

Challenges of Satisfaction of Key Stakeholders of the District Health System of Bangladesh and Ways to Improve: A Qualitative Study

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Abstract

Introduction: A qualitative study was conducted investigating insights of the key stakeholders of the Bangladesh's health system to explore determinants of their satisfaction and strategies for improvement.

Methods: Six homogenous focus group discussions were conducted during January 2016 including district public health administrators, private facility owners, public doctors, private doctors, rural patients, and civil society representatives from three districts. An expert translated video-taped sessions from Bengali into English. Two researchers reached consensus on independently coded validated transcripts. A 'directed content analysis' method was used to analyse the data.

Findings: The prime factors of stakeholders' dissatisfaction were grouped into organizational, political, socioeconomic, market and moral issues. Inefficient management of resources relating to bureaucracy, incompetent local administration, corruption and health-professional politics were the key barriers to satisfaction in the public sector; in the private sector these were deficient market regulation, and social status-gaps. These illustrate inter-sector tensions, an imperfect market and mistrust in healthcare. Risks of health catastrophe were perceived as likely in both sectors.

Conclusion: Decentralization of governance to a multisectoral body with ample resources and empowered of controlling a district public-private mixed health system would reduce authoritative and collaborative gaps, immoral practices and threats of market failure. Reduction of undue political influence and instituting a fair evaluation of performances are crucial to recover public doctors' and administrators' motivation and satisfaction. Community involvement in healthcare would improve people's trust on health system. Establishing balanced competitions between the public and private sectors, and implementing a health insurance system are the priority items to improve efficiency and economic protection in healthcare and finally people's health.

Keywords: satisfaction; public-private mixed; health system; health professionals; health administrators; corruption; decentralisation; Bangladesh.

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Introduction

Satisfaction in health care is a worldwide socioeconomic and political issue. Most studies on satisfaction in healthcare systems are focused on patients' opinions, and consider these to be the key indicator of satisfaction level. However, the satisfaction of

other stakeholders such as administrators and doctors is also important, since healthcare system outcomes depend heavily on their roles and interests. For example, without health workers' and especially doctors' adequate fit and satisfaction in organisational settings, patient well-being is at risk [1,2].

Health care services in Bangladesh are provided through public-private mixed provisions. Whereas the public sector financing is tax- and donor-based, the private sector is market-based. The private health market is rapidly growing since 1980s following adapting the neo-liberal market economy policy. The public sector is the main source of primary health care services, while nearly three-fourths of the total patients receive curative services from the private market. The district health system, which consists of primary and secondary level public facilities and secondary level private facilities, plays a significant role in the country's health as well as economic development, as it is the key source of health services to the majority of rural residents, who make up nearly 72% of a total population of 151 million [3,4]. To identify the factors influencing the satisfaction of administrators, doctors and rural patients in the public-private mixed district health system of Bangladesh, we have conducted a series of quantitative studies. The key findings of those quantitative studies are presented below:

a) Findings of the study on the roles and limitations of administrators in the district public and private health sectors

Inefficient utilisation of available resources in the centrally regulated public health system was identified as an obvious problem. This was associated with wide power gaps between the central and local authorities, and disparities between supply and demand with consequent wastage and misuse of scarce resources. In the private sector, the effectiveness of cost and quality regulation is sub-optimal. The system of licensing and accreditation of private health facilities is outdated, and hence ineffective. Local authorities' compliance with the stringent central bureaucracy and their satisfaction seem mutually exclusive. Optimal utilisation of the existing primary health care resources is a high priority. A potential market failure could be prevented and controlled by amending the licensing and accreditation rules involving multisectoral public-private mixed regulatory actors. A 'deconcentration' type of regulatory reform which includes increasing the capacity of the local authorities and implementing reward and sanction-based policy seems to be a promising strategy to improve rural people's health and economic well-being, as well as to enhance local administrators' satisfaction in healthcare [4].

b) Findings of the study on predictors of satisfaction of rural patients

Clients' satisfaction level (CSL) was identified as low in both the public and private health sectors, with significantly lower satisfaction in the public sector. Accessibility (in financial terms) predicted relatively high variations in CSL both in the public sector (18.2%) and in the private sector (25.0%). Availability predicted distinctly higher variations in CSL in the public sector (34.6%). Structural factors (i.e. tangibility, availability and accessibility) predicted higher variations in clients' satisfaction in the public sector, whereas service process features (i.e. responsiveness, reliability, empathy, communication and courtesy) had a greater influence in the private sector. Financial accessibility poses a

crucial risk of impoverishment in the healthcare system. Both structural and process-related features of healthcare are in ample need of reform in order to improve existing low satisfaction among rural patients.

c) Findings of the study on doctors' job satisfaction, turnover intention and burnout

A brief overview: We investigated correlations between work characteristics (i.e. organisational supports, social supports and job characteristics) and doctors' job satisfaction, turnover intention and burnout, and examined whether or not these differ for public and private doctors. We also explored predictors of doctors' job satisfaction, turnover intention and burnout.

Organisational supports (e.g. incentives, managerial support, performance evaluation and career growth) were the strongest predictors with a negative effect on job satisfaction and turnover intention for both public and private doctors; in this regard, the private doctors experienced more support. Despite doctors from both sectors reporting considerably high workloads in terms of weekly working hours and patient loads per day - with higher loads among the public doctors - this did not explain burnout in either group. The effects of health-professional politics on public doctors' satisfaction, turnover intention and burnout were alarming. Internal social supports had a significantly higher positive correlation with job satisfaction for the private doctors compared to the public doctors. Overall, improved organisational supports are crucial for enhancing doctors' welfare in both sectors.

Because of multidimensional interests of the key stakeholders, including administrators, doctors, patients and society as a whole, (dis)satisfaction in the public-private mixed health system of Bangladesh has evolved into a complex phenomenon. Deeper insights into the factors identified in the quantitative studies were needed in order to determine stronger evidence-informed policy implications. It was essential to assess key stakeholders' insights and interpretations in an effort to identify strategic policy interventions to improve their satisfaction in healthcare.

Thus, we considered a qualitative approach aimed at: triangulating the findings of our previous quantitative studies as well as identifying the factors influencing satisfaction in administrators, doctors and rural patients of the public-private mixed district health system through assessing in-depth views of those target groups, including civil society agents; and exploring potential interventions to improve their satisfaction in healthcare. The study findings would be an essential asset to policymakers in gaining a better understanding of the barriers to satisfaction in healthcare. By addressing evidence-informed interventions to improve satisfaction in the target actors, this study would ultimately contribute to people's access to healthcare and health in rural areas.

Methodology

Study design, settings and population

We conducted a qualitative study involving participants from three northern districts of Bangladesh. The country's key district (i.e. local) public health administrators are the Civil Surgeon and the Upazilla (i.e. sub-district) Health and Family Planning Officer (UHFPO). While the Civil Surgeon is the head of a district health system, the UHFPO is the manager of an upazilla primary health

care system, and is therefore accountable to the Civil Surgeon. In a centralised regulatory system, Civil Surgeons ultimately report to the Director General of Health Services through the divisional Director of Health [3]. Private health administrators are owners of the private facilities, and as such are liable to the Civil Surgeon for initial licensing processes and yearly accreditation of facilities. Public and private doctors are the two distinct types of health care providers. Private practice by public doctors is formally permitted after official public time. Thus, many of these doctors are dual-practitioners, i.e. treating patients privately for extra income in addition to a public job [1,5].

We collected data through homogeneous focus group discussions (FGDs) with the following key stakeholders: district public health administrators, owners of private health facilities, public doctors, private doctors, rural patients in both the public and private sectors, and civil society representatives. We defined rural patients as residents other than those in the district and upazilla headquarters. For administrators and doctors, at least three years and five years of experience, respectively, were considered essential. Civil society representatives were selected based on their well-known reputations in social activities (Table 1).

Sampling technique

Considering social and professional disparities among the stakeholders, we organised six homogeneous groups to enable participants within the group to speak freely. A purposive sampling method was used. The Principal Investigator contacted the defined participants through his professional and social networks. We planned to include six participants in each group, and to arrange all FGDs at one of the three sample district headquarters. For this purpose, potential participants' residences, business and professional links, and visits to that place were considered. Accordingly, ten respondents were initially contacted for each FGD. The first six contactees who agreed to join and matched a common date and time were finally selected. We included adult patients who had been treated and discharged from health facilities at least two weeks but not more than six weeks prior the FGD date. This was done to reduce risk of information bias resulting from immediate reactions to treatment outcomes as well as from short memory. Out of ten rural patients from both the public and private sectors who were identified and contacted through clinics/hospitals and rural NGO workers, seven ultimately joined the FGD.

Data collection

Discussion topics in the interview guide were based on key issues which we found in our previous three quantitative studies on the satisfaction level of administrators, doctors and rural patients in both the public and private district health sectors. Six interview guides were developed, consisting of common and group-specific topics aimed at engaging participants in free dialogue. Discussion topics were provided to the respondents in advance with three purposes, firstly, to ensure free decision making regarding joining the FGD; secondly, to allow them to prepare for meaningful participation; and thirdly, to give feedback on the discussion guidelines. The interview guides were started with open questions to enable the participants to raise any other

topics that they felt were missing. Three trained facilitators with public health backgrounds and extensive experience of working in the public (n = 2) and private (n = 1) health sectors facilitated the FGDs. While one of the facilitators focused on a specified FGD, the Principal Investigator acted as a general moderator.

Each session began with some common ground rules of disciplined discussion. Facilitators affirmed confidentiality and anonymity, and explained the need for video recording of the sessions. Informed consent was given by all respondents. To guarantee anonymity, participants were instructed to refer to each other's participant numbers in the dialogues. To ensure all respondents' active participation, discussion on each topic was started by a different respondent and others then contributed. However, we ensured participants' rights and autonomy with regard to their response or non-response to any topic. Each session took an average of 90 minutes. All sessions were video recorded. Data was collected during January 2016.

Data analysis

FGDs were conducted in the local Bengali language and an expert translated all recorded discussions into English. The Principal Investigator checked each translated transcript with video records to ensure validity of the translations of the discussions. The 'manifest coding' method was used for coding the texts, as described by Bernard & Ryan [6]. Two investigators (AR; TvdW) coded the transcripts independently and then compared their codes. We solved any discrepancies through discussion. We grouped codes into categories and sub-categories and then analysed the text using a 'qualitative directed content analysis' approach as described by Hsieh & Shannon [7]. NVIVO (version 10) was used to analyse the data.

Findings

Participants did not add any topics to the initial lists that were sent to them. However, the issues of corruption, unethical practice and inter-sector gaps in the health care system were raised during the discussion of other related topics. A high level of agreement, although not on all topics, was noticed among the participants of all FGDs; this increased our interest in the discrepancies.

Overall, lack of coordination between central and local administrators, inefficiency in human and material resource management, and insufficient skills of local administrators were identified as the key organisational barriers to satisfaction in the public health sector; in the private sector, these were deficient regulatory oversight, market control and public-private collaboration. Health professional politics (i.e. the reflection of the country's politics and of political allegiance in doctors' professional lives) was recognised as a key adverse influence on the satisfaction of public doctors and administrators. Unethical practices in association with demoralised doctors, private facility owners and pharmaceutical representatives were common threats to patients' economy and the dignity of the health profession. This section presents the stakeholders' views of challenges to their satisfaction as well as the differences between these views, and concludes with their recommendations for improving satisfaction in the health care system.

Table 1: Background information of respondents of six focus group discussions (FGDs).

Data source	Gender	Respondents' identity	Experience in years	Position/posting	Background/qualification
(FGD1) Public doctors	Male	FGD1- 1	14	District hospital	Cardiologist (MBBS, D. Card.)
	Male	FGD1- 2	11	UHC	General Surgeon (FCPS)
	Female	FGD1- 3	10	UHC	Obs. & Gyn. (MBBS, DGO)
	Male	FGD1- 4	14	UHC	Obs. & Gyn. (MBBS, DGO)
	Male	FGD1- 5	17	District hospital	GP (MBBS)
	Male	FGD1- 6	12	District hospital	GP (MBBS)
(FGD2) Public administrator	Male	FGD2- 1	27	CS	MBBS (GP)
	Male	FGD2- 2	20	UHFPO	MBBS, MPH
	Male	FGD2- 3	20	UHFPO	MBBS, MPH
	Female	FGD2- 4	19	UHFPO	MBBS (GP)
	Male	FGD2- 5	23	UHFPO	MBBS (GP)
	Male	FGD2- 6	34	Retired Director of Health	MBBS, MPH
(FGD3) Private doctors	Male	FGD3- 1	10	Private hospital	Dental surgeon (FCPS)
	Male	FGD3- 2	21	Diabetic hospital	GP (Diabetologist)
	Female	FGD3- 3	10	Private hospital	Diploma in Obs. & Gyn.
	Male	FGD3- 4	13	Private hospital	GP (MBBS)
	Male	FGD3- 5	9	Private clinic	GP (MBBS)
	Male	FGD3- 6	14	Private hospital	GP (MBBS)
(FGD4) Private administrators	Male	FGD4- 1	9	Owner	Doctor (MBBS, DMRD)
	Male	FGD4- 2	15	Owner	GP (MBBS)
	Male	FGD4- 3	14	Owner	Management (MBA)
	Male	FGD4- 4	5	Owner	Banker (MA, Accounting)
	Male	FGD4- 5	22	Owner	Lab. Technologist (BSc.)
	Male	FGD4- 6	13	Owner	Bachelor of Arts
(FGD5) Civil society representatives	Male	FGD5- 1	2 terms*	Municipality Mayor	Bachelor of Arts
	Male	FGD5- 2	15	Journalist	Master of Arts
	Male	FGD5- 3	24	Lawyer	Master of Arts (Law)
	Male	FGD5- 4	19	NGO Deputy Director	Master of Arts (DS)
	Male	FGD5- 5	16	College Teacher	Master of Arts (English)
	Male	FGD5- 6	2 terms**	Secretary (District-BMA)	MBBS, DCH
<u>Types of provision and disorder</u>					
(FGD6) Patients (FGD6-a: public patients; FGD6-b: private patients)	Female	FGD6- 1	Receives diabetic treatment from private facility		Official job
	Female	FGD6- 2	Operated acute appendicitis in a private clinic		Student
	Male	FGD6- 3	Operated gall stone in a public district hospital		Official job
	Male	FGD6- 4	Receives hypertension treatment from public facility		Retired banker
	Female	FGD6- 5	Operated acute cholecystitis in a private clinic		Student
	Male	FGD6- 6	Operated gall stone in a private clinic		Businessman
	Female	FGD6- 7	Operated appendicitis at public hospital and incisional hernia at private hospital		Housewife

Notes: * Indicates 5-years each term; ** Indicates 2-years each term; FGD: Focus Group Discussion; UHC: Upazilla Health Complex; MBBS: Bachelor Medicine And Bachelor of Surgery; D. Card: Diploma in Cardiology; FCPS: Fellow of the College of Physician and Surgeon; MPH: Master of Public Health; DGO: Diploma of Gynaecology and Obstetrics; CS: Civil Surgeon; UHFPO: Upazilla Health and Family Planning Officer; GP: General Physician; MBA: Master of Business Administration; DS: Development Studies; BMA: Bangladesh Medical Association; DCH: Diploma in Child Health; An Explanation of Respondent Identity: FGD1- 2 refers 'respondent 2 of focus group discussion 1'; FGD6-a: Public Patients; FGD6-b: Private Patients.

Public Health Administrators' and Public Doctors Views of Barriers to Satisfaction

We grouped the key barriers to the public health administrators' and doctors' satisfaction into three broad categories: organisational, political, and patient behaviour factors.

Organisational factors

Central-local power gaps and related effects: Wide gaps in power and coordination between central and local public health authorities were mentioned by the public administrators and doctors. Along with central dependency, local authorities' inadequate power to purchase drugs and equipment causes delays in supplying medical goods. Additionally, centrally supplied

drugs and equipment often do not comply with local authorities' opinions and needs. These issues were linked to misuse of scarce resources as well as limited delivery of and access to health care, all of which cause dissatisfaction among patients, doctors and administrators.

Human resource management in the public health sector: Local public administrators and doctors mentioned that the central authority transfers doctors, especially those from rural public facilities without taking local authorities' opinions and needs into account. Poor working conditions, inadequate salaries, lack of transport and residence facilities, limited career growth opportunities, lack of performance evaluation and non-provision of incentives for rural work were mentioned in this regard. These issues were claimed to be linked to doctors' disinterest in working in rural areas, which in turn aggravates the existing shortages of doctors. Participants remarked that the subsequent effects included urban distribution of doctors, excess workloads for the acting doctors, poor quality of services (e.g. long waiting time, short consulting times and overall delays in treatment) and the ultimate dissatisfaction among both doctors and patients.

Procurement and management of material resources: Public administrators and doctors jointly reported shortages of medicines and diagnostics. Additionally, they stated that the frequent malfunctioning of equipment is disappointing. Local administrators lack the authority to repair equipment without approval from central authorities, which is a lengthy process. Many of their opinions were that unskilled operators and/or intentional mishandling are likely reasons for equipment malfunction; however, there was disagreement on this point and the issue of corruption was raised.

"I do not totally agree that operators intentionally damage equipment. The central procurement system is faulty and corrupted. Supplied machines are defective from the beginning. What can an operator do with a faulty machine? The local authority can disagree in receiving any equipment if it does not comply with defined specifications. But there are risks of punishment and harassment" – a public doctor: FGD1- 4.

Skills and compliance in local public health management: Public administrators and doctors stated nearly identical opinions that most of the local public health administrators (i.e. Civil Surgeons and UHFPOs) have neither post-graduate medical degrees nor administrative training. These administrators have limited management skills that result in poor compliance (e.g. absenteeism) within the local managerial system.

"Postgraduate doctors feel uneasy work under an administrator who is a general practitioner and has no management training" – a public administrator: FGD2- 6.

Political issues

Both the public administrators and doctors expressed disappointments because of political grouping among doctors (i.e. health-professional politics) and political interference in routine administrative activities. Doctors' transfer and promotion often depend on political identity and backing rather than performance evaluation. This arose as a source of serious discontent.

"The rule is that public doctors must work in rural areas for at least two years. Is it possible for me to leave a rural facility and be posted at an urban facility by myself? The local authority is not empowered to transfer doctors. Who does violate the rule? Politics, corruption and nepotism are the drivers of rule violation" – a public doctor: FGD1- 4.

Patient behaviour factors

Doctors from both sectors mentioned that patients are not accustomed to the appointment system; patients all crowd into facilities at the same time in the early hours of the day, and everyone wants quick service. Hence, some patients receive treatment at late hours and therefore react badly. Patients are often not satisfied, even with a good prognosis, because of the economic consequences. In addition, patients frequently ignore doctors' schedules. These behaviours often complicate doctor-patient relationships.

Private Health Facility Owners' and Private Doctors Views of Barriers to Satisfaction

We grouped the key barriers to the private facility owners and doctors' satisfaction into two categories: organisational and market-related factors.

Organisational factors

Private doctors' well-being: Private doctors stated that despite their recognisable contribution to health care, they are treated poorly as professionals and employees. Since there is no national policy for private doctors, they lack job security, adequate salaries and benefits (e.g. pension), and career growth opportunities. Private doctors' frustration related to social status and welfare gaps compared to their public counterparts were understood to be fuelled by sharing their income opportunities with dual-practitioners in the private sector.

"Public doctors have good salaries and benefits. They market their profession in public facilities but sell their products in the private sector and become our competitors. However, we are not allowed to practise in public facilities" – a private doctor: FGD3-1.

Private health sector regulation: The private facility owners unanimously remarked that dealing with multiple public and local government offices for licensing and accreditation processes is irritating, costly and time-consuming. They pointed out that the national health policy was not officially disseminated to private providers. Non-recognition of the private sector's contributions to health care was mentioned by the private doctors and facility owners.

"The public sector is insufficient to meet the huge healthcare needs of the population. Health system achievements were not possible without the private sector. Also, the major income of public doctors is sourced from the private sector. However, its contributions remain unrecognised" – a private doctor: FGD3- 5. Private administrators expressed displeasure with discriminatory regulations between private and public facilities.

“Only private facilities have to fulfil defined licensing and accreditation criteria of manpower, equipment and environment. But no public health facility fulfils or is required to fulfil such criteria. Many patients stay on the floor in public facilities but we may have to pay charges for the same. It is unfair” - a private facility owner: FGD4- 3.

Both the private doctors and administrators stated that the private facility inspection team is faulty: it only includes public personnel, and two members of the team treat patients in the facilities under inspection. Due to faulty a regulatory system, bad performers are encouraged; in turn, the cost and quality of services vary widely. These points were also confirmed by public administrators, public doctors, civil society groups and patients. Such issues cause dissatisfaction among good performers.

Market-related factors

Private administrators remarked that due to high establishment and maintenance costs, high-interest bank loans, and conversely, low profit margins, private facilities need a great deal of time to achieve financial stability. They stated that cost and quality of services were often compromised because of unfair market competition. Patients frequently do not understand the trade-off in cost and quality. These issues were linked to mistrust and disgraceful bargaining between private providers and patients.

Public and private sector patients' views of issues influencing their satisfaction

We grouped the key influences on patient satisfaction on both sectors into two categories: service process factors and patient background.

Service process factors: Public sector patients commonly expressed their dissatisfaction because of long waiting times and short consulting times. These were confirmed by public doctors and administrators, who additionally pointed out high patient loads and a shortage of doctors as the explanation. Despite free provision of hotel services and available medicines and the minimum costs of diagnostics, patients stated that there was no guarantee of low-cost treatment in the public sector because of lacking medical supplies. Delayed operative treatment in public facilities was raised as an issue of serious discontent.

“I was admitted to a district hospital with appendicitis. I had to wait for an operation with severe pain because surgery was not considered urgent. When I was operated on, my appendix was found burst. I lost a lot of money and suffered for 22 days there. Lastly, I developed an ‘incisional hernia’. Then I went to a private clinic where my hernia operation was done on the same day by the same public hospital surgeon. I recovered within a week. If our doctors can provide good services in private clinics, they can also do the same in government hospitals. But why can’t or don’t they do so? The government allocates a big health budget. I cannot understand why we are not getting proper services in public hospitals” - a patient: FGD6a-7.

In contrast, short waiting times along long consulting times and quick surgical treatment were the key drivers of private patients’ utilisation of private facilities; however, the issue of quick service has become a topic of debate:

“Quick service does not guarantee good quality service. Operations should have proper justifications. Many operations in private facilities are done without indication because of business interests. In private facilities nearly all pregnant women need caesarean sections. I have doubts about that” - a private patient FGD6a- 4.

High health care costs combined with a lack of information about standard cost and service quality were common concerns of the private patients, and were confirmed by other groups.

Patient background: Public and private doctor and administrator groups pointed out that many patients are poor and their expectations are high. This causes gaps in supply and demand, and leads to patient dissatisfaction. Doctors from both sectors mentioned that patients are often treated by unqualified practitioners/traditional healers, and come to them at a late stage. The consequent unwanted health and economic outcomes dissatisfy both patients and doctors.

Civil society agents' views on the health care system

Civil society agents’ overall views on the health care situation were quite similar to those of other groups. Additionally, these agents strongly spoke out against unethical practices, and noted flaws in health care system regulation and the roles of the Bangladesh Medical Association, the state-affiliated professional organisation of doctors.

Unethical practices in health care: Civil society agents mentioned that two unethical practices impose financial burdens on the poor patient: firstly, ‘referral-fees’ which are offered by many diagnostic facilities to doctors for advising unnecessary tests; and secondly, gifts/financial benefits from pharmaceutical representatives for prescribing unnecessary drugs. These issues were confirmed by other groups, and in particular by the private facility owners, who mentioned that referral-fees alone account for a 30% increase in diagnostic costs for patients.

Loopholes in health care regulation: The civil society agents indicated two problems associated with health care regulation threatening people’s health and economy: firstly, Civil Surgeons lack sufficient power and are dependent on the central authority; and secondly, health care costs and quality are uncontrolled in the private sector because of weak monitoring and supervision.

The roles of the Bangladesh Medical Association (BMA): Civil society representatives’ comments on political influence in the health sector were quite similar to those of public administrators and doctors. However, they specifically raised questions about the political and professional roles of BMA.

“BMA started as a non-political professional organisation of doctors. Now because of party-based politics, the doctors’ community is divided. Transfers and promotions of doctors

based on political identity are unfair and not the real role of BMA. BMA should play major roles in stopping immoral practices in healthcare and preserving professional dignity”- a civil society agent: FGD5- 3.

The BMA representative argued that BMA never supports unethical practices. Transfers and promotions are normal administrative procedures. BMA-initiated transfers or promotions of doctors are usually affected to meet the needs of people.

Stakeholders’ views on improving satisfaction in health care

Decentralisation of defined powers, better central-local coordination in human and material resource management, postgraduate training in management or public health for local administrators, and a transparent procurement system were mentioned with regard to addressing key public organisational loopholes. To control health care costs, improve the quality of care and combat unethical practices, the various respondent

groups suggested that a multisectoral district health monitoring agent should be installed. Private doctors urged for a policy for their own group (Table 2).

As a general statement, the civil society agents stated that the economic impact for patients in the health care system is a crucial challenge to the country’s poverty reduction goal. This issue has to be addressed as a high priority so as to maintain the achievements of the health system and promote the country’s development.

Discussion

This study aimed to triangulate the findings of our previous quantitative studies on diverse determinants of satisfaction among administrators, doctors and patients in the district health care system through investigating insights from those target groups in addition to civil society agents, and to explore their views on potential interventions to improve satisfaction in the health system of Bangladesh.

Overall, these qualitative study findings have supported the

Table 2: Stakeholders’ recommendations of improving satisfaction in healthcare.

Health sector: Categories of factors	Problem areas	Recommended solutions	Source
A. Public: (i) Organizational factors	Central-local power difference and coordination	➤ Decentralization of specific authorities of purchasing drugs, and repair and maintenance of equipment using a defined proportion of local revenue.	FGD1 FGD2
		➤ Authority of Civil Surgeons should be increased to purchase local emergency medical needs. A multisectoral district purchasing committee could be formed.	FGD5
		➤ Drugs and equipment should not be supplied without local authorities’ opinions and need assessment.	FGD1 FGD2
		➤ Local doctors’ involvement in medicine selection and purchase.	FGD1
	Human resource management	➤ Strict implementation of the existing two-year rural working rule for public doctors, and no transfer of doctors without local authorities’ concern.	FGD1 FGD2
		➤ A completion of two-year rural working could be an incentive for career development opportunity,	FGD1
		➤ Provision of transport and low-cost residence facilities for doctors at rural set-up, ➤ Good working conditions,	FGD1 FGD2
		➤ Extension of internee training for a two-year instead of one year with a mandatory rural working for the second year,	FGD1
	Allocation and procurement of material resources	➤ Drug supplies and diagnostic facilities should be increased,	FGD1 FGD2 FGD5 FGD6
		➤ Equipment procurement system should be transparent,	FGD1
Management skills	➤ Postgraduate management training or Public Health degree should be mandatory for Civil Surgeons and Upazilla Health and Family Planning Officers	FGD1 FGD2	
(ii) Service process factors	Provider-related and demographic factors	➤ Establishment of good gate-keeping and referral systems, ➤ Increase in number of doctors,	FGD1 FGD2

Health sector: Categories of factors	Problem areas	Recommended solutions	Source
B. Private: (i) Organizational factors	Regulatory factors	<ul style="list-style-type: none"> ➤ Reduction of licensing fees, ➤ Provision of an integrated single licensing organization, 	FGD3
		<ul style="list-style-type: none"> ➤ Private health care costs and quality should be standardized and controlled through proper monitoring and evaluation system. 	FGD2 FGD3 FGD4 FGD5 FGD6-b
	Public-private discrimination: facility level	<ul style="list-style-type: none"> ➤ A policy defined independent district healthcare inspection team should be formed including multiple public-private representations, 	FGD2 FGD3 FGD4 FGD5
		<ul style="list-style-type: none"> ➤ Public facilities should also be inspected by the same inspection team with identical policy criteria, 	FGD4
	Public-private discrimination: doctor level	<ul style="list-style-type: none"> ➤ A national policy for private doctors to ensure job security, salary, pension and career growth opportunity, 	FGD3 FGD4
		<ul style="list-style-type: none"> ➤ Separation of public and private sector by stopping public doctors' involvement in the private sector, 	FGD3
(ii) Market-related factors	Economic factors	<ul style="list-style-type: none"> ➤ Provision of soft-loan for facility establishment, 	FGD4
	Market competition	<ul style="list-style-type: none"> ➤ Unqualified facilities should be penalized or closed, 	FGD4
C. Both public and private: (i) Moral factors	Process-factors	<ul style="list-style-type: none"> ➤ Referral-fee should be stopped by rules, and concerned facility and doctors should be sanctioned, 	FGD4 FGD5 FGD6-b
		<ul style="list-style-type: none"> ➤ Culture of gifts/financial benefits between pharmaceutical company representatives and doctors should be stopped by rule, 	FGD5
(ii) Patient-related factors	Socio-economic factors	<ul style="list-style-type: none"> ➤ Provision of health insurance, 	FGD1 FGD3 FGD4
	Health-seeking behaviour	<ul style="list-style-type: none"> ➤ Mass-population health awareness programme, ➤ Provision of facility-based patient counselling, 	FGD1 FGD3 FGD5
(iii) Politics in health sector	Health-professional politics in the public sector	<ul style="list-style-type: none"> ➤ Transfers and promotions of doctors should be based on policy-guided performance evaluation and strictly free from politics, ➤ Doctors' commitment is essential to be free from party-based politics, ➤ Doctors should be united for controlling professional misconducts, 	FGD1 FGD2 FGD5

Note: FGD: Focus Group Discussion

results of our previous quantitative studies and are also consistent with other studies [1,8]. With the exception of corruption, inter-sector authoritative gaps and moral issues, no notable new issues emerged; however, the insights in this regard were deepened. Organisational, political, social, economic, market-related and moral issues were the main barriers to satisfaction.

Addressing the dynamics of public administrators' and doctors' satisfaction

Centralised authority versus decentralisation

Due to stringent bureaucracy, the transfer of doctors and supply of medical goods are often based on a command and control system rather than a minimum evaluation of the local authority's opinion or needs. The consequent outcomes of inefficient resource use and dissatisfaction of local administrators are

consistent with the report of the National Health Service Confederation [9] suggesting that a bureaucratic health system design reduces frontline employees' satisfaction and efficiency.

According to public administrators, doctors and civil society representatives, adequate empowerment of local authorities and central-local coordination are crucial. Local authorities' opinion and needs should be prioritised in human and material resources management. Civil Surgeons should have the power to use a certain part of local revenues for emergencies in a transparent system. These recommendations imply administrative decentralisation (i.e. deconcentration). Findings from other studies show that decentralisation in health systems could be effective if there is ample political and bureaucratic support, managerial capacity and autonomy, and community involvement [10,11]. In Bangladesh, progress in all these areas is essential; in particular, postgraduate education in public health for local administrators is crucial to improving system compliance.

Corruption versus good governance

Corruption in the central command and control system is another potential cause of mismanagement of human and material resources. For instance, incidences of coercing local authorities into receiving central supplies of faulty equipment without a need assessment, as part of structured corruption, are not uncommon. Corruption is also linked to doctors' transfers and promotion. Good governance is absolutely necessary to mitigate corruption in human and material resource management.

Party-based health-professional politics; A complex issue

Health-professional politics is an influential barrier to public doctors' regular transfer, posting and promotion. Doctors are politically polarised for personal gain since performance is often not measured through fair evaluation. Thus, deprivation combined with tension drives public doctors' and administrators' dissatisfaction.

The Bangladesh Medical Association (BMA) needs to be proactive in controlling professional misconduct (e.g. referral-fees) rather than promote political leadership- and interest-based transfer and promotion of doctors. BMA is the right body to control its members' behaviour in order to protect people's economy and professional ethics. This practice of 'self-regulation' has proved to be effective elsewhere, e.g. in Canada [12].

A common view was that doctors need to be motivated to avoid party-based politics for the sake of their unity and dignity. Despite strong remarks on professional politics as an unexpected issue that leads to unfair evaluation, disparities and mistrust between public administrators and among doctors, no clear integral solution was suggested.

Challenges versus motivations for retaining doctors in rural settings

The existing rule of two years mandatory rural service for public doctors is seriously violated. Inadequate physical working conditions, inferior residence and transport facilities, and lack of incentives drive doctors to compete for preterm withdrawal from the rural facilities either by using political backing or resorting to corruption.

A policy for financial and/or non-financial incentives such as assurance of career advancement (post-graduation, promotion), good housing and transport facilities, and pleasant working conditions can retain doctors in rural areas. These findings are consistent with the study and such incentives have proved effective elsewhere in the world [13]. Additionally, the existing two-year rural working rule should be strictly implemented. Provision of a two-year internship instead of one year, with rural working obligation for the second year, would improve the situation.

Addressing the dynamics of satisfaction among private health investors

Private sector contribution versus public regulation, recognition and collaboration

The effects of a market economy substantially depend on the public capacity to regulate the market based on public-private collaboration [14]. Having emerged since the 1980s, the private health care sector is one of the fast-growing markets and has captured nearly two-thirds of the country's total health expenditures [15]. However, inadequate public-private collaborations in market regulation have resulted in wide variations in costs and quality. The market lacks user-friendly information on standard price and service packages which creates unfair competition and a disgraceful culture of bargaining. Mistrust between providers and patients are common. Unfair competition and information asymmetry lead to market failure.

The private facilities inspection system is ineffective, since the inspectors and dual-practitioners are often the same public officials; thus, good and bad performers are evaluated equally, and service quality is compromised by low costs. In contrast, there are no parallel service quality control criteria for the public health care facilities. This discrimination not only creates authoritative gaps, but also puts patients at risk in terms of health and economic loss in both sectors.

The private sector's contributions to the health system's achievements are undeniable, although they lack proper recognition. Notably, private doctors and owners remain uninformed of their roles in public health goals since the national health policy are not officially disseminated to them. This indicates a major need for public-private collaboration.

A public-private consensus-based policy on the national standard of price and quality of health care services seems essential. To improve regulatory compliance through controlling the cost and quality of health services as well as building collaboration in the health sector, an independent district regulatory body integrating public and private participation would be effective.

Tanzania's experience with the 'Tanzania Essential Health Interventions Project' is an inspiring example of reform through district-level decentralisation of authority [16]. The stakeholders' recommendations for building the capacity of local administrators and establishing a multisectoral independent oversight body form the basis of the district health system reform. Such a reform seems effective, though it may face resistance from interest groups. However, evidence from the Mumbai (India) shows that legal and political support along with key stakeholders' involvement in policymaking and implementation could resolve tensions [17].

Market establishment and maintenance; Economic as well as moral concerns

Establishing and running a private health care facility is challenging because of costly multicentre licensing and accreditation procedures, the costs of human and material resource management and taxation, and insolvency of many patients. This is either solved by securing bank loans or exploiting the health care costs through unnecessary diagnostics and drugs prescriptions. This 'supplier induced demand' has been systematised in collaboration with demoralised private investors, pharmaceutical representatives and doctors. We call it perverse association, which must be strictly prohibited by law. The state provision of soft loans could be effective in controlling need-based distribution of private facilities, cost and quality of health services, a fair information system, providers' ratings, and reinforcement (i.e. rewards for good performers, and support or sanctions for bad performers).

Addressing patients' satisfaction dynamics in the public and private sectors

Whereas costly but prompt operative treatments in private facilities are often publicly branded as commercially driven rather than based on actual indications, in contrast, free but delayed operations in the public sector are a type of business strategy to shift patients to private facilities. Once a surgical patient is admitted to a public facility, s/he must remain hospitalised until operation; this results in free provision of available drugs, beds and food. Needless prolonged hospital stays not only increase patients' economic burdens, but also waste scarce public resources. Thus, quick or delayed treatments in either sector are a serious concern in terms of health, economy and social capital. After recovering from an acute phase, patients could be discharged with a date of operation; this is practised in many countries, reducing the costs of hospital stays. Notably, people often feel that they are deprived despite the huge state health budget. However, what they believe to be huge is only one-third of total health expenditures [15]. All these facts indicate the need for community involvement in health care.

Overall, patients lack health awareness and display poor health-seeking behaviour. Many poor patients visit unqualified doctors before they come to qualified doctors [8]. Because of this, they already are unhappy because of monetary loss and ineffective treatment and good prognosis with qualified treatment is often not enough to satisfy them because of the mental and economic adversity they suffer.

A well-developed public sector is crucial to solving many problems in the health sector. Establishing this, increasing resource allocation and providing a 'gate-keeping' system and health insurance were common recommendations. However, we think that it is more useful to guarantee efficient use of the available resources than to increase resource allocation.

Experiences in developing countries suggest the same [18]. For patients' economic protection, the inspiring evidence of health insurance from developing countries such as 'community-based health insurance' in Rwanda [19], could be used as the basis for a pilot initiative.

Dynamics of the private doctors' satisfaction level

The non-existence of any policy, along with job insecurity, unstable salaries and benefits, and non-provision of pensions are the key factors distinguishing private doctors from their public counterparts; additionally, competing with public doctors in the private setting aggravates their frustration. A parallel policy for private doctors seems essential in order to reduce the professional, economic and social status tensions as well as the disparities that exist between private and public doctors despite their comparable education and background.

Healthy competition is the essence of a balanced market [20]. However, competition in the public health sector of Bangladesh is discouraged due to the system itself. Public-private division in terms of investment as well as manpower would create competition between the public and private sectors rather than public doctor-led competition within the private sector. Such inter-sector competition could be promoted on a small scale to verify its effects on controlling cost and quality, improving productivity and trust as well as reducing gaps between diverse providers within the health care system.

Strengths and weaknesses

To the best of our knowledge, this is the first qualitative study on satisfaction with Bangladesh's health care system involving a wide range of stakeholders. By recruiting the stakeholders from three districts with broad social and professional experiences and perceptions, we reduced the risk of selection bias. By arranging homogeneous focus groups and assuring anonymity, we effectively encouraged participants to speak freely. In addition to strengthening our previous study findings, this study delves deeper into the facts and challenges in the health care system and addresses solutions based on insights from diverse interest groups. Careful checking and comparing of the translated transcripts with video records reduced the risk of losing the specific meaning of Bengali expressions.

Conclusion and Recommendations

Confirming the findings of our previous studies, this study has explored deeper insights into factors of dissatisfaction in health care along with ideas for solutions. Wide central-local power gaps are the key contributors to the local public health administrators' dissatisfaction, while those in the private sector mention authoritative rather than collaborative relationships between the public and private counterparts. Whereas organisational barriers, corruption and managerial incompetence are linked to inefficient resource management in the public sector, the

private sector suffers from ineffective oversight relating to wide variations in health care costs and quality, unethical practices and an imperfect market. Furthermore, while private doctors contend for social status and economic security, public doctors compete for better postings and positions, and for surplus income from the private market. Risks of health catastrophe and low social capital are apparent in the health care system.

Strategic decentralisation of authority to district level is widely suggested as a method to improve satisfaction in the health sector. Although global experiences of the impacts of various health system reforms are mixed, encouraging examples of strategic reforms with political and bureaucratic supports are known. Taking into account the global experiences with best practices, the overall situation would be improved through gradual decentralisation of those centralised authorities which are explicitly linked to dissatisfaction among key stakeholders and the compromised productivity of the health system. Gradually developing each district health system into an integrated decentralised health care unit would improve efficiency. However, the key stakeholders' opinions and overall socio-political contexts reveal that the country's health system needs to be harmonised through the national system of public-private and central-local collaboration, rather than through a command and control approach. A national policy for the district health system should be developed based on a consensus from all key public and private stakeholders. The policy should be implemented through a single body with broad public, private and professional participation. This district health system regulatory body should have ample capacity, resources and authority.

To control costs and quality in the private health care market, piloting of publicly arranged soft loans for establishments

along with reinforcement-based regulation could be promising. However, a well-developed and efficient public sector is adamant that people's health and economy should be protected. A postgraduate public health degree should be obligatory to improve local public health administrators' competence as well as system compliance. Nevertheless, financial and/or non-financial incentives along with strict application of a two-year of rural working are essential for retaining doctors in rural areas. Through compensating dual-practitioners' income interest related to private practice, public-private separation by manpower could also be considered in order to test its effects on the productivity of the public sector. A policy for private doctors' welfare is another high priority.

Health insurance is a crucial priority, both to protect people from the impending threats of health catastrophe as well as to sustain and accelerate the country's economic growth. Further research is needed to develop a viable health insurance policy for Bangladesh.

Ethical Clearance

Ethical approval was received from the Faculty of Social Science, Rajshahi University, Bangladesh.

Competing Interest

All authors declare that they have no competing interests.

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