BACKGROUND

Since the 1970s, Bangladesh has seen remarkable improvements in health and social indicators. A key driver of its success has been increased access to healthcare services across the country, provided by government, non-government, and private providers.

Since the 1980s, for-profit private sector’s provision of healthcare services has grown rapidly, including maternal and newborn health (MNH) services. Figure 1 shows the increase of private sector provision of deliveries from 2007-2017.

Currently, about 80% of hospitals in Bangladesh are private facilities. Due to rapidly increasing numbers of facilities, many of these operate with little regulation. For public facilities, evidence suggests that quality of care is suboptimal. Across Bangladesh, facilities struggle to provide MNH and reproductive health (RH) services.

The Medical Practice and Private Clinics and Laboratories Ordinance of 1982 provided the legal framework for the operation of private healthcare facilities in Bangladesh. The ordinance specified that each clinic requires a license from the Ministry of Health & Family Welfare (MOHFW), and laid out seven criteria for quality of care and licensing. However, it is unknown whether private facilities follow these licensing practices, or whether they face barriers to licensing and quality of care.

STUDY OBJECTIVES

With support from the United States Agency for International Development (USAID), icddr,b conducted a study to explore the licensing practices, structural readiness, and service utilisation of profit-driven private health facilities in Bangladesh.

The study objectives were to:

- Assess private facilities’ licensing practices and compliance with licensing requirements
- Identify constraints of public health system in enforcing licensing regulations
- Document private facilities’ barriers to applying for and renewing licenses
- Examine readiness of private facilities to provide Maternal and Child Health (MNCH) services
METHODOLOGY

This study used a cross-sectional, mixed-methods design and was conducted in all 12 city corporations of Bangladesh, and 29 subdistricts of 10 randomly selected districts.

In every district, two subdistrict municipalities with at least four private health facilities were selected (except for Kishoreganj District, where there was only one subdistrict with four or more private facilities). Generally, city corporations are more heavily populated and urbanised than municipalities.

To assess licensing status, a census of all for-profit private facilities was done via a three-step process (Figure 2) to identify the 1,119 facilities used as the sampling frame.

Compliance with licensing criteria and readiness to provide MNH services were assessed by:
1. Record reviews;
2. A structured health facility assessment questionnaire administered in randomly selected facilities providing inpatient MNH care; and
3. Key informant interviews.

The final 349 facilities selected for assessment of licensing compliance and service readiness were randomly selected from the 1,035 facilities providing inpatient MNH care (out of the 1,119 providing inpatient care) in the selected districts and city corporations, and then stratified by the number of beds. Non-governmental organization and district municipal facilities were excluded from this survey because they are not profit-driven.

31 key informants at the national and district level were selected for the in-depth interviews.

RESULTS

Overall, findings showed that:

About two-thirds of private facilities were located in city corporations of urban areas, and about one-third in municipalities (less urban areas), as shown in Figure 3.

One-quarter of all facilities were large facilities with 21 or more beds.

In city corporations, large private facilities provided almost 80% of hospital beds.

In municipalities, small private facilities provided nearly 60% of hospital beds.
About 80% of facilities surveyed had an expired license, and only 6% had a valid licence on the day of the surveyor’s visit. About one-third had either not applied for a new license or for renewal.

Among those who applied to renew their licenses, only 20% had applied within one year of their previous license expiring.

While there was no significant difference between the proportions of large and small facilities which had applied for new or renewed licenses, all 100+ bed hospitals had applied for new or renewed licenses.

There was also a significant difference between city corporations and municipalities in licensing intent and compliance. Three-quarters of municipal facilities had applied for new or renewed licenses, compared to just over half of city corporation facilities.
**Licensing challenges**

There were a number of challenges to licensing. The 1982 Ordinance does not specify **validity period**, nor penalties for delays. Moreover, **inspections** are only carried out in facilities that submit licensing applications, incentivising some facilities not to submit applications at all.

**Facility owners** also highlighted their own reasons for licensing delays, including:

- Short validity of licenses;
- Multiple clearances required from authorities;
- Limited technical capacity of smaller facilities to process applications;
- Long wait times for application approval;
- Lack of feedback on application submissions;
- For small clinics, high license fees are particularly challenging.

**Compliance with licensing conditions**

The 1982 Ordinance outlined seven mandatory conditions to license private facilities. As **Figure 5** shows, nearly **90%** of facilities met **three** of these conditions: adequate floor space for each patient, air-conditioned operating theatre available, and at least one specialist available.

However, there was **poor compliance** with some of the conditions due to **unclear definitions and rules**, which meant that when facilities were assessed using standardised measures, compliance with some mandatory conditions - namely around infection control, essential equipment, and medicine - was poor.

**Infection prevention and control**: only **3%** of facilities had all necessary nine prevention precautions outlined in the Bangladesh Health Facility Survey (BHFS). About **half** had at least seven of the precautions. **Larger facilities** had better infection prevention measures in place, as did facilities in municipalities.

**Essential equipment**: **not a single** facility had all 36 pieces of equipment needed to be licensed. However, technology has progressed since the 1982 Ordinance, and newer integrated equipment is now available. Nonetheless, **smaller facilities** were still missing some critical equipment.

![Figure 5. Proportions of private facilities satisfying the seven licensing conditions](image-url)
There was variation in the availability of documents necessary to obtain a license:

- **Tax certificates** (86%) and **VAT certificates** (58%) were widely available (86%) across small and large facilities;
- **Environmental clearance certificates** (32%) and **narcotic licenses** (25%) were difficult to obtain, and smaller facilities had greater difficulties obtaining both.

### Mandatory supporting documents for licensing

Many facility managers were also unaware of reasons that a license may be canceled, suspended, or revoked. Only 3-4% of managers knew that changing a facility’s name or address, transferring the license to another owner, or failing to renew on time could result in cancelation or suspension.

### Availability and readiness of MNH care

Only 4% of facilities were providing all the basic client services for MNH care, including outpatient curative care, child growth monitoring, facility-based child vaccination, modern methods of family planning, antenatal care (ANC), and normal delivery.

While most private facilities were providing normal delivery services (95%), modern methods of family planning (88%), and outpatient curative care for children (78%), only 44% of facilities were providing antenatal care services.

![Figure 6. Readiness to provide ANC services according to the six WHO criteria](image-url)
Readiness to provide quality MNH services was low overall, and worse in smaller facilities, with availability of trained staff and guidelines being an overall challenge.

Readiness to provide quality ANC services was very low (Figure 6), with only 1% of facilities meeting all six WHO criteria required for ANC services.

Similarly, readiness to provide normal delivery services (Figure 7) was less than 1% as per the 13 WHO criteria for readiness. The primary missing criteria for normal delivery services were the guidelines for basic EmONC (1%), trained staff (11%), and partographs (15%).

Only 17% had trained staff and only 3% had ANC guidelines. For newborn care, only 8% of facilities had all six essential medicines, though facilities with 100+ beds were more likely to have all essential medicines (27%).

Availability of the nine pieces of essential equipment recommended for newborn care was also very low, with only 9% of facilities having all nine pieces.

**Figure 7. Readiness to provide normal delivery services according to the 13 WHO criteria**
**RECOMMENDATIONS**

1. **Revise and approve the draft DGHS 2016 guidelines, which add rules and procedures to the 1982 Ordinance**
   - The DGHS's 2016 draft guidelines currently includes a 2 year validity for licenses, clear application timing, fixed financial penalties for delayed submission, and an improved inspection process. Approval processing times and licensing conditions should also be clarified, along with requirements for regular reporting on the seven licensing conditions and for health utilization data reporting for license renewal.

2. **Estimate human resource requirements for inspection of all private facilities**
   - Increase in the number of human resources dedicated to licensing, and effective distribution of human resources and delegation of authority within DGHS at the national and district levels will be critical to ensuring timely licensing and quality assurance.

3. **Develop alternative modalities of compliance tracking and monitoring, e.g. sample auditing**
   - The online portal can be improved for electronic monitoring of registered facilities for timely license renewal applications, submission of service data, and improved compliance. Renewal reminders sent to facility owners in advance, with clear guidance, may improve the timely submission of applications.

4. **The DGHS should coordinate and organize dialogues with different government departments**
   - Regular collaboration will mitigate the obstacles and delay times in obtaining necessary prior approvals.

5. **Strengthen engagement of the Bangladesh Private Clinic Diagnostic Owners’ Association (BPCDOA) and the Bangladesh Private Medical College Association (BPMCCA)**
   - The private clinic owners’ association can organize training sessions as well as clarify the online license application process, mandatory certifications, and reasons for license cancellation, thus clarifying facility owners’ knowledge of the licensing process.

6. **Expand licensing conditions to include the availability of staff trained in MNH care**
   - Including the availability of staff trained in MNH care (including required numbers of Midwives and MNH providers) as a licensing criterion can improve poor MNH readiness and stagnating MNH indicators.

7. **The hospital services management of the DGHS should collaborate with program managers of maternal health and newborn care in the DGHS**
   - Program managers in hospital services management, maternal health, and newborn care should collaborate to develop plans for periodic assessment and compliance tracking for MNH service readiness.

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