Bangladesh Journal of Medical Education
ISSN: 2306-0654(Print), 2313-4224 (Online)
DOI: https://doi.org/10.3329/bjme.v17i1.87084

Vol.-17, Issue-01, January, 2026

Original Article

Physicians' Views on the 'Institutional Practice' Proposed by the Government of Bangladesh

Shabnaj Aktar[1], Md. Nazmul Hassan Refat[1], Abu Sadat Mohammad Nurunnabi[2], Rezwana Islam[1], Gul-E-Noor Tasmia[1], Sucheta Kanon[1], Rezwana Sultana[1], Mukta Das[1], Md. Abdullah Al Kafi Roman[3]

Abstract

Background: Initiative has been taken by the Government of Bangladesh to establish 'institutional practice' in government hospitals after regular working hour to bring those patients under the mainstream of healthcare, who often face financial hardship to access the same service from private healthcare facilities through out-of-pocket expenditure. **Objective:** This study examined physicians' views on the 'institutional practice' in terms of its opportunity, compatibility and complexity. **Methods:** This cross-sectional, descriptive study was conducted in three urban tertiary level public hospitals in Dhaka, Bangladesh. A total of 313 physicians of different specialties were selected through convenience sampling. Data was collected using a pre-tested, semi-structured questionnaire. A 5-point Likert scale was used to measure physician's views towards institutional practice. **Results:** The mean age of the participating physicians was 38.4±7.10 years. 62% of the physicians were male and 38% were female. The majority (55.9%) of physicians agreed that institutional practices can ensure healthcare for more patients. 46.6% agreed that this arrangement will serve as a source of additional income for health professionals. 59.7% agreed institutional practices can reduce out-of-pocket costs for patients. However, there were concerns about adequate compensation within institutional practices. 44.7% and 42.5% disagreed with the consultation and surgery fees respectively, as proposed by the government. Overall, 55.9% opined that this will increase their workload, while 38.7% anticipated difficulties in monitoring revenues. **Conclusion:** Although a large portion of physicians disagreed with the fee structure and duty schedule, the majority agreed with the prospective opportunities through adoption of institutional practice. The study findings can be utilized to modify and strengthen the policies to implement an effective 'institutional practice'.

Keywords: Institutional practice, opportunity, compatibility, complexity, government hospital

1. Department of Public Health and Hospital Administration, National Institute of Preventive and Social Medicine (NIPSOM), Dhaka-1212, Bangladesh.
2. Dalla Lana School of Public Health, University of Toronto, ON, Canada.
3. Upazila Livestock Office, Khansama, Dinajpur-5230, Bangladesh.

Address of correspondence: Dr. Shabnaj Aktar, Department of Public Health and Hospital Administration, National Institute of Preventive and Social Medicine (NIPSOM), Dhaka-1212, Bangladesh. Email: shabnajakter304@gmail.com

Introduction

Bangladesh is a densely populated country in South East Asia having significant improvement in its healthcare system in the last few decades. However, the healthcare infrastructure in Bangladesh includes both public and private healthcare facilities. The public healthcare system is organized under the Ministry of Health and Family Welfare and includes hospitals, clinics, and other healthcare centres. The private healthcare system, on the other hand, includes private hospitals, clinics, and diagnostic centres.[1] In government hospitals of Bangladesh,

healthcare services delivered under the hospital's public funding and administration and provide services at a low cost or for free.[1-3] However, recently, Government of Bangladesh announced the provision of 'institutional practice',[2,3] which refers to "a government physician will be able to deliver private, fee-for-service, within the same public hospital setting".[4] 'Institutional practice' commonly refers to an official arrangement by which medical services are provided, on a fee-for-service basis, to inpatients and outpatients in a public hospital.[1] Institutional practice also known as private wing at public hospital, Full paying patient service (FPP). Institutional practice enabled physicians to work in a familiar environment under the supervision and support of senior professionals. The Ministry of Health and Family Welfare of the Government of the People's Republic of Bangladesh finalized the 'Institutional Practice Guidelines 2023' to reorganize the structure of health services delivery and get more out of the existing public healthcare infrastructure. Through a pilot project, the government intended to introduce the institutional practice at 10 districts and 20 upazilas from end of March 2023. Under the proposed policy, government physicians are allowed to provide private consultation service at their own workplace after regular working hours (between 3 and 6 pm every day except holidays but twice a week by rotation). Besides, they are also allowed to serve at private healthcare institutions or anywhere else. Government also proposed a specific fee structure for consultation and medical/surgical procedure. Thus, the government decided to introduce such 'institutional practice' in the country in a limited scale; however, it might be expanded in large scale in near future after reviewing the outcomes of this pilot project.[2,3]

In addition, physicians of institutional practice exhibited lower levels of demand than patients visiting private hospitals. Additionally, they reported excellent job satisfaction from the institutional practice, which also spared them the trouble of having to travel to other clinics/hospitals for 'chamber practice'.[5] In the co-location concept, a public entity allots a portion of a public hospital's property and/or facilities to a private health care company for ongoing use in return for payment and particular advantages to the public hospital and its patients. Public or Parastatal Private Service Model refers to a private wing in a public hospital that does not involve investor ownership at all but allows physicians to care for private patients in designated areas of the public facility. Bangladesh government move under the so-called institutional practice system to allow public hospital and medical college doctors to carry out private

practice on the hospital premises after office hours is obviously a novel idea. The concept of institutional practice, as defined by the Ministry of Health and Family Welfare (MoHFW), provision of healthcare services after office hours delivered by the specialists and MBBS/BDS/equivalent doctors in their corresponding healthcare facilities to the general population in exchange for proposed fees. The decision to permit physicians to offer consultation services in private offices within government hospitals and medical colleges is a strategic move to leverage existing infrastructure for expanded healthcare delivery.[2,4,6,7] Under the trying circumstances, this study aims to examine physicians' views towards opportunity, compatibility and complexity of 'institutional practice'. The exploration of physicians' attitudes towards opportunities will allow institutions to pinpoint areas of potential improvement or expansion. Assessing the compatibility of institutional practices with physicians' values and preferences is fundamental for sustainable and effective implementation. When there is alignment between the institutional practices and the values of the physicians, it enhances job satisfaction, engagement, and overall effectiveness.

Methods

This cross-sectional, descriptive study was conducted in three tertiary level healthcare institutions in Dhaka, Bangladesh, between January and December of 2023. A total of 313 physicians working in three tertiary level public hospitals in Dhaka city, Bangladesh were enrolled in this study. Our study centres were: Bangabandhu Sheikh Mujib Medical University (BSMMU) Hospital, Dhaka Medical College Hospital and Shaheed Suhrawardy Medical College Hospital. The selection of participants was conducted using a convenience sampling technique. Data were collected by a pre-tested, semi-structured questionnaire. In this study, a pre tested, semi-structured questionnaire was used. The compatibility part of the questionnaire was made based on the variables in accordance with the rules and regulations of the 'Institutional Practice Guidelines 2023' as circulated by the Ministry of Health and Family Welfare of Bangladesh, while opportunity and complexity parts were formulated through a literature review. A 5-point Likert scale was used to measure physician's views towards institutional practice (marked as 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree). A pre-testing of the questionnaire was done on 30 physicians working at National Institute of Cardiovascular Diseases (NICVD), another tertiary level hospital in Dhaka city, to finalize the procedure and to evaluate the effectiveness of the research instrument. In

pre-testing process, the respondents were asked if they failed to understand any specific words or sentences. Any unacceptable or offensive words or expressions were also identified and noted.

Data collection was done from 313 physicians participated in the study, data was examined, validated, coded, post-coded, and input was given into a computer. For the final analysis, only fully completed questionnaires were received. Data was analyzed, following the objectives and variables of the study, using Microsoft Excel 2022 and Statistical Package for Social Science (SPSS) version 26.0 for Windows. Data was expressed as frequency and percentage to describe the sociodemographic characteristics and the variables related to the opportunity, compatibility and complexity domains of 'institutional practice'.

The study was approved by the Institutional Review Board of the National Institute of Preventive and Social Medicine (NIPSOM), Dhaka, Bangladesh (NIPSOM/ IRB/2023/06).

Results

The mean age of the participating physicians was 38.4±7.10 years. The majority of the participants 150(47.9%) belonged to the 28–35 years age group, while 63(20.1%) and 100(31.9%) were in the 36–43 years and ≥44 years age group respectively. 194(62%) were male and 119(38%) were female; male-female ratio was 1.63:1. Among them, 305(97.4%) were married, while 8(2.6%) were unmarried. 78% had 1–4 family members and 22% had 5–8 family members, who depend on their income. 15(4.8%), 33(10.5%) and 62(19.8%) were in the rank of full professor, associate professor, and assistant professor respectively, while 11(3.5%) were junior consultant, 15(4.8%) posted as registrar, 54(17.3%) as assistant registrar, and 83(26.5%) as indoor medical officer (IMO) or medical officer (MO) and 40(12.8%) were working as residents. More than half, i.e., 165(53%) already have had private practice outside of their working place (Table 1). More than half 175(55.9%) agreed that this service will ensure healthcare for the increasing number of patients. However, 107(34.2%) physicians disagreed with the notion that such arrangement will serve as a source of additional income for health professionals. 187(59.7%) physicians agreed that this system will reduce patients out of pocket expenditure, while 181(57.8%) opined that the patients will be able to seek medical care according to their own preferences in this system (Table 2). 136(43.5%) physicians agreed and 118(37.7%) disagreed with the schedule of 'institutional practice' (i.e., 3–6 pm). The majority of the physicians i.e., 174(55.6%) agreed, while 8(2.6%) strongly disagreed,

ISSN: 2306-0654(Print), 2313-4224 (Online)
DOI: https://doi.org/10.3329/bjme.v17i1.87084

Original Article

81(25.9%) disagreed, 49(15.7%) remained neutral and 1(0.3%) strongly agreed with the duty roster system proposed in the guideline. 297(94.9%) of them agreed with opportunity to inter-change duties, while 14(4.5%) were neutral about that and only 2(0.6%) disagreed. 140(44.7%) of them strongly disagreed with the prescribed fee structure for consultation, while 37(11.8%) disagreed, 55(17.6%) were neutral, and 81(25.9%) agreed. Similarly, 133(42.5%) strongly disagreed with the prescribed fee for surgical service and 33(10.5%) disagreed. while only 88(28.1%) agreed with the fees finding that reasonable and remaining 59(18.8%) were neutral. 219(70%) agreed, 3(1%) strongly agreed and 3(1.0%) disagreed with annual medical audit system, while 88(28%) remained neutral on that issue (Table 3). 48.9% disagreed that this system will create inequality of care provided to the patients within the same hospital; more than half, i.e., 55.9% agreed that this system will increase staff's workload. 51.4% agreed that it will increase mental stress of the employees. 121(38.7%) agreed and 4(1.3%) strongly agreed that there will be complications in monitoring the additional revenue, while 113 (36.1%) disagreed and 1(0.3%) strongly disagreed and 74(23.6%) remained neutral (Table 4).

Table 1: Sociodemographic characteristics of the physicians (n=313)

Variables	Category	Frequency	Percentage
Age group (in years)	28-35	150	47.9
	36-43	63	20.1
	≥ 44	100	31.9
Sex	Male	194	62
	Female	119	38
Marital status	Married	305	97.4
	Unmarried	8	2.6
Family members	1-4	243	78
	5-8	70	22
Designation	Professor	15	4.8
	Associate Professor	33	10.5
	Assistant Professor	62	19.8
	Junior Consultant	11	3.5
	Register	15	4.8
	Assistant Register	54	17.3
	Resident	40	12.8
	Indoor Medical Officer/Medical Officer	83	26.5
Already in private practice	Yes	165	53
	No	148	47

Bangladesh Journal of Medical Education
ISSN: 2306-0654(Print), 2313-4224 (Online)
DOI: https://doi.org/10.3329/bjme.v17i1.87084

Original Article

Table 2: Physicians' views towards opportunity of institutional practice (n=313)

Variables	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
Ensuring healthcare by health professionals	1 (0.3%)	114 (36.4%)	19 (6.1%)	175 (55.9%)	4 (1.3%)
Source of additional income	13 (4.2%)	107 (34.2%)	44 (14.1%)	146 (46.6%)	3 (1.0%)
Reduction of patients out of pocket expenditure	2 (0.6%)	76 (24.3%)	34 (10.9%)	187 (59.75)	14 (4.5%)
Increased scope of patients' own preferences	-	94 (30%)	28 (8.9%)	181 (57.8%)	10 (3.2%)

Table 3: Physicians' views towards compatibility of institutional practice (n=313)

Variables	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
Service schedule (from 3 to 6 p.m.)	21 (6.7%)	118 (37.7%)	38 (12.1%)	136 (43.5%)	-
Prescribed duty roster	8 (2.6%)	81 (25.9%)	49 (15.7%)	174 (55.6%)	1 (0.3%)
Scope of changing duty	-	2 (0.6%)	14 (4.5%)	297 (94.9%)	-
Prescribed fee for consultation					
Fee for surgical service					
Annual medical audit	-	3 (1.0%)	88 (28%)	219 (70.0%)	3 (1.0%)

Table 4: Physicians' views towards complexity of institutional practice (n=313)

Variables	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Inequality of care among patients within the same hospital	4 (1.3%)	153 (48.9%)	20 (6.4%)	126 (40.3%)	10 (3.2%)
Increased staff's workload	1 (0.3%)	109 (34.8%)	17 (5.4%)	175 (55.9%)	11 (3.5%)
Increased mental stress among employees	4 (1.3%)	122 (39.0%)	16 (5.1%)	161 (51.4%)	10 (3.2%)
Complicated monitoring of additional revenues	1 (0.3%)	113 (36.1%)	74 (23.6%)	121 (38.7%)	4 (1.3%)

Discussion

Understanding the perceived complexity of 'institutional practice' is critical for identifying potential barriers and challenges that may hinder effective implementation. The findings from such a study can provide valuable insights for healthcare institutions,

ISSN: 2306-0654(Print), 2313-4224 (Online)
DOI: https://doi.org/10.3329/bjme.v17i1.87084

improve overall job satisfaction among physicians, and ultimately enhance the quality of patient care.[7,8] In our study, a total of 313 physicians from three urban tertiary healthcare facilities were selected using a convenience sampling technique. Data were collected using a pre-tested, semi-structured questionnaire. A similar study was done in Ethiopia about the role of private wing set up in public hospitals in reducing medical professionals' turnover. In this study, a descriptive design with mixed approach was applied. Data were collected through questionnaire, key informant interviews, and document review. Data was collected from 5 hospitals and 192 health professionals.[9] The opinions of physicians regarding institutional practice as a source of additional income reflect a diverse landscape within the healthcare industry.[9] As our data showed that 46.6% of physicians agreed with the idea that institutional practice can serve as an additional income source indicates a substantial portion of the surveyed professionals see potential advantages in such practices. Another study found that 50% of doctors reported a positive impact on their income due to the establishment of private wings.[10] This initiative suggests that provisions to diversify revenue streams within healthcare institutions, such as by incorporating private wings, can be financially beneficial for health professionals. The rise in income resulting from private wings can have several implications for both individual physicians and healthcare institutions as a whole.[9] Nearly half of the respondents, 47.3%, agreed with the statement suggesting that there will be a rise in the sense of hospital ownership by health professionals. A significant portion, 41.5%, disagreed with the statement, expressing a different viewpoint on the likelihood of an increase in hospital ownership by health professionals. It is interesting to note the findings from other studies which suggested that the establishment of a private wing has a positive impact on staff members' sense of hospital ownership.[9,10] This increased involvement can contribute to a greater sense of ownership as staff members take on more active roles in the functioning of the private wing services in the same vicinity.[9-11] The majority of the physicians, i.e., 140(44.7%) strongly disagreed with the prescribed fee for consultation in institutional practice. Similar findings were reported in several previous studies as most of the respondents did not agree with the payment system of dual practice wing.[4,9,11] In the present study, 55.9% agreed that this system will increase staff's workload, while 51.4% agreed that it will increase mental stress of the employees. Several studies reiterate similar challenges associated with dual practice, including its

financial implications and extra workload for the service providers.[4,9-12] Those studies also reported possible effects on healthcare quality and access.[4,9-12] However, 48.9% of our respondents disagreed that this system will create inequality of care provided to the patients within the same hospital. To our knowledge, this is the first ever study done on 'institutional practice' after its declaration by the Government of the People's Republic of Bangladesh.

Several limitations exist in our study. Sampling technique was convenience sampling, not random sampling. Therefore, there is chance of selection bias. All categories of physicians according to their specialty were not involved. Physicians often had demanding schedules, with long working hours and a high volume of patient care responsibilities. This also caused challenges to find convenient time slots for data collection. The exact calculated sample size according to formula was 384; however, within defined data collection period, it was possible for us to collect data from only 313 physicians.

Conclusion

This study explored physicians' attitudes towards institutional practices, providing valuable insights that can inform policy decisions in healthcare institutions. The findings revealed a diversity of perspectives across different demographics and career stages. Most physicians were receptive to institutional practices that offered evident opportunities to enhance patient care and treatment outcomes. Concerns had emerged regarding adequate compensation structures, with many physicians expressing dissatisfaction with existing consultation and surgical fees. The study also uncovered mixed views on the feasibility and resource implications of implementing additional evening services.

Overall, the research emphasized the need for nuanced, context-specific approaches in designing institutional policies that impact physicians. There is also an evident need for better communication and transparency from institutions on compensation models, implementation plans for new initiatives, and performance monitoring systems. Based on the findings of the study, several recommendations can be proposed to address the diverse perspectives and concerns of physicians regarding institutional practices: The authority may consider implementing more flexible and inclusive approaches regarding service hour and duty roster of institutional practice. Measures should be taken to address economic realities faced by physicians, the perceived value of services and to revise the fee structures. Additional measure must be taken to strengthen the record keeping system in order to promote

ISSN: 2306-0654(Print), 2313-4224 (Online)
DOI: https://doi.org/10.3329/bjme.v17i1.87084

accountability, trustworthiness, and operational efficiency. By incorporating these recommendations, healthcare institutions can foster a more inclusive and responsive environment, addressing the concerns and preferences of physicians, ultimately contributing to improved healthcare delivery and outcomes.

Conflict of Interest: The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

References

1. Vaughan JP, Karim E, Buse K. Health care systems in transition III. Bangladesh, Part I. An overview of the health care system in Bangladesh. J Public Health Med. 2000;22(1):5-9.
2. Sujan MA. Govt. doctors can see patients after hours. The Daily Star. February 23, 2023. Available at: https://www.thedailystar.net/news/bangladesh/news/govt-doctors-can-see-patients-after-hours-3254741 (Accessed March 1, 2023).
3. Erfan MMU. Can private practice in government hospitals benefit doctors and patients? The Business Standard. February 17, 2023. Available at: https://www.tbsnews.net/thoughts/can-private-practice-government-hospitals-benefit-doctors-and-patients-586362 (Accessed March 1, 2023).
4. Do N, Do YK. Dual practice of public hospital physicians in Vietnam. Health Policy Plan. 2018;33(8):898-905.
5. Abera GG, Alemayehu YK, Herrin J. Public-on-private dual practice among physicians in public hospitals of Tigray National Regional State, North Ethiopia: perspectives of physicians, patients and managers. BMC Health Serv Res. 2017;17(1):713.
6. Andalib A, Arafat SMY. Practicing pattern of physicians in Bangladesh. Int J Percept Public Health. 2016;1(1):9-13.
7. Muhammad Nur Amir AR, Sharifa Ezat WP. Physicians' intention to leave from Malaysia government hospitals with existing retention strategy. J Public Health Policy Plan. 2020;4(3):30-7.
8. Girma F, Abeje Y, Tamrat G. The effectiveness of private services in public hospitals: the case of St. Paul Hospital, Addis Ababa, Ethiopia. J Healthc Qual Res. 2021;36(6):333-9.
9. Wright A, Soran C, Jenter CA, Volk LA, Bates DW, Simon SR. Physician attitudes toward health information exchange: results of a statewide survey. J Am Med Inform Assoc. 2010;17(1):66-70.
10. Abera GG, Alemayehu YK, Herrin J. Public-on-private dual practice among physicians in public hospitals of Tigray National Regional State, North Ethiopia: perspectives of physicians, patients and managers. BMC Health Serv Res. 2017;17(1):713.
11. García-Prado A, González P. Policy and regulatory responses to dual practice in the health sector. Health Policy. 2007;84(2-3):142-52.
12. Hipgrave DB, Hort K. Dual practice by doctors working in South and East Asia: a review of its origins, scope and impact, and the options for regulation. Health Policy Plan. 2014;29(6):703-16.