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Addis Ababa University

Addis Ababa University
College of Business & Economics
Department of Public Administration
and Development Management

**Practices and Challenges of Private Wing in addis Ababa
Hospitals**

**A Thesis Submitted to School of Graduate Studies Addis Ababa
University in Partial Fulfillment of the Requirments for the Masters
Degree of Pblc Management and Policy (Development Management)
in the Department of Public Administration and Development
Management**

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Student Declaration

I hereby declare that this thesis entitled “**Private Wing Practices and Challenges in Addis Ababa Hospitals**” submitted in partial fulfillment of the requirements for Master’s Degree in Public Administration and Development Management in the Graduate College of Addis Ababa University Faculty of Business & Economics, is my original work that has not been submitted for any degree or diploma program in this or any other institution and all resources are duly acknowledged.

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Examiners Certificate

This is to certify that the thesis of WOSSEN ALEMU entitled “**Private Wing Practices and Challenges in Addis Ababa Hospitals**” is found acceptable in quality, form and approved by the board of examiners.

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Acronyms and abbreviations

BoFED	Bureau of Finance and Economic Development
CEO	Chief Executive Officer
CGD	Center for Global Development
ETB	Ethiopian Birr
FMoH	Federal Ministry of Health
GP	General Practitioner
HIA	Health in Africa
HRH	Human Resource for Health
HSFR	Health Sector Financing Reform
IBRD	International Bank for Reconstruction and Development
IEG	Independent Evaluation Group
IDA	International Development Association
KII	Key Informants Interview
PEI	Patient Exit Interview
PPIAF	Private Participation in Infrastructure Advisory Facility
PSR	public sector reform
PW	Private Wing
RHB	Regional Health Bureau
TAG	Technical Advisory Group
USAID	United States Agency for International Development
WHO	World Health Organization

Abstract

Private wings have been implemented on a small scale within Ethiopian public hospitals. These 'differentiated amenities' involve the provision of better services to patients who, under a fee-for-service reimbursement mechanisms, pay out-of-pocket or through medical insurance. The public sector objectives for these wings include retention of highly qualified health personnel, additional revenue generation as well as wider benefits to the public health system, leading to better access for middle income class population groups and development of new models of service delivery which will help to finance the health system. According to the status report of health care financing synthesis report in 2005 EC, Ethiopia has about 45 hospitals which have established private wings and out of these seven hospitals are in Addis; among these hospitals in Addis, four are administered by Addis Ababa city Administration. The study was conducted with the objective of investigating Private wing Practices and Challenges of Hospitals in Addis Ababa and to identify the main challenging factors. In order to achieve this objective, primary data were collected from four selected hospitals administered in Addis Ababa City Administration. Sixty patients, sixty health professionals, four Chief Executive Officers (CEO's) through questionnaires, key informant interview (KII) with concerned bodies and Patient Exit Interviews were used to gather relevant information directly from service users. Secondary data were collected from HSFR (Health Sector Financing Reform) guidelines, TAG (Technical Advisory Group) reports, and PW (Private Wing) performance reports. Results of the study indicate that conflict of interest, Existence of Contextual differences in the operation of private wing, Unfair revenue sharing and unequal service provision, Gaps in legal frame work, Demand for specialized and selective services, Unregulated fee levels for private wing services, Absence of systematized regulatory mechanisms are important and challenging factors that influence the private wing system.

Finally, to enhance the existing functioning system of private wings, this study made recommendations Federal Ministry of Health and Hospital's management to deliberate considering the resources available for the sustainability and success of private wings.

Key words: Private wing, challenge, practice, prospect, health professionals and patients.

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CHAPTER I: INTRODUCTION

A private wing is an Annex or an extension within a hospital where medical services are provided to patients at full cost recovery i.e. no subsidies. (Yeshambel, Amsalu&Measho, 2014).

Private Wing Scheme was established in Sept 2010 in addition to general patient care. The scheme aims at ensuring high quality services to be offered to Private patients. Services offered include:

- a) **General Outpatient Services:** Consultation, Ophthalmology, Dermatology, Physiotherapy, Dental therapy, Orthopedics, Gynecology and Obstetrics, Pediatrics, Pharmacy
- b) **Procedures:** Minor & Major Operations
- c) **Diagnostic services:** X-ray, Laboratory, Ultrasound, ECG/EKG

The very purpose of establishment of private wings/rooms within the premises of a public health facility is to encourage retention of health workers (mainly specialists) and provide alternative choices to patients who use private providers; accordingly, forty five hospitals had established a private wing/room in a public hospital.

Construction of private wings within public facilities is promoting the establishment of special for-profit pharmacies beside public facilities, and allowing dual practice among medical practitioners. Managing this relationship is not easy, and whether these arrangements will be functional in terms of performance and transparency remains to be seen.

The most common problem cited by informants at public health facilities involved poor-quality care or lack of medicines, often leading patients with resources to seek private care. Although such a decision can be a legitimate choice between options, it appears that health care workers including nurses, health officers, and doctors sometimes intentionally divert patients to private practices where they can charge fees and earn more income. An earlier study of health care providers and patients identified the unregulated relationship between private and public practice as a large and growing threat to the integrity of health care provision (Lindelov, Serneels& Lemma, 2005).

The practice of holding dual jobs can compromise the care provided in public health facilities in several ways: -

- Staff may work hard in their private practices, where they are paid in relation to the number of consultations or drugs dispensed, and exert less effort in their public sector jobs, where their salaries are fixed.
- Staff may use their public practices to identify patients who can pay more for private services and then refer those patients to their private practices, promising higher-quality services or access to more sophisticated equipment.
- Providers may transfer resources, such as lab equipment, from the public sector to their private practices.

Private wing practice can contribute positively to the quality and quantity of health care services and increase access to care, but the rapid expansion of private provision in Ethiopia appears to be outpacing the government's capacity to regulate its relationship with the public sector. Ethiopia's strategy for dealing with these tensions is to formalize and regulate public-private interactions. (Janelle Plummer, 2012)

Despite the value of a private wing/room, the conflict of interest among staff concerning work assignments and payment, Unfair revenue sharing and unequal service provision, Gaps in legal frame work, Demand for specialized and selective services, Unregulated fee levels, Absence of systematized regulatory mechanisms appear to be major challenges to implementing private wings in public hospitals. Hospitals need to implement private wings more transparently to avoid conflict of interest among staff, and authorities (e.g., the hospital board, zonal health departments, RHBs, and the FMOH) need to make sure that private wings are not competing with regular wards and not compromising services in the regular ward. (HSFR, 2013)

1.1 Background of the Study

The World Health Organization (WHO) defines health financing as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system.” It states that “purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO, 2000).

The current Ethiopian government spending on the health sector is not sufficient to finance the intended level of health services. The unsatisfactory health service delivery conditions, combined with continued high population pressure, high attrition rate and the growing need for modern health care has led to a widening gap between the demand for care and the financial resources available to satisfy these needs. The provision of better health service at different levels is very much dependent on the availability and allocation of adequate resources. These resources cannot totally come from government treasury because government expenditures, financed through general tax revenue, will not meet the growing demand of health care.

Human resource for health (HRH) is also a big challenge in the Ethiopian health system. A WHO study revealed that nearly all countries must improve work environments by scaling up good practices to strengthen the management of existing resources, assure adequate supplies and facilities, and create monetary and non-financial incentives to retain and motivate health workers (WHO, 2004). Ethiopia remains to be one of the countries are most affected by critical shortage of health workers where a significant number of domestically trained professionals leave the country every year (MOT, 2011). The Federal Ministry of Health (FMoH) has been implementing a number of measures including establishment of private wings in public hospitals to increase motivation and reduce attrition rate of highly skilled health professionals who are employed in public hospitals.

The Health Sector Financing Reform (HSFR) project is one of those efforts intended to alleviate above mentioned problem areas. It is a USAID funded project which works to improve the quality and access to health services in Ethiopia through increasing resources available to the health sector. The project is aiming at implementing health sector financing reform and health insurance programs at national, regional, City, Sub City and health facility levels. The project works closely with the Federal Ministry of Health, Ethiopian Health Insurance Agency, regional/City Administration health bureaus and KifleKetema (Sub city) health offices to institute policy changes aimed at increasing resources to improve health service outcomes.

The Principal Components of Health Care Financing Reform in Ethiopia include development of the legal and regulatory provisions related to:

1. Local retention and use of facility user fee revenue
2. Fee waiver and exemption systems
3. Establishment and operation of hospital management boards and related steps toward hospital autonomy

4. Outsourcing of non-clinical health services
5. Management and operation of Private Wing (PW) in public hospitals

Currently there are about seven public hospitals that have established private wings/rooms in Addis Ababa of which four are under the City administration and three are under Federal administration. Preliminary observations have indicated that there is success in the implementation of private wings/rooms in these hospitals in terms of providing alternative care access to patients; mobilize additional resources, creation of satisfaction among staff, etc.

1.2 Statement of the problem

According to synthesis of data collected from health facilities through supportive supervision in year 2012/13 lack of adequate financing in public hospitals has been one of the most important limiting features to improved access and quality of the health care system accounting for growing attrition rate of health care professionals mostly noticed in urban areas. (HSFR, 2013)

To alleviate this hindering issue the Federal Ministry of Health (FMOH) in collaboration with HSFR (USAID funded project) brought private wing/rooms into practice at public hospitals among similar reform attempts.

To help the implementation of the PW, proclamations and regulations are issued at Federal and regional levels on PW Administration and Management. A prototype implementation manual is prepared by the Federal Ministry of Health to provide a technical guide for the operation of PW both at Addis Ababa city administration, federal and the regional governments. The manual is prepared on the basis of the health care financing strategy of the Ethiopian government, the proclamations for Health Service Delivery, Administration and Management, the regulations to implement these proclamations (FMOH Establishing Private Wing in Public Health Facilities- Operational Manual, 2009). But still government hospitals with two major problems; these are lack of facilities and adequate human resources. The problems results poor services in government hospitals.

1.3 Research Question

In general this research paper will focus on the following major questions.

1. What are the settings up process taking place for the implementation of private wing in Addis Ababa Hospitals?
2. What problems/challenges encountered by Addis Ababa public Hospital Private Wings regarding to revenue collection & apportionment while implementing Private wing?
3. Does Private Wing contributes for the staff motivation, retention and client satisfaction?
4. What are the contributions of Private Wing in resource mobilization and improving quality of health services?

1.4 Objectives of the Study

1.4.1 General Objectives

The overall objective of the study is to assess functioning of the private wings/rooms in Addis Ababa City Administration.

1.4.2 Specific Objectives

The specific objectives are to:

1. Assess the operations of the private wings/rooms as a whole, including the legal framework, role of the governing board/private wing committee, in hospitals which are implementing this particular reform component.
2. Examine the implications of establishment of private wings/rooms on the facility's overall health services utilization, health facility revenue and identify the main challenges encountered, draw lesson and propose solutions.
3. Assess level of satisfaction among staffs and clients.
4. Assess the contribution of Private Wing regarding to resource mobilization and improving quality of health service.

1.5 Significance of the study

The finding of the study is significant to the public hospitals PW team as well as to donors in that it can provide recommendations to draw lessons that will enhance existing working system of the private wing. It also will be used to identify best practices and lessons learned for future practice. Moreover, the findings will be communicated and used for policy decision in establishing the system in all the regions.

1.6 Scope of the study

Currently there are seven hospitals which have private wing practices in Addis Ababa. Of these four hospitals are administered under the city administration and three are at federal level. This study focused on assessing only on four hospitals namely **RasDestaDamtew Memorial, Yekatit 12, Menilik II and Empress Zewditu Memorial Hospitals** due to time and financial limitations.

1.7 Limitation of the study

Even though, beneficiaries of PW are medical doctors and patients, during the study it was unable to get overall information at the time of interviewing. The target group responded did not provide all the necessary information for the study.

Limitations are influences that the researcher cannot control. They are the shortcomings, conditions or influences that cannot be controlled by the researcher that place restrictions on my methodology and conclusions.

In addition, private wing is a relatively new phenomenon to the Ethiopian health delivery system and it is too early to get a comprehensive study of the functioning of this new system at this time.

1.8 Organization of the Report

The research is organized in to five chapters. The first chapter is an introductory part of the study presents the background of the study, statement of the problem, objectives of the study, significant of the study, scope of the study, limitation and organization of the study. Chapter two presents Literature review related to the topic, Chapter three describes the research methodology to be applied for the purpose of data collection methods, sampling techniques and population composition of the study. Chapter four describes results and analysis. Chapter five concludes the study and provides recommendation.

CHAPTER II: LITERATURE REVIEW

2.1 Private practice in public Hospitals in developing & developed countries (Private Patients in public hospitals)

This is an interesting subject, relevant to most developing and developed countries. In most countries, private practice is allowed to government (Public) doctors, as a solution to several problems. To list some, inability to cope with the severe demand of services solely by the public institutions, shortage of health personnel (not only doctors), low salaries paid by the government with which the public sector doctors are unable to meet the cost of living (thereby preventing brain drain). Whatever the reason, there are two main methods by which this could be practiced. (World Bank, 2009)

Firstly, to allow doctors to practice only during off hours. Some doctors choose to see patients in 'private hospitals' while the others choose to see them in 'consultation chambers' or in their homes.

Secondly, to have private patients in the same hospital premises, but in a separate ward, but doctors attend to their private patients only during the off hours, unless in a case of an emergency.

The latter method has several advantages whereas, the former has several disadvantages. Advantages of the latter method are that the doctor concerned remains in the hospital premises even during the off hours avoiding the difficulties in contacting them especially if the communication infrastructure is not perfect. He will be able even to attend to public patients without any delay. This helps the doctor to save a lot of time, which otherwise he has to spend driving round the city from one place to another (travelling is the main time consumer in some developing countries with poor roading and congestion.) Both categories of patients can be confident that the specialist doctors are not far away from them even during the off hours. This is in addition to the extra income generated for the government, which could be diverted for the non-paying patients. (World Bank, 2009)

Only disadvantage is the often quoted feeling of discrimination that some public patients experience as a result of having both categories of patients in the same ward. Of course one can overcome this problem by having separate 'paying wards' possibly with more comfortable surroundings (after all they are paying money for something), so that two

categories of patients do not see each other. A patient is a patient to the doctor whether he is paying or not, and I cannot comprehend how a doctor can be different to two patients one paying and the other not paying, at the time of consultation. The discrimination will only be possible if both categories have to share the limited facilities (like beds and waiting lists) which the authorities will have to see that either category is not enjoying at the expense of the other (by having two wards).

Another major advantage is that other categories of staff including junior doctors, nurses, attendants, medical laboratory technicians etc. are also benefited. Of course the jealousy which naturally generates in the other categories of staff can be minimized. Jealousy is originated by the fact that only doctors are benefited by private practice. It is not a secret that this jealousy has resulted in severe turbulence in hospitals, very often worsening to the extent of compromising patient care.

Administratively, even clerks at the admission counters and at the wards and in the accounting departments etc. are all benefited by having the private wards in the same hospitals, everybody getting a share of the income generated. Of course the available resources may not be adequate (like operating time in the existing theaters) but with a bit of hard work on the part of the medical administrators, it is not difficult to organize this. Obviously there will have to be some money invested necessary arrangements are made, before this system is implemented in a hospital which is used to a different system. It is quite clear in hospitals which follow this pattern from the inception have no problems at all by having private patients in the same hospital. (word Bank, 2009)

The world is fast becoming extremely money centered and the medical profession cannot be excluded. What needs to be done is to provide ways and means of engaging in private medical practice, not jeopardizing the services available for those patients who cannot afford the expensive private practice. Doctor himself has to have a very clear conscience, not to discriminate any of the two categories. Complaints procedures must be very clearly laid down and accessible and regulating authorities must keep a very close eye on doctors who abuse this system

2.1.1 Failure and Success in Public Services (South Africa)

One of the best ways to assess how well a government is performing is the degree to which it meets the needs of its citizens. Most African governments invest their largest budgetary allocations on health and education. South Africa is unusual in the degree to which it also spends on social welfare: only a few African countries can afford the payment for universal pensions and the other entitlements which keep around a third of the South African population dependent upon state grants. But if we want to compare

South African state effectiveness with the capacity of other African states, looking at education and health is probably fair and certainly illuminating; particularly as comparisons about quality don't always correlate with relative resource endowment. Within South Africa, contrasting the outcomes and quality of public provisions for education and health also offers its own insights about the reasons of why successes and failures happen.

In this paper, two brief overviews of public education and of public health respectively will show, on the one hand, a system that has been failing citizens badly and, on the other hand, public provisions that despite their shortcomings have obtained real gains. The last part of this article will make the case that the main reason for the comparative failure of South African schools and the relative success of South African health services is political.

Public Education

Opposition party politicians often claim that South Africa's system of public education is close to being the worst in the world. It's a view that was confirmed recently by a ministerial task team.(Department of Basic Education, 2014) We know from international comparative data that South Africa's public schooling performs very poorly. For example, an evaluation by the Southern and Eastern African Consortium for Monitoring Education Quality tests grade six students with a standardized set of questions on math and reading. Out of 15 African countries, South African students' performance was ranked tenth for reading and eighth for math in 2010.(Sacme Q, 2010) Annual national mathematics assessment by the Department of Basic Education of grade 9 students generated a 13 per cent score for basic competence in 2012. The same year, nearly thirty per cent of children in Grade Six were illiterate and forty per cent didn't have the numeracy that would be expected at this level.

What is striking about the comparisons with other African countries is that South African public education is relatively well resourced. Per capita expenditure is higher than anywhere else in Sub-Saharan Africa except for Botswana and Seychelles. It represents around 6 per cent of GDP – a much higher proportion than in most African countries, and moreover, since 2008, educational expenditure has been rising. Moreover in the last twenty years expenditure increasingly targets poor schools in poor neighborhoods, especially recently. The historic racial inequities in per capita public expenditure ended more than a decade ago and in consequence the provision of state-funded teachers in historically white and black schools is the same, though, of course today's middle class schools have recourse to private resources unavailable to poorer schools to pay for additional teachers. In comparison to elsewhere in Africa, South African teachers are

better qualified, trained for longer periods, and better paid – much better paid – and their pay has improved sharply, recently. So what we have is a relatively well resourced system performing badly when it is compared to the way schooling functions in much poorer national settings. And if we extend the comparisons internationally the relative picture is even less flattering. In 2012 the World Education Forum found that only 9 out of 142 national systems were working worse than South Africa's. Resource-related issues do explain some of the difficulties. Last year it was still the case that 23,000 South African public schools didn't have libraries or book collections. It's still the case that nearly a third of Eastern Cape schools lack electrical connections. Rural teachers are generally less well qualified and when tested often have inadequate subject knowledge compared to their urban counterparts. Too many teachers still struggle with junior classes with more than fifty pupils. The point is that, notwithstanding the equalization of expenditure provision, sharp resource inequities remain. Yes, in general, even very poorly resourced South African schools may be favorably endowed compared to schools in other African countries, but in South African inequity has an especially demoralizing impact. Reports of high absentee-ism by teachers, overuse of discretionary leave, especially before and after weekends, and strikes are especially concentrated in the more poorly resourced schools.

Reflecting this, overall averages indicate that teachers in historically black schools spend much less time in the classroom than teachers working in former white suburbs. There have been signals of incremental improvement. Secondary school completion rates are rising. Compared to the rest of Africa school enrolment in junior grades is excellent – almost universal. In the last couple of years testing suggests that math performance has become a little better among students who remain in school in Grade 9, a reflection of ministerial emphasis on “back to basics”, and probably a result of the concerted effort to provide nationally standardized subject workbooks. Fewer students drop out after Grade 9. Improving matriculation results may indicate genuine accomplishment, though experts warn that schools might be weeding out students who might be at risk of failing.(UNESCO, 2013) And, of course, when we consider the totality of South Africa's public education, one sector within it functions rather well. Keeping in mind the demographic changes experienced in student enrolments in South African universities, those among them that have changed most are performing outstandingly well, well up to international standards of achievements, as global higher education rankings confirm.

So it is not entirely a bleak picture. But given the resources that have been expended and the expectations that exist amongst the vast number of South Africans who still believe that education is the key to their children's future, one would expect clearer and less ambiguous evidence of achievement. And when we contrast the quality in public

education with the performance of the public health system, its shortcomings appear all the more pronounced.

Public Health

The great achievement over the last seven years or so in South African public health, has been the halting of the death rate for HIV/AIDS. This is, of course, largely a consequence of a massive growth in the number of South Africans who take antiretroviral medication, around three million today compared to 107,000 in 2005. Much of this medicine is prescribed by public health clinics, 2000 of which now offer the drugs and supply or help to organize the supportive regime that is needed by patients. Virtually all primary health care facilities test for HIV/AIDS: in 2010/2011 about ten million people underwent testing, much of it done by redeployed retired nurses. Infant mortality, up sharply between 1994 and 2003, is now down to 1994 levels as a consequence of treatment and support for pregnant women.

Meanwhile increasingly sophisticated preventative messaging has apparently impacted upon sexual behavior of younger people and another preventative measure, the provision of circumcision, has expanded very quickly for between 2010 and 2013 more than a million men underwent the operation. Much of this success is attributable to the mobilization of around 60,000 lay counselors or Community Health Workers who play a key role in helping to maintain patients' adherence to the treatment regime (Helen Schneider et al, H Hlopho and D van Rensburg, 2008) – the “attrition rate” of fall-off from treatment regimes by patients is at 3 per cent comparatively low. To be sure, the availability of these workers has a lot to do with the relative vitality of community based organization rather than the quality of the state's efforts to engender such support. But even so they are coordinated in a public program and paid for with state funded gratuities. Of course this effort has resulted in increasing state health expenditure, up to 13 per cent of the budget in 2013 from around 12 per cent in 2010, and the government has begun to depend substantially on foreign aid, though most AIDS-related spending is and will remain exchequer funded.

In other African countries, the redirection of health services to measures to address the HIV/AIDS pandemic has resulted in the erosion of other kinds of health care, most commonly with respect to antenatal care, supported birth deliveries, and immunizations. The evidence from South Africa indicates that these sorts of services have improved or at least expanded. Since 2005 there have been real increases in per capita health expenditure. Increases in the employment of nurses mean that nurses' patient loads in primary facilities have fallen. Usage of hospital facilities has increased, but despite

hospitals coping with more patients, Statistics South Africa's general household surveys testify to falling rates of dissatisfaction with the quality of hospital services.

Public health is still beset by inefficiencies including serious shortcomings in the administration of the HIV/AIDS treatment regime. Both the Eastern Cape and the Free State have had to interrupt treatment because of poor supply management and weak financial controls. Even the most favored urban hospitals are unable to secure equipment replacements as a consequence of unpaid bills. For instance in 2011, Soweto's Chris Hani Baragwanath owed one supplier R8 million. Overworked and consequently overstressed doctors misdiagnose. Even supply of bed linen and food for patients is hostage to incompetent managers in the provincial government who control contracting and tendering for hospitals. Government investment in capital expenditure on hospital buildings has little impact upon the routine maladministration of hospital services. In general, the Minister, Aaron Motsoaledi, freely concedes that the poor majority of South Africans encounter hospital facilities that by the kindest definition are certainly "second rate". There is still much that is seriously wrong with South African public health but aggregate statistics on access to services and outputs from these services as well as surveys of citizens' opinions does suggest a general trend in which public health is working better. It's a qualitatively and quantitatively different picture from education.

Why, though?

One reason is surely that the nature of the challenges addressed by each is different. In certain respects, and up to a point, in the case of health, some kinds of improvements can be achieved by comparatively simple engagements between the agency providing the service and the people in need. For example the spread of certain diseases can be checked by immunizations that might only be needed once or a few times only. In other words much can be achieved through improving people's access to health care.

Certainly, in the case of HIV/AIDS treatment patient engagement needs to be sustained and regular and supported by monitoring and counseling: not all kinds of public health can be undertaken through one-off encounters. But compared to the long term teaching and learning procedures that are involved in primary and secondary education achieving effective care for many kinds of illness is simpler. Prevention is more complicated and the processes that lead to behavioral change are very comparable with what happens in effective education. But a public health system can register gains in the way that has happened in South Africa while continuing to be weak in many respects.

Achieving comparable aggregate gains in education requires much more thoroughgoing systemic reform. Moreover, there is probably wider disagreement amongst experts in the field as to what is needed. The debate within South African educational circles about the merits or shortcomings of “Outcomes-Based Education” is a good example of this, though now there is general recognition that the curriculum the government launched in 1998 and which it has revised successively since then, in its early versions made very unrealistic assumptions about student willingness and ability to undertake self-directed learning. In any case, too many teachers simply didn’t understand how they were expected to teach the new syllabus.

The deeper reason though for the difference in results in education and public health is, surely, political. President Mbeki’s efforts to limit the provision of anti-retroviral medication to AIDS patients and his questioning of medical orthodoxy certainly did much harm. One calculation is that if medicine had been prescribed on the same scale that it is made available today when it first became really affordable, in the early 2000’s, several hundred thousand lives might have been saved. (P Chigwedere et al, 2008) But Mbeki’s efforts to change the government’s policy orientation on AIDS had an unintended positive effect. They prompted political mobilisation around the issue, not just through the institutional channels for public participation in policy making but also by extra parliamentary action undertaken by an extraordinarily effective social movement, the Treatment Action Campaign (TAC). Protest and citizen sponsored litigation helped to reshape policy. Litigation by itself would not have been enough, however. Rather the political theatre supplied by TAC’s street-based actions helped to open up the kinds of divisions within the ruling party to ensure that, within the executive, there was the necessary political will to act upon and implement constitutional court judgments. But civic action was important in another way too, because the NGO community also supplied through its own program models of how mass “rollout” of treatment could be managed using community support. Here the pioneering experiences of Medicine Sans Frontiers and the TAC in organizing their own treatment program in Khayelitsha and Lusikisiki were especially influential.

This set of impetuses for effective action has been missing in education so far. Not that there haven’t been successful instances of protest. The Equal Education movement assembled thousands of school children in a demonstration outside Parliament in February 2011 to back its complaints about the dilapidated state of the basic fabric in Eastern Cape schools – and indeed in response the government agreed to spend more money on repairing and improving buildings.

One year later Section 27 took the authorities to court over the delays in supplying workbooks. All that is well and good and certainly correcting inefficiencies in this kind of

resource provision may help make education significantly better. But what is needed in public education is the kind of social engagement on changing its functioning that extends well beyond demonstrations and a few court cases. Rural schools are especially affected by demoralized and undisciplined teachers –who too often have their behavior sanctioned by a protective and politically well connected trade union.

School Governing Bodies are supposed to check abuses and malpractice by teachers; in the countryside these function poorly, especially in settings in which many adults are illiterate and easily intimidated by patrimonial displays of authority. In the case of HIV/AIDS treatment, as noted above, models of good practice were developed by NGO's within desperately poor communities. In education, debate about its content and methods rarely moves outside the social circles inhabited by the policy elite and academic specialists.

A final consideration that makes the politics of public education different from health is that a massive expansion of bad education has one key success to its credit. It has facilitated very rapid social mobility. South Africans may score at the bottom of the league tables when it comes to proficiency in reading, writing and arithmetic, but access to secondary and higher levels of education has widened and hence the numbers acquiring the formal qualifications needed for entry into white collar jobs has swollen. In public health, the penalties and costs of inefficiencies are immediate and obvious to everybody: people die. In education, the cost are long term, and hence for politicians easier to ignore.

2.1.2 Partnerships with the Private Sector in Health

The private sector plays a significant role in delivering health care to people in developing countries. By some estimates, more than one-half of all healthcares even to the poorest people is provided by private doctors, other health workers, drug sellers, and other non-state actors. This reality creates problems and potential. By and large, developing-country health policy and donor-supported health programs fail to address the problems, or capture the potential of the private sector in health. Interest is growing, within the donor community and among policymakers in developing-country governments, to find ways to work with the private sector to accelerate progress toward high-priority health objectives. However, governments in many low and middle-income countries lack the essential skills and tools (for example, public-private partnership guidelines) to do this effectively. Recognizing this constraint to health-system development, the Center for Global Development (CGD) convened a working group to design a practical way for donors and technical agencies to support successful public-private interactions, focusing on the design of an advisory facility. (World Bank, 2009)

Advisory facilities, which provide a range of technical support and knowledge sharing services, have succeeded in other sectors, such as infrastructure development. For example, the Private Participation in Infrastructure Advisory Facility (PPIAF) housed at the World Bank helps government officials in developing countries involve the private sector in the provision of infrastructure services and facilities. The PPIAF offers strategic sector analysis, implementation support, and training and technical assistance in how to work with the private sector. With adaptation, the PPIAF model may serve well to bridge the capacity gap in the health sector.

But is there demand for such services? The working group confirmed strong interest in the types of services that could be provided by an advisory facility, expressed by a wide range of individuals in developing countries, from middle income countries such as India, Brazil, and other Latin American countries to the poorest developing countries in Africa and Asia.(World Bank, 2009)

The working group, comprising experts from bilateral and multilateral organizations, foundations, consultants, the private sector, and academia, defined the aims and organizational structure of a global advisory facility. They determined that the advisory facility's main purpose should be to strengthen interested developing-country governments' capacity to collaborate with private practitioners and organizations to achieve public health objectives. The advisory facility will support developing-country clients by brokering knowledge, serving as an agent for change, providing strategic advice, and offering technical and implementation support for engagement strategies (For example, contracting, social franchising, and accreditation). Mobilizing experts and organizational partners, the advisory facility will provide a wide range of services targeted to assisting governments in developing countries to create, evaluate, or strengthen public-private partnerships in health. The advisory facility will have a strong field presence to better respond to demand in developing countries through a hub-and-spoke organizational structure with a central management unit located in a host organization in Washington, D.C., and field presence in regional hubs.(World Bank, 2009)

To ensure the quality of activities and maintain accountability to donors and clients, the working group proposes a three-pronged governance and management structure: a council to oversee management and operations; regional technical advisory boards to review regional strategies; and an operational unit to manage daily operations, financial operations, and technical activities. The working group estimated that launching the advisory facility will require approximately US\$3.5 million in start-up funds with an additionalUS\$16 million over four years to expand its operations and meet anticipated country demand.

The working group gave careful consideration to the question of the appropriate institutional setup for the advisory facility and has determined it best to build the advisory facility within an existing institution rather than add to the already overcrowded field of global health initiatives. It has concluded that the most promising host institution would be the World Bank–International Finance Corporation (IFC) on the basis of its related Health in Africa (HIA) initiatives well as its success with a similar advisory facility in the infrastructure sector (the Private Participation in Infrastructure Advisory Facility). The members recommend some modest modifications for HIA: harmonizing HIA and a global facility's vision and mission by clearly specifying what success will look like; emphasizing transfer of capacity to developing-country experts and organizations as a guiding principle; and formalizing separation of investment-accelerating activities from policy, analysis, and implementation support in a global facility. (World Bank, 2009)

The working group members strongly believe that the creation of a global advisory facility established along the parameters outlined in this report will be responsive to expressed demand and will make a significant contribution to achieving public-health goals in developing countries. Furthermore, the working group members believe that housing the facility at the World Bank–IFC is the best approach. If, however, the World Bank–IFC decides not to host the facility, the working group proposes returning to the short list of other possible host institutions, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, and others.

Given the real momentum toward creating constructive partnerships between the public and private sectors, and the value of contributing to the broader discussions regarding health-system strengthening, there should be no backing away from the imperative to create a global facility to address the profound need for technical assistance on how to engage the private health sector. (World Bank, 2009)

2.1.3 Public Sector Reform: What Works and Why?

The effectiveness and efficiency of a country's public sector is vital to the success of development activities, including those the World Bank supports. Sound financial management, an efficient civil service and administrative policy, efficient and fair collection of taxes, and transparent operations that are relatively free of corruption all contribute to good delivery of public services. (World Bank, 2009)

The Bank has devoted an increasing share—now about one-sixth—of its lending and advisory support to the reform of central governments, so it is important to understand what is working, what needs improvement, and what is missing. To address these questions, the Independent Evaluation Group (IEG) has examined lending and other

kinds of Bank support for public sector reform (PSR) between 1999 and 2006 in four areas: public financial management, administrative and civil service, revenue administration, and anticorruption and transparency.

Although a majority of countries that borrowed to support PSR experienced improved performance in some dimensions, there were shortcomings in important areas and in overall coordination. The frequency of improvement was higher among International Bank for Reconstruction and Development (IBRD) borrowers than among International Development Association (IDA) borrowers. Performance usually improved for public financial management, tax administration, and transparency, but not usually for civil service. Direct measures to reduce corruption such as anticorruption laws and commissions rarely succeeded. Recommendations of this evaluation focus on improving guidelines for civil service and anticorruption reforms and on setting realistic objectives and sequencing of reforms. (word Bank, 2009)

The public sector is the largest spender and employer in virtually every developing country and it sets the policy environment for the rest of the economy. About one-sixth of World Bank projects in recent years have supported PSR because the quality of the public sector accountability, effectiveness, and efficiency in service delivery, transparency, and so forth is thought by many to contribute to development. Improving the efficiency of government counterparts is also essential for the effectiveness of the Bank's support for development. Two themes of this evaluation correspond to the primary dimensions of the public sector: how it manages finances over the budget cycle and how it organizes and manages its employees their recruitment, pay, and promotions. A third theme tax administration is a part of the public sector that the Bank has often supported with special projects or components. The fourth theme of the evaluation anticorruption and transparency has cross-cutting issues that appear in the other thematic areas and also in special components of some PSR projects. (Anticorruption components of sectoral projects are outside the scope of this evaluation, as are decentralization and legal and judicial reforms.) Forty-seven percent of IBRD borrowers and 74 percent of IDA borrowers in the period 1999–2006 had one or more projects with components in at least one of these four areas.

The evaluation team assembled and analyzed a database that combined information on all borrower countries and on the more than 460 projects that since 1990 have focused on PSR in one or more of the four thematic areas. The team also did in-depth studies of 19 countries, including field visits to 6, and supplemented this with information from IEG's recent country evaluations. The knowledge of outcomes is imperfect, because of measurement problems and the long lag between the start of reforms and seeing their full effects. Nonetheless, public sector performance on some key dimensions seems to

have improved in a majority of cases where there have been Bank lending and analytical and advisory activities. But outcomes vary substantially across country types and thematic areas. Success or failure of PSR in any country is determined mainly by government actions, but Bank actions have also contributed. (word Bank, 2009)

2.1.4 Patients' satisfaction and associated factors among private wing patients at Bahirdar FelegeHiwot Referral Hospital, North West Ethiopia

Measuring patients' satisfaction has become an integral part of hospital management strategies for quality assurance and accreditation process in most countries, distinguishing that lack of sufficient data can severely inhibit an organization's ability to understand its strengths and to target areas in which performance can be improved. (Assefa, 2011)

Measuring patient satisfaction is a way of assessing the process of care, describing the patient's viewpoint, and evaluating care by reflecting patient views back into the system and through comparing facilities (Redshaw M, 2008). It is also the best source of information about a health care systems' communication, education and pain management process that has enhanced patient-centered high quality care (Debono D, 2009).

Studies indicated that a satisfied patient has complied with the medical treatment prescribed, provider recommendation delivered, and continually using medical services at a specific health provider, which might resulted with, enhanced disease healing process, healthier and happier clients, whom contributing to the development of the country (Iliyasu Z, Abubakar I, Lawan U, 2010).

Studies conducted in different public hospitals in Ethiopia come up with overall client satisfaction ranging from 22.0% in Gondar to 77% in Jimma (Assefa, 2011). Different Studies reported that: patient provider relationship (courtesy, listening, consultations, etc), medical care and information, physical environment, lack of adequate transportation, in-patient services, hospital facilities and access to care, waiting time and cost of treatment, visiting of Doctors after registration, inadequate physical examination by providers, laboratory procedures, re-visiting of the doctor for evaluation with laboratory results, prescription paper for drugs and supplies, availability of prescribed drugs/medications from the hospitals' pharmacies, difficulty to locate different sections, cleanliness of toilets/bathrooms, availability of drinking water etc. were the frequently faced problems affecting satisfaction (Assefa, 2011).

Health care outcomes still have been defined by professionals and have largely reflected a clinical perspective, particularly in low income countries like Ethiopia, which is well differ from that of clients' outlook, considered as a difficult concept to be measured and interpreted; also considerably ignored by health care managers, which contradicted with suggestions of the emerging health care literatures towards patient views for the success of facilities (Sreenivas T, Suresh N, 2012). No studies has been published on private wing patients' satisfaction and associated factors under public hospitals, as well as, it is new initiative with rapid progress of scaling up country wide in Ethiopia, i.e. four hospitals in 2010, eighteen hospitals in2011, thirty one hospitals in 2012 has launched it, and more hospitals, work to inaugurate it (FMoH, 2012).

2.1.5 Health Care Financing Reform in Ethiopia: Improving Quality and Equity

Ethiopia endorsed a health care financing strategy in 1998 that envisioned a wide range of reform initiatives. The implementation of these reform initiatives was legalized through regional legislations and operationalized in line with prototype implementation frameworks that were modified and aligned within specific regional contexts. In 2004, actual implementation was initiated in Amhara, Oromia, and Southern Nations, Nationalities, and People (SNNP) Regional States following ratification and endorsement of regional proclamations, regulations, and directives by the respective regional councils (Parliaments), regional executive Councils (Cabinets), and Regional Health Bureaus (RHBs). Currently, the reforms have expanded to the remaining regions, with the exception of Afar and Somali, which are still in the process of endorsing legal and operational frameworks. All other regions (Tigray, Benshangul-Gumuz, Gambella, Harari, Addis Ababa, and Dire Dawa) have already begun implementation. (USAID, 2011)

The strategy recognized that health care should be financed through multiple financing mechanisms to ensure long-range sustainability. The reforms introduced include implementing revenue retention and use at health facility level, systematizing a fee-waiver system for the poor, standardizing exemption services, setting and revising user fees, introducing a private wing in public hospitals, outsourcing nonclinical services, and promoting health facility autonomy through the introduction of a governance system. The purpose of this background paper is to provide a glimpse of these reforms, the major progress and achievements made through their implementation, and the role of USAID's continued technical and financial support in implementation of these reforms and related results. (USAID, 2011)

2.2 Private wing in Ethiopia

According to FMOH Operational Manual 2009- Establishing PW in Public Health Facilities “Private Wing” refers to an official arrangement according to which medical services are provided, on a fee-for-service basis, to inpatients and/or outpatients in public hospitals and health Centers. (HSFR, 2013)

Private Wing of a public health facility provides diagnostic and treatment services at market or quasi market rate.

A PW initiative offers the opportunity to provide benefits for patients, staff and the health Facility.

Benefits for patients include:

- i. A higher level of amenities and customer service
- ii. A cleaner, more comfortable and secure environment
- iii. More convenient appointment times
- iv. Personal choice of doctor

Benefits for the staff include:

- i. A better work environment
- ii. Caring for people with an increased level of patient satisfaction
- iii. For eligible employees, a potential to increase earnings

Benefits for the health facility include:

- i. Help retain qualified facility staff
- ii. Increase revenue for institutional improvement – upgraded equipment, computer systems, new Clinical services, additional investment in staff training, etc.
- iii. Establish and role model a higher standard of non-clinical services throughout the facility
- iv. Improve quality health services, thereby improving patient satisfaction.
- v. Reduce waiting time in the general ward for non-Private Wing patients.
- vi. Improve reputation of the health facility
- vii. Act as an informal regulator of market pricing

FMOH manual also describes important core frames of PW as follows:-

2.2.1 The objectives of establishing PW in public health facilities include:

- i. Increase motivation and reduce attrition rate of health workers,
- ii. Improve the quality of health services,

- iii. Mobilize additional resources and subsidize the general ward,
- iv. Provide alternative care access for clients and
- v. Help hospitals be self-sustaining in the long run and carry out the basic health service and disease prevention policy of the government.

2.2.2 Set-up:

A PW shall be set up in the compound of the health facility.

2.2.3 Source of Initial Capital:

The health facility can mobilize funds from the following sources to establish PW:

- i. Donor finance
- ii. Credit from the retained health facility revenue without any interest.
- iii. Support from government budget.
- iv. Other sources

2.2.4 Service Integration/Segregation:

As long as the PW does not affect the services given in the general ward, it can use at no cost the facility infrastructure, registration and recording formats, request and prescription papers & equipment. The PW should pay at cost for consumables that it uses.

2.2.5 Key Considerations in the Establishment of PW:

- i. The establishment of the PW shall not negatively affect the services given in the general ward.
- ii. There should be no difference in quality of care between the PW and the general ward.
- iii. The establishment of PW must not compromise the drive to reduce waiting times in the general wards.

2.2.6 Conditions to be fulfilled to establish a PW:

- i. The health facility should set up a PW to provide those services that the facility has established a good reputation for or has a comparative advantage providing, when compared to other facilities.
- ii. The health facilities should make sure they have the necessary health and support staff available, and will not negatively affect the services given in the general ward.
- iii. The health facilities should make sure that the space of the PW is sufficient and convenient to clients and should not crowd out the general ward.
- iv. The establishment of the PW must be approved by the facility governing board or by the legally responsible body.

2.2.7 Service Delivery Options:

There is not only one approach or option for providing PW service. The Technical Advisory Group (TAG) defines what constitutes the PW Program for health facility planning. The day-to-day operation of a PW is done by each individual health facility with the cooperation, oversight and approval of the appropriate Regional/zonal/ Woreda Health Bureau. The decision to choose a suitable PW service delivery mode is left to the regional/zonal/ Woreda health bureaus and/or the health facility governing board.

2.2.8 The health facility could consider three service delivery modes/ options:

- i. The PW is a separate in-patient unit where PW patients are admitted for care.
- ii. The PW is an outpatient service that utilizes existing ambulatory care, radiology equipment and laboratory equipment during non-peak operating hours.
- iii. The PW is both an in-patient and outpatient service program.

After selecting the appropriate option, the TAG determines what the clinical focus service area should be of the private wing.

2.2.9 Formation of the Technical Advisory Group (TAG):

The first step toward implementing a PW initiative is forming a Technical Advisory Group. The Technical Advisory Group (TAG) is a team of experts from different sections of the facility brought together to implement the PW initiative. This working group carries out the business, facility and operational planning for the private wing.

Technical Advisory Group members bring to the effort a variety of skills and expertise from Financial Services, Medical Services and Facility Management.

The head of the Health Facility names a chairperson and selects members based on experience and competence with project planning, time available for the project, and credibility among the stakeholders.

The head of the Health Facility consults with the Technical Advisory Group on how the initiatives of developing a PW may be coordinated in the general ward to achieve the facility's objectives.

2.2.10 Roles and responsibilities of TAG:

- i. Conduct the SWOT analysis and make a realistic assessment as to whether or not the PW has the potential for success.
- ii. Develop the business plan, facility plan and operational plan for the private wing.
- iii. Define the constituents of the PW program for health facility planning

- iv. Assist health facilities in selecting appropriate PW option or approach and clinical focus.
- v. Develop criteria for assignment of staff in the private wing.
- vi. Provide recommendations on revenue sharing criteria for doctors and other health staff members participating in the private wing.
- vii. Develop the detailed working procedures of the private wing.
- viii. Develop a comprehensive list of factors and assumptions identified during the market analysis, personnel planning, operations planning and financial planning that pose significant risks to meeting goals.
- ix. Identify the types of service supports that departments are capable of providing at a higher level of quality and service to the Private wing.
- x. Propose expedient patient registration mechanisms that enhance customer service.
- xi. Develop service expectations and protocols in collaboration with facility administration and departments.

2.2.11 Staff deployment in the Private Wing:

- i. Health personnel with good knowledge, skills and ethics will be deployed in the PW on a rotation basis.
- ii. The criteria for selecting facility staff to be assigned in the PW shall be set by the facility management. In general, the selection criteria should be based up on: - Good reputation and performance, Proven ability to work with a team & Willingness to work in the private wing,
- iii. Whenever necessary to recruit manpower to a PW from among employees of a health facility, the health facility management shall set criteria for the recruitment. Health workers assigned to work in the PW shall work on a rotation basis.

- iv. The PW unit may use services such as security, housekeeping, general services, procurement, transport, and store from the general ward as long as the unit does not negatively affect the general ward services.

2.2.12 Financial Management

- i. The PW unit will collect its revenue either using the receipt purchased from the Finance and Economic Development Bureau or designing its own revenue collection receipt and having it published.
- ii. The revenue of the PW will be collected daily by cash collectors and should be kept in a safe box until the revenue is finally deposited in the bank.
- iii. Revenue collected from the PW should be deposited in a separate account, opened in the name of the private wing.
- iv. The money deposited in the bank account of the PW can only be withdrawn by joint signature of two or three of the following:- Health Facility Head, PW Coordinator, - Finance Officer assigned to the private wing.
- v. The PW should keep separate financial statements, bank accounts, and financial recording and receipt vouchers.
- vi. Any income or payment out of the accounts of the PW will be received or made using receipts or vouchers from the private wing.
- vii. Each and every receipt must be recorded in the account books in a timely fashion.
- viii. The account books will record revenue and expenditure accurately.
- ix. The book keeping shall be done in accordance with generally accepted standards of book keeping / accounting and shall be ready for audit at all times.
- x. The account/s of the PW will be audited at least once a year by the auditor of the health facility and auditors from the Government or by an independent auditor hired for the service.

- xi. The audit of a PW shall be conducted in accordance with Government rules and regulations and shall cover the all the assets of the private wing.

2.2.13 Reporting:

- i. The activity report of a PW will be prepared by the PW Coordinator monthly, quarterly, and annually and submitted to the Facility Head and other concerned bodies.
- ii. The Health Facility Head, together with facility management, critically reviews and submits the activity reports to the governing body.

2.2.14 Monitoring and Evaluation

According to Winnie (2000), in his review of design of monitoring and evaluation system the purpose of monitoring is described as to keep track of daily activities on a continuous basis in order to indicate as early as possible any shortcomings with regard to delivery of inputs and the execution of activities or production of outputs, in order that corrective measures can be undertaken in time. Thus, monitoring is primarily a device for improving program management. And evaluation as a structured process of assessing the success of a project in meeting its goals and to reflect on the lessons learned. (After Owen& Rogers, 1999)

The PW Coordinator, together with the Facility Head, regularly and systematically monitors the performance of the PW in relation to set facility objectives and activity plans. The coordinator is also responsible for evaluating performance at the scheduled evaluation time. Such evidence will help the facility management and board strengthen quality of care and make corrective measures when performance is not up to the expected level or not generating the intended results.

Consequently, PW Coordinators should send periodic activity and financial reports to the Facility Head. The Facility Head, in turn, critically considers the report of the PW and submits it to the governing board.

Supportive supervision is periodically conducted by the health facility and should be supported by feedback.

PW quality assurance program should be developed and launched when the PW opens. This is a multi-faceted program that provides continuous feedback to the PW management. Monitoring the implementation of the PW may be required in every step of PW process of development:

The above listed core points are described in the guide and all were reviewed in depth during the study. Additional related and relevant documents were also assessed as well.

CHAPTER III: RESEARCH METHEDODOLOGY

3.1 Introduction

This chapter presents the research methodology and the techniques applied including research design and approach, subjects of the study, sampling technique, population, sample size, data collection instruments and data processing and analysis techniques.

3.2 Research methodology and approach

Considering the purpose of this study, it is found appropriate to use Evaluation research methodology. Evaluation research is a methodological area that is closely related to, but distinguishable from more traditional social research. According to Alan and Ruth (1999), what distinguishes evaluation research from other types of social research activity has nothing to do with research design, techniques, of data collection or methods of data analysis. Indeed, evaluation involves the application of the methods of social research. According to Alan and Ruth what serves to distinguish evaluation research from other forms of social research is simply a question of purpose. An evaluation is action oriented. It is conducted to determine the value or impact of a policy, program, practice or an intervention with a view to making recommendations for improvement. As cited by Alan and Ruth, Stufflebeam and Shinkfield (1985) stated that the most important purpose of evaluation is not to prove but to improve.

As indicated earlier there is no unique design, techniques or methods of data collection to be applied in the evaluation research. Thus, in this study, Quantitative and Qualitative methods were used to gather the necessary data. Quantitative research consists of those studies in which the data concerned can be analyzed in terms of numbers while qualitative research can describe events, persons and so forth scientifically without the use of numerical data. In addition, quantitative research results are more readily analyzed and interpreted. On the other hand, qualitative research is more open and responsive to its subject. Both types of research are valid and useful and are not mutually exclusive.(Best and Khan, 1989). Therefore, both qualitative and quantitative methods of research were applied in this study.

In this research, both qualitative and quantitative research approaches were used to gather the necessary data. In the qualitative approach stakeholder survey, review of documentation, focus group discussion, interview and questionnaires were used. The

research involved interviewing of PW focal persons of implementing partners and HSFR technical staff team.

3.3 Research Design

The assessment study is designed to cover four public hospitals in Addis Ababa which are currently implementing private wings/rooms in their premises. These include [RasDestaDamtew Memorial](#), [Yekatit 12](#), [Menilik II](#) & [Empress Zewditu Memorial](#); the assessment also includes sixty exit interview clients fifteen from each, Sixty health professionals and four CEOs sixteen from each.

3.4 Population and sampling technique

Determining sample size is very important because sample that are too large may waste time and resource, while sample that are too small may lead to inaccurate results. (Six Sigma) The population size for this research is seven hospitals which are implementing PW and are in Addis Ababa. From the seven hospitals namely: RasDestaDamtew Memorial, Yekatit 12, Menilik II, Empress Zewditu Memorial, ALRET, Emanuel and St. Paul Hospitals, there are four hospitals under Addis Ababa city Administration with a professional employees of more than 160. The current numbers of hospitals applying private wings found in Addis Ababa region are seven. Due to time constraint to cover all the seven hospitals by using convenience sampling the four hospitals which are accessible and proximate have been selected for the purpose of the study. A convenience sample is one of the main types of non-probability sampling methods. A convenience sample is made up of people who are easy to reach.

For the study sixty health professionals and four CEOs from the four hospitals have been selected to fill the questionnaires. To draw the sample size from the total population the following Taro Yamane (1967) sampling formula, which is appropriate for small size population has been employed.

$$n = \frac{N}{1 + N(e^2)}$$

Where,

n= Sample Size

N= Total Population Size and,

e= the standard error with 95% confidence level (the level of precision)

$$n = \frac{160}{1 + 160(.05)^2}$$

$$n = \underline{64}$$

Each hospital private wing scheme has Hospital Manager/CEO, Medical Director, General Practitioners, Specialists, Gynecologist, Obstetrician, Pediatrician, Surgeon, Nurses, Radiologists, X-Ray Technicians, and Lab Technician & Pharmacists. Among these, Sixteen employees (three specialists, two pediatricians, two General Practitioners, Six nurses, two support staffs and the rest one CEO from each private wing) have been selected using purposive sampling and have filled the questionnaire. The purposive sampling technique, also called judgment sampling, is the deliberate choice of an informant due to the qualities the informant possesses. (Ma. Dolores C. Tongco 2007)

3.5 Instruments, Sources and Data Collection

The data collection instruments were designed in such a way that they would capture both quantitative and qualitative data information from all target hospitals. Under mixed method approach, the researcher bases the inquiry on the assumption that collecting diverse types of data best provides on understanding of a research problem (Creswell, 2003). In designing the data collection instruments, close-ended questions were used wherever possible to allow easy summary and reporting of results. Moreover, some open-ended questions were also used in areas where it was deemed necessary to avoid prompting or leading interviewees in a particular direction.

The main research instruments developed and used for the assessment were structured questionnaires, key informant interviews (KII) and patient exit interviews (PEI). The three types of data collection instruments used for the assessment and brief description of same are:

(a) Questionnaires: Two types of questionnaires were used in the target hospitals for gathering pertinent data and information about the implementation of the private wing/room. These include:

- Questionnaires for CEO of the hospital and/or members of the private wing committee. And hence, four questionnaires were filled in by all the target hospitals.
- Questionnaire for health professionals participating in the private wing. Here a total of 64 (16 from each hospital) people participated in responding to this particular questionnaire.

(b) Key Informant Interviews: - They are qualitative; the interviews are loosely structured, relying on a list of issues to be discussed. Key informant interviews

resemble a conversation among acquaintances, allowing a free flow of ideas and information. Interviewers frame questions spontaneously, probe for information and takes notes. (USAID Center for Development and Information Evaluation December 1996), (Mountain States Group, Inc, 1999). KII were conducted with people who could provide general, personal, and professional views about the private wing. Five KIIs were conducted, either with the medical directors or private wing coordinators of the target hospitals and one technical advisor from HSFR project i.e. one person from each hospital.

(c) Patient Exit Interviews: Exit interviews were used to gather relevant information directly from service users of the private wing/room in each of the selected hospitals. A total of sixty (fifteen from each hospital) patients exiting the private wings/rooms are interviewed for the assessment.

The data collection instruments developed for the purposes were tested in RasDesta hospital. All the data collection instruments are attached under Annex 2.

The data collected is edited, checked for its consistency, captured and analyzed using simple Microsoft Excel software.

3.6 Data Collection

The study was conducted using the following data collection methods:

3.6.1 Primary data sources

Questionnaires, interviews, Focus group discussions and field visit were conducted to get firsthand information with beneficiaries, partners, government focal persons and the TAG team

3.6.2 Secondary data sources

Secondary data analysis can be literally defined as “second-hand” analysis. It is the analysis of data or information that was either gathered by someone else or for some other purpose than the one currently being considered, or often a combination of the two (Cnossen, 1997). HSFR guidelines, TAG reports, PW performance reports were reviewed.

3.7 Data Processing and Analysis

The qualitative and quantitative data collected through key informant interviews, focus group discussions and review of documents were analyzed. Data from document review were summarized and analyzed using Microsoft Excel supported by tables, figures, graphs and charts. In addition, interview data were analyzed to reveal themes and issues that emerged from the discussion.

CHAPTER IV: RESULTS AND ANALYSIS

4.1 General

In Ethiopia, a private wing refers to an official arrangement according to which medical services are provided, on a fee-for-service basis, to inpatients and/or outpatients in public hospitals and health Centers. The private wing is part of the health facility where the staff members practice during their part-time: off-work hours and holidays. The prototype private wing manual indicates that a public hospital should establish a private wing in those services that it has strengths and is of greater public demand. Currently, Forty five public hospitals have established private wings in their premises [see Table 4.1].

Table 4.1 Private wing Establishments in Ethiopia (As of December, 2015)

N / S	Name of Hospital	Zone	Region*	# PW	Type of Service provided
1	Ras Desta Damtew Memorial	A/A	A/A	4	outpatient
	Yekatit 12	A/A	A/A		outpatient
	Menilik II	A/A	A/A		outpatient
	Empress Zewditu Memorial	A/A	A/A		outpatient
2	Dessie	S/Wollo	Amhara	4	Both inpatient and outpatient
	Felege Hiwot	Bahir Dar	Amhara		Both inpatient and outpatient
	Debre Markos	E/Gojjam	Amhara		Outpatient
	Debre Birhan	N/Shoa	Amhara		Outpatient
3	Pawe Hospital	Metekel	Benishangul Gumuz	1	Both inpatient and outpatient
4	Dil Chora	Dire Dawa	Dire Dawa	1	Both inpatient and outpatient.
5	Adama	Adama C/A	Oromia	21	Outpatient
	Bishoftu	Beshoftu C/A	Oromia		Outpatient

	Limu Genet	Jimma	Oromia		Outpatient
	Chiro	W/Hararge	Oromia		Outpatient
	Begi	W/wollega	Oromia		Outpatient
	Shashemene	W/Arsi	Oromia		Outpatient
	Goba	Bale	Oromia		Outpatient
	Ginir	Bale	Oromia		Outpatient
	Fitche	N/shoa	Oromia		Outpatient
	Nekemte	E/wollega	Oromia		Outpatient
	Metu Karl	Illibabur	Oromia		Outpatient
	Denbidollo	Kelem/Wollega	Oromia		Outpatient
	Gimbi	West Wollega	Oromia		Outpatient
	Robe	Bale	Oromia		Outpatient
	Deder	East Hararge	Oromia		Outpatient
	Bule Hora	Borena	Oromia		Outpatient
	Bisidimo	East Hararge	Oromia		Outpatient
	Garamuleta	East Hararge	Oromia		Outpatient
	Robe Didea	Arsi	Oromia		Outpatient
	Gida Ayana	East Wollega	Oromia		Outpatient
	Ambo	West Shoa	Oromia		Outpatient
6	Abi Adi	Central	Tigray		Outpatient
	Adewa	Central	Tigray		Outpatient
	St. Mary	Central	Tigray		Both inpatient and outpatient
	Kahsay abera	Humera	Tigray		Outpatient
	Alamata	South	Tigray	9	Both inpatient and outpatient
	Sehul	North West	Tigray		Both inpatient and outpatient
	Adigrat	East	Tigray		Outpatient
	L/Karl / Maichew Hospital	Southern	Tigray		Outpatient
	Mekelle Hospital	Mekelle	Tigray		Outpatient
7	Karamara Hospital	Fafem	Somali	1	Outpatient
					Both inpatient and outpatient
8	ALRET	Federal	Federal		Both inpatient and outpatient
	Emanuel	Federal	Federal	4	Both inpatient and outpatient
	St. Paul	Federal	Federal		Both inpatient and outpatient
	Jimma	Teaching & Referral	Federal		Both inpatient and outpatient
	Current Total Number of Private Wings			45	

(Source: Health Sector Financing Reform /HSFR/ project, 2015)

4.1.1 Setting up Process

Initiation: The first hospital to start private wing in Addis Ababa public hospital in September 2010 was RasDestaDamtew Memorial. When hospitals that established private wings were asked what initiated them to start private wings, all of them stated that the training given by HSFR project and the experience sharing visits to other hospitals have contributed to initiate private wings.

Besides, almost 75% of hospitals stated they have undertaken public awareness programs regarding private wing and the services provided both prior to and during their operations. After the commencement of private wings, the principal methods used to create public awareness on the services provided in the private wings were posters, brochures and public media.

After this they prepared proposals before establishing private wings. Besides, all hospitals responded that the proposal contained list of health professionals willing to work in the private wing, members and duties of private wing committees, list of medical equipment and service delivery rooms, and management and distribution of revenues.

Approval and membership in Technical Advisory Group /TAG/: The hospitals were also asked to indicate who approved the establishment of private wings. All hospitals responded that after getting approval by the management committee, the hospital board approved the establishment. And all hospitals have established private wing committee or Technical Advisory Group /TAG/. As regards to members of the TAG a representative from nurses, Pharmacy heads, medical doctors were of hospitals that established private wings. Therefore, in one out of four hospitals, find laboratory head as members of TAGs.

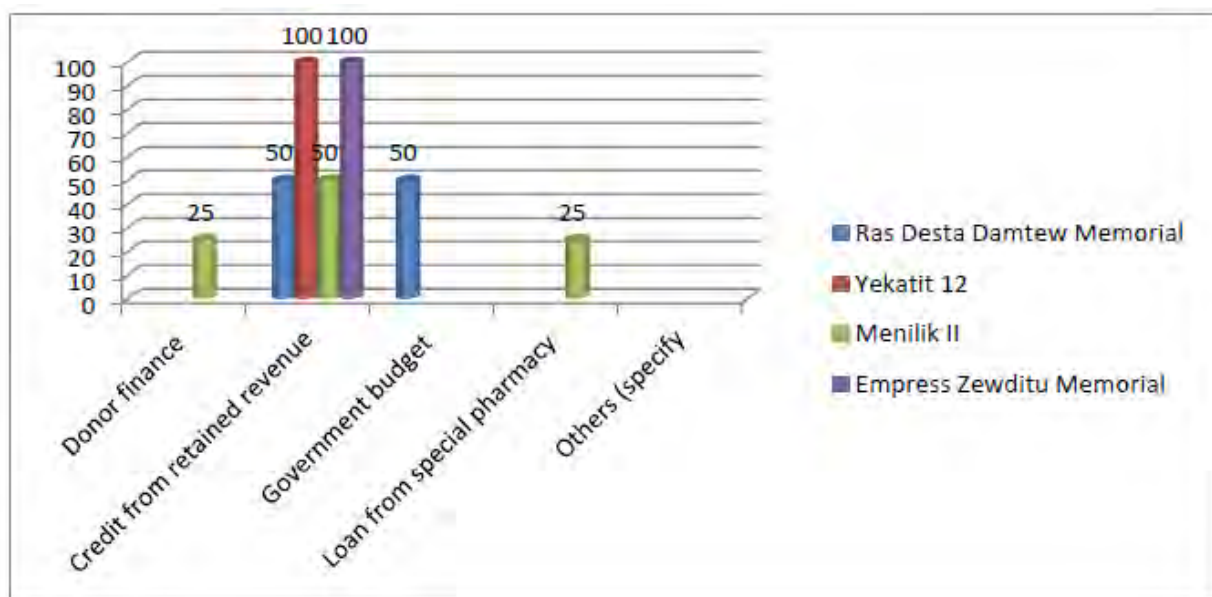
Table 4.2: Staff in the hospital becomes members of the private wing committee / TAG

No	members of the private wing committee/TAG	Ras Desta Damtew Memorial	Yekatit 12	Menilik II	Empress Zewditu Memorial
1	Medical director	No	Yes	No	No
2	General Manager	Yes	Yes	Yes	Yes
3	Pharmacy head	Yes	Yes	Yes	Yes
4	Medical doctor	Yes	Yes	Yes	Yes
5	Finance head	Yes	Yes	Yes	Yes
6	Laboratory head	Yes	No	No	No
7	Nurse	Yes	Yes	Yes	Yes

(Source: Own research)

Source of seed money: Hospitals were asked to indicate the source of seed money to establish private wings. The results revealed that retained revenue (75%), government budget (50%), loan from special pharmacy and donor finance (25%) were the major sources of working capital. In most of the cases, the startup capital emanated from more than one source

Figure 4.1: Percentage response of hospitals on sources of seed money to establish private wings in public hospitals



(Source: Own research)

Of those which established private wings from retained revenue and/or special pharmacy, 75% repaid their loans in due time while 25% did not. The average amount of startup capital was ETB 26,250.00 the minimum was ETB 5,000.00 (Empress Zewditu Memorial hospital) and the maximum was ETB 53,000 (RasDestaDamte Memorial hospital)

4.1.2 Services and staff assignment

Types of services: All of the hospitals responded that they provided outpatient services only. The major outpatient services provided in the private wings include operations and diagnostic services [see Table 4.3].

Table 4.3: Major outpatient services that are currently provided in private wings

N/S	General outpatient services	Procedures	Diagnostic services
1	Consultation	Minor operations	X-ray
2	Ophthalmology	Major operations	Laboratory
3	Dermatology		Ultrasound
4	Physiotherapy		ECG
5	Dental therapy		
6	Orthopedics		
7	Gynecology and obstetrics		
8	Pediatrics		
9	pharmacy		

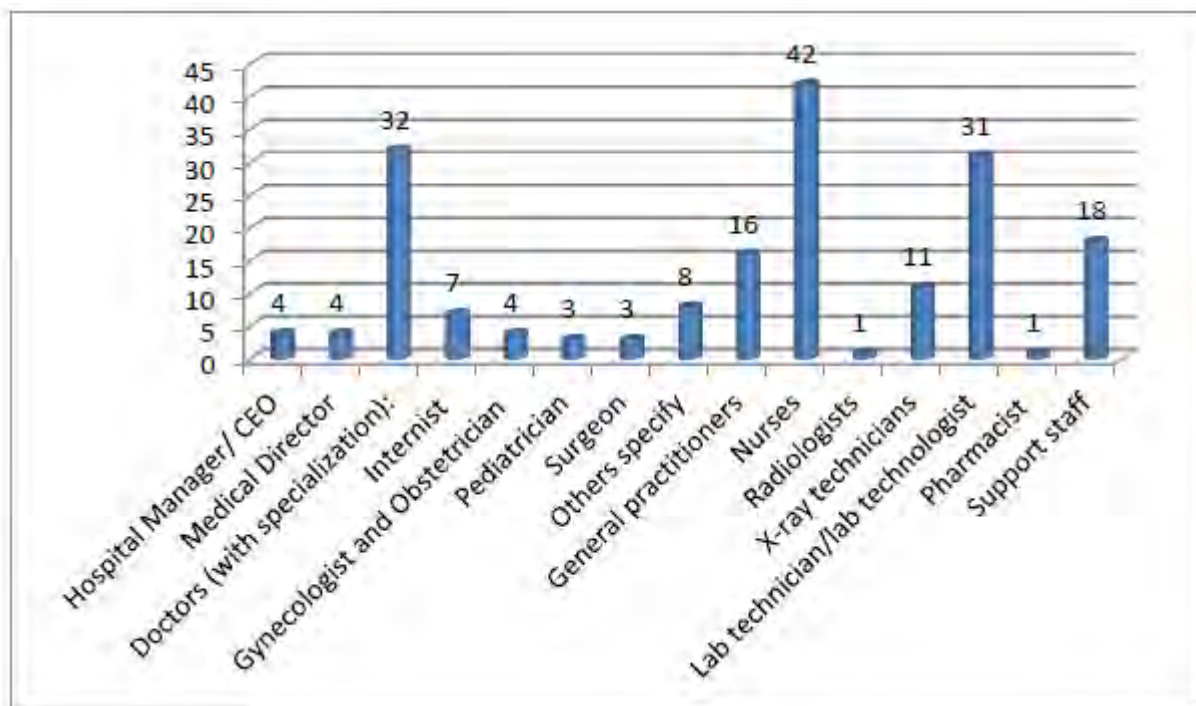
(Source: Health Sector Financing Reform /HSFR/ project, 2015.)

The majority of facilities (75%) also responded that the services provided in the private wings were those declared in the directives of the respective city administration legal frameworks. All hospitals indicated that private wings provided services during off-work hours including Saturdays, Sundays and Public Holidays. Operating hours per day varies across hospitals from 5:00 PM to 10:00 PM on week days and from 8:00 AM to 4:00 PM on weekends. However, the majority of hospitals operated 2 hours during week days and about 75% of them operated 24 hours during weekends.

Non-clinical quality differentiation in the private wings: Most of the private wings made some non-clinical quality differentiation in the private wings. Sufficient service rooms (11.1%) and better quality service rooms (11.1%), patient privacy services (50%) are worth mentioning.

Staff assignment: Regarding the criteria used to assign staff in the private wings, the majority of hospitals responded with choice of customer service as a major criterion. Some of the facilities reported that clinical competency and proven ability to work in a team were also used to assign employees in the private wings. In terms of the number of the daily assignment of health workers, finance and Admin (160), nurses (42) take the lead followed by Doctors with specialization (32) [see Figure 4.2].

Figure 4.2: Daily assignment of health workers in private wings



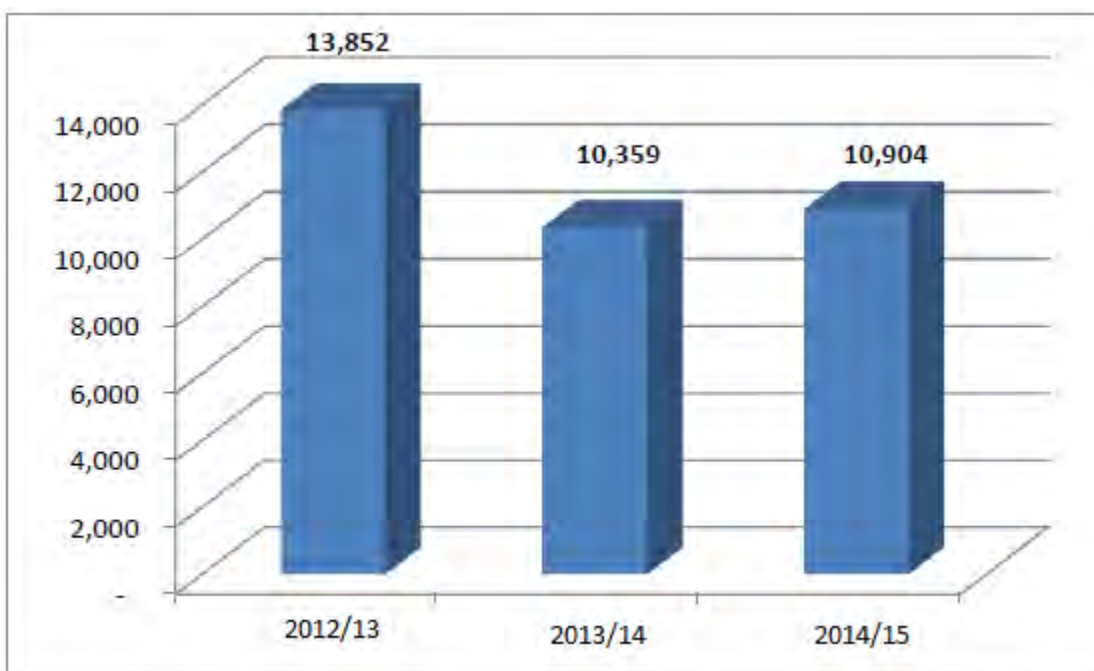
(Source: Own research)

Reporting procedures: Respondents were also asked to explain the reporting procedure between private wing and the hospital management. Two of the hospitals (RasDestaDamtew Memorial and Empress Zewditu Memorial Hospital) stated that the TAG reports to the management committee and the management committee in turn reports to the board. Menilik II hospital also reported that Chief Executive Officers (CEO) directly reported to the board. Yekatit 12 hospital used a mix of the above procedures. See [Annex 1, Table 3]. As to the frequency of the report to the board, the majority of the hospitals (75%) responded quarterly while one hospital semi-annually [Annex 1, Table 4].

4.1.3 Service utilization by clients

Average number of private wing clients has declined in 2012/13. This may be attributed to the fact that during 2011/12 there were only two hospitals (RasDestaDamtew Memorial and Menilik II) with relatively a good number of private wing customers. However, a year after, the remaining two hospitals joined them having a relatively small number of clients. This has brought the average down. As figure 4.3 illustrates, the average number of clients has risen up again during 2014/15.

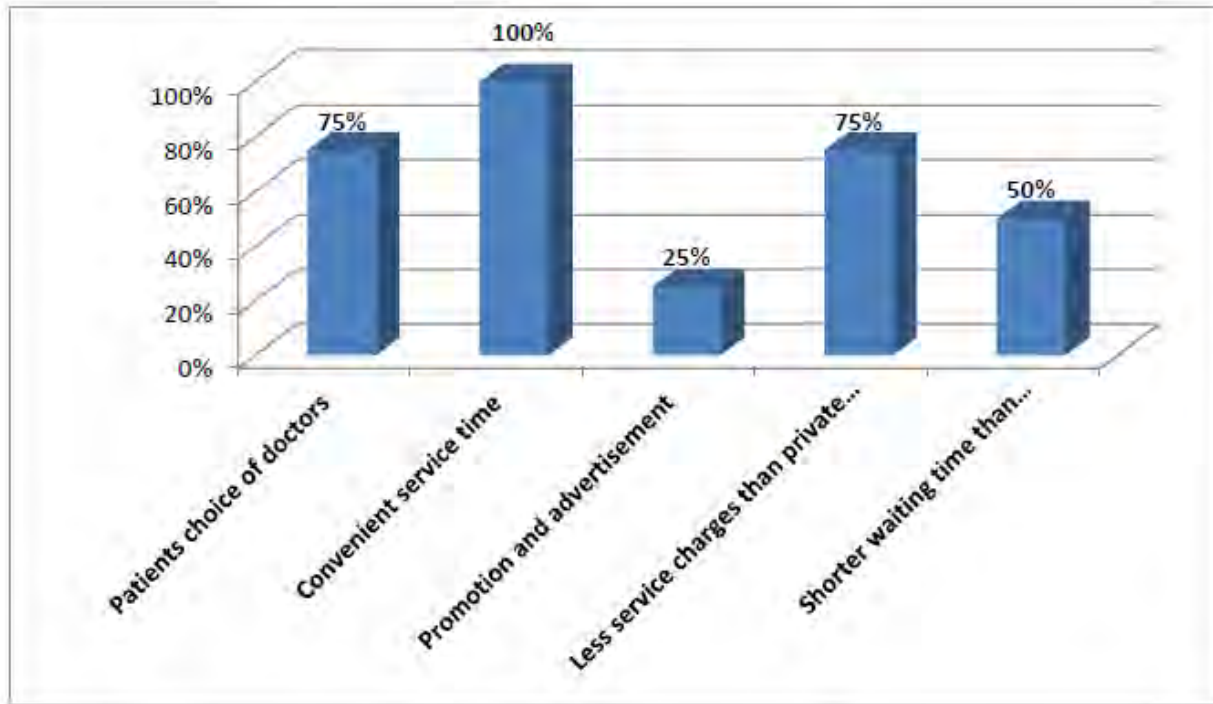
Figure 4.3: Trend of average number of private wing service users per hospital (2012/13 - 2014/15)



(Source: Own research)

75 percent of the hospitals indicated that increasing trend in patient flow has been observed through time. Major factors that contributed for the increase in patient flow were the following: patients could see the physicians of their choice, service time was convenient for clients, promotion and advertisement were made for private wings, service charges were less than private providers and waiting time to get private wing services was much shorter than the regular ward [see Annex 1 Table 5].

Figure 4.4: Response of hospitals to major factors that contributed for increase in patient flow in private wings (percentage).



(Source: Own research)

Hospitals were asked to tell the mechanism whereby private wing patients could be referred to the regular ward. The majority of hospitals (75%) responded that when private wing patients required admission in the regular ward or when they came along with referral papers they were referred to the regular ward.

As to the registration formats, 100% of the hospitals reported that they did not have patient cards specifically printed for private wings. They rather used the regular ward cards.

4.1.4 Acquisition of medicines and medical supplies

Two of the hospitals responded that budget pharmacies were the major sources of medicines and medical supplies for private wing clients. The remaining two hospitals also reported private pharmacies were the second important sources of medicines for clients. The majority of private wings (75%) procured medicines and supplies from the hospital in the form of loan. About 25 percent of hospitals got medicines and medical supplies in by hospital pharmacists for the private wings from government/private drug stores. When private wings procured medicines from hospital's budget pharmacy, most of the hospitals (75%) reported the reimbursement took place every month. They also

indicated that due to the supply of medicines to private wings, the regular ward did not come upon shortage of drugs and medical supplies.

4.1.5 Availability and use of guidelines

Hospitals were requested to indicate if they were aware of the private wing prototype manual developed by the Federal Ministry of Health /FMoH/ in collaboration with the Health Sector Financing Reform /HSFR/ project. All of the hospitals responded that they were indeed aware of the prototype manual.

4.2 Revenue collection and apportionment

Fee setting and revision: With reference to fee setting for private wing services, two of the hospitals assessed the price of private clinics and took intermediate price between the regular ward and the private clinics. However, one hospital simply added a certain percent on the regular ward prices. The other one hospital set prices based on the direction of the Regional Health Bureau /RHB/ and paying capacity of the clients.

The increase and magnitude of the price in private wing services is illustrated in Table 4.4.

Table 4.4: Fees charged in regular and private wing services of the hospitals

No.	Name of hospital	Department	Types of procedure	Regular price*	Private wing price	Percentage change
1	Ras Desta Dantew Memorial	Surgery	Sub-total Thyroidectomy	170	2,000	1,076.5
2	Yekatit 12	Surgery	Sub-total Thyroidectomy	170	2,300	1,253.0
3	Menilik II	Surgery	Thyroid lobectomy	120	2,000	1,566.7
4	Empress Zewditu Memorial	Ophthalmology	Dacryocystorhinotomy with intubation	65	1,800	2,669.0

* The regular price is stated on the price list endorsed by the cabinet and issued by the health bureau of Addis Ababa city administration, 2004.

(Source: Adapted and modified from the Addis Ababa City Administration Cabinet (2004): Official List of service Prices)

Two of the Addis Ababa hospitals in Table 4.4 above, RasDestaDamte Memorial and Minilik II, were working under similar context and provided services, more or less for similar profile of clients. If we consider the price list of Addis Ababa city administration endorsed in 2004 as a benchmark for regular price, the price differentials (in the case of Empress Zewditu Memorial the disparity was more than 2000% and for the remaining three, it was more than 1000%) between regular and private wing services for similar types of medical procedure is very wide. The fees charged were almost closer to the rate of adjacent private hospitals. This infringes the principle of the establishment of private wing in public hospitals. This might be a result of partly the absence of comprehensible legal backing at federal level that helps to establish a standardized price for each procedure in a private wing services.

From a financial point of view, public hospitals may have good reason to promote more-profitable services to patients on the basis of willingness to pay. Because this strategy has enabled them to improve facilities infrastructure, update equipment, and retain the most popular physicians. However, the downside of this approach is that private wings might be tempted to under-provide basic health care services that are not profitable.

Use of vouchers: The private wings were also asked to indicate the source of revenue collection vouchers. The assessment has shown the practice was different from one private wing to the other. All stated that they used revenue collection vouchers issued by the Bureau of Finance and Economic Development /BoFED/.

In addition to private wing revenue collection vouchers, one facility used specific vouchers to receive and take out commodities. However, the majority of private wings (three of the hospitals) did not have vouchers particularly printed for private wings. All of private wings have opened separate bank account to deposit private wing revenues. And, all private wings responded that they are used to keeping separate accounting records/books against regular ward.

The facilities were also asked to tell if they ever get audited by internal or external auditors. All of them replied they got audited. Of which, three of the hospitals got audited by the internal auditors of the hospitals whereas one of the hospitals by external auditors.

Magnitude of private wing revenue: With regard to the amount of revenue collection in private wings, there is wide variation across private wings. Revenue collection was higher in those private wings which established the project earlier; however, it was found to be small in the newly established private wings. For example, the minimum and maximum amount of revenue collected in 2013/14 was ETB 312,062.00 in Empress Zewditu Memorial and 5,383,853.00 in Menilik II respectively.

Table 4.5: Average cost and revenue of private wings (2012/13 -2014/15)

N.	Fiscal year	Average Cost	Average Gross Revenue	Average net revenue	No. of Hospitals
1	2012/13	1,876,497.83	2,207,644.50	331,146.68	2
2	2013/14	1,872,129.19	2,202,505.30	330,376.11	4
3	2014/15	2,016,440.13	2,372,282.50	355,842.38	4

(Source: Own research)

Facilities were asked to indicate how the percentage share of revenue among cadres of health workers was determined. And all private wings stated that revenue sharing rule was already included in the private wing directive/manual.

Consequently, All hospitals allocated 15% of the net revenue of the private wing to the general ward of the hospital. The rest, 85% of net revenue was apportioned among health workers (including support staff) participating in the private wings. Above all, major problems include:

- 1) Complicated and lack of clarity in the apportionment of revenue both among health workers and for the general ward,
- 2) Variation within the city administration for the same service provision among similar cadres of health workers
- 3) Disorganized bookkeeping and accountancy of private wing revenue and expenditure.

As regards the percentage share of private wing revenue among the different cadres of health workers, it varies widely across the cadres of workers. The major principle of revenue sharing in the private wing is that those health workers who are assigned to work in their specialty for a specific type of health service take the lion’s share. Therefore, the share of revenue for a laboratory technician in laboratory services will be higher than that of a nurse. So does for an ultrasound radiologist who works in Sonography. The share of specialists and general practitioners is higher when the type of service is examination or minor and major procedures.

Similar ways of considering the 85% share were observed. All of the private wings divided the 85 percent into 70% and 15% for health professionals and support staff respectively and allocated the share in percent accordingly. This means the 70 percent share was further apportioned in percent, considering it as 100%, among health professionals and the 15 percent share was also treated in a similar fashion. Health professionals’ survey result indicated that on average, specialists earned 41 percent of their total monthly income from private wings. According to table 4.6 below, the uppermost beneficiaries of private wings were specialists, radiologists, general practitioners and nurses in the order of importance. The very objective of the establishment of private wings in public hospitals is to retain highly qualified health professionals in the public health facilities. And one of the retention mechanisms, among others, is increasing the amount of their earnings through private wings practices. And fortunately, the

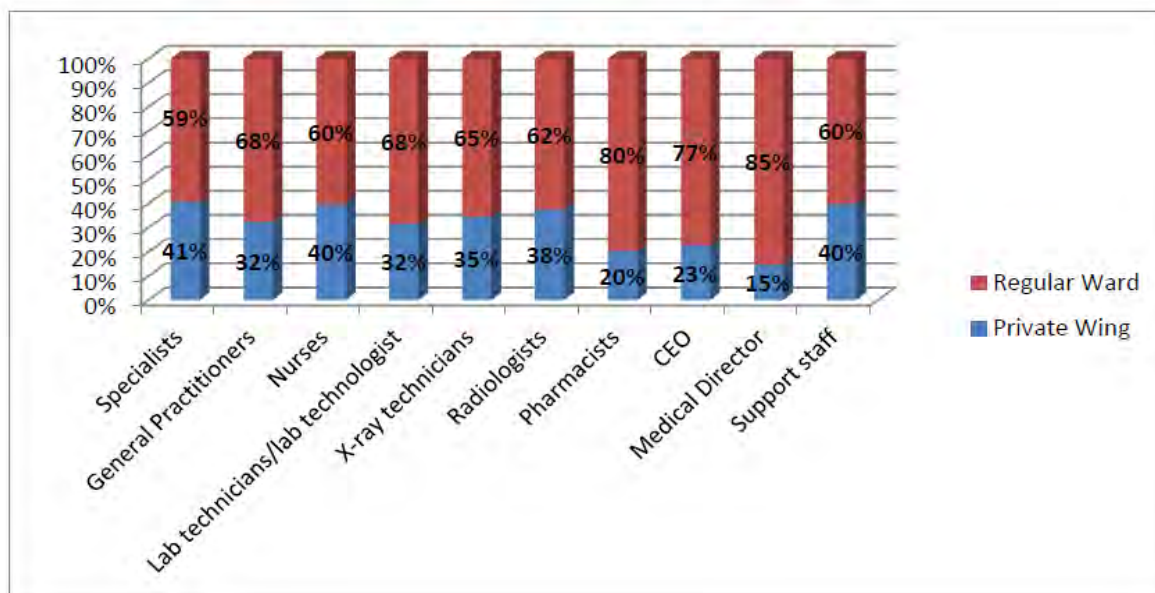
result obtained from the assessment has agreed to this objective. As Table 4.6 shows, the top recipients of private wing income were specialists, earning 68 percent of their regular income.

Table 4.6: Average monthly earnings of health workers from regular and private wings

No	Cadres of workers	Average monthly earning (ETB)		Share of private wing income from total monthly income (%)	Share of private wing from regular income (%)
		Regular	Private		
1	Specialists	16,055.75	10,958.25	41	68
2	General practitioners /GPs/	7,159.50	3,420.75	32	48
3	Nurses	3,064.50	2,015.50	40	33
4	Lab. Technicians	2,785.75	1,283.67	32	46
5	X-ray Technicians	2,599.25	1,371.25	35	53
6	Radiologists	16,443.00	9,868.50	38	60
7	Pharmacists	3,152.00	800.00	20	25
8	CEOs	6,178.50	1,794.00	23	45
9	Medical Directors	8,917.00	1,540.00	15	17
10	Support Staff	1,845.00	1,226.75	40	66

(Source: Own research)

Figure 4.5: Proportion of average monthly earnings of health workers from private and regular wards



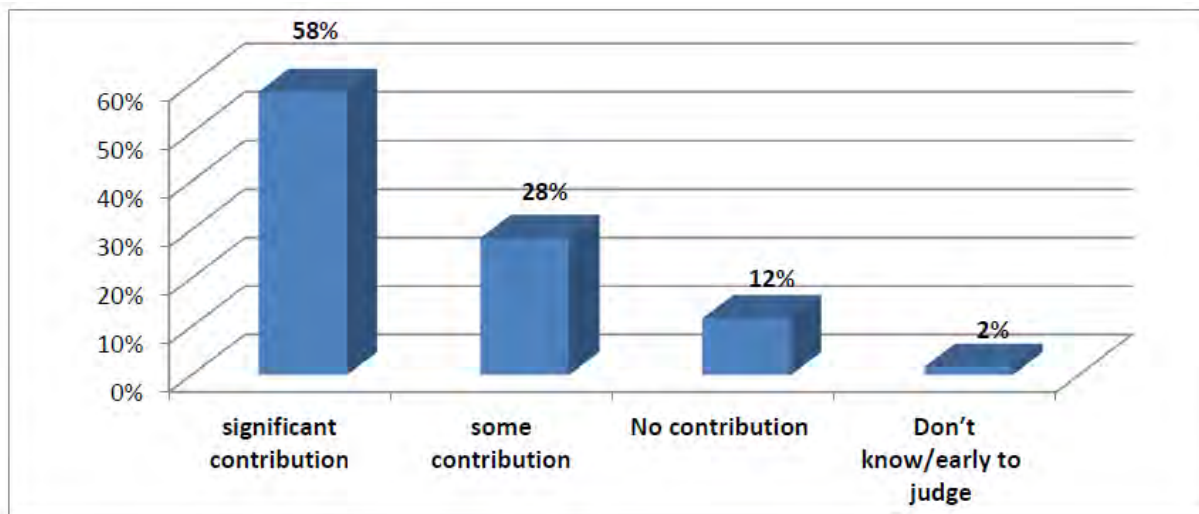
(Source: Own research)

In the private wing directives and manuals of health facilities, the share of hospitals /general wards from the private wings is declared to be 15 percent of the net revenue. Differences were also observed in the apportionment of revenue among the different cadres of health workers across hospitals.

4.3 Contribution to staff motivation, retention and client satisfaction

Motivation and retention: Three hospitals (75%) believed that private wings have contributed greatly to the retention and motivation of health professionals [see Annex 1 Table 6]. Health facilities were also asked to indicate if there were health professionals currently working in private clinics as part timers. The majority of hospitals reported that there were health professionals working in private clinics as part-time workers. However, the facilities also reported that from those health professionals who practiced in private clinics, the majority of them were still working in the private wings. Health professionals participating in the private wings were asked to provide their opinions on the contribution of private wings to staff retention. As figure 4.6 illustrates, a little more than 86% of them reported that private wings indeed contribute to staff retention.

Figure 4.6: Health professionals’ response on the contribution of private wings to staff retention (Percentage)



(Source: Own research)

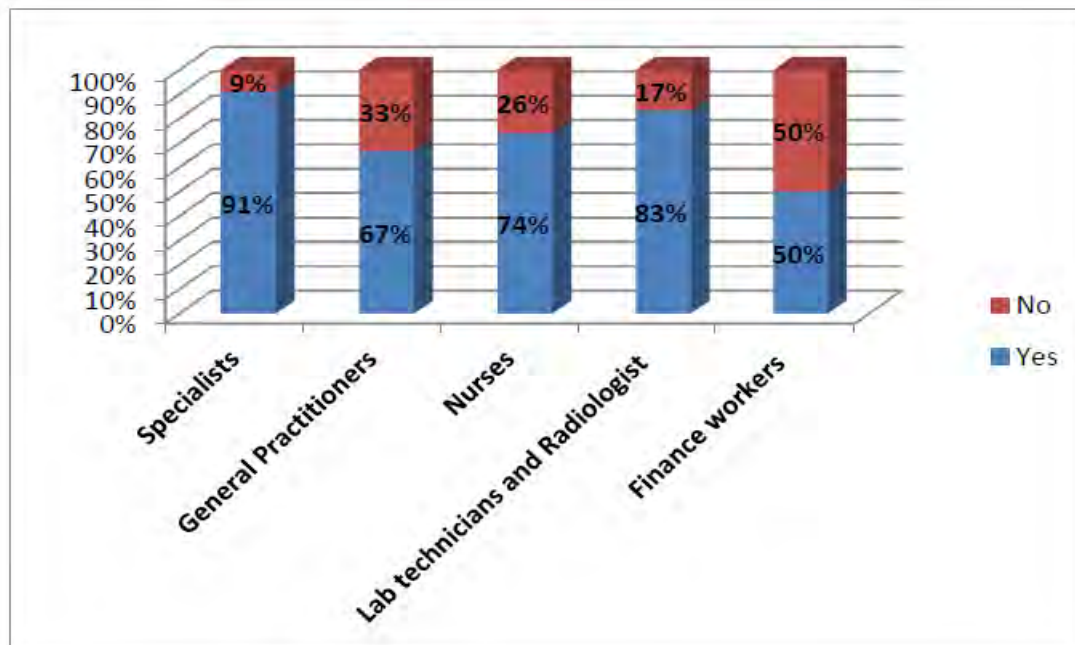
With regard to health professionals' opinions on the benefits of private wings to facility staff and the public in general, all respondents indicated additional income, alternative service facility and better quality of services to the public as major benefits.

Comparing private wings with private clinics, health professionals were also asked to provide their opinions on the benefits accrued to working in private wings. They mentioned four major benefits:

- 1) The health professionals felt free and easy because they worked at their own facilities;
- 2) They maintained ethics because they were free of any influence from private clinic owners;
- 3) There was no time wastage as the private wing was located in the compound of the hospital; and
- 4) The staff earned more income in shorter hours than they used to get in the private clinics.

As to the opinions of health professionals whether they would continue to work in their hospitals for the next three years or not, 91% of specialists and 83% of laboratory technicians expressed their intention to continue working in the hospitals for the next three years.

Figure 4.7: Intention of health workers whether they will continue to work in the next three years or not (percentages).



(Source: Own research)

As figure 4.7 illustrates, the highest intention to work in the hospitals was displayed by specialists. And this result is consistent with the objective of establishing private wings in public hospitals: retention of highly qualified health professionals. Overall, more than fifty percent of health workers (see the vertical line in figure 4.7 above) had the intention to continue working in the next three years. Those who did not want to continue working in the hospitals in the next three years gave different reasons. Insufficient incentive (40.4%), plan to continue further education (25%) and looking for a better job (19.2%) were the major reasons. With regard to challenges encountered in the private wing, the respondents replied that lack of materials /instruments and medical equipment/, shortage of room space for service provision and unfair revenue sharing among the staff were the major ones.

Health professionals also rated their job satisfaction before and after the commencement of the private wings. As Table 4.7 depicts, the percentage of health workers who rated their job satisfaction under each category has improved after they began working in the private wings.

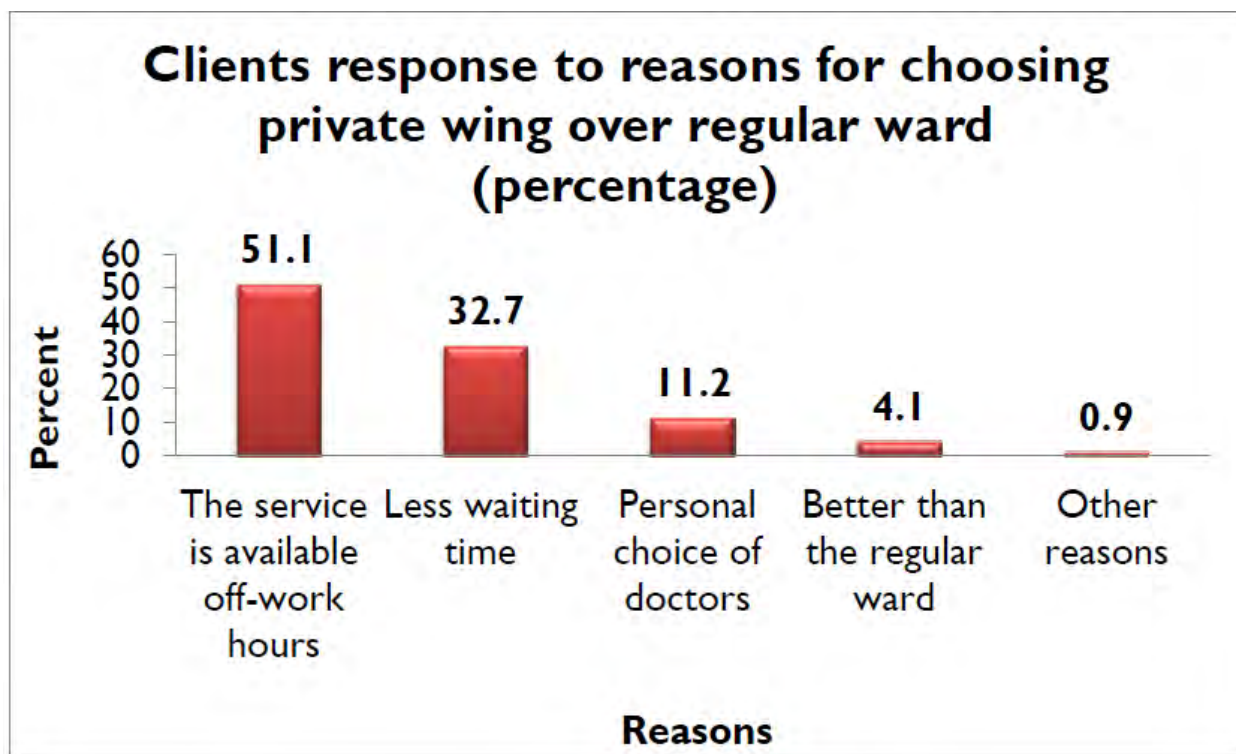
Table 4.7: Percentage of health workers who rated their job satisfaction before and after the opening of private wings

No	Category	Ratings (percent) (n=60)					
		Not satisfied		Satisfied		Extremely satisfied	
		Before	After	Before	After	Before	After
	<i>General working environment:</i>						
1	Flexibility in Work schedule	13.9	8.8	45.2	50.3	7.8	18.8
2	Variety of job responsibilities	7.9	5.1	49.4	51.7	9.1	20.5
3	Degree of independence associated with work	7.0	5.5	50.9	56.8	15.2	24.6
	<i>Pay and promotion prospective:</i>						
4	Total earning	42	21	18.9	31.5	0.6	8.3
5	Recognition for work accomplished	17	13.9	35.8	47.4	5.7	17.5
	<i>Use of skills and abilities:</i>						
6	Opportunity to utilize skills and talents	8.2	6.0	43.7	47.8	14	23.5
7	Opportunity to learn new skills	13.9	13.2	40	43.6	8.2	19.9
	<i>Amenities, medical equipment and supplies:</i>						
8	Availability of medical equipment	17.4	15.1	34.1	37.4	4.2	10.6
9	Availability of drugs and medical supplies	16.3	13.4	36.3	43	5.6	9.9
10	Infection control	10.5	9.4	38.3	44.7	9.9	16.5
11	Night shift facilities (e.g. bed. room. etc.)	38.9	39.9	28.7	28.2	4.5	6.1

(Source: Own research)

Client satisfaction: the majority of private wing clients (71%) had the knowledge of the presence of private wing in a public hospital before coming to the facilities. Clients were also asked how they knew about private wings. The majority of the clients (73%) heard from somebody else who used the service before. And nearly 17 % of the clients read posted papers in the hospital. Availability of the private wing service during off-work hours and less waiting time to get services were the major reasons for clients to choose private wing over regular ward. Some eleven percent of private wing service clients also responded with personal choice of doctors as major reason to choose private wings.

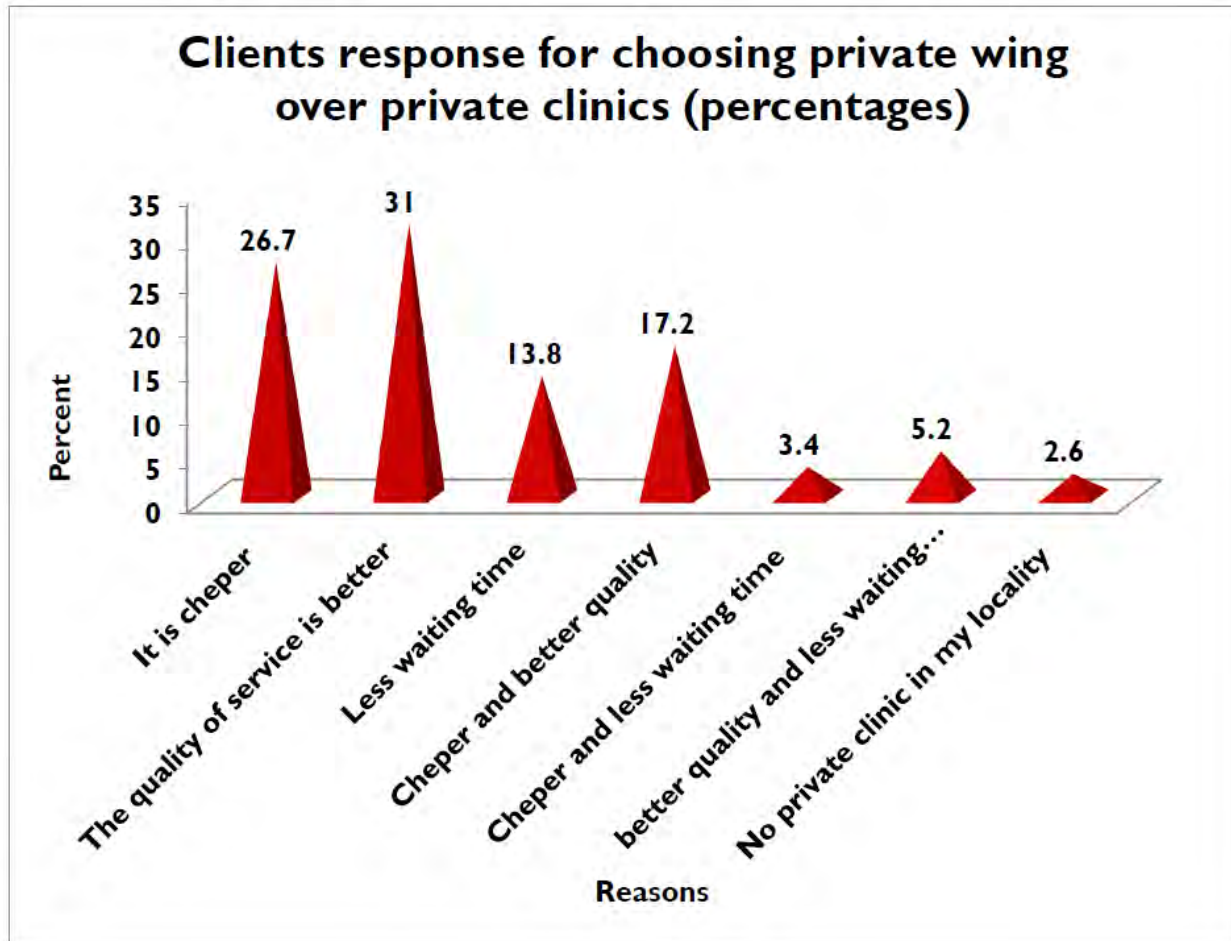
Figure 4.8: Private wing clients’ response to reasons for choosing private wing over regular ward (percent)



(Source: Own research)

Private wing clients were also asked to explain why they chose private wings over private clinics. As figure 4.9 below depicts, the majority of private wing clients (31%) indicated quality of the service and nearly 27 percent of clients responded affordability as major reasons for choosing private wings over private clinics. A little more than 17 percent of the respondents also indicated a combination of both affordability and better quality advantages of the private wings.

Figure 4.9: Private wing clients’ response for choosing private wings over private clinics (percentages)



(Source: Own research)

Regarding the services and the courtesy of health staff of private wings, the result of the research was promising [See Table 4.8]. The treatment of clients by private wing health staff and cleanliness of private wings were promising. Almost more than 80 percent of the clients responded that doctors and nurses treated patients courteously. A little more than 40 percent of the respondents indicated that the bathrooms /latrines of the private wings were so clean.

Table 4.8: Number and percentage of clients’ response on the treatment and sanitation of private wings

N.O	Mode of treatment/cleanliness	Count/Percent	Strongly disagree	Disagree	Agree	Strongly agree	Total
1	Nurses treated me with courtesy	Count (n)	2	5	38	15	60
		%	3.33	8.33	63.34	25	100
2	Nurses listened carefully	Count (n)	0	6	38	16	60
		%	0	10	63.33	26.67	100
3	Nurses explained things the way I could understand	Count (n)	0	8	37	15	60
		%	0	13.33	61.67	25	100
4	Doctors treated with courtesy	Count (n)	1	3	38	18	60
		%	1.67	5	63.33	30	100
5	Doctors listened carefully	Count (n)	0	8	35	17	60
		%	0	13.33	58.33	28.33	100
6	Doctors explained things the way I could understand	Count (n)	1	5	37	17	60
		%	1.67	8.33	61.67	28.33	100
7	The out-patient department was clean	Count (n)	5	4	41	10	60
		%	8.33	6.67	68.33	16.67	100
8	The bathrooms/Latrines were clean	Count (n)	4	12	38	6	60
		%	6.67	20	63.33	10	100

(Source: Own research)

Similarly, private wing clients’ response on the provision of information on prescribed medicines was encouraging [Table 4.9]. Almost 94% of the clients were prescribed with new medication. And a little more than 60% of the respondents replied that all the medications they needed were available in the hospitals pharmacy.

Table 4.9: Number and percentage of clients’ response on the provision of information on prescribed medicines

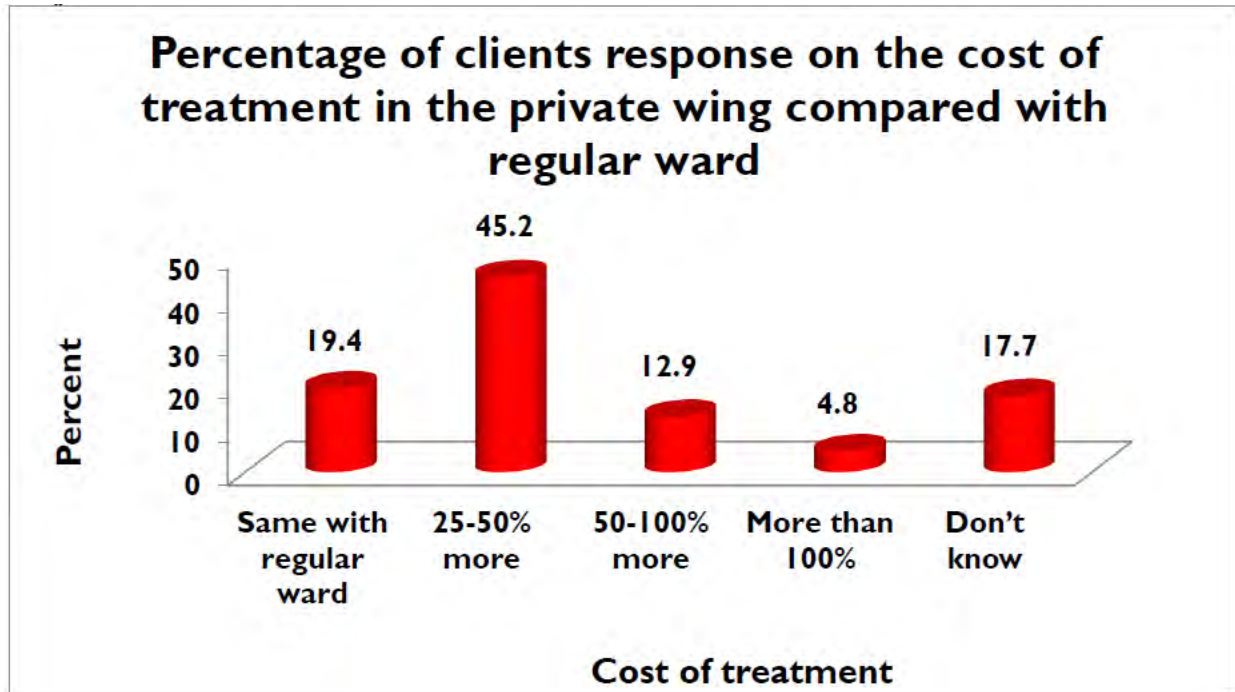
N.	Provision of medication	Count/Percent	Yes	No	Total
1	I was prescribed new medication at this visit	Count (n)	56	4	60
		%	93.33	6.67	100
2	The staff told me what the medication was for	Count (n)	36	13	49
		%	73.47	26.53	100
3	The staff described the possible side effects in a way I could understand	Count (n)	18	31	49
		%	36.73	63.27	100
4	All the medications I need were available	Count (n)	31	19	50
		%	62	38	100
5	Someone discussed with me what symptoms to look out for after I left the health facility	Count (n)	15	35	50
		%	30	70	100
6	It was easy for me to find my way around the facility	Count (n)	46	14	60
		%	76.67	23.33	100

(Source: Own research)

As Annex 1, Table 9 illustrates the majority of the private wing clients (95.5%) responded doctors prescribed medicines for private wing clients during that particular visit. And most of the clients (84.7%) pointed out that they procured the medicines from the hospital’s pharmacy during the day. However, the majority of respondents (54.5%) stated that they do not usually get prescribed medicines from the hospitals pharmacy. A number of them (88.7%) indicated that they usually buy medicines from private drug vendors. Whereas a small portion of clients (9.75%) bought medicines from the hospitals’ pharmacy and an insignificant portion of them (1.6%) from Red Cross pharmacies.

Clients exiting from the private wings were also asked to provide their personal opinions (from the given choices) on how much did they pay in the private wings compared to the regular ward payment. A good number of the outpatient clients (45.2%) responded that private wing fees were 25 -50% more than the regular ward. And a little more than 19% of the respondents stated that the fees were similar to the regular ward payment [see Figure 4.10].

Figure 4.10: Percentage of clients’ response on the cost of private wing services based on subjective belief



(Source: Own research)

The majority of the respondents (69.5%) replied that prices charged in the private wings were fair. While 28.2% of the clients replied that the prices were not fair. And the rest (3.3%) stated that the charges were somewhat expensive [see Table 4.10].

Table 4.10: Percentage of respondents on the fairness of private wing fees

N.	Response	Percent
1	Yes, it is fair	69.5%
2	No, it is not	28.2%
3	Somewhat expensive	3.3%

(Source: Own research)

A significant proportion of private wings clients (67.6%) also indicated that they did not find the physicians /specialists by whom they wanted to be seen during the visit. Only a little more than 32 percent of them were lucky to be seen by doctors of their choices. Overall, the majority of clients (87.9%) responded that they were satisfied with the services of the private wings [see Figure 4.11].

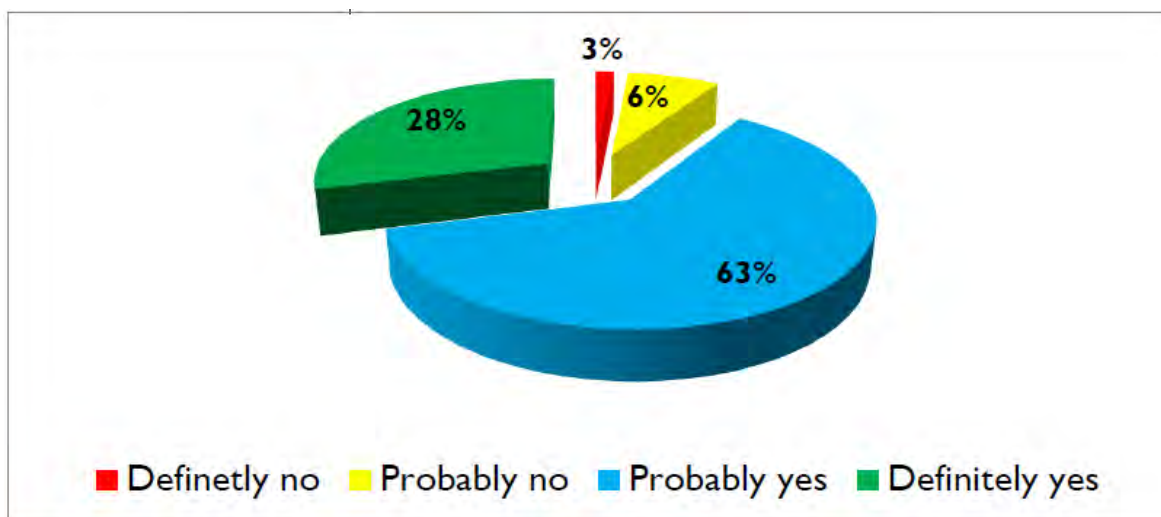
Figure 4.11: Percentage of clients' response on the satisfaction of private wing services.



(Source: Own research)

A small number of private wing clients (12%) who were not satisfied with the services recommended that staff be responsible and careful; and doctors should treat patients properly. They also indicated that patients should be seen by their choice of doctors. The private wing clients were also asked if they would recommend the private wing services to their friends and families. A total of 91 percent of the respondents gave an affirmative response.

Figure 4.12: Percentage of private wing clients who will recommend private wings to friends and families



(Source: Own research)

Finally, clients were asked to indicate the rating of the hospital on a scale of 0 to 10 (0 being the worst facility while 10 being the best facility). The research result revealed more than 83 percent of the respondents gave a scale of 6 and above out of 10 [See Table 4.11]. Private wing service ratings by clients (percent) on a scale of 0 -10.

Table 4.11: Private wing service ratings by clients (percent) on a scale of 0 – 10 (0 being the worst facility, 10 being the best facility)

No.	Rating scale out of ten	Count	Percent of clients
1	Zero	1	2%
2	Two	0	0%
3	Three	3	5%
4	Four	1	2%
5	Five	5	8%
6	Six	6	10%
7	Seven	14	23%
8	Eight	14	23%
9	Nine	6	10%
10	Ten	10	17%
	Total	60	100%

(Source: Own research)

4.4 Contribution to resource mobilization and improving quality of health services

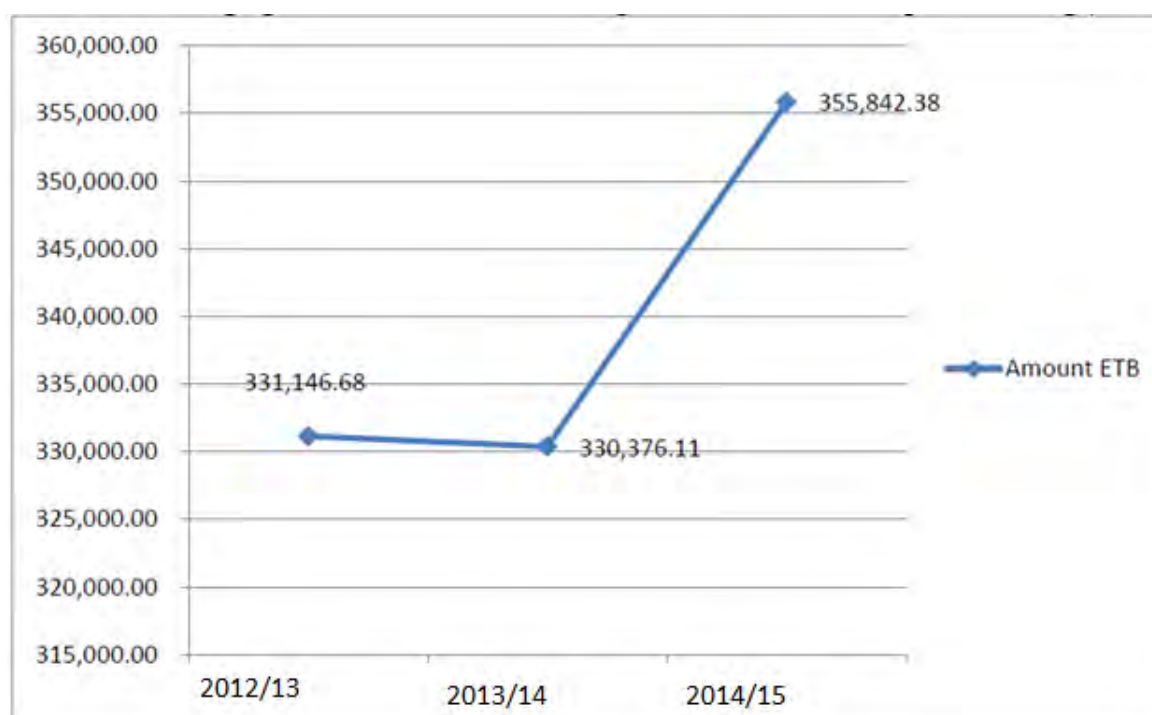
As Table 4.12 illustrates, the average amount of private wing revenue per hospital transferred to the general ward of the facilities in the past three years was ETB 331,146.68, 330,376.11 and 355,842.38 during 2012/13, 2013/14 and 2014/15 respectively.

Table 4.12: Minimum, maximum and average amount of revenue transferred to the regular ward during 2011/12 to 2013/14

Fiscal Year	Minimum	Maximum	Average
2012/13	316,647.00 (Minilik II)	345,646.35 (Ras Desta Damtew Memorial)	331,146.68
2013/14	39,469.43 (Empress Zewditu Memorial)	569,665.50 (Ras Desta Damtew Memorial)	330,376.11
2014/15	46,809.30 (Empress Zewditu Memorial)	807,577.95 (Menilik II)	355,842.38

(Source: Own research)

Figure 4.13: Average growth of the share of hospitals' revenue from private wings



(Source: Own research)

Revenue collected from private wings was principally used for quality improving services. The respondents stated that the amount of revenue collected from private wings was pooled together with other sources of retained revenue of hospital. After appropriation, the retained revenue was strictly invested in quality improving services together with government block grant.

CHAPTER V: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of the major findings

The private wing aims at providing quality health care at an affordable fee and retaining highly qualified health staff within reach while doing their private practice within the hospital premise. Following same principle, private wing establishment has been advocated in the city administration to address widely shared symptoms of inefficiency, user dissatisfaction, brain drain to the private sector, emigration of professionals to neighboring countries, and failure to reach the poor. A significant innovation has started to occur after the establishment of private wings in public hospitals.

Current practices regarding private wing services in public hospitals face certain problems and challenges. There are signs of declining efficiency, wasteful investment and relative negligence of some other services. Lessons drawn from the assessment will be useful to the growing number of public hospitals that are scheduled to commence private wing services.

A summary of findings which found from primary and secondary data's are used to evaluate those public hospitals involved in the practices of private wing services are listed down as follows:

Conflict of interest:

- i. There is a tendency for public hospitals to increase their private wing revenue by offering more-expensive and more-profitable services (RasDestaDamtew Memorial and Menilik II hospitals have set higher fees for selected services that are deemed to generate more revenues). This has resulted in introducing conflict of interest in physicians- patient relationships.
- ii. The other most difficult and fundamental challenge is that specialists (and they are the major category of health professionals who benefit a lot from the scheme) who earn substantial income from the private wing are likely to oppose changes that threaten their incomes. In addition specialists do not want to share a part of their benefit to the pool that should be shared by other professionals.
- iii. Some clients feel that there is partiality and discrimination between regular and private wing services in providing medical treatment, allocating medical equipment, human resource and time. This is a typical appearance for the worst-case scenario in

which public hospitals are entering into a conflict between the public and private interest. Some hospitals increased the number of unnecessary medical treatment in private wing services in order to increase their revenue.

Existence of Contextual differences in the operation of private wing:

The hospital sector is characterized by huge variations in scale, functions, tasks, management systems and operational mechanisms, as well as overall performance.

Unfair revenue sharing and unequal service provision:

- i. The problem of equity in revenue sharing with respect to private wing services in public hospital is and remains a serious problem.
- ii. Evidence from the assessment result in private wing practices as cited in this paper indicates that the revenue sharing mechanism has led to inequitable distribution of hospital revenue where specialists obtain the lion's share, at the expense of other health professionals.
- iii. There is wide discrepancy and lack of harmony/commonly acceptable formula in revenue sharing arrangements.
- iv. Private wing service is subsidized by public funds where the private wings use public electricity, water supply, rooms and the like.
- v. The poorer the care provided to the regular patients compared with the private ones and the longer the queues for certain medical procedures, the greater the likelihood that public/regular patients will move in to the private service. These aspects of private wing services are difficult to monitor and control.
- vi. Absence of comprehensive regulation covering movements of patients between public/regular and private rooms in government hospitals.
- vii. As there was no strong monitoring and evaluation, both by the Federal Ministry of Health and the respective hospital management, regulations are openly violated.

Gaps in legal frame work:

- i. Regulation for administration of federal hospitals (regulation No.167/2009) and guideline for the implementation of private wing service in federal hospitals have been in place. Nevertheless, both federal legal frameworks have their own limitations. When compared to the regional legal frameworks they are prepared in a very generalized/ condensed manner. Therefore they need to be backed by well elaborated implementation manual which comprises all elements of private wing operations
- ii. There is weak control over total public hospital expenditure and a lack of incentives for efficiency and rational, evidence-based service provision.

Demand for specialized and selective services:

- i. The demand for private wing services is highly selective and focuses on well-clearly defined (ophthalmology, gynecology, dermatology, dentistry) areas. A physician in internal medicine or pediatric ward, where the demand for private wing service is low, will hardly perform any private wing service procedures.
- ii. The problem is that expanding choices available to a group of well off patients who are able to pay for private wing services, may decrease the wellbeing of other patients, in that they may have to wait longer time for surgeries and other clinical procedures and may receive less attention and get less information by their physicians.

Unregulated fee levels for private wing services:

- i. Absence of coherent legislation at federal level that helps to establish a standard rate for each procedure in a private wing service.
- ii. Some public hospitals function like private hospitals; some public hospital doctors also function like private independent practitioners; and both hospitals and doctors obtain significant revenue from charging fees-for-services and earning surpluses from drug sales on a cost-plus basis.
- iii. In the Ethiopian context, service fee is a continuing concern among those seeking health care services, given their low earnings. Such costs include consultation fees,

laboratory test charges, travel, drugs and accommodation. While basic health care service is supposed to be reasonably affordable in public hospitals, patients end up bearing the costs of medicine and laboratory tests. An indication of actual charges and additional costs to be paid by people in public hospitals is provided in Table 4.3

Absence of systematized regulatory mechanisms:

There is no clear distinction between regular patients/services on the one hand and private wing patients/ services on the other. Although doctors may have part-time private practices and part-time employment contracts with public hospitals, this should be highly regulated. If abused, the privilege must be withdrawn by hospital management. This would require careful system to monitor the private wing performance. Above all, setting firm regulating mechanism is required.

Unavailability of profile display:

Unavailability of private wing service booklets, which includes the names of the senior physicians eligible to offer the service.

Differentials in fee scheduling:

Different fee schedules for the same procedure/operation.

Weakness in creating awareness:

Both health professionals and the public at large are not well aware of the services of private wings

5.2 Conclusions

- **Setting up:**The majority of the hospitals indicated that they decided to open private wings after conducting client assessment both in public and private health facilities. The seed money was obtained from the retained revenue of the facilities and government budget. The private wing services are provided in the regular ward rooms.
- **Service utilization, revenue collection and apportionment:** One of the key considerations in the establishment of private wings is the provision of services for private wing clients. However, a significant number of private wings did not make any non-quality differentiation compared to the regular ward. Nevertheless, the number of clients maximizing services is rising. The average number of private wing clients has increased from 10,359 in 2013/14 to 10,904 in 2014/15. Correspondingly, the average net revenue of private wings has also increased

from ETB 1, 8762,129.19 in 2013/14 to ETB 2,016,440.13 in 2014/15. 100 percent of the hospitals that established private wings followed the so called 15 to 85 revenue allotment ratio. That is 15 percent of the net revenue of the private wing is channeled to the hospital and 85 percent of the net revenue to the staff. However, some differences were observed in the apportionment of revenue between hospital and staff. A wide variation was seen in the allocation of net revenue among the different cadres of health workers.

- **Staff motivation and retention:** as clearly indicated in the prototype of private wing manual, the very objective of the establishment of private wings in public hospitals is to retain highly qualified health professionals in the public health facilities. And one of the retention mechanisms is increasing the amount of earnings these professionals earn through private wing practices. And fortunately, the result obtained from the assessment has concurred to this objective. Top recipients of private wing income were specialists, earning 41 percent of their regular income. That is equivalent to 61 percent of their total monthly income. Radiologist, general practitioners and nurses follow specialists in that order of importance. Besides, health professionals revealed their satisfaction on the general working environment, pay and promotion prospect and opportunity to utilize skills and talents after the opening of private wings. Accordingly, a large number of health professionals believed that the initiation of private wings has greatly contributed to the retention and motivation of health professionals. A significant number of health professionals have showed their intention to continue working in their hospitals at least in the coming three years.
- **Client satisfaction:** Availability of private wings services during off-work hours together with relatively less waiting time to get the services was found to be the major reason for private wing clients to visit private wings. The majority of clients (70%) also reported that the private wing fees are fair. And overall, close to 90 percent of the clients were satisfied by private wing services.
- **Problems and challenges:** Given the contextual difference of public hospitals that established private wings, the major problems revealed in the assessment are unchecked service charges, unfair revenue sharing among private wing staff, the tendency to select those outpatient services that are likely to generate more revenue and neglect pro-poor basic services and divergence between the endorsed private wing rules/regulations and practice. With respect to challenges, the major ones are the revenue apportionment mechanism among the different cadres of workers and the income tax issue of private wing revenue.

5.3 Recommendations:

Based on the findings of the research, the following recommendations are developed on major intervention areas responsible bodies to improve the operation of private wings and scale up the scheme to other health facilities:

Legal framework and manuals:

- The FMoH should revise and update the current private wing manual/guide so as to make it national prototype guideline.
- Public hospitals implementing should have complete legal framework and standardized private wing manual approved by the council and boards respectively.

User fees:

- User fees charged in Public hospital private wings should be approved by the hospital board and then by the council.
- Private wing user fees should be periodically regulated.
- User fee charged should be standardized in all hospitals.
- The ministry should provide a reference guide for hospital board members to help them decide on appropriate user fees.

Accounting and reporting:

- There has to be a transparent book keeping and accounting system to manage and report the revenue, expenditure and apportionment of private wing income.
- Standardized reporting system to the board should be devised.
- Fulltime accountant/s should be assigned (as appropriate) for private wings.

Accountability, transparency and compliance to policy:

- Private wings should be thoroughly accountable to hospital managements. And the hospital managements in turn, as the law clearly designates, should be liable to the board.
- Grievances and views of health staff should be presented to the hospital management.

- The issue of private wing income tax should be deal with MoFED.
- The hospital management should have a normative mechanism to control and avoid conflict of interest:
 - Between the private wing and the general ward
 - Among health professionals (heath staff and support staff, specialists and others health staff)
- Health professionals working in private wings should not trim the regular working hours in order to maximize their attendance in the private wing.
- As the problem of stock out will be more frequent in hospitals with private wings, hospitals should be able to manage stock outs of essential medicines.

Monitoring and evaluation:

- There should be a strong and periodic monitoring and evaluation of the performance of private wings by the FMoH.
- The FMoH should develop a regular monitoring and evaluation schedule with a standard checklist.
- It is necessary to make sure that there is no tradeoff between private wing and regular ward clients. That is, private wing service should not jeopardize the regular ward service.

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ANNEXES I: TABLE OF RESULTS

Table 1: Methods used to create public awareness to initiate private wing services

Methods					
	Posters posted in the compound of the hospital	Brochures distributed out of the hospital	Microphones	Public media	Public meetings
No. of hospitals	4	3	2	4	0

Table2: Status of awareness of the public about private wing services (percentage response of hospitals)

No.	Response	Frequency	Percent
1	Yes	3	75
2	No	1	25
3	Somehow	0	0
	Total	4	100

Table 3: The reporting system of private wings (percentage response of hospitals)

No.	Reporting system	Frequency	Percent
1	The TAG directly reports to the hospital board	0	0
2	The TAG reports to the management committee and Mgmt. committee to board	2	50
3	The CEO directly reports to the board	1	25
4	Choice 2 and 3 above	1	25
	Total	4	100

Table 4: Frequency of reporting made to the hospital board (percentage of hospitals)

No.	Reporting period	Frequency	Percent
1	Monthly	0	0
2	Quarterly	3	75
3	Semi-annually	1	25
Total		4	100

Table 5: Percentage of hospitals that responded on major factors that contributed for increase in patient flow in the private wings.

N.	Major Factors	Percentage	Numbers (n)
1	Patients choice of doctors	75	3
2	Convenient service time	100	4
3	Promotion and advertisement	25	1
4	Less service charges than private providers	75	3
5	Shorter waiting time than regular ward	50	2

Table 6: Percentage of hospitals' response on the contribution of private wings to the retention of health workers

N.	Response	Frequency	percent
1	Yes	3	75
2	No	1	25
Total		4	100

Table 7: Minimum, maximum and average private wing service users (2011/12 - 2013/14)

	Minimum	Maximum	Average
Total users 2012/13	11,200	16,504	13,852
Total users 2013/14	6,618	18,018	10,359
Total users 2014/15	5,339	20,354	10,904

Table 8: Sources of clients' knowledge about private wings in public hospitals

No.	Mode of knowledge	Frequency	Percent
1	Read posted papers in the hospital	16	27
2	Heard from somebody else who used the service	32	53
3	Know about it from the media	4	7
4	Announcement of the hospital at public gathering	3	5
5	Heard from somebody & announcement of the hospital	5	8
6	Total	60	100

Table 9: The Daily assignment of health workers in private wings

N/S	Type of health profession	Total
1	Hospital Manager/ CEO	4
2	Medical Director	4
3	Doctors (with specialization):	32
4	Internist	7
5	Gynecologist and Obstetrician	4
6	Pediatrician	3
7	Surgeon	3
8	Others specify	8
9	General practitioners	16
10	Nurses	42
11	Radiologists	1
12	X-ray technicians	11
13	Lab technician/lab technologist	31
14	Pharmacist	1
		167

ANNEXES II: Questionnaires

Dear Sir/Madam

My name is WossenAlemu, a graduate student in the Masters Program in Public Management and Policy (MPMP), College of Business and Economics, Addis Ababa University. I am conducting a research project paper on "**Private wing Practices and Challenges in Addis Ababa Hospitals**". It is a Partial Fulfillment of the requirements for Masters Degree in Public Management and Policy (MPMP).

The objectives of the study:

1. To assess the operations of the private wings/rooms as a whole, including the legal framework, service delivery, the governing board, management, etc. in Addis Ababa hospitals which are implementing this particular reform component.
2. To examine the implications of establishment of private wings/rooms on the overall health services utilization, health facility revenue, alternative access to patients, satisfaction among staff & reduction in attrition rate, etc.
3. To identify the main challenges encountered, draw lesson and propose solutions to improve the performance of the program.

I am inviting you to take part in this research study by completing the attached questionnaires. The questionnaire will require approximately 30 minutes completing. In order to ensure that all information will remain confidential, please do not include your name.

Thank you for taking the time to assist me in my educational endeavors. If you require additional information or have questions, please contact me.

Sincerely,

WossenAlemu

+251-911-182024

e-mail:- gunchu_munchu@yahoo.com.

Addis Ababa, Ethiopia

Questionnaires for CEO of the Hospital

Section 1: Background Information

1. Hospital Name _____

Section 2: Hospital Profile

1. Hospital catchments area population: (Indicate if it is estimated number or geographically defined by RHB/FMOH)

Male: _____ Female: _____ Total: _____

2. Could you provide us information on the number of hospital staff?

S/N	Type of profession	# staff working:		Remark
		In regular hospital ward	Out of which how many are participating in private wing/room	
1	Hospital Manager/ CEO			
2	Medical Director			
3	Doctors (with specialization):			
3.1	Internist			
3.2	Gynecologist and Obstetrician			
3.3	Pediatrician			
3.4	Surgeon			
3.5	Others specify			
4	General practitioners			
5	Nurses			
6	Radiologists			
7	X-ray technicians			
8	Lab technician/lab technologist			
9	Pharmacist			
10	Support staff			

3. Total number of beds in the hospital: _____

Section 3: Establishment of Private Room/Wing

1. When did you start private wing/ room in this hospital?

(Month and Year)EFY. _____

2. What initiated you to start private wing?

1. HCF training by HSFR project
2. Federal ministry of health
3. Experience sharing visits to other regions/hospitals/countries
4. Initiated from employees
5. Other: specify _____

3. When you decide to open the private wing what considerations have you made to know the potential success of private wing?

1. Undertaken assessment of the views of regular ward clients 1.Yes 2. No
2. Undertaken assessment of clients in the private clinics 1.Yes 2. No
3. Studied/observed the success of other hospitals in the region/other regions 1.Yes2. No
4. Other: specify _____

4. Has the hospital undertaken any public awareness programs regarding private wing prior to and during its operation? 1. Yes 2. No

5. What methods did you use for public awareness regarding private wing services?

1. Posted within the compound of the hospital 1. Yes 2. No
2. Distributed brochures in and out of the hospital 1. Yes 2. No
3. Used microphones in public places 1. Yes 2. No
4. Used the public media such as newsletters, radio and TV 1. Yes 2. No
5. Other: specify _____

6. Do you believe that the public is well aware of private wing services? 1. Yes 2. No

7. If No to Q.6, what are your plans for the future?

8. Has the hospital prepared a proposal before establishing private wing?

1. Yes 2. No

9. If Yes to Q.8, what were the contents of the proposal?

1. List of health professionals willing to work in private wing 1. Yes 2. No

2. Services to be provided including their price 1. Yes 2. No

3. Identify medical equipment and rooms 1. Yes 2. No

4. Identify members and define duties, of private wing committee 1. Yes 2. No

5. Management and distribution of revenue obtained 1. Yes 2. No

6. Others: specify _____

10. Who approved the establishment of private wing/room?

1. The hospital board

2. The management committee

3. The Health Bureau

4. Other:specify

11. If No to Q 10, how did the hospital approve the opening of private wing?

12. Have you established the private wing committee/Technical Advisory Group (TAG)?

1. Yes 2. No

13. Which staff in the hospital become members of the private wing committee/TAG?

1. Medical director 1. Yes 2. No

2. General Manager 1. Yes 2. No

3. Pharmacy head 1. Yes 2. No
4. Medical doctor 1. Yes 2. No
5. Finance head 1. Yes 2. No
6. Laboratory head 1. Yes 2. No
7. A nurse 1. Yes 2. No
8. Other: specify _____

14. Does the facility develop the following for the private wing?

1. Business plan 1. Yes 2. No
2. Facility plan 1. Yes 2. No
3. Operational plan 1. Yes 2. No

15. What is the source of your seed money? (More than one response Possible)

1. Donor finance 1. Yes 2. No
2. Credit from retained revenue 1. Yes 2. No
3. Government budget 1. Yes 2. No
4. Loan from special pharmacy 1. Yes 2. No
5. Others (specify) _____

16. How much was the initial capital of the private wing? _____

17. If the starting capital source is from retained revenue/special pharmacy, have you repaid?

1. Yes 2. No

18. What criteria does the hospital propose to assign/deploy staff in the private wing/room?

- 1. Demonstrated clinical competence 1. Yes 2. No
- 2. A recognized attitude of customer service 1. Yes 2. No
- 3. Proven ability to work with a team 1. Yes 2. No
- 4. Uses regular evaluation results in the regular ward 1. Yes 2. No
- 5. All employees are allowed to participate despite their evaluation results 1. Yes 2. No
- 6. Other: specify

19. List down the departments which are participating in the private wing and how many Professionals are participating from each?

20. How is the private wing related to hospital management?

- 1. The TAG/the private wing committee directly reports to the hospital board
- 2. The TAG/the private wing committee reports to the management committee and the management to the board.
- 3. Other:specify_____

21. How often do you report to the hospital board?

1.Monthly 2. Quarterly 3.Semi-annually 4.Annually 5. Other specify_____

22. Have you assigned a coordinator for medical doctors who participate in the private wing?

- 1. Yes 2. No

23. Who assigns coordinator for medical doctors and nurses?

- 1. The private wing committee
- 2. The board
- 3. The management committee
- 4. Other Specify: _____

24. Have you assigned a coordinator for nurses who participate in the private wing?

- 1. Yes 2. No

25. If No to Question 24, who assigns nurses to the private wing?

26. Do you have terms of reference for health professionals /staffs participating in the private wing?

- 1. Yes 2. No

27. Do you have a system of checking whether there are any discrimination in the provision of clinical services in the regular ward and private wing?

- 1. Yes 2. No

26. If Yes to Q.27 please describe briefly :

27. Describe briefly the facility's monitoring mechanisms for its private wing services?

Section 4: Health service delivery in private wing/room

1. Who determined what services to be provided in the private wing?

1. Already determined in the directive 1. Yes 2. No
2. Private wing committee 1. Yes 2. No
3. By the board 1. Yes 2. No
4. The management committee 1. Yes 2. No
5. Other: specify _____

2. At what time do you provide services in the private wing?

1. Off working hours during the week including national holiday, Saturdays and Sundays.
2. 24 hours
3. Other specify: _____

3. For how many hours do you operate per day on week day's _____ and weekends?

4. Which health care services are provided in the private wing?

1. In-patient only
3. out-patient only
3. Both

5. What kinds of services are provided in the outpatient department of the private wing?

1. _____
3. _____
3. _____
4. _____
5. _____
6. _____

6. What kind of diagnostic services are provided in the private wing?

1. X-ray
2. Laboratory
3. Ultra sound
4. ECG
5. Others
specify: _____

7. If the private wing is providing inpatient services, is it providing using a facility that is built separately for private wing 1. Yes 2. No or the regular wards facilities? 1.Yes. 2.No

8. If you are using the regular ward facilities, how many beds are allocated for private wing?

9. If the allocated beds are not occupied by private wing, do you use it for the regular service clients?

1. Yes 2. No

10. Did you providing inpatient services, 1. Yes 2. No

11. If Yes to Q10 : list down the kinds of services:

1. _____
3. _____
3. _____
4. _____
5. _____

12. What non-clinical services have you improved for private wing clients compared to the regular ward?

13. Does the private wing have posted detailed profiles and schedule of physicians' /specialists' to clients?

1. Yes 2. No

14. What physical/room spaces were available and what additional investments were made to make them usable for the private wing?

1. Unused/underutilized rooms provided by the Hospital
2. Renovation of the existing rooms
3. Newly constructed rooms
4. Other specify _____

15. Private wing service utilization in current and previous years

No	Type of users	Number of Users			Remarks: Major reasons for substantial increase/decrease in patient flow
		2006 EFY	2007 EFY	2008 EFY (up to Dec 31)	
1	Adult Male				
2	Adult Female				
3	<5 Children				
	Total				

16. Have you had increasing trends in patient flow through time?

1. Yes 2. No

17. If Yes to Q16, what factors contributed for this increase in patient flow?

1. Patients can see physician of their choice 1. Yes 2. No
2. It is convenient time for most patients 1. Yes 2. No
3. Continuous promotion and advertising about private wing service 1. Yes 2. No
4. Service charges are lower than private health facilities 1. Yes 2. No
5. Waiting time is shorter than the regular ward 1. Yes 2. No

6. Other specify: _____
18. Where is the private wing (or users of the private wing are) getting medicines?
1. From the hospital budget pharmacy 1.Yes 2. No
 3. From private pharmacies 1.Yes 2. No
 3. Others specify: _____
19. How many nurses, physicians, laboratory technicians and administration staffs are assigned per day in the private wing?
1. Physicians _____
 2. Specialists _____
 3. Lab technicians _____
 4. Nurses _____
 5. Finance and admin staffs _____
 6. Cleaners _____
 7. Guards _____
 8. Pharmacists _____
 9. Other: specify- _____
20. Who is responsible for purchasing consumable medical supplies to the private wing?
1. The private wing coordinating committee
 2. The management committee
 3. Uses the hospital's supplies in the form of loan
 4. Other specify: _____
21. If from the hospital budget pharmacy, how often are the medical supplies replaced to the regular ward?
1. Every week
 2. Every month
 3. Every two months
 4. Every three months
 5. Not replenished so far
 6. Other: specify _____
22. Did the regular ward experience shortage of drugs and medical supplies since the start of the private wing?
1. Yes 2. No
23. If Yes to Q 22, what do you think is/are the reason/s?
1. The private wing is not buying and replacing the drugs and medical supplies on time
1. Yes 2. No
 2. Due to the increase in patient flow since the start of private wing
1. Yes 2. No
 3. Others specify: _____

24. Have you undertaken staff satisfaction surveys for private wing before?

1. Yes 2. No

25. What were the results of the surveys?

26. What measures have you taken to correct the shortcomings you identified after the survey?

27. Have you done patient satisfaction on the private wing service?

1. Yes 2. No

Section 5: Income and expenditures of hospital private wing/room

1. What mechanisms do you use to set fees for services/decision-making process/ in the Private wing /room?

1. Assessed the price of private clinics and took intermediate price between the regular ward and the private clinics,
2. Simply added a certain percent on the regular ward price
3. Other: Specify_____

2. Have you revised the price of services for private wing?

1. Yes 2. No

3. If Yes to Q.2 why?

4. What were the increments in prices for each?

	Type of Service	Fee Rate in Birr		Remarks
		Initial Price	Increments	
4.1	Card/Consultation Fee			
4.2	Lab Test (List)			
4.3	Supplies and consumables (List)			
4.4	Bed per day			
4.5	Other (Specify)			

5. How do you collect revenue?

1. Printed own receipt
2. Use receipts issued by BOFED
3. Other specify: _____

6. If you are using your own printed receipt, who approved it?

1. RHB
2. BOFED
3. Board
4. Private wing committee (TAG)
5. Other specify: _____

7. Do you have models specific to the private wing to receive and take out commodities?

1. Yes 2. No

8. How big is the variation in fee/price rates between private wing/room and regular hospital ward?

	Type of Service	Fee Rate in Birr		Remarks: on difference between stated fee rates in Birr
		at Regular Hospital Ward	at Private Wing	
8.1	Card/Consultation Fee			
8.2	Lab Test:			
8.3	Supplies and consumables			
8.4	Bed per day			
8.5	Other (Specify): _____ _____			

9. How much was gross revenue, the total cost and net revenue of the private wing in 2006, 2007 and 2008 EFY?

No.	Year	Gross Revenue	Cost	Net Revenue	Remark
1	2006 EFY				
2	2007 EFY				
3	2008 EFY (up to the recent month)				

10. How did you determine the percentage share of revenue by type of staff?

1. It is included in the directive/private wing manual 1.Yes 2. No
2. After discussions with staffs of the hospital with the facilitation of the management committee and advisory committee for private wing. 1. Yes 2. No
3. Considered the experience of other hospitals 1.Yes 2. No
4. Other: Specify: _____

11. How is the net revenue shared between the hospital and staff (in %)?

1. Share of hospital (in %) _____

2. Share of staff (in %) _____

12. What is the total amount of Birr transferred to the regular ward since its establishment? For what purpose does the transferred money to the hospital used?

Amount in Birr: 2006 _____

2007 _____

2008 _____

13. What is the percentage share of revenue for each health facility staff after deducting the share of the hospital?

a) Specialists _____

b) General Practitioners _____

b) Nurses _____

c) Lab technicians/lab technologist _____

d) X-ray technicians _____

e) Radiologists _____

f) Pharmacists _____

g) CEO _____

h) Medical Director _____

i) Support staff _____

14. Have you opened a separate bank account for private wing?

1. Yes 2. No

15. Does the private wing have a separate accounting record/book from the regular ward?

1. Yes 2. No

16. Have you ever audited the private wing?

1. Yes 2. No

17. If Yes by whom:

1. Internal auditor of the hospital
2. External auditor
3. Both
4. Other: specify _____

Section 6 Availability and Use of Guidelines/Protocols, Standards and Formats

1. Are you aware of the private wing manual developed by the FMOH in collaboration with the HSRF project?

1. Yes 2. No

2. If No to Q 1, specify what type of manuals you are using? (More than one response possible)

1. Developed own manual
2. Use HCF directives
3. Adopted private wing manual issued by RHB
4. Other: specify _____

5. What is the mechanism for a private wing patient to be transferred to the regular patient? _____

6. Does the private wing has its own patient card or uses the regular ward cards? _____

7. If you are using a different patient card from the regular, how do you treat cases/ patients that use the regular and private wing on different dates? _____

8. Do you have protocols and SOPs (Standard Operational Procedures?)

1. Yes 2. No

9. If Yes. List down the protocols and SOPs

1. _____
2. _____
3. _____

Section 7 Staff Motivation

1. Do you think that the private wing has contributed to the retention and motivation of health professionals?

1. Yes 2. No

2. Which and how many health professionals have quitted working in private clinics after the opening of private wing?

3. Do you currently have health professionals working part time in other private clinics?

1. Yes 2. No

4. If Yes to Q3, are they also working in the private wing?

1. Yes 2. No

Why? _____

5. What is the number of health professionals who quitted two years before and after the start of private wing?

No.	Profession Type	No. of employees who quitted before the start of private wing		No. of employees who quitted after the start of private wing	
		Year 1	Year 2	Year 1	Year 2
1					
2					
3					
4					
5					

6. On average how much does a general practitioner, specialist, laboratory technician etc. earn working in your hospital from the regular ward and private wing separately per month?

No.	Position	Average monthly earning from regular ward (Include basic salary and over time)	Average monthly earning from private wing	Number of hours and days worked per month in the private wing
1	Specialists			
2	General Practitioners			
3	Nurses			
4	Lab technicians/lab technologist			
5	X-ray technicians			
6	Radiologists			
7	Pharmacists			
8	CEO			
9	Medical Director			
10	Support staff			

7. Do you think the income generated from private wing by the health professionals is sufficient for staff retention?

1. Yes 2. No

8. If No to Q.7, what other measures could be taken to retain more staffs _____

Thank You for your time!!

Questionnaire for Health Professional participating in the private wing

Section 1: Background Information

1. Hospital Name _____

Section 2: General Issues (Overall Questions)

1. For how many years have you worked relevant to your current position? _____

2. How long have you worked for this hospital? _____

3. Has the private wing contributed to staff retention?

a. Has/will have significant contribution.

b. It has some level of contribution.

c. No contribution

d. Don't know/early to judge

e. Other: specify _____

4. In your opinion what are the benefits of private wing to the staff of the hospital and to the public in general?

5. In your opinion what are the benefits of working in private wing as compared to private clinics in your spare time?

6. Do you intend to continue working in this hospital for the next three years?

1. Yes 2. No

7. If No why?

8. What challenges have you encountered so far while working in the private wing?

9. Do you have any comments regarding private wing in the hospital?

Section 2: Rating your job satisfaction before and after opening of private wing

1 not satisfied at all	2 somewhat satisfied	3 Satisfied	4 extremely satisfied
---	---	------------------------------	--

Some aspects of your job will directly be affected by the establishment of private wing using the scale above rate your level of satisfaction for the following aspects of your job both before and after the opening of private wing.

	RATE BEFORE STARTING OF PRIVATE WING	RATE AFTER STARTING OF PRIVATE WING	REMARK
GENERAL WORKING CONDITIONS	Please circle your responses		
Hours worked each week in the hospital	1 2 3 4	1 2 3 4	
Flexibility in work scheduling	1 2 3 4	1 2 3 4	
PAY AND PROMOTION POTENTIAL			
Total earning	1 2 3 4	1 2 3 4	
Recognition for work accomplished	1 2 3 4	1 2 3 4	
USE OF SKILLS AND ABILITIES			
Opportunity to utilize your skills and talents	1 2 3 4	1 2 3 4	
Opportunity to learn new skills	1 2 3 4	1 2 3 4	
WORK ACTIVITIES			
Variety of job responsibilities	1 2 3 4	1 2 3 4	
Degree of independence associated with your work roles	1 2 3 4	1 2 3 4	
AMENITIES, MEDICAL EQUIPMENTS AND SUPPLIES			
Availability of medical equipment	1 2 3 4	1 2 3 4	
Availability of drugs and medical supplies	1 2 3 4	1 2 3 4	
Infection control	1 2 3 4	1 2 3 4	
Facilities during night shift (food, bed etc.)	1 2 3 4	1 2 3 4	

Thank You for your time!!

Questionnaire for key informant

Section 1: Background Information

1. Hospital Name _____

Section 2: General Issues (Overall Questions)

1. What do you think is the benefits of the private wing/room in this hospital?
 - a. Increase client satisfaction by providing flexible service provision time for clients and providing the option of being seen by physician of their choice
1. Yes 2. No
 - b. Retain qualified staff by motivating health professionals through additional income.
1. Yes 2. No
 - c. Increase revenue for institutional improvement
1. Yes 2. No
 - d. Other: specify _____
 - e. Describe three major challenges encountered while implementing private wing/ room in this hospital.
a) _____
b) _____
c) _____
2. Do you collect customer views on the quality of your services in the private wing?
1. Yes 2. No
3. Do you think that clients are satisfied with the services of private wing?
1. Yes 2. No
4. In your opinion how is the private wing perceived by its clients and users of the hospital regular ward?

5. What risks have you identified in the implementation of private wing?

6. What kinds of differentiation in the quality of non-clinical services do you make?

Thank You for your time!!

Questionnaire for patients exiting from private wing

Section 1: Background Information

1. Hospital Name _____
2. Do you mind answering a few questions for our survey of private wing in the hospital?
 1. Yes
 2. No
3. Did you directly go to the private wing of the hospital?
 1. Yes
 2. No
4. If No who directed you to go to the private wing of the hospital?

5. Did you know about private wing before you come to the hospital?
 1. Yes
 2. No
6. If Yes to Q 5, how did you know about the private wing of the hospital?
 1. Read posted papers in the hospital.
 2. Heard from somebody else who used the service.
 3. Know about it from the media such as newspapers, radio or TV.
 4. Announcement of the hospital at public gatherings.
 5. Other: specify _____
7. Why do you choose private wing services over the regular ward today?
 1. I can get to be treated by a doctor of my own.
 2. The service is available off working hours.
 3. Less waiting time
 4. Other: specify _____
8. Why do you choose private wing over private clinics?
 1. It is cheaper.
 2. The quality of services is better.
 3. Less waiting time.
 4. Other: specify _____
9. Did the doctor prescribe you with drugs today?
 1. Yes
 2. No
10. If Yes to Q.9, were you able to get the drug(s) from the hospital's pharmacy?
 1. Yes
 2. No
11. Do you usually get prescribed drugs from the pharmacy?
 1. Never

- 2. Sometimes
- 3. Often
- 4. Always

12. If No to Q. 11, where do you buy prescribed drugs?

- 1. Private pharmacies.
- 2. Government owned pharmacies out of the hospital.
- 3. Other: specify _____

13. How much did you pay to get services from private wing?

- 1. For card/consultation: _____
- 2. For laboratory: _____
 - a. _____
 - b. _____
- 3. X-ray: _____
- 4. Other: specify _____

14. In your opinion, do you think that the price charged in the private wing is fair?

- 1. Yes
- 2. No

15. How much more do you have to pay in the private wing compared to the regular ward?

- 1. The same
- 2. 25% - 50% more
- 3. 50% - 100% more
- 4. More than 100% more

16. Did you find the physician/ specialist by whom you want to be seen?

- 1. Yes
- 2. No

17. Are you satisfied with the services of private wing?

- 1. Yes
- 2. No

18. If No to Q. 17, what should be done to improve the services?

19. Please rate your satisfaction

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. During this visit, nurses treated me with courtesy and respect.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. During this visit, nurses listened carefully to me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. During this visit, nurses explained things in a way I could understand.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. During this visit, doctors/health officers treated me with courtesy and respect.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. During this visit, doctors/health officers listened carefully to me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. During visit, doctors/health officers explained things in a way I could understand.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. I could distinguish between doctors/health officers and nurses.	1. Yes		2. No	
8. The outpatient department was clean.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. The bathrooms/latrines were clean (leave blank if not applicable).	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10. I was prescribed new medication at this visit.	1. Yes		2. No	
11. It was easy for me to find my way around the facility.	1. Yes		2. No	
12. On a scale of 0-10 (0 being the worst facility, 10 being the best facility), I would you rate this health facility a:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 0 1 2 3 4 5 6 7 8 9 10 Worst.....Best			
13. I would recommend this private wing to my friends and family.	1 <input type="checkbox"/> Definitely No	2 <input type="checkbox"/> Probably No	3 <input type="checkbox"/> Probably Yes	4 <input type="checkbox"/> Definitely Yes

Thank You for your time!!

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. During this visit, nurses treated me with courtesy and respect.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. During this visit, nurses listened carefully to me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. During this visit, nurses explained things in a way I could understand.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. During this visit, doctors/health officers treated me with courtesy and respect.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. During this visit, doctors/health officers listened carefully to me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. During visit, doctors/health officers explained things in a way I could understand.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. I could distinguish between doctors/health officers and nurses.	1. Yes		2. No	
8. The outpatient department was clean.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. The bathrooms/latrines were clean (leave blank if not applicable).	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10. I was prescribed new medication at this visit.	1. Yes		2. No	
11. It was easy for me to find my way around the facility.	1. Yes		2. No	
12. On a scale of 0-10 (0 being the worst facility, 10 being the best facility), I would you rate this health facility a:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 0 1 2 3 4 5 6 7 8 9 10 Worst.....Best			
13. I would recommend this private wing to my friends and family.	1 <input type="checkbox"/> Definitely No	2 <input type="checkbox"/> Probably No	3 <input type="checkbox"/> Probably Yes	4 <input type="checkbox"/> Definitely Yes

Thank You for your time!!

በሕዝብ ሆስፒታሎች ውስጥ በሚገኙ የግል ሕክምና መስጫ ዘርፍ ተጠቃሚ ታካሚ ዎች የተዘጋጀ መጠይቅ

ክፍል አንድ

1. የሆስፒታሉ ስም _____

2. በግል ሕክምና መስጫ ዘርፍ ላይ የሚኖሩ ንግድ ተቀባይ ዎች ለመመለስ ፍቃድ ያደኛኑዎት?

- 1. አዎን
- 2. አይደለም

3. ወደ ግል ሕክምና መስጫ ዘርፍ የሄዱት በራስዎ ነው?

- 1. አዎን
- 2. አይደለም

4. መልስዎ አይደለም ከሆነ ወደ ግል ሕክምና መስጫ ዘርፍ እንዴት መጡ?

5. ወደ ሆስፒታሉ ከመምጣት ዎ በፊት የግል ሕክምና ዘርፍ ስለመኖሩ ያውቁኑበር?

- 1. አዎን
- 2. አይደለም

6. በጥያቄ ጥርፍ ላይ መልስዎ አዎን ከሆነ የግል ሕክምና ዘርፍ ስለመኖሩ እንዴት አወቁ?

- ሀ. በሆስፒታሉ ከተለጠፉ ማስታወቂያዎች
- ለ. የአገልግሎት ተጠቃሚ ከሆነ ሌላ ግለሰብ
- ሐ. ከጋዜጣ፣ ከቴሌቪዥን፣ ከራዲዮ
- መ. ሆስፒታሉ በሕዝብ መሰብሰቢያ ዎች ባደረገው ማስታወቂያ

ሠ.

ሌላ _____

7. በሆስፒታሉ ከሚገኘው መደበኛ አገልግሎት ይልቅ በግል ሕክምና መስጫ ዘርፉ መታከሙን ለምን መረጡት?

ሀ. በራሴ የሐኪም ምርጫ መታከም ስለምችል

ለ. ከሥራ ሰዓት ውጭ አገልግሎቱን ማግኘት ስለምችል

ሐ. የመጠበቂያ ሰዓቱ አነስተኛ ስለሆነ

መ. ሌላ _____

8. በሆስፒታሉ የሚገኘውን የግል ሕክምና መስጫ ዘርፍ በውጭ ከሚገኙ የግል ክሊኒኮች እንዴት መረጡት?

ሀ. ዋጋው አነስተኛነው

ለ. የአገልግሎት ጥራቱ የተሻለነው

ሐ. የጥበቃ ጊዜው አነስተኛነው

መ. ሌላ _____

9. ዛሬ ወደ ደክተር ሰራተኛዎች መድኃኒት ታዘልዎታል?

1. አዎን

2. አይደለም

10. ለጥያቄ ቁጥር 9

መልስዎ አዎን ከሆነ በሆስፒታሉ ውስጥ ከሚገኘው የመድኃኒት መደብር መድኃኒቱን ማግኘት ችለዋል?

1. አዎን

2. አይደለም

11. በሆስፒታሉ የመድኃኒት መደብር ውስጥ መድኃኒት ሁል ጊዜ ያገኛሉ?

ሀ. በፍጹም

ለ. አንዳንድ ጊዜ

ሐ. ሁልጊዜ

12. በጥያቄቁጥር11 ላይ መልስዎ አላገኝም ከሆነ የታዘዘልዎትን መድኃኒት ከየት ያገኛሉ?

ሀ. ከግል መድኃኒት ቤቶች

ለ. ከሆስፒታሉ ውጭ ከሚገኙ የመንግሥት መድኃኒት ቤቶች

ሐ. ሌላ _____

13. በሆስፒታሉ ውስጥ ከሚገኘው የግል ሕክምና ዘርፍ አገልግሎት ለማግኘት ምን ያህል ይከፍላሉ?

ሀ. ለካርድ _____

ለ. ለላቦራቶሪ _____

1 _____

2 _____

3 _____

4 _____

ሐ. ኤክስሬይ _____

መ. ሌላ ካለ ይግለጹ _____

14.

በእርስዎ ላብ በሆስፒታሉ ውስጥ በሚገኘው የሕክምና ዘርፍ የሚጠየቁት የሕክምና ጋተ መጣጣኝነው ይላሉ?

1. አዎን

2. አይደለም

15. ከመደበኛው አገልግሎት አንጻር በግል ሕክምና ዘርፍ የሚከፈሉት ክፍያ

ሀ. አንድ አይነት ነው

ለ. ከ25 እስከ50 በመቶ ብልጫ አለው

ሐ. ከ50 እስከ መቶ በመቶ ብልጫ አለው

መ. ከመቶ በመቶ በላይ ብልጫ አለው

16. የሚፈልጉትን የሕክምና ባለሙያ አግኝተዋል?

1. አዎን

2. አይደለም

17. በግል ሕክምና ዘርፍ ባገኙት አገልግሎት ረክተዋል?

1. አዎን

2. አይደለም

18. ለጥያቄቁጥር17 መልስዎ አይደለም ከሆነ አገልግሎቱን ለማሻሻል ምን መደረግ አለበት ይላሉ?

19. የአገልግሎት እርካታ ዎንብ ለውሰን ጠረጴዳው ስጥ ያመልክቱ።

	በፍጹም አልሰማም	አልሰማምም	እሰማለሁ	በእርግጠኛነት እሰማለሁ
1. በሕንጻው ውስጥ ነርሶች በአገልግሎት ሰጪዎች አስተናገድ ውስጥ ናቸው።	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. በሕንጻው ውስጥ ነርሶች በጥሩ አገልግሎት ይሰጣሉ።	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. በሕንጻው ውስጥ ነርሶች ሁኔታዎች ለእኔ በሚገባ መልኩ አስረድተውኛል።	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. በሕንጻው ውስጥ ሐኪሞች የጤና መሪዎች በትህትና በአገልግሎት አስተናገድ ውስጥ ናቸው።	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. በሕንጻው ውስጥ ሐኪሞች የጤና መሪዎች በጥሩ አገልግሎት ይሰጣሉ።	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. በሕንጻው ውስጥ ሐኪሞች የጤና መሪዎች ሁኔታዎች ለእኔ በሚገባ መልኩ አስረድተውኛል።	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. ሐኪሞች የጤና መሪዎችን ነርሶችን በሚገባ አለያለሁ	1. አዎ 2. አይደለም			
8. የተመሳሳይ ሕንጻዎች ገንዘብና ጥራት በሚገባ የተጠበቀ ነው።	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. የመታጠቢያ ቤቶች ገንዘብና ጥራት፣ የማይመለከት ምንም ዓይነት ጥያቄዎችን ይዘላለት/	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10. በዚህ ሕንጻው ውስጥ አዳስ መድኃኒት ታዘልኛል	1. አዎ 2. አይደለም			
11. በሆስፒታሉ ውስጥ ያለውን ችግር መዘዋወር ችያለሁ	1. አዎ 2. አይደለም			
12. ከ0-10 ባለው ምደባ በጣም መጥፎ የሕንጻው ተቋም፣ 10 እጅግ በጣም ጥሩ የሕንጻው ተቋም ነው/ እርስዎ ይህን የሕንጻው ተቋም በስንተኛው ተራ ቁጥር ይመድቡታል?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 በጣም መጥፎ እጅግ በጣም ጥሩ			
13. ይህንን የጤና ተቋም ለገደቆች ለሌሎች ለመስጠት ይጠቀማሉ?	1 <input type="checkbox"/> በፍጹም አልጠቀምም	2 <input type="checkbox"/> ላልጠቀም እችላለሁ	3 <input type="checkbox"/> ልጠቀም እችላለሁ	4 <input type="checkbox"/> በእርግጠኛነት እጠቀማለሁ

አመሰግናለሁ!!