



Organized by:

**Workshop**  
on  
**Private Healthcare Sector and Patient  
Protection in Bangladesh**

YWCA Conference Hall, Asad Gate, Dhaka 1205  
October 30, 2023

## Workshop on Private healthcare sector and Patient protection in Bangladesh

Organised by People's Health Movement, Bangladesh  
and COPASAH- Hub on Accountability and  
Regulation of the Private Sector (HARPS)

30 October 2023, Dhaka



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I.

## Introduction

The COVID-19 pandemic has been a traumatic experience for all of us, yet this public health emergency has also given a resounding wake-up call to people across the world, regarding the challenges posed by an unregulated, commercialised private healthcare sector. As patients struggled to access life-saving care during the COVID crisis, the negative consequences of marketisation of healthcare systems were exposed in many countries including Bangladesh, India and other South Asian countries. The pandemic underscored the importance of regulating private hospitals and protecting patients' rights, prompting health activists in many countries to better understand the private healthcare sector, while advocating for policies that would prioritize public health over profit margins.

This is the context for the COPASAH Hub on Accountability and Regulation of Private Sector (HARPS) to organise a series of activities across South Asia during 2022-23, for documenting and analysing people's experiences related to the private healthcare sector. After organising a national workshop in India in December 2022, and an intensive interaction with Nepal-based health activists and journalists in May 2023, the proposal emerged to organise a national workshop in Bangladesh, to exchange experiences and promote documentation regarding people's experiences in the private healthcare sector. Thanks to proactive responsibility taken by PHM Bangladesh and the Nagorik Uddyog (Citizen's Initiative) team who collaborated with HARPS-COPASAH, the national workshop on 'Private healthcare sector and Patient protection in Bangladesh' was successfully organised on 30th October 2023 at Dhaka, with participation by around 35 health sector and civil society representatives from across Bangladesh. These included public health specialists and medical professionals, health activists, representatives of women's rights groups, prominent health sector

NGOs including Gonoshasthya Kendra, and journalists.

This brief report of the workshop seeks to capture the main ideas, discussions and proposals for documentation which emerged during the deliberations. We start the report with an overview of key features of the private healthcare sector in Bangladesh, to provide a backdrop for the workshop discussions. This is followed by the main report, which is not in form of exhaustive minutes but rather recounts quotes and points shared by various participants, organised around the following major themes which emerged during the workshop:

- Background regarding privatisation of healthcare in Bangladesh
- Concerns about quality of care and high charges in private sector
- Commercial influence of pharma industry
- Role of government and public health sector challenges
- Interactions between public health system and private sector
- Weak regulation and accountability of private healthcare
- Concerns expressed by doctors

This is followed by the proposed plan for documentation of patients' experiences in private hospitals which emerged during the workshop. After this we have briefly presented five case stories recounted by various patients and their relatives or journalists, which were collected by the Nagorik Uddyog team. These striking case stories illustrate the kinds of experiences that innumerable patients face in commercialised private hospitals in Bangladesh. Similarly, we have included several

excerpts of media reports collated by Nagorik Uddyog from leading newspapers (Bangla and English), these news items describe prominent issues that have been faced by people regarding private hospitals and healthcare facilities in Bangladesh, during and after the COVID pandemic. This is followed by key references and acknowledgements related to organisation of the workshop. At the end of the report, we provide a set of annexures which includes the workshop schedule, list of participants, and set of resource materials published by SATHI and HARPS.

We feel that the in-depth discussions as well as background material generated through the productive Dhaka workshop can serve as a repository for collective learning, in the following forms-

1. Acting as a valuable resource for advancing civil society action on private healthcare and patients' rights in Bangladesh, enabling detailed documentation of patient and healthcare provider experiences related to commercialised healthcare.
2. Providing analysis of the current accountability and regulatory deficits within the private healthcare sector.
3. Serving as a foundation for:
  - Developing grassroots-level actions, as well as formulating policy demands related to private healthcare.
  - Proposing solutions to safeguard people's interests and patients' rights.
  - Promoting an ethical working environment, and ensuring improved conditions for doctors and frontline healthcare providers within the private healthcare sector in Bangladesh.



Today with initiative taken by HARPS-COPASAH in partnership with PHM networks within each country, health activists in India, Bangladesh and Nepal have embarked on processes of documentation and analysis of the private healthcare sector within each of their national contexts. The challenge today lies not only in demanding improved regulation and protection of patients' rights, but also raising awareness among the public about their rights as patients and citizens, empowering them to demand accountability from healthcare providers. We hope that this workshop report

based on our deliberations in Bangladesh will prove to be a small but useful resource for the ongoing movement for health rights in South Asia, towards ensuring equitable, affordable, and quality healthcare for all.



## II. Key features of private healthcare in Bangladesh

In Bangladesh today the dominant source of healthcare is the private sector, similar to the situation in other South Asian countries like India, Pakistan and Nepal. Hence it is important to understand the present scale of private healthcare and its growth over the past few decades, the phenomenon of commercialisation of healthcare and its consequences for patients, and the status of regulation of this sector.

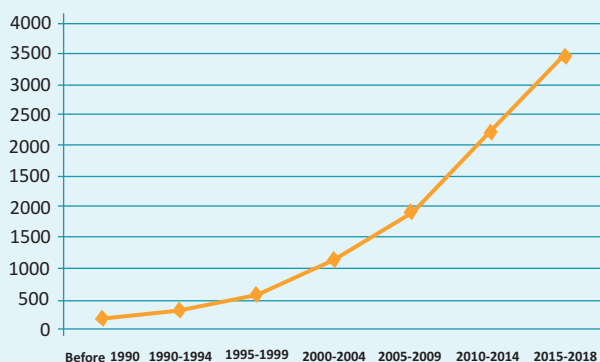
### Scale and growth of private healthcare in Bangladesh

#### Vignettes of private sector dominance in the health system of Bangladesh:

- The number of private hospital beds surged from 570 in 1999, to 4,452 in 2018.
- Private diagnostic centres also saw a dramatic increase, from 997 in 1999 to 10,292 in 2018.
- Approximately 78% of doctors practicing modern medicine work in the private sector.
- Private healthcare accounts for 76.8% of total healthcare spending.
- Of the 109 medical colleges in the country, 72 are privately owned.

In 2019, Bangladesh had 5321 private hospitals compared to 618 government hospitals. The number of beds in private hospitals was 91,537 compared to 54,660 beds in public hospitals, meaning that 63% of hospital beds in Bangladesh were in the private sector. (DGHS, 2022). The private healthcare sector has grown rapidly especially during the last two decades, the number of private hospitals in Bangladesh having multiplied by nearly eight times in last two decades, increasing from 570 in 1999 to 4452 in 2018. (Bangladesh Bureau of Statistics, 2021)

**Chart 4.1**  
Growth of private hospitals (Cumulative number)



It is notable that in Bangladesh nearly four-fifth of the doctors having qualifications in modern medicine are working in the private sector. Out of total of 119,350 registered MBBS physicians and BDS dentists, 26,648 (22.3%) were working in the public health system under the DHGS (DGHS, 2022), while the remaining 92,702 doctors were working in the private sector.

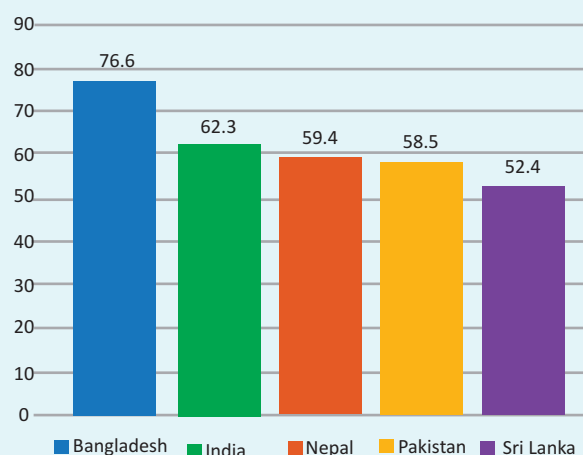
The private healthcare sector in Bangladesh is characterized by a diverse range of providers, including hospitals, clinics, diagnostic centres, and specialized treatment facilities. The

number of private diagnostic centres has grown massively in the last two decades, having multiplied over ten-fold from 997 centres in 1999, to 10,292 centres in 2018 (Bangladesh Bureau of Statistics, 2021). There are also huge number of informal and non-qualified practitioners, it is estimated that in rural Bangladesh, around 65% of primary health care is provided by informal allopathic providers (M. Monaemul Islam Sizar, 2019).

As in most South Asian countries, in Bangladesh today private healthcare expenditure forms the major chunk of total healthcare spending. In Bangladesh the share of private healthcare spending is 76.8% out of total healthcare spending.

Along with the increasing number of hospitals and hospital beds, over the last few years the private sector has witnessed a tremendous growth of medical teaching institutions. Out of 109 medical colleges in Bangladesh, 37 are run by the government and 72 are operated by the

**Private healthcare expenditure as % of total healthcare spending (2020)**



private sector (DGHS, 2022). The number of private medical colleges nearly doubled between 2009 to 2020, increasing in number from 40 to 70. Similarly, out of total of 101 institutes in Bangladesh providing training for nurses at Basic BSc. or post-Basic BSc. levels, 82 are in the private sector. (DGHS, 2022)

This predominance of the private healthcare sector is reflected in the larger share of private facilities in healthcare utilisation. For example, 65% of mothers in Bangladesh deliver in health institutions, within which 45% deliver in private health facilities, while only 20% deliver in public or NGO health facilities.

## Commercialisation and its consequences – high costs and irrational care

The private healthcare sector in Bangladesh has witnessed a high degree of commercialization, associated with overcharging and unethical practices. Patients often complain about inflated medical bills and non-transparent billing practices. Out-of-pocket expenditure is very high and accounts for 69% of total health spending, and has been rapidly increasing during last few decades. On average, a household spends 7.5% of their total income on healthcare and the poorest 20% of households in Bangladesh spend around 13.5% of their income on healthcare, with often catastrophic consequences.

*Incidence of catastrophic payment in Bangladesh is the highest in the Asia Pacific region. ... The high levels of OOP payment combined with informal payments for health services at public sector facilities are impoverishing millions of households annually (WHO, 2015).*

The human cost extracted by privatized healthcare became especially visible during the COVID-19 pandemic. The cost of COVID

care in Bangladesh was around 12 times higher in private hospitals, compared to the average cost in public health facilities (The Daily Star, 2022).

Another negative aspect of commercialisation of healthcare is the tendency for overuse of medicines and procedures, which is driven by profit orientation. Reviews of studies on antibiotic usage in Bangladesh reveal widespread availability of antimicrobials without prescription, and rise in their irrational use (Roksana Hoque, 2020). Due to their unregulated use, there is high prevalence of resistance to antibiotics among most tested pathogens, with many of the common first-line antibiotics now having become mostly ineffective (Iftekhar Ahmed, 2019). The overall Cesarean section rate in Bangladesh is excessive, with such operations forming 45% of all deliveries. The C-section rate is extremely high at 68% in private hospitals, compared to being 20% in public hospitals (National Institute of Population Research and Training, 2023).

Overall Bangladesh suffers from the 'mixed



health system syndrome' with domination by the commercialised private sector, in this respect being similar to India and other South Asian countries. During the past few decades there has been inadequate expansion of resources of the public health system leading to its relative stagnation, combined with major, unregulated growth of the private sector. Complicating issues further, private hospitals are often staffed by healthcare professionals who are formally employed in the public sector.

## Lack of effective regulation of private healthcare sector

Despite its huge, dominant presence and rapid growth, the regulatory framework governing private healthcare sector in Bangladesh has remained very weak. Entities like the Directorate General of Health Services (DGHS) and Bangladesh Medical and Dental Council (BMDC) are responsible for licensing of private healthcare establishments and medical professionals respectively. However, the effectiveness of these regulatory bodies has been far from adequate to enforce regulations to ensure fair pricing, transparent billing practices, ethical practices and quality of care in the private sector.

The Medical Practice, Private Clinics and Laboratories Ordinance 1982 was promulgated over four decades back to regulate private hospitals and healthcare establishments in Bangladesh. This ordinance lays down criteria for issuance of licenses for private clinics, and even specifies the maximum rates to be charged by private hospitals and clinics for key services. The BMDC which was established in 1980, governs registration of medical

Such public health system professionals hold second jobs in the private sector, compromising the quality of care in their primary institutions. We need to discuss the status and behaviour of both the private and public health sectors, keeping in view their interrelationships and regulatory processes to understand the current situation of healthcare in Bangladesh.

practitioners and dentists to standardise their qualifications. However, actual implementation of these regulations has been extremely weak, due to the limited capacities and legal power of these agencies (WHO, 2015), as well as significant conflicts of interest. The 1982 ordinance has not been updated despite massive transformations in the healthcare sector over last 40 years, and the DGHS which is charged with responsibility of regular inspection and regulation of private hospitals appears to have inadequate staff to discharge this major responsibility. Regulation of prices of services in private hospitals also remains only on paper, as highlighted by a study (Ashim Roy, 2016) –

*Though a fee-schedule has to be publicly displayed, charges often exceed the schedule since all private respondents reported their autonomy in determining prices. ... Due to lack of information and cost-capping in the private sector, healthcare prices are commonly agreed through bargaining between clients and providers. ... consequently, both cost and quality often are compromised.*

BMDC is also hampered in its ability to act independently, and requires approval from the Ministry of Health and Family Welfare prior to taking action. BMDC has not utilised its power to regulate behaviour of medical professionals, even though malpractice by doctors appears widespread (WHO, 2015)

In summary, the private healthcare sector in Bangladesh has grown substantially over last two decades, and this expansion has been accompanied by growing commercialization linked with frequent overcharging and lack of standardised care.

The regulatory framework for the private healthcare sector remains largely nominal and dysfunctional. Despite policy declarations promising the fulfilment of right to health in Bangladesh, accessible, affordable, and quality healthcare for all still remains an unfulfilled dream. Collective assertion of patients' rights while developing social mobilisation to demand effective regulation and accountability of the private healthcare sector, appears to be an overdue agenda to be urgently taken up by the people of Bangladesh.



### III.

## Key points shared by participants and plan for documentation

The workshop proceedings (schedule given in Annexure VII a) were initiated with the welcome and introduction being given by Mr Zakir Hossain, Chairperson, People's Health Movement – Bangladesh. This was followed by an outline of COPASAH given by Dr. Dhananjay Kakade from HARPS and SATHI, followed by an overview presentation by Dr. Abhay Shukla on the private healthcare sector, with reference to the situation in Bangladesh and India. This presentation started with tribute to Dr. Zafarullah Choudhury, a pioneer in global health and founder of Gonoshasthya Kendra.

The main deliberations started with a panel discussion involving expert panellists. Subsequent to which there was open sharing by various participants about their experiences related to private healthcare sector in Bangladesh. After this, another session focussed on existing regulatory frameworks related to private healthcare sector, and status of implementation of these regulations. Following this a plan for documentation was proposed by Dr. Dhananjay Kakade, in response to which various participants offered to collect further information. The main themes which emerged during the discussion and selected points under each theme have been presented below.

### Background regarding privatisation of healthcare

#### Ms. Farida Akhter

Privatization started in the 1990s with policies of the World Bank, which weakened government services, this was the starting point of privatisation in Bangladesh. The process of corporatization today is similar in different sectors, from pesticide business to pharma companies.

*Some big multinational corporations are manufacturing pesticides which increase illnesses in communities, and the same companies are also marketing medicines to cure illnesses.*

Certain private hospitals repeat the same tests many times on patients, to justify their investment on buying expensive laboratory machines. The growing pressure of expecting higher returns on corporate investments creates a profit-oriented mindset in healthcare, which is responsible for this situation.

## Concerns about quality of care and high charges in private sector

### Ms. Farida Akhter

Doctors should not be unjustly victimised, but they do need to be held accountable. The current legal system is imbalanced against patients, because medical malpractice is a bailable offence, but if the relative of a patient damages a hospital that is non-bailable. Unfortunately there is no forum for patients and their relatives to express grievances, and there is no channel for a patient who has been wronged to get justice.

Now death in a private hospital has become very expensive, patients are not allowed to die 'normally'. If a family member is in terminal condition even with no chance of improving, they are often put on life support. This intensive care is often exorbitantly expensive, and at some point when there is no hope of recovery, the relatives have to take a decision and declare that the patient should be taken off the ventilator. During Covid times, we were surprised to notice that normal pregnancies had increased, the babies born were healthy even though less mothers were getting caesareans in private hospitals due to COVID restrictions. Today infertility treatments are aggressively marketed by claiming a 40% success rate, but these hospitals do not tell the full truth – this means their treatment has 60% failure rates.

*Today both birth and death in a private hospital have become very expensive.*

### Dr. Mashrura Jabin

We see lots of media coverage about 'Bua chikitsa' (bad treatment). These are judgements given by journalists without having medical background. There does exist a board involving doctors and officials to find out if there is maltreatment. But the system does not seem to be working as expected. My question is why there are no regulations to ensure good quality health care?

### Dr. Zahed Masud

*In the morning when the same doctor sees patients in a public hospital, they only prescribe two medicines. In the evenings, they run their private clinic and suggest ten medicines for the same illness. Why is this happening?*

### Ms. Rebeka Saniat

Private hospitals tend to hype their services, the surgery is good, but post-surgical care may be below par. Another major challenge is inflated costs.

*Gonoshasthya Kendra charges Tk 1100 for a round of dialysis, whereas some private hospitals charge Tk 5000 for a dialysis session.*

## Commercial influence of pharma industry

### Dr. Zahed Masud

When doctors from commercial background become policymakers, it is likely that they will tend to benefit private interests. In the last few governments, the health ministers have been either doctors or persons related to pharmaceutical companies. Such decision-makers have their own commercial priorities, and may not work impartially in public interest.

*The pharma industry is very strong, they can influence any government. President Ershad enacted a progressive drug policy in 1982 to get popular support. However just before the declaration of this policy, the US ambassador met the President and pressurised him not to go ahead with*

*this pro-people policy. That shows us how powerful is the pharma industry.*

### Dr. Md. Mushtuq Hussain

The aggressive marketing of the pharmaceutical company induces many doctors to recommend so many antibiotics and other medicines, which may not be essential. There should be strong campaigns and regulation to prevent this, we need wide discussions to come up with a solution.

### Mr. Altaf Hussain

*How come company medical representatives become the teachers of doctors regarding medicines?*

## Role of government and public health sector challenges

### Dr. Rashid E Mahbub

Do we need private hospitals if the government takes care of everyone through public health services? Basic medical care must be a responsibility of the government. In the public sector today there is a shortage of beds. This situation has allowed the private sector to grow, since the public hospitals are not sufficient.

### Dr. Zahed Masud

In a country like ours where so many people are poor, how can we have such a big

private sector? We have a sound public health system in Bangladesh which needs to be further strengthened. However the present setup is pushing people in the direction of the private sector.

In many public facilities after 11 am, you will not get any doctors. Most Upazila health complexes don't have a women-friendly healthcare system, since women patients do not enjoy sufficient privacy, and they lack care by women doctors.



#### Dr. Mahmudur Rahman

The public hospitals also have problems of mismanagement and corruption. Even poor people often have to leave public hospitals due to various problems there, and then seek care in the private sector.

#### Ms. Rebeka Saniat

We have good doctors in public hospitals, but due to political interference they get transferred unfairly. The health sector budget is very paltry. The Upazila health complexes are not technically updated with modern equipment.

## Interactions between public health system and private sector

#### Dr. Mahmudur Rahman

*Regarding doctors working in the public health system, after their regular duties they should be prevented from working in private clinics to avoid malpractices. However this decision should be implemented after consulting all the stakeholders.*

Many private hospitals are dependent on doctors from the public system, who come and give care in the private setup during their extra time. Due to this situation, some smaller private hospitals are unable to manage proper services due to irregular presence of such government doctors. For

example, some surgeons keep shifting from hospital to hospital.

#### Dr. Md. Mushtuq Hussain

Universal health care system needs to be implemented in Bangladesh by combining resources from the public system and from the private sector, because the government hospitals don't have all the facilities. The rates to be charged by private hospitals from the Government under such an arrangement should be fixed by agreement between the public system and private providers. We should have a system like the National Health Service in UK.

## Weak regulation and accountability of private healthcare

#### Dr. Rashid E Mahbub

Monitoring the large number of private healthcare facilities is difficult. Who will ensure this monitoring? The DGHS office alone is insufficient for this.

Suppliers of medical goods to the private sector are also very profit driven, and ensuring quality of supplies becomes very difficult.

There is major variation in the price of cardiac stents provided by different suppliers. By purchasing cheaper stents and then charging patients at high rates, some private hospitals are making large profits.

#### “ **Dr. Mahmudur Rahman**

There are some doctors and hospitals who should not get licenses but they are still getting the licenses. Big hospitals can manage clearances and government permission, but fulfilling the requirements is more difficult for smaller and medium sized hospitals. For instance, the mandatory condition of establishing a water treatment plant may be difficult to fulfill for many hospitals.

#### “ **Dr. Zahed Masud**

Regulation is important in every sector, to ensure standards when activities are carried out related to public interest.

*If an engineer makes a fault, the bridge which was constructed under his supervision may collapse. But a doctor's mistake is much graver, due to their mistake an entire family may collapse. That is why it is so important that we should have regulatory bodies for healthcare.*

In many cases there is intentional negligence. In such situations there is need for medical scrutiny. However regulatory bodies for healthcare in Bangladesh do not seem to be working at all. The Director General Health Services(DGHS)is supposed

to regulate private hospitals through the process of licensing. Bangladesh Medical and Dental Council (BMDC) registers medical professionals and has authority over doctors. But unfortunately even in cases where there is very clear evidence about medical mistakes, usually no action is taken. Doctors are able to influence the Council decisions, conflict of interest is a reality everywhere.

The DGHS is tasked with renewing the licenses of thousands of private healthcare institutions every year, but even though they wield huge power they do not have enough inspectors to visit the hospitals. It will take them may be ten years to properly inspect all the facilities with their existing capacity. Presently DGHS has concentrated powers under its umbrella to manage and regulate a very wide range of areas. Actually such regulatory work should be conducted by an autonomous expert body, which has public mandate and sufficient human power capacity.

#### “ **Ms. Rebeka Saniat**

If we want to strengthen social logic in the health sector, we must raise our voice jointly. It is not possible to achieve this by individuals working in isolation. We need to be considered patients, instead of being termed as commercial‘clients’.

#### “ **Mr Altaf Hossain**

If a patient complains about medical negligence by a private hospital, the final decision is taken by the Health ministry, not by courts. Regarding monitoring of private hospitals, there are presently no specific

rules, regulations or bylaws. Hence implementation of regulation is very weak, the process is compromised by the politicians.

*Some big hospitals carry out programmes for Corporate Social Responsibility (CSR) and show some charitable work to cover up their tracks. We don't want CSR, we want accountability and regulation leading to proper service for patients.*

#### 🗨️ **Dr. Abhay Shukla**

In the South Asian subcontinent, laws alone are often not sufficient. Laws plus social mobilisation for rights can lead to change.

*Health is considered to be quite a technical subject. However just like war is too important to be left to the generals, we cannot leave health policies only to doctors.*

Changes can be ensured if we work together and collaborate. We have various experiences of promoting patients' rights in Maharashtra. If we want to take up some selected activities, one of the first things is to prepare a charter of patients' rights based on existing documents and widely circulate it. Everyone should know about their basic rights in a healthcare establishment.

For example, patients should have the right to seek a second opinion. Their medical reports and records will have to be shared by the hospital with the patient and relatives, so that they can consult a second doctor for opinion. We should also have the

right to buy medicine from whichever medical shop we find convenient, the hospital cannot force us to purchase medicines from their pharmacy only. No hospital can be allowed to detain the dead body of the patient on the grounds that the bills have not been paid. Social awareness and dialogue around these issues can help the government to draft a proper charter and guidelines on patient's rights.

We also need to note that doctors and nurses are often doing their work under a lot of stress. Patients and care givers need to respect the human dignity of healthcare providers, and should never resort to violence under any circumstances. We want healthcare providers and users to have mutual respect and equitable relationships.

#### 🗨️ **Ms. Shamima Chowdhury**

*Presently in private hospitals we don't have any rights, there is no display of patients' rights charter. If those were displayed in each facility, at least the patients would be able to speak up.*

#### 🗨️ **Dr. Sutapa Islam Ankhi**

If each hospital conducts regular internal audits, we can overcome many challenges. In GK on every Saturday we have internal review meetings, and share experiences about patients who have required special care. This helps us to continuously upgrade our services. We recommend that every private hospital should have such internal review meetings.

## Concerns expressed by doctors

### Dr. Mushtuq Hussain

Ordinary people have the impression that all doctors are involved in profiteering, but this is not true. Some influential doctors who are in control are really making profits, while the junior doctors, doctors working in remote areas are not so privileged, they do not have power. The local politicians take advantage of this.

### Dr. Mohammad Abul Bashar

Mostly doctors are not well oriented about how to talk or communicate with the

patients. This is a big problem. There has to be a culture of communicating with patients. Doctors or their assistants need to ensure that proper detailed information is provided to the patients and relatives.

### Dr. Mashrura Jabin

In the Covid period, doctors in Bangladesh struggled a lot to provide care to patients. Most of the doctors have been treating people in the best capacity they have. With limited resources, we did our best to help patients.

## Broad plan for documentation emerging from the workshop

This session conducted by Dr. Dhananjay Kakade broadly covered three topics – creating evidence by documenting existing accountability deficit in the private health sector; planning to use such documentation effectively; and creating discourse based on such documentation. The following types of sources for documentation were discussed to enhance documentation in Bangladesh-

### ▪ Newspaper Articles

Investigating reputed newspapers for articles on healthcare pricing, patient

billing complaints, reports on healthcare schemes, and any investigative journalism pieces on the private health sector.

### ▪ Patient Testimonies

Collecting first-hand accounts from patients who have experienced overcharging or denial of benefits. Ensuring to gather supportive documentation to corroborate these stories, such as bills, denial letters, and communication with health providers.

- **Trend Analysis**

Research and document specific patterns of non-accountable practices in the private health sector. This may involve reviewing academic studies, or audits that have identified systemic issues.

- **Case Studies**

Look for detailed case studies that examine instances of healthcare denial or unethical practices in private healthcare. Academic journals, healthcare watchdog reports, and healthcare advocacy groups can be good sources for such studies.

- **Interviews with Healthcare Professionals**

Conduct or find interviews with insiders from the private health sector who can provide insights into the systemic issues and the reasons behind them.

- **Social Media and Forums**

Patient forums and social media can be an informal source of patient experiences and stories.





## IV.

### Private healthcare accountability issues - Selected case stories and media reports

#### IV – a. CASE STORIES

##### a. Zahid Hossain's ordeal with wrong treatment and high expenditure

Zahid Hossain faced a serious health problem in August 2022 and was admitted to a leading cardiac institution after a heart attack. The diagnosis revealed three arterial blockages, which were partially remedied by the placement of two stents. The medical expenses incurred amounted to approximately four and a half lakh Taka (around \$4100).

For nearly a year, the patient's health was stable until he encountered severe dehydration caused by dysentery, leading to kidney complications. On September 20, 2023, the patient was admitted to a regional medical centre in Barisal. Following a specialist's recommendation, the patient was transferred to a private hospital. From September 21 to 30, 2023, the patient underwent treatment at this hospital, where, due to alleged improper treatment, his creatinine levels rose sharply, resulting in a severe reaction that included the spread of black spots across his body. Despite various tests and treatments at this hospital, the patient's condition worsened, necessitating an urgent transfer to a prominent hospital in Dhaka on September 30, 2023. The bill from the hospital, where patient was admitted in September 2023, amounted to 7,08,000 Taka (around \$6400)

In addition to above, Zahid ended up paying an additional 5,50,000 Taka to Dhaka hospital. The leading physician has also indicated that the patient was subjected to incorrect medical procedures in the hospital where he was admitted previously.

Towards the twilight of his career, the patient has exhausted most of his savings on these medical expenses, leaving him in serious financial distress. This narrative reflects a larger issue of unaffordable charging by some private hospitals, a distressing trend that leaves many patients and their families in ruin.

## b. Family's loss amid medical mismanagement and neglect

A pharmacist from Charfashan and his spouse, a family planning assistant, welcomed their first child through caesarean section. When expecting their second child, the mother began experiencing abdominal pain early in the morning on May 28, 2019, and was admitted to a local hospital in Charfashan, under the care of a doctor who scheduled to perform a caesarean that afternoon. However the doctor was away at his primary job at government hospital and returned to the hospital later in the afternoon.

The caesarean which was initially scheduled for 2 pm was delayed, and the pharmacist, concerned by whispers he overheard from the operation theatre, discovered unauthorized staff attempting caesarean without the doctor's supervision. Upon confronting them, he was forcibly removed from the area. The doctor arrived briefly afterwards, and it was announced that the procedure had been completed and a son was born.

However complications arose, including severe bleeding that required four units of blood, which the pharmacist promptly provided. He noticed swelling in his spouse's abdomen, and tensions escalated when the doctor, upon reviewing the situation, expressed anger over the unauthorised procedure. At one point, he shouted at his assistant, "Why did you do this caesarean section without me? You have no experience in this matter."

In the evening, as the mother's condition deteriorated, she was referred to a better facility on the doctor's advice. Tragically, she passed away while being transferred to another hospital in Barishal.

This incident adds to the reported cases of medical negligence and malpractice in private healthcare facilities, with little to no decisive action from authorities, despite the growing number of such incidents and facilities.

## c. Hospital found culpable, yet no action taken

On June 28, 2018, a journalist's two-year-old daughter was admitted to a private hospital for a sore throat and tragically passed away the following day during treatment. This incident sparked a public outcry and movement against the hospital, citing negligence and malpractice.

Subsequently, on July 28, the grieving father filed a legal case naming the hospital's Managing Director and three other individuals. In response to a writ petition filed by the father on August 14, the Health Ministry established a four-member inquiry committee. The committee was led by the acting Civil Surgeon of Chittagong at the time, the head of the Pediatric Department of a medical college, and a journalist union official.

The investigation report was delivered to the president of the journalist union on the night of July 5 and was publicly disclosed at a press conference at the Chittagong Press Club the next day by the union's general secretary. Despite the investigation report finding three doctors culpable, no action has been reported against them to date.

#### d. High Costs, Minimal Care : A Patient's Predicament with Hospital Billing

During the COVID pandemic, a hospital in the capital city charged a patient named Saifur Rahman 1.5 lakh Taka for basic medical services, including blood tests and X-rays, after he was admitted for COVID treatment. Despite not requiring surgery or intensive care, and even purchasing additional medications externally, his bill from May 23, 2020, to June 2, 2020, totalled 1,70,875 Taka. He was unable to pay this amount and was thus detained in the hospital until late evening, ultimately negotiating his release for 150,000 Taka.

The patient reported that the hospital, which was initially operating under a government contract for COVID-19 treatment, had performed only basic diagnostic tests. He was surprised by the high charges, given that two blood tests and two X-rays would typically cost around 2,000 rupees in total.

Media reports detailed the bill, including various charges such as doctor's fees, hospital bills, investigative tests, medication, and service charges, culminating in the total bill of over 1.70lakh Taka. When questioned, the hospital's administration cited the termination of their contract with the government for COVID care as of May 31, which led to the patient bearing the full costs. In response to concerns about the exorbitant bill for minimal treatment, the hospital's director invited the patient to review the bill with a journalist's reference, promising to investigate the issue.

#### e. Bill of nearly Tk 7 lakhs for 13 days of COVID treatment in private hospital

Mr. Salim was admitted to Parkview Hospital on July 4, 2020, after contracting COVID-19. Upon admission, he was required to make an advance payment of Tk 50,000 to initiate the treatment, a payment which was promptly submitted.

Unfortunately, on July 17, 2020, Salim passed away. Following his death, the family of the deceased has claimed that they faced harassment regarding the hospital bill from Parkview Hospital. According to the relatives, Parkview Hospital demanded a total of 6.97 lakh taka for the 13-day treatment of the deceased individual, along with additional charges exceeding 1 lakh taka for medicines. Subsequently, with the intervention of local political leaders, they were granted a discount of 1.47 lakh taka. The family then settled the remaining amount with the hospital.

The last two cases highlight the broader issue of patients being majorly overcharged during the COVID pandemic in various regions of Bangladesh.

## IV- b. MEDIA REPORTS

*There are numerous media reports which highlight how even basic patients' rights are frequently violated in private hospitals in Bangladesh. In the following section, we have attempted to summarise with illustrative examples, how widespread accountability gaps in the private healthcare have been exposed by the media.*

### 1. Chattogram hospital overcharges Tk2200 for cannula, charges money without doing tests!

Royal Hospital, a private hospital in Chattogram city, has been accused of declaring a two-and-half-year-old boy as COVID-19 positive, without performing any Covid test while overcharging for fitting cannula.

*(<https://www.tbsnews.net/bangladesh/health/ctg-hospital-overcharges-tk2200-cannula-charges-money-without-doing-tests-299299>)*

### 2. Bill payment conflict: Private hospital owner arrested over baby's death

Rapid Action Battalion (RAB) members arrested a private hospital owner over the death of a baby who was denied treatment, following a conflict of bill payment.

*(<https://www.thedailystar.net/news/bangladesh/crime-justice/news/bill-payment-conflict-private-hospital-owner-arrested-over-babys-death-2934416>)*

### 3. Body detained for unpaid bills: HC asks police to record case against private hospital

The High Court has directed Shajahanpur police station in Dhaka to record a case against Proshanti Hospital Limited, on an allegation relating to its holding back the body of Mohin Uddin Parvez, a COVID patient, to coerce the family of the dead person to pay Tk 1.56 lakh.

*(<https://www.dhakatribune.com/bangladesh/216827/body-held-for-unpaid-bills-hc-asks-police-to>)*

### 4. Unnecessary C-Sections: A major public health issue in Bangladesh

Data from Save the Children Bangladesh shows that nationally, about 820,512 C-sections were performed in 2016, and 571,872 of them were unnecessary.

*(<https://www.thedailystar.net/opinion/news/unnecessary-c-sections-major-public-health-issue-bangladesh-2041353>)*

#### **5. Doctors, nurses leave C-section patient, newborn in OT as DGHS raids**

Doctors, nurses and other employees of a hospital in Narayanganj yesterday abandoned a mother and her newborn baby on an operating table, after hearing that Health directorate officials were raiding unlicensed hospitals in the area.

*(<https://www.thedailystar.net/news/bangladesh/news/abandoned-operation-table-3034871>)*

#### **6. Jhenaidah woman dies from alleged wrong surgery, hospital fined Tk50,000**

A private hospital has been fined Tk50,000 for providing medical services in an unsanitary environment, and causing death of woman patient due to negligence.

*(<https://www.dhakatribune.com/bangladesh/nation/313805/jhenaidah-woman-dies-from-alleged-wrong-surgery>)*

#### **7. 6-year-old dies in "wrong treatment": 3 doctors, nurse arrested**

In October 2020, the hospital was sealed off on charges of wrong treatment, medical malpractice and an unhygienic atmosphere. Two years later, they are back at it again.

*(<https://www.thedailystar.net/news/bangladesh/crime-justice/news/6-year-old-dies-wrong-treatment-3-doctors-nurse-arrested-3026571>)*

#### **8. BMDC is Bangladesh's sole investigation authority for medical malpractice. Is it willing and equipped to do the job?**

People with bonafide complaints against medical professionals or hospitals have alleged that the agency does not take adequate steps to address malpractices and negligence.

*(<https://bdnews24.com/health/lhtepo4ui>)*

#### **9. COVID corruption and governance failure- issuance of fake test reports without testing and minimum of 5000 Tk taken to collect sample from the patient's home.**

JKG Healthcare has been accused of issuing fake COVID-19 test results without analyzing samples, for which they charged individuals 5,000 to 8,600 Taka. The CEO of JKG and four others were arrested by the Tejgaon division of the Dhaka Metropolitan Police, after it was confirmed that at least 37 people received fraudulent results.

*(<https://www.prothomalo.com/bangladesh/crime/পরীক্ষা-ছাড়াই-করবে-না-শনাক্তরে-অভিযোগ-জকেজেরি-সহিও>)*





#### 10. COVID related overcharging - bill for '30 minutes' oxygen is 86,000 Taka!

Anwar Khan Modern Hospital has faced accusations of overcharging and negligence from the relatives of COVID-19 patients. In a recent case, a 67-year-old patient named Mozammel Haque was reportedly billed 86,400 Taka for 30 minutes of oxygen given over two days. His son, Touhidul Haque Sohel stated that his father received minimal medical attention, with no doctors visiting except for a brief appearance at the door, yet they were charged a 49,000 Taka consultant fee. The patient required minimal oxygen yet the room service charge was billed at 45,400 Taka. This incident is among others where patients have been billed exorbitantly, and negotiated lower final payments after intervention.

(<https://www.prothomalo.com/bangladesh/হাসপাতাল-কর্তৃপক্ষের-অবহেলো-ছিল-এসরি-বদৈ-যুক্তকি>)



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## VI. Acknowledgements

As publishers of this report, on behalf of SATHI team we express sincere gratitude to each of the following organisations and persons, who majorly contributed to organisation of the workshop, and enabled preparation of this report:

- First and foremost we express deep appreciation of Mr. Zakir Hossain - Chairperson PHM-Bangladesh, who coordinated all stages of organising the workshop while ably dealing with various challenges along the way. We are also grateful to Md. Animur Rasul, Coordinator, PHM-Bangladesh for his sincere support to make the event successful. Along with them we sincerely appreciate the contributions of the entire Nagorik Uddyog team, especially Sultan Md. Salauddin Siddique, Mahboob Akter and all other team members who worked as our partners through all stages of preparation and organisation of the workshop and made this event possible.
- Special thanks to Farhan Hossain Joy for providing extensive documentation, including the case stories and media reports required for the workshop which have added value to the entire process; and for preparing the detailed minutes of the workshop competently and in shortest possible time, which forms the basis for this comprehensive report.
- Sincere appreciation for the PHM-Bangladesh Circle, all the PHM organisers and members who collaborated with SATHI-HARPS through the process of mobilising for the workshop and contributed extensively during the workshop deliberations.
- We are thankful to all the participants during the workshop, including several senior health sector experts, women's movement leaders, doctors, journalists and health activists who spared time for the event and participated enthusiastically in the deliberations through offering their experiences and insights.
- We would like to acknowledge the valuable contributions of our colleagues in the SATHI team – especially Jessy and Shweta who have offered important support and inputs during this entire process, and Sharada who has capably managed the designing of this report.
- Finally we would like to thank PAI and particularly Eve Brecker who facilitated the necessary support with adequate flexibility, ensuring that the workshop could be organised in timely manner, as part of activities organised through the COPASAH network.

# VII. Annexures

## a. Workshop Schedule

### Profile of participants–

Public health experts and academics, health activists, social activists including women’s groups, journalists, practicing doctors and health professionals associated with private sector, officials with experience of private healthcare sector.

No.	Time	Topic	Presenter / Facilitator
1.	10.30 – 11 am	Welcome and introduction of participants	Zakir Hossain
2.	11 – 11.30 am	Background of the workshop and about HARPS - COPASAH Overview of private healthcare sector in South Asia and Bangladesh	Dr. Dhananjay Kakade Dr. Abhay Shukla
3.	11.30 am - 1.30 pm	Panel discussion on ‘Experiences regarding Private healthcare Moderator – sector in Bangladesh’ <b>Panelists:</b> <ul style="list-style-type: none"><li>▪ Dr. Md Mushtuq Hossain</li><li>▪ Farida Akter</li><li>▪ Dr. Mahmudur Rahman</li><li>▪ Dr. Sutapa Islam Ankhi</li></ul>	Moderator – Dr. Dhananjay Kakade
4.	1.30 – 2.30 pm	Lunch	
5.	2.30 – 3.15 pm	Existing regulatory frameworks related to private healthcare sector and status of implementation	Dr. Zahed Masud Dr. Abhay Shukla
6.	3.15 – 3.45 pm	Proposed format and plan for documentation – patient stories, case studies of particular hospitals / schemes, as well as identifying relevant studies and reports	Dr. Dhananjay Kakade
7.	3.45 – 4.45 pm	Short listing of responsibilities and timelines for documentation	Zakir Hossain and Dr. Dhananjay Kakade
8.	4.45 – 5 pm	Summing up and vote of thanks	Nagorik Uddyog representative

## b. List of participants

No.	Name	Affiliation
1.	Prof. Dr. Rashid-E-Mahbub	Chairperson, Health Right Movement (Sastho OdikarAndolon)
2.	Dr. Mohammad Mushtuq Husain	Coordinator at Directorate General of Health Services (DGHS)
3.	Zakir Hossain	Chairperson, PHM-Bangladesh
4.	Dr. Dhananjay Kakade	SATHI, India and HARPS
5.	Dr. Abhay Shukla	SATHI, India and HARPS
6.	Dr. Shutopa Islam Akhi	Gonoshasthaya Nagar Hospital (GK)
7.	Dr. Badrul	Gonoshasthaya Nagar Hospital (GK)
8.	Dr. Mohammad Abul Bashar	Associate Professor, Head of the Department Community Medicine, Somaj Vittik Medical College, Savar
9.	Dr. Masrura Jabin	Associate Professor, Gonoshasthaya Nagar Hospital, Dhaka
10.	Alamgir Kabir	Associate Professor, Gonoshasthaya Kendra (GK), Savar
11.	Samia Afrin	Vice-Chair, PHM-Bangladesh, Project Director, Naripokkho
12.	Khondokar Rebaka Sunyet	Executive Director, Coalition for the Urban Poor (CUP)
13.	Tamanna Sultana Tanni	Coalition for the Urban Poor (CUP)
14.	Dr. Altaf Hossain	Executive Director, BAPSA
15.	Parveen Akter	Executive Director, Bhomisto
16.	A.H.MBazlur Rahman	CEO, BNNRC
17.	Farida Akter	UBINIG

No.	Name	Affiliation
18.	Shima Das Shimu	UBINIG
19.	Dr. Zahed Mohammad Masud	Executive Director, AITAM
20.	Mahmudur Rahman	DushthaShasthya Kendra (DSK)
21.	Ziaur Rahman	Senior Program Manager, WBB Trust
22.	Najmun Nahar	Project Manager, Naripokkho
23.	Shamima Chowdhury	Program Manager, BAPSA
24.	Dr. Silvana Israt	DORP
25.	Md. Abu Bakar	SETU
26.	Shahabuddin	Sadar Road, Barishal
27.	Parveez Kamal	Member of Victim family, Chittagong
28.	Sohel Rana	Journalist, Bulletin Bholo
29.	Mizanur Rahman	Member of Victim family, Gangachara, Rangpur.
30.	Saiful Masum	Journalist, Ajker Pttrika
31.	Abu Jafar Samsuddin	Journalist, Shodosh Protidin
32.	Alauddin Ali	Executive Director, SSDF
33.	Aminur Rasul	Coordinator, PHM-Bangladesh
34.	Farhan Hossain Joy	Reporter
35.	Sultan Md. Salauddin	Reporter
36.	Md. Mahbub Akhter	Management Team Member
37.	Sanaton Kumar Malo	Nagorik Uddyog
38.	Najm Begum	Executive Director, AMKS



## C. Resource materials published by HARPS and SATHI

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**Published by**

**SATHI (Support for Advocacy and Training to Health Initiatives)**

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**December, 2023**