

Improving Private Health Care Data Collection in Bangladesh

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Introduction

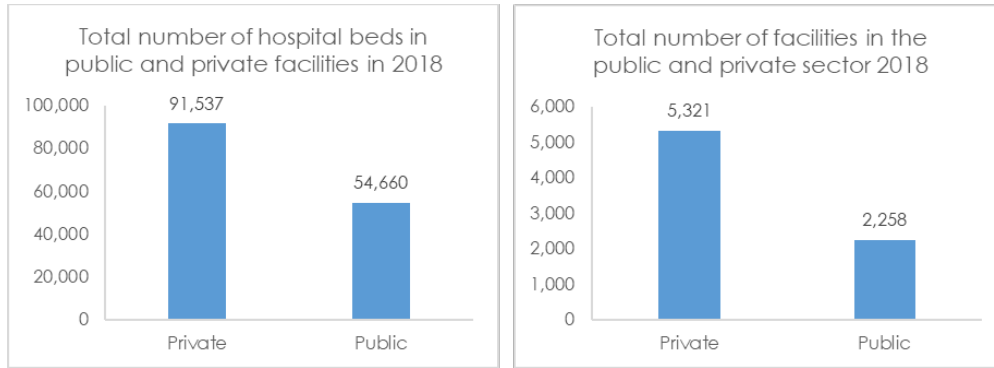
Health care is data intensive. Each transaction between a service-seeker and a health care provider generates data as a by-product. Routinely collected health data from the public and private sectors are essential for understanding health trends. Decision-makers need these data to develop appropriate health policies, allocate resources, and prioritize interventions. The recent COVID-19 pandemic exposed health systems to new challenges illustrating the need and relevance of timely and accurate data from all sectors to make informed decisions (WHO, 2020). While government agencies responsible for managing health care collect routine public health data on a regular basis, there is often a lack of systematic and regulated mechanisms for collecting data from the private sector, even though the private sector plays an important and often dominant role in health service delivery in many lower- and middle-income countries (LMICs). This brief focuses on the need for data collection from the private sector and nongovernmental organizations (NGOs) within a comprehensive national health information system (HIS) in Bangladesh and offers recommendations to achieve this.

Public and Private Sector Health Care in Bangladesh

- In Bangladesh, private sector facilities play a predominant role in health care service delivery in urban areas, though they are no less important in rural areas. They also have greater capacities to service the health care needs of citizens in terms of number of facilities or hospital beds.

The health sector of Bangladesh is pluralistic, with both public and private sector providers delivering health care. The Ministry of Health and Family Welfare (MOHFW) is responsible for the provision of primary health care in rural areas, which is managed through two large organizations, namely, the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). In urban areas, public health care services are managed by different local government agencies, such as city corporations and municipalities, which are statutory bodies under the Ministry of Local Government and Rural Development. These organizations have limited budgets for the provision of health care. For-profit private sector facilities play a predominant role in health care service delivery in urban areas, though they are no less important in rural areas. NGOs are also active in urban areas and mainly serve disadvantaged or poorer populations in both urban and rural areas.

Public and private sector facilities vary by location, size, and type of facility. The total number of public facilities under the DGHS is 2,258 (this includes primary- and secondary-level facilities, as well as 255 tertiary-level facilities). In the private sector, the number of registered private clinics/hospitals is 5,321, for a total of 7,579 public and private facilities countrywide. The private sector is heterogeneous and includes hospitals, specialists, clinics, pharmacies, and informal providers (Ahmed et al., 2013). In terms of the number of facilities, and more specifically hospital beds, the private sector far exceeds the public sector. The number of hospital beds in the private sector is 91,537 compared to 54,660 hospital beds in the public sector. In addition, 9,529 private diagnostic centers are also registered with the DGHS (DGHS, 2020). The private sector, therefore, plays a significant role in health care service delivery, making its health data critical for informing health decisions.



Source: Health Bulletin 2019, DGHS

Availability of Private Sector Data

- The government has a limited data sharing arrangement with the private sector and NGOs.
- Regular and systematic data from both the public and private sectors is required to make sound, evidence-based decisions and timely interventions.
- As important providers of health care, private sector facilities generate and retain considerable health data at the point of care.
- The government should prioritize the development of systematic and regulated mechanisms for collecting private sector data to support national policies or interventions.

The DGHS has a limited data sharing arrangement with the private sector and NGOs. Few health data are collected from the private sector other than those related to disease-specific programs such as the expanded program on immunizations (EPI), malaria, tuberculosis (TB), and maternal and child health care. For example, the DGHS, in collaboration with UNICEF, has been running facility-based Emergency Obstetric Care (EmOC) programs in all districts of Bangladesh. In addition to public facilities, a few private clinics, hospitals, and NGOs participate in the program and send EmOC data to the DGHS. Data from the private sector and NGOs accounted for about 16% of the total EmOC data in 2018 (DGHS, 2020).

All private facilities are required to send mortality data to the DGHS as a part of the Civil Registration and Vital Statistics (CRVS) system, which is monitored by a high-level committee of the government working on CRVS.¹ COVID-19 brought a fresh imperative for data collection from the private sector. Indeed, when managing public health emergencies, prompt early sharing of data through outbreak investigation and surveillance are vital (Moorthy, et al., 2016). The DGHS has plans to collect¹ approximately 10-15 new data elements from the private sector within the District Health Information Software 2 (DHIS2) platform. The DGHS believes that the private sector will respond to their request for this data. In time, it should be possible to expand the datasets for use in health management in any situation, emergency or otherwise.

The Government of Bangladesh (GOB) requires regular and systematic data from the private sector to ensure that it has access to the comprehensive information, from both the public and private sectors, necessary to make sound, evidence-based decisions and timely interventions. A good case for this can be made in respect to data on Caesarian sections performed in private sector facilities. A DGHS publication reported that nearly half of the country's deliveries in 2018 occurred in private facilities—with those same facilities accounting for 84% of deliveries by C-section (DGHS, 2020). This could be cause for investigation as it raises concerns about the health of women delivering in private facilities. With access to timely, comprehensive data, government actions could be guided towards determining whether there are any nonmedical reasons for such a high trend; as postulated with a similar situation in India (Muzaffar & Mohammad Akram, 2019).

¹ Discussion with Mr. Shukendu Shekhar Roy, Senior System Engineer, DGHS. A set of 10-15 data elements was envisaged in initial discussions with the private sector, which would submit the data in DHIS2. Alternately, it would be possible to collect through application programming interfaces (APIs).

As important providers of health services, private sector facilities generate and retain considerable health data at the point of care. Given the enormous gaps in data from the private sector, the government must prioritize the development of systematic and regulated mechanisms for integrating private sector data into the national HIS. The current lack of a regulatory instrument creates uncertainty regarding the collection of data from the private sector. Legislation regarding data collection from the private sector should be enacted spelling out which data should be collected, as well as how, and at what frequencies, that data should be submitted.

Regulatory Provisions

- The law governing health care in the private sector was issued in 1982 and has not undergone any substantive changes. The absence of subordinate regulation creates impediments in enforcing the law.
- The oversight function or regulatory mechanisms are weak and dysfunctional.

In Bangladesh, private health care institutions, including NGOs (clinics/hospitals and diagnostic centers), need to be registered with the DGHS under the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance (MPPCLO), 1982 (GOB, 1982). The MPPCLO has not undergone any substantive changes to date. Usually, subordinate legislation, called rules, are framed to operationalize different provisions of the law. No such rules have been issued under the MPPCLO. The National Health Policy 2011 recognized the need for formulating health-related laws and regulations for private clinics in one of its objectives (MOHFW, 2011). However, this objective remains unfulfilled. Through the formulation of new rules under the MPPCLO, the MOHFW can make it mandatory for private facilities and others to submit data on a regular basis.

Following the emergence of COVID-19 as a global pandemic, the MOHFW engaged public and private sector facilities alike in the provision of emergency services. However, some private operators deviated and malpractice issues surfaced. In addition, some were found to be operating without valid licenses. Preliminary findings of a study conducted by the USAID-funded Research for Decision Makers (RDM) project on the licensing status of private clinics and hospitals provides additional information (covering 1,119 facilities). The study found that during visits to private health care facilities, only 6% were able to produce a valid license. The study also found that 79% of facilities were operating with an expired license and 14% never had a license at all. Of the 79% of facilities operating without a license, 59% applied for renewal or a new license and 39% did not apply for any (Research for Decision Makers (RDM), 2020). Newspaper reports suggest that the number of private hospitals, clinics, and diagnostic centers in the country may be around 11,940 (a number much higher than official figures) (বেজিনা ইসলাম, 2020). Those operating without valid licenses applied for licensure after scrutiny following the COVID-19 pandemic, but many were found to lack the minimum requirements in terms of equipment, quality, etc., required under the law. Facing a huge backlog and the constraints of onsite inspection by designated officials,² the DGHS allowed exemptions for some important compliance provisions required by other regulatory authorities.³ In this instance, inadequate institutional arrangements, as well as a lack of human resources, appears to have hampered the oversight functions of the DGHS (Kabir et al., 2014). An electronic platform offers opportunities for greater monitoring and compliance of licensing requirements. (Research for Decision Makers (RDM), 2020).

² Facilities are meant to be physically inspected by district officials for approval or renewal, but the sheer number of facilities places a great burden on officials in performing this regulatory responsibility.

³ Clearance from environmental and narcotics authorities, etc., were temporarily postponed to facilitate quick disposal of cases.

Digital Health Initiatives in Bangladesh

- The DGHS aims to develop and implement a comprehensive HIS using hospital automation systems, with electronic health records for all citizens to enable any hospital (public or private) to share data.
- Private clinics and hospitals collect and maintain sensitive personal health records, which should be regulated in order to address the confidentiality and privacy issues through appropriate legislation.

The GOB is pursuing the goal of a digital Bangladesh, prioritizing, among others, the health sector. The DGHS has embarked on digitizing routine data and has implemented DHIS2 and other tools. The current sector program of the MOHFW's 4th Health, Population and Nutrition Sector Program (HPNSP) (Jan. 2017-June 2023) aims to introduce electronic health records (EHRs) for all citizens.⁴ The DGHS aims to develop and implement a comprehensive HIS using shared health records (SHRs) embedded in hospital automation systems, to enable any hospital (public or private) to share data.

The DGHS published an interoperability document, mainly representing health service registries (DGHS, 2012). It has also created a health facility registry⁵ with geolocations and other registries. National standards like CCDS⁶ and Geocode⁷ are followed by the DGHS. It also has a web-based registration system for private facilities. All of these could serve to develop a system for collecting data from the private sector. However, developing a comprehensive digital system is an enormous undertaking and requires legal, technical, and organizational arrangements with change management (World Health Organization & International Telecommunication Union, 2012). The lack of a National Health Strategy also hinders strategic development in the digital health domain⁸ involving both public and private sector data.

Private entities such as clinics and hospitals manage information and communications technology (ICT) resources according to their own organizational goals. Digitization has taken over the public and private sectors, and, depending on organizational capacities, complex or simple systems are in operation⁹ in hospitals or diagnostic centers. These organizations employ tools that capture data relating to persons with geographical and personal identifiers. Large corporate hospitals are setting up specially designed, state-of-the-art integrated HIS to record and monitor all activities and to store patient information in a digital format for ease of access and long-term storage.¹⁰ They collect personal data and maintain sensitive personal health records which may include personally identifiable information (name, sex, address, personal identification and phone numbers, payment history, etc.). These types of activities appear to remain unregulated and/or not covered by any accountability framework other than voluntary ones or those imposed by accreditation standards, if any. Therefore, the government must address the confidentiality and privacy issues surrounding digital health data from both the public and private sectors by formulating appropriate legislation for ensuring norms of use and accountability to address threats of misuse, either due to systemic failures or deliberate actions on the part of the depositories to monetize data.

⁴ Included in the MIS operational plan of the DGHS.

⁵ Accessible at <http://facilityregistry.dghs.gov.bd>.

⁶ CCDS stands for Citizen Core Data Structure. It is a standard set by the Cabinet Division of the Government of Bangladesh on personal identifiers, educational, and employment status, etc.

⁷ Geocode is the GOB georeferencing code for different administrative areas set up by the Bangladesh Bureau of Statistics.

⁸ While this report was in the process of preparation, a workshop was held where a draft of the National Digital Health Strategy, prepared by local and international experts, was discussed.

⁹ Private diagnostic centers employ state-of-the-art digitized equipment with the ability to share and exchange data across the system.

¹⁰ Retrieved from the webpages of United Hospital (<https://www.uhlbd.com/page/about>) and Evercare Hospital (<https://www.evercarebd.com/>). Accessed 10 November 2020.

Points for Consideration and the Way Forward

- In Bangladesh, the availability of data from the private sector is scarce and mostly limited to maternal and child health (MCH) service statistics.
- The availability of private sector data within the public HIS contributes to better health systems planning by providing a comprehensive mapping of the health sector.

The experiences of other countries show that data sharing between the government and the private sector is not very common in LMICs (Bhattacharyya et al., 2016). Bangladesh is no exception. The availability of data from the private sector is scarce and mostly limited to maternal and child health (MCH) service statistics. Data sharing may lead to additional costs and work in terms of human, financial, and technological resources for the private sector. Further, the private sector may be reluctant to share data if there is a lack of trust and the intention of the regulator is not clear to them, or if it is not made clear how such data would be used by the government. However, data collection from not-for-profits is more easily managed when they are engaged with the public sector or development partners (Bhattacharyya et al., 2016).

The availability of private sector data within the public HIS contributes to better health systems planning by providing a more comprehensive mapping of the health sector. The public sector can better harness private sector data by establishing a sustainable system for data collection and synthesis, and through increased communication, improved trust, and successful relationship building (Gautham et al., 2016).

The Millennium Development Goals (MDGs) emphasized measurement for monitoring progress. The Sustainable Development Goals (SDGs) envisage a data revolution with broader scope and greater detail for monitoring different indicators with granularity and periodicity (Independent Expert Group, 2014). One of the targets of the health SDG (#3) is to achieve Universal Health Coverage (UHC) by 2030. The health-related SDGs require, among others, valid and reliable routine health facility reporting along with other administrative data. The Bangladesh Planning Commission identified that reporting requirements would be immense for the MOHFW under SDG 3, with 57 items to report on, and highlighted the availability of survey or census data for most indicators (Planning Commission, 2017). However, the DGHS recognizes that there are significant challenges in monitoring SDG health indicators due to a lack of data, or gaps in data, from the private sector (DGHS, 2020). Additionally, the MOHFW is committed to achieving UHC, which requires engagement of both public and private sector facilities. Depending on how the MOHFW proceeds—for example, if it includes private insurers and the option of purchasing health services—the data requirements could be massive. All of these possible options highlight the need for the collection of private sector data by the DGHS/MOHFW.

Recommendations

In consideration of the above analysis, the following recommendations are made:

1. The MOHFW/DGHS should create a legal instrument in the form of rules under the MPPCLO to facilitate data collection from private facilities, including NGO-operated facilities, in an electronic format as part of a comprehensive HIS. Compliance with these rules could be a condition for renewal of licenses.
2. As there are no such instruments in place at present, the DGHS should engage in dialogue with stakeholders to collect data from the private sector, leveraging its role as the licensing authority.
3. As private sector health care organizations continue to collect sensitive health data from their clients, they must ensure the privacy of personal data and confidentiality through the same or, preferably, a separate legal instrument.
4. The MOHFW should ensure that insights from private sector data inform program and policy decisions.

Conclusion

A robust health system requires a reliable and comprehensive data system that includes data from both the public and private sectors. Data collection from the private sector and from NGO facilities is needed and can be ensured by appropriate legislation. Digital technologies are revolutionizing the health domain, offering new potential for collecting data from the private sector. A comprehensive HIS must include public and private sector data to ensure efficient and effective planning of health services, optimal allocation of resources, and ultimately improved health policies and outcomes.

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