

Private Healthcare: Governance Challenges and Way Out

Executive Summary

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Research Advisors

Dr. Iftekharuzzaman

Executive Director, Transparency International Bangladesh (TIB)

Professor Dr. Sumaiya Khair

Adviser, Executive Management, TIB

Mohammad Rafiqul Hassan

Director, Research and Policy, TIB

Supervision

Shahzada M Akram, *Senior Programme Manager, Research and Policy, TIB*

Researchers

Taslima Akter, *Programme Manager, Research and Policy*

Muhammad Julkarnayeen, *Deputy Programme Manager, Research and Policy*

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Contact:

Transparency International Bangladesh (TIB)

MIDAS Center (Level 4 & 5)

House # 5, Road # 16 (New), 27 (Old)

Dhanmondi, Dhaka-1209, Bangladesh

Tel: +880 2 9124788, 9124789, 9124792

Fax: +880 2 9124915

E-mail: info@ti-bangladesh.org

Website: www.ti-bangladesh.org

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1. Introduction

1.1 Background and Rationale

According to the National Household Survey (2015) of TIB, a large proportion of households (63.3%) receive healthcare services from private institutions alongside the public ones. According to the Health Bulletin 2015 of the Directorate General of Health Services (DGHS), a substantial number of Bangladeshi physicians (60.3%) is associated with private healthcare activities. Over the last four decades, the number of registered private healthcare service providing institutions has had an astounding growth – from mere 33 in 1982 it increased to 15,698 in 2017 (DGHS, 2017). This sector has been given importance in various government plans and policies. The Seventh Five Year Plan (FY 2016 - FY 2020) has emphasized on building a strong and effective regulatory mechanism, formulating government rules and regulations, ensuring delivery of information to the healthcare receivers on quality of healthcare service providers and developing robust and responsible professional organizations for the development of private health sector. It has been mentioned in the National Health Policy (2011) that the private institutions would be encouraged to play supplementary roles, necessary rules and regulations for the private institutions would be formulated and applied to maintain quality healthcare services, and steps would be taken to maintain the cost of tests and other expenditure within a tolerable limit.

However, allegations of various irregularities and corruption are being published in various mass media reports as well as research findings against the private institutions, which include, *inter alia*, higher treatment cost, wrong diagnosis of diseases, commission based services, running of healthcare services without registration, and overall deficiency in the expected service quality, etc. There is a dearth of comprehensive investigative research on the governance of this sector although various research and discussions questioned the quality of private healthcare. Health sector is one of the priority areas of TIB activities, and it has already carried out a number of researches on quality of government health service and its governance challenges both at the local and at the national levels. This research has been conducted as a continuation of such activities.

1.2 Objectives and scope of research

The main objective of this research is to identify the challenges of governance in the private healthcare programs and to recommend the ways to overcome such challenges. The specific objectives of this research are to:

1. Review the existing legal and institutional framework governing private healthcare institutions.
2. Identify the nature of irregularities and corruption existing in the private healthcare institutions; and
3. Identify the reasons behind the existing irregularities and corruption.

In this research, private healthcare services have been defined as the care provided by the privately registered hospitals, clinics and diagnostic centers. The scope of the research includes legal and institutional framework (relevant laws, rules and policies, regulatory and supervisory institutions and their efficiency etc.), institutional capacity (human resource, infrastructure, medical equipment, waste management, infection prevention mechanisms, cleanliness, marketing activities etc.), care services (services of doctors, nurses and other employees, diagnosis, emergency and specialized services, operation, maternity care, medicine, service charge, healthcare environment and disclosure of information etc.), and regulatory and monitoring activities (registration and renewal, ownership and partnership, management information systems, inspection, complaints, penalty etc.).

It should be noted that the result of this research is not equally applicable for all the private healthcare institutions, doctors, nurses, employees, and other relevant stakeholders who are involved in this sector. Since it is a qualitative study, generalization may not be possible but it gives an indication of the prevailing scenario that exists at the private healthcare sector of the country.

1.3 Methodology and Timeline

This is a qualitative research where data collection and analysis were made following qualitative research methodology. Primary data were collected from three sources : 1) from key informant interviews (total 706) from management/owners of private healthcare institutions, service providers, service recipients, regulatory and supervisory authorities and other stakeholders; 2) from focus group discussions (total participants 310 in 27 discussions where 14 male and 13 were female groups), and 3) from direct observations. Data were collected countrywide from 116 registered private healthcare institutions (66 hospitals and clinics, 50 diagnosis centers). Institutions were selected from every divisional city, eight district towns under each division, and eight upazilas under each selected districts (total 24). Considering the size of the population and number of the institutions, 26 were selected from Dhaka City and 90 from other areas of the country. Opinions of the healthcare service recipients at local levels were taken into consideration while selecting these institutions. Laws and rules related to private healthcare, government documents, research and news reports in mass media and information from websites were used as sources of secondary data. The research was carried out from January 2017 through December 2017.

2. Review of Relevant Laws and Policies

Various laws and policies are there to regulate and supervise the private medical institutions. These include The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance 1982, The Bangladesh Medical and Dental Council Act 2010, The Mobile Court Act 2009, The Consumers' Right Protection Act 2009, The Medical Waste (Management and Processing) Rules 2008, The Environment Conservation Rules 1997, The Nuclear Safety and Radiation Control Rules 1997, and The National Health Policy 2011.

However, some limitations are identified with regard to these laws and rules. The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance 1982, the premier law for governing the private healthcare institutions, has not been updated so far and no rules have been enacted based on this ordinance yet. The government has been working to finalize a private healthcare act. However, the draft Private Healthcare Act could not be finalized yet due to the lack of coordination among all the stakeholders, conflict of interest and political will though the government has been working on it for more than a decade. In effect, private healthcare institutions are now being regulated and supervised through executive orders issued time to time. The 1982 Ordinance however has the following limitations:

- **Registration, infrastructure and human resources:** Healthcare institutions are not defined on the basis of the type of care and thus the scope of the care is not determined. It has not been mentioned that from which authorities of DGHS clearance certificates would be required for taking registration of private healthcare institutions. The time of renewal of the registration has not been mentioned. Furthermore, the minimum standard (compulsory units, infrastructure, essential equipments, skills of the required physician, nurse and other staff per bed) for different types of institutions has not been mentioned. The minimum number of care providers in diagnosis centers, their education qualifications and skills are also not outlined. There is no specific guideline on ensuring healthy environment although it mentions to ensure (Clause 9) for the healthcare receivers.
- **Costs of care:** The costs of care mentioned in the ordinance is not realistic for the present context, although it was consistent with the time when the law was enacted. The Ordinance mentions the costs of different services of surgical operation (operation charge, medicine, normal delivery with anesthesia) and radiology and laboratory tests (Clause 3), though the costs are not updated. In addition, some of the costs (for example, bed, admission fee etc.) have not been mentioned in the ordinance. The doctors' consultation fee was mentioned in the ordinance, which was later repealed following an amendment in 1984 (Clause 5). The consultation fee and different care costs charged by the healthcare institutions were required to be shown in open places (Clause 7) of chambers, clinics and laboratories, which, however, was relaxed through the amendment of 1984 (Clause 4).

- **Information storage:** No directions have been given by regulatory bodies/ authorities and care/service providers for the information preservation (registration and renewal, inspection, human resources etc.). Concomitantly, no guideline was given to the doctors and healthcare institutions to preserve the information (nature of disease, suggested tests and medicine, number of births and deaths, maternity care etc.) of the service recipients/ care receivers.
- **Punishment:** Given the current realities, the extent of punishment in the existing law is inadequate. Moreover, it has not been mentioned that where the service recipients would complain against the irregularities of the healthcare institutions.

Often the incidents of alleged deaths of patients as a result of negligence and erroneous treatments by physicians are heard, but there is no provision for lodging complaints about such incidents. On the other hand, there is no specific law to protect the security of the care providers and institutions in case of heated altercations, mayhem and vandalism at hospitals between the relatives of the care receivers and doctors and staffs of the hospitals regarding care related matters (care receivers' death and others). With regard to private healthcare institutions or sector, there is no special programs in the different health related plans of the government.

3. Institutional Capacity of the Private Healthcare Institutions

3.1 Ownership and partnership

The owners and partners of the institutions selected under this study include government employees (police, doctors and nurses of government hospitals), doctors of private institutions, doctor's wife, politicians, journalists, medical representatives, expatriates, businessmen, corporate groups, retired government employees, village doctors, teachers, pharmacists, housewives etc. The number of partners and shareholders in these institutions ranges from two to 226. On one hand there is a tendency to include government officials, politicians and journalists as partners to influence the regulatory and monitoring activities, while on the other hand another tendency is to include doctors and nurses of government hospitals, village doctors, and medical representatives as owners or partners to ensure greater number of care receivers.

3.2 Registration and renewal

Most of the institutions start healthcare services without any registration, although according to law it is not permitted to operate private hospitals, clinics or diagnostic centers without license. Moreover, the concerned authority has no statistics of unregistered private healthcare institutions. Hospitals, clinics and diagnostic centers are required to take environmental clearance certificate in accordance with the Environment Conservation Rules 1997. But 97 out of the selected 116 institutions were found not to have taken the clearance certificates from the Department of Environment (DOE). Moreover, according to the Environment Conservation Rules 1997, it is prohibited to establish the enlisted industries (including hospitals, clinics and pathological labs) in residential areas, but 42 out of the 116 institutions are located in residential areas. In case of 22 institutions, there are hospital, residential and commercial institutions in one building.

At the district and divisional levels, private healthcare institutions take permission to provide services related to General Medicine, Surgery, Gynae. and Obs while applying for registration. However, later they start providing specialized services (ICU, CCU, NICU, Cardiac etc.). For instance, 20 out of selected 66 hospitals/ clinics are engaged in providing specialized care. Sometimes, extra beds are used without permission – 36 institutions included in the study have increased the number of their registered beds, and among them 23 have not taken any permission for that.

It is alleged that money is forcibly collected in the process of registration, which varies from a minimum of Tk 5,000 to Tk 300,000, depending on the location of the institution, and connections of owners/ partners at the higher level.

Although the law stipulates that it is mandatory for all institutions to renew their licenses every year, 14 out of the 116 institutions have not renewed their licenses timely. There are cases where renewal have been given in spite of the fact that they have not fulfilled the criteria for renewal. In most of the cases, the time of inspection is conveyed earlier to the institutions which allow them to keep the personnel and required documents ready for that specific period. In some cases, institutions are getting their renewal illegally in exchange of money without fulfilling any criteria for renewal, and in other cases, institutions are given renewal in exchange of money without any inspection. In this case the amount varies from Tk 500 to Tk 50,000.

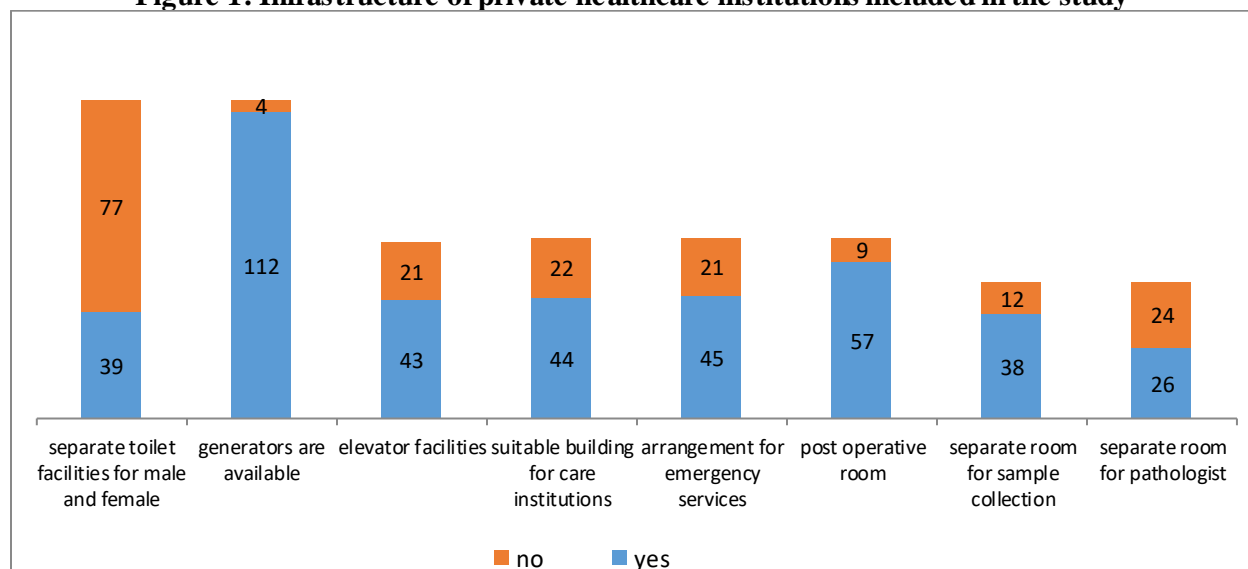
3.3 Physical infrastructure

Most of the clinics and diagnostic centers are set up in rented buildings, which may not be suitable for offering healthcare services. Sometimes the area of the floor allotted to service recipients is very small. For instance, a cabin is divided into two rooms by hardboard partition, and three to four beds are kept in a small room. After placing bed in one ICU, movement area in that room was reduced to a significant extent.

There is no arrangement for providing emergency services at the upazila level and at some district level institutions (21 out of the 66 hospitals/ clinics included in the study). Though there are arrangements for operations in the 66 institutions of the study, there is no post-operative room in nine institutions, and in some cases post-operative rooms are not used for patients. Twelve among the 50 diagnostic centers included in the study do not have any separate sample collection room, and no separate rooms for pathologists in the 24 institutions.

Elevators must be there in more than three-storied buildings. However, 21 among 64 institutions located in three-storied buildings included in this study do not have elevator facilities. Stairs and elevators in some institutions are risky for using stretcher/ trolley for the service recipients. There are no separate toilet facilities for males and females in 77 institutions. Generators are available in 112 institutions for emergency and round the clock power supply, whereas in four institutions generators were found out of service at the time of data collection. Air conditioning is required for proper preservation of pathological instruments and reagents. But in some institutions no air conditioning is there, and in some institutions they are not used all the time. Parking arrangements are inadequate in most of the institutions.

Figure 1: Infrastructure of private healthcare institutions included in the study



3.4 Human Resources

Full time doctors: The existing law requires three doctors round the clock for every 10 beds in the private hospitals/ clinics. However, the analysis suggests that in the hospitals/clinics included in the research the average number of doctors is 1.1 in upazila towns, 1.3 in district towns, 2.3 in divisional cities (except Dhaka), and 3.2 in Dhaka city. Among these institutions (66), 52 have no full time doctors. Most of the institutions at the district and upazila levels have no doctors of their own, and services are provided on-call basis.

Table 1: Human resource in the healthcare institutions included in the study

Area	No full-time physician	No full-time nurse	No full-time cleaner	Hospital/ clinic included in the study
Upazila town	13	14	7	14
District town	13	16	8	16
Divisional city	11	9	6	14
Dhaka city	15	14	8	22
Total	52	53	29	66

Full time nurses: The existing law requires six diploma nurses round the clock for every 10 beds in the private hospitals/clinics. However, in the hospitals/clinics included in the research, the average number of nurses is 1.1 in upazila towns, 1.5 in district towns, 6.2 in divisional cities (except Dhaka), and 6.4 in Dhaka city. Among these institutions (66), 53 have no full time nurses. Persons without diplomas but experienced are used to perform the duties of nurses in these institutions. On the whole, though the country requires 47,056 nurses, currently there is a deficit of 20,281 nurses. The country has shortage of nurses to provide specialized care (currently only 210 are trained to provide specialized care).

Medical technologists and others: Most of the technologists at the upazila and district levels are not certified. Diagnostic centers at different levels do not have their own pathologists, radiologists and sonologists – mostly their jobs are done by on-call services. There is also a shortage of anesthesiologists at the upazila and district levels.

Full time cleaners: Though it is required to keep three cleaners round the clock for every 10 beds, 29 institutions of out of the 66 included in the study have no full time cleaners.

3.5 Medical equipments

Mandatory medical equipments such as oxygen in the emergency division, sucker machine, nebulizer, sterilizer, and urgent medicines were not found in some of the upazila and district level institutions. Moreover, diathermy, anesthesia, functioning OT lights, spotlights etc. were not found in the operation theaters, and there was no cardiac monitor, ventilation support in the post-operative rooms.

Common refrigerators instead of laboratory refrigerators are used in most of the institutions to regulate temperature of medicines, and in such cases separate thermometers are used. Many institutions at the district and upazila levels do not use needle destroyer, and in cases they have, they do not destroy the needles immediately. In some cases, it has been alleged that they sell used needles and syringes outside.

3.6 Medical waste management

In most of the institutions the rules related to medical waste segregation and disposal are not properly followed. The rule to use specific colors of waste bins according to the types of medical waste is not followed in many institutions. It is found that 18 institutions are using minimum four-color waste bins (black, red, yellow, blue), whereas 30 institutions are using three-color waste bins (black, red and yellow). Some institutions keep different colored waste bins, but this rule is not followed for every unit, and in some institutions different types of medical waste are kept in one pot. The relevant city corporation/ municipality do not pay attention to dispose of medical waste properly. Furthermore, employees of the institutions lack adequate knowledge and training for managing and processing such waste.

Fumigation to sterilize the hospitals is not done in many institutions. Besides, autoclave machines of three institutions were found out of service during the period of data collection.

3.7 Healthy environment

Although the private healthcare institutions ensure healthy environment while applying for registrations, this environment is not maintained afterwards. Complete healthy environment was absent in 32 out of the total 116 institutions included in the study. Unclean floor of wards and cabins, damp floor of ICU room, unclean bed sheet, filth here and there, unpleasant smell, closed door cabins without any window, inadequate light and air, dust over the equipment of the diagnostic centers can be mentioned. Toilets of 41 institutions were found unclean.

4. Healthcare

4.1 Care provided by doctors

Healthcare receivers informed that in some cases they did not get full time support of the doctors according to their needs, especially at night in time of medical emergency. No doctors were found during post-operative complexities or follow ups at upazila or district levels, as the specialist doctors come for consultation from outside of the locality for one or two days.

4.2 Care provided by nurses/ maids/ ward boys

In some cases, care receivers did not get the services of nurses though they called them during emergency needs. Rather it is alleged that the nurses misbehaved or showed agitated expression. Sometimes in some institutions at the upazila level, maids are kept to perform the duties of nurses. Even they misbehave or become agitated when they are called in times of need.

4.3 Maternity care

There are complaints that sometimes caesarian sections (C section) are performed much before the expected date of delivery, and in some cases targets are given for C section by the owner of the clinic. The salary of the doctor is delayed in case of surgeries are fewer in number. It is alleged that doctors, on behalf of the owners, motivate the mother to go for C section to get maximum profit. According to one study, the rate of caesarian birth was 4% in 2004, which increased to 23% in 2014 (Bangladesh Demographic and Health Survey, 2014). However, the World Health Organization (WHO) suggests it should be 10-15 percent. The rate of the births through C section in private hospitals/ clinics is 80% (Stop Unnecessary C-Section, 2016).

4.4 Specialized care

As there is no specific guidelines by the regulatory body about the arrangements required for the specialized care, different institutions offer their services in different ways. There have been complaints that patients are kept in ICU even after their deaths or when it is not necessary. It is also alleged that some owners set specific profit targets for ICUs.

4.5 Diagnosis

Physicians are accused of prescribing unnecessary tests to the patients. There are allegations that institutions use low quality or expired reagents. There are also allegations that in some institutions specialists' signature are taken beforehand on blank pads. In some institutions technicians sign on behalf of the doctors, and in some other cases institutions give reports without doing any tests (bucket test). Mostly at the upazila level and in some cases at the district level, tests results are not found to be correct. In such cases, when patients do not get well after receiving healthcare for many days, they repeat the test in any city area or in two or three other institutions and find that the earlier report was incorrect.

4.6 Costs of care

Costs of care varies in different institutions depending on the area (upazila, district and division), and nature of institutional set up. There are huge variation in costs for diagnosis. The costs of such tests in public hospitals are also quite low than that of private diagnostic centers.

On the other hand, the consultation fee for doctors varies from Tk 200 to Tk 2,000, depending on the educational qualification and experience. For old patients different consultation fees are taken, and in some cases fees are taken for showing reports. For contractual C section the costs range from Tk 5,000 to Tk 200,000 depending on the type of bed.

Table 2: Differences of costs in healthcare institutions and comparison with public institutions

Name of Test	Cost in private healthcare institution (Tk)	Cost in public healthcare institution (Tk)
Lipid profile	700 - 1,650	300
Platelet count	70 - 500	50
Serum creatinine	210 - 580	50
Serum calcium	210 - 700	80
Ultra-sonogram (whole abdomen)	550 - 800 (normal) 800 - 2,200 (digital color)	210 (normal)

4.7 Medicine

Sometimes the patients are required to buy medicines from outside, while sometimes medicines are included in the package deal. In such cases, the care receivers or their attendants are not informed of the amount of medicine used for the treatment or all the medicine are not supplied as promised in the deal. There are allegations that sometimes the care receivers are forced to buy additional medicines, and the remaining ones are sold outside later.

5. Marketing of private healthcare

A commission-based marketing system has developed in the private healthcare sector. Persons who are associated with commission at different phases include government and private doctors, health assistants, family planning workers, village doctors, medicine sellers of drug houses, midwives, receptionists of private healthcare institutions, rickshaw pullers and professional brokers. The amount of commission varies from 25% to 50% of the cost of the service. Even commission is given for sending cases for C section, and the amount ranges from Tk 500 to Tk 5,000. It is alleged that sometimes service recipients are harassed by professional brokers, as they divert the patients to another institution either by giving wrong information or by force. Such incidents happen mostly to illiterate or unaware people who come from rural areas.

6. Information disclosure

Licenses are not hung in noticeable places in 85 of the 116 institutions included in the study, while information about consultation fee was shown only partially in 28 institutions. Moreover, though information is provided about second visits or time limit in some institutions, it is not given for all doctors. Most of the institutions do not give receipts to the service recipients. In most of the cases information about the full time duty doctors are not shown or preserved in the institutions, and in some cases information regarding on-duty consultants (on-call or permanent) are not also shown.

Only the costs of tests are made visible for the public in most of the institutions, while the costs of other services are not disclosed. In some cases, only rent for bed is shown. Information related to laboratory tests is not shown in 21 among the selected 50 diagnostic centers. Though in some institutions information is hung on using specific color of waste bins according to the types of medical-waste, most of the institutions do not follow this rule. Out of the selected institutions, 90 out of 116 do not show any guidelines on using specific color of waste bins according to the types of medical-waste.

The regulatory authorities do not have any arrangement for publishing updated information about private healthcare institutions. Moreover, adequate information is not available regarding registered doctors. BMDC's register does not have any system of recording about the nature of complaints and follow up information, and there is no system of preserving and publishing complaints on the website.

7. Supervision

7.1 Supervision of healthcare institutions

The supervisory activities of regulatory bodies are not adequate for maintaining quality in the private healthcare institutions. In most cases the regulatory bodies carry out inspection activities only during the licensing and renewal period, and no inspection is done at other times. As all the institutions do not renew their licenses every year, they remain beyond the purview of inspection. If any irregularities are found, no follow-up action is taken.

Though at times the mobile courts inspect the private healthcare institutions and impose fine and give punishment in case of any deviation of law, such activities are very limited. It is observed that 25 institutions included in the study were fined by mobile courts.

7.2 Supervision of doctors

Use of additional degrees and fake designations by doctors are noticed in most of the cases. The incidence of fake doctors punished by mobile courts is not adequate. There are allegations that doctors give time to private institutions while performing government duties, and sometimes their names are used by some private institutions where they do not provide services.

Table 3: Causes-Results-Impacts due to lack of governance in private healthcare system at a glance

Causes	Results	Impacts
<ul style="list-style-type: none"> ▪ Legal limitations (absence of law and rules and updated law) ▪ Poor application of laws/policies ▪ Lack of capacity of stakeholder (infrastructure, human resource, equipments) ▪ Lack of regulation and supervision ▪ Lack of transparency ▪ Lack of accountability ▪ Conflict of interests and political influence 	<ul style="list-style-type: none"> ▪ Irregularities in registration and renewal ▪ Commission-based care system ▪ Proper and quality healthcare not ensured ▪ Improper waste management and processing ▪ Absence of healthy environment ▪ Irregular supervision ▪ Expensive healthcare services 	<ul style="list-style-type: none"> ▪ Spread of ultra-profit-based commercialization in the name of healthcare ▪ Spread of fraudulent healthcare ▪ Increased risks of financial and physical damage up to death of the service recipients ▪ Lack of confidence among the people on healthcare system ▪ Increased tendency to go abroad for healthcare ▪ Risks of increased transmission of disease

8. Overall observations

The research findings suggest that the tendency of commercialization in private healthcare in Bangladesh is quite evident. This is characterized by too much profit-oriented and commission-based care, where quantity of institutions has taken over the issue of ensuring quality. The government is not paying much attention albeit the sector is very important. This is reflected through giving less emphasis on the sector in policy and planning, not updating the relevant laws, not developing the regulatory structure, poor monitoring and supervision, and poor coordination among stakeholders. As a result, the sector has become beyond control on one hand, while some individuals are extracting illegal opportunities on the other. Poor efficiency and the tendency of irregularities are evident, especially at the upazila and district levels. On the whole, the general care receivers have become hostages to the system and victims to enormous financial and physical loss, and access to quality healthcare is not ensured as well.

9. Recommendations

On the basis of the findings of the study, the following recommendations are proposed to strengthen the governance of the private healthcare:

Law and Policy

1. An independent commission should be formed to regulate the private healthcare institutions.
2. The revised law has to be finalized and adopted to regulate private healthcare sector, where the following points must be included:
 - There should be clear definition of nursing homes, clinics, general hospitals, specialized hospitals and diagnostic centers. Separate categories should be made according to the types of care provided by the institutions. Following this category, a minimum standard including infrastructure, personnel, equipment, waste management etc. should be determined for every institution;
 - Registration and renewal fees according to the types of the institutions;
 - All relevant clearance certificates for registration to be made mandatory;
 - Costs of care according to the type of institution/ production cost/ experience and qualification of doctor;
 - Mandatory disclosure of necessary information and publicizing;
 - The extent of punishment must be increased in a realistic way.
3. Private healthcare institutions should be brought under the purview of the Right to Information Act (in terms of providing information and disclosure).

For Regulatory bodies

4. Institutional capacity (both at central and field levels) should be developed to strengthen the regulatory and monitoring of private healthcare institutions.
5. Relevant officials should be assigned to inspect a specific number of institutions per month.
6. A third party should be employed to scrutinize and verify the registration and renewal process at the Directorate General of Health Services (DGHS).
7. Online licensing application and renewal processes should be introduced.
8. All updated information related to the healthcare institutions and their care services (registration number of the institutions, renewal period, full time personnel and their registration numbers, infrastructure facilities) should be preserved at the DGHS and these information should be open to all.
9. The committee established for proper medical-waste management and processing should be activated and city corporation/ municipality/ unions must be ensured to follow the right processes of medical-waste management.
10. In addition to the existing system of searching the website by the doctors' registration number or their types of education, the search option should include doctors' name and their details.
11. A formal system of lodging complaints should be introduced by the relevant authorities (DGHS, BMDC) for the healthcare receivers of the private institutions.
12. The supervisory role of BMDC should be expanded further all over the country to identify and prevent the unethical publicity and activities of physicians.
13. The DGHS should identify the unregistered healthcare institutions and take legal actions against them.
14. The relevant associations should play a pivotal role for maintaining quality assurance in the private healthcare institutions.

Care Services

15. In order to provide women-friendly care, separate and usable toilets for men and women, breastfeeding corner, presence of female care givers should be ensured in all institutions.
16. Specific dresses for all care givers or use of their ID cards should be ensured.
17. Registration numbers should be made compulsorily visible for the care givers in relevant places (for example, nurse's uniform/ ID card, doctor's prescription and visiting card).
