PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	An exploratory qualitative study to understand the underlying motivations and strategies of the private-for-profit healthcare sector in urban Bangladesh
AUTHORS	Adams, Alayne; AHMED, RUSHDIA; Shuvo, Tanzir; Yusuf, Sifat; Akhter, Sadika; Anwar, Iqbal

VERSION 1 - REVIEW

REVIEWER	Meenakshi Gautham London School of Hygiene and Tropical Medicine, UK
REVIEW RETURNED	30-Nov-2018

GENERAL COMMENTS	Overall: The paper focuses on an important topic but lacks coherence. Understanding the business strategies, incentives and motivations of private facilities is a relevant objective, but there is no conceptual framework underpinning the analysis. In the absence of a conceptual/theoretical framework, the findings appear thin and put together in an ad hoc manner. You should look at some literature on business strategies of private enterprises and develop a coherent framework within which you can locate and discuss your findings. For example, the pharmaceutical influence on doctors' prescribing is well known and well documented in literature, and it is not clear how this fits in with the other business strategies adopted by facilities. There is no information on pricing or how profits are determined or about any differences in clientele. The second objective (identifying potential points of entry to improve service quality….) has not been addressed in the main study but only brought up marginally in the discussion. It could be removed as a study objective and instead you could just focus on the business strategies and what those imply in terms of quality improvements and UHC. Methods: It is not clear what kind of facilities were included and what was their capacity (except for the bed strength)– were they tertiary or secondary or primary facilities? Do the high-end tertiary facilities have the same kind of strategies as the lower end ones? What were the differences if any? The methods section needs more details of how these facilities were selected in the first instance, even if they selected purposively – what were the variability criteria? Were they selected from different parts of the three sites? Was there a list of facilities available?

	It is not obvious how the patient exit interviews have been used/analysed and the same goes for facility observations. You could present the data from the observations and try to develop some way of categorising the facilities. Results – please avoid quantifying any qualitative findings (table 2) Introduction: Can you provide information on the public-private breakup of the health sector in terms of overall distribution and utilisation for general illnesses? Language – There are several grammatical errors and the manuscript needs a thorough editorial review.

REVIEWER	Catherine Goodman London School of Hygiene and Tropical Medicine UK
REVIEW RETURNED	06-Dec-2018

GENERAL COMMENTS	This paper presents primarily qualitative interview data from private for-profit health facility owners/staff and local stakeholders from 3 cities in Bangladesh, to explore the motivation and business practices of the private facilities. I found the results rich and interesting, particularly in terms of business strategies, and a valuable addition to the current literature in this area. However, I have a number of concerns about the paper which would need to be addressed before publication, as described below. I was also somewhat surprised by the choice of journal for this paper – while I understand that BMJ Open has a wide remit, I did wonder if this paper would have fitted better in a journal with a more health systems focus, and more explicitly LMIC remit – but I will leave that for the Editors to assess. Major concerns 1. There is a need for more background on the health system in urban Bangladesh in order to interpret these findings. What I am missing is a paragraph in the introduction which would describe the public system (in terms of types of facilities, financing etc), the NGO facilities available, and would also explain the structure of the private sector. In particular the authors use the terms “formal” and “informal” without defining these, and do not explain the full range of private providers. On page 9 they also mention “private clinics” and “private practitioners” but I wasn’t sure how these related to the facilities in the study. 2. The limitations of the research are not sufficiently addressed. There is a brief section on this towards the end of the paper. I would suggest that this be integrated into the Discussion section, and more comprehensive in terms of the range of limitations covered and the depth with which they are considered. In particular I would have liked to see: a. Consideration of the limitations of the sampling strategy – which seemed purely convenience (and not purposive as stated by the authors), and only covered registered/licenced facilities – and therefore on both accounts may have been not at all representative of all private facilities. b. How typical of Bangladesh were the 3 cities that you worked in? c. I would have liked to see more discussion of how you addressed potential social desirability bias, especially as your focus on motivations means that you are particularly prone to this. You mention that such bias could exist but don’t explain if and how you tried to address this, and how it might have affected your results.

	You also took at face value the claim that facilities sometimes served the “poor, the vulnerable and the disadvantaged”. Do you have any evidence to back this up? Most studies find that such formal, licenced facilities serve only the richer quintiles of society. You also note that respondents cited social service and social status as a medic as motivations – but don’t probe why this would motivate them to join the private as opposed to public health sector. 3. It would have been good to have included some descriptive data on the health facilities – such as number of staff, number of beds, range of services offered, type of equipment, whether inpatient care was provided etc. I believe some of this would have been collected through the “observations” – could some of this be presented? If this is not done, it’s unclear that the structure observations should really be included as the only data from them seems to be one sentence on wait times... 4. Throughout the presentation of Business strategies I did not get a strong feeling of whether views were quite uniform across interviewees or whether they varied by type of interviewee, or size or other characteristics of the facility, or city. It would be good to use the data matrices employed for data analysis to explore this. 5. The discussion of policy implications is currently very thin and needs strengthening. This is not covered in the Discussion, but only in the Conclusions, by a few statements which are not well elaborated or justified. For instance, the authors state that the values of “quality and professionalism” could be “leveraged in efforts to ensure that private-sector services are safe and effective” but do not provide any further explanation of how this could be done. Similarly they state that “widespread use of informal discounts and subsidies by private sector providers provide a similar segue into discussions of UHC, and how participation in insurance schemes might be advantageous in terms of retaining and growing clientele especially among the urban poor” but do not explain how this could have relevance of insurance schemes. In the final paragraph they mention that policy makers should “incentivize their efforts to provide services of quality” and to engage in “beneficial competition”, but again the potential approaches and their limitations are not fleshed out. Also in the Abstract you mention that you have identified “potential entry points including regulatory mechanisms and governance” but I didn’t see any identification of regulatory entry points in the main text. A more nuanced and detailed discussion of how their results might influence policy is required. 6. It would be good in the Introduction / Discussion to set these findings more clearly within the international context and debates around the private sector – how typical do you think these findings would be of other LMIC? Minor comments 7. The writing of the Results and Discussion is very good, but there are a number of English mistakes in the Abstract / Intro / Methods which require review 8. Pg 3 para 2 – CS rate has risen from 17% in 2011 to 26% - in what year? 9. Pg 3 para 3 – you say the increase in private providers reflects “the inability of the public sector to generate sufficient supply on its own” – would it also reflect perceived quality gaps in the public sector? 10. Pg 5 – The section on Participants would fit better in methods than in Results. You should also provide more details on the

	characteristics of interviewees e.g. gender, age, health qualification. 11. Pg 5 – it was unclear to me how many facilities had been covered – was either an owner or a staff member interviewed for each facility so that the total is 30 facilities? Or was more than one person interviewed in some facilities? 12. Pg 5 – did any facilities or individuals refuse interviews? 13. Pg5-6 – I was not sure how to interpret the ticks in the table – are they an indication of strength of views across participants? Or are they actual counts of the number of times these issues were mentioned (which would not be appropriate). Perhaps a key is required? 14. Pg 8 – para 1 can you give some examples of health packages? 15. Pg 8 and Discussion – you comment on the brevity of consultations and say they are not much different form the public sector – so how long are they in the public sector? 16. Pg 9 – provide USD equivalent for Taka 17. Pg 12 – you mention the need to include preventive and promotive services in the private sector, but have provided no evidence in the results that these are absent.

REVIEWER	Lauren Suchman Institute for Global Health Sciences, University of California San Francisco USA
REVIEW RETURNED	24-Jan-2019

GENERAL COMMENTS	Abstract: - Page 2 Line 16: Please clarify “adverse family events members” Intro: - Please elaborate more on the growth of the private sector. What is driving it from both the provider and patient sides? Other than pregnant women, who is using it? If it is mainly used by wealthier patients, for example, then how can it contribute to UHC? - Page 3 Lines 37-38: I imagine formal providers also sometimes prescribe more costly drugs to turn a profit. Is this really limited to informal providers? Methods - While you have told the reader that private facilities are largely growing in urban regions, it would help to have some more context here so the reader knows how to interpret your findings. What % of the population of Bangladesh lives in urban areas? Is the country rapidly urbanizing? - Page 4 Lines 16-17: How were the initial clinics chosen before snowball sampling went into effect? - Page 4 Lines 21-22: What criteria did you use to sample patients for exit interviews? Results: - Page 5 Lines 14-39: I recommend shifting the “Participants” sub-section up to Methods. This is your sample. - Page 5 Line 51 – Page 6 Line 13: I am confused by this table and exactly what information the check marks convey. I would suggest using raw numbers or percentages instead of the check marks and also getting rid of the footnote.

	- Page 7 Lines 6-8: A great point, but a little hard to follow because the wording is confusing. Please re-write for clarity. - Page 8 Lines 6-13: Please describe the packages a bit more. Are these fixed in advance or are patients offered package deals based on what they need when they present at the clinic? If packages are fixed in advance, this might incentivize unnecessary treatments as well. - Page 8 Lines 25-30: Is there any data from the patient exit interviews that cross-references with the quote above? How did patients feel about their relationship with their provider? A quote to support this would be helpful.

REVIEWER	Barbara McPake University of Melbourne, Australia
REVIEW RETURNED	04-Feb-2019

GENERAL COMMENTS	1. There is potential interest in this paper but there is a need for greater clarity in some aspects of methods, a more critical approach to evaluating the participants' responses, and at least if the second objective of the paper is to be justified, a more thorough and critical approach to evaluating policy options. 2. Arrangements for provision of publicly funded primary care in urban Bangladesh are unusual if not unique in their use of contracts with NGOs in place of any direct public provision. As the authors point out, but only at the end, this leaves gaps as the contracts cover maternal and child care only. Hence, the system is designed to rely on private provision of care, it does not just arise by default because of the gaps left without acknowledged intention as it does in most other countries. This is important background needed at the outset. The response to private sector shortcomings cannot rely on 'beneficial competition' as implied in the discussion/conclusion, without a change of direction in the urban primary care system. 3. The authors note in both the 'strengths and limitations' and the discussion, that respondents were unwilling to disclose strategies - something described as a methodological limitation in the strengths and limitations section, which I'm not sure that it is. They only note in the discussion, that the potential for inaccurate responses is likely also. It is not uncommon for people to claim philanthropic motivations for privately rewarding activity but that critical lens is not acknowledged in the reporting or discussion of all professions of virtue. While this might be to some extent unavoidable - you can only report what has been said, there would be some opportunities to check claims against behaviors. Did those who claimed they wanted to provide access to poor people have arrangements in place to waive or reduce fees on evidence of poverty for example? Given the other methods applied of exit interviews and clinic observation, it should be possible to cross-check on such claims to some extent. The juxtaposition of these claims on the one hand and the evidence of exploitative behaviors on the other, undermines the credibility of the conclusion reached that a surprising amount of philanthropic motivation is present. Your final sentence in the limitations: 'Were more time available for rapport building, richer and more trustworthy data might have been

	produced' serves to undermine confidence in the study. Wouldn't it be better for example, to have interviewed fewer people if the time budget was highly constrained, on the basis that a small amount of reliable data is superior to a large amount of poor quality data? 4. It would be helpful to clarify the definition of a 'small and medium sized private sector facility' the population of which formed the sampling frame for the study. It wasn't clear to me whether these were all registered facilities or whether they included unregistered ones. I assume 'facility' implies a physical building, rather than for example, a temporary stall in a market place, but exactly what it would take to qualify needs to be clarified. Also in relation to clarity of methods, a bit more information is needed on what respondents were asked about. It looks like key stakeholders were asked what they thought motivated private providers and what strategies they used. Were providers asked about their own motivations and strategies or those of their owners? What were the main headings in each interview guide? 5. The second objective of the paper is stated as: 'identifying potential points of entry to improve service quality and access to the urban poor that also serve the business interests of this sector.' but this is only touched upon in the Conclusions section where a number of possible ideas are briefly considered. For the second objective to be met, I think a much more substantial policy implications section is needed, spelling out these option in much more detail so that exactly what might be considered is fully explained, and critiquing the ideas on the basis of evidence of similar strategies applied elsewhere. 6. These are my major concerns - some more minor ones follow. 6.1 I think also that a clearer link between the larger concerns of the introduction about the role of the private providers in UHC and a better understanding of motivation and strategies needs to be drawn explicitly... ie. why does understanding motivations and strategies inform policy in relation to strengthening UHC? (And by the way, isn't SDG target 3.7 a sub-component of 3 and therefore logically impossible to be 'even more daunting'?) 6.2 You indicate that exit surveys suggested a universally positive quality evaluation by users of the facilities, but you should also note I think the two sources of bias in evaluating that: first, a selection bias - people who use a clinic do so because they have a positive evaluation of it; second a bias caused by proximity to the provider staff - people may report positive views because they fear being overheard. If you too particular steps to ensure that the exit interview was private and clearly so, then the second problem might be minimised but the first still applies. 6.3 You indicate that 'contrary to expectations', human resource challenges were not just a public sector concern. Whose expectations? I think there is a reasonable existing body of

	evidence that the private sector struggles to recruit qualified staff too.

REVIEWER	Neil Lunt University of York
REVIEW RETURNED	04-Feb-2019

GENERAL COMMENTS	This is an interesting theme and study. However, I do not feel that the paper, as currently structured and written, is ready for publication. I offer a few reflections. • The paper needs a stronger purpose: no clear theme. • It risks being very superficial about many things. The section on financial motivations tells us very little. We would expect there to be personal motivations. What about linking this issue to theoretical literature on motivations and behaviour? • Many issues receive a mention but there is absence of sustained coverage (collusion, pricing, trust) • What does the information on the consultation times add? • Section on 'Referral' – the quote lines 44-7 does not follow. There is then a jump from ICU to patient desires. • Page 8 line 54, 'Majority of respondents' – who is this referring to? • Page 9 – is the top paragraph making a case for public health organisations? • In the Discussion/ Conclusion a number of weaknesses of the paper are evident. Too many themes are introduced but not dealt with: o Issues of social desirability not really dealt with o The importance of patient friendly services (a bit obvious; as against what – patient unfriendly services?). o Importance of making patients 'happy' – requires more discussion. o Introduction of issues that we don't have evidence for in the paper (e.g. discounted prices on 'free medical samples') o What about supplier-induced demand; quality; regulation and health governance o There is a risk that it echoes view from a private sector but without putting them fully in a context where are critical appraisal is possible. Minor There are places where phrasing is odd or does not follow from preceding (e.g. page 2line 2- 'perilous and flawed…; page 2, line 43; page 3 lines 26-28 needs clarifying).

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Reviewer Name: Meenakshi Gautham

Institution and Country: London School of Hygiene and Tropical Medicine, UK

Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below

Overall:

1. The paper focuses on an important topic but lacks coherence. Understanding the

business strategies, incentives and motivations of private facilities is a relevant objective, but there is no conceptual framework underpinning the analysis. In the absence of a conceptual/theoretical framework, the findings appear thin and put together in an ad hoc manner. You should look at some literature on business strategies of private enterprises and develop a coherent framework within which you can locate and discuss your findings.

For example, the pharmaceutical influence on doctors' prescribing is well known and well documented in literature, and it is not clear how this fits in with the other business strategies adopted by facilities.

Response: In response to the suggestion that our analysis be underpinned in terms of the corporate business strategy literature, we have integrated Christensen et al. (1982) simple yet well-established Business Policy Model in to the paper, and structured the findings and discussion sections accordingly.

2. There is no information on pricing or how profits are determined or about any

differences in clientele.

Response: Efforts to probe about the monetary aspects of their business were unsuccessful. Huge reluctance to share.

3. The second objective (identifying potential points of entry to improve service

quality….) has not been addressed in the main study but only brought up marginally in the discussion. It could be removed as a study objective and instead you could just focus on the business strategies and what those imply in terms of quality improvements and UHC.

Response: The authors agree with the reviewer. The objectives of this study have been modified: 1) to explore the underlying motivations of owners and providers entering into and sustaining activities in the formal for-profit private health sector; and 2) to understand how the business strategies and incentives governing formal-for-profit private sector enable or hinder access and quality.

4. Methods: It is not clear what kind of facilities were included and what was their

capacity (except for the bed strength)– were they tertiary or secondary or primary facilities? Do the high-end tertiary facilities have the same kind of strategies as the lower end ones? What were the differences if any?

Response: The private-for-profit facilities included in the study sample were secondary level hospitals and primary care clinics. This has been clarified in the text. In terms of business strategies, across the sector (small and medium sized hospitals and/or clinics), patterns were remarkably similar i.e. patient-friendly services, use of brokers or agents, strategic referrals and human resource work-arounds.

5. The methods section needs more details of how these facilities were selected in

the first instance, even if they selected purposively – what were the variability criteria? Were they selected from different parts of the three sites? Was there a list of facilities available?

Response: We have clarified details concerning sampling in this revision – purposive (KIIs and exit interviews), snowball methods (IDIs)

6. It is not obvious how the patient exit interviews have been used/analysed and the

same goes for facility observations. You could present the data from the observations and try to develop some way of categorising the facilities.

Response: Observation data were removed from analysis. Framework analysis of patient/exit interviews yielded some findings, but not all were pertinent to the paper's overall focus/argument.

7. Results – please avoid quantifying any qualitative findings (table 2)

Response: The authors accept the comment from the reviewer. Table 2 has been removed in the revision.

8. Introduction: Can you provide information on the public-private breakup of the

health sector in terms of overall distribution and utilisation for general illnesses?

Response: This breakdown has been included.

9. Language – There are several grammatical errors and the manuscript needs a

thorough editorial review.

Response: The paper has been reviewed and revised.

Reviewer: 2

Reviewer Name: Catherine Goodman

Institution and Country: London School of Hygiene and Tropical Medicine, UK

This paper presents primarily qualitative interview data from private for-profit health facility owners/staff and local stakeholders from 3 cities in Bangladesh, to explore the motivation and business practices of the private facilities. I found the results rich and interesting, particularly in terms of business strategies, and a valuable addition to the current literature in this area. However, I have a

number of concerns about the paper which would need to be addressed before publication, as described below.

I was also somewhat surprised by the choice of journal for this paper – while I understand that BMJ Open has a wide remit, I did wonder if this paper would have fitted better in a journal with a more health systems focus, and more explicitly LMIC remit – but I will leave that for the Editors to assess.

Major concerns

1. There is a need for more background on the health system in urban Bangladesh in order to interpret these findings. What I am missing is a paragraph in the introduction which would describe the public system (in terms of types of facilities, financing etc), the NGO facilities available, and would also explain the structure of the private sector. In particular the authors use the terms "formal" and "informal" without defining these, and do not explain the full range of private providers. On page 9 they also mention "private clinics" and "private practitioners" but I wasn't sure how these related to the facilities in the study.

Response: An orientation to the urban healthcare system has been incorporated, which situates the private sector in all its diversity, and identifies remaining gaps. The informal – formal spectrum is also explained – very difficult to define and classify facilities – i.e. even well-respected private hospitals may lack up-to-date registration.

2. The limitations of the research are not sufficiently addressed. There is a brief section on this towards the end of the paper. I would suggest that this be integrated into the Discussion section, and more comprehensive in terms of the range of limitations covered and the depth with which they are considered. In particular I would have liked to see:

a. Consideration of the limitations of the sampling strategy – which seemed purely convenience (and not purposive as stated by the authors), and only covered registered/licenced facilities – and therefore on both accounts may have been not at all representative of all private facilities.

Response: Sampling approaches have been clarified.

b. How typical of Bangladesh were the 3 cities that you worked in?

Response: We discuss the characteristics of the 3 sites selected for study and their justification on page 4 second paragraph, under Methods in sub-section titled, Study Site.

c. I would have liked to see more discussion of how you addressed potential social desirability bias, especially as your focus on motivations means that you are particularly prone to this. You mention that such bias could exist but don't explain if and how you tried to address this, and how it might have affected your results. You also took at face value the claim that facilities sometimes served the "poor, the vulnerable and the disadvantaged". Do you have any evidence to back this up? Most studies find that such formal, licenced facilities serve only the richer quintiles of society. You also note that respondents cited social service and social status as a medic as motivations – but don't probe why this would motivate them to join the private as opposed to public health sector.

Response: Social desirability bias is identified as a limitation of the study in the Discussion section. The researchers were aware of this issue while collecting data, and made considerable efforts to build rapport and trust.

3. It would have been good to have included some descriptive data on the health facilities – such as number of staff, number of beds, range of services offered, type of equipment, whether inpatient care was provided etc. I believe some of this would have been collected through the "observations" – could some of this be presented? If this is not done, it's unclear that the structure observations should really be included as the only data from them seems to be one sentence on wait times...

Response: Considering its limited contribution to study objectives, and the comment from the reviewer, the authors decided to remove Observational data from this manuscript.

4. Throughout the presentation of Business strategies I did not get a strong feeling of whether views were quite uniform across interviewees or whether they varied by type of interviewee, or size or other characteristics of the facility, or city. It would be good to use the data matrices employed for data analysis to explore this.

Response: this study followed a framework analysis approach. Strategies presented in the findings section were common practices reported by the various private sector respondent groups as apparent in data matrices.

5. The discussion of policy implications is currently very thin and needs strengthening. This is not covered in the Discussion, but only in the Conclusions, by a few statements which are not well elaborated or justified. For instance, the authors state that the values of "quality and professionalism" could be "leveraged in efforts to ensure that private-sector services are safe and effective" but do not provide any further explanation of how this could be done. Similarly they state that "widespread use of informal discounts and subsidies by private sector providers provide a similar segue into discussions of UHC, and how participation in insurance schemes might be advantageous in terms of retaining and growing clientele especially among the urban poor" but do not explain how this could have relevance of insurance schemes. In the final paragraph they mention that policy makers should "incentivize their efforts to provide services of quality" and to engage in "beneficial competition", but again the potential approaches and their limitations are not fleshed out. Also in the Abstract you mention that you have identified "potential entry points including regulatory mechanisms and governance" but I didn't see any identification of regulatory entry points in the main text. A more nuanced and detailed discussion of how their results might influence policy is required.

Response: The study objectives have been revised accordingly. The revised Discussion includes reference to policy implications, insurance schemes and regulation as suggested by the reviewer.

6. It would be good in the Introduction / Discussion to set these findings more clearly within the international context and debates around the private sector – how typical do you think these findings would be of other LMIC?

Response: A few brief references to the applicability of findings to other LMIC contexts are incorporated, but the analysis is highly specific to Bangladesh, to this particular segment of a hugely diverse sector, and to the urban context in particular.

Minor comments

7. The writing of the Results and Discussion is very good, but there are a number of English mistakes in the Abstract / Intro / Methods which require review

Response: The necessary corrections have been made.

8. Pg 3 para 2 – CS rate has risen from 17% in 2011 to 26% - in what year?

Response: in the year 2014, correction made in Page 3 paragraph 2.

9. Pg 3 para 3 – you say the increase in private providers reflects "the inability of the public sector to generate sufficient supply on its own" – would it also reflect perceived quality gaps in the public sector?

Response: There is some debate about public-private differences in perceived and technical quality. However, the coverage gap in urban public services is clear – the private sector has stepped into this space.

10. Pg 5 – The section on Participants would fit better in methods than in Results. You should also provide more details on the characteristics of interviewees e.g. gender, age, health qualification.

Response: This change was made. Respondent details were not collected due to the sensitive nature of study.

11. Pg 5 – it was unclear to me how many facilities had been covered – was either an owner or a staff member interviewed for each facility so that the total is 30 facilities? Or was more than one person interviewed in some facilities?

Response: Observations have been removed from study methods. However, purposively sampled facilities, exit interviews and interviews with formal providers and owners from those same facilities were conducted.

12. Pg 5 – did any facilities or individuals refuse interviews?

Response: We only interviewed persons recommended to us vis snowball sampling. No refusals but reluctance in answering certain questions was sometimes apparent.

13. Pg5-6 – I was not sure how to interpret the ticks in the table – are they an indication of strength of views across participants? Or are they actual counts of the number of times these issues were mentioned (which would not be appropriate). Perhaps a key is required?

Response: The table has been removed.

14. Pg 8 – para 1 can you give some examples of health packages?

Response: An example has been provided.

15. Pg 8 and Discussion – you comment on the brevity of consultations and say they are not much different form the public sector – so how long are they in the public sector?

Response: This has been clarified.

16. Pg 9 – provide USD equivalent for Taka

Response: This has been done.

17. Pg 12 – you mention the need to include preventive and promotive services in the private sector, but have provided no evidence in the results that these are absent.

Response: Point well taken. Reference to the service mix of NGOs and private sector is made in the introduction only. We touch on it again in the conclusion given the importance of comprehensive services in the quest for UHC!

Reviewer: 3

Reviewer Name: Lauren Suchman

Institution and Country: Institute for Global Health Sciences, University of California San Francisco, USA

Abstract:

- Page 2 Line 16: Please clarify “adverse family events members”

Response: The necessary corrections have been made on page – 2.

Intro:

- Please elaborate more on the growth of the private sector. What is driving it from both the provider and patient sides? Other than pregnant women, who is using it? If it is mainly used by wealthier patients, for example, then how can it contribute to UHC?

Response: This is explained in the intro – the urban public sector is limited to tertiary level facilities and a contracted-out NGOs providing MNCH services.

- Page 3 Lines 37-38: I imagine formal providers also sometimes prescribe more costly drugs to turn a profit. Is this really limited to informal providers?

Response: Issues of oversupply are mentioned.

Methods

- While you have told the reader that private facilities are largely growing in urban regions, it would help to have some more context here so the reader knows how to interpret your findings. What % of the population of Bangladesh lives in urban areas? Is the country rapidly urbanizing?

Response: These data have been included in the Introduction.

- Page 4 Lines 16-17: How were the initial clinics chosen before snowball sampling went into effect?

Response: The point of entry for sampling was the respondent identified through snowball method.

- Page 4 Lines 21-22: What criteria did you use to sample patients for exit interviews?

Response: Patient exit interviews were conducted purposively from both in-patient and out-patient units in facilities where in-depth interviews with owners, managers and providers were conducted.

Results:

- Page 5 Lines 14-39: I recommend shifting the “Participants” sub-section up to Methods. This is your sample.

Response: As suggested by the reviewer the table has been shifted to page 5, under sub-section Study methods and Sampling strategy in Methods

- Page 5 Line 51 – Page 6 Line 13: I am confused by this table and exactly what information the check marks convey. I would suggest using raw numbers or percentages instead of the check marks and also getting rid of the footnote.

Response: We accept the comment by the reviewer and the table has been removed.

- Page 7 Lines 6-8: A great point, but a little hard to follow because the wording is confusing. Please re-write for clarity.

Response: On new page 7, we have re-written the lines for clarity.

- Page 8 Lines 6-13: Please describe the packages a bit more. Are these fixed in advance or are patients offered package deals based on what they need when they present at the clinic? If packages are fixed in advance, this might incentivize unnecessary treatments as well.

Response: They are fixed packages - can be c-section packages, diagnostic tests. An example has been provided.

- Page 8 Lines 25-30: Is there any data from the patient exit interviews that cross-references with the quote above? How did patients feel about their relationship with their provider? A quote to support this would be helpful.

Response: Findings from patient exit interviews with a supportive quotation have been incorporated on new page 8.

Reviewer: 4

Reviewer Name: Barbara McPake

Institution and Country: University of Melbourne, Australia

Please leave your comments for the authors below

1. There is potential interest in this paper but there is a need for greater clarity in some aspects of methods, a more critical approach to evaluating the participants' responses, and at least if the second objective of the paper is to be justified, a more thorough and critical approach to evaluating policy options.

Response: Necessary corrections to Methods and Results sections have been attempted, and Study objectives have also been revised: The authors agree with the reviewer. The objectives of this study have now modified: 1) to explore the underlying motivations of owners and providers entering into and sustaining activities in the formal for-profit private health sector; and 2) to understand how the business strategies and incentives governing formal-for-profit private sector enable or hinder access and quality. Because the last objective on policy entry points has been removed, less emphasis on policy options is needed.

2. Arrangements for provision of publicly funded primary care in urban Bangladesh are unusual if not unique in their use of contracts with NGOs in place of any direct public provision. As the authors point out, but only at the end, this leaves gaps as the contracts cover maternal and child care only. Hence, the system is designed to rely on private provision of care, it does not just arise by default because of the gaps left without acknowledged intention as it does in most other countries. This is important background needed at the outset. The response to private sector shortcomings cannot rely on 'beneficial competition' as implied in the discussion/conclusion, without a change of direction in the urban primary care system.

Response: A section has been incorporated in the Introduction which describes the urban health care system emphasizing in particular the limited nature of public primary provision, how the private sector fits in, and gaps remaining.

3. The authors note in both the 'strengths and limitations' and the discussion, that respondents were unwilling to disclose strategies - something described as a methodological limitation in the strengths and limitations section, which I'm not sure that it is. They only note in the discussion, that the potential for inaccurate responses is likely also. It is not uncommon for people to claim philanthropic motivations for privately rewarding activity but that critical lens is not acknowledged in the reporting or discussion of all professions of virtue. While this might be to some extent unavoidable - you can only report what has been said, there would be some opportunities to check claims against behaviors. Did those who claimed they wanted to provide access to poor people have arrangements in place to waive or reduce fees on evidence of poverty for example? Given the other methods applied of exit interviews and clinic observation, it should be possible to cross-check on such claims to some extent. The juxtaposition of these claims on the one hand and the evidence of exploitative behaviors on the other, undermines the credibility of the conclusion reached that a surprising amount of philanthropic motivation is present. Your final sentence in the limitations: 'Were more time available for rapport building, richer and more trustworthy data might have been produced' serves to undermine confidence in the study. Wouldn't it be better for example, to have interviewed fewer people if the time budget was highly constrained, on the basis that a small amount of reliable data is superior to a large amount of poor quality data?

Response: We agree the term “methodological limitation” is not appropriate, it has thus been revised. The revised Discussion section now elaborates these limitations. Given the sensitive nature of the topic, the investigators allowed for as much rapport building as possible within the time-limited scope of the project, however, it is possible that a lengthier period of rapport building may (or not!) have yielded richer data.

4. It would be helpful to clarify the definition of a 'small and medium sized private sector facility' the population of which formed the sampling frame for the study. It wasn't clear to me whether these were all registered facilities or whether they included unregistered ones. I assume 'facility' implies a physical building, rather than for example, a temporary stall in a market place, but exactly what it would take to qualify needs to be clarified. Also in relation to clarity of methods, a bit more information is needed on what respondents were asked about. It looks like key stakeholders were asked what they thought motivated private providers and what strategies they used. Were providers asked about their own motivations and strategies or those of their owners? What were the main headings in each interview guide?

Response: The facilities included in this study were registered. The study was undertaken in the context of a larger health facility mapping study in different city corporations of Bangladesh which identified (self-reported) registered private-for-profit health facilities that constituted the sampling frame of this study. As assumed by the reviewer, the term “facility” implies that the service is provided in a permanent physical location (not a temporary stall in a market place). To help clarify, definitions of different health facilities are provided in Box 1 in the Annex attached as a Supplementary file with the revised manuscript.

The suggestion about providing information on the different respondent groups interviewed is acknowledged, and details are provided on page 5 under the sub-section Data collection in the Methods section.

5. The second objective of the paper is stated as: 'identifying potential points of entry to improve service quality and access to the urban poor that also serve the business interests of this sector.' but this is only touched upon in the Conclusions section where a number of possible ideas are briefly considered. For the second objective to be met, I think a much more substantial policy implications section is needed, spelling out these option in much more detail so that exactly what might be considered is fully explained, and critiquing the ideas on the basis of evidence of similar strategies applied elsewhere.

Response: The authors agree with the reviewer. The objectives of this study have now modified: 1) to explore the underlying motivations of owners and providers entering into and sustaining activities in the formal for-profit private health sector; and 2) to understand how the business strategies and incentives governing formal-for-profit private sector enable or hinder access and quality.

In addition, the policy implication section in the conclusion has been expanded upon to include a more critical analysis of potential policy directions.

6. These are my major concerns - some more minor ones follow.

6.1 I think also that a clearer link between the larger concerns of the introduction about the role of the private providers in UHC and a better understanding of motivation and strategies needs to be drawn explicitly... ie. why does understanding motivations and strategies inform policy in relation to strengthening UHC? (And by the way, isn't SDG target 3.7 a sub-component of 3 and therefore logically impossible to be 'even more daunting'?)

Response: This has been clarified in the discussion. The SDG faux pas has been corrected.

6.2 You indicate that exit surveys suggested a universally positive quality evaluation by users of the facilities, but you should also note I think the two sources of bias in evaluating that: first, a selection bias - people who use a clinic do so because they have a positive evaluation of it; second a bias caused by proximity to the provider staff - people may report positive views because they fear being overheard. If you too particular steps to ensure that the exit interview was private and clearly so, then the second problem might be minimised but the first still applies.

Response: Selection bias was identified as a limitation.

6.3 You indicate that 'contrary to expectations', human resource challenges were not just a public sector concern. Whose expectations? I think there is a reasonable existing body of evidence that the private sector struggles to recruit qualified staff too.

Response: This has been clarified.

Reviewer: 5

Reviewer Name: Neil Lunt

Institution and Country: University of York

Please leave your comments for the authors below

This is an interesting theme and study. However, I do not feel that the paper, as currently structured and written, is ready for publication.

I offer a few reflections.

1. The paper needs a stronger purpose: no clear theme.

Response: The authors acknowledge the comment from the reviewer. In the authors' defense, we want to clarify that the purpose of this manuscript is to explore the existing and probable engagement of the private-for-profit health sector in achieving universal health coverage for the urban poor through understanding their motivation and business strategies.

2. It risks being very superficial about many things. The section on financial motivations tells us very little. We would expect there to be personal motivations. What about linking this issue to theoretical literature on motivations and behaviour?

Response: This section has been clarified.

3. Many issues receive a mention but there is absence of sustained coverage (collusion, pricing, trust)

Response: new pages 8, 9 & 10 touch on collusion, new pages 8, 9, 10 & 12 reference costing, and pages 8 & 11, trust issues.

4. What does the information on the consultation times add?

Response: this point has been clarified.

5. Section on 'Referral' – the quote lines 44-7 does not follow. There is then a jump from ICU to patient desires.

Response: These sections have been rewritten.

6. Page 8 line 54, 'Majority of respondents' – who is this referring to?

Response: Here majority of the respondents refer to formal providers, formal owners and managers, key stakeholders – this has been added to the text as identified by the reviewer.

7. Page 9 – is the top paragraph making a case for public health organisations?

Response: This has been clarified.

8. In the Discussion/ Conclusion a number of weaknesses of the paper are evident. Too many themes are introduced but not dealt with:

Response: These sections have been reorganized and rewritten.

8.1. Issues of social desirability not really dealt with

Response: This is referred to in limitations

8.2. The importance of patient friendly services (a bit obvious; as against what – patient unfriendly services?).

Response: Yes, this is discussed on new pages 11, 12 & 13 as suggested by the reviewer.

8.3. Importance of making patients 'happy' – requires more discussion.

Response: This has been elaborated in the Discussion section in the revised version

8.4. Introduction of issues that we don't have evidence for in the paper (e.g. discounted prices on 'free medical samples')

Response: Thanks for the comment. Pages 9 & 12 discusses the issue of discounted prices on "free medical samples"

8.5. What about supplier-induced demand; quality; regulation and health governance

Response: Even though this was beyond the focus of our study objectives, given the broad spectrum of UHC, these topics are discussed with evidence from existing literature on pages 11, 12 & 13.

8.6. There is a risk that it echoes view from a private sector but without putting them fully in a context where are critical appraisal is possible.

Response: This is a Limitation which we tried to overcome with careful probing, however, it is acknowledged as a weakness in a study of this nature.

Minor

9. There are places where phrasing is odd or does not follow from preceding (e.g. page 2line 2- ‘perilous and flawed…; page 2, line 43; page 3 lines 26-28 needs clarifying).

Response: Changes have made.

VERSION 2 – REVIEW

REVIEWER	Lauren Suchman University of California, San Francisco USA
REVIEW RETURNED	26-Apr-2019

GENERAL COMMENTS	Thank you for addressing my comments. The manuscript has improved greatly and I feel confident recommending it for publication by BMJ Open.