

# **Private Sector Health Services in Bangladesh: An Exploratory Study**

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## ACRONYMS

BDS	Bangladesh Dental Society
BMA	Bangladesh Medical Association
BPMPA	Bangladesh Private Medical Practitioner's Association
DGHS	Director General of Health Services
DPHE	Department of Public Health and Engineering
ESP	Essential Services Package
GDP	Gross Domestic Product
GOB	Government of Bangladesh
HEU	Health Economics Unit
HNPSP	Health, Nutrition Population Sector Programme
HPSP	Health and Population Sector Programme
MCH	Maternal and Child Health
MOHFW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization
PHSA	Private Health Sector Assessment
PIP	Project Implementation Plan
TFR	Total Fertility Rate
UMIS	Unified Management Information Systems
WHO	World Health Organization

# CONTENTS

Section #	Title	Page #
1.	Introduction .....	1
2.	Objective and Methodology.....	1
3.	Concept of Private Health Sector .....	3
4.	Types, Number and Locations of Private Sector Health Personnel and Facilities.....	4
4.1.	Private Medical Practitioners and Human Resource Situation for Health.....	4
4.2.	Number of Medical Professionals in Private Medical Colleges and Institutions.....	6
4.3.	Registered Private Hospitals/Clinics by Number of Beds and Medical Human Resource by District .....	7
5.	Networks of Private Health Practitioners and Health Facilities.....	9
6.	Health Policies in Bangladesh.....	10
7.	Government and Professional Organization's Regulations to Oversee and Regulate the Private Health Sector .....	11
8.	Economics of Private Sector Health Services : Some Relevant Issues .....	12
9.	Health Financing Approaches in Private Sector.....	15
10.	Discussion and Conclusions .....	18
	References.....	21

*Annex 1: Proposed Scope of Work (Supplied by EngenderHealth)*

*Annex 2: The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982*

## 1. Introduction

Bangladesh, a small country with a large population of about 130 million contained in 147,570 square kilometres (56977 sq. miles) is almost entirely surrounded by India (North, West, East) except for a short frontier with Myanmar at south-east, and a southern coast line on the Bay of Bengal. The country has agro-based economy with GDP growing at a rate of 4.0-4.5%. The country for administrative purpose is divided into 6 Divisions, 64 Districts (Zilas), 507 Thanas/Upazila (sub-districts) and 4,484 Unions, 87319 villages<sup>1</sup>. The country has a unitary form of government run by democratically elected representatives of the people.

Although there has been success in health services, still more than 60 percent of the population has no access to basic health care. According to government's documents less than 40 percent of the population has access to basic health care.<sup>2</sup> Other issues include overall poor utilization of government facilities, as well as cost effectiveness, sustainability and quality of public sector services. So the proportion of the global burden of disease carried solely by Bangladesh is enormous.

## 2. Objective and Methodology

As per the Scope of Work, the main objective of this phase 1 work of the two-phased study was to explore development of a profile of the private sector health services in Bangladesh (see SoW, Annex 1). The second phase of the study will deal with costing model pertaining to private sector health services in Bangladesh. One of the basic purposes of the phase 1 work was to prepare the groundwork for the costing model by identifying status of availability of relevant data and information as well as future requirements for relevant costing exercises.

The specific purposes of this study included the following:

- i) To identify the types, number and locations of private sector health facilities.
- ii) To analyse relevant issues pertaining to the economics of private sector health services.
- iii) To identify networks of private health practitioners and health facilities.
- iv) To identify the government unit's and professional organization's regulations to oversee and regulate the private health sector.
- v) To explore available health financing approaches in private sector.

The major dimensions of methodology including specific objective-wise variables/indicators and source of pertinent data/information is presented below (Table).

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<sup>1</sup> Bangladesh Bureau of Statistics (2000). *BBS-Statistical Pocket Book, Bangladesh, 2000, P-3, 81.*

<sup>2</sup> Ministry of Health and Family Welfare (1998). *Health and Population Sector Programme 1998-2003. Part I. Dhaka*

<b>Objective 1: To develop a profile of private sector health services in Bangladesh</b>			
<b>Specific Objective</b>	<b>Variables/Indicators</b>	<b>Activity</b>	<b>Information Sources</b>
a. To identify the types, number and locations of private sector health facilities	i. Type of private practitioners* ii. Type of maternity centres** iii. Type of hospitals, diagnostic and imaging centres, and dental clinics *** iv. Number of private practitioners* v. Number of maternity centres** vi. Number of hospitals, diagnostic and imaging centres, and dental clinics *** vii. Distribution of private practitioners by locations**** viii. Distribution of maternity centres by locations**** ix. Distribution of hospitals diagnostic and imaging centres, and dental clinics ****	i. Review of government and non-government health statistics, donors reports and research reports ii. Collection of statistics from different networks of health professional and health facilities	i. Health statistics of Government, non-government and donors ii. Research reports iii. Different networks of health professional and health facilities
b. To identify and describe networks of private health practitioners and health facilities	i. Organized networks of private health practitioners ii. Organized networks of health facilities iii. Informal networks of private health practitioners iv. Informal networks of health facilities v. Donors' involvement in organizing and supporting networks vi. Mode of financing for operating the networks vii. Promotional activities of the networks	i. Review of government and non-government health statistics, donors reports and research reports ii. Collection of statistics from different networks of health professional and health facilities iii. Discussion with the concern authorities.	i. Health statistics of Government, non-government and donors ii. Research reports iii. Different networks of health professional and health facilities
c. To identify the government unit's and professional organization's regulations to oversee and regulate the private health sector	i. Existing government units to oversee and regulate private health sectors ii. Government rules to oversee and regulate private health sectors iii. Government standards to oversee and regulate private health sectors iv. Government regulations to oversee and regulate private health sectors v. Professional organizations (e.g., medical associations) that oversee and regulate private sector health services (if any) vi. Role of professional organizations (e.g., medical associations) to oversee and regulate private sector health services (if any)	i. Review of government's rules, regulations and standards ii. Collection of reports on situation of implementing rules regulation and standards iii. Discussion with the concerned authorities. iv. Discussion with network leaders of health professional/facilities	i. Government's rules, regulations and standards ii. Reports on situation of implementing rules, regulation and standards iii. Concerned government authorities. iv. Network leaders of health professional/facilities
<b>Objective 2: To explore health financing approaches in private sector</b>			
a. To explore health financing approaches in private sector	i. Existing health financing schemes in NGO and private health sector ii. Performance of the schemes iii. Institutions tested the identified schemes iv. Types of health services covered v. Cost for services vi. Cost determination process vii. Cost sharing pattern in the scheme viii. Advantages and disadvantages of the scheme from different points of view	i. Review of government, non-government and donor organization documents ii. Review of documents and statistics of health insurance agencies, NGOs offering health schemes iii. Discussion with private practitioners and clinics	i. Documents of Government, non-government and donor organization ii. Documents and statistics of health insurance agencies, NGOs offering health schemes iii. Private practitioners and clinics.

\* If data is available private practitioners will include both qualified (modern and traditional) and non-qualified (e.g. quacks)). Otherwise MBBS will be covered.

\*\* Maternity centre may provide other medical services

\*\*\* Hospitals may provide diagnostic and imaging services. If detailed such data is not available, only hospital data will be sought.

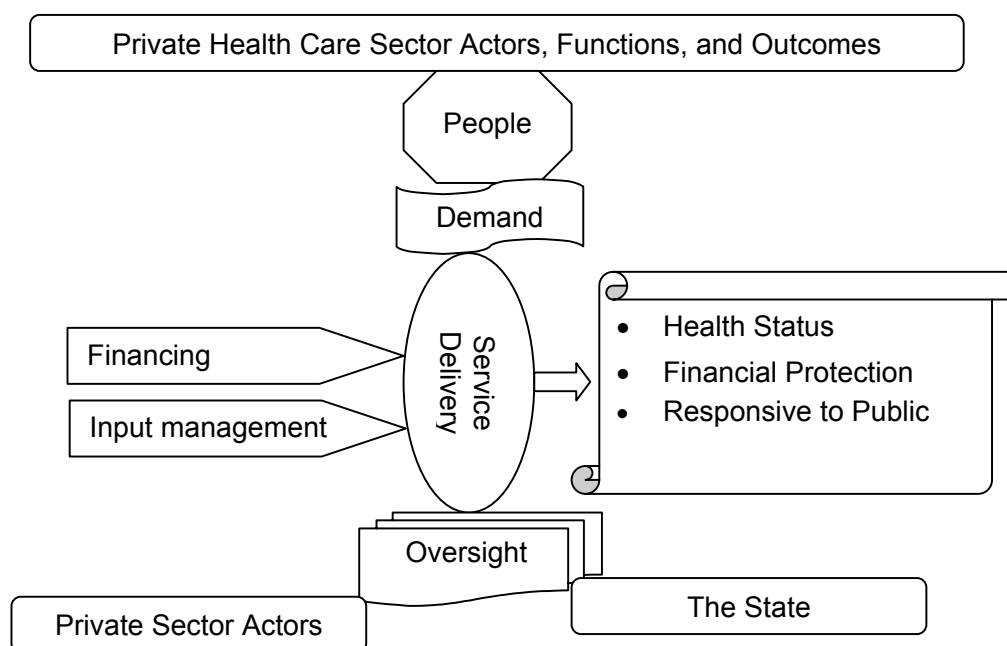
\*\*\*\* If available, data will be provided up to the lowest administrative units.

### 3. Concept of Private Health Sector

In Bangladesh, the private sector in health is generally understood to refer to private, for-profit, medically trained providers. Their range of practice varies from solo practice, small nursing homes, to large hospitals. The private sector also offers ancillary services such as diagnostic centers, ambulance services, and pharmacies. However, a much broader set of non-government actors is involved, that may be categorized according to organizational type (non-profit or profit), size and scope of service (solo practice, small nursing home, large specialized hospital), or system of care (Bangladesh indigenous system of medicine – ayurvedic, unani; or western medicine – allopathic). Many non-qualified and untrained providers offer a combination of systems of medicine, but allopathic tends to dominate. In addition, there are a large number of private actors offering services or managing other inputs to the health sector through private initiatives (consulting firm, construction firms etc.).

Many see the process of privatization as a remedy for the problems inherent in the public sector financing of health, and a way to strengthen their policies and strategies. It is considered that private endeavours are free from political constraints normally associated with the public sector run by bureaucracy, and the privatization will lead to improved resource management, thereby resulting in efficient and effective delivery of services. There is also the belief that privatization could free scarce government resources which could be utilized to improve provision of health services to the poor. On the other hand, it is assumed in opposition to privatization, that imperfect market conditions and relevant distortions in the health sector will lead to outcomes such as over-supply of services and excessive investigation, leading to cost escalation and unnecessary cost to patients. Concern is also expressed that privatization will lead to wide disparity in people's ability to access quality health care. A conceptual framework showing the functioning of private health care sector is presented below in Figure-1.

Figure-1: Conceptual framework showing functioning of the Private Health Care Sector



The objective of health system activities by the private health care sector is to promote, maintain and to recover people's health. In the private health care system, three broad categories of actors e.g. "People", "The State", and "Private Sector Actors" are considered as major stakeholders. "People" are considered at the centre of this system. The "State" is represented by the Ministry of Health and Family Welfare, Directorate of Health, Directorate of Family Planning at the central, state, and local levels, whose primary activities relate to the health sector. There are other important public bodies that affect the health system, including the judiciary, Ministry of Finance and Planning, and other sectoral ministries such as Women and Child Affairs, Education, Water Resources, Social Welfare etc.

The health system also responds to demand, which is not so much a function of the health system as it is a function of people. Demand for each health services creates one of the most important health sector markets.

The functions of private health care system include financing, input management (non-financial), and health service delivery. The main financing functions are the collection of financial resources, pooling of funds (e.g. through insurance), and the allocation of these resources for purchasing of services. The management of inputs is related to generating and using resources for health such as human resources, knowledge and software, drugs, medical equipment, supplies, and capital (e.g. buildings). Service delivery functions are divided among ambulatory clinical services, inpatient, hospital-based, clinical services. In Bangladesh, the prominent nature of private health care services are diagnostic, preventive and therapeutic. The fourth main function, oversight, is largely a responsibility of the State.

The concept of oversight goes beyond the conventional idea of regulation, or setting and enforcing rules, to other functions such as developing policy and providing strategic direction to the health system. The other oversight role of state include mediation of actions between different actors, developing partnerships or networks with different providers or financiers in health sector, inform the people and providers about performance, quality, or pricing, and monitoring and evaluation of health sector performance.

Health status, financial protection and consumer responsiveness are three major types of outcomes in health sector. Health status is generally determined by several indicator e.g. mortality, fertility, nutrition, illness, disability etc. The second health system outcome, financial protection, is a measure of the financial loss due to illness, which can include direct costs of health care and lost earnings due to illness. Consumer responsiveness of the health system is measured by how satisfied the public is with various aspects of health services. It also includes consideration of whether health services treat people with respect, and whether they are provided with protection against malpractice and exploitation.

## **4. Types, Number and Locations of Private Sector Health Personnel and Facilities**

### **4.1. Private Medical Practitioners and Human Resource Situation for Health**

According to the Director General of Health Services source, the total number of registered physicians in Bangladesh is 33,326. However, the number of private practitioners registered with the Bangladesh Private Medical Practitioners' Association (BPMPA) is 10,529 and that with the government is around 9,000. Thus it is difficult to ascertain who constitute the rest, 13,797 registered physicians (33,326 – 19,529). According to BPMPA, except 9000 government doctors the rest 24,326 doctors are either private practitioners or serving in non-governmental facilities, but among these 24,326 practitioners only 10,529 doctors are members of BPMPA.

Specialty	Male	Female	Total
General	5000	400	5400
Pediatrician	500	200	700
ENT (specialist)	10	20	30
Skin and VD Specialist	12	28	40
Ophthalmologist	1600	50	1650
Urologist	100	0	100
Surgeon	200	45	245
Gynaec and Obs	20	130	150
Anesthesiologist	300	20	320
Radiologist	25	100	125
Ultrasonography Specialist	250	50	300
Pathologist/Microbiologist	60	60	120
Hospital Management	4	0	4
Medicine Specialist	49	50	99
Tropical Medicine Specialist	50	50	100
Nutrition Specialist	4	6	10
Endocrinologist	2	0	2
Nephrologist	3	0	3
Cardiologist	8	2	10
Chest Physician	12	8	20
Orthopaediatric	40	0	40
Physiotherapist	5	0	5
Psychiatrist	8	2	10
Dental Practitioners	707	339	1346
Total	8969	1560	10529

Source: Bangladesh Private Medical Practitioner's Association (Upto December, 1998) and Bangladesh Dental society.

Human resources situation for health in Bangladesh is poor. The ideal ratio of doctor, nurse and paramedics should be 1:4:10, but the present ratio of the same is 1:0.6:0.2. At present there are 33,326 doctors, 18,435 nurses and 7,757 paramedics, but it should be 38,326 doctors, 1,53,304 nurses and 3,83,260 paramedics in number<sup>3</sup>. In addition to the above mentioned professionals there are 1,462 registered dental surgeons, 26,912 *Pallichikitsoks* and 435 registered Homeo and Ayurvedic doctors serving for health of the people. Currently 12,689 nurses, 4,884 paramedics are working under the government services.

Sl. No.	Category	Number
01	Registered Doctors, 2002	33,326
02	Registered Dentist, 2002	1,462
03	Registered Nurses, 2002	18,435
04	Paramedics (Passed)	7,757
05	Pallichikitsok (Rural Non-qualified Medical Practitioner): Persons practicing allopathic medicine without formal education and registration to do so.	26,912
06	Dentist under health services (created post)	594
07	Nurses under health services	12,689
08	Paramedics under govt. service	4,884
09	Registered Homeo and Ayurvedic Doctors	435

Sources: Ahsanullah (2002); UMIS, (2001); Health and Population Statistical Report 1999-2000.

<sup>3</sup> Ahsanullah, A.B.M., Director General of Health Services, (2002), *Is Our Medical Education Addressing Sectoral Objectives and Current Health Problems*.

In the existing reports and literature there is no statistics on the number of public sector doctors who also work in the private sector. But it can be said that a large part (share is unknown) of the public sector doctors in Bangladesh practice privately before and after their official working hours.

The number of registered medical doctors in 1997 was 26,608<sup>4</sup> and it was 33,326<sup>5</sup> in 2002. Therefore, it can be concluded that the average annual number of graduates from medical schools over the 5 years is 1344.

## 4.2 Number of Medical Professionals in Private Medical Colleges and Institutions

A large number of doctors and specialists are working in the private health sector. Most of them are working on part-time basis. According to a recent survey, the following private medical colleges/institutions have a total of 1606 doctors.

Sl. No.	Name of Private Medical College	Number of Medical Professionals		
		Male	Female	Total
1	Bangladesh Medical College	100	42	142
2	Zahurul Islam Medical College	111	19	130
3	Community Based Medical College	55	10	65
4	Z.H. Sikder Women's Medical College	53	10	63
5	Jalalabad Ragib Rabeya Medical College	25	10	35
6	Uttara Women's Medical College	43	18	61
7	Dhaka National Medical College	54	17	71
8	Shaheed Mansur Ali Medical College	40	12	52
9	Institute of Applied Health Science	110	10	120
10	North East Medical College	35	20	55
11	Al Sefa Medical College	14	6	20
12	University Dental College	10	5	15
13	Pioneer Dental College	50	13	63
14	City Dental College	32	9	41
<b>Sub-Total</b>		<b>732</b>	<b>201</b>	<b>933</b>
<b>Other Institutions</b>				
1	BIRDEM (Diabetic Hospital)	251	90	341
2	Children's Hospital, Dhaka	60	21	81
3	Model Satellite Clinic	2	7	9
4	Red Crescent Hospital (Holy Family)	116	71	187
5	Shishu Hospital, Chittagong	35	20	55
<b>Sub-Total</b>		<b>464</b>	<b>209</b>	<b>673</b>
<b>Grand Total</b>		<b>1196</b>	<b>410</b>	<b>1606</b>

Source: Bangladesh Health Bulletin 1997, UMIS, DGHS, MOHFW, GOB, Dhaka, 1999

<sup>4</sup> Ministry of Health and Family Welfare, Government of Bangladesh (1999). Bangladesh Health Bulletin 1997.

<sup>5</sup> Ahsanullah, A.B.M., Director General of Health Services, (2002), *Is Our Medical Education Addressing Sectoral Objectives and Current Health Problems*.

### 4.3 Registered Private Hospitals/Clinics by Number of Beds and Medical Human Resource by District

According to Bangladesh Health Bulletin 1997 there are 483 hospitals and clinics, 8246 beds, 1104 doctors and 4058 nurses engaged for serving in private health care sector in Bangladesh. Among the private hospitals and clinics around 50 percent of those are located in Dhaka division and rest are located in other divisions. Apart from the other divisional features in Dhaka there are 753 cabins in the hospitals in Dhaka. In addition, a number of non-government organizations (NGOs) are operating at almost every level throughout the country, but according to UMIS of DGHS no statistics is available on NGO's operating health facilities in the country.

Sl. No.	District	Number of Hospitals/Clinics	Number of Beds	Number of Doctors	Number of Nurses
<b>Rajshahi Division</b>					
01	Panchagarh	-	253	60	107
02	Thakurgaon	2	20	6	12
03	Dinajpur	9	135	28	60
04	Rangpur	15	180	53	116
05	Nilphamari	1	10	3	5
06	Lalmonirhat	-	-	-	-
07	Kurigram	2	18	5	11
08	Gaibandha	2	23	6	11
09	Joypurhat	4	37	11	21
10	Bogra	16	202	50	101
11	Serajgonj	2	16	5	10
12	Pabna	5	54	16	29
13	Natore	4	38	11	22
14	Naogaon	2	20	6	12
15	Nawabgonj	3	30	8	18
16	Rajshahi	13	253	60	107
<b>Rajshahi Division Total:</b>		<b>80</b>	<b>1289</b>	<b>328</b>	<b>642</b>
<b>Khulna Division</b>					
17	Kushtia	7	112	28	55
18	Meherpur	4	35	10	17
19	Chuadanga	9	78	21	39
20	Jinaidah	12	107	30	51
21	Magura	3	28	8	11
22	Narail	2	22	7	12
23	Jessor	14	172	47	91
24	Satkhira	3	29	8	15
25	Khulna	29	333	85	166
26	Bagerhat	-	-	-	-
27	Perojpur	-	-	-	-
28	Jhalkathi	-	-	-	-
29	Barguna	-	-	-	-
30	Patuakhali	1	10	3	6
31	Bhola	-	-	-	-
32	Barisal	5	52	13	26
<b>Khulna Division Total:</b>		<b>89</b>	<b>978</b>	<b>260</b>	<b>489</b>

Sl. No.	District	Number of Hospitals/Clinics	Number of Beds	Number of Cabin	Number of Doctors	Number of Nurses
<b>Dhaka Division</b>						
33	Shariatpur	-	-		-	-
34	Madaripur	-	-		-	-
35	Gopalganj	-	-		-	-
36	Faridpur	-	-		-	-
37	Rajbari	-	-		-	-
38	Manikgonj	2	20		-	6
39	Dhaka	195	4321	753	2036	2029
40	Munshigonj	-	-		-	-
41	Narayangonj	3	33	-	8	16
42	Narshigdi	3	32	-	9	17
43	Gazipur	-	-	-	-	-
44	Tangail	3	270	-	56	91
45	Jamalpur	3	32	-	8	16
46	Sherpur	2	20	-	6	11
47	Mymensingh	22	218	-	64	120
48	Kishoregonj	-	-	-	-	-
49	Netrokona	-	-	-	-	-
<b>Dhaka Division Total:</b>		<b>233</b>	<b>4946</b>	<b>753</b>	<b>193</b>	<b>2312</b>

Sl. No.	District	Number of Hospitals/Clinics	Number of Beds	Number of Doctors	Number of Nurses
50	Sunamgonj	-	-		-
51	Sylhet	16	7	57	112
52	Moulvibazar	2	25	7	11
53	Hobigonj	-	-		-
54	Brahmanbaria	8	89	22	46
55	Comilla	9	102	28	55
56	Chandpur	2	22	6	12
57	Laxmipur	1	10	3	6
58	Noakhali	7	70	19	40
59	Feni	4	36	9	20
60	Khagrachhari	-	-	-	-
61	Rangamati	2	164	32	51
62	Chittagong	29	493	136	259
63	Bandarban	-	-	-	-
64	Cox's Bazar	1	15	4	3
<b>Chittagong Divisional Total:</b>		<b>81</b>	<b>1033</b>	<b>323</b>	<b>615</b>
<b>Country Total:</b>		<b>483</b>	<b>8246</b>	<b>1104</b>	<b>4058</b>

Source: Bangladesh Health Bulletin 1997, UMIS, DGHS, MOHFW, GOB, Dhaka, 1999

Note: The most recent Bulletin published in 2001 does not provide up to data on these issues.

Statistics provided by Directorate General of Health Services regarding number of private clinics and recent statistics provided by Bangladesh Private Clinic and Diagnostic Centre Owners' Association show that the growth of private health care sector seems to be very high. According

to the information provided by the Bangladesh Private Clinic and Diagnostic Centre Owners' Association, the scenario of private health care sector is as follows:

- There are around 700 registered clinics and 3000 diagnostic centres in Bangladesh. However, the same source claims that the number of unregistered clinics and diagnostic centres could be three times than the registered ones;
- In those private clinics and hospitals there are 15,000 beds for inpatient services;
- Around 8,000 doctors are working with the private clinics and hospitals;
- Around 10,000 diploma and trained nurses are working with the private clinics and hospitals;
- Around 10,000 health technicians are serving in the private clinics and hospitals;
- Apart from doctors, nurses and technicians, the private health care sector has generated employment for around 175 thousand people;
- More than Tk.10 billion has been invested through private health care sector; and
- Around one thousand specialist doctors are providing services through these private clinics and hospitals.

Lack of available data on the above issues made us think that these are the trends of the private sector but our observations give us reasons to assume that the magnitude of the sector could be wider than the figures presented.

A survey is needed to conduct to ascertain the number of private clinics in Bangladesh, because we did not find the exact number of private clinics in recent official statistics of Ministry of Health. It is also required to conduct a participatory research study to explore the underlying reasons and conditions that contribute to the growth of the private sector.

## **5. Networks of Private Health Practitioners and Health Facilities**

There are several networks of private health practitioners and health facilities. The major ones are mentioned below:

- (a) Bangladesh Medical Association (BMA)
- (b) Bangladesh Dental Society (BDS)
- (c) Bangladesh Private Medical Practitioners' Association (BPMPA)
- (d) Bangladesh Private Clinic and Diagnostic Center Owners' Association
- (e) Association of Homeopathic, Ayurvedic and Unani Practitioners.

All these associations are government approved and are operated by their own constitutions. Discussions with the resource persons of the mentioned organizations indicated that these organizations are membership based professional organizations. All the organizations do not perform any activities, which are related to regulatory functions for private health care sector.

Almost no service delivery network exists in Bangladesh except National Health Network (NHN) of Bangladesh Diabetic Association. National Health Network operates a network of around 50 district level clinics especially for the diabetic patients. These district level clinics provide limited curative services and diagnostic facilities.

## 6. Health Policies in Bangladesh

Bangladesh inherited the pre-independence policies of health services with priority assigned to the development of hospital service care particularly in urban areas. The first five-year plan (1973-78) envisaged the need for expanding the health care coverage in the rural areas through the establishment of a 31-bed hospital with other preventive care (specially Smallpox Eradication, TB Control and Malaria Control) at the Thana level under a scheme called Integrated Thana Health Complex (ITHC).

During the Second Five Year Plan (1980-85), Bangladesh being a signatory to the Alma Ata Declaration, adopted the Primary Health Care concept. During the same period, family planning activities were integrated with MCH services and initiated implementation through integrated programme. Multi-sectoral population control activities was also launched through involvement of nine different ministries (other than Health and Family Welfare).

During the Third Five-year Plan (1985-90), focus was on primary health care services including the immunization and nutrition education programme under "Health for All Programme by the Year 2000". The main strategies taken were to pursue the delivery of immunizations to rural areas, to ensure the awareness of environmental health, and nutrition education to the rural households in order to make the delivery of primary health care successful.

In the Health and Population sectors, the objectives of the Fourth Five Year Plan were to enhance the physical infrastructure network upto union levels through construction of more Upzilla Health Complexes, Union Health and Family Welfare Centres, and enhancing number of beds at secondary and tertiary level hospitals. In addition to the infrastructure development, during this period, emphases were given to Primary Health Care with specific programmes on MCH-based Family Planning and expanded programme on Immunization, communicable disease control<sup>6</sup>.

During the Fifth Five Year Plan<sup>7</sup> period government has adopted the National Health Policy. The main aim of the National Health Policy is in pursuance of the Article 15(A) of the Constitution- "Supply of basic medical requirements to all levels of the people of the society", in pursuance of the Article 18(A) of the Constitution- "Improvement of nutrition of the people and public health".

During the early Fifth Five Year Plan period the Government drafted a Health and Population Sector Strategy (HPSS) in collaboration with the development partners and NGOs. The main sectoral objectives of the HPSS were (a) maintenance of the momentum of efforts in Bangladesh to lower fertility and mortality; (b) reduction of maternal mortality and morbidity; and (c) reduction in the burden of communicable diseases. The Essential Services Package (ESP) identified in the HPSS consists of basic reproductive and child health services, including family planning, maternal care and immunization as well as control of selected communicable diseases, limited curative care and behavioral change communication. The ESP has been planned to be delivered through different levels of primary health care systems (Community, Unions and Upzilla levels).

In July 1998, the government has formulated a five year Programme Implementation Plan (PIP) for the Health and Population Sector Programme (HPSP), based on the principles of HPSS.

<sup>6</sup> Barkat, Abul and Murtaza Majid, 2002, *Position Paper on Health, Population and Family Welfare Sector*, paper prepared for Planning Commission, Ministry of Planning of the Government of the People's Republic of Bangladesh

<sup>7</sup> Fifth Five Year Plan 1997-2002, Planning Commission, Government of Bangladesh, March, 1998.

During the preparation of HPSP a logical frame work approach was used to strengthen the design process. The major components of the programme are: (i) essential services package; (ii) service wide management system; (iii) integrated support service system; (iv) improved hospital management; (v) sector wide management system; (vi) policy and regulatory framework; and (vii) other health and nutritional services. HPSP has already completed almost five years of its implementation and has achieved limited success.

There were some design flaws and gaps in HPSP. The government has taken initiative to address these design flaws and gaps in its newly proposed Health, Nutrition, and Population Sector Programme (HNPSP). The goal of the proposed HNPSP (2003-2006) is supposed to be sustainable improvement of health, nutrition and family welfare status of the population of Bangladesh, especially the most vulnerable – poor, women, children and the elderly. The present government's development objective for the health sub-sector is to ensure quality services at every level (primary to tertiary including specialized hospitals). The objective towards nutritional improvements will focus on reducing moderate and severe malnutrition and improving the nutritional status of the people, particularly women children and under five and elderly. The objective of the family welfare programme is to maintain the momentum of efforts of Bangladesh to lower fertility and mortality; reduce maternal mortality and morbidity; and strengthen these activities with a view to reducing the TFR from its present static status.

The capacity of the private sector to assume a larger role will be assessed under the upcoming HNPSP. The areas include the current extent of private provision of services in the essential service package, the type of provider (allopathic, homeopathic, unani, ayurveda practices, etc.), the cost of and quality of such services, and their sources of financing. Based on such investigation, a more effective involvement of the private for profit sector in health and population will be sought. In this regard, the MOHFW will develop principles for partnership with private sector and also collect baseline information on costs, efficiency, capacity of ESP delivery and training needs.<sup>8</sup> It should be mentioned here that no private provider or provider's network offer a full ESP.

## **7. Government and Professional Organization's Regulations to Oversee and Regulate the Private Health Sector**

In the framework of health system there are three broad categories of actors e.g. "People", "The State", and "Private Sector Actors". People are placed at the top of the health system, since we consider the promotion, maintenance, and recovery of people's health to be the defining characteristics of health system activities. There are other important public bodies that affect the health system, including the judiciary, Ministry of Finance, the Planning Commission, and sectoral ministries such as Women and Child Affairs, Education, DPHE etc.

The rapid development of the private sector has improved access by the population to medical care, especially in the urban areas. The 1982 Private Clinic and Laboratory Act provides guidelines for regulating the private sector. Other than MOHFW's regulations, trade licensing procedures, taxation systems, regulation of recruitment of manpower and staff development, access to bank credit, procedures for utility connections etc.; procurement of equipment and

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<sup>8</sup> Ministry of Health and Family Welfare, Government of Bangladesh (1998). *Health and Population Sector Programme (1998-2003), Part I*. p.63. As part of promoting the Public-Private partnership in health, the World Bank and other development partners are now in the process of undertaking various studies e.g. World Bank's AAA (Analytical Advisory Assistance) framework.

supplies; and adopting medical ethics etc. all together affect the private sector and have significant impact on it.<sup>9</sup>

The 1982 Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance (No. IV) of 1982 (Annex-2) defines the main elements of the regulatory framework regarding the private provision of health care services in Bangladesh.

The 1982 Ordinance specifies that no person shall establish a private clinic without a license (from the Ministry of Health and Family Welfare) under this Ordinance. There are some conditions and procedures for getting a license for operating a private clinic.

The MOHFW will grant a clinic a License if it has:

- Proper accommodation with hygienic environment for the patients.
- At least 80 square feet of floor space for each patient.
- An air-conditioned operating theatre.
- Up to 37 types of specified essential equipment (ranging from an autoclave to bedpan).
- Adequate supply of life saving and essential medicines.
- Round the clock presence of one registered medical practitioner, two nurses and one sweeper per ten beds.
- Specialists for the operation, treatment and supervision of patients.

These conditions are predominantly input based with no mention or scope for monitoring the actual quality of clinical care provided. But much of the focus of international health reforms in the late 1980s and 1990s has been to redirect attention away from input based public sector provision towards health systems that pay more attention to the quality of health care services and outcomes.

If an owner wants to register his/her clinic then application needs to be addressed to Director-General of Health with a registration fee of Tk.5,000. The ordinance does not specify any time period during which a licensing decision will be made.

Private health care sector is still governed by the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982. This twenty years old ordinance still exist as the latest regulation regarding private health care sector. Moreover, there is no new laws or regulations that are under development or debate at this time.

Directorate of Health Services of the Ministry of Health and Family Welfare is responsible for overseeing private health services.

## **8. Economics of Private Sector Health Services: Some relevant issues**

The basic motivation for promoting private sector development and public-private “partnerships” in health is the incentive that profit motive creates for efficient production of goods and services. Profit maximizing firms use inputs efficiently, innovate and use technology to reduce costs and improve quality and respond to consumer demands.

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<sup>9</sup> Ministry of Health and Family Welfare, Government of Bangladesh (1998). *Health and Population Sector Programme (1998-2003), Part I.* p.56.

Studies shows that there is generally a low price elasticity for health services for households with higher incomes levels (see studies in footnote 12). International experience also suggests that expenditure on health care services increases faster than rate of economic growth.

The data on the growth in private clinics suggests a steady long term growth from 1977/78 to 1989/90 but then an accelerated growth pattern, above this trend, in the 1990s<sup>10</sup>. The possible explanations would be interesting in any future planning. While Bangladesh has experienced increased economic growth in the last ten years, this alone is unlikely to have stimulated the high attributed rate of increase in clinics. Relatively less stringent application of the 1982 Ordinance may be contributed to such change. But this is unlikely to explain the total change. The scope for higher profits than experienced elsewhere in the economy is likely to have played a role since 1990. However, there is another factor to be considered. The clinics that were established in the 1980s and are still in existence are by definition robust, with a longer track record of profit. It is possible that the increase in new clinics will be offset by unknown number of clinic closures. A clearer picture could be possible if the DGHS were able to keep a more up to date and comprehensive account of clinics.

Studies report increase in prices for private clinical services well above the rate of inflation. According to a study, this not only demonstrated the lack of regulation but also the existence of super-profits and non-competitive market behaviour associated with localised oligopolies.<sup>11</sup> However, due to lack of time series on prices it is difficult to support or refute this observation. Evidence of oligopolistic behaviour does come from discussions with clinic owners. They confirmed the tendency for competition with other clinics to take place through improvements in quality of care rather than reductions in prices for inpatient treatment. In addition, casual evidence of the cost of out-patient visits to general practitioners, which is in theory regulated, supports the suggestion of price increases well beyond the rate of inflation. Consultation fees of Tk.500 and Tk.1,000 have been quoted in the press, which far exceed the Tk.40 set out in the 1982 Ordinance.

Information containing in the HEU study suggests that most clinic owners do operate as cost minimisers and profit maximisers. It also suggests that smaller clinics are the optimal size to establish given market demand and management capacity.

For private clinics, the average return on capital, expressed as a function of total variable cost, is 37. 8% (profit can not be ascertained due to lack of information on fixed cost). Rates of return to capital vary considerably as summarized below:

The return on capital is highest for:	The return on capital is lowest for:
<ul style="list-style-type: none"> <li>• Registered clinics 42%</li> <li>• Polyclinics – 39%</li> <li>• Doctor owned – 38%</li> <li>• Clinics classified under quality group B. 40%</li> <li>• Clinics in Dhaka, Dinajpur and Pabna – 50%</li> </ul>	<ul style="list-style-type: none"> <li>• Non-registered clinics 26%</li> <li>• Maternity clinics – 21%</li> <li>• Non - Doctor owned – 36%</li> <li>• Clinics classified under quality group D. 25%</li> <li>• Clinics in Chittagong 18%, Noakhali 22% and Sylhet – 25%</li> </ul>

Source: MOHFW (1999). Health Economics Unit, "Private Sector Medical Clinics and Hospital Survey".

Note: The above rates of return are indicative of existence of super profits from an imperfect market.

<sup>10</sup> The Health Economics Unit, MOHFW (1999). *Private Sector Medical Clinics and Hospital Survey*.

<sup>11</sup> Khan, MM. (1996). *Development of Private Health Care Facilities in Dhaka City: Impacts on Costs Access and Quality*.

The government survey of private medical clinics provides mixed evidence on the market behaviour of providers. Localised competition exists in some towns and districts with higher income levels or population densities or better accessibility. This competition does contribute to lead clinics to operate at a level where average costs are lowest. The qualitative evidence suggests competition is manifested in product differentiation through improvements in quality rather than price reductions. Indirect estimates suggest a return to capital that is comparable with and marginally higher than that attained in other sectors. This may explain the recent increase in the entry of new clinics, although further information on the number of clinics closing is required to confirm the growth level.

Based on the analysis of the available studies<sup>12</sup> for private sector medical clinics and hospitals, the following having high policy utility can be concluded:

1. *Distortion in National Policy.* The private health care sector suffers from policy distortions that discourage firms to grow in size. Policy distortions also focus attention on inputs and not the quality of care per se. This has detrimental implications on improving the financing of the health care in the private sector and the size of operation and as a result the national coverage. Moreover, the existing policy encourage rent seeking behaviour in the public sector.<sup>13</sup>
2. *Location and Ownership of Private Sector Health Facilities.* Private medical clinics appear where there are significant masses of medical college professors to own and operate them, indicating that it is an important issue that determines their coverage.
3. *Public-Private Partnership.* When the proportion of beds provided by private medical clinics exceeds a threshold percentage of GOB Beds in a geographical area, then “public-private partnerships”, become feasible with potential for technical and allocational efficiency gains.
4. *Higher Autonomy Matters.* Private clinics show lower lengths of stay and higher occupancy rates than public clinics of comparable size indicating a greater degree of resource efficiency than comparable public clinics. This suggests that there is a scope for efficiency gain by providing autonomy or contracting out the facility with appropriate cost recovery schemes and service mix.
5. *Private Clinic profitability and Market Structure.* There is some potential for efficiency gains from private public partnerships in some locations in Bangladesh where competition is stronger. Although private clinics exhibit some aspects of competitive behaviour, careful pilot testing of public private partnerships is required to ensure that consumers capture efficiency gains. Again, private operators seem to operate more efficiently at smaller clinic sizes, which calls for taking into consideration the issue of scales while anticipating efficiency gains.

<sup>12</sup> MOHFW (1999). Health Economics Unit, “Private Sector Medical Clinics and Hospital Survey”; Kawnine N., Thomas N., Killingsworth J & Vincent K (1997). “An assessment of the flow of funds in N the Health and Population Sector in Bangladesh”, Research Paper No. 5 Health Economics Unit (Dhaka: MOHFW, January 1997); Mahmud M Khan (1996), “Development of Private Health Care Facilities in Dhaka City: Impacts on Costs Access and Quality”; Mahmud M Khan (1998), “The Regulatory Environment faced by the Private Health Care Sector of Bangladesh: First Draft,” (ICDDR,B: Dhaka); Rahman Talukdar (1997), “Private Health Sector Facilities in Bangladesh”, Report by the Institute of Economic and Private Sector Development (Dhaka: IEPSPD, 15 October 1997). Several other IEPSPD reports were also reviewed but not used in this document.

<sup>13</sup> Barkat A (1998). “Governance of Public Health in Bangladesh”; in R. Sobhan (ed). *Crisis in Governance: A Review of Bangladesh's Development*, Centre for Policy Dialogue and UPL: Dhaka.

## 9. Health Financing Approaches in Private Sector

Health financing mechanisms include public financing, health insurance, user fees, donor financing, non-State collective non-profit-making financing and development loans. Allocation of financial resources is a major issue in a country with limited resources. The World Bank also calculates that total annual spending of eight dollars per person is more than enough to provide acceptable standards of clinical care<sup>14</sup>. As envisaged in the "Macroeconomics and Health-Investing in Health for Economic Development" -- Report of the Commission on the Macroeconomics and Health, December 2001, WHO, the level of the health-spending in the low-income countries is insufficient to address the health challenges they face. According to the recent estimate by the WHO Commission on Macroeconomics and Health (2001) the set of essential interventions costs, on average, about \$34 per person per year, which is much higher than the current level of public spending of around \$5 recorded for Bangladesh. The huge resource gap in financing the health needs of the poor cannot be met without additional resource mobilization from external resources<sup>15</sup>.

The sources of health financing in Bangladesh include government allocation, loan from World Bank and other financial institutions, International Development Agencies, financial assistance from NGOs, community participation in cost-sharing, health insurance system, health cooperative systems, private investment by business entrepreneurs, income-generating mechanisms, bank loan, joint ventures etc.

The largest proportion of funding for healthcare comes from household expenditure 63%, followed by 18% MOHFW Development Budget, 13% MOHFW Revenue Budget, 3% Non-Profit NGOs and Donors and 3% Other Public Revenues<sup>16</sup>. However, experts differ on this issue. Many experts in public fora have claimed that household health expenditure (out-of-pocket expenses) may be as high as 80% of total health expenditure; over 80% of the incidences of morbidity is treated by private health providers, etc.

In revenue and development budgets of 2002-2003, the allocations for health are 5.53 percent and 9.44 percent respectively, which were 5.42 percent and 9.02 percent respectively for 2001-2002. So, health budget has increased slightly but it is inadequate comparing to the needs. In the budget (both revenue and development) of 2002-2003, the total allocation for health sector is Tk.31368.60 million which is 7.27 percent of the total budgetary amount of Tk.431.72 billion.

In Bangladesh, private sector health financing includes household expenditures, private nursing home investments and drug funds from non-governmental organizations (NGOs). Most Bangladeshi usually obtain majority of their drugs from the private sector. Private nursing homes, doctors in private clinics and other health practitioners prescribe medicines to patients who must buy them at full price. Private expenditures for pharmaceuticals in developing countries typically account for 50 to 90% of all expenses on drugs. Even for the rural people and the urban poor, the most common source of drug is direct out-pocket purchase from the private market<sup>17</sup>.

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<sup>14</sup> World Health Organization, *Access to Drugs and Finance*, Geneva, 1991. p.1

<sup>15</sup> Economic Relations Division, Ministry of Finance, Government of the People's Republic of Bangladesh, 2002, *A National Strategy for Economic Growth and Poverty Reduction*. p.35.

<sup>16</sup> Ministry of Health and Family Welfare, Health and Population Sector Programme (HPSP), NICARE and The British Council, (2000), *Public Private Partnership – A DFID Supported Component of HPSP*

<sup>17</sup> World Health Organization (1998). *Health Reform and Drug Financing*, p.iii

It is estimated that there are thousands of traditional healers, such as faith healers, Ayurvedic and Unani practitioners, who are examples of private sector participation in rural health care even if the quality of such care remains unassessed. Moreover, growing numbers of private pharmacies in the country indicate increasing private sector involvement in health care.

In the informal sector there are large number of “unqualified” private practitioners who are dispensing drugs without any authority and training. Most poor patients go to these people and pay large amount of money even for minor illness. There are also qualified medical practitioners providing services to the people. Majority of middle class people go to them as first point of contact.

In order to make the existing hospital services more attractive and of better quality some services, especially in large hospital (e.g. medical college hospitals), is expected to contract out to private sector. The services will include maintenance, cleaning, laundry services, security services, hospital waste management, diet and food supply etc.

According to knowledgeable sources e.g. Private Clinic and Diagnostic Laboratory Owners' Association and Bangladesh Private Medical Practitioner's Association (BPMPA) currently no government-private as well as private-NGO partnership exist in the health sector.

In recent years GO-NGO collaboration has developed. In the field of health service delivery especially in Family Planning Government provide logistics support to a large number of NGOs. For ensuring access to urban health services of the city dwellers, especially the poor, the Government has developed partnership with several NGOs in the 4 city corporation areas under Urban Primary Health Care Project (UPHCP). EngenderHealth, an international NGO is currently working with District and Upazila level GOB health facilities for strengthening sterilization and other clinical FP methods. Concern, Bangladesh, an NGO workers with a few Municipalities and Upazila Health Complexes for capacity building of health workers.

In recent years some joint ventures of private sector and foreign investors are seen in the process of development. Already some hospitals are in operation which has established jointly with foreign partners, and foreign specialist doctors come to work in those hospitals.

Private financing is the predominant funding mechanism in Bangladesh's health system. Private sector funding consists almost completely of direct payment by households. The role of NGO financing is small (<3% of total), as NGOs receive most of their funds from foreign and local donors. Employer spending, private health insurance and other forms of third party financing are minimal (<1%)<sup>18</sup>. Though private investment in developing and operating private hospitals, clinics and diagnostic centres is not negligible, but nothing is mentioned about this sort of investment in the recent National Health Accounts reports.

American Life Insurance Company, Bangladesh (ALICO) and Delta Life Insurance Company provide limited medical coverage along their life insurance schemes. According to ALICO's hospital care accident and sickness hospital income supplementary contract a person is insured for medical expenditure for 52 weeks or up to Tk.547,500. But the coverage of health insurance is very low in Bangladesh.

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<sup>18</sup> The Health Economics Unit, Ministry of Health and Family Welfare and Data International Ltd., Bangladesh (1998). Bangladesh National Health Accounts 1996/1997.

According to National Health Accounts the largest single source of health care financing is direct payments by households, which accounts for 63% of the total. Government financing is only the second largest source of funds, contributing to 34% of the total. NGOs, private insurance and employers together account for less than 1% of total financing<sup>19</sup>.

Only two Insurance Companies offer accident and sickness benefits during hospitalization as a supplement their life insurance schemes, but they were not found to organize private clinics into networks (such as HMOs, i.e. health maintenance organizations).

Several approaches of private sector health financing are in practice:

- **Private household expenditure:** Households bear the major portion of the total health expenditure (63%) in Bangladesh. The extent of formal employment is limited; therefore, the health insurance system didn't developed much.
- **User charges:** Faced with limited resources for health and population services many development institutions in Bangladesh are considering implementing cost-recovery schemes. User fees are seen as a critical means to raise revenue from households, to help secure sustainability of the health programmes. This approach is already in practice by several NGOs and health department of government.
- **Health insurance system:** Commercial health insurance is extremely limited in Bangladesh. During 1997-98, there was only one company providing health insurance<sup>20</sup>. There are two other prominent approaches for rural risk sharing systems in Bangladesh e.g. *Gonosasthya Kendra* Health System in Savar and Grameen Bank Prepaid Health Plan<sup>21</sup>. *Gonosasthya Kendra* Health System, in Savar, cover 37,000 households. In this system the annual premium is Tk.3-10, medicines are free or reduced 25%-75%, and consultation fee is Tk.3-5 for the poor. Grameen Bank prepaid health plan system covers 38,000 households. The annual premium is Tk. 5,070 and consultation fee is Tk.2 for the poor.
- **Community-based insurance scheme:** Some NGOs are trying to establish community-based insurance scheme especially in their catchment area, but their efforts are yet insignificant and pilot in nature.
- **Private Firm Expenditure:** The largest known example of employer provided health services is in the tea garden, where employers have traditionally provided on-site medical services to their workers...The largest three tea companies spent Tk.80 million on health care provided to their employees<sup>22</sup>. Many entrepreneurs in the export-processing zone (EPZ) and few readymade garment manufacturers (RMG), realizing the potential linkages between workers good health and the productivity have introduced health services for their workers (78% female workers) in the factories. Although, still in the embryonic stage, these interventions have high potentials to grow in the future.

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<sup>19</sup> Ibid. p.2.

<sup>20</sup> Ibid. p.25

<sup>21</sup> Shepard, D.S. (1997), Rural Health Insurance and Essential Health Services, cited in Desmet M, Chowdhury AQ, Islam MK: The Potential for Social Mobilization in Bangladesh: the Organization and Functioning of two Health Insurance Schemes, paper presented in Health Insurance in Development Countries, Antwerp, Belgium, January, 1997.

<sup>22</sup> The Health Economics Unit, Ministry of Health and Family Welfare and Data International Ltd. Bangladesh (1998). *Bangladesh National Health Accounts 1996/1997*. p.25.

- **Private investment by business entrepreneurs:** A large number of entrepreneurs have already invested for establishing private hospitals, diagnostic clinics for profit.
- **Private health initiative in association with local government institutions:** Some of the municipalities offer health services utilizing their own resources. These efforts can be strengthened in association with local government institutions.
- **Private nursing home and pathological laboratory investment:** Hundreds of private nursing homes, hospitals and pathological laboratories have been operated in Bangladesh through private investment.

It should be mentioned here that inadequate data support made this section to be less descriptive.

## 10. Discussion and Conclusions

A Private Health Sector Assessment (PHSA) is designed to collect information on existing private markets for health goods and services, the strengths and weakness of these markets, especially the regulatory environment and the role of the public sector in fulfilling its stewardship function, and the general economic and policy environment for private sector development in the health sector.<sup>23</sup> But inadequacy of reliable data and very limited scope of collecting primary data on the private health care sector due to time and resource constraints restricted the opportunity for an all encompassing assessment of the private health sector in Bangladesh in this study. Observations of the research team give reasons to assume that the magnitude of the sector could be wider than the figures presented. A comprehensive assessment of private health care sector in Bangladesh is essential to draw firm conclusions as well as to form the basis for good costing models (phase 2 of the study).

Various actors e.g. people, government and private sector handle the core functions of the health system (financing, inputs, service delivery, and oversight), to produce outcomes in the areas of health status, financial protection, and consumer responsiveness. But in Bangladesh, almost all the important areas of the health system that have been seriously neglected e.g. people especially the poor, private sector actors, the functions of financing and oversight (e.g. regulation, policy development, facilitation, monitoring, information and disclosure).

One of the main problems with the private health sector is that it has grown in an undirected fashion, with virtually no effective guidance on the location and scope of practice, and without effective standards for quality of care or public disclosure on practices and pricing. Quality of health care in the private sector has become a major concern now a days.

In order to meet government's health sector goals, it is needed to harness the private sector. In addition, it is also required to create a conducive policy environment for supporting private sector development in health i.e. to help grow the private sector. Private health care sector is still governed by the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982. Though many parts of the ordinance have become obsolete but still it exist as the latest regulation regarding private health care sector. Moreover, there is no new laws or regulations that are under development or debate at this time.

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<sup>23</sup> Chakraborty, Sarbani (2001). *Conducting A Private Health Sector Assessment (PHSA)*. The World Bank.

Regulation is an essential element in harnessing private sector participation within all sectors of a modern economy. The unique character of health care as a social as well as a private good reinforces the importance of the regulatory role in the health sector<sup>24</sup>. Regulatory system can aim to protect people by countering market failures and distortions, bringing efficiencies to areas in which the market has been retarded, or correcting market the market's emphasis on a single dimension (such as cost). In the health sector, some regulatory roles can have an economic focus aiming to address provider monopolies, combat scarcity of certain necessary services (such as primary care) or curb wasteful service utilization. A more socially oriented set of regulatory roles can aim at: equitable and needs-based access to health care for the whole population; safety and well-being by ensuring the appropriate delivery of quality services; individual choice by ensuring choice of provider and insurer; and social cohesion by providing care through a national health care service or a social health insurance system.

In the informal sector there are large number of "unqualified" private practitioners who are dispensing drugs without any authority and training. Most poor patients go to these people and pay large amount of money even for minor illness. In the health seeking process a large portion of the population especially the poor receive medical services from the unqualified practitioners. Special attention is needed to assess the extent and quality of services provided by the unqualified medical practitioners.

There are some hospitals in operation and going to start their operation which have established jointly with foreign partners, and foreign specialist doctors come to work in those hospitals. Official data is unavailable to draw conclusion about the coverage of this services.

Many of our planning experts forget that the absence of nutritious food, safe drinking water, hygiene and education is the cause of most of our health problems today. Unfortunately, the health care of the rich is what gets the attention of the doctors, private hospitals and diagnostic laboratories. As a result, expensive, technology-based medical treatment gets prominence. Consequently, people have become the sacrificial lambs of today's market forces. The health of the poor has turned into illness, which has in turn been transformed into an industry and business. Since households (out of pocket) are responsible for 63 percent of the total health expenditure so those who harvest the profits from this is the private health care sector. It is frequently reported that medical profession as well as health care services are gradually losing its moral fibre. Profit maximizing attitude of the private health care sector makes the people unable to receive health service even in the desperate needs. In Bangladesh, 35.6 percent<sup>25</sup> population live below national poverty line and a large majority of the poor seek health from the private sector especially from the non-qualified service providers of private sector so private health care sector should also be pro-poor keeping in mind the endemic poverty situation in Bangladesh.

Based on the analysis of the existing knowledge-base about the private sector health services in Bangladesh, it would be appropriate to conclude the following:

1. Official data/information about private sector health professionals and facilities are incomplete, suffer from reliability, and are not adequate enough to draw firm conclusions.
2. Policy distortions discourage firms to grow.

<sup>24</sup> Saltman, R.B. and Busse, R. (2001 in press). Balancing Regulation and Entrepreneurialism in Europe's Health Sector: Theory and Practice. In Saltman R.B., Busse R. and Mossialos, E. (eds) *Regulating Entrepreneurial Behaviour in European Health Care System*. Buckingham: Open University Press.

<sup>25</sup> UNDP (2001). Human Development Report 2001.

3. Public-private partnership in health is feasible.
4. Private sector interventions could be profitable, if designed appropriately (for which all relevant data/information need to be collected and analysed before entering in to such endeavors).
5. Private sector (including NGOs) organizations specialized in health sector can be of high utility in entering into the venture of serving the health in the private industries and business sectors. This private-private partnership can be productive and efficient in financing people's health. Relevant operations research studies and piloting of innovative practices would be useful to guide the future.
6. A large-scale study on private sector health services in Bangladesh including provision for primary data collection including survey of qualitative dimensions is warranted to set the firm basis for the promotion of private entrepreneurship as well as public-private partnerships in HEALTH.

## References

- Ahsanullah, ABM. Director General of Health Services, (2002), Government of Bangladesh. *Is Our Medical Education Addressing Sectoral Objectives and Current Health Problems.*
- Bangladesh Bureau of Statistics. *BBS-Statistical Pocket Book*, Bangladesh, 2000
- Barkat, Abul and Murtaza Majid (2002). *Position Paper on Health, Population and Family Welfare Sector*, paper prepared for Planning Commission, Ministry of Planning of the Government of the People's Republic of Bangladesh.
- Barkat A (1998). "Governance of Public Health in Bangladesh", in R. Sobhan (ed). *Crisis in Governance: A Review of Bangladesh's Development*, Centre for Policy Dialogue and UPL: Dhaka.
- Chakraborty, Sarbani (2001). *Conducting A Private Health Sector Assessment (PHSA)*. The World Bank.
- Economic Relations Division, Ministry of Finance, Government of the People's Republic of Bangladesh. (2002). *A National Strategy for Economic Growth and Poverty Reduction.*
- The Health Economics Unit, Ministry of Health and Family Welfare and Data International Ltd., Bangladesh (1998). *Bangladesh National Health Accounts 1996/1997.*
- Health Economics Unit, Ministry of Health and Family Welfare(MOHFW) (1999). *Private Sector Medical Clinics and Hospital Survey.*
- Kawaine N., Thomas N., Killingsworth J and Vincent K. (1997). *An assessment of the flow of funds in the Health and Population Sector in Bangladesh*, Research Paper No. 5, Health Economics Unit (Dhaka: MOHFW, January 1997)
- Khan, MM (1996). *Development of Private Health Care Facilities in Dhaka City: Impacts on Costs Access and Quality.*
- Khan, MM (1998). *The Regulatory Environment faced by the Private Health Care Sector of Bangladesh: First Draft*, (ICDDR,B: Dhaka).
- Ministry of Health and Family Welfare, Government of Bangladesh (1998). *Health and Population Sector Programme (1998-2003), Part I.* Dhaka
- Ministry of Health and Family Welfare (1999). *Bangladesh Health Bulletin 1997.* Dhaka.
- Ministry of Health and Family Welfare, Health and Population Sector Programme (HPSP), NICARE and The British Council (2000). *Public Private Partnership – A DFID Supported Component of HPSP.*
- Planning Commission, Government of Bangladesh (1998). *Fifth Five Year Plan 1997-2002.* Dhaka.

Rahman Talukdar (1997). *Private Health Sector Facilities in Bangladesh*, Report by the Institute of Economic and Private Sector Development (Dhaka: IEPSD, 15 October 1997).

Saltman, R.B. and Busse, R. (2001 in press). Balancing Regulation and Entrepreneurialism in Europe's Health Sector: Theory and Practice. In Saltman R.B., Busse R. and Mossialos, E. (eds) *Regulating Entrepreneurial Behaviour in European Health Care System*. Buckingham: Open University Press.

Shepard, D.S. 1997. Rural Health Insurance and Essential Health Services, cited in Desmet M, AQ Chowdhury, MK Islam: *The Potential for Social Mobilization in Bangladesh: the Organization and Functioning of two Health Insurance Schemes*, paper presented in Health Insurance in Development Countries, Antwerp, Belgium, January, 1997.

UNDP (2001). *Human Development Report 2001*.

World Health Organization (1991). *Access to Drugs and Finance*. Geneva.

World Health Organization (1998). *Health Reform and Drug Financing*.

## ANNEX – 1

### Proposed Scope of Work (Supplied by EngenderHealth)

#### Phase 1:

- 1) **Profile of private sector health services in Bangladesh.** Develop a detailed profile of private sector health services provided in Bangladesh. This should be done from a literature search of available published sources, studies and research reports, and through contacts with all major donors (DFID, GTZ, USAID, EU, World Bank, etc.), selected NGOs/cooperating agencies (e.g., Futures, CRS) working in Bangladesh, and the Government of Bangladesh. We would like a summary, analysis and documentation of the following types of information:
  - a) Consumer behavior: What is the extent of utilization of private sector health services in Bangladesh? What health services do clients seek from the private sector? Are there studies of clients health-seeking and behavior and what do they tell us about their preferences for what kind of health provider (e.g., doctor, paramedic, pharmacist, quack, etc.) and the sector they seek services from, and why?
  - b) Type, number and location: Describe the extent of private sector health facilities (e.g., private practitioners, maternity centers, hospitals, etc.) in Bangladesh? What are the numbers of clinics, services offered, location and distribution?
  - c) Networks: Identify and describe any organized or informal networks of private health practitioners and /or health facilities? (e.g., under an umbrella organization, or as part of a single company? Is there any donor involved in organizing or supporting these networks, of are such networks totally privately financed? How do the networks promote themselves and get clients? How do they finance themselves?
  - d) Regulations: What government units oversee and regulate the private health sector? What government rules, standards and regulations govern private sector health services? Are there any professional organizations (e.g., medical associations) that oversee and regulate private sector health services? If so, provide a profile of what they do.
  - e) Quality: What is the quality of health services provided in the private sector? What training do they need? What are the greatest challenges or obstacles to ensuring quality services in the private sector.
  - f) Donors: Briefly describe any health projects that donors are supporting in the private, for profit sector.
  
- 2) **Health financing approaches in the private sector.** Research and describe the various schemes that are been used or tested in Bangladesh to finance health care provided by NGO and private sector service providers (e.g., health cards, insurance, subsidized fee-for-service, other schemes?).

- a) Describe the schemes. How do these schemes work?
- b) What institutions (e.g., NGOs, private companies) have tested and used them?
- c) What health services do they cover?
- d) What are the costs and how were these arrived at?
- e) Who pays for what (clients? companies? donors? etc.) and how much do they pay?
- f) Do the schemes work?
- g) What are the advantages and disadvantages from the points of clients , providers, the founders/insurers?
- h) In addition to special financing schemes, please describe what the typical fees (or range of fees) are that clients pay for ESP services when they do to a private physician or private clinic.

## **Phase 2:**

**3) Costing the model:** We have developed a draft concept paper describing an approach or model for creating and marketing networks of private sector health facilities to provide services at a low fee for service basis to covered populations. We anticipate that corporations and donors may want to sponsor or fund the creation of the networks, or help finance provision of health services to the covered populations. This model needs yet to be developed in greater detail based in part on the results of research in Phase 1, and EngenderHealth's own programming expertise in Bangladesh. Once the model is developed on greater detail we will need to cost it, including the following activities and elements:

- a) Assessment of health-seeking behavior for the target populations
- b) Assessment and identification of eligible sites.
- c) Development of services guidelines, clinical protocols and training curricula to be used in the networks
- d) Delivery of the range of training and continuing education that will be needed to initiate and develop the networks to phase it and provide the full range of quality ESP services.
- e) Provision of on-site TA to initially activate and then continuously improve services at the enrolled sites.
- f) Monitoring to ensure quality and re-certify enrolled sites
- g) The costs of the subsidization or financing scheme for corporations or donors to underwrite the costs of services.
- h) Development of the structure of the standardized that clients or insurers will be asked to pay for various types of ESP services.
- i) The costs for marketing the services.

**ANNEX-2**

**Extraordinary  
Published by Authority**

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**Thursday, May 27, 1982**

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GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH  
MINISTRY OF LAW AND LAND REFORMS  
Law and Parliamentary Affairs Division

**NOTIFICATION**

Dacca, the 27<sup>th</sup> may, 1982.

No.324.Pub.- The following Ordinance made by the Chief Martial Law Administrator of the People's Republic of Bangladesh, on the 26<sup>th</sup> May, 1982, is hereby published for general information:-

**THE MEDICAL PRACTICE AND PRIVATE CLINICS  
AND LABORATORIES (REGULATION) ORDINANCE, 1982**

Ordinance No. IV of 1982  
AN  
ORDINANCE

*to regulate medical practice and functioning of private clinics and laboratories.*

WHEREAS it is expedient to regulate medical practice and functioning of private clinics and laboratories;

Now, THEREFORE, in pursuance of the Proclamation of the 24<sup>th</sup> March 1982, and in exercise of all powers enabling him in that behalf, the chief Martial Law administrator is pleased to make and promulgate the following Ordinance :-

1. Short title,-- This Ordinance may be called the Medical Practice and private clinic and laboratory (Regulation) Ordinance, 1982.
2. Definitions – In this Ordinance unless there is anything repugnant in the subject or context,--
  - (a) "Director General" means the Director General of health service; Government of the People's Republic of Bangladesh;
  - (b) "Medical practice " includes medical consultation, surgical operation conduction of labour, pathological or radiological examination and any other medical examination or service;

THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

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- (c) "Prescribed" means Prescribed by rules made under this ordinance;
  - (d) "Private Clinic" means a Clinic, Hospital or Nursing Home, by what ever name called, owned by any person, other than the Government, where patients are admitted and kept for treatment;
  - (e) "Private Laboratory" means a Laboratory or Clinic, by what ever name called, owned by any person, other than the Government, where tests, investigations or examination, including X-ray and electrocardiogram, are held for Diagnosis or Clinical Purpose;
  - (f) "Recognized additional Medical Qualification" means any Medical Qualification included in the Third Schedule to the Medical and Dental Council Act. 1980(XVI of 1980);
  - (g) "Registered Medical practitioner" means a person register or provisionally registered as such under the Medical and Dental clinic Act. 1980 (XVI of 1980);
  - (h) " Schedule" means a schedule to this ordinance;
3. Charges and fees for Medical consultation, etc. the maximum charges and fees that may be demanded by a registered medical practitioner or in a private clinic or private laboratory for Medical consultation, surgical operations, conduction of labour, electrocardiogram, pathological or radiological examinations and other medical examinations or services, as the case may be, shall be such as are specified in schedule A :
- Provided that these charges and fees shall not apply in the case of patients who are not Bangladeshis.
4. Prohibition of private medical practice during office hour. No registered medical practitioner in the service of the Republic shall carry on private medical practice during office hour.
5. Maintenance of Chambers. Every registered medical practitioner carrying on private medical practice shall maintain a chamber in a hygienically sound condition with necessary facilities for the examination of patients and a room for the waiting of patients and their attendances.
6. Maintenance of registers, etc. (1) Every registered medical practitioner carrying on private medical practice and every private clinic and private laboratory shall maintain a register showing the names and addresses of the patients.
- (2) Every registered medical practitioner carrying on private medical practice and every private laboratory shall issue receipts in printed form for the charge and fees realized from the patients and preserve the counterfoils of such receipts for inspection.
7. Display of charges and fees.--- Every registered medical practitioner carrying on private medical practice and every private clinic and private laboratory shall prominently display in the chamber, clinic or laboratory, as the case may be, a list of charge and fees that may be demanded this Ordinance.
8. License to establish private clinic--- No person shall establish a private clinic without a license under this Ordinance.
9. Conditions for license --- No license for establishing a private clinic shall be issue unless the following conditions are fulfilled namely.
- (a) There is proper accommodation with hygienic environment for patients.
  - (b) There is at least eighty square feet of floor space for each patient.
  - (c) There is an air-conditioned operation theater.

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THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

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- (d) There are such essential equipments as are specified in schedule B;
  - (e) There are adequate supply of life saving and essential medicines.
  - (f) There are such number of full time registered medical practitioner nurses and other staff as are specified in schedule C;
  - (g) There are specialists for the operation, treatment and supervision of patients
10. Application for license----- (1) Any person intending to establish a private clinic shall supply in the prescribed form to the director general for a license.
- (2) The owner of a private clinic already in existence shall on or before the 30<sup>th</sup> June 1982 apply in the prescribed form to the director general for a license.
  - (3) The director general may, on receipt of an application under such sub section (1) or
  - (4) (2), make such enquiries as he considers necessary, and shall grant the application, if he is satisfied that the conditions for running a clinic as mentioned in section 9 have been fulfilled, or, by order, reject it, if he is not so satisfied.
  - (4) If the director general grant the applications, he shall issue in the prescribed form, a license to applicant.
  - (5) A private clinic already in existence shall close down after the 33<sup>rd</sup> June, unless an application for a license has been made under sub-section -2.
  - (6) Where an application for a license made under sub-section (2) is rejected the clinic shall close down after the expiry of thirty days from the date of receipt of the order of such rejection and if an appeal against such order is preferred under section 12, and such appeal is rejected, the clinic shall close down on the date of receipt of the order of such rejection.
11. Inspection, etc. -1) The Director General or any officer authorized by him in this behalf may inspect any chamber of a registered medical practitioner or private clinic or private laboratory to see if the provisions of this Ordinance are being followed. 2) If on such inspection it is found that the registered medical practitioner or the owner of the clinic or laboratory has contravened or failed to comply with any provision of this Ordinance, The Director General may --
- a) in the case of a registered medical practitioner, recommend to the Government to debar him from carrying on private medical practice;
  - b) in the case of a clinic, by order, cancel the license in respect thereof;
- Provided that no such license shall be cancelled unless the owner of the clinic has been given an opportunity of showing cause against such cancellation;
- c) in the case of a laboratory, recommended to the Government to close down the laboratory.
- (3) If, upon consideration of a recommendation made under sub-section (2), the Government decide to take the action recommended, it may, by order:-
- (a) in the case of registered medical practitioner, debar him from carrying on private medical practice for such period as it may specify;
  - (b) in the case of a laboratory, close it down:
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THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

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Provided that no such action shall be taken unless the registered medical practitioner or as the case may be, the owner of the laboratory has been given an opportunity of showing cause against such action.

12. Appeal and review.-
  - 1) Any person aggrieved by an order of the Director General may within thirty days from the date of receipt of the order, prefer an appeal to the Government.
  - 2) Any person aggrieved by an order of the Government may within thirty days from the date of receipt of the order, make a petition to the Government for review of the order.
  - 3) The decision of the Government on an appeal or a petition for review shall be final and shall not be called in question in or by any Court.
13. Penalty.-
  - (1) If any registered medical practitioner or any owner of a private laboratory contravenes any provision of this Ordinance, he shall be punishable with fine which may extend to five thousand taka, and the Court, while convicting such owner may order forfeiture to be Government of all or any of the movable property in the laboratory.
  - (2) If any owner of a private clinic contravenes any provision of this Ordinance, he shall be punishable with imprisonment for a term, which may extend to six months, or with fine which may extend to five thousand taka, or with both, and the Court, while convicting such owner, may order forfeiture to the Government of all or any of the movable property in the clinic.
14. Cognizance.—No Court shall take cognizance of an offence under this ordinance except on a complaint in writing made by the Director General or an officer authorized by him in this behalf.
15. Power to amend Schedules—The Government may, by notification in the official Gazette, amend the Schedules from time to time.
16. Power to make rules.—The Government may by notification in the official Gazette, make rules for carrying out the purposes of this Ordinance.

THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

SCHEDULE – A

(See Section 3)

I. MAXIMUM FEES FOR MEDICAL CONSULTATION

		First consultation	Second or subsequence consultation for same illness.	Consultation at Patient's residence.
		Taka	Taka	Taka
1.	Registered medical practitioners in the service of the Republic.	40.00	20.00	80.00
	(i) Professors, Associate Professors of holders of equivalent rank.			
	(ii) Associate Professors Civil Surgeons, or holders of equivalent rank, or holders of recognized additional medical qualification.	30.00	15.00	60.00
	(iii) Others	20.00	10.00	40.00
2.	Registered medical practitioners not in the service of the Republic.	40.00	20.00	80.00
	(i) Holders of recognized additional medical qualification.			
	(i) Others	20.00	10.00	40.00

II. MAXIMUM CHARGES FOR SURGICAL OPERATIONS

		Taka
1.	Major operations, such as, Cholecystectomy, partial gastrectomy, caesarian section, etc.	600.00
	Operation room charge	
	Anesthesia charge 1 <sup>st</sup> hour with cons of drug and gas.	800.00
2.	Intermediate operation, such as, appendisectomy, Suprepublic eystotomy, etc.	2000.00
	Operating Charge	
	Operation room charge	300.00
	Anesthesia charge 1 <sup>st</sup> hour with cons of drug and gas.	400.00
3.	Minor operations, such as, hydrocele, fistulectomy, hernia, D&G, biopa, closed reduction of fractures, etc.	1000.00
	Operating Charge	
	Operation room charge	200.00
	Anesthesia charge 1 <sup>st</sup> hour with cost of drug and gas.	250.00
	Operating Charge	400.00

**III. MAXIMUM CHARGES FOR DELIVERIES**

	Taka
1. Normal delivery      Delivery charge including labor room charge	400.00

**IV. MAXIMUM FEES FOR ELECTROCARDIOGRAM AND RADIOLOGICAL EXAMINATIONS**

	Taka
1. Electrocardiogram Contrast investigation	60.00
2. Barium meal of stomach and duodenum with fluoroscopic examination.	180.00
3. Barium meal follow through	250.00
4. Barium swallow (esophagus)	170.00
5. Barium enema (large bellow)	250.00
6. Intravenous cholecystogram	250.00
7. Oral cholecystogram	170.00
8. Retrograde pyelogram	250.00
9. Intravenous pyelogram	250.00
10. Bronochogram	250.00
11. Encephalogram	250.00
12. Puripheral artoriograms on film	300.00
13. Cystogram	170.00
14. Sinogram	150.00
15. Mycologram	300.00
16. Voinogram	190.00
17. For each film of size 15" x 12" or 14" x 14"	50.00
18. For each fild of size 10" x 12"	40.00
19. For each film of size 10" x 8"	40.00
20. Dental	10.00

**V. MAXIMUM FEES FOR LABORATORY INVESTIGATIONS**

	Taka
1. Hemoglobin	8.00
2. Total count (RBC & WRC)	10.00
3. Differential count (D C)	8.00
4. E.S.R.	8.00
5. Platelet count	10.00
6. Reticulocyto count	10.00
7. Circulating cosinophil count	10.00
8. R.B.C. morphology	10.00
9. P.C.V.	10.00
10. M.C.V.	15.00
11. M.C.H.C.	15.00
12. Blood for Malaria parasite	8.00
13. Blood for microfilaria	10.00
14. Oametic fragility	20.00
15. Coagulation	8.00
16. Bleeding time	5.00
17. L. D. body	25.00
18. Marrow for iron pigment	10.00
19. Stool, routine examination	10.00
20. Occult blood	10.00
21. Urine, routine examination	10.00
22. Urine, single test	5.00

## THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

	Taka
23. Diacetic acid	5.00
24. Urobilinogen	10.00
25. Total protein in urine	10.00
26. Trypsin	10.00
27. Pregnancy test, qualitative, with kit	80.00
28. Pregnancy test, qualitative for each dilution, with kit	175.00
29. Histopathology (Biopsy)	80.00
30. Other cytology	40.00
31. Pap smear	40.00
32. Culture, routine	40.00
33. Sensitivity	40.00
34. A.F.B. Culture	40.00
35. A.F.B. (on tech)	80.00
36. Smear and stain, any	15.00
37. Throat swab for KLB	20.00
38. Fungus	20.00
39. Fungus culture	50.00
40. Skin scraping for AFB	25.00
41. Stool and blood culture	40.00
42. Gonococcal culture, in ordinary media	60.00
43. Gonococcal culture, in special media (NCV media)	100.00
44. V.D.R.L. (Qualitative)	25.00
45. V.D.R.L. (Quantitative)	75.00
46. STS (WFKT VDRL etc.)	100.00
47. Fluorescent trapanosomal antibody test	200.00
48. Dark field microscopy	30.00
49. Widal test	50.00
50. Test with febrile antigen set (widal, Brucella, Rickettsia)	100.00
51. Mone test	40.00
52. Poul Burnel	40.00
53. Rose wasler test	50.00
54. Aldehyde test	10.00
55. Chopra's test	10.00
56. R.A. test (Latex agg. Test for rheumatoid arthritis)	60.00
57. L.E. call	30.00
58. L.E. Phenomenon	60.00
59. A.S.O.	60.00
60. Alpha feto-protine	200.00
61. Preparation of sutovacine	50.00
62. Wasserman reaction	20.00
63. Kalm test	30.00
64. Complement fixation test for anything	50.00
65. Blood sugar	20.00
66. Glucose tolerance test	75.00
67. Blood Urea	25.00
68. Blood creatinine	30.00
69. Serum cholesterol	40.00
70. Serum uric acid	30.00
71. Serum Alkaline	40.00
72. Serum Acid phosphatase	40.00
73. Serum thymol turbidity	25.00
74. Serum Zinc sublpate turbidity	25.00
75. Serum G.O.T.	40.00

THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

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	Taka
76. Serum GPT	40.00
77. Serum LDH	40.00
78. Serum Total Protein A/G ratio	60.00
79. Serum calcium	40.00
80. Serum sodium	30.00
81. Serum potassium	30.00
82. Serum Chloride	30.00
83. Serum iron	60.00
84. Serum iron-binding capacity	60.00
85. Serum amylase	50.00
86. Serum inorganic phosphate	30.00
87. Allapton bodies	20.00
88. Chyle	20.00
89. C.S.F.—(a) Sugar, (b) Protein, (c) chloride	20.00
	(for each item)
90. Van den berg reaction	10.00
91. Taka tara test	30.00
92. Pleural fluid	20.00
93. Urinary calcium	60.00
94. 17-keto steroid	125.00
95. Gastric analysis	50.00
96. Semen analysis	40.00
97. Prostatic smear (including collection)	40.00
98. V.M.A.	200.00
99. Plasma electrophoresis	100.00
100. Plasma chrome tography	100.00
101. Prothrombin time	40.00
102. Blood group and type	30.00
103. Cross match	30.00
104. Coombs direct and indirect	40.00
105. Antibody titer	80.00

SCHEDULE B  
{(See Section 9 (d))}

ESSENTIAL EQUIPMENTS TO BE KEPT IN PRIVATE CLINICS

1. Cot.
2. Bedside locker/table.
3. Operation table, hydraulic or trendelenburg facilities (where applicable)
4. Ceiling Lamp, shadow less ( where applicable).
5. Emergency light, battery – operated.
6. Saline stand.
7. General instrument sets.
8. Catheters, Ryles' tubes, Stomach tubes, Flatus tubes.
9. Patient trolley.
10. Stretcher.

THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

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11. Bed pan
12. Urinal.
13. Douche can.
14. Oxygen cylinder with flow meter and mask.
15. Endotracheal incubation set with laryngoscope, etc.
16. Ambu bag.
17. Transfusion set.
18. Electric sucker.
19. Autoclave (to be procured, if not available within the country, within months of issuance of License)
20. Sterilizer.
21. Anesthetic machine.
22. Surgical drums.
23. Scissors, knives and forceps of all types.
24. Ophthalmoscope.
25. Proctoscopy.
26. Auroscope.
27. Refrigerator.
28. Labour table (For obstetrics and Gynae only.)
29. Entonox machine (For obstetrics and Gynae only.) (to be procured, if not available within the country, within six months of issuance of licence).
30. Vacuum extractor (For obstetrics and Gynae only.)
31. Obstetric forceps. (For obstetrics and Gynae only.)
32. Cranioperforator. (For obstetrics and Gynae only.)
33. Cranioclads. (For obstetrics and Gynae only.)
34. Curettes (For obstetrics and Gynae only.)
35. Rabin's insufflators sets (For obstetrics and Gynae only).
36. Cervical pouch biopsy forceps (For obstetrics and Gynae only).

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THE BANGLADESH GAZETTE, EXTRA, MAY 27, 1982

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SCHEDULE C

{ ( See section 9 (i) }

FULL TIME STAFF

- |  |                    |                 |
|--|--------------------|-----------------|
| 1. One Registered Medical Practitioner | For every ten beds | Round the clock |
| 2. Two nurses                          | For every ten beds | Round the clock |
| 3. One Sweeper                         | For every ten beds | Round the clock |

Dacca  
The 26<sup>th</sup> May 1982

H M ERSHAD, ndc, psc  
Lieutenant General  
Chief Martial Law Administrator  
And  
Commander-in-Chief.

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MANIRUZZAMAN  
Deputy Secretary