



CHALLENGES AND OPPORTUNITIES IN HEALTHCARE MANAGEMENT IN RURAL PAKISTAN

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Abstract

Objective: This study aimed to assess the usual precautions, basic amenities, basic equipment, lab capacity, and needed pharmaceuticals in Pakistani public-primary healthcare facilities.

Study Design: Cross-sectional study

Place and Duration: This study was conducted at Department of Anatomy, Institute of Basic Medical Sciences, Khyber Medical University, Peshawar

Methods: Several structured questionnaires were included in this survey, with the subjects being the rural health facilities. Information was supplied by the administrative leaders of all public primary health care facilities in Pakistan's rural districts, as well as by extra employees if needed. SPSS version 20 was used to analyze the data.

Results: Out of the 20 health facilities that were evaluated, only 46 percent of RHCs had a sign board that could be read. 58% of RHCs have a female medical officer serving as the administrative head. The things that were ignored the most were the restroom and electricity backup. Pakistan's Rural

Health Care (RHC) has a difficulty because the Basic Health Units' (BHUs) laboratory capability, standard precautions, and basic facilities all clearly deviated from standards.

Conclusion: The government of Pakistan is clearly working hard to meet primary healthcare targets, but more has to be done to mainstream institutional, political, and societal commitments along with updated RHC standards.

Keywords: Primary healthcare, Healthcare facilities, Service readiness, Health systems

INTRODUCTION

The definition of a healthcare system is an orderly collection of people and resources that collaborate to provide healthcare services that meet the needs, goals, and satisfaction levels of a nation's citizens. Global healthcare encompasses 195 nations that work together to enhance health and lessen the burden of sickness. In order to provide a reasonable justification for the functioning of healthcare systems, four models are presently in use throughout the world that combine public and private facilities [1]. Pakistan is a developing nation that has maintained the British healthcare system, which uses the "Beveridge model," in place since the country's division. The primary, secondary, and tertiary levels make up the three-tiered healthcare system in this instance. In order to deliver the best care possible, the public and private sectors collaborate. However, the overall healthcare burden has resulted in a failure to deliver quality healthcare, particularly in the government system. Over the past ten years, the government has spent a pitiful 0.5-0.8% of GDP on healthcare, far less than the 6% of GDP suggested by the World Health Organisation (WHO) [2].

But Pakistan has recently been recognising these shortcomings and developing measures that aim to improve the country's healthcare system. The Alma Ata Declaration mandated that primary healthcare (PHC) be provided by the system. Since then, Pakistan has provided basic healthcare services, including immunisations, mother and child healthcare, and nutrition, to over 70% of the rural population. Subsequent developments have brought about the addition of measurements of an individual's well-being, ranging from physical health to social and mental health, as determinants of their quality of life.

In 2015, there were 1,167 hospitals, 5,695 dispensaries, 5,464 BHUs subhealth centres, 733 maternal and child health centres, 675 rural health centres, 339 TB facilities, 118,869 total beds, and 1,613 people per bed, according to a GALLUP report based on the Pakistan Economic Survey 2015–16.3, 4] 67.4% of Pakistani households, according to the Pakistan Social & Living Standards Measure (PSLM) study, employ private health experts.[5] In Pakistan, the private health service providers are made up of medical professionals, paramedics, lab workers, pharmacists, drug dealers, traditional healers, herbalists, homoeopathic physicians, Hakeem, and unlicensed practitioners, or quacks. Private health services in Pakistan included 20,000 beds, 73,650 private healthcare facilities, 8 specialised hospitals, and 692 medium- and small-sized hospitals.(7) Physicians make up 7.8% of the population per 10,000, according to the World Health Organisation, compared to 3.8% for nurses and midwives. In addition, the proportion of doctors per 10,000 people, nurses per 10,000 people, and midwives per 10,000 people in urban and rural areas are, respectively,14.5%,3.6%,7.6%, and 2.9%.* [8]

It is essential to focus on all aspects of quality in order to attain sustainable quality in healthcare. International forums like NICE recommendations, IHI, and a few others provide evidence that supports this claim.[9] These days, there is an urgent need to investigate and test different ways to quality improvement, community response, and/or local outcomes. It will support the development of sensible, workable, and long-lasting policies. [10] The introduction of our medical record system should be our top priority, with side updates applied as needed to allow for the documentation of data and occurrences.8. This will therefore assist in defining and identifying the present quality parameters that are being established, as well as the problems and challenges encountered in developing each of

the quality features and areas that require improvement. In [11] Primarily, it will aid in the measurement of data since it is believed that without data, no measurement can be made; consequently, no work or management can be done, leaving society in the dark. [12]

MATERIALS AND METHODS

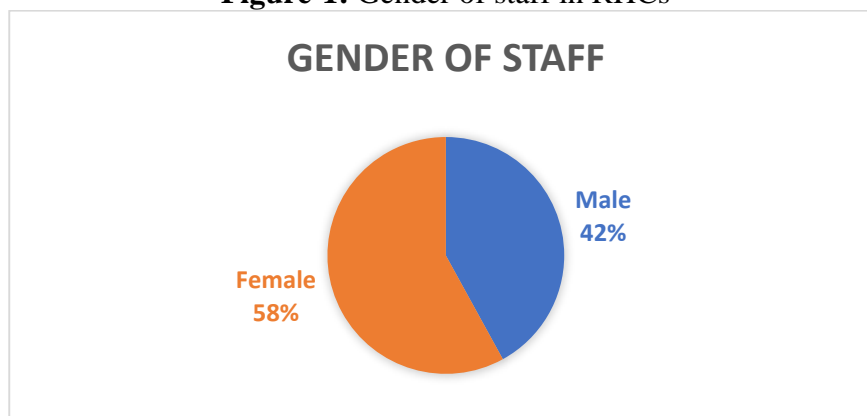
This study was conducted at Department of Anatomy, Institute of Basic Medical Sciences, Khyber Medical University, Peshawar. Visits to rural health clinics were part of the research. The study encompassed all public-primary health care facilities (RHC) in the tehsil due to their low quantity, whereas MCH centres and dispensaries were not included due to the unavailability of some services. With some contextual adaption to Pakistan's public primary health care system in accordance with Minimum Service Delivery Standards (MSDS), the WHO tool for Service Availability and Readiness Assessment (SARA) was employed. Additionally, it underwent pretesting on a single RHC, during which time any questions or ambiguities were identified and cleared up.

The scale of service preparedness in this study had a Cronbach's alpha coefficient of 0.655. For each of the five service readiness components, an overall percentage was produced. The District Health Office granted approval prior to data collection, and the Hospital's ethical review board granted permission to perform the study.

RESULTS

Out of all RHCs, only 46% had a sign board that could be read. Only male medical officers (MO) headed the remaining RHCs, with women medical officers (WMOs) accounting for 58% of these positions.(figure 1)

Figure-1: Gender of staff in RHCs



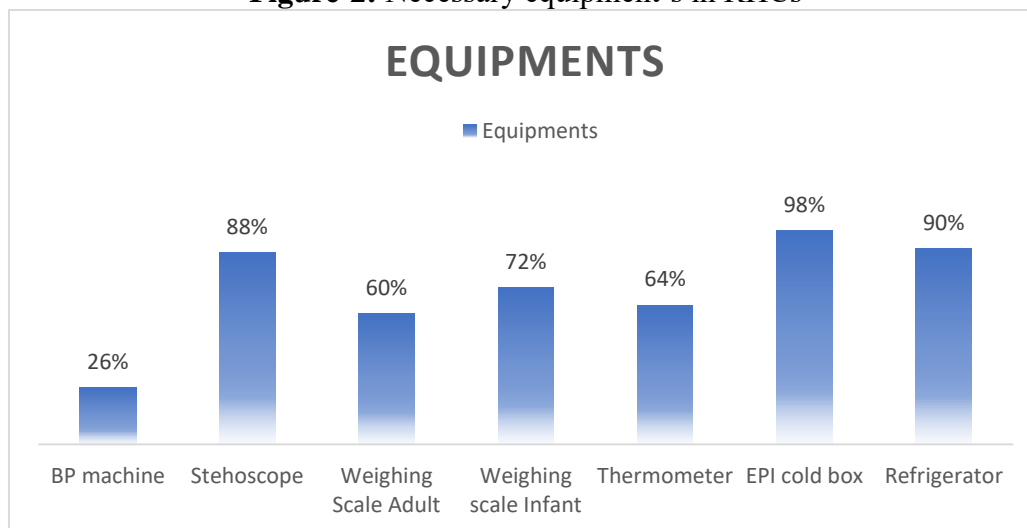
RHUs were not satisfied with basic amenities. The areas that were most often overlooked were the toilet and power backup. For RHUs, a manual pump or well was the most common source of water (38%) followed by a tanker system (35%) and a piped source (16%). Because the payment had to be paid by MO/WMO and is refunded by the government at a very slow pace, the RHU that depends on the tanker system is mostly left without water. (table 1)

Table-1: Amenities among RHCs

Variables	Available	Functional	Not Functional
Ambulance	78%	44%	34%
Landline Telephone	30%	12%	18%
Water (at facility)	86%	50%	36%
Backup for Electricity	28%	20%	8%
Washroom	66%	46%	10%
Separate examination room	28%	22%	6%

Concerns were raised regarding seven essential pieces of equipment. A blood pressure (B.P.) machine was found in 26% of RHUs, along with a stethoscope (88%), an adult weighing scale (60%), an infant weighing scale (72%), a thermometer (64%), an EPI cold box (98%), and a refrigerator (90%). Not one RHC had all of the necessary equipment in working order. (figure 2)

Figure-2: Necessary equipment's in RHCs



Actually, the government did not provide laboratory testing facilities for RHUs; yet, three tests—blood glucose, haemoglobin, and pregnancy test—are advised. The haemoglobin test was functional in 15% of RHUs, the blood glucose test in 38% of BHUs, and the pregnancy test in 22% of BHUs. In addition to the prescribed tests, a small number of RHUs provided Random Blood Sugar (RBS) and Tuberculosis Directly Observed Treatment Short Course (DOTS).

DISCUSSION

In Pakistan, the total fertility rate is nearly constant at 3.9.[13,14] and the IMR remains at 65 per 1000 live births despite all efforts made in the health sector. In Punjab, just 14.6% of deliveries take place in public hospitals, and only 2.2% of people visit primary care facilities; the remaining individuals either avoid this tier of treatment or choose private hospitals.[15]The investigation brought to light the areas where PHC facilities' service readiness was lacking. In order to analyse the advantages and disadvantages of a nation's health systems and support health professionals in their decision-making processes, public health facilities must undergo routine evaluation.[16]

Although there is no set boundary for health systems, low- and middle-income countries should undergo a lengthy developmental process to strengthen their systems from the primary to the tertiary level. What matters is not how much money the government has spent on health systems, but rather what policies and procedures have been put in place to make the systems efficient and effective.[17] Pakistan's funding for healthcare must be increased immediately in order to upgrade its facilities and address the country's labour crisis. Building and modernising healthcare facilities need to be the government's first priority, especially in rural areas. Furthermore, investigations into novel financing strategies are needed to raise money for medical care. One of these creative models is the creation of PPPs. The Sehat Sahulat Programme (SSP) was introduced by Pakistan in 2015 as part of the WHO's universal health coverage (UHC) strategy. The Pakistani government and commercial insurance companies worked together to make this work. Giving underprivileged and marginalised groups access to free healthcare services has been its primary objective. Notwithstanding the fact that this programme has improved healthcare accessible and been mainly successful, certain obstacles, such as limited coverage and reimbursement delays, limit its efficacy [18]. However, this programme can act as a basis for more PPPs.

The province governments have taken a commendable step in eliminating ghost staff by implementing biometrics, which would improve attendance and healthcare delivery.[19] It is necessary to do field study on potential absenteeism causes and the incentives that may persuade workers to work in rural and periurban health clinics. Research from Bangladesh indicated that extended travel times, inadequate facilities, resources, and incentives for physicians and personnel, as well as subpar clinical equipment, contributed to absenteeism. Twenty [20]

The essential facilities and tools required to conduct preventative and curative activities are inadequate in Pakistan [21]. Consequently, in order to determine the shortcomings of health systems, regular evaluation is required. In Pakistan, the provision of critical medications, as per the eight components of the Alma-Ata Declaration, is also severely ignored. Therefore, the current state of affairs indicates the necessity of interventions. For healthcare to move more quickly, certain better adapted standards with institutional, political, and societal influence are required.

One of the eight elements of the Alma-Ata Declaration is the supply of critical medications. The findings of our investigation indicated that all PHC facilities sampled had an essential medicine list, even if the MOs of RHUs were not satisfied with the list. The Senior Medical Officer's (SMO) increased purchasing authority over the MO, which is also recommended for better PHC, can be used to justify the disparity in service preparedness between PHC facilities.[22]The laboratory capacity, standard precautions, and basic facilities of RHUs demonstrated a glaring divergence from the norm, posing a challenge to Pakistan's PHC.

CONCLUSION

The government of Pakistan is clearly working hard to meet primary healthcare targets, but more has to be done to mainstream institutional, political, and societal commitments along with updated RHC standards.

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