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**ASSESSMENT OF *THE* MINISTRY
OF HEALTH GUIDELINES FOR
LICENSING PRIVATE CLINICS**

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ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival
ENT	Ear, Nose, Throat
HSDP	Health Sector Development Program
IV	Intravenous [fluid]
MOH	Ministry of Health
NGO	Nongovernmental Organization
OPD	Outpatient Department
RHB	Regional Health Bureau
SNNPR	Southern Nations and nationalities People's Region
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The main purpose of the *MOH Guidelines for Licensing Private Clinics* (heretofore referred as *Guidelines*) is to serve as a regulatory mechanism regarding provision of health services in the private sector at the regional level. Specifically, the *Guidelines* aim to protect both consumers and private providers, control the quality and quantity of care provided, and clarify the role of the MOH, Investment Authority, and Regional Health Bureaus (RHBS) in licensing private health institutions.

The *Guidelines* outline requirements for licensing higher, medium, small, and special clinics for each region according to building, medical equipment, pharmaceutical, and manpower specifications, in addition to the obligations and responsibilities of private owners. The *Guidelines* were developed by a multi-disciplinary team in 1994/95 and were issued to the Regional Health Bureaus in 1995.

The objectives of this assessment were to evaluate the implementation of the *Guidelines*, determine the size and assess the development of the private sector, and evaluate the perceived quality of care provided by licensed private practitioners. The Ministry of Health (MOH), with the support of the BASICS project, undertook the study in eight regions that included Tigray, Amhara, Oromia SNNPR, Harari, Dire Dawa, and Addis Ababa.

Data were collected from each RHB, a sample of private providers, and a sample of patients, using pre-tested questionnaires. The person responsible for licensing private clinics was requested to complete the RHB questionnaire in collaboration with the RHB head. Ten private providers were selected purposively in collaboration with the RHB, and owners of private establishments were the primary respondents for this survey. Within each private establishment, approximately five patients were selected randomly for interview.

This assessment resulted in useful information on the implementation and application of the *Guidelines* at the regional level. The major findings of the assessment are as follows:

Regional Health Bureaus

- The number of private clinics per 100,000 population varies by region, from a low of 0.64 in the SNNPR, to a high of 12.9 in Addis Ababa.
- Approximately 50 percent of health professionals working in private clinics do not have government release papers. Many practitioners are working on a part-time basis, for which there are no regulations.
- Supervision and monitoring of licensed private providers are weak and need to be improved by allocating more personnel to these functions at the regional or zonal level.

- Complaints have been received from the public about the quality of services provided by private practitioners, including high fees, unnecessary investigations, and prescriptions
- Recordkeeping regarding the number and source of applications received is weak. An improved system needs to be established in all regions

Private Providers

- Specialists were found working in medium and small clinics, which is a practice that contradicts the recommendations of the *Guidelines*
- Some of the sample of private providers had difficulty obtaining a license, this problem was more common for medium clinics. Excessive waiting time between the submission of the application and the appointment for inspection was mentioned, as well as the high cost of meeting all of the requirements
- Contrary to regulations, 41 percent of clinics did not display their license and 59 percent did not display their fee schedules. These findings suggest that greater monitoring and supervision from either the Regional Health Bureau or the zonal level is required
- All clinics provide basic curative services and many offer minor surgical care. However, very few facilities in the sample provided essential preventive services, such as immunizations, antenatal care, and family planning. This represents a missed opportunity to get the private sector involved in major public health priorities under the Health Sector Development Program (HSDP)
- Activity levels of some private providers appear low, which raises questions about the location/placement of the facility, the quality of care being provided, and the need for another health facility in the area. This aspect needs to be investigated more thoroughly
- Many clinics were in violation of the recommendations of the *Guidelines* with respect to the number of beds authorized in each clinic
- Complaints were received from the public in 44 percent of the facilities sampled, complaints that ranged from poor quality of care to lack of drugs to long waiting times. These complaints need to be addressed and followed up by the RHB. The *Guidelines* should include recommendations on how to proceed in cases of complaints or malpractice

Patients

- Patient interviews revealed that patients generally have a good opinion of their private providers and would come back for further treatment. Female patients tended to be more

critical of the service they received than were male patients. Patients rated private clinics as having a slightly higher quality of care than public facilities.

- Patients in the sample tended to seek care from private facilities first. The majority chose to visit private clinics (53%), followed by public hospitals (27%). In Tigray, Amhara, Addis Ababa, and Harari regions, patients preferred public hospitals to private clinics, however, in Oromia, SNNPR, and Dire Dawa, patients choose private clinics first.
- For the most part, patients felt that fees were commensurate with the service given, however, in Tigray, this figure was reduced to 60 percent.
- Patients identified less waiting time (35%) and better treatment (23%) as factors that differentiate private facilities from public ones.

There was a consensus that the *Guidelines* need to be revised. The main suggestions are reported below.

- With regard to manpower requirements, Regulations and guidance on part-time workers and on staffing patterns in general and specialty clinics in particular need to be addressed.
- With regard to medical equipment, Guidance on proper disposal, updating and upgrading of equipment, and preferred sources of procurement of equipment need to be addressed. In addition, there were many recommendations to prioritize and revise the current list of equipment to be more in line with local conditions and public health facilities.
- With respect to buildings and facilities, there was an overwhelming consensus among private providers and RHBs that the standards are difficult to meet, particularly when buildings are rented. The suggestion to revise the *Guidelines* to include minimum standards and conditions of facilities and to leave the details to a particular region or provider is a good one. The *Guidelines* should consider regulations regarding the location of a private practice, such as environmental conditions, presence or absence of other health care providers (public and private), and proximity to bars, restaurants, music halls, etc.
- With regard to pharmaceuticals and drugs, the *Guidelines* need to consider recommendations on drugs for emergency situations, address preferred sources for procuring pharmaceuticals, and revise and strengthen the list of drugs that different clinics can dispense.
- With respect to obligations and responsibilities, revision of the *Guidelines* needs to take into account moral and ethical responsibilities of private providers, perhaps by building on those outlined by the Ethiopian Medical Association. Procedures for legal action in response to complaints and malpractice need to be stated in the *Guidelines*.

- Finally, RBHs and private practitioners provided some useful recommendations for strengthening public-private partnerships with regard to health care provision. These include—
 - Encouragement by Regional Health Bureaus for private sector practitioners to offer preventive services, such as family planning and immunization
 - Integration of private providers into a national referral system, including use of epidemiological information from private providers into the public health statistics
 - Upgrading of skills and continuing education of private practitioners by the public sector
 - Inter-sectoral collaboration among the Regional Health Bureaus, central Ministry of Health, Investment Authority, Trade, municipalities, Ethiopian Medical Association, and others

1 INTRODUCTION

Ethiopia came into contact with modern medicine towards the end of 19th century. Since then, Ethiopia has experienced a number of political, cultural, social and economic changes. Different health policies were formulated and the Ministry of Health (MOH) was responsible for organizing, administering, and monitoring the provision of health services.

Due to budgetary constraints, the MOH was not in a position to fulfill the increasing health demands of the population. Nongovernmental organizations (NGOs) were viewed as a resource to fill the gap between available health services and health needs. To strengthen the health system and provide adequate health care for a growing population, the development of the private sector became an important arena. However, until 1990, lack of a documented policy regarding private sector participation held up progress in this domain.

In 1990, the government implemented a restructuring and adjustment program in line with the new economic policy directive that made development of the private sector a priority in the health reform. Incorporated in this policy is the promotion and participation of the private sector and NGOs in the health care delivery.

Therefore, in accordance with the power and responsibilities set forth in Proclamation No. 4/95 and Regulation No. 174/1994, the MOH issued a set of *Guidelines* that encourages the participation of domestic and foreign investors, as well as national and international organizations in the health sector.

A three-day workshop was conducted in December 1994 in Nazareth to discuss and clarify the draft *Guidelines*. Participants in this workshop included heads of RHBS, experts in private health institutions, representatives from the Investment Authority, and other concerned authorities. The workshop participants shared constructive ideas and experiences and contributed to the enrichment and strengthening of the *Guidelines*.

A multi-disciplinary team composed of a physician, radiologist, pharmacist, nurse, medical laboratory technologist, environmental health expert, structural engineer, and an economist developed the *Guidelines*. The draft *Guidelines* were submitted and approved by the Policy Committee of the Ministry of Health before being forwarded to the regions in June 1995 for implementation.

1.1 Purpose of the *Guidelines*

The main purpose of the *Guidelines* is to serve as a regulatory mechanism regarding provision of health services in the private sector. Specifically, the *Guidelines* aim to protect both consumers and private providers, control the quality and quantity of care provided, and clarify the role of the MOH, Investment Authority, and Regional Health Bureaus in the licensing of private health institutions.

1.2 Description of the *Guidelines*

The *Guidelines* outline requirements for licensing higher, medium, small, and special clinics for each region.¹ An individual who has obtained the proper release from government work can submit an application for licensing of a particular type of clinic, which must meet the requirements outlined in the *Guidelines* (and in Regulation 174/1994) with respect to the type of facility (dimensions and quality of construction), medical equipment, manpower and staffing, and drug supply. A temporary license is usually issued prior to actual inspection for a license. Once an application has been filed with the RHB, an appointment for inspection along the requirements outlined in the *Guidelines* is set up.

The *Guidelines* and Regulation 174/1994 also provide information about the issuance and renewal of licenses, suspension and cancellation of licenses, and permits for expansion and reconstruction. In addition, the Regional Health Bureaus are required to inspect licensed institutions in order to ensure that the facility remains in good operating order. Licenses must be renewed yearly within the first three months of the fiscal year (by the end of September).

Table 1 provides some information on the different characteristics of each type of clinic. A special clinic provides specialty care, such as Ob/Gyn, dental, ENT, or dermatology, and is operated by a specialist.

Table 1 Comparison of Clinics for Licensing by Type

Type of Clinic	Owner/Licensee	Staffing	Beds	Drugs
Higher	Specialist	Specialists, laboratory technicians, X-ray technicians, nurses, other staff	Up to 5	Limited list
Medium	General Practitioner or Health Officer	GP, laboratory technicians, nurses, other staff	0	Limited list
Small	Nurse or Health Assistant	Nurse, health assistant, experienced workers	0	Limited list

Fees are charged for obtaining and renewing a license for a private clinic, as well as for expanding the current facility (see Table 2).

Table 2 Licensing Fees (in Birr)

Type of Clinic	Licensing Fee	Renewal Fee	Expansion Fee
Higher	400	200	200
Medium	300	150	150
Small	200	100	100

¹ Licensing of private hospitals is the domain of the central Ministry of Health.

2 METHODOLOGY OF THE ASSESSMENT

In order to assess the implementation of the *MOH Guidelines for Licensing Private Clinics*, the Ministry of Health with the support of the BASICS project undertook a study in eight regions Tigray, Amhara, Oromia, SNNPR, Harari, Diredawa, Benishangul-Gumuz, and Addis Ababa. However, because of time constraints and transportation difficulties, it was not possible to conduct the assessment in Benishangul-Gumuz²

The objectives of the assessment were to evaluate the implementation of the *MOH Guidelines*, determine the size and assess the development of the private sector, and evaluate the perceived quality of care provided by licensed private practitioners³

Data were collected from each RHB, a sample of private providers, and a sample of patients, using pre-tested questionnaires. Annexes 1-3 contain copies of each of the questionnaires developed for this study. The person responsible for licensing private clinics was requested to complete the RHB questionnaire in collaboration with the RHB head. Ten private providers were selected purposively in collaboration with the RHB. Owners of private establishments were the primary respondents for this survey. Within each private establishment, approximately five patients were selected randomly for interview.

Two teams of two MOH experts conducted the assessment between May 3 and June 6, 1998. Team 1 visited Tigray, Amhara, and Addis Ababa. Team 2 surveyed Oromia, SNNPR, Harari and Dire Dawa. Annex 4 provides further details of the zones that were included in the assessment.

The assessment focused on an analysis of the implementation experience of the main aspects of the *Guidelines*, but is by no means an exhaustive review of the private sector. The assessment did not evaluate the financial records of private providers, in large part because of the sensitivity of performing this type of assessment.

3 RESULTS AT THE REGIONAL HEALTH BUREAU LEVEL

At the regional level, the study was interested to know the total number and type of private practitioners currently registered with the Regional Health Bureau, as well as staffing in private facilities and information on the licensing process. Usually the person responsible for licensing at

² Other regions, such as Somali, Afar, and Gambella were not considered for the assessment as the number of licensed private clinics was thought to be limited.

³ This assessment was conducted at the present time because of a request from the Ministry of Health in an ESHE Steering Committee meeting, Debre Zeit in 1996. Fulfillment of this request was delayed due to changes in leadership in the Health Services and Training Department and placement of the BASICS health care financing advisor in late September 1997.

the RHB completed the Health Bureau questionnaires. The study team felt that the quality and reliability of some of the information provided was limited. Many regions were unable to complete the survey forms, which led to missing and incomplete information on licensing statistics.

3.1 Scope of Private Clinics

Table 3 illustrates the number of private practitioners currently operating in each region by type of facility. A total of 803 licensed private clinics are operating in the 7 regions included in the study. Small clinics account for 64 percent of all licensed clinics, followed by medium clinics (20%) and higher clinics (16%). Addis Ababa accounts for the majority of private providers in the sample regions (37%), followed by Oromia (31%) and Amhara (15%).

The number of clinics per 100,000 population also was estimated for each region in the study.⁴ The SNNPR had the lowest clinic to population ratio (0.64/100,000 population) and Addis Ababa had the highest (12.9/100,000). The overall estimate for the seven regions was 1.5 clinics per 100,000 population. These data suggest an extreme, but not surprising, urban bias in the supply of private clinics.

Table 3 Number of Private Clinics Currently Operating by Region

Region	Higher Clinic	Medium Clinic	Small Clinic	Total	Clinics/100,000 Population
Tigray	12	12	4	28	0.83
Amhara	3	15	105	123	0.83
Oromia	9	27	223	259	1.29
SNNPR	5	15	51	71	0.64
Addis Ababa ⁵	95	82	122	299	12.92
Harari	-	4	5	9	6.32
Dire Dawa	2	7	5	14	5.1
Total	83	162	514	803	1.54

The reported number of health professionals granted a license to operate a private clinic in the seven selected regions is presented in Table 4. Health assistants received licenses in greater proportion than other health professionals (52%), followed by nurses (44.6%), and general practitioners (21.6%). Addis Ababa granted the greatest number of licenses to health professionals (37%).

⁴ Population figures from the Federal Democratic Republic of Ethiopia, Ministry of Health, Health and Health Related Indicators, Health Information Processing & Documentation Team, Planning and Project Department, January 1998.

⁵ Of the 95 higher clinics in Addis Ababa, 44 are special clinics.

Table 4 Total Number of Health Professionals Granted a Private License

Region	Specialist	GP	HO	Nurse	HA	LT	XT	Total
Tigray	13	9	0	0	2	2	0	26
Amhara	2	17	-	53	50	1	-	123
Oromia ⁶								259
SNNPR	4	15	2	20	30			71
Addis Ababa	64	90	19	32	90	2	-	297
Harari	3	-	-	3	2	-	-	8
Dire Dawa	-	4	2	5	2	4	-	17
Total ⁷	95	173	24	357	420	42	1	801

Note GP= General Practitioner, HO =Health Officer, HA = Health Assistant, LT = Laboratory Technician, XT = X-ray Technician

In Table 5, the number of health professionals working in licensed clinics is reported for the sample of clinics in the study. There are a total of 2,43 health professionals per 100,000 population working in any licensed private clinic. Health assistants are the most common professionals working in licensed facilities, followed by laboratory technicians. Addis Ababa has the greatest number of health professionals working in licensed private clinics. The number of professionals working in private clinics has implications for potential drain on available manpower in the public sector.

Finally, these results suggest that private clinics are run, in large part, by health assistants who may not have sufficient training to treat the range of patients coming to a particular clinic. This raises the issue of whether quality of care is affected by whom is granted a license according to the *Guidelines*.

Table 5 Total Number of Health Professionals Working in Any Licensed Facility

Region	Specialist	GP	HO	Nurse	HA	LT	XT	Total
Tigray	-	2	-	-	-	-	-	2
Amhara	2	20	-	-	-	15	3	40
Oromia ⁸	-	-	-	-	-	-	-	311
SNNPR	4	21	2	26	100	23	2	178
Addis Ababa	46	86	6	120	281	154	11	704
Harari	4	3	-	-	6	4	-	17
Dire Dawa	-	1	-	2	7	-	-	10
Total	56	133	8	148	394	196	16	1,262

Note GP= General Practitioner, HO =Health Officer, HA = Health Assistant, LT = Laboratory Technician, XT = X-ray Technician

⁶ Data by type of clinic for Oromia were merged with information on the number of health professionals working in licensed facilities (Table 5)

⁷ The total number does not add to 803 as in Table 3 because of reporting errors

⁸ Data were available only in aggregate form for Oromia Region

Table 6 reports the total number of health professionals working in any private clinic, whether the clinic was licensed or not. This figure is nearly two times the number of professionals working in licensed facilities and suggests that regulation of health professionals working in the private sector is not very effective at the regional level. Comparison with the number of personnel working in public facilities would provide additional, interesting results, but is not performed here.

Table 6 Total Number of Health Professionals Working in Private Clinics

Region	Specialist	GP	HO	Nurse	HA	LT	XT	Total
Tigray	13	11	-	-	2	2	-	28
Amhara	4	37	-	53	50	16	3	163
Oromia	9	38	1	244	244	38	1	570
SNNPR	8	136	4	46	130	23	2	249
Addis Ababa	110	176	25	152	371	156	11	1,001
Harari	7	3	-	3	8	4	-	25
Dire Dawa	-	5	2	7	9	4	-	27
Total	151	306	32	505	814	238	6	2,063

Note GP= General Practitioner, HO =Health Officer, HA = Health Assistant, LT = Laboratory Technician, XT = X-ray Technician

In addition to the number of facilities and staffing patterns, the study collected data on the number of government health professionals working part time in private facilities without a release paper. The proportion of professionals ranged from 98 percent in Tigray, 50 percent in Addis Ababa and Dire Dawa, and 3 percent in Harari Region. These figures, while indicative, suggest that there is widespread leakage between the public and private sectors with regard to employment on a part-time basis. The current *Guidelines* do not provide regulations regarding part-time workers. It is clear that more regulatory efforts are needed with respect to part-time employment.

3.2 Licensing Process

Information on the number of license applications received at the RHB and the number granted were collected on the survey form. Unfortunately, this information was not available for many regions, despite its importance in monitoring licensing activity at the RHB. The study was unable to determine the proportion of clinics licensed as a function of the number of applications. It is recommended that this information begin to be routinely maintained by the person responsible for licensing at the RHB.

Table 7 Applications Received and Licenses Granted at RHBs

Region	Application Received	License Granted
Tigray	24	Unknown
Amhara	Unknown	Unknown
Oromia	Unknown	Unknown
SNNPR	71	71
Addis Ababa	Unknown	Unknown
Harari	7	7
Dire Dawa	7	7

3.3 Supervision

After licensing, RHBs are required to monitor and supervise private facilities. Regional Health Bureaus prepare a checklist during supervision visits, and evaluate such aspects as staffing, functioning of medical equipment, sanitation, and the condition of the facility.

For this study, questions were asked regarding the frequency of supervision between October 1, 1997 and March 30, 1998 by RHB staff. Table 8 illustrates the results. We can see that the reported frequency of supervision of higher clinics is low (13% of all licensed clinics), whereas supervision of small clinics is more frequent (67%), perhaps because they are easier to supervise. Data were not available for all RHBs, limiting any conclusions that can be drawn from these figures. Facilities also may be supervised by Zonal Health Departments.

Table 8 Supervision of Private Facilities

Region	Higher Clinic	Medium Clinic	Small Clinic	Total
Tigray	0	0	0	0
Amhara	3	15	105	123
Oromia		6	32	38
SNNPR	4	2	16	22
Addis Ababa	2	2	2	6
Harari		2	2	4
Dire Dawa	2	7	4	13
Total Supervision	11	34	161	206
Total Licensed Facilities	83	162	514	759
Proportion Supervised	13%	21%	67%	27%

3.4 Complaints Received

Regional Health Bureaus have received some complaints regarding private institutions, usually with regard to high fee schedules and a penchant for unnecessary investigations. Other complaints include too little time spent with patients, incorrect diagnosis and treatment, unnecessary prescriptions, unethical and illegal functioning of clinics, and poor quality of services.

Private providers complain about the need for government release papers to work in a private institution, even as a part-time worker in their spare time

3 5 Suggestions for Improving the *Guidelines*

All of the RHBs found the *Guidelines* useful for their work in licensing, renewing licenses, and supervision. However, many comments were received on how the contents of the *Guidelines* could be improved. Below is a summary of these comments.

A Manpower

All of the RHBs felt that manpower requirements outlined in the *Guidelines* need to be reviewed and updated. Below are some of the suggestions provided.

- The number of and types of manpower are not clearly differentiated between each type of health institution.
- The staff for medium clinics is not enough.
- Standards for specialties should be established, particularly for urban areas.
- In small clinics, it may be sufficient to have one nurse and a health assistant to operate the clinic.
- Part-time employment of government workers should be addressed.

B Medical equipment

Most of the RHBs had suggestions to make regarding the type of medical equipment that needs to be included for a specific type of clinic.

- Ultrasound machines should be required in higher clinics as part of the X-ray department.
- An autoclave should be required equipment in small clinics.
- The approved sources of medical equipment should be specified in the *Guidelines* in order to ensure high quality, functioning equipment.
- The list of medical equipment should be prioritized and revised along the basis of the services and functions of individual clinics.

C Building and facility

Suggestions for improving the facility standards outlined in the *Guidelines* are as follows

- The building standards for special clinics are uniform and should be specific to the services they deliver and their staffing patterns. There is need for greater flexibility in the standards for special clinics
- A range of specifications should be developed for each type of clinic (e.g., a minimum and a maximum standard)
- Because most clinics operate in rented facilities, it is difficult to achieve the standards set forth in the *Guidelines*. There needs to be more flexibility in this area
- The size requirements for some rooms are difficult to meet and should be revised
- Facility standards should include some guidance on location of a site with regard to the number of other providers, population served, and environmental conditions (health hazards)

D Pharmaceuticals and drugs

With regards to pharmaceuticals and drugs for each type of clinic, the RHBs felt that the type of drugs to be supplied by each type of clinic is not clearly differentiated. The preferred source of drugs is not identified. The pharmaceuticals list must be revised, and IV solution must be included in the list

E Obligations and responsibilities

With respect to the obligations and responsibilities of private sector professionals outlined in the *Guidelines*, the RHBs had these comments

- While the *Guidelines* clearly state the obligations and responsibilities, they are difficult to enforce due to the lack of legal procedures
- The section on obligations and responsibilities should include ethical and moral responsibilities that private providers must follow
- Clarification regarding liabilities needs to be included in the *Guidelines*

3 6 Additional Information That Should Be Included in the *Guidelines*

- The *Guidelines* do not explain what should be done with a previous license if the owner wishes to upgrade from one type of clinic to another
- There are no *Guidelines* regarding a family health clinic
- The requirement of release papers for all staff working in private clinics needs to be reviewed, given the shortage of manpower that exists in the government sector. The five-year service requirement should be reviewed
- The standards of private clinics should be similar to public health institutions, and private institutions should be integrated within the referral system. The referral system between private clinics and government hospitals needs to be clearly stated. The use of information from private clinic activity reports should be defined clearly
- There needs to be clear statements regarding the fees for issuing and renewing licenses. Legal procedures and payments for liabilities need to be included
- The *Guidelines* should include information about how to relate with other sectors, such as trades and municipalities, with respect to licensing

3 7 Additional *Guidelines* Requested by the RHBs

Regional Health Bureaus would like additional guidelines on the licensing of radiological units, family health clinics, private health centers, NGO clinics, colleges, and companies. One region suggested that it be able to modify the national *Guidelines* to its own needs.

4 HEALTH FACILITY RESULTS

The assessment included a survey of private clinics in order to discover their experiences regarding the application of the *Guidelines* to their licensing process. In general, 10 private health facilities were surveyed in each participating region, with the exception of the Harari Region, in which only 8 facilities were visited. Facilities were selected purposively in collaboration with Regional Health Bureaus. A total of 68 interviews were conducted. Annex 2 contains a copy of the questionnaire used at the facility level. Questions were asked about staffing, the licensing procedure, types of services provided, and patient load. Respondents, usually the owner of the facility, were asked for their suggestions and opinions about how to improve the *Guidelines*.

4.1 Sample of Facilities

Table 9 illustrates the distribution of clinics selected for the survey by region. Most of the facilities were medium clinics (47.6%), followed by higher clinics (27%).

Table 9 Distribution of Private Clinics in the Sample

Region	Higher	Medium	Small	Special	Total
Tigray	6	2	2	0	10
Amhara	1	5	3	1	10
Oromia ¹	1	7	1	0	9
SNNPR ¹	5	4	0	0	9
Addis Ababa	2	3	3	2	10
Harari ¹	0	5	2	0	7
Dire Dawa ¹	2	4	2	0	8
Total	17	30	13	3	63

4.2 Staffing Patterns

Two hundred and fourteen staff worked in the 63 sample clinics. Higher clinics had 82 staff working in them, medium clinics, 101 staff, and small clinics, 25 staff. Table 10 summarizes the staffing patterns by type of clinic in the survey.

All types of clinics had specialists working in them: 94 percent of higher clinics, 27 percent of medium clinics, and 8 percent of small clinics. These figures contradict the regulations outlined in the *Guidelines*, in which specialists can only work in higher clinics.

Laboratory technicians worked in 94 percent of higher clinics, 93 percent of medium clinics, and 15 percent of small clinics. X-ray technicians were present in only 29 percent of higher clinics and 10 percent of medium clinics, so that few of the clinics in the sample were able to provide radiological diagnostic facilities.

Table 10 Staffing Patterns in Sample Private Clinics

Type of Staff	Higher (N=17)	Medium (N=30)	Small (N=13)	Total
Specialist	94 1%	26 7%	7 7%	28
General Practitioner	82 4%	70%	-	35
Health Officer	5 9%	6 7%	7 7%	4
Nurse	94 1%	43 3%	53 8%	36
Health Assistant	76 5%	86 7%	100%	54
Laboratory Technician	94 1%	93 3%	15 4%	46
X-ray Technician	29 4%	10%	-	8
Dental Technician	5 9%	-	-	1
Midwife	-	-	-	1
Experienced Worker	-	-	7 7%	1
Total	82	101	25	214

Table 11 below illustrates the average number of staff by type of facility. In the sample analyzed for the survey, an average of 1.25 specialists were found in both higher and medium clinics and an average of 2 specialists were found in the sample of small clinics. These results contradict the regulations found in the *Guidelines*, which specify that specialists may only work in higher clinics.

Table 11 Average Number of Staff per Private Clinic in the Sample

Type of Staff	Higher (16)	Medium (30)	Small (13)	Special (3)	Average (63)
Specialist	1.25	1.25	2	1	1.25
General Practitioner	1.5	1.19	-	-	1.31
Health Officer	1	1	1	-	1
Nurse	1.19	1.15	1.14	-	1.17
Health Assistant	2.31	1.42	1.15	1.5	1.57
Laboratory Technician	1.31	1.11	1	-	1.17
X-ray Technician	1.2	1	-	-	1.13
Dental Technician	1	-	-	-	1
Midwife	-	-	-	1	1
Experienced Worker	-	-	1	-	1

4.3 Licensing Procedures

While most practitioners reported no difficulty in obtaining a license, 12 percent of the sample stated that they had difficulty. Practitioners in medium clinics reported the most problems in this area. Oromia and SNNPR reported the greatest difficulties in obtaining a license, as evidenced by the information in the following table.

Table 12 Number of Clinics Having Difficulty Obtaining a License by Facility and Region

Region	Higher	Medium	Small	Total
Tigray	0	0	0	0
Amhara	0	1	0	1
Oromia	0	2	1	3
SNNPR	1	2	0	3
Addis Ababa	0	0	0	0
Harari	0	1	0	1
Dire Dawa	0	0	0	0
Total	1	6	1	8

Reasons given for difficulties included bureaucratic procedures, difficulty in obtaining medical equipment specified in the *Guidelines*, difficulty in meeting the requirement of more than five years of practice for a physician, and difficulty in fulfilling the requirements regarding facility size and specifications. It appears that the procedures for obtaining a license were not the most difficult aspect, but meeting the requirements was.

The majority of licenses (48/56) were granted from 1996 to the present and the greatest number of licenses was granted in July, November, and December of those years.

The study evaluated whether the license and the fee schedule were visibly displayed in each health facility, according to the regulations found in the *Guidelines*. In the sample, 26 percent of facilities did not display their license and 51 percent did not display their fee schedules. Table 13 illustrates the results of the study in this regard. Higher clinics in the sample are more remiss in not displaying either their license (41%) or fee schedule (59%) in a clearly visible location. Among NGOs, 30 percent did not display fee schedules and 55 percent did not display their license in a visible place.

Thirteen facilities in the sample displayed neither their license nor their fee schedules, including eight facilities in Tigray (six higher clinics, one medium, and one small) and two facilities in Amhara (one higher and one small clinic). Oromia, SNNPR, and Harari regions each had one facility that did not display their documents.

Table 13 Number of Clinics Displaying Their License and Fee Schedules by Type of Clinic

Type of Facility	License Displayed			Fee Schedule Displayed		
	Yes	No	Total	Yes	No	Total
Higher Clinic	10	7 (41%)	17	7	10 (58.8%)	17
Medium Clinic	23	4 (14.8%)	27	12	16 (57%)	28
Small Clinic	9	4 (30.7%)	13	6	6 (50%)	12
Specialty Clinic	3	0	0	2	1 (33.3%)	3
NGO	5	6 (55%)	11	7	3 (30%)	10
Total	45	15 (25%)	60	27	33 (55%)	60

These results suggest that education and monitoring of licensed private practitioners need to be more effective so that these simple regulations can be followed for the benefit of patients

4.4 Services Provided

The study evaluated the types of services being provided by private facilities in the sample in order to determine the scope of private sector involvement in health care. Table 14 presents the findings of this study.

All clinics and NGOs in the study provide basic curative care. Minor surgery is performed in 53 percent of higher clinics, 37 percent of medium clinics, and 15 percent of small clinics in the sample. These results contradict the staffing norms and requirements for small clinics, which are not supposed to be performing surgeries.

The main finding in this table is that only a small proportion of private providers at all levels are providing preventive services, including childhood (14.7%) and tetanus toxoid immunizations (16%), family planning (26.5%), and antenatal care (1.5%). By contrast, a greater proportion of sample NGOs provided basic preventive services, such as vaccination (82%) and family planning (73%). However, no NGO in the sample provided antenatal care. Delivery services were not provided to large extent in the sample facilities.

Table 14 Proportion of Clinics in the Study Sample Offering a Particular Health Service

Service	All Clinics	Higher	Medium	Small	Specialty	NGO
Curative care	100%	100%	100%	100%	100%	100%
Tetanus toxoid immunization	16%	5.9%	10%	7.7%	33.3%	81.8%
Childhood immunizations	14.7%	5.9%	10%	7.7%	33.3%	72.7%
Family planning	26.5%	23.5%	20%	23%	33.3%	72.7%
Minor surgery	38.2%	52.9%	36.7%	15.3%	--	9.1%
Dental care	4.4%	11.8%	--	--	--	9.1%
Delivery	5.9%	11.8%	6.7%	--	--	9.1%
Health education	13.2%	--	20%	23%	--	9.1%
Antenatal care	1.5%	--	3.3%	--	--	--

There is a very high correlation between provision of tetanus toxoid and childhood immunizations in a particular facility (0.94), and a good correlation between provision of family planning and immunization services (0.4). This result suggests that if a facility offers one type of preventive service, it is likely to provide others. Surprisingly, there is a negative correlation between the provision of family planning services and antenatal care (-0.07), and a very weak correlation between family planning and delivery services (0.27), so that provision of family planning does not necessarily mean that supportive services are being provided together.

The survey findings suggest that the private sector is not a major provider of preventive and some basic health services, and this represents a missed opportunity to extend access to priority health services, such as antenatal care, family planning, and immunization services, to the population of Ethiopia. Clearly, there is much scope for greater collaboration between the public and private sectors in the provision of preventive health care services, particularly under the HSDP.

4.5 Activity Levels

The study also evaluated the number of patients seen in each facility and the number of beds available for emergency services. In general, the number of patient visits is highest for higher clinics and lowest for special clinics. The average number of patients per day for all clinics was 18.7, ranging from 3 to 120. Higher clinics had 20 patients per day on average, followed by 16 patients per day in medium clinics, 14 patients per day in small clinics, and 8 patients per day in special clinics. Monthly and yearly figures often were multiples of data collected on a daily basis, and not recorded or analyzed separately by providers.

Thus, higher clinics had approximately four more visits per day than medium clinics, with an extra investment of staff, equipment, facility, and supplies. Higher clinics may be providing much needed services in the community, however, low expected utilization rates may not justify licensing, since the cost of establishing a private clinic may not be compensated enough by patient load to become a viable enterprise.

Table 15 Summary of Activity Levels by Type of Clinic in the Sample

Type of Clinic	Patients/Day	Patients/Month	Patients/Year
Higher	20.2 (3-50)	570 (80 - 1,150)	6,058 (900 - 15,000)
Medium	16.47 (4-40)	413.7 (120 - 1,050)	5,271 (1,200 - 14,400)
Small	14.07 (3-50)	263.7 (90 - 578)	3,395 (1,080 - 6,935)
Special	8.3 (5-10)	216.7 (150 - 300)	2,440 (1,320 - 3,600)
All Clinics	18.7 (3 - 120)	450 (80 - 2,300)	5,308 (900 - 25,318)

Different trends emerge when evaluating activity levels by region. Table 16 shows that for Tigray and Amhara regions, patient loads can be higher for smaller clinics, which is contrary to the trend established in Table 15. The SNNPR has the highest number of patients per day for all clinics (21), and Addis Ababa has the lowest (less than 10 patients per day). The low figure for Addis Ababa could reflect the larger marketplace for health care providers there, so that patients have a greater choice. These results also raise the issue of the distribution of private practitioners in one area.

Table 16 Number of Patients/Day Type of Clinic and Region in the Sample

Type of Clinic	Higher	Medium	Small	Special	Average
Tigray	13.2	7	39	-	17.1
Amhara	20	23.6	13.3	10	18.8
Oromia	30	16.4	15	-	17.8
SNNPR	2	19.3	-	-	20.7
Addis Ababa	15	9	7.7	7.5	9.5
Harari	-	14	9.5	-	12.7
Dire Dawa	37.5	18.25	4	-	19.5

On average, facilities in the sample averaged six beds for emergency cases. Higher clinics averaged 6.1 beds (with a range between 2 to 12 beds). Medium clinics had 2.75 beds on average, ranging from 1 to 6 beds. Small clinics averaged 2.5 beds, ranging from 1 to 4 beds. Special clinics had 4.5 beds on average. NGOs in the sample had an average of four beds, ranging from one to eight beds.⁹

The average numbers of beds available in the sample facilities is in clear violation of the recommendations found in the *Guidelines*. For instance, small and medium clinics are not supposed to have any beds for emergencies, and higher clinics can have no more than five beds each. Clearly, the supervision and inspection of clinics has not been sufficient to detect variation from the recommended *Guidelines*.

4.6 Complaints Received

The survey inquired whether the public had made a complaint against a particular facility. A total of 14 complaints had been made against the sampled facilities (or about 23%). Table 17 illustrates the distribution of complaints by region. The greatest proportion of complaints was made in the SNNPR (44% of the sampled facilities), followed by Oromia (38% of sampled facilities).

⁹ One NGO facility in the SNNPR reported 73 beds and had received its license in 1978. This facility was removed as an outlier in the analysis.

Table 17 Complaints Received from the Public

Region	Yes	No	Total	Type of Clinic
Tigray	2 (22%)	7	9	Higher, small
Amhara	2 (20%)	8	10	Higher, small
Oromia	3 (37.5%)	5	8	Medium, small
SNNPR	4 (44.4%)	5	9	Higher, medium
Addis Ababa	2 (20%)	8	10	Higher, small
Harari	1 (14.3%)	6	7	Medium
Dire Dawa	0	8	8	
Total	14 (23%)	47	61	

Reasons for the complaints were varied and included distance to the facility is too great (19%), waiting time is too long (12.5%), service quality is poor (31%), drugs are not available (25%), and other complaints (12.5%). These complaints suggest that there is room for improving the quality of health care services provided in private facilities.

4.7 Suggestions for Improving the Guidelines

Respondents were asked to provide comments or suggestions for improving the Guidelines with regard to requirements for manpower, medical equipment, building and facility, pharmaceuticals and drugs, and obligations and responsibilities of owners/licensees. Responses were reviewed and the most prevalent and well-articulated are summarized below.

A Manpower

With regard to the manpower requirements for obtaining a license, respondents had the following suggestions:

- Specialists are not necessary to run higher clinics. Two general practitioners would be sufficient, given the shortage of specialist manpower available in some regions. In addition, emergency cases, particularly operations, are referred to public hospitals and other facilities.
- General practitioners are not necessary to run a medium clinic and qualified nurses should be able to be granted a license to open a private clinic.
- More night-duty nurses and health assistants are needed to provide higher quality inpatient care.
- Because of the expense and difficulty in obtaining X-ray machines, an X-ray technician should not be a mandatory personnel requirement for a higher clinic.

- Private facilities should be able to train their own auxiliary health personnel
- Government health workers should be allowed to work part time in private facilities during their leisure hours, without obtaining a release from government service
- In some regions, the scarcity of trained laboratory technicians makes it difficult to meet the staffing requirements regarding this type of personnel
- The manpower list in the *Guidelines* does not include requirements for midwives and radiologists
- The number of nurses should be increased to two, the number of health assistants to two, and the number of laboratory technicians to one in small clinics
- In medium clinics, one general practitioner, one nurse, and one laboratory technician are sufficient

B Medical equipment

With respect to the requirements for medical equipment, respondents had these suggestions and comments

- It is difficult to meet all of the requirements for medical equipment prior to obtaining a license Private establishments should be allowed to fulfill these requirements as their practice grows, within a specified period of time
- Other medical equipment needed include fetal stethoscope, emergency resuscitation kit, oral rehydration therapy set, health education materials, vaginal speculum, enema can and catheter, hematocrit, centrifuge, and electric boiler
- Medical equipment should be relevant and specific to the specialty of the clinic The standard of clinics is with regard to medical equipment in the developed world and does not take into account the prevailing realities of Ethiopia and the capacity of health professionals who own clinics
- All medical equipment listed is important, but in a rural clinic where the electricity supply is not reliable, the most delicate and expensive equipment should not be required
- Availability of medical equipment in the local market is problematic Equipment should be allowed to be imported duty-free
- The requirement for a photometer is very difficult to meet for a higher clinic

- There should be no limitations on the type of investigative or therapeutic medical equipment used for handling a patient, provided there is skilled manpower available to use the equipment. Restrictions should not be placed on the type of equipment to be used.
- The government should facilitate the purchasing and procurement of medical supplies. There are some problems in customs offices and in the central public health pharmacy. Bureaucratic management should be improved.
- Because the *Guidelines* require an autoclave, a sterilizer and electric boiler should be optional. If the facility does not provide delivery services, then delivery equipment should not be required.
- The medical equipment requirements for small clinics exceed those of government health units and should be made commensurate. For instance, sterilizers are required in private facilities, but are often not found in health centers.
- The list of medical equipment should be prioritized, with the most essential equipment required to obtain a license and optional equipment that can be purchased depending upon the intended services to be provided.
- The *Guidelines* have no policies regarding updating medical equipment and destroying the equipment that no longer works or is obsolete.

C *Building and facility*

With respect to the requirements for facility specifications, the respondents had these suggestions and comments for improving the *Guidelines*:

- Buildings that match the specifications outlined in the *Guidelines* are difficult to find, particularly for small clinics. Specifications are incompatible with buildings available on the market and with rental rates.
- Two examination rooms are not always necessary—one room can suit the purpose in higher clinics.
- Size specifications for the examination room and waiting area are too large. Size requirements for laboratory and the OPD are too small.
- The *Guidelines* should specify that examination and treatment rooms should be well-ventilated.
- Suggest reducing the size of the examination room in medium clinics from 20 square meters to 15 square meters.

- The number of rooms should not be limited and should relate to the capacity and services provided in the clinics
- Many of the clinics licensed are rented in buildings that were not designed for the purpose of housing a medical establishment
- Specifications should be more flexible and negotiable with the clinic owner, depending on the services that will be provided in the clinic and the market for facilities in the region or area
- The *Guidelines* should have specific criteria regarding the standard and general condition of the building, but specific dimensions, like height, should be left to the individual owner
- An additional room for the pharmacy, laboratory, and file room should be considered in small clinics

D Pharmaceuticals and drugs

With respect to the requirements for pharmaceuticals and drugs, the respondents had these suggestions and comments for improving the *Guidelines*

- Higher clinics that admit inpatients should be allowed to sell drugs
- Clinics should be allowed to dispense antibiotics, minerals, such as iron folate, anti-helminthic drugs, wound care supplies, IV fluids, antihistamines, fast-acting hypertensive drugs, atropine, anticonvulsants, emergency drugs, antimalarial drugs, psychotropic and narcotic drugs, and cough syrup, among others
- The list of drugs that can be dispensed by small clinics is very limited and should be expanded
- One of the reasons for low utilization of private clinics is that the drugs required are not always available, such as penicillin, analgesic, and antipyretic tablets
- Emergency drugs are not defined and should be part of the *Guidelines*
- If a clinic has its own pharmacist, it should be allowed to have its own pharmacy to dispense drugs
- Drugs in the central store are limited, but private practitioners are not allowed to import drugs. Drug shortages are a problem. Government and drug distributors do not provide private practitioners with drugs, which leads to procurement of drugs in side markets

- The government should allow provision of pharmaceuticals, medical equipment, and reagents from governmental sources, or arrange legal sources of these supplies

E Obligations and responsibilities

With regard to requirements for obligations and responsibilities, the respondents had these suggestions and comments for improving the *Guidelines*

- Government employees should be allowed to work in private clinics on a part-time basis in their spare time, without requiring a release form
- Bed requirements for medium clinics should be changed to three to five beds
- The obligation that requires a physician to have five years of experience prior to obtaining a license imposes difficulties. If a physician has a clearance to practice, s/he should also be allowed to have a license
- The RHBS should be more supportive and less faultfinding
- Obligations and responsibilities should be based on Ethiopian public health standards and principles
- Licensing of specialty clinics should be encouraged, such as neurology, ENT, OB/Gyn, ophthalmology, and EEC
- Encourage provision of preventive health services in private clinics
- While obtaining a license is difficult, working without a license is easy

F Other comments

- Part-time practice should be allowed and licensed
- The environmental quality of the site or location of the clinic should be considered, such as whether a music shop, bar, pharmacy, or drug store is nearby
- It is very expensive to fulfill the criteria and the requirements are the same regardless of whether the clinic will be located in a rural or urban area. Suggest different *Guidelines* for different localities
- Government health institutions should cooperate with private establishments

- A license should be legally recognized For instance, a patient who is diagnosed with a disease in a private facility should be allowed to present a paper from the private facility as proper documentation of the case The patient should not have to repeat the diagnosis in a public facility
- Opportunities should be given for private sector personnel to participate in training, seminars, and conferences, and newly-introduced medical findings should be shared with private practitioners in order to improve the quality of health services
- Private providers should be encouraged to provide family planning and immunization services, allowing that they have the appropriate manpower and facilities to do so
- Government offices should support private providers and make the latest medical information available to them
- Private institutions should be integrated into the national health plan
- Evaluation and guidance of private providers to ensure that proper care is rendered to the public is essential
- Information and epidemiological data should be shared between private institutions and the public sector Prevention and control of communicable diseases should be part of health services of the private sector, since cases detected are recorded daily Government support and encouragement in this respect is mandatory, particularly for diseases such as HIV/AIDS and tuberculosis
- Physicians should be consulted in the preparation [revision] of the *Guidelines*
- The strict obligation of having a release from government practice should be removed Part-time employment in the private sector should be allowed
- The five-year service of a physician prior to obtaining a license does not make sense, given that a physician has enough experience to discharge his responsibilities after graduation and is going to serve the population in government health facilities There is a double standard between public and private service
- The *Guidelines* are fine, but the main problem is the interpretation and applicability of them For instance, the majority of existing clinics work either without a license or without fulfilling the requirements
- The *Guidelines* do not include obligations with respect to prophylaxis measures, teaching, consulting, and information exchange

- Zones should be given authority to give a license, particularly for a higher clinic. There is no need for Regional Health Bureaus to license clinics, though there is a role at this level for licensing hospitals.
- All licenses should be processed and granted at the woreda level in order to save time and money and to decrease the workload at higher levels.
- The licensing process should be shortened and the bureaucracy limited. The time between submission of an application and an appointment for inspection is too long and a waste of time and resources.
- The problem is not granting licenses, but supervising clinics once licensed. "I have seen clinics admitting patients in containers, kitchens, and dirty houses, particularly in Addis." Another problem is that after giving a legal license, the treatment records of patients in private clinics are not accepted in government facilities and hospitals.
- The Ethiopian Medical Association should be involved in the licensing process to assure adequate quality of care, that malpractice is not taking place, and that high professional standards are being followed.

5 RESULTS FROM THE PATIENT SURVEY

The objective of the patient survey was to evaluate the quality of care received in private clinics that had been licensed by the different Regional Health Bureaus. A total of 330 questionnaires were completed for the patient survey. Fifty patient questionnaires were completed in each region except Addis Ababa, where 41 interviews were conducted, Harari, where 40 interviews were conducted, and Dire Dawa, where 49 interviews were conducted. Two facilities in Addis Ababa refused to grant permission for the survey team to conduct interviews with patients. Approximately 50 percent of respondents were interviewed in medium clinics, 33 percent were interviewed in higher clinics, and the rest of the interviews were conducted in small clinics.

Patients were asked a variety of questions regarding their perceived quality of care, the cost of their present visit, their choices regarding health care seeking, as well as personal characteristics, such as age, sex, and employment. Annex 3 contains a copy of the pre-tested questionnaires used for this study.

Not all respondents answered every question, either because they could not or did not want to. This study does not address response bias or the extent of sampling bias. Rather, the results should be considered indicative of the perceptions and beliefs of patients using private clinics.

5.1 Patient Characteristics

The main employment of respondents was analyzed. 24.6 percent were unemployed, 18 percent were merchants, 12.8 percent were farmers, and 18.7 percent had other types of employment. Only 5.6 percent of the sample were professionals or semi-professionals, who were equally divided between males and females. Over 80 percent of the merchants were male, and most of the unemployed respondents were female (91%). Civil servants in the sample were predominantly male (79.3%), as were farmers (80.5%).

The mean age of respondents was 32.8 years. The sample of male respondents (55.3%) was slightly older on average (35.6 years) compared to the sample of female respondents (29.5 years).

5.2 Patient Health Care-seeking Behavior

Most of the respondents (59%) visit private health facilities first when taken ill. This result is not surprising since interviews were conducted in private facilities and there may be a greater tendency among those clients to report using private clinics first. Table 18 illustrates that men reported greater rates of use of private clinics than women in the sample.

Table 18 Type of Facility Used for Treatment by Gender of Respondent

Type of Facility	Male	Female
Public (n=151)	49%	51%
Private (n=173)	60.7%	39.3%

The results also suggest that respondents in higher and medium clinics had a greater probability of visiting a private clinic first. However, for respondents in small clinics, they had a greater probability of using public facilities first. Patients using small private clinics do so only after first visiting public institutions where the cost of care may be less.

Table 19 Distribution of Source of Treatment in the Study Sample

Clinic	Public	Private	Self-Care	Total (n=324)
Hospital	26.5%	1.5%	--	28.1%
Health Center	16.0%	0.3%	--	16.4%
Health Station	0.6%	--	--	0.6%
Clinic	3.7%	49.4%	0.3%	53.4%
Pharmacy	--	1.2%	--	1.2%
NGO	--	0.3%	--	0.3%
Total	46.9%	52.8%	0.3%	100%

Table 19 shows the distribution of first choice of provider for the study sample. Private clinics were the first choice of the majority of the sample (53.4%), followed by public hospitals (26.5%) and public health centers (16%). Not surprising again is the preference of this particular sample for private clinics.

The data in Table 20 show differences in first choice preferences by region. For instance, the majority of respondents from Tigray, Amhara, Addis Ababa, and Harari clinics preferred to seek care first from public hospitals. Oromia, SNNPR, and Dire Dawa respondents preferred to seek care first from private clinics. Differences among regions may be due to variation in the availability of different types of providers.

Table 20 Distribution of Source of Treatment in the Study Sample

Region	Public	Private	Self-Care
Tigray	63.3%	36.7%	nil
Amhara	79.6%	20.4%	nil
Oromia	26.5%	73.5%	nil
SNNPR	8.0%	92%	nil
Addis Ababa	74.4%	25.6%	nil
Harari	64.1%	33.3%	28.2%
Dire Dawa	22.4%	77.6%	nil

5.3 Perceived Quality of Care

Respondents were asked several questions regarding the quality of the service rendered in the particular private clinic where they were interviewed and to speculate whether the price paid was commensurate with the quality of service. Table 21 reports the mean perception of quality by type of clinic, on a scale ranging from excellent (1) to poor (5). The mean value for quality is reported in the first column. Most clinics were rated either very good or good. Dire Dawa clinics were rated the highest (2.32), compared to Harari clinics (2.75).

Table 21 Perceived Quality of Care by Region and Type of Clinic

Region	Overall Score	Higher Clinic	Medium Clinic	Small Clinic
Tigray	2.38 (34)	2.3 (26)	2.75 (4)	2.5 (4)
Amhara	2.89 (45)	2.78 (9)	2.86 (22)	3.0 (14)
Oromia	2.67 (45)	2.4 (5)	2.66 (35)	3.0 (5)
SNNPR	2.50 (42)	2.43 (28)	2.64 (14)	N/A
Addis Ababa	2.68 (35)	2.56 (9)	2.57 (14)	2.83 (12)
Harari	2.75 (40)	2.56 (9)	2.69 (26)	3.4 (5)
Dire Dawa	2.32 (39)	2.4 (10)	2.2 (20)	2.7 (9)

Sample size in parentheses

Higher clinics in each region were rated as having slightly higher quality (lower figures) than medium and small clinics, which were uniformly rated lower (higher figures). Women rated the quality of private facilities less than male respondents did. For instance, the majority of men (49.4%) responded that their facility had very good quality, whereas the majority of women (56%) rated their facility as having good quality.

Table 22 shows that private facilities were generally rated as having slightly higher quality of care (2 49 compared to 2 65, respectively), although some respondents rated both public and private hospitals higher than clinics

Table 22 Quality of Care by Type of Health Facility

Facility	Public	Private	Self-care	Total
Hospital	2 54 (83)	2 0 (5)	N/A	2 5 (88)
Health Center	2 84 (49)	2 0 (1)	N/A	2 82 (50)
Health Station	3 0 (2)	N/A	N/A	3 0 (2)
Clinic	2 58 (12)	2 5 (158)	3 0 (1)	2 5 (171)
Pharmacy	N/A	2 5 (4)	N/A	2 5 (4)
NGO	N/A	2 0 (1)	N/A	2 0 (1)
Total	2 65 (146)	2 49 (171)	3 0 (3)	2 57 (320)

Sample size in parentheses N/A refers to not applicable in a specific case

Nearly 90 percent of respondents felt that payment was commensurate with the treatment received Table 23 shows that within each region, the majority of respondents believed payments were commensurate with service received However, there is no clear trend by type of clinic In Tigray, only 60 percent of respondents being treated in medium clinics thought payment and service were commensurate, however, in the SNNPR, 100 percent of medium clinic respondents felt that way

Table 23 Proportion of Respondents Who Believed the Level of Payment Was Commensurate to the Service Received

Region	Higher Clinic	Medium Clinic	Small Clinic
Tigray	76 9% (26)	60% (5)	100% (4)
Amhara	100% (9)	82 6% (23)	78 6% (14)
Oromia	100% (5)	88 6% (35)	100% (5)
SNNPR	92 9% (28)	100% (14)	N/A
Addis Ababa	88 9% (9)	88 6% (14)	91 7% (12)
Harari	100% (9)	100% (24)	100% (5)
Dire Dawa	90% (10)	85 0% (20)	88 9% (9)
Total	89 5% (96)	89 6% (135)	89 8% (49)

Sample size in parentheses, N/A refers to not applicable in a specific case

Respondents were asked whether they would return to the same facility for treatment Eighty-nine percent stated that they would, 11 percent would not Table 22 illustrates the result by type of facility, which shows that 94 percent of patients would come back to medium clinics, compared to 81 percent of patients in small clinics While both of these numbers are high, the lower value for smaller clinics suggests that either the quality of care they received was not as good as expected or there are other factors, such as cost, that would prevent patients from returning

Table 24 Percent of Respondents Stating They Would Return to the Same Provider for Treatment

Facility	Percent Stating they Would Return
Higher Clinic	85.2%
Medium Clinic	94%
Small Clinic	81.3%
Special Clinic	100%
Total	88.9%

5.4 Comparison between Public and Private Sectors

The survey explored how patients perceived differences between public and private facilities. Table 25 summarizes the main results. The main advantage of private facilities is less waiting time (35% of respondents). Better treatment (23%) and good reception of patients (4%) also were cited as advantages of private facilities. Surprisingly, availability of a physician and drugs were not characteristics rated very highly by the sample, though these are often cited as reasons why patients do not go to public facilities.

Table 25 Reasons for Preferring Private to Public Facilities

Characteristic	Number (n=300)	Percent
Better treatment	70	23.3%
Less waiting time	106	35.3%
Good reception of patients	13	4.3%
Good laboratory facilities	1	0.33%
Good facility overall	1	0.33%
Physician available	6	2.0%
Drugs available	3	1.0%
More privacy	2	0.67%
Other reasons	98	32.67%

6 CONCLUSIONS AND RECOMMENDATIONS

The assessment of the *MOH Guidelines for Licensing Private Clinics* has revealed much useful information on the implementation and application of the *Guidelines* at the regional level. The major findings of the assessment are as follows:

6.1 Regional Health Bureau

- The number of private clinics per 100,000 population varies by region, from a low of 0.64 in the SNNPR, to a high of 12.9 in Addis Ababa.

- Approximately 50 percent of health professionals working in private clinics do not have government release papers. Many practitioners are working on a part-time basis, for which there are no regulations.
- Supervision and monitoring of licensed private providers are weak and need to be improved by allocating more personnel to these functions at the regional or zonal level.
- Complaints have been received from the public about the quality of services provided by private practitioners, including high fees, unnecessary investigations, and prescriptions.
- Recordkeeping regarding the number and source of applications received is weak. An improved system needs to be established in all regions.

6.2 Private Providers

- Specialists were found working in medium and small clinics, which is a practice that contradicts the recommendations of the *Guidelines*.
- Twelve percent of the sample of private providers had difficulty obtaining a license. This problem was more common for medium clinics. Excessive waiting time between submission of application and appointment for inspection was mentioned, as well as the high cost of meeting all of the requirements.
- Contrary to regulations, 41 percent of clinics did not display their license and 59 percent did not display their fee schedules. These findings suggest that greater monitoring and supervision from either the RHB or the zonal level is required.
- All clinics provide basic curative services and many offer minor surgical care, however, very few facilities in the sample provided essential preventive services, such as immunizations, antenatal care, and family planning. This represents a missed opportunity to get the private sector involved in major public health priorities under the HSDP.
- Activity levels of some private providers appear low, which raises questions about the location/placement of the facility, the quality of care being provided, and the need for another health facility in an area. This aspect needs to be investigated more thoroughly.
- Many clinics were in violation of the recommendations of the *Guidelines* with respect to the number of beds authorized for each type of clinic.
- Complaints were received from the public in 44 percent of the facilities sampled, ranging from poor quality of care to lack of drugs to long waiting times. These complaints need to be addressed and followed up by the Regional Health Bureau. The *Guidelines* should include recommendations on how to proceed in cases of complaints or malpractice.

6.3 Patients Surveyed

- Interviews revealed that patients generally have a good opinion of private providers and would come back for further treatment. Female patients tended to be more critical of the service they received than male patients. Patients rated private clinics as having a slightly higher quality of care than public facilities.
- Patients in the sample tended to seek care from private facilities first. The majority chose to visit private clinics (53%), followed by public hospitals (27%). In Tigray, Amhara, Addis Ababa, and Harari regions, patients preferred public hospitals to private clinics, however, in Oromia, SNNPR, and Dire Dawa, patients chose private clinics first.
- For the most part, patients felt that fees were commensurate with the service given, however, in Tigray, this figure was reduced to 60 percent in medium clinics.
- Patients identified less waiting time (35%) and better treatment (23%) as factors that differentiate private facilities from public ones.

6.4 Revision of the *Guidelines*

There was a consensus that the *Guidelines* need to be revised. The main suggestions are reported below.

- With regard to manpower requirements. Regulations and guidance on part-time workers, on staffing patterns in general and in specialty clinics in particular, need to be addressed.
- With regard to medical equipment. Guidance on proper disposal, updating and upgrading of equipment, and preferred sources of procurement of equipment need to be addressed. In addition, many recommendations were made to prioritize and revise the current list of equipment to be more in line with local conditions and similar to that available in public health facilities of commensurate size.
- With respect to buildings and facilities, there was an overwhelming consensus among private providers and RHBs that the standards are difficult to meet, particularly when buildings are rented. The suggestion to revise the *Guidelines* to include minimum standards and conditions of facilities and to leave the details to a particular region or provider is a good one. The *Guidelines* need to consider regulations regarding the location of a private practice, such as environmental conditions, presence or absence of other health care providers (public and private), proximity to bars, restaurants, music halls, etc.
- With regard to pharmaceuticals and drugs, the *Guidelines* need to consider recommendations on drugs for emergency situations, address preferred sources for

procuring pharmaceuticals, and revise and strengthen the list of drugs that different clinics can dispense

- With respect to obligations and responsibilities, revision of the *Guidelines* needs to take into account moral and ethical responsibilities of private providers, perhaps by building on those outlined by the Ethiopian Medical Association. The *Guidelines* need to state the procedures for legal action in response to complaints and malpractice
- Finally, Regional Health Bureaus and private practitioners provided some useful recommendations for strengthening public-private partnerships with regard to health care provision. These include—
 - Encouragement of private sector practitioners to offer preventive services, such as family planning and immunization by RHBs
 - Integration of private providers into a national referral system, including use of epidemiological information from private providers into the public health statistics
 - Upgrading of skills and continuing education of private practitioners by the public sector
 - Inter-sectoral collaboration among the Regional Health Bureaus, central Ministry of Health, Investment Authority, Trade, municipalities, Ethiopian Medical Association, and others

ANNEXES

ANNEX 1

REGIONAL PROVIDER QUESTIONNAIRE

ASSESSMENT OF PRIVATE SECTOR GUIDELINES
Regional Health Bureau Questionnaire

The Ministry of Health, with the support of the BASICS Project is conducting a national assessment of the implementation of the Guidelines for Licensing Private Clinics. This assessment requires data collection from the Regional Health Bureau, selected private clinics, and patients. The results from this assessment will be presented and discussed at a national workshop scheduled for August 1998. Individuals involved in licensing private practitioners in the region should be responsible for filling out this questionnaire. Your cooperation in completing this form is greatly appreciated.

Region _____

Persons completing this form

Name	Position	Signature
_____	_____	_____
_____	_____	_____

1. What is the total number of health institutions in this region as of March 30, 1995 (GC)? What is the source of data used to answer this question? _____

Type of Institution	MOH	NGO	Private	Other	Total
Hospital					
Health Center					
Clinic					
Health Post					
Health Station					
Other (specify _____)					
Private Clinic					
- Higher					
- Medium					
- Small					
Private Clinical Laboratory					
- Higher					
- Medium					
- Small					
Private Radiologic Center					
- Higher					
- Medium					
- Small					
TOTAL					

5 What is the total number of health professionals working in private health institution in your region as of March 30, 1998 (G C)?

Type of Health Professional	Received License	Working in a Licensed Facility
Specialist		
General Practitioner		
Health Officer		
Nurse		
Health Assistant		
Laboratory Technician		
X-ray Technician		
Others (specify _____)		
TOTAL		

6 For each type of private practice, who received the license to establish the practice and how many health professionals work in this practice as of the time of receiving the license as of March 30, 1998 (G C)?

A Higher Clinics

Type of Health Professional	Received License (Number)	Number of Health Professionals Working There
Specialist		
General Practitioner		
Health Officer		
Nurse		
Health Assistant		
Laboratory Technician		
X-ray Technician		
Other (specify _____)		
TOTAL		

B Medium Clinics

Type of Health Professional	Received License (Number)	Number of Health Professionals Working There
Specialist		
General Practitioner		
Health Officer		
Nurse		
Health Assistant		
Laboratory Technician		
X-ray Technician		
Other (specify _____)		
TOTAL		

C Small Clinics

Type of Health Professional	Received License (Number)	Number of Health Professionals Working There
General Practitioner		
Health Officer		
Nurse		
Health Assistant		
Other (specify _____)		
TOTAL		

D Clinical Laboratories

Type of Health Professional	Received License (Number)	Number of Health Professionals Working There
Laboratory Technician		
Laboratory Technologist		
Other (specify _____)		
TOTAL		

E Radiologic Diagnostic Centers

Type of Health Professional	Received License	Number of Health Professionals Working There
Radiologist		
X-ray Technician		
Other (specify _____)		
TOTAL		

7 Do any health professionals employed by the government work outside of office hours in a private setting? If yes, estimate the proportion of total government employees work in a private setting

Yes _____ Proportion (%) _____ No _____

8 When were the Guidelines for Licensing Private Clinics received at the Regional Health Bureau? Month _____ Day _____ Year _____ (G C)

9 How many people are responsible for licensing private clinics at the Regional Health Bureau? What is their position or title?

Number _____ Position/Title _____

10 How many of the people responsible for licensing private clinics attended the workshop on the Guidelines in Nazareth in 1995 (G C)? Number _____

11 How many private licensed establishments have been supervised by the Regional Health Bureau in the previous six months (October 1, 1997 – March 30, 1998 GC)?

Type of Facility	Number Supervised in Previous Six Months
Higher Clinic	
Medium Clinic	
Small Clinic	
Clinical Laboratory	
Radiologic Diagnostic Center	
TOTAL	

12a What is the process of monitoring or supervising a private practice? _____

12b If the Regional Health Bureau does not monitor or supervise private practitioners, why not? _____

13 Do you find the Guidelines useful for your work? Please explain

14 How can the Guidelines be improved for each of the different topics covered? Use additional space if required

A Human Resource _____

B Medical Equipment _____

C Buildings _____

D Pharmaceuticals and Drugs _____

E Obligations and Responsibilities _____

F Other (specify _____) _____

15 Are there any articles in the Guidelines which need further clarification or explanation? Please describe _____

15 Do you have any other comments or suggestions for revising or updating the Guidelines? Please describe _____

16a Does the Regional Health Bureau require any additional technical support for licensing of private clinics? If yes, what type of support? Yes ___ No ___

16b Does the Regional Health Bureau require additional Guidelines? Yes ___ No ___
If yes, for which areas of licensing or for which types of private practitioners?

17a Has the Regional Health Bureau received any complaints about a private clinic from a government employee? Yes _____ No _____ If yes, what was the nature of the complaint(s)

17b Has the Regional Health Bureau received any complaints about a private clinic from the public? Yes _____ No _____ If yes, what was the nature of the complaint(s)

ANNEX 2

PRIVATE PROVIDER QUESTIONNAIRE

Annex 2

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ASSESSMENT OF PRIVATE SECTOR GUIDELINES
Private Provider Questionnaire

Number

1 Region _____

2 Zone _____

3a Name of private establishment _____

3b Title or position of respondent (should be owner) _____

4 Type of private establishment (check appropriate box which corresponds to the type of private establishment where the patient is being interviewed)

Higher Clinic Medium Clinic Small Clinic

NGO Facility

5 What is the number of health professionals currently employed by this private facility?

Type of Health Professional	Number Employed
Specialist	
General Practitioner	
Health Officer	
Nurse	
Health Assistant	
Laboratory Technician	
X-ray Technician	
Other (specify _____)	
TOTAL	

6 When did the health facility receive its license? (in G C) _____
Month/ Day Year

7 Did you have any difficulty in securing a license for this facility? Yes No

If yes, please explain _____

8a Is the license placed where it is clearly visible? Yes No

8b Is the fee schedule placed where it is clearly visible? Yes No

45

9. What type of services are provided by this health facility? (check all that apply)

- a Curative Care
- b Immunizations for women (TT vaccination)
- c Immunizations for children (measles, polio, DPT, BCG)
- d Family Planning
- e Minor Surgery
- f Other (please specify) _____

10. What is the average number of patients seen in this facility? (write number in box)

- a Per Day
- b Per Month
- c Per Year

11. Number of beds available for emergency cases?

12. How many patients occupied these beds in the last three months? (January 1 - March 30, 1998 G.C.)

13. Have any complaints about this private facility been made by the public?

Yes No

If yes, what was the nature of the complaint(s) _____

14. Do you have any comments or suggestions for improving the Guidelines for Licensing Private Clinics for each of the articles below?

a. Manpower _____

b Medical Equipment _____

c Building _____

d Pharmaceuticals and Drugs _____

e Obligations and Responsibilities _____

f Other (specify _____) _____

15 Do you have any additional comments on the Guidelines? _____

16 Do you have any suggestions for improving the licensing process? _____

ANNEX 3

PATIENT QUESTIONNAIRE

ASSESSMENT OF PRIVATE SECTOR GUIDELINES Patient Questionnaire

Number

1 Region _____

2 Zone _____

3 Name of private establishment _____

4 Type of private establishment (check appropriate box which corresponds to the type of private establishment where the patient is being interviewed)

Higher Clinic Medium Clinic Small Clinic

NGO Facility

5a What is your profession? _____

5b What is your age (in years)? _____

5c What is your gender? Male Female (check the right box)

6 Where do you usually go when you first get sick? (Check appropriate box)

a. Public or MOH facility b Private Facility

c Home or Self-Care d No Answer

6 What type of facility do you visit? (Answer this question only if (a) or (b) are marked in Question 5 above)

a Hospital b Health Center c Health Station

d Clinic e Pharmacy f Other (Specify _____)

7 What is your opinion of the quality of service provided by this private facility? (check the appropriate box)

Excellent Very Good Good Satisfactory Poor

8 Is the service rendered in this facility commensurate to the payment? (check the appropriate box)

Yes

No

If no, explain _____

9 Would you come back to this facility again for treatment in the future? (check the appropriate box)

Yes

No

If no, explain why not _____

10 How would you compare the quality of the service you received in private health facilities with the service you received in a public/government facility?

11 What is your opinion about the quality of service you received in this health facility?

ANNEX 4

ZONES VISITED DURING THE ASSESSMENT

Annex 4 Zones Visited during the Assessment

Region	Zones Visited in the Assessment
Tigray	Mekele and Central
Amhara	West Gojam (Bahir Dar) and N Gondar
Oromia	Arsi and East Shoa
SNNPR	Sidama and Gedeo
Addis Ababa	1,2,3,4, and 5
Harari	H1/K1, H1/K2, H1/K7, H2/K14, H2/K16, and H3/K10
Dire Dawa	H1/K2, H1/K4, H1/K5, K1/K6, H2/K8, H2/K16, and H3/K16