STRATEGIC COMPARISON, EVALUATION, AND ANALYSIS OF HEALTH CARE DELIVERY SYSTEM: PAKISTAN VERSUS CAMERON, MEDIATING ROLE OF TRANSFORMATIONAL LEADERSHIP.

Salman Sarwar[1]*, Atiq Ur Rehman[2], Nazia Kousar[3], Hina Younas[4], Sana Ullah Umair[5]

Abstract

The paper is aimed to understand, evaluate, and compare the healthcare facility and delivery system between Pakistan and Cameroon. This paper reviews the healthcare facility system, several challenges, weak areas in health policies implementation and also present recommendations to improve Healthcare System for both developing countries. Healthcare sector has generally direct impact on the economy of country. Health care setups are under intense pressure they have been never before, in particular private medical and health care setups. Document analysis has been used to carry out the research. The method is library-based research, and the collected data is taken from secondary sources. The study has carried only one area of vast subject as the evaluation and comparison. The outcomes of this study show that health facilities lack basic rights of health for all in the aforesaid counties. Though Pakistan appeared to be a better unit in comparison. Healthcare facility plans must be aligned as government priority.

Keywords: Healthcare delivery system, Pakistan healthcare, Cameron health facility, private health care setups, comparisons of healthcare system.

[1]*University of Cyberjaya, Selangor Malaysia. Email: Salmansarwar333@gmail.com
[2]Associate Professor, University of Lahore.
[3]Assistant Professor, Pharmacy Department University of Lahore. Email: Hafiza.nazia@dnsc.uol.edu.pk
[4]University of Sargodha. Email: Hinayounis219@gmail.com
[5]Faculty of Pharmacy, University of Lahore. Email: umair10391@gmail.com

***Corresponding Author:** Salman Sarwar
*University of Cyberjaya, Selangor Malaysia. Email: Salmansarwar333@gmail.com

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1. Introduction

Pakistan is geographically situated as significance force for the all-economic powers across the globe. Its education and health policy become of great significance to catch world attention.

1.1. Healthcare Regulatory authorities

The Ministry of National Health Services, Regulation & Coordination, Pakistan Medical Council, Pakistan Council of Homoeopathy, Pakistan Nursing Council, and Council of Tibb. On June 30, 2011, the federal government transferred the Ministry of Health to the provinces in accordance with the 18th Amendment. The majority of the initiatives and duties of the Health Ministry have been delegated to provincial health ministries, notwithstanding its reinstatement in April 2013 (5). The Pakistan Medical Commission (PMC) was founded as a body corporate in 1962 and is a regulating organization under the PMC ordinance. The goal is to give Pakistani citizens access to high-quality healthcare (6).

2. Pakistan's healthcare delivery system

2.1. Primary Medical Care

This is the first stage of healthcare, where patients interact with the system and receive assistance in preventing and curing illnesses.

2.2. Rural health centers and basic health units At the Union Council level, Basic Health Units (BHUs) provide services to around 25,000 individuals. Referral, curative, and preventive services are provided. Certain health packages are provided via maternal and child health (MCH) services, which are provided at basic health units. BHUs also provide clinical, administrative, and logistical support to Lady Health Workers (LHWs) (7).

Over 100,000 individuals receive health-related services from Rural Health Centers (RHCs). Along with non-patient services, several stages of promotion, prevention, curation, diagnosis, and referrals are provided here. Additionally, it provides BHUs, LHWs, and MCH Centers with managerial, clinical, and logistical support (7).

3. Secondary Healthcare

This is the intermediate stage of healthcare, pertaining to the provision of therapeutic, diagnostic, and technical services. At the district and tehsil levels, this package of services is highly recommended. This includes hospital admissions and specialist consultations.

3.1. Headquarters for the Tehsil and District

Tehsil Head Quarters (THQs) served a population ranging from 500,000 to one million people. The majority of THQs have 40–60 beds. THQs are thought to provide basic healthcare services as well as sporadic comprehensive obstetrics, emergency, and infant care. Treat patients referred by Lady Health Workers, BHU, and RHCs (7). District Head Quarters (DHQs) serve a population of one to three million people and are located at the district level. DHQs provide inpatient, diagnostic, curative, prophylactic, and referral services. All DHQs offer referral care to patients referred by BHUs, RHCs and Tehsil Head Quarters [(7)].

3. Tertiary Healthcare

Tertiary Healthcare hospitals generally provide specialized inpatient care. Specialized Healthcare services mostly for inpatients and on referrals from primary or secondary health professionals [(7)].

Methodology

Document analysis method has been undertaken to find the output of this study. Document analysis is a valuable research method that has been used for many years.This technique carries the format of analyzing various types of documents including books, newspaper articles, academic journal articles, and institutional reports. Any document containing text is apotential source for qualitative analysis (Patton, 2015). Document is a term used to refer to awide variety of material including visual sources, such as photographs, video, and film (Merriam & Tisdell, 2016). Like documents consisting of texts, those that consist of visual material can be a source for qualitative analysis (Flick, 2018).

Data collection

Since this study consist of national interest for any country, so the data has been mainly collected from the government healthcare agencies such as Pakistan Healthcare Commission, Pakistan medical and Dental Council, and Cameron healthcare ministry information cell. The last two decades have been primarily established as base study but Covid 19 era has an impact. All necessary newspapers, newsletters, magazines, research papers and reports have been collected to conduct an analysis.

Challenges in Health System of Pakistan

The Pakistani healthcare system has been beset by severe issues such as scarce resource availability, inequality, understaffing and low skill levels, administrative mismanagement, and gender insensitivity. Politicians have typically planned and

designed Pakistan's health system, with medical experts working with them to carry it out (9). Cost and accessibility to healthcare, particularly for the nation's rural population, are major issues due to a lack of resources for medical personnel and improper use of monies allocated for the primary healthcare sector (3). Furthermore, it is believed that statistics from the health care information management system are unreliable for assessing and improving services at the primary and secondary levels. Because of the lack of resources, research and development are not being done. Policies created for health care are typically subpar, and problems with implementation occur when they are not workable or consistent with the available resources. There are a number of reasons for this, including a lack of funding for public health services, political meddling, corruption, and a lack of accountability for subpar work (3). Other significant obstacles stand in the way of Pakistan's ability to offer high-quality healthcare services. These include the dual burden of disease, the vertical service delivery system, the development of insufficient human resources in the health sector, the population boom, illiteracy and poverty, a lack of health education in the community, and inadequate sewage and sanitation.

Health Policies of Pakistan

Pakistan announced its first official national health policy in 1990. A strong commitment to health was stated in the first National Health Policy, which increased health spending to 5% of GNI. In order to enhance health, family planning and clean water were prioritised (10). In 1997, a second national health policy was developed. The idea of health for all served as its foundation (HFA). HIV/AIDS, traffic accidents, violence, TB, cancer, diabetes, and mental health were all discussed (10). The Third National Health Policy (2001) is once more predicated on the idea of health for all. Reduced communicable disease, improving gender equity, resolving gaps in basic and secondary healthcare, addressing the health sector's disparity between rural and urban areas, and advancements in the pharma industry are among the ten main areas that have been identified (10). There was only a draft policy created then. Federal and Provincial Governments agreed on common Nation Health Vision (2016-2025). Vision statement is to improve health of all Pakistanis particularly women and children through affordable universal access to quality Healthcare Services, delivered through responsive health system [(11)].

Table 1.1

Types of Hospital in Pakistan	Numbers of Hospitals	Types of Hospital In Cameroon	Numbers of Hospitals
Public Hospital	924	District Hospital	164
Dispensaries	4,916	General Hospital	4
Basic Health Units	5336	Regional Hospital	14
Rural Health Centers	595		
MCH Centers	1,138	Integrated health centers	1920
TB Centers	371	Specialized Centers	
First Aid Points	1080	Sub-division medical centers	155
Population per bed	1,515		
Population to health facility ratio	11,413	Population to health facility ratio	111,111

Table 1.2

Types of Health Care Provider	Pakistan	Cameroon
Doctors	139,555	28560
Dentists	9,822	2789
Nurses	69,313	5920
Midwives	26,225	3741
Medical Technologists	7,891	1690
Health Visitors	10,731	1265
Registered Vets	4800	1981

Table 1.3

Diseases	Pakistan	Cameroon
Communicable, maternal, perinatal, and nutritional diseases	41%	69%
Non-communicable diseases	59%	89%
CVDs	21%	11.56%
Injuries	16%	45%
Cancer	6%	4.45%
Diabetes	2%	7%
Respiratory diseases	7%	49%
Other Chronic diseases	7%	28%

Weaknesses in Health Policies of Pakistan

Health policies primarily concentrate on curative healthcare, which includes expanding the number of hospitals, labs, ambulances, and contemporary equipment without considering how these resources will be used by untrained medical professionals (18). In drafting the policies, lessons are learned from the prosperous nations' achievements, disregarding the social, cultural, and religious contexts as well as the disparities in wealth (18). Instead of addressing the cultural and environmental factors that contribute to disease prevention, the contents of health plans present the same old biomedical model that deals with disease treatment (18). Although they are managed and operated by the federal government, all vertical programs are implemented at primary healthcare centers. Due to their lack of participation in the planning process, this causes discord at the BHU and district levels. Monitoring and evaluation is another gap in health policies. No system to compile, evaluate and use data for assessment and policy reforms at district level. As a result, data is not presented to Federal Ministry for feedback and evaluation of vertical programs [(18)].

PRESENTATION OF HEALTH SYSTEM OF CAMEROON

The organization of the Cameroon health system was defined in 1989 by the Ministry of Health Public by Decree No. 89/011.

The development and execution of health policy are guaranteed by the Ministry of Public Health. As a result, it creates plans for the implementation of health policies, oversees the development, organization, and technical inspection of public and private health facilities, regulates the practice of health care professionals, manages public health institutions, supervises pertinent professional associations, and creates and carries out training programs for Ministry of Public Health employees. It also helps to retrain and retrain staff members of the permanent body of public health and Cameroonian health stakeholders operate under a three-tiered system: central, intermediate, and peripheral. Every level has unique administrative features and functions.

CENTRAL LEVEL

There are two categories of HFs at the central level: first and second category hospitals. As referral structures, they now fall short of their potential primarily because of inadequate technological platforms, delayed patient referrals and usage of care services, and expensive service charges that most patients cannot afford. These hospitals now provide subsidies for certain services in an effort to lower the costs associated with managing certain chronic illnesses, such as cancers, terminal kidney diseases that require hemodialysis, etc. However, due to the absence of long-term health risk pooling arrangements, the services and medical care provided by these hospitals continue to be out of reach for those from lower socioeconomic classes.

Furthermore, these hospitals provide MHP and CHP in the same manner as district hospitals, MHCs, and IHCs; they are meant to provide technical support to HFs at the devolved level. It is intended to conduct an assessment in order to determine what barriers and challenges these entities face in effectively carrying out their duties. Lastly, at the central level, regular coordination meetings provide a forum for guidelines, information sharing, and solution suggestions. As a result, its substance needs to be enhanced and should cover the examination of structural and organizational bottlenecks that impede the accomplishment of desired objectives. Meetings of the steering committees and multi-sector committees of priority health programs provide additional chances to confer with important stakeholders to resolve intersecting health concerns and guarantee the effectiveness and coherence of the basic needs. Even though regional public health delegates are responsible for overseeing the development and execution of health policy at the devolved level, the meetings are irregular and do not include them (multi-sector technical meetings).

Regional Delegations for Public Health (RDPH) at the Intermediate Level: Ten Regional Delegations for Public Health comprise the intermediate or regional level (RDPH). Their ongoing responsibilities include administrative management, coordination, and technical assistance for health districts throughout the region. There are health care and activity control brigades at the level of regional delegates. However, no study has yet been able to assess the true degree of mission implementation.

The majority of RDPH lack health development plans. Furthermore, the Consolidated Regional Health Development Plans (CRHDP), which were created between 2006 and 2009, were not fully implemented due to a shortage of financing. According to the TS/SC-HSS97 report on missions conducted in 2013 across the ten regions, there is a global shortage of financial, material, and human resources. Regional delegations and district medical officers are also not equipped to carry out the management process to the fullest extent possible. The region's ability to plan, coordinate, and provide technical support is hampered by this qualitative and quantitative shortfall in human resources.

Thus, instead of a single, consolidated plan and just one monitoring/evaluation plan for the delegation, these delegations have: (i) a multitude of subject plans with numerous duplicates and monitoring/ evaluation tools.
Health facilities at the intermediate level: Currently, there are 14 regional hospitals at this level, along with additional facilities that fall into the third category. These hospitals are meant to receive referrals from operational level health facilities. However, it is challenging to evaluate performances objectively due to a lack of pertinent functional evaluation. When it comes to these institutions' human resources, capacity growth doesn't always fit into a pre-existing training schedule. This scenario can be partially explained by the lack of a personnel management plan at this level and the financial resources available in comparison to expressed or acknowledged training demands.
Coordination meetings also offer a chance for knowledge exchange and the application of best practices among carers. But because to a shortage of finance, they are not as regularly organized.

Peripheral level / Health district.
The national territory was divided into health districts by Decree No. 95/013 of February 7, 1995, and the autonomy of these districts represents the pinnacle of their development (viability process).

"Reduce by one third the global burden of death by setting up a health facility that provides the Minimum Health Package (MHP), within an hour's walk and for 90% of the population" was one of the goals set forth in the 2001–2015 Health Security Strategy (HSS)99. Health districts should be established in order for them to carry out their mandate and provide the populace with primary healthcare100, 101.
However, as no recent study has been done, it is now challenging to evaluate the state of development of the 189 health districts in the nation. Nonetheless, in 2007 only 7.4% of health districts were regarded as developed. Under these circumstances, the majority of buildings at this level of the health pyramid lack the development necessary to adequately offer people high-quality MHP and CHP.

In addition, the PETS II survey's findings revealed that, among operational-level health facilities, 24.5% lacked delivery kits, 39.5% lacked a heat sterilization system, 67.5% lacked caesarian kits, and 11.6% lacked working microscopes. Three subsectors make up each level: traditional medicine, private medicine, and public medicine.

All public health facilities fall under the category of the public sector, as do quasi-public facilities run by other ministries (Defense, Employment and Labor, the Business Social, Gender and Education). First category hospitals are at the top of the pyramid, followed by second category hospitals at the regional level, which are in charge of overseeing the numerous district hospitals. Due to its deteriorating equipment, antiquated infrastructure, and insufficient human resources, this subsector is inefficient.

In Cameroon, the private sector plays a significant role in the provision of healthcare services. In order to help patients, they may work in tandem with the government. Health facilities are among the non-profits (religious organizations, organizations, and NGOs) and profit-making establishments. This subsector manages to elude the oversight of health authorities across all tiers.

The third subsector is traditional medicine, which is not yet regulated. However, the Ministry of Health has established a department dedicated to traditional medicine, established the Centre for Research on Medicinal Plants and Traditional Medicine (CRPMT/IMPM), developed a legal framework that is being embraced, and encouraged

the formation of traditional practitioners' associations as means of promoting this medicine.
Accessibility and Infrastructure for Health From 3039 in 2007 to 3370 in 2009, health coverage through healthcare institutions has improved. There are four general hospitals (first category), four central hospitals (second category), eleven regional hospitals (third category), and 164 hospitals in the Cameroon health system. 1,888 health centers and District 155 district health centers are integrated, with 1600 functioning. We need to add 289 clinics/polyclinics, 193 private nonprofit health centers, 93 private hospitals, and 384 care practices. To illustrate the population distribution, it also requires 12 testing labs, 5 drug manufacturers, 14 wholesalers, 331 pharmacies (181 in Yaounde and Douala), 1 National Central of Supply Essential medicines and medical consumables, 10 supply centres regional pharmaceutical (GARP), 4 public medical schools in Yaoundé, Douala, and Buea, 1 private medical school (University des Montagnes), and 39 training institutions.

The following are examples of health providers: government hospitals, public health clinics, religious institutions, non-governmental organizations (NGOs), private clinics, pharmacies, and traditional physicians employed by drug retailers. Many state-owned businesses also provide health centers for their employees. For example, SONARA, a corporation that produces oil in Cameroon, has a health center open to the public as well as its employees.

The bulk of non-profit facilities are operated by the Catholic and Protestant Health Services: For example Cameroon Baptist Convention (protestant) that has been in the country now for more than 60 years, comprises 5 hospitals (2 of which are 250-bed hospitals), 23 integrated Health Centers, 43 primary Health Centers, Pharmaceutical procurement and distribution department, a Private Training School for Health Personnel (PTSHP), a Center for Clinical Pastoral Education and Social Services (CECPES), Services for People with Disabilities, among others (11)

CAMEROON HEALTH FACILITES

REGIONS	Faith based non profit	Private none profit	Private for profit	Public	Total
ADAMAWA	38	39		124	201
CENTRE	187	750	191	474	1602
EAST	59	74		177	309
FAR-NORTH	19	65		356	440
LITORAL	184	581	148	144	1157
NORTH	18	49	6	254	327
NORTH-WEST	90		45	234	369
WEST	83	318		415	816
SOUTH	35	72	1	206	314
SOUTH-WEST	354		92	191	318
TOTAL	747	1948	483	2675	5853

STRENGTH AND WEAKNESSES

Being one of the most demanding industries in the nation, the health care sector puts pressure on the government to work hard and put more creative policies, effective strategies, programs, projects, and plans into place for the public's successful health care delivery. As a result, they are working to find solutions for the significant problems the healthcare industry faces. The government offers professional health workers chances for career advancement, in-service training, paid study leave, frequent refresher courses and workshops, and postgraduate programs both domestically and abroad, some of which are supported by the government.
There is still a big hole to be filled in the distribution of resources, even though the state, as the primary health provider, deserves some recognition for its efforts in health care. Hopefully, the country's decentralization program would bring about a permanent shift in the circumstances. The lack of a national health insurance policy, which renders care inaccessible for many, the shortage of healthcare workers combined with the rising trend of infectious and communicable diseases, poor management (a poor political and managerial environment that does not permit nor encourage healthcare workers to perform at best level), and these are some of the major weaknesses of the healthcare system.

Troubles for Cameroon Healthcare system.

Cameroon faces several health-related issues, including: inadequate methods of addressing healthcare demands, as seen by demographic indicators; a disproportionately large brain drain of healthcare professionals; a difficulty to maintain the transfer of health technologies, particularly

following the withdrawal of. Two major challenges to health have been made obvious with the introduction of the 2001-2015 HSS: strengthening the DHS (District Health System) and ensuring the proper implementation of health programs to achieve the MDGs on health. The following issues are linked to these challenges: building the human capital required for health facilities to operate properly and to provide high-quality care; guaranteeing the most vulnerable have financial and geographic access to necessary medical supplies; enabling the nation to respond to emergencies and natural disasters and their aftermath; lowering the rates of maternal and newborn mortality through the use of integrated and effective interventions; monitoring factors associated with prevailing circumstances. In majority of the developing countries, private healthcare sectors, donor, and out of pocket expenditures are the primary contributors in health care services that may raise human capital and economic growth of the country. Whereas, public health sectors remain underprivileged due to structural fragmentation, lack of resources, and functional inabilities.

Conclusion

Pakistan's healthcare system, particularly primary healthcare, is beset by issues. Decentralization offers the chance to radically alter primary healthcare and improve its effectiveness and efficiency for the general public. Restructuring the ineffective primary healthcare system is one of the reforms' objectives. Building elements of the healthcare system include workforce health, technology, leadership, financing, and research. Monitoring and evaluation are crucial for achieving access coverage and high-quality services (03, 18 and 20).

Recommendations

Integrating primary, secondary, and tertiary care and fostering symbiotic relationships are essential components of a robust and efficient healthcare delivery system. Pakistan's healthcare delivery system might be improved by planning and implementing a number of measures, including this integration. The main suggestions for enhancing Pakistan's healthcare system are listed below.

I. A more comprehensive and holistic approach would be preferable to the curative biological model. To enhance people's health, other factors like the environment, societal issues, and cultural characteristics must be addressed concurrently.

I. It would be highly beneficial, if policy making is decentralized and delegated to districts, because they can adopt better and realistic approach for the problems they encounter on daily basis·

II. More resources should be kept into capacity building of the administrators at district level to understand contemporary health issues, because the root causes of problems are not addressed while formulating policies, due to lack of knowledge about concerned place and population·

III. All stakeholders should be involved in planning, decision and implementation of programs at all levels to ensure efficiency and sustainability of programs.

IV. Better monitoring and evaluation tools should be constructed to get valuable and unbiased feedback to policy makers and implementers·

V. Other key measures can be taken to improve Healthcare sector of Pakistan; control population growth, increase literacy rate, increase health budget, control corruption in public health projects, regionalization of Healthcare services, and promote health education, proper check on quackery and exchange of human resource and knowledge with developed countries.

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