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An exploratory qualitative study to understand the underlying motivations and strategies of the private-for-profit healthcare sector in urban Bangladesh

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Abstract

Objectives: This paper explores the underlying motivations, strategies and incentives governing formal for-profit private healthcare sector in urban areas of Bangladesh.

Methods: This is an exploratory qualitative study that employs key informant interviews (20) with government and private sector leaders, in-depth interviews (30) with clinic owners and service providers, structured facility observations (30) and exit interviews (30) with patients in Dhaka, Sylhet and Khulna city corporations of Bangladesh.

Results: Although profit generation is a driving force behind the initiation of for-profit private healthcare business and the provision of services, non-financial motivations were also prevalent such as personal ambition, a desire to serve the disadvantaged, obligations to continue family business, the desire for greater social status, or adverse family events members.

Amongst the most common strategies employed by this sector include use of brokers, patient-friendly services such as discounts and service-packages along with building a relationship of trust and dependence, perilous and flawed referral mechanisms to ensure growing patient-flow and business. The use of consultant specialists and other medical staff from public health sector is another critical strategy evident confirming the widespread occurence of dual practice. Chronic shortage of full-time, trained medical staff was one of the reasons underlying this practice. Incentives from pharmaceutical companies are also seen influential on the services and medicines prescribed by private for-profit providers.

Conclusions: In the context of growing population need accompanying rapid urbanization, engagement of the substantial for-profit private sector is critical in efforts to achieve universal health coverage. Our study identifies potential entry points including regulatory mechanisms and governance to improve service quality rendered by this sector. Further research can elucidate what regulatory mechanisms work well on which strategies employed by the formal for-profit private health sector.

Strengths and limitations of this study

- This exploratory study is among the first in Bangladesh to query the underlying motivations and strategies of the urban private for-profit sector.
- The study employs qualitative methods to enable in-depth understanding of factors influencing healthcare practices as reported by private facility owners and providers.
- A methodological limitation of the study was the unwillingness of certain respondents to disclose strategies they employ to grow and flourish their private sector business.

Keywords

Private sector, for-profit private sector, motivations, business strategies, formal health sector, urban health systems, Bangladesh

Abbreviations used

Universal Health Coverage (UHC), Directorate General Health Services (DGHS), Antenatal Care (ANC), Non-Governmental Organization (NGO), Intensive Care Unit (ICU),

INTRODUCTION

The SGD3 goal of reaching Universal Health Coverage (UHC) by 2030 is challenging in pluralistic health care systems such as Bangladesh.[1] These challenges are amplified in the context of rapid urban growth, where the private-for-profit sector accounts for an increasing share of the health market.[2, 3] In Bangladesh, reaching the SDG target 3.7 - ensuring every person access to affordable quality healthcare services, including financial risk protection - is even more daunting given that 67% of national health expenditure is already out-of-pocket.[4] However, Bangladesh is also a country that routinely defies expectations, witnessed in its spectacular health achievements over the last four decades in terms of reductions in total fertility rate and rates of maternal, infant, and childhood mortality.[5] Although some of this success may be due to coverage of publicly financed free services,[6] and its role in reducing use-inequities,[7] the contribution of private health care sector remains poorly understood. This understanding is complicated by the widespread phenomenon of dual practice, whereby a large proportion of public sector providers are also involved in private practice to supplement income.[8, 9] Given its primary for-profit orientation, there is widespread scepticism about the potential contribution of the private sector towards UHC. In the absence of strong regulatory capacity on the part of the state, these concerns relate to inappropriate prescription, inequitable access due to escalating costs, and poor quality of care. As a result, the public sector continues to be the major focus of Government efforts towards UHC targets.[10]

But recent data suggest that neglect of this sector is short sighted. For example, the 2016 Bangladesh Maternal Mortality Survey (BMMS), shows that for obstetric complications, only 25.5% of women visited public sector facilities and the rest used some kind of private facility or informal provider as a first source of care.[11] The use of the private sector for delivery services is also increasing. According to BMMS data, only 2.6% of mothers delivered in private sector facilities in 2001, rising to 11.3% in 2010, and 29% in 2016, whereas the use of the public sector increased from 5.8% (2001) to 14% (2016) over the same period.[11] The contribution of the private sector to the explosive growth of C-section delivery is particularly concerning. According to 2011 Bangladesh Demographic and Health Survey (BDHS) data, more than half of all C-sections are taking place in private sector facilities, and of all deliveries occurring in these private facilities, 72% are by C-section.[12] The dramatic rise in c-section rates from 17% in 2011 to 26% of all deliveries nationwide[13] implies that the private sector share is continuing to increase.

In Bangladesh, the private-for-profit sector in health, whether formal or informal, are profit-oriented businesses that charge health care consumers above actual service costs. In the formal sector, this might include diagnostic tests and the basic surgical procedures, whereas in the informal sector, unqualified doctors or drug sellers may purvey costly pharmaceuticals whether needed, or not.[10, 14] While the private-for-profit sector tends to concentrate in urban areas such as Dhaka, as well as larger Divisional cities and towns, it is growing in size and geographic reach. Data from the Directorate General Health Services (DGHS) show an increase in the number of registered private for-profit facilities from 1038 in 2007 to 5023 in 2017,[15, 16] reflecting both a rise in demand for services, and the inability of the public sector to generate sufficient supply on its own. At the same time, the number of unregistered clinics, hospitals and diagnostic centres is substantial. Recent evidence from a comprehensive mapping of all health facilities in Sylhet City Corporation, finds that 40% had not fully complied with annual registration requirements.[17]

Despite the size of the private-for-profit sector and its critical role in health service delivery in Bangladesh, relatively little is known about the underlying motivations and strategies that underpin the business. With the broader goal of enabling UHC in urban areas, this qualitative study examines the private-for-profit sector on three cities in Bangladesh with the objectives of 1) exploring the underlying motivations, strategies and incentives governing formal for-profit private sector service provision in urban areas; and 2) identifying potential points of entry to improve service quality and access to the urban poor that also serve the business interests of this sector.

METHODS

Study Sites

This exploratory qualitative study was carried out in three major city corporations of Bangladesh that were purposively selected to capture a wide range of performance on key indicators of healthcare access and utilization such as rates of vaccination coverage, ANC coverage, child mortality, and maternal mortality according to Bangladesh Demographic and Health Survey 2011.[12] These were: Dhaka, the national capital and fastest growing megacity in the world; Khulna, a Divisional capital located in a district considered high performing in terms of key health indicators, and Sylhet, a Divisional capital in one of the poorest health-performing districts in the country.

Study Methods and Sampling Strategy

Data collection occurred between September 2013 and March 2014 and consisted of key informant interviews with government and private sector leaders, in-depth interviews with clinic owners and providers, structured facility observations and short, directed exit interviews with patients. To identify potential respondents for in-depth interviews, in each city, key informants were purposively sampled, interviewed, then asked to suggest potential respondents. This snowball sampling method helped identify small and medium-sized private sector facility owners and providers willing to participate in the study. Using a purposive sampling strategy, facility observations and exit interviews were also performed to document patient experiences in the same facilities where observations occurred.

Data Collection

Twelve researchers with social science degrees were involved in data collection under the guidance of two supervisors with extensive field experience and expertise in qualitative methods and analysis. A period of rapport building with key stakeholders in each study site was critical to the success of this research given known difficulties in accessing this sector. Suspicion about motives, intimidation regarding possible regulatory repercussions and lack of availability due to time constraints and opportunity costs were issues encountered throughout data collection. These dynamics were handled carefully to facilitate access.

Two or three researchers were involved in each interview: a facilitator, and one or two note-takers. In addition to detailed hand-written field notes, audio-recorders were used to record the interviews. These were transcribed verbatim into Bangla (Bengali) as soon as possible following data collection, and field notes and observations were written up in the same time frame. Transcripts were then translated into English by skilled translators, and a sub-sample of translated transcripts were reviewed by senior researchers to cross-check data fidelity. Observations of health facilities were also performed using a checklist that considered the extent of available infrastructure, waste management and wait room conditions.

Data Analysis

Framework analysis was performed utilizing codes and data displays to systematically examine emerging patterns and themes.[18] A team approach to analysis was employed to minimize individual bias with multiple analysts involved in coding and interpreting data. To begin, each transcript was coded independently on hard copy by two researchers. Initially, seven a priori codes were prepared and, later, inductive codes were also included in the coding framework. After assessing intra-coder and inter-coder reliability by having two analysts independently coded the same sections of text, codes were applied by the research team to transcripts and observations. Memos were kept throughout the coding process to record and develop emerging insights. After the coding was completed, three people were assigned to incorporate coded transcripts into ATLAS-ti. Each person was assigned a different study site: Dhaka Khulna or Sylhet. Once all the transcripts were inputted and merged, code reports were generated based on a priori themes. In order to better identify patterns in the data, data matrices were prepared which helped display the data and allow for more systematic analysis.

Ethical Considerations

The project was approved by the Research Review Committee and Ethical Review Committee of icddr,b. Prior to interview, written informed consent to participate in the study was obtained from each respondent, as well as permission to be audio-recorded. All elements of consent were described to the respondent orally to clarify the purpose of the research, the measures undertaken to ensure confidentiality, and their right to withdraw from the interview at any time, for any reason. Arrangements for the place and time of interview were organized in advance according to the respondent's convenience and privacy.

RESULTS

Participants

In total, 110 respondents from 3 city corporations participated in the study. In this paper we focus on the formal private-for-profit sector comprising those involved in small to medium-sized licensed and registered healthcare businesses (10 – 150 beds) in the roles of health care providers, owners, and patients. Key informant interviews were also conducted with officials from the Ministry of Health, the Bangladesh Medical & Dental Council, the Bangladesh Medical Association, the pharmaceutical industry as well as members of the Private Clinic Owner's Association. Table 1 displays the range and numbers of interviews and observations undertaken to capture the underlying motivations guiding private sector behaviour, and the strategies they utilize in making their business profitable.

Table 1: Number and types of interviews and observations conducted

Types of Respondents	Dhaka	Sylhet	Khulna	Total
For-profit health facility owners	5	5	6	**16**
For-profit service providers	4	5	5	**14**
Key informants	5	7	8	**20**
Exit interviews with in-patients	5	5	5	**15**
Exit interview with out-patients	5	5	5	**15**
For-profit health facility observations	10	10	10	**30**
Total	**34**	**37**	**39**	**110**

Motivations of private providers and owners

To understand the motivations underlying the involvement of private sector owners and providers in the healthcare market, respondents were asked to describe their how they came to be involved in the business. The table below stratifies motivational factors by three categories of respondent: clinic owners, healthcare providers and key stakeholders representing the Ministry of Health, the Bangladesh Medical & Dental Council, the Bangladesh Medical Association, and the Private Clinic Owner's Association.

Table 2: Factors motivating initiation into the private healthcare market comparing private owners, providers and other stakeholders

Motivating Factors*	Clinic Owners (n=12)	Formal Providers (n=11)	Key Stakeholders (n=10)
Profit	✓✓✓	✓✓	✓✓✓

Financial security	✓	✓	✓✓✓
Social service	✓✓✓	✓✓✓	✓
Social status		✓✓	✓
Ambition	✓	✓✓✓	
Family influence	✓✓	✓✓✓	

*Multiple responses from respondents when asked about their motivations underlying entry into the profession.

Two groups of motivational factors, financial and personal, emerged from analysis.

Financial motivations

The monetary rewards associated with running a successful healthcare business was a strong pull-factor motivating entry into private sector. The industry was widely perceived as financially lucrative, and therefore an appealing professional choice. As one doctor in Sylhet explained, "*the main reason I entered the private sector was business. I worked in a small town near Dhaka city. 55-60 private clinics are there in that small town. All are running well, also gaining profit....*".

There was a general assumption that working as a doctor in the private sector ensured financial security given increasing demand for services in urban areas, with many respondents describing the importance of a stable income for themselves and their families. According to a private provider in Khulna: "*The thing that attracted me to this profession is financial solvency…I assumed that I will have a superior financial status and I do get that by joining this profession*."

Personal motivations

In addition to financial interests, personal motivations also played a role in entering the private healthcare profession. First among these was the desire to furnish needed services to the public, and the personal fulfilment derived as a result. A number of respondents noted a particular concern for the poor, the vulnerable, and the disadvantaged who would otherwise not have the chance to receive proper care. This commitment was identified as an impetus for entering the private healthcare sector, and a reason for continuing their professional engagement. Recognition of the social status associated with those pursuing a career in healthcare, and conferred to specialist doctors in particular, was another motivating factor identified by respondents.

At the other end of the spectrum was personal ambition, and the desire to be involved in a challenging, fast growing profession, or in certain cases, the ambitions of family members which some feel obliged to fulfil. Pressure from family to pursue private medical practice was widely cited, largely due to the perceived status and income the business afforded or because an existing family business needed to be sustained. As one provider from Khulna explained: *This business is in our family. The forefathers of my father used to run it, after them, my father. I practiced with my father for a very long time, then after (his) death I (took charge).*

In a number of instances, particular personal circumstances served as impetus for engaging in the private healthcare market. One clinic owner and provider described his decision to start a clinic as a result of his mother's death and desire to do something concrete in her memory: *When I started my fourth year of medical school, my mother died. At that time, I couldn't take care of my mother due to my studies. I established this clinic in the name of my mother.*

Similarly, a clinic manager in Dhaka, claimed that an experience with poor quality healthcare prompted the creation of the facility in which he worked:

> *Our Director's child died in a renowned hospital of Bangladesh … because of the carelessness of the doctors and nurses. So, our Director decided to build a NICU where patients will not face such kinds of carelessness.*

Interesting in these narratives of how our respondents came to be involved in private for-profit healthcare, was the extent to which they departed from, or contextualized the profit-seeking motivations we tend to associate with private sector practice.

Business strategies of private providers, managers and owners

Private formal health sector actors report using multiple strategies to ensure the success and sustainability of their medical practice. These strategies help them increase client flow and satisfaction and derive profits out of the services provided.

Use of brokers or agents

The use of medical brokers or *Dalals* were reported by many respondents as a widespread method to ensure patient flow. Employed by many private healthcare facilities to divert or convince clients to use their services, *Dalals* typically operate near the entrance of public hospitals, or in areas of the city where new migrants to the city first settle. Interestingly, informal providers such as drug-sellers and unlicensed or "village" doctors in the vicinity may also act as *Dalal* for formal private clinics, receiving payments according to the number of patients referred, or in other cases, a percentage of service charges. A private clinic manager from Dhaka explained the importance of this strategy:

> *Many patients are referred (through agents or brokers). Relatives of a patient who have received services from us (in the past), may also increase publicity. (In return) we give them services at low cost.*

Public sector providers are similarly known to act as middlemen, referring patients to their own private practices or those in which they are shareholders. In other instances, they may refer to other private facilities, and like *Dalal,* receive a commission for referral. While some of these referrals may be clinically indicated, a number of stakeholders reported that this practice of "referral for commission" was widespread among private sector doctors, diagnostic centres and clinics, and used to boost revenue through collusion. A top-ranked government health officer in Khulna described the involvement of doctors in referral and the financial benefits that are accrued:

> *Suppose, I am an owner of a diagnostic centre. Many brokers are available to me. I will tell them to collect patients from wherever they can, (and) they will be given a percentage. If, a doctor sends patients to me for pathology (testing), I will give him a 40% or 50% commission. If I get 2000 taka by doing the pathology, then 1000 taka is for me and the other 1000 is for the doctor - the doctor is happy, and so am I. If 10 patients are sent daily, he will receive 10,000 BDT. (Likewise), if I refer patients to the doctor's facility, he will send patients to my diagnostic service for tests.*

Although these practices increase patient flow, several stakeholders noted how referrals orchestrated by brokers are sometimes unnecessary. Thus, brokers employed to divert patients away from free government services, may serve to increase the cost of treatment and, therefore, the patient's financial burden, and in the case of unnecessary treatment, lead to potentially adverse health consequences.

Patient-friendly services

A number of strategies were identified whereby for-profit healthcare businesses aimed to make their services more appealing to both current and potential clientele. One such strategy was the use of patient discounts. The majority of private practitioners interviewed describe how reductions in the costs of services were regularly offered for both strategic and philanthropic purposes – as a strategic means of enticing new patients, or recognizing those who remain loyal clients; and philanthropic, allowing poorer patient to access services they otherwise cannot afford. As one private sector provider explained:

> *There is not a fixed percent, but they do so according to the (financial) state of the patient… Normally we grant 15% for tests and 10% for the bed rent. Sometimes we have to give more – even above 50%.*

Another widespread strategy was the provision of health packages that bundle services and products together at a fixed price. This decreases costs to patients compared to the cumulative price of individual services, and, in some instances, creates a space for negotiation between clinics and clients. While this practice was reported to increase patient flow, a number of detrimental consequences for private sector providers/clinic owners were identified, especially in the context of patient complications which result in additional, unanticipated tests and procedures that the package does not include.

Finally, almost all private providers mentioned the importance of forging trust within the doctor-patient relationship as a means of ensuring client loyalty and continuity of care. Respondents described efforts made within the clinical setting to make patients feel valued and comfortable, recognizing that client perceptions of provider behaviour and attitudes are important determinants of whether they adhere to treatment or return for subsequent visits. As explained by a doctor in Sylhet:

> *While the first aim is that the patient gets cured, my behaviour is also important…We, the doctors…tell our students that not all diseases are organic. Some are psychosomatic (and hence) our behaviour with patients is a major factor in providing care. The patient (must) have faith in a doctor that he will be cured ……. The doctor must create such faith through conversations and discussion time (with patients) …*

Our observations revealed that the importance of provider conduct does not depend on the duration of the provider-patient interaction or the length of waiting time to consult the providers. Interviews with patients exiting private facilities revealed that even though average consultation times were only 6 to 7 minutes in length and waiting times were 5 minutes to 2 hours and thirty minutes, reports of patient satisfaction with private sector services were uniformly positive.

Another aspect of patient-friendly care was the provision of extended hours of service to meet the needs of the poor working population, which several private clinic owners noted, provide a competitive advantage over day-time available services from NGOs and the Government sector.

Referral

A large majority of respondents justified the referral of complicated cases to public hospitals and medical colleges in contexts where there was a lack of capacity to manage patients with speciality medical needs, or those with emergent, deteriorating or potentially fatal health conditions. Several providers further noted the reputational risk inherent in being held responsible for a patient's death, and hence the use of referral as a strategy to avoid potential fatalities that might damage their professional reputation or that of the facility in which they work. Referral shifted responsibility for potential accusations of malpractice to the receiving facility, which most commonly was the city's public hospital. As one private sector owner/provider from Khulna admitted, *"We don't take the risk of keeping critical patients. They are referred to the Government Hospital, where there are ICU facilities, or to larger private hospitals based on their (financial) ability."*

This widespread practice highlights broader limitations in critical care capacity within urban areas that need to be addressed,[19, 20] and the particular vulnerability of the urban poor, as the place of referral is very often determined based on their ability to pay. Even if a private hospital is closest, many providers stated that they were more apt to refer poorer patients to public facilities or medical colleges, while better-off patients were sent to closer private facilities. Patient's desires, frequently motivated by perceived quality of services, was a further factor influencing referral patterns.

Interestingly, the majority of the respondents in the study, recognized that an absence of a formalized approach for referral contributed to poor health outcomes. Several providers specified how lack of a clear referral system meant that many patients went to formal providers at a very late stage in their

illness when treatment was difficult for doctors to provide. It was also noted that unnecessary medications were given to patients by informal providers such as drug sellers, which could be avoided if formal care was sought earlier. Several private sector providers suggested the need for a system of referring primary care physicians who direct patients to private or public specialists as appropriate. Training and continuing education for both formal and informal providers were also proposed as a means of avoiding misdiagnosis and ensuring that complications were addressed in a timely manner.

While no systematic pattern of referral was apparent from our interviews, most admissions to private clinics appeared to occur with the recommendation of a private practitioner. As discussed earlier, receipts of under-the table-incentives and rewards are oftentimes instrumental in decisions to refer patients to or from the private health facilities. In these cases, both brokers and private sector providers are complicit in the use of monetary benefits as a means of directing referral in a manner that satisfies their business interests. More virtuous behaviour was also reported. Some providers stated that their referral decisions were based on the quality of care provided at the receiving facility, and several claimed that instead of taking commissions from referral facilities, they asked that patient discounts be provided instead.

Irrespective of the referral destination, exit interviews with patients emphasized their implicit trust in the provider's recommendation, with some suggestion that the greater the trust between patient and provider, the more likely a patient would follow the medical advice offered. Explaining how they were referred to the clinic they were exiting, one patient in Sylhet explained: *"We consulted with our private doctor here. The doctor transferred us here. We depend on his choice and support"*.

Incentives from pharmaceuticals

Nearly all private practitioners described regular visits from pharmaceutical representatives on a monthly, weekly or even daily basis to advertise medicines for prescriptions. They also reported receiving different types of incentives from pharmaceutical companies to buy their drugs, although this practice is prohibited by the *Code of Pharmaceutical Marketing Practices* which states that "no gift or financial inducement shall be offered or given to members of the medical profession for purposes of sales promotion". Incentives in the form of money, samples and gifts were reported to significantly influence the prescription pattern of practitioners, sometimes promoting unnecessary and irrational prescribing patterns. For example, one clinic owner explained how incentives from pharmaceutical representatives influenced doctors' prescription practices:

> *…different companies pay doctors month after month for recommending their medicines…. even giving cash…now if doctors recommend (these drugs), we have little choice (but to keep them in our store) …*

Another provider from Sylhet described how pharmaceutical representatives influenced his prescription decisions, and the tendency to use what is given without monitoring effectiveness:

> *I generally prescribe those medicines which work effectively; still there are some influences such as medical representatives (who) come frequently. They come in the morning, in the evening, automatically we need to keep their medicines …we use those, prescribe those, but we don't (always) get to check ourselves whether they work or not.*

The pharmaceutical representative's approach to the private sector provider is carefully calculated in advance, as one agent in Khulna recounted:

> *I see which pharmaceutical company's medicine the doctor is prescribing... We get data from different sources. Some are paid 100,000 taka annually, or 3000 to 5000 taka monthly ... then I request him (doctor) to kindly give me a chance and make him a monetary offer. If he agrees then I provide him the agreed amount monthly or yearly. Then he writes our drug in the prescription.*

Some key stakeholders indicated an awareness of the consequences of pharmaceutical influence on patients, including the development of drug resistance and financial impoverishment by obliging patients to purchase expensive and sometimes unneeded medicines. Respondents also pointed that aggressive pharmaceutical marketing may also promote the prescription of low quality drugs. Decisions about what drugs to stock become a function of price and discounts received, and not what is best for the patient in terms of treatment efficacy. As one pharmaceutical company manager explained, sometimes these drugs are not even intended for the local market:

> *Sometimes they (medical representatives) they sell a product not meant for local sale to medicine shops at a discounted rate […] then motivate drug sellers and doctors not to sell another company's product as they will not get any benefit from them.*

Another common practice among private providers was the sale of free drug samples at discounted rates to patients with less capacity to pay.

Human resource strategies

Many respondents noted the continual challenge of ensuring adequate, trained human resources in an increasingly competitive urban healthcare market. A widespread practice by private clinics was the use of medical staff from the public sector as consultants for specialist and general services. Duty doctors were most often medical staff with less experience, including honorary trainees, postgraduate medical students and occasionally interns. As office hours in public hospitals typically extend from 8 am to 2 pm, in theory public sector doctors engaged in private sector practice are only available later in the day. As one clinic owner from Sylhet noted, as a result, staff shortages and the provision of specialized services in particular, were limited during morning hours: *"The consultants are mostly from the public medical college. So, we face this (doctor shortage) problem from 8:00am-3:00pm."*

Other respondents noted that the practice of public-sector doctors attending patients at private facilities during office hours was not uncommon, with one clinic manager from Dhaka, asserting: *"It is not ethical that, in some clinics of this area, the doctors and trainees of the Government Medical College see patients in between office hours."*

An interesting related strategy to overcome doctor shortages during daytime hours was the widespread use of on-call doctors. These doctors typically practice in public sector facilities in close proximity to a private sector clinic that relies on their services and will respond to calls when needed. As one clinic owner (and provider) from Sylhet explained: *"Within a few minutes we come to see the patients. Within five to ten minutes the specialist also comes here. If we are informed we come here from anywhere. Or another specialist comes to manage everything."*

This strategy was popular among private clinic owners given its perceived cost savings over standard practices of recruiting and paying the salaries of three doctors to cover a 24-hour service, or having to hire specialist doctors full-time when their services are not always needed. It was also noted that the strategy was not without hazards. Given that many private clinics rely on commonly performed surgeries (C-sections, appendectomies) to ensure financial sustainability, in the context of life threatening complications, reliance on on-call doctors who are located off-site, may substantially heighten risk to patients.

Recruiting and retaining qualified nurses was also identified as a major challenge by many private sector respondents. As a result, nursing care was often provided by unqualified or untrained persons such as cleaners and *aya*s who are meant to provide non-technical care-giving support to patients and their families. According to private sector respondents, the reliance on unqualified personnel was due to the dearth of qualified nurses on the market, and the high salaries they command. As one clinic owner from Dhaka despaired:

"It is impossible for me to keep 6 nurses (on staff); it is not possible for any clinic to give 60,000 taka for their salary (10,000 taka each). Maybe it is possible for (large private hospitals like) Apollo and

Square, but not for me. (Instead) we must hire secondary school certificate girls (and train them on the job)…

Contrary to expectations that human resource shortages are only a public-sector concern, private sector respondents reported similar challenges, yet differed in the wide variety of strategies, both innovative and egregious, used to circumvent costs associated with keeping qualified, full-time medical personnel on staff**.**

DISCUSSION

This exploratory study is among the first in Bangladesh to query what drives the private for-profit sector and its growing importance as a source of primary healthcare in urban Bangladesh. In-depth interviews with private sector owners, doctors and other stakeholders challenged widespread perceptions that financial interests are the only motivations prompting entry into the private healthcare business. While profit and financial security are mentioned, motivations related to service, social status, and family obligation were also indicated as reasons for starting and continuing their involvement.

Among the strategies that were mentioned by private sector respondents, the use of brokers and agents were particularly important in growing their business. Referral fees paid to these middlemen were acknowledged to ensure a fresh client flow, and a competitive advantage in an increasingly crowded market, however, the costs incurred are ultimately passed on to the patient as reflected in the rising rate of out of pocket expenditures.[4]

An almost consensus viewpoint among private sector respondents was the necessity of patient-friendly services for market capture, especially when the competition also includes free or low-cost public or NGO services. Evidence from the global literature indicates that patients are willing to pay for private healthcare if they perceive that doctors are respectful and responsive to their needs.[21, 22] It is further established that good provider-patient relations increase the likelihood of a sustained treatment-seeking,[23, 24] and new clientele. In our study, duration of consultation did not appear to be an important factor influencing patient perceptions of quality. Exit interviews with private sector patients revealed that average consultation time was only slightly longer than what is typical in the public sector.[25] The importance of making patients happy, however, was a strong thematic across our interviews. Evidence of this was the widespread use of discounts on consultation fees, drugs and procedures as a means of encouraging patient loyalty and defray OOP for the urban poor, as well as extended service hours that accommodate the schedules of the working class. Innovations in adapting service pricing and delivery modalities to the needs and preferences of customers is emblematic of private sector practice globally,[26] and is important to take into account in pursuing UHC.

Strategies around referral were consistent across private sector respondents, with complicated cases almost universally being directed to public sector tertiary facilities. However, the absence of formal urban referral system that embraces both private and public sectors, serves to heighten patient risk due to inappropriate referrals, or referrals made too late. The development of such a system which identifies the fastest and safest route to appropriate critical care services, whatever the location, represents a critical area for policy attention. This includes the transfer of patient information so that expensive diagnostic tests aren't needlessly repeated,[27] as well as enhanced capacity for first aid services to ensure that patients are stabilized during transport, and the availability of proximate and effective ambulatory services.

The influential role of pharmaceutical agents over prescription practices was also ubiquitous across private sector interviews. Many respondents valued the incentives that they receive from pharmaceutical companies, some of which are passed onto patients, such as discounted prices on "free" medicine samples. A few others expressed concerns that the medicines pushed by pharma reps were expensive, or unknown in terms of efficacy. The utility of pharmaceutical incentives in supporting private sector business has been emphasized by others,[28] and it is well recognized that

aggressive marketing strategies undermining patient safety and ethical medical conduct, need firm regulation.

A number of strategies were reported by private facility owners to reduce costs and overcome the scarcity of human resource such as nursing staff and specialist doctors. These include the use of on-call specialists from the public sector, reliance on doctors in training or recent medical graduates, as well as filling sector-wide gaps in nursing care by providing onsite nursing training to unqualified personnel. The implications of these adaptive mechanisms in terms of quality and costs to the public health system and to consumers themselves, warrants assessment. The widespread and largely unregulated phenomena of dual practice adds specific layer of complexity, and requires greater accountability even if there are efficiency or retention benefits to the health system as a whole.[10, 29]

LIMITATIONS

A major limitation of our study was the unwillingness of certain respondents to divulge the strategies they employ to grow and flourish private sector businesses. In a number of other cases respondents may have constructed their replies to mitigate what they perceive are unfavourable assumptions about the unethical business practices they employ. Were more time available for rapport building, richer and more trustworthy data might have been produced.

CONCLUSION

In urban Bangladesh, the private for-profit sector plays a crucial role in meeting the growing demand for healthcare in a context in which public provision is limited to tertiary care and contracted-out maternal and child care services.[20] Within this highly heterogeneous sector, small and midsize private clinics are important purveyors of healthcare in urban markets. Focusing on the motivations and strategies undergirding this market segment, our findings confirm prevailing assumptions about the primacy of commercial interests, and their sometimes-deleterious effects on provider behaviour. Yet at the same time, beyond their underlying profit motive, certain strategies yield benefits to healthcare consumers. Among our respondents, quality and professionalism were almost universally recognised as critical to sustaining a healthcare business in a competitive urban market. These interests can be usefully leveraged in efforts to ensure that private-sector services are safe and effective. The widespread use of informal discounts and subsidies by private sector providers provide a similar segue into discussions of UHC, and how participation in insurance schemes might be advantageous in terms of retaining and growing clientele especially among the urban poor. Indeed, the professional expectations and payment mechanisms inherent in working through insurers or contracting out arrangements may also serve to discourage over-service and excessive fees that disproportionately impact the poorest.[30]

Incentives to extend a largely curative business model to include preventive and promotive services will also be critical in ensuring comprehensive primary care coverage in urban areas.[29] Most importantly, policies that support UHC within the realities of a highly pluralistic health market, must accommodate the financial interests of the large and growing private sector and incentivize their efforts to provide services of quality.[31] Given the weak regulatory capacity of national and local authorities and professional associations alike, an approach that enhances “beneficial competition” may be a more realistic way forward.[9] Policies and programs that support private sector quality through training or other incentives,[31] thus enabling even greater market share, may function to drive out the subset of private sector players whose business model relies on overcharging or providing sub-standard care.

Author contributor-ship

Criteria #1: Substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data – AMA, RA, TAS, SSY, SA, IA

Criteria #2: Drafting the work or revising it critically for important intellectual content – AMA & RA drafted the manuscript. TAS, SSY, SA, IA reviewed critically for important intellectual content. AMA & RA finally revised the version submitted with inputs from all other co-authors.

Criteria #3: Final approval of the version published – AMA, RA, TAS, SSY, SA, IA

Criteria #4: Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved – AMA, RA, TAS, SSY, SA, IA

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Competing interests

The authors declare no competing interests.

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Ethics approval

Ethical Review Committee of icddr,b.

Data sharing statement

The data sets analysed in the current study are not publicly available, but are available from the Ethical Review Committee of icddr,b upon reasonable request after meeting the necessary criteria for access to confidential data.

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An exploratory qualitative study to understand the underlying motivations and strategies of the private-for-profit healthcare sector in urban Bangladesh

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Abstract

Objectives: This paper explores the underlying motivations and strategies of formal small and medium-sized formal private for-profit sector hospitals and clinics in urban Bangladesh and their implications for quality and access.

Methods: This exploratory qualitative study was conducted in Dhaka, Sylhet and Khulna City Corporations. Data collection methods included key informant interviews (20) with government and private sector leaders, in-depth interviews (30) with clinic owners, managers and providers, and exit interviews (30) with healthcare clients.

Results: Profit generation is a driving force behind entry into the private healthcare business and the provision of services. However, non-financial motivations are also emphasized such as aspirations to serve the disadvantaged, personal ambition, desire for greater social status, obligations to continue family business, and adverse family events.

Strategies employed to maintain market position are examined using the Business Policy Model which include: ***products and services***, and efforts to make these attractive including patient-friendly discounts and service-packages, and building "good" doctor-patient relationships; ***the market environment***, cultivated using medical brokers and referral fees to bring in fresh clientele, and receipt of pharmaceutical incentives; and finally, ***organizational capabilities***, in this case overcoming human resource shortages by relying on medical staff from the public sector, consultant specialists, on-call and less-experienced doctors-in-training, unqualified nursing staff, and referring complicated cases to public facilities.

Conclusions: In the context of low public sector capacity and growing healthcare demands in urban Bangladesh, private for-profit engagement is critical to achieving Universal Health Coverage (UHC). Given the informality of the sector, the nascent state of healthcare financing, and a weak regulatory framework, the process of engagement must be gradual. Further research is needed to explore how engagement in UHC can be enabled while maintaining profitability. Incentives that support private sector efforts to improve quality, affordability, and accountability are a first step in building this relationship.

Strengths and limitations of this study

- This exploratory study is among the first in Bangladesh to query the underlying motivations and strategies of the urban private for-profit sector.
- The study employs qualitative methods to enable in-depth understanding of factors influencing healthcare practices as reported by private facility owners and providers.
- A limitation of the study was the unwillingness of certain respondents to disclose strategies they employ to grow and flourish their private sector business.

Keywords

Private sector, for-profit private sector, motivations, business strategies, formal health sector, urban health systems, Bangladesh

Abbreviations used

Universal Health Coverage (UHC), Directorate General Health Services (DGHS), Antenatal Care (ANC), Non-Governmental Organization (NGO), Intensive Care Unit (ICU),

INTRODUCTION

The SGD3 goal of reaching Universal Health Coverage (UHC) by 2030 is challenging in pluralistic health care systems such as Bangladesh.[1] The country is also urbanizing rapidly as reflected in an average urban population growth rate of 3% per year, and an astonishing 7% per year in poor informal settlements.[2, 3] If these trends continue, by 2040 over half of Bangladesh's total population will reside in urban areas.[4] In this context, challenges to achieving UHC are amplified as demand for services increases, and the healthcare market shifts towards the private sector.[5,6] In Bangladesh, reaching the SDG target 3.7 - ensuring every person access to affordable quality healthcare services, including financial risk protection - is particularly daunting given that 67% of national health expenditure is already out-of-pocket.[7] However, Bangladesh is also a country that routinely defies expectations, witnessed in its spectacular health achievements over the last four decades in terms of reductions in total fertility rate and rates of maternal, infant, and childhood mortality.[8] Although some of this success may be due to coverage of publicly financed free services,[9] and its role in reducing use-inequities,[10] the contribution of private health care sector remains poorly understood. This understanding is complicated by the widespread phenomenon of dual practice, whereby a large proportion of public sector providers are also involved in private practice to supplement income.[11,12] Given its primary for-profit orientation, there is widespread scepticism about the potential contribution of the private sector towards UHC. In the absence of strong regulatory capacity on the part of the state, these concerns relate to inappropriate or unnecessary care, inequitable access due to escalating costs, and poor quality of care. As a result, the public sector continues to be the major focus of Government efforts towards UHC targets.[13]

But recent data suggest that neglect of this sector is short sighted. For example, the 2016 Bangladesh Maternal Mortality Survey (BMMS), shows that for obstetric complications, only 25.5% of women visited public sector facilities and the rest used some kind of private facility or informal provider as a first source of care.[14] The use of the private sector for delivery services is also increasing. According to BMMS data, only 2.6% of mothers delivered in private sector facilities in 2001, rising to 11.3% in 2010, and 29% in 2016, whereas public sector delivery trended from 5.8% (2001) to 14% (2016) over the same period.[14] The contribution of the private sector to the explosive growth of C-section delivery is particularly concerning. According to 2011 Bangladesh Demographic and Health Survey (BDHS) data, more than half of all C-sections took place in private sector facilities, and among deliveries occurring in private facilities, 72% were by C-section.[15] A nationwide rise in C-section rates from 17% in 2011 to 23% in 2014[16] implies that the private sector share is continuing to increase.

In Bangladesh, the private-for-profit sector in health consists of profit-oriented businesses that charge health care consumers above actual service costs. The sector includes a heterogenous set of providers which vary in the degree to which they operate within or outside the purview of regulation, registration or oversight by government or professional bodies, or possess formally recognized training. At one end of this spectrum are formal private for-profit hospitals and clinics offering diagnostics and both general and specialized medical treatment including surgical procedures, while at the other, unqualified doctors or drug sellers purvey pharmaceuticals whether needed, or not.[13, 17]

In urban areas, the density of private sector services is remarkable. Unlike rural Bangladesh where government healthcare infrastructure is available at district, sub-district and community levels, in urban areas the public health system is limited to a handful of poor functioning urban dispensaries and secondary and tertiary hospitals operated by the Ministry of Health and Family Welfare. Designated responsible for urban primary healthcare, yet lacking implementation capacity, the Ministry of Local Government has contracted-out primary healthcare services to NGOs on a project basis[18, 19] with a predominant focus on maternal and child health.[20] Filling the gap in public primary services is the urban private sector which accounts for over 90% of health care facilities (Annex 1) in urban areas.[20] Nationally, data from the Directorate General Health Services (DGHS) show an increase in the number of registered private for-profit facilities from 1038 in 2007 to 5023 in 2017,[21, 22] reflecting both a rise in demand for services, and the inability of the public sector to generate

sufficient supply on its own. Yet even within so-called formal facilities, irregular practises are common. For example, recent evidence from a comprehensive mapping of all health facilities in Sylhet City Corporation, found that 40% of private clinics, hospitals and diagnostic centres had not fully complied with annual registration requirements.[23]

Despite the size of the urban private-for-profit sector and its critical role in health service delivery in Bangladesh, relatively little is known about its underlying motivations and business strategies. In this study we focus on small and medium-sized formal private for-profit health facilities (between 10-150 bed capacity) given their substantial urban presence. In Dhaka alone they represent about 55% of all hospitals and clinics, with public and NGO sector facilities accounting for the remaining 19% and 26% respectively.[20] With the broader goal of enabling UHC in urban areas, our objectives are: 1) to explore the underlying motivations of owners, managers and providers entering into and sustaining activities in the small and medium-sized formal for-profit private healthcare business; and 2) to understand how the business strategies and incentives governing the small and medium-sized formal-for-profit private sector enable or hinder quality and financial access.

To frame our exploration of business motivations and strategies, we draw on the Business Policy Model (BPM),[24] the basic concepts of which still undergird the logic of current corporate strategy analysis.[25] BPM is made up of three basic elements - products/markets, the market environment, and organizational capabilities - which interact to determine how a private sector business performs. Specifically, the model specifies how the financial success of a particular good or service offered by a private sector business is a function of its alignment with the market environment and the organization's capabilities. In the case of healthcare provision, the goal of the private-for-profit sector is to ensure that its products or services, constitute the most "profitable value-proposition" in the current market environment, that the market shows sufficient long-term demand for those services and that the services offered align with organizational capabilities to add value. Based on this framework, we will consider how urban small and medium-sized private owners, managers and providers strategize around products, markets and capabilities to ensure success in sustaining and growing their healthcare business. Of particular interest is how these strategies impact quality and access by the urban poor.

METHODS

Study Design

This exploratory qualitative study was conducted in three city corporations in Bangladesh, and involved interviews with government and private sector leaders, formal private-for-profit healthcare actors, and consumers of these services.

Study Site

Three cities were purposively selected to capture a wide range of performance on key indicators of healthcare access and utilization such as rates of vaccination coverage, ANC coverage, child mortality, and maternal mortality.[15] These were: Dhaka, the national capital of Bangladesh, and among the fastest growing megacities in the world; Khulna, a divisional capital located in a district considered high performing in terms of key health indicators, and Sylhet, a divisional capital in one of the poorest health-performing districts in the country. Within each of these cities, we focus individuals involved in small to medium-sized licensed and registered (as reported) private for-profit healthcare businesses (10 – 150 beds) in the roles of owner, manager, healthcare provider, and patient.

Study Methods and Sampling Strategy

A total of 80 respondents were interviewed from September 2013 to March 2014. In each city, Key Informant Interviews (KIIs) were conducted with a purposive sample of local officials from the Ministry of Health, the Bangladesh Medical & Dental Council, the Bangladesh Medical Association, the pharmaceutical industry as well as members of the Private Clinic Owner's Association. At the end of each KII, respondents were asked to recommend the names of small and medium-sized private

clinic owners and providers who might be willing to participate in In-Depth Interviews (IDIs). This snowball sampling method helped identify potential respondents working in a sector that is otherwise difficult to access. IDI respondents included private healthcare facility owners, managers and providers. Using a purposive sampling strategy, in-patient and out-patient exit interviews were also performed to document client experiences in the same facilities in which IDIs were conducted. Table 1 displays the types and numbers of interviews conducted in each study sites.

Table 1: Types and numbers of interviews conducted in each study site

Types of Respondents	**Dhaka**	**Sylhet**	**Khulna**	**Total**
Key informants	5	7	8	**20**
For-profit health facility owners & managers	5	5	6	**16**
For-profit service providers	4	5	5	**14**
Exit interviews with in-patients	5	5	5	**15**
Exit interviews with out-patients	5	5	5	**15**
Total	**24**	**27**	**29**	**80**

Data Collection

Guided by two supervisors with extensive field experience and expertise in qualitative methods and analysis, data collection was performed by 12 social science researchers. Semi-structured KII and IDI guidelines were prepared for different groups of respondents. KIIs explored urban health challenges; the range of private care providers and services provided; quality of care, dual practice and referral mechanisms, as well as known strategies to maintain profitability including incentives provided by pharmaceutical companies. IDIs with private healthcare owners, managers and providers considered their underlying motivations in choosing and remaining in the sector; services provided and available human resources; linkages with other formal providers, pharmaceutical representatives and brokers; typical referral mechanisms; sustainability and quality of care practices; and challenges and suggestions for better coordination with the public sector.

Exit interviews elicited narratives concerning the experience and satisfaction of healthcare consumers frequenting private sector facilities in terms of the quality and affordability of services received, and whether they intended to return to the same facility in future. In each city, senior researchers tapped into existing networks to identify a number of well-positioned key informants for interview, many of whom provided support in identifying respondents and facilitating access. These existing relationships were crucial to entrée, rapport building and trust in a sector that is typically closed to outsiders.

Two or three researchers were involved in each interview: a facilitator, and one or two note-takers. In addition to detailed hand-written field notes, interviews were recorded digitally. Recordings were transcribed verbatim into Bangla as soon as possible following data collection, and field notes and observations were written up in the same time frame. Bangla transcripts were translated into English by skilled translators, and a sub-sample of translated transcripts were reviewed and back translated by senior researchers to cross-check data fidelity.

Data Analysis

Framework analysis was performed utilizing codes and data displays to systematically examine emerging patterns and themes.[26] A team approach to analysis was employed to minimize individual bias with multiple analysts involved in coding and interpreting data. To begin, each transcript was coded independently on hard copy by two researchers. Initially, seven “a priori codes” were defined and later, inductive codes were also included in the coding framework. After assessing intra-coder and

inter-coder reliability by having two analysts independently code the same sections of text, codes were applied by the research team using Atlas-ti. Code reports were generated based on "a priori" themes and other inductive codes to facilitate the identification of patterns and themes. Data displays were also used to visualize patterns across categories and concepts, and permit systematic analysis.

Ethical Considerations

The project was approved by the Research Review Committee and Ethical Review Committee of icddr,b. Prior to interview, written informed consent to participate in the study was obtained from each respondent, as well as permission to be audio-recorded. All elements of consent were described to study respondents orally to clarify the purpose of the research, the measures undertaken to ensure confidentiality, and their right to withdraw from the interview at any time, for any reason. Arrangements for the place and time of interview were organized in advance according to the respondent's convenience and privacy.

Patient and Public Involvement

The research questions and outcome measures of this study were identified with the participation of a technical advisory group comprised of formal healthcare owners, managers and providers, policy makers, and academics. Neither patients nor the public were involved in study design. Patient involvement was limited to participation in exit interviews which captured their experiences and satisfaction with care received from formal private for-profit clinics. Study findings were shared and discussed through a series of dissemination workshops involving international and bilateral donors, researchers, government officials from the Ministry of Health and Family Welfare involved in hospital services management, planning and quality improvement, as well as leaders from professional medical, nursing and private clinic associations.

RESULTS

Motivations of private healthcare owners, managers and providers

To understand the motivations underlying the involvement of private sector actors in the healthcare market, respondents were asked to describe how they came to be involved in the sector, and their reasons for sustaining their business. Two groups of motivational factors emerged from analysis – financial and personal.

The monetary rewards associated with running a successful healthcare business were a strong pull-factor motivating entry into the private sector. The industry was widely perceived as financially lucrative, and therefore an appealing professional choice. Formal for-profit business owners described how profit is a central motivation and that the provision of quality care is critical to ensuring *"good"* business i.e. financial gain. One doctor in Sylhet explained, "*the main reason I entered the private sector was business. I worked in a small town near Dhaka city. 55-60 private clinics are there in that small town. All are running well, also gaining profit...*". They also explained how profit was generated when necessary services are provided that the public sector is unable to furnish due to insufficient capacity.

There was also a general assumption that working as a doctor in the private sector ensured financial security given the rising demand for services in urban areas. Many providers further described how the opportunity for a stable income for themselves and their families was a key reason for joining and remaining in the profession. According to one private provider in Khulna: "*The thing that attracted me to this profession is financial solvency…I assumed that I will have a superior financial status and I (sustained) that by joining this profession*."

In addition to financial interests, personal motivations also played a role in entering the private healthcare profession. First among these was the desire to furnish needed services to the public, and

the personal fulfilment that this yields. A number of respondents noted a particular concern for the poor, the vulnerable, and the disadvantaged who frequently lack access to quality care. For these providers, a commitment to rectify these inequities was identified as an impetus for entering the private healthcare sector, and a reason for continuing their professional engagement.

At the other end of the spectrum was personal ambition. For some respondents, the desire for social status associated with a career in healthcare, and conferred to specialist doctors in particular, was an important factor motivating their decision to engage in private sector practice. Others indicated their aspirations to be part of a challenging, fast growing profession. Frequent reference was also made to the expectations and ambitions of family members. Pressures from family to pursue private medical practice were widely cited, largely due to the perceived status and income it commands, or because an existing family business needed to be sustained. As one provider from Khulna explained: *This business is in our family. The forefathers of my father used to run it, after them, my father. I practiced with my father for a very long time, then after (his) death I took charge.*

In a number of instances particular personal circumstances compelled entry into the private healthcare market. One clinic owner and provider described his decision to start a clinic following his mother's death and his desire to do something concrete in her memory: *When I started my fourth year of medical school, my mother died. At that time, I couldn't take care of my mother due to my studies. I established this clinic in (her) name.* Similarly, a clinic manager in Dhaka, claimed that an experience with poor quality healthcare prompted the creation of the facility in which he worked: *Our Director's child died in a renowned hospital of Bangladesh … because of the carelessness of the doctors and nurses. So, our Director decided to build a NICU where patients will not face such kinds of carelessness.*

Interesting in these narratives was the spectrum of reasons why our respondents came to be involved in the private healthcare sector ranging from the profit-seeking motivations we typically associate with the sector, to a desire to serve the public. Recognizing this complexity of motivations helps clarify the strategies the sector employs in maintaining their healthcare business, and how they might be leveraged to increase access to the urban poor.

Business strategies of private healthcare owners, managers and providers

Private formal health sector actors reported multiple strategies to ensure business success and sustainability. These strategies helped them increase client flow and satisfaction, and derive profits out of the services provided. Adapting the Business Policy Model to the context of private sector healthcare, we consider these strategies under the broad headings of products and services, the market environment and organizational capabilities. A particular interest in this exploration is how strategies in these areas can either facilitate or hinder access by the urban poor.

Products/services

A number of strategies were identified whereby for-profit healthcare businesses aimed to make their services more appealing to both current and potential clientele. One such strategy was the use of patient discounts. The majority of private practitioners interviewed reported using discounts to entice new patients, and to reward existing client loyalty. However, philanthropic motivations were also common, with many private sector clinics offering discounts to allow poorer patients access to services they otherwise could not afford. As one private sector provider explained:

> *There is not a fixed percent, but they do so according to the (financial) state of the patient… Normally we grant 15% discounts for tests and 10% for the bed rent. Sometimes we have to give more – even above 50%.*

Another widespread strategy was the provision of health packages that bundled services and products together at a fixed price for procedures such as c-section and appendicectomy surgery. This decreased costs to patients compared to the cumulative price of individual services, and, in some instances,

created opportunity for negotiation between clinics and clients. While this practice was reported to increase patient flow, in certain instances they had detrimental financial consequences especially when patient complications required additional, unanticipated tests and procedures that the package did not include, yet the clinic was obliged to cover.

Finally, almost all private providers mentioned the importance of cultivating a positive and trusting doctor-patient relationship as crucial to ensuring client loyalty and continuity of care. Respondents described efforts made within the clinical setting to make patients feel valued and comfortable, recognizing that client perceptions of provider behaviour and attitudes are important determinants of whether they adhere to treatment or return for subsequent visits. As explained by a doctor in Sylhet:

> *While the first aim is that the patient gets cured, my behaviour is also important…We, the doctors…tell our students that not all diseases are organic. Some are psychosomatic (and hence) our behaviour with patients is a major factor in providing care. The patient (must) have faith in a doctor that he will be cured …The doctor must create such faith through conversations and discussion time (with patients) …*

Our findings revealed that positive perceptions of provider conduct were not contingent on the duration of wait time for consultation, nor the length of the provider-patient interaction. Interviews with patients exiting private facilities revealed that even though average consultation times were only 6 to 7 minutes in length and wait times varied between 5 minutes and 2 hours and thirty minutes, reports of patient satisfaction with private sector services were uniformly positive. Many noted their provider's efforts to make them feel comfortable, and the quality of services received. As described by one patient leaving a private clinic in Khulna: *"The quality of service is good here… much better than other facilities. The (doctor's) behaviour is very good… he examined me carefully, the nurses, duty doctors and the doctor visited me regularly…"*.

The provision of extended service hours was another strategy that was widely perceived to offer a competitive advantage over the daytime operations of NGO clinics by offering greater access to the working population.

Market environment

A number of strategies were used to maintain market position and cultivate demand for private sector services. Among these was reliance on medical brokers or *Dalals* as a means to ensure patient flow. Employed by many private healthcare facilities to divert or convince clients to use their services, *Dalals* typically operate near the entrance of public hospitals, or in areas of the city where new migrants to the city first settle. A number of respondents also indicated that informal providers such as drug-sellers and unlicensed or "village" doctors may also act as *Dalal* for formal private clinics, receiving payment according to the number of patients referred, or in other cases, a percentage of service charges. A private clinic manager from Dhaka explained the importance of this strategy:

> *Many patients are referred (through agents or brokers). Relatives of a patient who have received services from us (in the past), may also increase publicity. (In return) we give them services at low cost.*

Public sector providers are similarly known to act as middlemen, referring patients to their own private practices or those in which they are shareholders. In other instances, providers described referring patients to other private facilities, and like *Dalal,* receiving a commission for referral. While some of these referrals may be clinically indicated, a number of stakeholders reported that this practice of "referral for commission" was widespread among private sector doctors, diagnostic centres and clinics, and used to boost revenue through collusion. A top-ranked government health officer in Khulna described the involvement of doctors in referral and the financial benefits that are accrued:

> *Suppose, I am an owner of a diagnostic centre. Many brokers are available to me. I will tell them to collect patients from wherever they can, (and) they will be given a percentage. If, a doctor sends patients to me for pathology (testing), I will give him a 40% or 50% commission.*

> *If I get 2000 taka (USD 23.72) by doing the pathology, then 1000 (USD 11.86) taka is for me and the other 1000 (USD 11.86) is for the doctor - the doctor is happy, and so am I. If 10 patients are sent daily, he will receive 10,000 BDT (USD 118.59). (Likewise), if I refer patients to the doctor's facility, he will send patients to my diagnostic service for tests.*

Although these practices were perceived to increase patient flow, several stakeholders noted how referrals orchestrated by brokers may be disadvantageous to the urban poor. Diverting patients away from free government services toward private sector providers, brokers effectively increased the cost of care and the patient's financial burden, and even more when treatment is unnecessary.

Another practise that nurtures the market environment for private sector services was the close relationship with pharmaceutical companies. Nearly all private practitioners described regular visits from pharmaceutical representatives on a monthly, weekly or even daily basis with the purpose of marketing their products. They also reported receiving incentives to buy and prescribe certain drugs, although this practice is prohibited by the Government's *Code of Pharmaceutical Marketing Practices* which states that "no gift or financial inducement shall be offered or given to members of the medical profession for purposes of sales or promotion."[27] Incentives in the form of money, drug samples and gifts were received routinely, and many admitted their influence on prescription patterns. As one clinic owner explained:

> *... month after month, different companies pay doctors for recommending their medicines…. even giving cash…now if doctors recommend (these drugs), we have little choice (but to keep them in our store) ...*

Another provider from Sylhet described how the ubiquitous presence of pharmaceutical representatives had effectively changed his prescription practices:

> *I generally prescribe those medicines which work effectively; still there are some influences such as medical representatives (who) come frequently. They come in the morning, in the evening, automatically we need to keep their medicines ...we use those, prescribe those, but we don't (always) get to check ourselves whether they work or not.*

This strategy of cultivating and sustaining provider loyalty is carefully calculated, as one pharmaceutical representative in Khulna recounted:

> *I see which pharmaceutical company's medicine the doctor is prescribing... We get data from different sources. Some are paid 100,000 taka (USD 1185.95) annually, or 3000 (USD 35.58) to 5000 taka (USD 59.30) monthly ... then I request him (doctor) to kindly give me a chance and make him a monetary offer. If he agrees then I provide him the agreed amount monthly or yearly. Then he writes our drug in the prescription.*

A number of key stakeholders expressed concern about the consequences of pharmaceutical influence on patients, including the development of antibiotic resistance and financial impoverishment by obliging patients to purchase expensive and sometimes unneeded medicines. Private sector providers were also aware of the negative consequences of aggressive pharmaceutical marketing such as the prescription of low-quality drugs, and some expressed concern that decisions about what drugs to stock may be determined by price and discounts received, and not what is best for the patient in terms of treatment efficacy. As one pharmaceutical company manager explained, sometimes drugs purveyed by pharmaceutical reps are not even intended for the local market:

> *Sometimes they (medical representatives) they sell a product not meant for local sale to medicine shops at a discounted rate […] then motivate drug sellers and doctors not to sell another company's product as they will not get any benefit from them.*

Interestingly, several private sector providers justified their relationship with pharmaceutical representatives by explaining their practice of passing on free drug samples to patients with less capacity to pay – for prices well below standard rates.

Organizational capabilities

Many respondents noted the continual challenge of ensuring adequate, trained human resources in an increasingly competitive urban healthcare market. A consequent practice by private clinics was the use of medical staff from the public sector as consultants for specialist and general services. Duty doctors were most often medical staff with less experience, including honorary trainees, postgraduate medical students and occasionally interns. As office hours in public hospitals typically extend from 8 am to 2 pm, in theory, public sector doctors that engage in private sector practice are only available later in the day. As one clinic owner from Sylhet noted, staff shortages and the provision of specialized services in particular, were therefore limited during morning hours: *"The consultants are mostly from the public medical college. So, we face this (doctor shortage) problem from 8:00am-3:00pm."*

Other respondents noted that the practice of public-sector doctors attending patients at private facilities during office hours was not uncommon, with a clinic manager from Dhaka, asserting: *"It is not ethical that, in some clinics of this area, the doctors and trainees of the Government Medical College see patients in between office hours."*

One common strategy to overcome doctor shortages during daytime hours was the use of on-call doctors. These doctors typically practice in public sector facilities in close proximity to a private sector clinic that relies on their services, and will respond to calls when needed. As one clinic owner (and provider) from Sylhet explained: *"Within a few minutes we come to see the patients. Within five to ten minutes the specialist also comes here. If we are informed we come here from anywhere. Or another specialist comes to manage everything."*

This strategy was popular among private clinic owners given its perceived cost savings over standard practices of recruiting and paying the salaries of three doctors to cover a 24-hour service, or having to hire specialist doctors full-time when their services are not always needed. It was also noted that the strategy was not without hazards. Given that many private clinics rely on commonly performed surgeries (C-sections, appendectomies) to ensure financial sustainability, in the context of life threatening complications, reliance on on-call doctors who are located off-site, may substantially heighten risk to patients.

Recruiting and retaining qualified nurses was also identified as a major challenge by many private sector respondents. As a result, nursing care was often provided by unqualified or untrained persons such as cleaners and *aya*s who are meant to provide non-technical care-giving support to patients and their families. According to private sector respondents, the reliance on unqualified personnel was due to the dearth of qualified nurses on the market, and the high salaries they command. As one clinic owner from Dhaka despaired:

"It is impossible for me to keep 6 nurses (on staff); it is not possible for any clinic to give 60,000 taka (USD 711.57) for their salary (10,000 taka each, USD 118.59). Maybe it is possible for (large private hospitals like) Apollo and Square, but not for me. (Instead) we must hire secondary school certificate girls and train them on the job…

In circumstances when a private sector clinic is unable to handle a complicated case due to lack of capacity, referral to public hospitals and medical colleges was justified. Respondents noted this practise was especially common among patients requiring speciality care, or those with emergent, deteriorating or potentially fatal health conditions. Several providers further noted the reputational risk in being held responsible for a patient's death, and hence the reliance on referral as a strategy to avoid potential fatalities that might damage their professional reputation or that of the facility in which they work. Referral shifted responsibility for potential accusations of malpractice to the receiving facility, which most commonly was the city's public hospital. As one private sector owner/provider from Khulna admitted, *"We don't take the risk of keeping critical patients. They are referred to the Government Hospital, where there are ICU facilities, or to larger private hospitals based on their (financial) ability."*

This widespread practice highlights broader limitations in critical care capacity within urban areas that need to be addressed.[28, 29] It can also exacerbate the vulnerability of the urban poor, as the referral destination is often determined based on ability to pay. Even if a private hospital is closest, many providers stated that they were more apt to refer poorer patients to public facilities or medical colleges, while better-off patients were sent to closer private facilities. Patient's desires, frequently motivated by perceived quality of services, was a further factor influencing referral patterns. More virtuous behaviour was also reported. Some providers stated that their referral decisions were based on the quality of care provided at the receiving facility, and several claimed that instead of taking commissions from referral facilities, they asked that patient discounts be provided instead.

Interestingly, almost all of the respondents in the study acknowledged that the absence of a formalized referral system contributed to poor health outcomes, and described the challenge of patients arriving too late for effective treatment. Suggestions were also made that a formal referral system be implemented to assist primary providers in ensuring patients be directed to appropriate levels of care.

DISCUSSION

This exploratory study is among the first in Bangladesh to query the underlying motivations and strategies of the urban private for-profit sector and their implications for health care quality and accessibility. However, certain limitations must be acknowledged. The most challenging of these was the reluctance of some private sector respondents to divulge details about the strategies they employ to grow their business. In other instances, respondents may have constructed their replies in a socially desirable manner to mitigate judgement about the business strategies they employ, especially if unethical or informal practises were revealed. Although efforts were made to maximize trust by approaching respondents through personal contacts and social networks, richer and more trustworthy data might have been produced had a lengthier period of rapport building been possible. While a risk of selection bias was inherent in our approach, this was justified given our concern that private sector respondents would not divulge their business strategies to strangers. Selection bias may also have occurred in exit interviews as clients may have been more inclined to give a positive evaluation of the quality of care received at the time of discharge.

An interesting first insight emerging from analysis was the complexity of motivations prompting involvement in the private for-profit sector. In-depth interviews with owners, managers and providers challenged widespread perceptions that financial interests are the singular driving force for engagement in private healthcare business. Rather, public service, social status, and family obligation figured prominently alongside profit and financial security as factors motivating participation. Leveraging these non-financial motivations might serve to further encourage social responsibility in the sector, or potential participation in health financing schemes that aim to increase affordable healthcare access to the urban poor. That being said, private sector engagement is ultimately contingent on success in turning a profit.[30] In other words, the scope for market expansion must be sufficient to support lower per patient revenues typically associated with fee for service and prepayment schemes.[31–33]

In this paper, the analysis of strategies was usefully structured around the Business Policy Model.[24, 25] As the model specifies, in order to deliver a profitable value proposition, private healthcare actors must employ strategies that enable a best fit between the products or services offered, the market environment and their organization's capabilities. In this discussion we consider each of these components to gain insight about the complex ecosystem in which the urban private sector is located, and the manner in which business interests are pursued within a competitive healthcare market. Of particular interest is how the strategies employed are conducive to achieving greater efficiency, equity or scale, and their implications for Bangladesh's broader policy goals in support of UHC.

As regards products and services, there was a near-consensus viewpoint among study respondents about the necessity of providing patient-friendly services and making patients "happy". These

objectives appear to be backed up by a range of "patient-loyalty" strategies that included "good" provider behaviour, the discretionary use of discounts on consultation fees, drugs and procedures and offering extended service hours convenient to the working population. Interestingly, however, exit interviews with patients revealed that consultation time was only slightly longer than public sector facilities and did not appear to be an important factor influencing patient perceptions of quality.[34] These results correspond with global evidence that patients are willing to pay for private healthcare if they perceive providers are respectful and responsive to their needs,[35, 36] and that good provider-patient relations increase the likelihood of sustained treatment-seeking,[37, 38] and attracting new clientele. Indeed, adapting service pricing and delivery modalities to the needs and preferences of healthcare customers is emblematic of private sector practice globally.[39] This behaviour can be explained by the aspiration to gain and sustain market share through customer loyalty when other private sector actors or NGOs may be offering lower-cost services.

To ensure their position in a crowded healthcare market, many private sector respondents indicated their reliance on brokers and agents Referral fees paid to these middlemen ensured a fresh client flow and competitive advantage. Among those "captured" were patients diverted from Government facilities where services are free. Very similar was the widespread practice of offering referral fees to doctors who direct their patients to preferred private sector clinics.[30] In both cases, these practices are only effective market strategies if the costs incurred amplify profit. It was unclear, however, whether such calculations were made, and the extent to which they end up being subsidized by patient out-of-pocket expenditures.[7]

The role of pharmaceutical agents in shaping the market environment and the prescription practises of private sector doctors was also widely acknowledged. Many private sector respondents valued the incentives that they receive from pharmaceutical companies, some of which are passed onto patients, such as discounted prices on "free" medicine samples. A few others expressed concerns that the medicines pushed by pharmaceutical representatives were expensive, or unknown in terms of efficacy. The adverse influence of pharmaceutical incentives on private sector business has been emphasized by others,[40–42] and it is well recognized that aggressive marketing strategies undermine patient safety and ethical medical conduct, and need firm regulation.[40–44]

Capacity constraints related to human resources, especially of nursing staff and specialist doctors, were almost universally identified by private sector respondents. At the same time, concerns related to the costs of keeping full-time staff were also acknowledged. A variety of work-around strategies were reported to overcome gaps and minimize costs such as the use of on-call specialists from the public sector, reliance on doctors-in-training or recent medical graduates, as well as filling sector-wide short-falls in the number of nurses through onsite and unregulated nurse training to unqualified personnel. The implications of these adaptive mechanisms in terms of quality and costs to the public health system and patient safety, warrants assessment. Moreover, these strategies provide insights into some of drivers of the widespread phenomena of "dual practice" that many health systems struggle to manage from cost, quality and accountability perspectives.[13, 30, 45–46]

Other strategies employed to overcome capacity limitations included the referral of complicated cases to public sector tertiary facilities. Several respondents noted that the absence of a formal urban referral system inclusive of both private and public sectors heightens patient risk as inappropriate or late referrals may result. The development of a system which identifies the fastest and safest route to appropriate critical care services, whatever the location, represents a critical area for policy attention. This includes the transfer of patient information so that expensive diagnostic tests aren't needlessly repeated,[47] enhanced capacity for first aid services to ensure that patients are stabilized during transport, and the availability of proximate and effective ambulatory services.

Although our study was focused on so-called "formal" small to medium-sized private health facilities in urban Bangladesh, striking was the degree to which "informality" characterized most aspects of their business model ranging from the way prices were levied, health workers deployed, and business hours set. Not a single respondent indicated the existence of a written business plan or even standard operating procedures to guide the day-to-day or longer-term development of services. Similarly

lacking, was a formal or standardized system of reporting on the volume, quality or costs of services provided. Paradoxically, "professional reputation" – subjectively or tacitly determined by the "public" -- was noted as critical to sustaining a successful healthcare business. In short, we observed a variety of stopgap strategies that align services, market environment and are illustrative of a sector that is getting by, but with little apparent emphasis on achieving greater efficiency or scale.

This qualitative exploration of the motivations and business strategies of those involved in small and medium-sized urban private for-profit healthcare delivery offers insight on how this sector might be harnessed more effectively toward the broader national policy aims of UHC. Features of the sector that represent strengths or positive assets include professed motivations of service, patient centeredness and responsiveness, innovative approaches to pricing, sensitivity to differential ability to pay, and the desire to maintain a professional reputation within the healthcare market. These features have established the sector's legitimacy and dominance in the urban context, and account for its popularity as a source of care.[30, 39, 45] They also align to some degree with UHC goals of affordable access to quality healthcare without risk of financial harm.

At the same time, certain adverse practices exist that are contrary to Bangladesh's aspirations for UHC.[48] Patient-brokers and pharmaceutical incentives are likely to lead to over-supply of services and over-prescription that don't match with needs and may promote public health threats such as antimicrobial resistance.[49] Furthermore, staffing models that rely on part-time, junior and unregulated training pose serious problems with quality and safety of services. From an affordability perspective, accessibility amongst the poorest segments of the population is unclear and the pay-per-service model of provision is likely to strain household budgets and push significant numbers into poverty.[50, 51]

Given the size and centrality of this sector to urban health in Bangladesh.[20, 23], the policy conundrum becomes how best to amplify strengths and shore-up shortfalls of this important segment of the urban health system. Perhaps the most challenging attribute of the sector is its inherent informality in a broader health systems context that is also characterized by weak governance, particularly in urban areas. This context argues against sweeping de jure regulatory reforms on multiple fronts as they are highly unlikely to be implemented in any meaningful way. Rather, more discrete, focused efforts on specific parts of the sector i.e. pharmaceutical prescription practices that engage the principal actors in changing behaviours may be more effective in nudging the private sector more towards the goals of UHC.

While our findings are appropriately contextualized for urban Bangladesh, they also resonate with other LMICs characterized by increasing urban healthcare demand, a growing private sector, and a weak regulatory environment.[52] However, the need remains for nuanced ethnographic work which examines the particularities of a highly diverse sector, and the unique manner in which products, markets and capacity are aligned to sustain successful business.[53] Understanding these complexities and the larger ecosystem in which the private sector operates, will lend itself to policies that are fit for purpose and effective in harnessing supply, and ensuing quality and affordable access to the urban poor.

CONCLUSION

In urban Bangladesh, the private for-profit sector plays a crucial role in meeting a growing demand for healthcare in a context of limited public provision. Within this massive, heterogeneous yet predominantly informal range of providers, small and midsize private clinics and hospitals are important purveyors of so-called "formal" healthcare services. Focusing on the motivations and strategies undergirding urban private healthcare business, our findings confirm prevailing assumptions about the sector's profit orientation, informality, and sometimes deleterious practises. At the same time certain strategies yield benefits to healthcare consumers like the sector's emphasis on responsive, patient-friendly services. Given the weak regulatory capacity of national and local authorities and

professional associations alike, the provision of incentives that promote greater accountability within the private-for-profit sector, and reward efforts to increase the affordability and quality of services may be a more realistic strategy towards UHC. Support in extending the private sector's largely curative focus to include preventive and promotive services is also critical given the lacunae of primary care services in urban areas. Most importantly, policies that support UHC within the realities of a highly pluralistic health market must accommodate the financial interests of this massive, diverse and growing private sector. Policies and programs that encourage private sector quality and effectiveness, and enable even greater market share, may function to drive out the subset of private sector players whose business model relies on over-charging, over-supplying or providing sub-standard care.

Author contributor-ship

Criteria #1: Substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data – AMA, RA, TAS, SSY, SA, IA

Criteria #2: Drafting the work or revising it critically for important intellectual content – AMA & RA drafted the manuscript. TAS, SSY, SA, IA reviewed critically for important intellectual content. AMA & RA finally revised the version submitted with inputs from all other co-authors.

Criteria #3: Final approval of the version published – AMA, RA, TAS, SSY, SA, IA

Criteria #4: Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved – AMA, RA, TAS, SSY, SA, IA

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Competing interests

The authors declare no competing interests.

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Ethics approval

Ethical Review Committee of icddr,b.

Data sharing statement

The data sets analysed in the current study are not publicly available, but are available from the Ethical Review Committee of icddr,b upon reasonable request after meeting the necessary criteria for access to confidential data.

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Annex 1:
Box 1: Operational definition of facilities by their types

Facility Type	Definitions
Hospital	Any formal institution providing both outdoor and indoor services with more than 30 beds (≥31).
Clinic	Any formal institution with or without indoor services having less than or equal 30 beds (≤30).
Diagnostic Center	Facilities that provide medical testing and imaging facilities and some out-patient services.
Blood Bank	A facility that provided blood collection, preservation and sometimes transfusion services exclusively.
Doctors' Chamber	Private or sole practice, either standalone or attached to a drug or optic shop.
Drug Shop	A formal or informal (unlicensed) facility that sells drugs as its primary service.
Optic Shop	A formal or informal facility that provides optical services.
Static Services	Services provided at a fixed location on a regular basis.
Satellite Services	Services provided at designated locations on certain hours and days of the week.

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	2
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	3–4
Purpose or research question - Purpose of the study and specific objectives or questions	4
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	4
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	5
Context - Setting/site and salient contextual factors; rationale**	4
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	4–5
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	6
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	5

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	5
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	4–5
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	5–6
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	5–6
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	5–6

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	6–11
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	6–11

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	11–13
Limitations - Trustworthiness and limitations of findings	11

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	15
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	15

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388