. Now the patient ask us, where can we apply for this? This also we don't know. They will have to find it on their own."

I8C X6: "No, I Just fill the forms. Somebody else has them."

Profession might also be seen without clear outer boundaries, this means that there might not be a profession which represents a "perfect" physician. The respondents represents pulmonologists, oncologists, onco-surgeons and radiologists and might therefore feel that they belong to these sub specialties rather than the generic name of physician. A pulmonologist expresses this as:

I1C X1: "We only deal with lung cancer, only one part… The oncology people are different (from me)"

4.7 General opinion on the scheme

In general the scheme seems to be accepted by the physicians as a good initiativ from the state. Some of the administrative physicians for example say:

I2Z X2: "So it's a very good scheme, in India, in contrast to your country this is rare"

I6Z X1: "This Mukh Mantri, the head of the Punjab government taking on this program, you know it's a very good program started by the government."

A clinician states:

I8Z X1: "I believe it is a very good program. We have our own difficulties but still it is very good".

The effects of the scheme also seem to be generally appreciated.

I2Z X1: “Program is very good, people are being helped”

I5Z X1: “It’s a good scheme, its helping people. Many of them are getting money...”

The only reason of doubt among the interviewees was concerning the implementation and local troubles that might occur.

I7Z X3: “It is a very good and noble effort of the government. But the problem is the cashless system which has to be implemented in a good way. A lot of insurance companies are operating by the best of standards but in government sector of Punjab, they don’t understand money, they think everything is for free and they are quite ineffective. They are not able to function…”

I2Z X3: “But we need manpower and have asked for this, but this is lacking. We need manpower to maintain the people that are coming to us... We have an account of everywhere, and we follow the procedure.”

I8Z X2: “If a large percentage of the patients can be cured then I believe we should have more money from the scheme, there is room for improvement. And if they want to be more conservative on spending money maybe they should spend a little more on preventive things.”

4.8 Conclusion

The general picture created by the physicians seems to derive at a consensus in their initial feelings towards the scheme. Most of them see it as a good initiative by government and as something that helps a lot of people. Thereafter their feelings are mixed. Some, especially the clinicians, seem to have misgivings with the practical implementation and reach of the program. Administrative physicians on the other hand saw more economical or administrative-related problems and stayed generally more supportive towards a positive opinion on the implementation.

Through the theory of front-line bureaucracy we can discern two features in the physician’s environment. They have a large amount of discretion when dealing with patient and their autonomy is dependent, not by regulation but rather upon resources. This gives the physicians a split view on their surroundings, they can freely treat their patients under the scheme, but only if they do so within their indorsed resources. This can, since the resources are inconsistent between different hospitals, influence the physicians to derail from one another in form of implementing the state policy. Especially since there does not seems to be enough follow-up measures from the state-level.

In conclusion, the physicians can be said to exercise positive power in order to change the outcome of the policy today, but still most of them feel disempowered; trying to fully implement the programs scope.

The power which affects the physicians influence over the outcome of MMPCRKS is not uniform, because all the physicians seem to carry their very own amount of organizational power. Our analysis is that the physicians are indeed a *disempowered* profession. They are trying to implement the MMPCRKS but they can't get empowered while lacking sufficient information and recourses. The same is true for the cancer program which is ought to disempowering them due to a complicated bureaucratic system which hampers their effort to implement the scheme. In the answers presented there are no clues for physicians exerting negative power however there is much suggesting that they exercise positive power in order to change the outcome of the policy. The positive power primarily exerted by the physicians doesn't seem to be inductive regarding initiating influence upwards, toward politicians or regulating authority. The positive power is instead aimed toward the own practice through taking on own administrative initiatives to better coop with goal attainment.

The professional latitude, which gives space for more positive power, is relatively big among the interviewed physicians. This might be due to a lack of rules and regulation given to them. The coercive dimension of institutional power, the governments way of managing the physicians, seem to be unsatisfactory and some of the physicians even feel disempowered lacking guidelines advising them how to better implement the program.

4.9 Discussion

The general research area was chosen in accordance to, and not limited to the field of public administration. The study hence, also explore the neighboring area of public health, something which is natural in an interdisciplinary subject.

The problem in selecting which physicians to investigate might have generated a bias, because there is an overrepresentation in the amount of administratively working physicians among our respondents. During the initial planning for the research, we also had contact with an external source, a professor, from one of the local universities in Punjab. She helped us in finding the centrally placed sources, i.e. physicians, potentially also creating a bias. There is however no known link between her or the university and the examined scheme or interviewees to sustain such criticism.

Cultural differences and language difficulties where sometimes present during the course of the interviews. It's not however likely to have severely impacted our understanding of the empirical data collected, and in any such case, unclear statements have not been used in the analysis or conclusion.

The mapping of empirical data found, id est, the citations, was made under consequent theoretical concepts. This mapping was conducted in a separate annex, to be easier accessible for the reader and thereby further facilitating the face validity of the study. The analysis later was built on the summaries and conclusion made in context with the theories. This was also coded to become more readable.

Our understanding is that we have collected valuable information from the physicians examined. Regarding the scheme; there is room for improvement. Today, there is a potentially inherent and structural default within the policy; coherent to the general lack of guidelines. The responsible department could therefore provide more specific guidelines and create a new system where the application process for the funds is simplified. By making these efforts, it is possible that the physicians would feel more empowered to treat all the patients eligible according to the programs scope. Although we haven't find any clear case of physicians exerting negative power to change the outcome of the program, further studies in the field of frontline bureaucracy and power could also benefit from examine the physicians' attitudes in a broader sense.

Nevertheless the correlation between a general positive attitude and the absence of articulated negative power is clear. Complementary analysis of policy documents would probably also be beneficial for future research in similar cases.

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ATTACHMENTS

Attachment 1 – Figure 1

Steps to be followed by Cancer Patients seeking Financial Help under Mukh Mantri Punjab Cancer Raahat Kosh Scheme

1. First of all, Download Application Proforma and Estimate Proforma for Patients or obtain the same from concerned Civil Surgeon Office.
2. Concerned Hospital (where the treatment of patient is going on) should fill the estimated amount for further treatment of patient in the Estimate Proforma.
3. Attach a recent photograph on the application form.
4. The Estimate Proforma and photograph (on the Application Form) should be attested by the Concerned Hospital.
5. Please attach the following documents with the Application:
   a. Two recent attested Photographs
   b. Residence Proof
   c. Attested copy of Lab Report Confirming a diagnosis of Cancer.
   d. Attested copy of details of any Previous Treatment.
   e. Self-declaration
6. The Application should be submitted to the District Civil Surgeon Office by the Patient/Relative(s).

For Further Information, Please contact:

Cancer Control Cell, Punjab
Phone No. 0172-5012356
E-mail-cancercontrolcellpunjab@yahoo.com

Fig 1

Attachment - Coded chosen quotes

Power

Disempowered

Through lack of information:

I1A X1 - "The patient from Punjab we can recommend medicines for and say that the cancer program exist and that if they want, they can apply for it. Now the patient ask us, where can we apply for this? This also we don't know. They will have to find it on their own."

I1A X2 - "…maybe 40-50 % come back with the form and then they don't know how long it's going to take before they can get the money. They don't know how much they are going to get. And again we never know if a particular person got the money or not. From my understanding, most of them do not get the money."

I1A X5 - "And then it is up to you and the government how quickly they give the money. So, this is the problem, we don't know when it comes, how quickly it comes, how much comes. …There is not much time to wait, most cases are discovered late."

I1A X6 - "I learned it from the newspapers…"

I1A X10 - "Yes, yes, this is all handled by me only..."

I1A X11 - "…But unfortunately, this country you know, there is a lot of promises from the state... this kind of things I often very populistic."

I7A X14 – "There should also be a sign outside every district hospital of how to get the cancer fund. Now there is information at the libraries, but not many people go to the libraries. There should be a sign like this."

I8A X6 - "No, I just fill the forms. Somebody else has them."

Through bureaucratic impact on the actual treatment:

I1A X5 - "And then it is up to you and the government how quickly they give the money. So, this is the problem, we don't know when it comes, how quickly it comes, how much comes. …There is not much time to wait, most cases are discovered late."

I1A X7 - "… patients' needs to get the medicine by this date. There seems to be late, they need to deliver better welfare and speed up the process…"

I2A X3 - "We send them the bills, telling how much money has been spent on drugs from the fund. The government then sanction money. It's financially audited. So moneywise we have to declare to them what has happened. Sometimes they do take time to send us the money."

I6A X13 – "You know - when you're dealing with the government it always take some time..."

I7A X1 – "Most countries in Europe have a cashless system regarding the healthcare. Here we also have cashless schemes, but these are undertaken by the insurance companies. But it is another thing with the government…"

I7A X2 – "The insurance company will give us a sanction for "X amount" and then we have to treat the patient for "x-amount". But getting the money is the problem, because knowing when the money is coming is something like a mental service…"

I7A X4 – “In India, when the government does the set up… Sorry to say, but they are a bit lethargic so getting money from them can take some time. You have to understand the financial implications of this scheme, if we don’t get the money we won’t be able to treat the patient. By comparison, if we deal with a insurance company, they will do the medical auditing and put money on our account and the patient does not need to run anywhere to get the treatment, that’s the mayor difference.”

Through Bureaucratic impact on policy:
I1A X8 - "But remember we have signed this form many times, but I cant remember anyone coming back to me, saying: “look sir, the money has come”. They usually come back and we give them whatever they can afford. But I never seen someone come back saying they got the money."
I1A X12 - "We give the government all the information they ask, files and such. You know it takes a lot of my time as well, and then we don’t see any of them come back."
I7A X12 – “… the problem with this scheme is that we after 50 % of the 150 000 rupees which is the sanctioned amount from the government is used we send the bill there. But we think it is quite unjust. There is actually 50 % of the patients which are at the follow up state, and we have advised the government to narrow down this 50 % to 30 %, so when these 30 % are exhausted we can send the bill.”

Through lack of guidelines which make the physicians fail in defending their own discretion:
I4A X8 - "I feel it is ok, but I feel that right now, there should be certain guidelines and such."
I4A X13 - "No, how should I work, there are no guidelines."

Through lack of resources to make full use of the policy:
I7A X8 – “But for the patients who come here, most of the are terminal who come here , and the problem is that we don’t have a hospital for terminal ill patients. Like a hospice thing with palliative care. So they occupy resting beds, they occupy essential services where we actually could treat a patient who can survive.”
I7A X16 – “As far as we get income from the scheme… it is a loss making for us, the hospital.”
I7A X17 – “Since we are a charitable institution so we participate for this reason. We only get 5-6 % cut on the medicine prices, and there is a lot of job storing and administrating the medicines.”
I7A X18 – “… government sector of Punjab, they don’t understand money, they think everything is for free and they are quite ineffective. They are not able to function…”
I8A X4 - “The standardized procedures provides a more uniform care. But there is a problem that there is a set amount of medicines that can be used under this scheme. Sometimes the patient needs another treatment and then he has to pay himself.”
I8A X8 - “Companies will produce new things so and all the time we are thinking that it maybe is not a thing that is leading to a cure, I would not be very happy to write out these

kinds of medicines in a palliative setting but if it is curative I would, and I think there is room for improvement here. We should have more access to money for the curable patients."
I8A X10 -"Yes."

Normative dimension
Through doing as usual:
I1A X3 – "The welfare department knows how many percent whom apply but It's not my job to have contact with the welfare department."
I1A X13 - "…here no one can tell us how things is run here. Our job at the department is to treat the patient in a specific field, if the money comes we treat them."

Coercive dimension
Lack of coercive dimension:
I1A X9 - "But in regards to guidelines? No no such things."
I4A X8 - "I feel it is ok, but I feel that right now, there should be certain guidelines and such."
I4A X13 - "No, how should I work, there are no guidelines."

Through regulations regarding the cancer care:
I7A X9 – "Basically they discuss all the SOP's, standard operation procedures, which have to be followed. Then the implementation comes and any patient can come for screening here and we will do our responsibility, we will cure them and we cooperate with other hospitals which are also part of the program and provide awareness and treatment."
I7A X10 – "Yes, it has been improved since the guidelines came from 2014."

Resistance – Negative Power
Through not complying with the new policy:
I1A X3 – "The welfare department knows how many percent whom apply but it's not my job to have contact with the welfare department."

Induction – Positive Power
Through initiation of an activity which is not included in the policy:
I1A X4 - "It's not my job to give out the information about the program but I do it anyway, but in the end it's up to the patient if they want to apply or not."
I1A X14 - "No, some extra administrative job. But we don't mind, it's for the good of the patients."
I2A X2 - "That depends on the cycle they are given, it all depends."
I4A X2 - "Yes, yes. Generally what happens is that the patient comes here, right. We have that form there and we have it in Punjabi and Hindi also."
I4A X3 - "There are three but the cabin is very small and we have somewhere between 40-50 people coming in every day. So we try to inform them all, for example I am hired for this purpose. So if they need this fund, then we counsel them first. We take the undertaking, that

you don’t have any insurance, that you are a resident of Punjab, that no one in your family works or has any reimbursement from the government."
I4A X4 - "They don’t need to do anything, all is the hospitals headache. We take care of everything. This is how it works because they don’t have to pay anything they don’t have to wait."
I4A X5 - "The patient generally don’t know what to do. So we fill everything, the form. We give the estimate from the doctor, we tell them to get this document, and we make their file, right. I make their file and then once its completed. I tell them that, “now you must go to your home town, then meet this doctor there”. “Then hand it over to them and do not leave unless you get the acknowledgement slip”. Otherwise he go there and the doctor there he is not interested in this extra work and he leave the file on the table only. So the file is lying there, he sitting at home and I sit here waiting for the patient. Therefore I tell them not to leave before they get the acknowledgment slip..."
I4A X6 - "Yes it’s the same; they are getting the discounted rates that are already in this system. So all I have to do is to select to the Mukh Mantri scheme and the rates comes with that also."
I4A X9 - "But then like this one is only for cancer patients. So I for one, is hired simply for this purpose. So I’m taking care of everyone who is coming and I’m guiding them and filling their form."
I4A X10 - "At the end of the day, I need to explain it to my supervisors you know, I can show them when they ask, “What are you doing for your job”. So that’s why I made it as simple as possible, everyone can understand it."
I4A X11 - "Earlier it was just a copy, but now to be sure we are keeping the original and giving the copy back to the patient. Because they need it for record but we can claim it and they have to pay us the money. This is what I initiated. This is done, and then we start the procedure."
I4A X12 - "Yes, yes"
I4A X14- "Then I keep these reports if he dies, that he was certainly dying in the reports also, this is also my initiative."
I4A X16 - "...Earlier the girl whom you met was taking care of all this, but then she was all alone and it was too much for her. Then they hired me you know, I have been here 2 months only but pretty much everything I change it. So I cleaned up the administrative part and told everyone this is how it should be done in this system."
I4A X17 - "I’ll have to do it easy so that I don’t work myself to death. But it’s a one part job, if I don’t do my job, no one else will take the fall for it. If I don’t come to work one day, then it’s not working. Then they simply say, “He’ll be here tomorrow and he’ll tell you all about it”."
I7A X6 – “We are a big hospital and we promote cancer checkups, we have checkup brochures and we advise people to go for health checkups.”
I7A X11 – “When he comes to us, he doesn’t need to go home because our civil surgeon takes care of it, he do all the job, he gets the file sanctioned, he send it and we get the approval from the government.”

Through actively trying to impact the policy makers:
I2A X4 - "This is good for society. But we need manpower and have asked for this, but this is lacking. We need manpower to maintain the people that are coming to us."
I4A X7 - "Most of the time we get persons who come and get the form filled by us and there are chances that these persons don't come back. They are just not interested. There are several reasons. Medicine gives certain consequences… Otherwise regarding the fund, it gets approved every time the file goes from here. And we don't leave anything on the patient's shoulders, we get it done every time. We see to it, we give it to them, they do not open it, just simply hand it over, so that nothing can be misplaced."
I7A X12 – "… the problem with this scheme is that we after 50 % of the 150 000 rupees which is the sanctioned amount from the government is used we send the bill there. But we think it is quite unjust. There is actually 50 % of the patients which are at the follow up state, and we have advised the government to narrow down this 50 % to 30 %, so when these 30 % are exhausted we can send the bill."
I8A X2 - "First we have to confirm the diagnosis and then it has to be confirmed here again, as a part of standard care… Rather than to wait for confirmation from an outside hospital, to make it more uniform. I can't say that we are the bosses, but to make it more uniform it is being done fast so that the cancer is definite and it is not just radiological…"

Front-line Bureaucracy

Discretion
Practical physicians:
I1B X1: "…the departments will be independent, here no one can tell us how things are run here"
I1B X2: "…Our job at the department is to treat the patient in a specific field, if the money comes we treat them"
I1B X6: "…No, some extra administrative job. But we don't mind, it's for the good of the patients"
I4B X1: "…Yes, yes. Generally what happens is that the patient comes here, right. We have that form there and we have it in Punjabi and Hindi also"
I4B X2: "…I tell them that, "now you must go to your home town, then meet this doctor there". "Then hand it over to them and do not leave unless you get the acknowledgement slip""
I4B X3: "…However there are times that you do not see, you know, me being an employee and taking the initiative of guiding them"
I4B X4: "…I feel its ok but I feel that right now, there should be certain guidelines and such"
Have the Mukh Mantri Scheme had an effect on your work, your everyday work?
I6B X1: No, no. We just deal with the patient, and we meet the patient. We are here when the patient is coming and our hospital is empanelled by the Punjab government.
I8B X1: No, I just fill the forms. Somebody else has them.,

I6B X2: But there is a problem that there is a set amount of medicines that can be used under this scheme. Sometimes the patient needs another treatment and then he has to pay himself.
I6B X3: Would you say that you feel bounded by the financial ceiling (1.5 lakh)?
Yes.
I1B X9 The patient from Punjab we can recommend medicines for and say that the cancer program exist and that if they want, they can apply for it. Now the patient ask us, where can we apply for this? This also we don't know. They will have to find it on their own.
So you came up with your own solutions to the administrative problems?
I4B X12 - "Yes, yes"

Administrative physicians:
I2B X1: "…We have doctors that subscribe drugs and an administration that take care of the rest…"
I2B X6: "…Whatever the treating doctor say, we use, we have good deals with companies and medicines are comparative here, so it's cheap"
I4B X8: "…No, how should I work, there are no guidelines. Their policy is only this (points the earlier mentioned criteria's of the scheme). Now however if I see a patient with cancer who does not have any insurance, of course I will feel for them, I will sympathies. You know. I put myself in their shoes, it all I'm doing, my work"
I4B X10: "…Like I'm not being judgmental here, but it depends on person to person. Like, you see how many patients are already waiting. And we have a huge appointment lists"
X1B I5: "…It's actually very simple, the patient gets a form and we fill in an estimate. Then they have to show ID and that they live in Punjab"
X2B I5: "…There is information available on the internet, both on English and Punjabi"
I7B X2: When he comes to us, he doesn't need to go home because our civil surgeon takes care of it, he do all the job, he gets the file sanctioned, he send it and we get the approval from the government.

Autonomy
Practical physicians:
I1B X3: "…I learned it from the newspapers… No one has given us information"
I1B X4: "…But in regards to guidelines? No, no such things"
So what you are saying is that no one told you to inform the patient
I1B X5: "…Yes, yes, this is all handled by me only"
I1B X7: "…We give the government all the information they ask, files and such. You know it takes a lot of my time as well, and then we don't see any of them come back."
I1B X8: "…I don't know why they send you to me... We only deal with lung cancer, only one part"
I4B X6: "...At the end of the day, I need to explain it to my supervisors you know, I can show them when they ask, "What are you doing for your job?". So that's why I made it as simple as possible, everyone can understand it"

I4B X7: "…This is what I initiated. This is done, and then we start the procedure (after explaining the procedures at the hospital)"
I4B X9: "…But if they kick me out and they have somebody who does not work with this. They simply say, "Ok I see what can be done, I'll give you a call and then ill inform you". This is how it works in other systems, those who does not want to take the headache of all this stuff. It's not an easy task. Because I do the billing, keep record of the test and the.. When the test have been don, I keep the reports also. Then I keep these reports if he dies, that he was certainly dying in the reports also, this is also my initiative"
I4B X11: "...Earlier the girl whom you met was taking care of all this, but then she was all alone and it was too much for her. Then they hired me you know, I have been here 2 months only but pretty much everything, I change it. So I cleaned up the administrative part and told everyone this is how it should be done in this system"

Administrative physicians:
I2B X5: "…But we need manpower and have asked for this, but this is lacking. We need manpower to maintain the people that are coming to us"
X3B I5: "…It's actually very simple, the application leave here, then It need to be stamped and cleared, then we can start treatment"
I5B X4 "...But sometimes some people don't come back and collect the money, that is a problem. So basically some patients don't come back to collect the money.
Any idea why?
- No, but you can perhaps go to the specific doctor there and find out. But sometimes they fail to collect"

Profession

Administrative physician

I4C X1: "The patient generally don't know what to do. So we fill everything, the form. We give the estimate from the doctor, we tell them to get this document, we make their file, right. I make their file and then once it's completed. I tell them that, "now you must go to your home town, then meet this doctor there". "Then hand it over to them and do not leave unless you get the acknowledgement slip". Otherwise he go there and the doctor there he is not interested in this extra work and he leave the file on the table only. So the file is lying there, he sitting at home and I sit here waiting for the patient. Therefore I tell them not to leave before they get the acknowledgment slip..."

Clinical physicians

I8C X1: "No, I just fill the forms. Somebody else has them."

I1C X1: "We only deal with lung cancer, only one part… The oncology people are different (from me)"

I1C X2 - "The patient from Punjab we can recommend medicines for and say that the cancer program exist and that if they want, they can apply for it. Now the patient ask us, where can we apply for this? This also we don't know. They will have to find it on their own."

Research question one

Administrative
I2 X1: "Program is very good, people are being helped"
I2 X2: "So it's a very good scheme, in India, in contrast to your country this is rare"
I2 X3: "But we need manpower and have asked for this, but this is lacking. We need manpower to maintain the people that are coming to us... We have an account of everywhere, and we follow the procedure."
I5 X1: "It's a good scheme, its helping people. Many of them are getting money..."
I6 X1: "This Mukh Mantri, the head of the Punjab government taking on this program, you know it's a very good program started by the government."
I7 X3: "It is a very good and noble effort of the government. But the problem is the cashless system which has to be implemented in a good way. A lot of insurance companies are operating by the best of standards but in government sector of Punjab, they don't understand money, they think everything is for free and they are quite ineffective. They are not able to function…"

Clinical
I4 X1: "… Otherwise is feel good about the scheme, it's an incredibly good initiative taken by the government and the state."
I8 X1: "I believe it is a very good program. We have our own difficulties but still it is very good".
I8 X2: "If a large percentage of the patients can be cured then I believe we should have more money from the scheme, there is room for improvement. And if they want to be more conservative on spending money maybe they should spend a little more on preventive things."